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The Status of Maternal Healthcare in India since Independence: A Historical Review

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Abstract

Maternal healthcare has been one of the most closely observed, and most unevenly realised, parameter of public health policy in India since 1947. This Research article traces the historical trajectory of maternal and child health policy across eight decades, from the community-health vision of the Bhole Committee and the family-planning dominated Five-Year Plan era, through the reproductive and child health reforms of the 1990s, to the National Rural Health Mission and Janani Suraksha Yojana launched in 2005, and the more recent insurance-based model of Ayushman Bharat. It delve on three key indicators - the Maternal Mortality Ratio (MMR), the Infant Mortality Rate (IMR), and the rate of institutional delivery, within this policy history and brings the data up to the most recent nationally representative estimates, drawn from the Sample Registration System and the National Family Health Survey. India's MMR has fallen from an estimated 1,287 per 100,000 live births in 1957 to 88 per 100,000 live births in 2021-23, while institutional delivery has risen from roughly a third of all births in the late 1990s to 88.6 per cent by 2019-21. The article argues that this transformation, though substantial, remains geographically and socially uneven, concentrated in a predictable set of high-burden states, rural districts, and marginalised communities, and closes by situating these gaps within ongoing scholarly debates about the adequacy of a facility-push, incentive-based model of maternal care.

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Introduction

Maternal healthcare occupies a peculiar place in the history of Indian public health. It is simultaneously one of the country's most publicised policy successes and one of its most persistent unfinished agendas. In the eight decades since independence, India has moved from a country where a woman's chance of dying from causes related to pregnancy and childbirth was among the highest in the world to one that is now declined to low, though has not yet reached, global benchmarks for safe motherhood. This transformation was neither linear nor evenly distributed. It unfolded through distinct policy eras, each shaped by the political economy and administrative priorities of its time, from the community health vision of the Bhole Committee in the 1940s (Government of India 1946), through the population-control-dominated decades of the 1960s to 1980s, to the rights and access-based reforms ushered in by the National Rural Health

Mission after 2005, and more recently the ambitious model of Ayushman Bharat. This article traces that trajectory, situating the well-known indicators of maternal and child health - the Maternal Mortality Ratio (MMR), the Infant Mortality Rate (IMR), and the rate of institutional delivery, within the broader arc of health policy since 1947, and brings the data up to the most recent nationally representative estimates available.

The Inheritance at Independence

When India became independent in 1947, its health infrastructure was weak, urban-biased, and overwhelmingly curative in orientation. The Health Survey and Development Committee, chaired by Sir Joseph Bhole had already documented the scale of the problem in its 1946 report. It highlighted a rural population with almost no access to trained birth attendance, widespread reliance on untrained dais

(traditional birth attendants), and mortality levels that were only crudely estimated because systematic vital registration hardly existed at the time (Government of India 1946). Later reconstructions of the historical data situate the Maternal Mortality Ratio in the range of well over 1,000 deaths per 100,000 live births during the 1950s, a level that would today be considered a humanitarian emergency. The Bhore Committee's recommendation of a three-tiered rural health system built around primary health centres became the focussed template that Indian Health planners would incorporate in modified form, for the rest of the twentieth century. Its immediate implementation, however, was constrained by the fiscal constraints of a newly independent state and by a political leadership more preoccupied with famine, partition-related displacement, and industrial development than with rural maternal care.

The Planning Era: Family Planning and Maternal Care (1951–1990)

The Five-Year Plans that structured Indian development policy from 1951 onward gave maternal and child health care, a place within a broader family welfare framework, but not the central place. In 1952, India became the first country in the world to adopt an official national family planning programme, and for the following three decades demographic control, driven by anxieties about population growth outpacing food supply and economic growth, consumed a large share of political attention and administrative energy within the health sector. Maternal and child health services existed, but largely as an adjunct to family planning delivery points rather than as a freestanding priority. Rural health infrastructure did expand steadily through the Primary Health Centre and Sub-Centre network as envisaged by the Bhore Committee, and this expansion, combined with general improvements in nutrition, sanitation, and female literacy, produced a slow but real decline in mortality. Reconstructed estimates suggest the MMR fell from roughly 1,287 in 1957 to about 892 by 1970, and to the 550–570 range by 1990 (Data For India, UN Maternal Mortality Estimation Inter-Agency Group [UN-MMEIG] 2025). Institutional delivery, by contrast, remained a marginal practice through this period with mostly home birth, attended in the majority of cases by family members or informally trained dais rather than a skilled birth attendant. This remained the norm across most of rural India as late as the early 1990s.

The 1990s: Reproductive and Child Health Programming Amid Structural Reform

The 1990s introduced two developments that would shape the next maternal health policy. The first was influenced by the 1994 International Conference on Population and Development in Cairo, Egypt. Indian policy began to shift away from a target-driven family planning model toward a broader Reproductive and Child Health (RCH) framework that treated maternal survival as one component of reproductive rights rather than an incidental outcome of fertility control. The second development was the economic liberalisation that began in 1991 that brought fiscal consolidation to public expenditure, including health. At the same time that new global commitments first the Cairo agenda, later the Millennium Development Goals adopted in 2000 were raising the political significance for taking care of maternal mortality. The first round of the National Family Health Survey (1992–93) offered India its first nationally representative, survey-based estimate of the MMR, placing it

at 424 per 100,000 live births, a figure that, however imprecise, made the scale of the problem visible in a way that hospital-based and indirect estimates had not (International Institute for Population Sciences [IIPS] 2022).

The National Rural Health Mission and Janani Suraksha Yojana (2005–2013)

The most consequential policy turn in the history of Indian maternal healthcare came in April 2005, with the launch of the National Rural Health Mission (NRHM). The NRHM was conceived as a systemic response to the weaknesses of the rural public health infrastructure: chronic underfunding, understaffed facilities, and poor last-mile connectivity between villages and functioning health centres (Ministry of Health and Family Welfare [MoHFW] 2005). Its most visible component was the Janani Suraksha Yojana (JSY), a conditional cash transfer scheme that paid pregnant women particularly those below the poverty line, and with a special focus on low-performing states. It was a cash incentive to deliver in a government or accredited private health facility rather than at home. JSY was administered alongside a new cadre of community health workers, the Accredited Social Health Activists (ASHAs), who received their own incentive payment for each successful facility delivery they facilitated. An early and widely cited impact evaluation found that JSY was associated with a substantial rise in both antenatal care visits and institutional delivery, alongside a reduction in early neonatal deaths. In 2011, the government supplemented JSY with the Janani Shishu Suraksha Karyakram (JSSK), which entitled every woman delivering in a public facility to a genuinely free delivery, marking a shift from a conditional-incentive model toward an entitlement-based one. This was a significant step in the history of improving the maternal health post-independence. It not only institutionalized the childbirth care but also worked as a motivation for the poor women across the country.

From NHM to Ayushman Bharat: Consolidation and the Integration

In 2013, the NRHM was subsumed, along with a newly created National Urban Health Mission, into a unified National Health Mission (NHM), extending the maternal and child health architecture built after 2005 to urban slum populations that had previously fallen outside its scope (Kumar 2021). A second major structural shift arrived in 2018 with Ayushman Bharat, which combined a network of Health and Wellness Centres intended to strengthen comprehensive primary care with the Pradhan Mantri Jan Arogya Yojana, a publicly funded health insurance scheme covering hospitalisation costs, including many obstetric complications, for a large share of poor and vulnerable households. Where the NRHM-era reforms had concentrated on getting women into public facilities for delivery, the Ayushman Bharat era has been more explicitly concerned with the financial protection dimension of maternal care and with strengthening primary-level services as the entry point into the integrated health system, as recommended by the various health committees in 20th C.

Infant Mortality Rate: Decades of Decline

The Infant Mortality Rate defined as deaths of children before their first birthday, per 1,000 live births, is one of the more reliably tracked indicators in the Indian health statistics system because it has long been reported through the Sample Registration System (SRS), a continuous large-scale

demographic survey run by the Office of the Registrar General of India (ORGI). The overall trajectory has been one of sustained decline, interrupted by periods of slower progress. India's IMR stood at roughly 110 per 1,000 live births as recently as 1981; four decades later it had fallen to

roughly a quarter of that level (ORGI). The pace of decline accelerated markedly after the mid-2000s, coinciding with the NRHM and JSY period, and continued through the 2010s alongside the broader child survival gains recorded under the National Health Mission.

Table 1: Infant Mortality Rate in India, Selected Years

Period/Source	IMR (per 1,000 live births)	Notable context
1981 (SRS)	110	Pre-liberalisation baseline
2014 (SRS)	39	Eve of intensified NHM push
2015–16 (NFHS-4)	41	Survey-based estimate
2019–21 (NFHS-5)	35.2	Marked decline over NFHS-4
2021 (SRS)	27	SRS Statistical Report 2021
2023 (SRS-based estimate)	~25 (rural 28/urban 18)	Persistent rural–urban gap

Despite this progress, India's IMR remains above the level associated with high-income health systems, and the composition of infant deaths has shifted: an increasing share now occurs within the neonatal period, and within that, in the first week of life, pointing to gaps in emergency new born care and referral rather than in basic access to a birth attendant (United Nations Inter-agency Group for Child Mortality Estimation [UN IGME] 2024). The persistent rural-urban gap indicates that geographic and infrastructural disadvantage continues to translate directly into differential survival chances for new-borns.

Maternal Mortality Ratio: From Independence to the Present

The Maternal Mortality Ratio refers to the number of maternal deaths for every 100 000 live births during the same time period resulting from pregnancy-related risks or aggravated causes. It has followed a similarly direction, if statistically harder to pin down, downward path. Because maternal death is a comparatively rare event, its measurement has always depended on either large pooled samples, as in the SRS's triennial bulletins, or on modelled international estimates, as produced by the UN Maternal Mortality Estimation Inter-Agency Group (UN MMEIG 2025). The two data streams do not always agree precisely, but they tell the same broad story.

Table 2: Maternal Mortality Ratio in India

Period	MMR (per 100,000 live births)	Source/Notes
1957 (reconstructed)	~1,287	Pre-SRS retrospective estimate
1990	556–570	Baseline for SDG/MDG comparisons
1997–98	398	First SRS triennial estimate
2004–06	254	Year JSY was launched (2005)
2014–16	130	Decade into NRHM/JSY implementation
2016–18	113	-
2018–20	97	First time below National Health Policy 2017 target of 100
2019–21	93	-
2022–24	87 (SRS)	Most recent SRS bulletin

By the most recent SRS bulletin, covering 2022–24, India's MMR stood at 87 per 100,000 live births, translating into roughly 22,000 to 24,700 maternal deaths annually depending on whether the SRS or the modelled UN/Lancet estimate is used (ORGI, UN MMEIG 2025). Both figures represent a decline of between 80 and 86 per cent since 1990, a rate of improvement that international comparisons place well ahead of the roughly 48 per cent global average reduction over the same period (Press Information Bureau [PIB] 2025). Eight states like Kerala, Maharashtra, Telangana, Andhra Pradesh, Tamil Nadu, Jharkhand, Gujarat, and Karnataka have already reached the Sustainable Development Goal target of an MMR below 70, while high-burden states such as Uttar Pradesh, Madhya Pradesh, and Assam remain well above the national average, illustrating that the aggregate national figure conceals very large subnational disparities (PIB 2025).

Institutional Delivery: The Central Policy Lever

If there is one indicator that captures the change in Indian maternal healthcare since 2005 most directly, it is the rate of institutional delivery i.e childbirth taking place in a hospital or other health facility under the supervision of trained staff, rather than at home. Nationally representative survey data show institutional delivery rising from roughly a third of all births in the late 1990s to around 90 per cent by the late 2010s, with the steepest gains occurring in the decade

following the launch of JSY. The National Family Health Survey's fifth round (2019–21) recorded institutional births at 88.6 per cent nationally, an increase of nearly ten percentage points over the previous round (2015–16), with a large share of that increase concentrated in public rather than private facilities (IIPS 2022). The remaining gap, however, is neither small nor evenly spread. NFHS-5 data show institutional delivery above 99 per cent in Kerala and Goa, while Nagaland, despite improving from 32.8 per cent (NFHS-4) to 45.7 per cent (NFHS-5), remained the lowest-performing state in the country (IIPS 2017, 2022).

Regional Disparities and Health Care Impact

Aggregate national indicators tend to understate the unevenness of India's maternal and child health transition. Three axes of disparity recur across the data. The first is regional. The historically termed Empowered Action Group states such as Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttarakhand, and Uttar Pradesh continue to record the country's highest maternal and child mortality burdens, a pattern that has persisted across every round of the NFHS since the 1990s (IIPS 2022). The second is the rural-urban divide, which remains roughly ten IMR points wide even as both rates have fallen. The third is social group as studies using successive NFHS rounds consistently find higher infant and child mortality among Scheduled Caste

and Scheduled Tribe households compared with the general population (Bango and Ghosh 2023). A further, less discussed indicator is maternal nutritional status: anaemia among pregnant women, at 52.2 per cent in NFHS-5, was higher than the 50.4 per cent recorded in NFHS-4, indicating that gains in facility-based delivery have not been matched by equivalent progress on the underlying nutritional determinants of safe pregnancy (IIPS 2017, 2022).

Interpreting the Transition: Policy Debates and Open Questions

The scale of improvement in India's maternal and child health indicators since 2005 is not seriously disputed, but its interpretation is contested in ways relevant to broader debates about the direction of Indian health policy. One line of critique questions whether a scheme built primarily around getting women into a facility for delivery was ever sufficient on its own to prevent maternal death. Most maternal deaths result from complications requiring timely emergency obstetric intervention rather than from home birth as such (World Health Organization South-East Asia Journal of Public Health [WHO SEARO] 2012). On this reading, the rise in institutional delivery is a necessary but not sufficient condition for further MMR decline. A second, related debate concerns financing. Several studies note that government health expenditure remains comparatively low in several of the highest-burden states, even as out-of-pocket expenditure on health remains substantial in better-performing states, raising questions about the financial sustainability and equity of the current mixed public-private model of maternal care as it continues to evolve under Ayushman Bharat. These debates remain open in the scholarly literature and are best understood as ongoing questions for policy design rather than settled conclusions.

Conclusion

Measured against where it stood in 1947, India's maternal healthcare system has been transformed. A Maternal Mortality Ratio in four figures has fallen to under 100 and an Infant Mortality Rate above 100 has fallen below 30; and institutional delivery, once a minority practice, is now close to universal in national aggregate terms. This transformation was not the product of a single policy but of a sequence of overlapping reforms emerging from the Bhole Committee's original infrastructural vision, the family-planning-dominated decades that partially crowded out maternal care, the rights-based reorientation of the 1990s, the demand-side and entitlement reforms of the NRHM-JSY-JSSK period after 2005, and the more recent turn toward insurance-based universal health coverage under Ayushman Bharat. What the data equally make clear, however, is that the remaining distance to India's own Sustainable Development Goal (SDGs) commitments is concentrated in a predictable and persistent set of places. A handful of high-burden states, rural districts with weak referral infrastructure, and socially marginalised communities whose access to quality obstetric and neonatal care still lags substantially behind the national average. Further historical regional research is needed to establish how far the current facility-push, insurance-linked model can close these remaining gaps on its own.

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