

When Reaching the Hospital Is Not Enough

Emergency Obstetric Care and the Limits of India's Progress

When India's maternal mortality ratio is cited in policy circles, the number that travels is 97 per 100,000 live births, the figure from the 2020 Sample Registration System. It represents a decline from 398 in 1997, and on a graph it looks striking. It should look striking. Three decades of public health investment, ASHA workers covering the last mile, JSY cash incentives pulling women into hospitals, LaQshya upgrading labour rooms. The architecture of intent has been genuinely ambitious.

But the story that number tells is incomplete, and in certain parts of India it is close to dishonest.

Assam recorded an MMR of 195 in the latest SRS data. Uttar Pradesh stood at 137 and Madhya Pradesh at 173. Kerala and Andhra Pradesh were at 30 each, figures comparable to high-income countries. The Empowered Action Group states account for roughly 75 per cent of all maternal deaths nationally. That gap is not statistical noise. It is the shape of a structural failure, one that has persisted across policy cycles and election cycles alike.

At the centre of that failure is a specific, under-examined deficit: the availability and quality of Emergency Obstetric Care.

What EmOC Is and Why It Matters

Emergency Obstetric Care refers to the set of medical interventions required when a delivery goes wrong. The WHO defines it through a package of nine signal functions, seven for Basic EmOC and two additional ones for Comprehensive EmOC. Basic facilities should be able to administer parenteral antibiotics, oxytocin and anticonvulsants, perform manual removal of the placenta and retained products, assist vaginal deliveries and resuscitate newborns. Comprehensive facilities add the capacity for caesarean sections and blood transfusions.

These are not exotic capabilities. They are the minimum required to address the complications that kill women: haemorrhage, sepsis, eclampsia, obstructed labour. In India, haemorrhage alone accounts for 47 per cent of maternal deaths. These deaths are preventable. Nearly all of them are preventable. That is what makes this a policy problem rather than a medical mystery.

The distinction between institutional delivery and Emergency Obstetric Care is one that India's public health discourse has not always been clear about. The JSY scheme was effective at doing one specific thing: pulling women out of home deliveries and into hospitals. Institutional

delivery rates rose from 78.9 per cent in NFHS-4 to 88.6 per cent in NFHS-5. That is a real and meaningful shift.

But arriving at a hospital and receiving emergency care are not the same thing. A woman who delivers at a sub-district hospital that lacks blood transfusion capacity or a functioning anaesthetist has technically had an institutional delivery. She has not had access to Emergency Obstetric Care in any meaningful sense.

The Infrastructure Problem

India has around 3,559 designated First Referral Units across its public health system. Of these, approximately 1,685 are operational in any functional sense, which works out to roughly 47 per cent. District Hospitals perform better at 85 per cent operational, but Sub-District Hospitals stand at 42 per cent and Community Health Centres at 22 per cent. The note that explains this gap in government data is quietly devastating: most facilities lack the obstetrician-anaesthetist dyad necessary to perform surgical procedures that define Comprehensive EmOC.

This is not a budget problem in isolation. It is a staffing and deployment problem. Specialists trained in urban medical colleges do not relocate to Mandla or Sheopur. Generalist doctors posted to rural CHCs cannot perform caesarean sections, not because of incapacity but because the system has not trained or equipped them to do it. The government has tried to address this through LSAS training, an 18-24 week course that upskills MBBS doctors in life-saving anaesthesia, and through CEmONC training for General Medical Officers. These are sensible initiatives. Their coverage remains thin.

The Three Delays Model, developed by Thaddeus and Maine in 1994, should no longer require introduction at a policy seminar. The first delay is in the decision to seek care, shaped by low awareness, gender inequality and financial constraint. The second is in reaching a facility, shaped by distance, terrain and transport access. The third is in receiving appropriate care once you arrive. Most of India's maternal health policy architecture has addressed delays one and two. The community ASHA, the JSY incentive, the 108 ambulance, the maternity waiting home: all of these operate at stages one and two.

Delay three receives considerably less attention. And delay three is where women die in facilities that should be saving them.

Who Is Paying the Highest Price

If you map who lacks access to functional EmOC in India, you get something that looks almost identical to a map of social exclusion. Rural women, tribal communities, Dalits, internal migrants, adolescents and the urban poor face the greatest barriers to emergency obstetric

care. This is not incidental. Access mirrors social hierarchies in ways that are structurally produced and politically sustained.

The child marriage data tells part of this story. NFHS-5 found that 23.3 per cent of women nationally had married before 18. In Bihar and West Bengal the figure was above 40 per cent. Early marriage means early pregnancy, and adolescent pregnancy concentrates obstetric risk in exactly the population that is least able to navigate a health system, least likely to identify warning signs and most likely to be delivering in an area where the nearest Comprehensive EmOC facility is non-functional or absent.

Anaemia in pregnancy deserves more attention than it typically receives in this discussion. NFHS-5 recorded anaemia among pregnant women at 52.2 per cent nationally, up from 50.4 per cent in NFHS-4. Among all women aged 15 to 49 it reached 57 per cent. A severely anaemic woman who haemorrhages during delivery has almost no physiological reserve. The malnutrition story and the EmOC story are not separate problems. They converge at the delivery table.

What the Evidence Shows Actually Works

The Jamkhed Project in rural Maharashtra offers a data point worth examining carefully. Despite 85 per cent home deliveries in the study area, maternal survival was high, and roughly 79 per cent of complications successfully reached hospitals through an NGO-coordinated referral network. The lesson is not that hospitals are irrelevant. It is that what saves lives is not a facility on a government register but a functional referral and emergency care network built around it.

What this kind of work demonstrates is something national data consistently obscures: the distance between a scheme on paper and functional care on the ground is large, and closing it requires sustained investment in human systems, coordination structures and community trust, not just physical infrastructure.

The Argument That Needs Making

India's progress on maternal health is real. An 83 per cent decline in MMR since 1990 outpaces the global average of 45 per cent. Institutional delivery rates have risen. Postnatal care coverage has improved. These gains should be acknowledged.

But SDG 3.1 targets an MMR below 70 per 100,000 live births by 2030. India is at 97. The states farthest from that target are the same states that have been farthest from it for decades. Closing that gap will not come from another round of coverage-oriented schemes. It will require confronting the specific failure around EmOC: the functional deficit in rural facilities, the specialist shortfall, the weak referral chains between Basic and Comprehensive EmOC

centres and the social exclusion that determines whose complications get treated and whose do not.

None of this is new in the literature. Thaddeus and Maine identified delay three in 1994. The signal function framework for measuring EmOC availability has existed since 2009. The state-level disparities have been documented in every NFHS round. What is missing is not knowledge. What is missing is the political and administrative commitment to treat Emergency Obstetric Care as the primary indicator of a health system's seriousness about maternal survival, rather than as a technical footnote beneath the institutional delivery numbers.

Dying from a postpartum haemorrhage because the nearest district hospital has no blood bank is a preventable death. It is also a traceable failure, traceable to specific staffing decisions, facility operationalisation gaps and referral system weaknesses that have identifiable custodians. The next phase of India's maternal health progress will require holding those gaps accountable, not just counting the hospitals they sit inside.

Key Data Sources

NFHS-5 (2019-21), IIPS and ICF | SRS Special Bulletin on Maternal Mortality (2018-20, 2020) | WHO Signal Function Framework (2009/2023) | MoHFW National Guidance Note on FRU Operationalisation (2021) | Thaddeus & Maine (1994), Three Delays Model