GOAL:5

IMPROVE MATERNAL HEALTH

5 ImproveMaternal Health

Target 6: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

5.1 Among the national socio-demographic goals for 2010 specified by the National Population Policy, several goals pertain to safe motherhood, 80 percent of all deliveries should take place in institutions by 2010, hundred percent deliveries should be attended by trained personnel, and the maternal mortality ratio should be reduced to a level below 100 per 100,000 live births. Empowering women for improved health and nutrition is one of the 12 strategic themes identified in the policy to be pursued either as stand-alone programmes or as intersectoral progr-ammes.

Maternal Mortality Ratio

5.2 International Conference on Popul-ation and Development in 1994 had recom-mended reduction in maternal mortality by at least 50 per cent of the 1990 levels by the year 2000 and further one half by the year 2015. As per the estimates available so far, there were 407 maternal deaths per 1, 00,000 live births at national level during 1998 as against 437 in 1991. Going by the estimated MMR level in 1991 the target for MMR under the Millennium Development Goal (MDG) for improving maternal health is quantified as 200 maternal deaths per lakh of live births by 2007 and 109 per lakh of live births by 2015. The Office of the Registrar General, India under the Ministry of Home Affairs, apart from conducting population census and monitoring of registration of births and deaths, has been evaluating indirectly the impact of governmental progra-mmes/schemes on fertility and mortality using the Sample Registration System (SRS). SRS is the largest demographic sample survey in the country and is being used to provide direct estimates of maternal mortality through a nationally repres-entative sample.

5.3 A Report based on the study carried out by the Registrar General, India, in collaboration with the Centre for Global Health Research University of Toronto, Canada provides estimates of maternal mortality for the period 1997-2003. The study shows that overall MMR which was in the vicinity of 400 in 1997-98, has come down to about 300 in 2001-03, thus registering a decline of 24 per cent during this period based on SRS data. Nearly two-third of the maternal deaths in the country are reported to occur in the EAG States and in Assam. The retrospective MMR surveys under the study for 1997- 1998 gives the all-India estimate of MMR during 1997-98 as 398 against 407 as per earlier estimate for 1998. The overall average rate of MMR decline during the period 1997-2003 has been, of 16 points per year. At this rate of decline, both the NRHM Goal of a MMR of 100 by 2012 and the MDG of 109 by 2015, may be difficult to achieve. The SRS has recently released data on MMR for the years 1997-1998, 1999-2001, 2001-2003.

- About two-thirds of maternal deaths occur in a handful of the states - Bihar and Jharkand, Orissa, Madhya Pradesh and Chhattisgarh, Rajasthan, Uttar Pradesh and Uttaranchal (the Empowered Action Group or EAG states) and in Assam.
- The overall relative decline of nearly 24 per cent during 1997-2001 includes a 16 per cent relative decline in the EAG states and in Assam. In contrast MMR has fallen by 7 per cent in the southern states of Andhra Pradesh, Karnataka, Kerala and Tamil Nadu.
- In 2001-03, the lifetime risk of a women dying of childbirth-causes is 1.8 per cent in the EAG states and in Assam, 0.4 per cent in southern states and 0.6 per cent in other states.

- Based on about 26 million births in 2004, nearly 78,000 maternal deaths are estimated (95%CI 74,000-82,000) in India in that year.
- The leading causes of maternal death have been, haemorrhage (38%), sepsis (11%), and abortion (8%).
- The risk of a female dying of maternal and non-maternal causes is higher in the rural areas or in an EAG state or in Assam. Low level of education among females specifically enhances the risk of maternal death appreciably.
- Only about 28 per cent of all births at 2003 occur in private or public institutions and increases in proportion have been slow from 1990.

Fig. 17

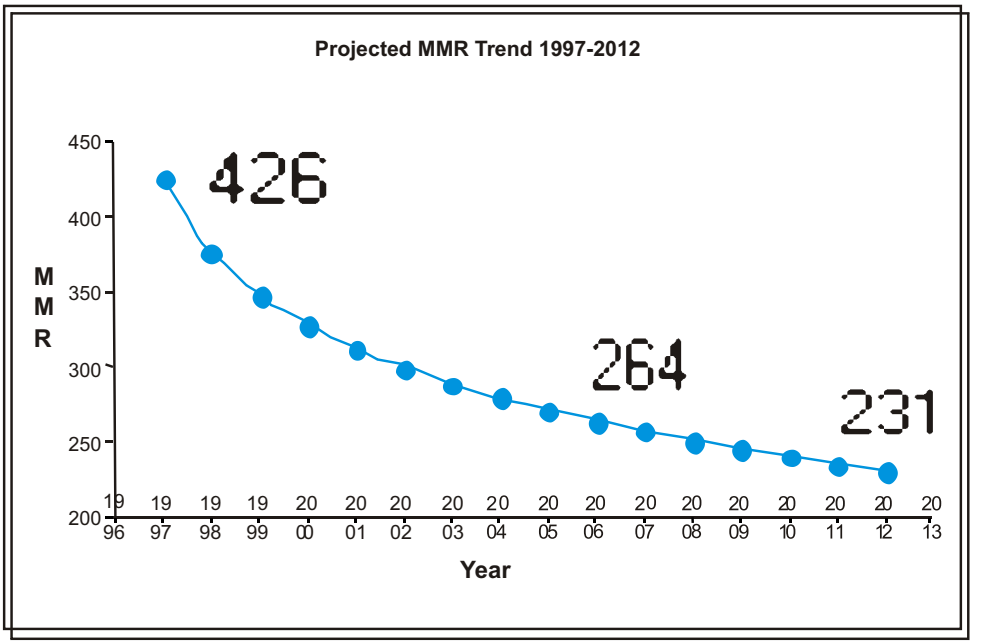
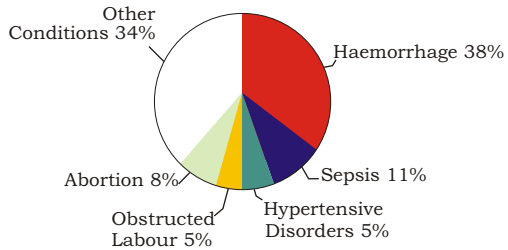


Table 5.1 : Maternal Mortality Ratio-State-wise

Major State	MMR (1997-98)	MMR (1999-01)	MMR (2001-03)
India Total *	398	327	301
Assam	568	398	490
Bihar/ Jharkhand	531	400	371
Madhya Pradesh/ Chhattisgarh	441	407	379
Orissa	346	424	358
Rajasthan	508	501	445
Uttar Pradesh/ Uttaranchal	606	539	517
Andhra Pradesh	197	220	195
Karnataka	245	266	228
Kerala	150	149	110
Tamil Nadu	131	167	134
Gujarat	46	202	172
Haryana	136	176	162
Maharashtra	166	169	149
Punjab	280	177	178
West Bengal	303	218	194
Others	-	276	235

*: Includes Other than Major States as well
(Source: RGI, (SRS), 1997-98, 1999-2001, 2001-03)

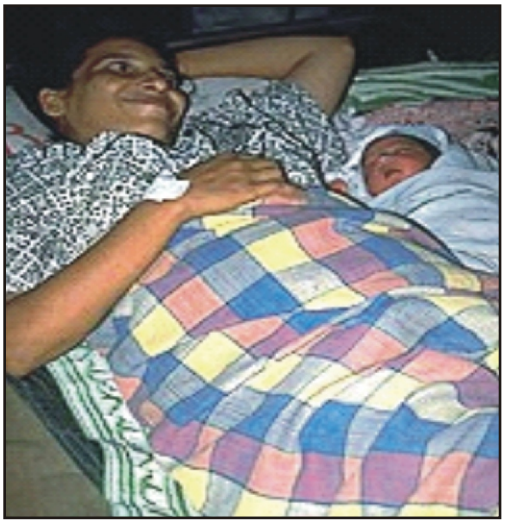
Fig.18
Causes of Maternal Death in India



5.4 The estimates of maternal mortality at State/ UT level not being very robust, MMR can only be used as a rough indicator of the maternal health situation in the country. Hence, it is desirable for a country like India that other indicators duly reflecting maternal health status like antenatal check up, institutional delivery and delivery by trained personnel, etc. is also compiled for monitoring.

5.5 In view of the high MMR of 301 per100,000 live births, the National Population Policy 2000 has set the goal of reducing MMR to less than 100 per 100,000 live births by the year 2012, end year of the National Rural Health Mission. Several specific initiatives are under implementation to address this issue. These are under implementation in all States and UTs since 1992 (CSSM) and later during Reproductive and Child Health programme, Phase I and also in the Phase II. These interventions pertain to improving Essential Obstetric Care; Emergency Obstetric Care; cash assistance to pregnant women from poor families to go to a health centre for treatment and management of complications of pregnancy; provision of drugs and equipment at Sub-centre, PHCs and First Referral Units (FRUs); provision of

contractual staff- Medical manpower including specialists like Anest-hetists and Gynecologists as well as paramedical staff for providing obstetric and newborn as well as child care. Funds were also provided to the states and UTs for making available 24 hours delivery services at selected Primary Health Centres and Community Health Centres. Focus was made on training of dais (traditional Birth Attendant). In order to increase access, funds have been provided for organizing Reproductive and Child Health camps in remote and under utilized Primary Health Centres in all districts of weak / EAG States.

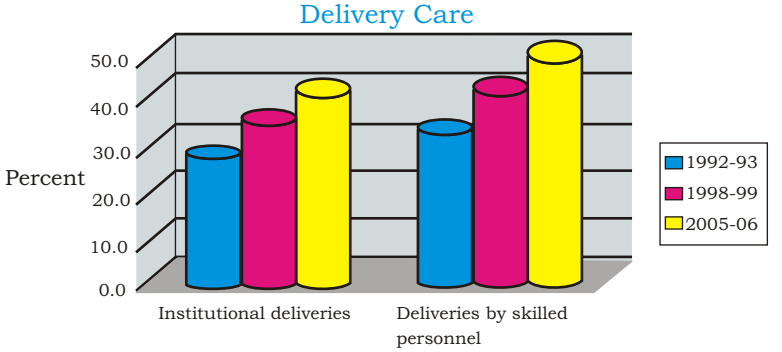


5.6 The results of the RCH household surveys carried out in all 593 districts and the results of the National Family Health Surveys, the latest being the NFHS-III (2005-06), reveal that there has been improvement in provision of ante-natal care, institutional and safe deliveries and postnatal care. There are however some critical gaps in the delivery of services causing impediments to attaining the national health policy goal. The State-wise details of the key maternal health indicators are given at Table 5.4.

Table 5.2: Proportion of Antenatal Care and Safe Deliveries

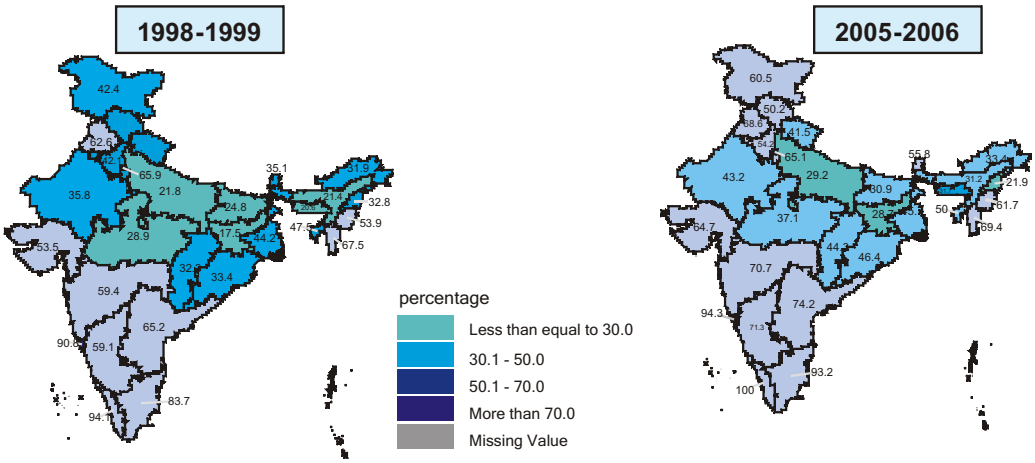
Indicator		NFHS-I 1992-93	NFHS-II 1998-99	NFHS-III 2005-06
1.	**Antenatal Care**			
i)	Any Visit	62.3	65.4	
ii)	Three visits	43.9	44.2	50.7
2.	**Deliveries**			
i)	Institutional	26.1	33.6	40.7
ii)	Safe Deliveries	33.0	42.4	48.3
3.	**TT (Pregnant Women)**	53.8	66.8	

Fig.19
Delivery Care



Source: Ministry of Health and Family Welfare

Fig. 20
Deliveries by skilled health personnel



5.7 The background characteristics of delivery care as revealed from the DLHS-II (2002-04) show that only 19 percent of deliveries took place in government health institutions, 22 percent in private health institutions and a large proportion of births (59%) took place at home. More than 69% of deliveries in urban and only 30% of the deliveries in rural areas took place in health institutions. Overall, 12% of deliveries at home were attended by health professional. The percentages of births attended by health professional are more among the women below age 30 than among women aged 30 or more. Births to women who had completed 10 or more years of schooling have three times higher deliveries attended by health professionals than that of the non-literate women. Less than half of the births are safe in India. In urban areas more than three-quarter (76%) of the deliveries were safe as against little less than two-fifths (37%) in rural areas.

Interventions for reducing Maternal Mortality and Morbidity

5.8 With a view to increase access to quality health care including services in Immunization and Safe Motherhood, Government has launched the National Rural Health Mission (NRHM) in the year 2005 with special emphasis on rural population throughout the country. Eighteen states which have weak public health indicators and/or weak infrastructure have been identified as high focus states. These States are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh. The Mission will operate over a period of seven years from 2005 to 2012.

5.9 Under the NRHM (2005-2012) and the RCH Programme Phase-II (2005-10) the Government of India is actively pursuing the goals of reduction in Maternal Mortality by focusing on the 4 major strategies of essential obstetric and new born care for all, skilled attendance at every birth, emergency obstetric care for those having complications and referral services. The other major interventions are provision of Safe Abortion Services and services for RTIs and STIs.

5.10 **Essential Obstetric Care:**

This includes antenatal care, institutional

safe delivery services and post natal care. For timely and early detection of emergencies it is of utmost importance that minimum of three ante-natal checkups be conducted wherein all the components of essential obstetric care be provided to the women. Government has instructed all states and UTs to focus on these services and monitor it closely.

- **Provision of 24 Hrs Delivery Services at PHC:** Under RCH – II, all the CHCs and 50% of the PHCs are proposed to be operation-alized for providing round the clock delivery services. The States and UTs have been advised to make a comprehensive plan and the central Government is investing large amount of money for operationalising these PHCs.
- **Post natal care for mother and newborn:** Ensuring post natal care within first 24 hours of delivery and subsequent home visits on day 3 and 7 are the important components for identification and manage-ment of emergencies occurring during post natal period. The ANMs, LHVs and staff nurses are being made aware of and also oriented for tackling emergencies identified during these visits.

5.11 **Provision of Emergency Obstetric and Neonatal Care at FRUs** by operationalising all FRUs in the country. While operation-alization, the thrust should be on the critical components such as manpower, blood storage units and referral linkages etc. Availability of trained manpower (Skill Based Training for MBBS doctors) should be linked with operationalization of FRUs

5.12 **Skilled Attendance at Birth:** To manage and handle some common obstetric emergencies at the time of birth, the Government of India has taken a policy decision to permit Staff Nurses and ANMs to give certain injections and also perform certain interventions under specific emergency situations to save the life of the mother. There is a commitment to provide skilled attendance at every birth and for implementing this we first need to train our SNs / ANMs as SBAs who can function at community level.

5.13 **Referral Services at both Community and Institutional level.** Establishing referral linkages between the community and First Referral Units (FRUs) is an essential component for utilization of services particularly during Emergencies. Since emergencies during the process of birth can not be predicted, it is essential to place effective referral linkages which can be accessed by all pregnant women in case of emergency.

5.14 **Training of MBBS Doctors in Life Saving Anesthetics Skills for Emergency Obstetric Care**

Provision of adequate and timely Emergency Obstetric Care (EmOC) has been recognized globally as the most important intervention for saving lives of pregnant women who may develop complications during pregnancy or childbirth. The operationalization of First Referral Units, at sub- district i.e. CHC level for providing EmOC to pregnant women is a critical strategy of RCHII, which needs focused attention. It has not been possible to operationalise these FRUs till now due to various factors most pertinent being shortage of specialist manpower, i.e. Gynecologist and Anesthetist, particularly at district and sub district level. In view of this, for effective and better management of Emergency Obstetric needs at the grass

root level, Government of India has taken a policy decision and is implementing 18 weeks programme for training of MBBS doctors in anesthetic skills for Emergency Obstetric care at FRU. The training shall be undertaken for only that number of MBBS doctors who are required for the operationalisation of FRUs and CHCs and shall be limited to the requirement of tackling emergency obstetric situations only. In no way, will it be a replacement of the specialist anesthetists who are working after pursuing degree / diploma in the subject. Guidelines for the training programme have been disseminated to the States for taking initiatives in identifying the medical colleges in the state where this training programme can be conducted. Training is already underway and till March 2007, 41 doctors have been trained in Life Saving Anesthetic Skills and are successfully practicing these skills.

5.15 **Obstetric Management Skills**

Government of India has also introduced training of MBBS doctors in Obstetric Management Skills in collaboration with Federation of Obstetric and Gynecological Society of India. A 16 weeks training programme in obstetric management skills including Caesarian Section operation is being implemented.

5.16 **Safe Abortion Services/ Medical Termination of Pregnancy (MTP):**

It is an important component of the ongoing RCH Programme and it is one of the means of reducing maternal mortality. 8% of the maternal deaths are due to unsafe abortions. For expanding and strengthening safe abortion services under RCH Programme, the MTP Act and Rules have been amended in 2002-03 for delegation of powers to recognize MTP centres to the district. Provision of MTP services at 24 X 7 PHCs, CHCs and FRUs are being strengthened by training of medical manpower in techniques of MTP by the States.

Table 5.3: Medical Termination of Pregnancy performed over time

Year	Number of institutions approved for MTP	Number of medical termination.
1980-81	3294	3,88,405
1991-92	7121	6,36,456
1994-95	8511	6,27,748
1997-98	9119	5,12,823
1999-00	9645	7,39,975
2000-01	9806	7,25,149
2001-02	9223	7,70,114
2002-03	10633	7,44,680
2003-04	11032	7,63,126
2004-05	11668	6,99,298

5.17 **Provision of RTI/STI services at all FRUs, CHCs and at 24 X 7 PHCs is also being made under RCH II**

Convergence with the National AIDS Control Programme (NACP) is envisaged in provision of these services, in terms of utilization of services for case management, laboratory services, counseling services, drugs, equipments, blood safety etc.

5.18 **Prophylaxis and treatment of Nutritional Anaemia:**

As per results of NFHS III (2005-06), 56.1% of ever married women aged 15-49 years are Anaemic. The problem is more sever during pregnancy, with 57.8% of pregnant women (15-49 years) being anaemic. A programme for prophylaxis

Setting up of Blood Storage Centers at FRU

Timely treatment for complications associated with pregnancy is sometimes hampered due to nonavailability of Blood Transfusion services at FRU. To facilitate establishment of Blood Storage Centers at FRU, the Drugs and Cosmetics Act has been amended. Government of India under RCH-II will provide guidelines for funding and procurement of equipment.

and treatment of anaemia has been under implementation through out the country since 1997-98. Under this programme all pregnant and lactating women are provided with one tablet (containing 100 mg of elemental iron and 5 mg of Folic Acid) daily for 100 days. Those who have severe anaemia are provided with double dose of these tablets.

5.19 **Janani Suraksha Yojana**

Janani Suraksha Yojana (JSY) is a safe motherhoodintervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. The Yojana, launched on 12th April 2005 is being implemented in all states and UTs. JSY is a 100 % Centrally Sponsored Scheme.

(a) The Yojana has identified ASHA, the Accredited Social Health Activist as an effective link between the Government and the poor pregnant women in l0 low performing states, namely the 8 EAG states and Assam and J&K, the remaining NE States and tribal and hilly districts of all other States. Her main role is to facilitate pregnant women to avail services of maternal care and arrange referral transport.

(b) The scheme focuses on the poor pregnant woman with special dispensation for states having low institutional delivery rate namely, the States of Uttar Pradesh, Uttar-akhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Orissa, Rajasthan and Jammu and Kashmir

5.20 **Village Health and Nutrition Day**

Organizing of Village Health & Nutrition Day (VHNDs) at Anganwadi center at least once every month to provide ante natal/ post partum care for pregnant women, promote institutional delivery and health education apart from other various services. As per information from the states 19.95 lakhs of VHNDs have been organized till March 2007.

5.21 **Indian Public Health Standards (IPHS):**

Implementation of Indian Public Health Standards (IPHS) for Primary Healthcare Facilities, will ensure quality of services by providing infrastructure, equipments and specialist man-power.

Accredited Social Health Activist (ASHA)

- ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services. She would be a promoter of good health practices. She will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals. Her roles and responsibilities would be:
- ASHA will take steps to create awareness and provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health & family welfare services.
- She will counsel women on birth preparedness, importance of safe delivery, breastfeeding andcomplementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child.
- ASHA will mobilize the community and facilitate them in accessing health and health related services available at the village/sub-center/primary health centers, such as Immunization, Ante Natal Check-up (ANC), Post Natal Check-up (PNC), ICDS, sanitation and other services being provided by the government.
- She will work with the Village Health & Sanitation Committee of the Gram Panchayat to develop a comprehensive village health plan.
- She will arrange escort/accompany pregnant women & children requiring treatment/ admission to the nearest pre- identified health facility i.e. Primary Health Centre/ Community Health Centre/ First Referral Unit (PHC/CHC /FRU).
- ASHA will provide primary medical care for minor ailments such as diarrhoea, fevers, and first aid for minor injuries. She will be a provider of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme.
- She will also act as a depot holder for essential provisions being made available to every habitation like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc. A Drug Kit will be provided to each ASHA. Contents of the kit will be based on the recommendations of the expert/technical advisory group set up by the Government of India.
- Her role as a provider can be enhanced subsequently. States can explore the possibility of graded training to her for providing newborn care and management of a range of common ailments particularly childhood illnesses.
- She will inform about the births and deaths in her village and any unusual health problems/ disease outbreaks in the community to the Sub-Centres/Primary Health Centre.
- She will promote construction of household toilets under Total Sanitation Campaign.
- Fulfillment of all the se roles by ASHA is envisaged through continuous training and upgradation of her skills, spread over two years or more.

5.25 **National Population Policy (NPP)** brought out in February 2000, inter-alia, represents the commitment towards (a) voluntary and informed choice and consent of citizens while availing of reproductive health care services and (b) continuation of the Community-Needs-Assessment approach in administering family planning services. The NPP 2000 provides a policy framework for advancing goals and prioritising strategies during the current decade to meet Reproductive and Child Health (RCH) needs of the people to bring the Total Fertility Rate (TFR) to 2.1 by 2010 to achieve the replacement level. It is based upon the need to simultaneously address issues of child survival, maternal health, and contraception while increasing outreach and coverage of a comprehensive package of reproductive and child health services by the government, industry and the voluntary and non-government sector.

Demographic goals in NPP 2000

a) Address the unmet needs for basic reproductive and child health services, supplies and infrastructure;

b) Reduce IMR to below 30 per 1000 live births;

c) Reduce MMR to below 100 per 100,000 live births;

d) Achieve universal immunisation of children against all vaccine preventable diseases;

e) Achieve 80 per cent institutional deliveries and 100 per cent deliveries by trained persons;

f) Achieve counseling and services for fertility regulation and contraception with a wide basket of choices.

g) Integrate Indian System of Medicine (ISM) in the provision of RCH services and in reaching out to households; and

h) Promote vigorously the small family norm to achieve replacement level of TFR.

Table 5.4

KEY INDICATORS OF MATERNAL HEALTH (INDIA) – COMPARISON NFHS 1, 2 & 3

Name of States	Population Covered	Any ANC			Three ANC			Institutional Delivery			IFA tablets Consumed for 90 days			Birth Attended by SBA(Doctor, Nurse, LHV, ANM, other health personnel			PNC within 2 days		
		N 1	N 2	N 3	N 1	N 2	N 3	N 1	N 2	N 3	N 1	N 2	N 3	N 1	N 2	N 3	N 1	N 2	N 3
Bihar	Urban		67.0	53.0			36.2		39.0	48.0			24.7			56.1			33.0
	Rural		32.0	32.0			14.5		13.0	19.0			7.9			27.6			13.1
	Total		34.0	34.0		15.9	16.9		15.0	22.0			9.7		24.8	30.9			15.3
Jharkhand	Urban		70	86			67.1		41	54			25.9			28.7			44.0
	Rural		36	55			28.8		8	11			11.9			62.2			10.5
	Total		42	61		24.5	36.1		14	19			14.6		17.5	28.7			17.0
Uttar Pradesh	Urban		63	79			40.9		37	40			16.4			50.5			9.9
	Rural		29	64			22.6		11	18			6.7			23.8			31.1
	Total		35	67		14.6	26.3		15	22		20.7	8.7		21.8	29.2			14.2
Uttaranchal	Urban		82	92			71.5		42	60			43.0			64.6			52.3
	Rural		36	69			36.2		16	29			20.8			34.4			23.1
	Total		45	75		19.7	44.8		21	36			26.2		34.6	41.5			30.2
Madhya Pradesh	Urban		83	93			58.4		53	60			20.2			66.4			53.4
	Rural		57	77			34.6		13	20			9.2			28.0			20.1
	Total		63	81		27.1	40.2		22	30			11.8		28.9	37.1			27.9
Chhatisgarh	Urban		87	97			82.3		32	58			32.1			74.0			63.6
	Rural		51	88			49.2		10	8			19.7			38.5			17.6
	Total		57	89		33.2	54.7		14	16			21.8		32.3	44.3			25.3

Name	Population Covered	Any ANC			Three ANC			Institutional Delivery			IFA tablets Consumed for 90 days			Birth Attended by SBA(Doctor, Nurse, LHV, ANM, other health Personnel			PNC within 2 days		
		N 1	N 2	N 3	N 1	N 2	N 3	N 1	N 2	N 3	N 1	N 2	N 3	N 1	N 2	N 3	N 1	N 2	N 3
Rajasthan	Urban	51	71	92			74.7	34	48	68			30.7			77.0			21.7
	Rural	30	43	71			32.5	8	15	23			8.1			34.6			56.8
	Total	33	49	76	18. 1	23.6	41.2	12	22	32			12.8	19.3	35.8	43.2			28.9
Orissa	Urban	80	88	95			79.2	41	55	65			42.0			68.9			35.9
	Rural	62	80	86			58.0	10	19	35			31.4			42.9			54.1
	Total	64	81	87	34.9	48.0	60.9	14	23	39			32.8	19.0	33.4	46.4			38.3
J & K	Urban		96	95			90.5		74	76			35.1			83.0			73.0
	Rural		82	82			69.9		28	49			25.5			54.8			41.4
	Total		84	85		67.2	74.2		36	54			27.5		42.4	60.5			48.0
Himachal Pradesh	Urban	95	97	93			76.2	60	72	79			46.9			78.4			52.3
	Rural	75	85	90			61.2	14	25	42			37.7			47.6			39.6
	Total	76	86	90	41.0	61.6	62.6	17	29	45			38.6	25.6	40.2	50.2			40.8

N 1-1992-93,

N 2-1998-99,

N 3-2005-06.

Name of States	Population Covered	Any ANC			Three ANC			Institutional Delivery			IFA tablets Consumed for 90 days			Birth Attended by SBA(Doctor, Nurse, LHV, ANM, other health personnel			PNC within 2 days		
		N1	N2	N3	N1	N2	N3	N1	N2	N3	N1	N2	N3	N1	N2	N3	N1	N2	N3
Assam	Urban	83	89	87			68.9	52	60	59			31.1			62.4			37.1
	Rural	50	59	69			32.3	8	15	18			13.7			27.5			10.9
	Total	53	60	71	24.9	30.9	36.3	12	18	23	24.9	30.9	15.6	18.0	21.4	31.2			13.8
Arunachal Pradesh	Urban	90	79	79			56.6						24.3			65.4			43.4
	Rural	44	58	51			28.3						6.6			20.8			15.2
	Total	51	61	59	31.9	40.9	36.4	20	31	31			11.6	22.0	31.9	33.4			23.3
Nagaland	Urban	84	81	84			57.9						90			54.3			30.5
	Rural	49	56	49			23.9						18			17.9			5.7
	Total	39	60	57	15.0	21.9	31.6	6	12	12			3.5	18.9	32.8	25.9			11.3
Manipur	Urban	78	91	95			85.9						21.8			85.2			70.1
	Rural	58	75	85			64.0						10.8			52.8			40.9
	Total	88	88	88	41.3	54.7	70.1	23	35	49			13.9	39.9	53.9	61.7			49.1
Meghalaya	Urban						81.0						32.7			78.1			68.5
	Rural						47.8						13.3			22.2			20.7
	Total	55	54	68	41.4	32.0	53.4	31	17	30			16.6	37.9	20.6	31.7			28.8
Mizoram	Urban	93	100	88			75.1						34.0			91.1			72.1
	Rural	86	85	62			41.3						16.4			47.4			32.0
	Total	90	92	75	69.2	75.1	57.8	49	58	65			25.0	62.2	67.5	69.4			51.5
Tripura	Urban	98	88	86			72.5						33.3			79.7			30.4
	Rural	60	67	78			56.5						16.3			45.4			26.1
	Total	66	70	79	38.4	47.2	58.7	70	45	49			18.6	32.2	47.5	50.0			26.7
Sikkim	Urban		97	99			96.1		58	88			58.8			92.4			82.4
	Rural		68	89			65.0		28	43			36.2			50.2			42.9
	Total		72	90		44.1	69.4		32	49			39.4		35.1	58.8			48.5

N1-1992-93,
N2-1998-99,
N3-2005-06.

Name of States	Population Covered	Any ANC			Three ANC			Institutional Delivery			IFA tablets Consumed for 9 0 days			Birth Attended by SBA(Doctor, Nurse, LHV, ANM, other health personnel			PNC within 2 days		
		N1	N2	N3	N1	N2	N3	N1	N2	N3	N1	N2	N3	N1	N2	N3	N1	N2	N3
Tamil Nadu	Urban	97	99	100			98.5	91	93	95			47.9			96.4			93.0
	Rural	95	98	98			94.8	50	73	87			39.2			90.6			86.6
	Total	96	98	99	88.4	90.9	96.5	64	79	90			43.2	69.3	83.7	93.2			89.6
Maharashtra	Urban	92	95	97			86.3	75	81	85			30.5			87.6			70.4
	Rural	80	88	90			65.5	26	35	61			30.5			56.5			48.7
	Total	85	91	93	63.3	66.2	75.3	45	53	66			30.5	53.1	59.4	70.7			58.8
Karnataka	Urban	89	94	95			96.9	68	79	85			79.2			100.0			91.1
	Rural	86	84	88			92.4	27	39	57			76.3			99.5			86.1
	Total	87	87	91	95.4	98.6	93.9	39	51	67			77.3	90.2	94.1	99.7			87.7
Kerala	Urban	99	100	100			96.9	93	99	100			79.2			100.0			91.1
	Rural	98	99	100			92.4	88	92	99			76.3			99.5			86.1
	Total	98	99	100	95.4	98.6	93.9	89	93	100			77.3	90.2	94.1	99.7			87.7
Andhra Pradesh	Urban	95	99	98			90.2	69	79	85			46.2			89.1			82.1
	Rural	88	90	95			84.0	23	40	61			35.8			66.9			63.7
	Total	90	92	96	75.3	80.2	86.0	34	50	69			39.3	48.9	65.2	74.2			69.8
Gujarat	Urban	86	92	95			81.5	64	69	78			48.3			83.9			72.7
	Rural	74	84	83			55.8	24	33	42			28.9			54.6			43.8
	Total	78	87	87	61.3	61.2	64.9	37	46	55			35.7	43.4	53.5	64.7			54.0
Punjab	Urban	92	91	93			76.7	35	56	60			29.6			70.7			61.9
	Rural	86	69	89			70.2	22	32	48			24.2			67.4			51.6
	Total	88	75	91	62.2	58.4	72.5	25	38	53			26.1	47.3	62.6	68.6			55.3
Haryana	Urban	88	79	96			75.5	38	47	67			42.9			79.0			63.3
	Rural	73	52	87			52.8	12	15	30			23.1			45.9			32.5
	Total	76	58	89	45.8	38.2	58.8	17	22	39			28.3	31.5	42.1	54.2			40.6
Goa	Urban	96	97	99			96.4	89	91	93			78.9			94.6			80.4
	Rural	97	100	97			93.2	86	91	92			63.3			93.8			75.8
	Total	97	99	98	89.8	96.3	95.0	88	91	93			72.0	89.2	90.8	94.3			78.4
West Bengal	Urban	86	96	97			87.3	67	80	79			37.4			80.2			67.4
	Rural	76	89	92			55.8	22	31	34			20.8			36.8			29.9
	Total	78	91	93	50.3	57.4	62.4	32	40	43			24.3	33.9	44.2	45.7			37.8
N1-1992-93,																			
N2-1998-99,																			
N3-2005-06.																			

Name of States	Population Covered	Any ANC			Three ANC			Institutional Delivery			IFA tablets Consumed for 9 0 days			Birth Attended by SBA(Doctor, Nurse, LHV, ANM, other health personnel			PNC within 2 days		
		N1	N2	N3	N1	N2	N3	N1	N2	N3	N1	N2	N3	N1	N2	N3	N1	N2	N3
All India	Urban	84	86	91	-	-	73.7	58	65	69	-	-	34.5	-	-	75.2	-	-	60.7
	Rural	59	60	72	-	-	42.8	17	25	31	-	-	18.1	-	-	39.1	-	-	28.1
	Total	65	66	77	43.9	44.2	50.7	26	34	41	-	-	22.3	33.0	42.4	48.2	-	-	36.4