



# Evaluation of Frequency & Sociodemographic Determinants of Maternal Mortality and Maternal Near Miss Events in a Rural Tertiary Care Institute of India

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## KEYWORDS

Maternal Mortality, MNM, Incidence, Socio-demographic determinants, Indicators.

## ABSTRACT:

**Aim and Background:** The health of mothers is crucial because it determines the position of women in society. Bringing the maternal mortality rate down to below 70 per 100,000 live births by 2030 is one way to achieve the UN Sustainable Development Goals of improving maternal health. [1]

**Material and Method:** A rural Indian tertiary care hospital conducted prospective observational research for two years. The Ministry of Health and Family Welfare (HFW) of the Government of India's Maternal Near Miss (MNM) Study Operational Procedures Dec 2014 (Annexure I) were used to categorise MNM cases. The study covered all occurrences of maternal death that occurred throughout the time frame. MMR, Case Fatality Rate, MNMIR, MNM:MM Ratio, Mortality index were observed. Socio-Demographic correlations of MNM and MM cases with age, parity, occupation, socioeconomic status, literacy and distribution in rural and urban population were analysed in this study. Results: During the period of study 8508 deliveries, 8,240 live births (LB), 125 MNMs and 29 MMs were recorded. MNMIR was 15.1/1000LB, MNM:MM ratio 4.3:1 and MM index 18.8%. Leading cause of MNM was haemorrhage(36%) and MM was medical disorders(34.4%).MNM (80.8%) and MM(75.9%) were more amongst the age of 20-29 yrs. Both MNM and MM were significantly more in multigravida (57.6% & 58.6% respectively). Significantly more MNM (62.4%) and MM (75.9%) cases were housewives than working women and more MNM and MM cases were educated less than 5th std. (MNM - 64% and MM -58.6%) In socioeconomic status significantly more MNM (80.8%) and MM (89.7%) cases were women below poverty line and from rural population [MNM (72%) and MM (89%)]. Conclusions: While bleeding was more common, infectious and medical conditions had higher case fatality rates. Housewives, women from low-income backgrounds, those living in rural areas, and women without a high school diploma were found to have a much higher risk of having a worse maternal healthiness result.

## INTRODUCTION

A woman, a mother, is the rock upon which her family and her country are built. Her health and safety are the responsibility of the entire country, not just her immediate family. About 529,000 mothers die from complications during childbirth every year. As a result, [1]

one woman dies from complications during pregnancy every minute.[2]. The Registrar General of India (RGI)

has reported that India's (MMR) MM Ratio has reduced from 130 per 100,000 living births in SRS 2014–16 to 97 per 100 000 in 2020 as part of the Sample Registration System (SRS)[3]

When a woman dies due to complications arising from her pregnancy or its care (as opposed to accidental or unintentional causes), we call this a maternal mortality (MM) death.[4]

The World Health Organisation (WHO) defines a



Therefore, only cases that satisfied the MNM criteria specified by the Maternal Health Division of the Minister of HFW of the Government of India [8] were incorporated into the study as "a woman who nearly died but survived after a complication that occurred during pregnancy, childbirth, or within 42 days of terminating a pregnancy, either by chance or because of the care she received" [5].

### Objective

- To examine maternal mortality and maternal near-miss rates during a two-year period at a rural Indian tertiary care facility.
- To determine the most common triggers for maternal adverse events and fatalities.
- To examine the correlation between maternal near-miss and maternal death cases in the same population by examining the sociodemographic factors (age, parity, occupation, socioeconomic position, and literacy).

Because they directly reflect on problems and hurdles that have to be addressed during the process of health care, Therefore, only cases that satisfied the MNM criteria specified by the Maternal Health Division of the Minister of HFW of the Government of India [8] were incorporated into the study. cases are more likely than maternal deaths to produce robust findings and quick reporting on maternal care issues [6,7].

### MATERIAL AND METHODS

- The research has been done at a Central Indian Rural Tertiary Care Institute. Patients who met the study's inclusion and exclusion criteria between January 2022 and December 2023 were enrolled after receiving approval from the institute's ethics committee.
- This was prospective observational research.

There will be a two-year time limit.

The sample size was large because all MNM patients admitted and all cases of maternal death were included. There were 8,904 live births during the past two years, with 118 cases of MNM & 17 cases of maternal fatality. Accordingly, we anticipated a sample size of between 110 and 120 for MNM and 15 to 20 for Maternal Mortality.

Sample size formula based on prevalence:

$$N = Z^2 * p(1-p)$$

d2

Were

Z=Statistic for the level of significance 5% = 1.96

P=Prevalence of MNM from previous studies =10% =0.10

d= Error of margin =6% =0.05(Upto 7% error of margin is allowed)

$$N = 1.962 * 0.10*(1-0.10) = 0.3457/0.0036$$

0.06 2

= 96

Total sample size of 100 patients is needed

### •INCLUSION CRITERIA

We included all cases of MNM diagnosed in the tertiary care institution between January 2022 , and December 2023 according to the MNM Review Operations Guidelines Dec 2014 by the Maternal Health Division of the Department of HFW of the Government of India [8].

The diagnostic criteria for Perinatal Near Miss cases were derived from the Maternal Health Division's Operational Guidelines for MNM Reviews, which may be found in Annexure I. Cases involving a mother needing medical attention after a near-miss [8] must otherwise qualify. Cases should be identified and classified using at least one criterion from each of the following three areas: clinical findings; investigations; and interventions; or any criterion that shows cardiorespiratory collapse from the numerous categories of opposing events and disorders related with MNM. Pregnancy-specific obstetric and medical illnesses, preexisting disorders made worse during pregnancy, then accidental/incidental disorders in pregnancy make up the three groups into which adverse occurrences during pregnancy are divided. Locate each type of undesirable occurrence. Explain in detail what illnesses, problems, or complications might arise as a result of each unfavorable occurrence.

The study includes all cases of maternal mortality.

We filed the Facility Based Maternity Death Review (FBMDR) papers and filled out the Facility Based MNM Review instrument as mandated by the Government of



India. □

## EXCLUSION CRITERIA:

All cases of maternal mortality were included; there were no exclusion criteria.

Therefore, only cases that satisfied the MNM criteria specified by the Maternal Health Division of the Minister of HFW of the Government of India [8] were incorporated into the study.

- Upon admission, patients and their families were briefed on the study's purpose, written consent was obtained, and the MNM-R tool (ANNEXURE II) was completed in cases of MNM, as outlined in the Government of India's MNM Review Operational Guidelines Dec 2014.

- The Facility based Maternal Death review form (ANNEXURE III) was filled out for all of the maternal deaths that were a part of the study, in accordance with the Maternal Death review Guidelines 2010, NRHM provided by the Government of India [9].

All of the information collected was entered into a Microsoft Excel spreadsheet and coded. The continuous data were represented by mean and SD, whereas the categorical data were represented by rates, ratios, and percentages. A p-value of under or equal to 0.05 was considered statistically important. Microsoft Excel 2013 and IBM SPSS version 12 were used for all statistical analysis and calculations. The Z-test was used to analyse the percentages.

□ The following outcome indicators were calculated-

- (1) Maternal Mortality Ratio.
- (2) Case Fatality Rate.
- (3) The number of cases of MNM per 1,000 LB is the MNM incidence ratio. The MNM IR is calculated as  $1000 * (MNM/LB)$ .
- (4) The mortality ratio for MNM is the fraction of all cases of MNM to all maternal fatalities. Better treatment is indicated by a higher ratio. MNM: 1MM.
- (5) Mortality index: the ratio of maternal fatalities to the whole number of women with critical illnesses. More women with this potentially fatal illness die when the index is high, while a lower index indicates better health

care.

## ETHICAL AND RESEARCH (SCIENTIFIC) COMMITTEE APPROVAL

Ethical and research (scientific) committee approval from the institution was obtained.

Informed consent from all study participants

To ensure that the consent is –

- (a) Given voluntarily,
- (b) Fully informed,
- (c) Is obtained from persons who are competent to do so.

Conflicts of Interest- We declare that we had no conflicts of interest.

## RESULTS

In addition to 8,240 live births and 12,725 obstetric admissions, 125 occurrences of MNM and 29 cases of MM were observed during the study period.

The present study found that the rates of MNM and MM were both considerably higher among women aged 20–29 ( $p < 0.0001$  and  $p < 0.002$ , respectively).

In both MNM and MMs multigravida women were significantly more than primigravida. ( $p$  value of 0.00014 and 0.00001 respectively,  $< 0.05$ ).

62.4% of MNM and 75.9% of MM patients were housewives, 20.8% of MNM and 20.7 % of MM were labourer or daily wage workers and 16.8% of MNM and 3.4 % of MM were working women who worked either in office or some industry or hospital. Both MNM and MM were observed to be more common in housewives than working women.

Amongst MNM and MM events were more common in women who were educated less than 5th std. than women who were educated more than 6th std. but the difference was not significant ( $p$  value  $> 0.05$ ). Amongst both MNM and MM cases, women who were educated more than 12th std. were significantly less than those who were educated less than 12th std. ( $p$  value- 0.00001 & 0.00001,  $< 0.05$ ).

In this study both MNM and MM cases were significantly more common in women who were below poverty line than women who were above poverty line ( $p$  value- 0.0001 & 0.0002,  $< 0.05$ ).



Patients from rural areas were overrepresented in both MNM (72%) and MM (89%); this was statistically significant ( $p = 0.025, 0.05$ ). Patients from metropolitan areas were overrepresented in the MNM cases compared to the MM cases ( $p = 0.012, 0.05$ ).

There were 36 percent of MNM occurrences related to bleeding, 24 percent to medical issues, 21 percent to HDPs (high blood pressure), 15 percent to infections, and 4 percent to difficulties during birth.

Medical problems accounted for 34.4% of maternal deaths, infections for 24.1%, high-risk pregnancies for 10.4%, accidents for 13.7%, and difficulties during labour and delivery for 3.4% of deaths. There was a statistically important difference in the proportion of working and nonworking women in MNM cases with haemorrhage ( $p = 0.004, 0.05$ ), but not between the proportions of working and nonworking women in MNM cases with HDPs ( $p = 0.0012, 0.05$ ).

Housewives outnumbered working women by a statistically significant margin ( $p 0.05$ ) in MM cases including haemorrhage, HDPs, and medical illnesses.

In the present study, in the cases of MNM, of the cases with haemorrhage 60% were amongst BPL group and were educated less than 5th std. ( $p$  value- 0.03,  $<0.05$ ), 13.3 % amongst BPL group and educated more than 6th std., and 26.6 % were non BPL registered and educated more than 6th std.

Of the cases with medical disorders 67.8 % were amongst BPL group and were educated less than 5th std. ( $p$  value- 0.0002,  $<0.05$ ), 21.4% amongst BPL group and educated more than 6th std., and 10.7% were non-BPL registered and educated more than 6th std.

Of the cases with infection 73.6 % were amongst BPL group and were educated less than 5th std. ( $p$  value- 0.0001,  $<0.05$ ), 15.7 % amongst BPL group and educated more than 6th std., and 10.5% were non-BPL registered and educated more than 6th std. Of the cases with HDPs 66.6% were amongst BPL group and were educated less than 5th std. ( $p$  value- 0.0002,  $<0.05$ ), 14.8% amongst BPL group and educated more than 6th std., and 18.5% were non BPL registered and educated more than 6th std. Of the cases with labour related disorders 33.3% were amongst BPL group and were educated less than 5th std.

In the present study, in the cases of MM, of the cases with

haemorrhage 50% were amongst BPL group and were educated less than 5th std., 50% were amongst BPL group and were educated more than 6th std. Of the cases with medical disorders, 50 % were amongst BPL group and were educated less than 5th std., 30% were amongst BPL and educated more than 6th std., 20% were amongst non-BPL registered and educated more than 6th std. Of the cases with HDPs none were amongst BPL group and were educated less than 5th std., the cases with infections, 42.8 % were amongst BPL group and were educated less than 5th std., 57.2% were amongst BPL and educated more than 6th std. Of the cases with labour related disorders 100% were amongst BPL group and were educated less than 5th std.

Of the cases with incidental/accidental causes 75% were amongst BPL group and were educated less than 5th std. and 25% were amongst non-BPL registered and educated more than 6th std. ( $p$  value- 0.00001,  $<0.05$ )

In the present study, amongst MM cases significant number of women who had incidental/ accidental causes were amongst BPL group and educated less than 5th std.

## DISCUSSION

The MNM Incidence ratio in the present study was 15.1 / 1000 live births which was similar to MNM incidence ratio (MNMR) in a study conducted at a tertiary care hospital in Karnataka, India (17.8/1000 live births).

[10] Similar findings were seen in studies conducted by Patil R et al 2023 of 16.6/ 1000 LB [11], Raut et al 2021 of 16.27 /1000 LB [12], Manandhar R et al 2023[13] of 12.5 /1000 LB, Vijaya Lakshmi et al 2022[14] of 9.8/1000 LB. Other studies which were conducted in developing countries and used similar criteria had MNM Incidence Ratio between 12–40/1000 live births [ 5,15,16]

This study's Near Miss rate of 1.8% was comparable to the Near Miss prevalence seen in a systematic analysis of 82 research from 46 countries by Tuncalp et al 2012[17], which ranged from 0.04 to 4.54%. The rates are highest in Asia and Africa's developing and underdeveloped nations. In Asia, the rate was 5.07%, in Africa it was 14.98%, and in Latin America and the Caribbean it was 4.93%. Studies conducted in high-income regions showed a near-miss rate between 0.79 and 1.38 percent. [18]



MNM to Maternal Mortality ratio was found to be 4.3:1 in the present study which was alike to 3.6:1 in a study by Raut et al 2021, 7.4:1 in a study by Vijaya Lakshmi et al 2022 [12,14].

Irshad I et al 2023 reported at much higher ratio of 24:1 in their study conducted in Pakistan [15].

MM is reduced and healthcare quality improves when the ratio is high.[7] Other information in the literature that warrant the study of near miss cases confirm the frequency of at least four MNM for every one MM. [19]

The current investigation found the SMOR for severe maternal outcomes to be 18.6 per 1000 LB. Souza et al. (2013) found an overall SMOR aimed at WHO MCS countries of 9.9/1,000 live births, and in nations with a moderate MMR, the SMOR was 6.5/1,000 live births [20], both of which are significantly lower than the rate seen here. SOMR values as high as 63.28 were reported by Thakur et al., 2023 in India [21], and 41.4 in Tanzania [16].

This study's MMR of 351.9 per 100,000 live births was comparable to a previous one from Karnataka, India, which found an MMR of 313 per 100,000 live births[10].

The death rate in the Brazilian study was also 260 per 100,000 live births.[22] Since our facility serves a largely rural area, both the number of referrals and the number of deaths are higher than average.

The current study's Maternal Mortality index was 18.8%, which is on par with the overall MMR index from the WHO Multi-country Survey (16.1%), and the mortality index observed for nations with a moderate MMR was 5.6%.[20]

In their research, Raut et al. 2021 found a mortality index of 21% [12].

More women with serious problems die when the index is high (>20%), indicating poor quality obstetric care. When the index is low, less than five percent of women with severe illnesses die. [7]

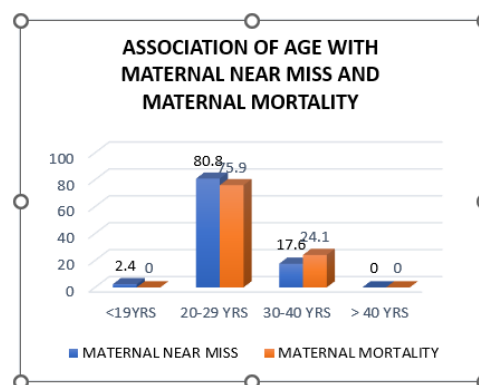
#### ASSOCIATION OF AGE, EDUCATION, OCCUPATION, PARITY, RURAL OR URBAN RESIDENCE WITH MNM AND MM CASES.

Only 2.4% of mothers in this study were teens, whereas 80.8% were in their twenties, and 17.6% were in their thirties or forties. Seventy-five-point nine percent of the

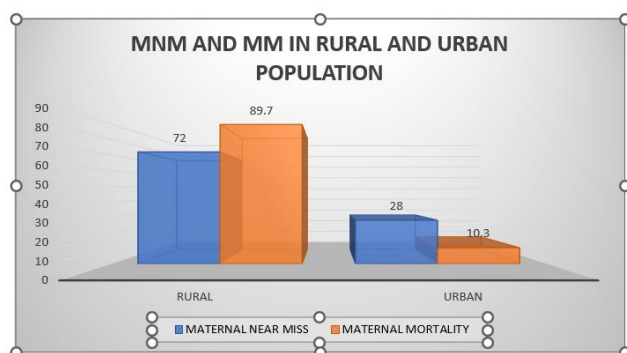
women who died from Maternal Mortality were aged twenty-nine to forty. The bulk of patients in the MNM group (40%) were between the ages of 20 and 24, with a further 32% falling between the ages of 25 and 29, 11% between the ages of 35 and 44, 9% falling between the ages of 30 and 34, and 8% falling below the age of 19. Similar results were found by Vijaya Lakshmi C et al 2022[14]. Most patients in the mortality group were between the ages of 25 and 29 (35.71%), then between the ages of 20 and 24 (28.5%), then between the ages of 30 and 34 (14.28%), and between the ages of 35 and 44 (7.4%). The mean age of the near-miss cases in this study is 26.54 years, and the majority of the cases fall between the age range of 25 to 30. This is consistent with the findings reported by Raut et al. in 2021.[12]

Other studies reported similar findings where more number of women in MNM and MM cases were between ages of 20-30 years [10,23,24,25].

Forty-eight percent of the MNM instances in this analysis had first-time mothers, whereas 57.6 percent involved multiple births, and 1.6 percent involved grand multiparas. Primigravida made up 37.6% of the Maternal Mortality cases, multigravida 58.6%, and grand multipara 3.4%. Raut et al. 2021 reported similar results, noting that there was more multigravida (69.05%) among the near miss instances than primigravida [12].



**Figure 1 ASSOCIATION OF AGE WITH MNM AND MATERNAL MORTALITY**



**Figure 2 MNM AND MM IN RURAL AND URBAN POPULATION**

Other studies conducted in Tanzania and Pakistan reported similar findings in which MNM and Maternal Mortality cases were more amongst multiparous women cases 53.9% [16,26]

In the present study, 62.4% of MNM and 75.9% of MM patients were housewives and were significantly more than working women. A study conducted by Kaye et al, in Uganda also reported similar findings in which 62% of all MNM cases were housewives.[27]

In the present study, both MNM (64%) and MM (58.6%) cases were more common in women who were educated less than 5th std. than women who were educated more than 6th std. Raut et al 2021 demonstrated that lower education and illiteracy correlates with increased percentage of cases of near miss in each group [12].

According to research by Vijaya Lakshmi et al. in 2022[14], the vast majority of people in the MNM and mortality groups were illiterate (52%) and had only completed primary school (21.4%).

The study directed by Chhabra et al in a tertiary care hospital of India similar findings were reported where 71.1% of the MNM and Maternal Mortality cases educated less than 5th std [28].

Low literacy rate was associated with MNM and Maternal Mortality cases in other trainings conducted in other emerging countries like Uganda, Sudan and India [16,23,24,25,27]

In the present study, 80.8% of MNM and 89.7 % of MM cases were women below poverty line and 19.2% of MNM and 10.3% of MM were women above poverty

line. These findings were alike to other studies conducted in Uganda, India, Brazil and Egypt where MNM and MM cases were more in women with low socioeconomic status [5, 25, 27, 28]

Similar to studies conducted in Sudan in 2011 and India in 2014, the majority of instances of MNM and MM in this study were from rural areas, while only 20% of MNM cases and 10.3% of MM cases were found in urban areas. [23,29]

In this study, amongst MNM cases significant number of women who had haemorrhage, hypertensive disorders of pregnancy, infection and medical disorders were in BPL group and educated less than 5th std. while no significant difference was seen amongst MM cases.

Of MNM cases with haemorrhage, women who were housewives were significantly more than working while amongst those with HDPs women who were working were significantly more than those who were housewives. Thus, occupation could be significantly associated with causes of MNM and MM. However, further studies need to be done in this aspect.

## CONCLUSION

Although, endeavours are being made all over the world for many decades now for decreasing maternal mortality, there is still much that needs to be done. It was observed in this study that determinants like multiparity, illiteracy, low socioeconomic status, rural residence and occupation were significantly associated with MNM and Maternal Mortality.

Most of these determinants lead to decreased awareness, knowledge of risk factors and lack of ability to access proper health care and thus are responsible for poor maternal health. Thus, all such women need to be made more aware of warning signs of complications through thorough local and national campaigns in order to bring change in the scenario.

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**Conflict of interest** – We declare no conflict of interest

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**Table 1 ASSOCIATION OF PARITY AND AGE WITH MNM AND MM**

Age	< 19YRS			20-29 YRS			30-40 YRS			Total
	P0	P1-P3	>P3	P0	P1-P3	>P3	P0	P1-P3	>P3	
MNM	1	2	0	42	56	2	8	14	0	125
MM	0	0	0	10	12	0	1	5	1	29





**Table 2 MATERNAL MORTALITY AND MNM INDICATORS**

TABLE -1 - MATERNAL MORTALITY AND MATERNAL NEAR MISS INDICATORS		
Maternal near miss: mortality ratio - [MNM : 1 MM]	125:29	4.3:1
Women with life-threatening conditions- (WLTC= MNM + MM)		154
MNM incidence ratio - [MNM IR = MNM/LB]		15.1/1000 live births
Severe Maternal Outcome Ratio - [SMOR = (MNM + MM)/LB]		18.6/ 1000 live births
Mortality index - [MI = MM/(MNM+MM)]		18.8%
Maternal Mortality Ratio = MM x 100,000/LB		351.9
CASE FATALITY RATE = No. of individuals during a specific period of time dying of a disease X 100/ Number of individuals with the disease in that time period	HEMORRHAGE	8.1%
	INFECTION	26%
	HDPs	10%
	MEDICAL DISORDERS	26%
	LABOUR RELATED DISORDERS	14.2%
	INCIDENTAL/ ACCIDENTAL CAUSES	100%

**Table 3 ASSOCIATION OF LITERACY AND SOCIOECONOMIC STATUS WITH MNM AND MM CASES**

	MATERNAL NEAR MISS			MATERNAL MORTALITY		
	BPL	NON BPL	TOTAL	BPL	NON BPL	TOTAL
<b>ILLITERATE TO 5<sup>TH</sup> STD.</b>	80	0	80 (64%)	17	0	17 (58.6%)
<b>6<sup>TH</sup> TO 12<sup>TH</sup></b>	20	13	33 (26.4%)	9	0	9 (31.0%)
<b>&gt; 12<sup>TH</sup></b>	1	11	12 (9.6%)	0	3	3 (10.3%)
<b>TOTAL</b>	101	24	125	26	3	29
	80.80%	19.20%	100%	89.7%	10.3%	100.0%

**Table 4 ASSOCIATION OF OCCUPATION WITH CAUSES OF MNM AND MM**

	MATERNAL NEAR MISS				MATERNAL MORTALITY			
	HOUSEWIFE	DAILY WAGE WORKER	WORKS IN A OFFICE/ INDUSTRY/ HOSPITAL	TOTAL MNM	HOUSE WIFE	DAILY WAGE WORKER	WORKS IN A OFFICE/ INDUSTRY/ HOSPITAL	TOTAL MM
HEMORRHAGE	29 (64.4%)	9 (20%)	7 (15.5%)	45	3 (75%)	0	1 (25%)	4
INFECTION	12 (63.1%)	3 (15.7)	4 (21.0%)	19	4 (57.1%)	3 (42.8%)	0	7
HYPERTENSIVE DISORDERS OF PREGNANCY	12 (44.4%)	9 (33.3%)	6 (31.57%)	27	3 (100%)	0	0	3
MEDICAL DISORDERS	22(78.5%)	3 (10.7%)	3 (10.7%)	28	7 (70%)	3 (30%)	0	10
LABOUR RELATED DISORDERS	3 (50%)	2 (33.3%)	1 (16.6%)	6	1 (100%)	0	0	1
INCIDENTAL/ ACCIDENTAL	0	0	0	0	4 (100%)	0	0	4
<b>TOTAL</b>	78 62.4%	26 20.8%	21 16.8%		22 75.9%	6 20.7%	1 3.4%	



**Table 5 ASSOCIATION OF LITERACY AND SOCIOECONOMIC STATUS WITH CAUSES OF MNM AND MM**

Socio-economic status	Causes	Education				Total	
		Illiterate	Literate to 5 <sup>th</sup> std.	6 <sup>th</sup> -12 <sup>th</sup> std.	> 12 <sup>th</sup> std.		
<b>MATERNAL NEAR MISS</b>	<b>BPL Certified</b>	Medical disorders	4	15	6	0	25
		Infection	3	11	2	1	17
		Hypertensive disorders of pregnancy	3	15	4	0	22
		Hemorrhage	2	25	6	0	33
		Labour,related disorders	1	1	2	0	4
	<b>TOTAL</b>		13	67	20	1	101
	<b>Not BPL certified</b>	Medical disorders	0	0	3	0	3
		Infection	0	0	0	2	2
		Hypertensive disorders of pregnancy	0	0	3	2	5
		Hemorrhage	0	0	7	5	12
Labour,related disorders		0	0	0	2	2	
<b>TOTAL</b>		0	0	13	11	24	
		13	67	33	12	125	
	<b>Total</b>	10.4%	53.6%	26.4%	9.8%		
<b>MATERNAL MORTALITY</b>	<b>BPL Certified</b>	Medical Disorders	0	5	3	0	8
		Infection	0	3	4	0	7
		Hypertensive disorders of pregnancy	0	3	0	0	3
		Hemorrhage	1	1	2	0	4
		Labour,related disorders	0	1	0	0	1
	Incidental/accidental	0	3	0	0	3	
	<b>Total</b>		1	16	9	0	26
	<b>Non-BPL certified</b>	Medical disorders	0	0	0	2	2
		Infection	0	0	0	0	0
		Hypertensive disorders of pregnancy	0	0	0	0	0
Hemorrhage		0	0	0	0	0	
Labour,related disorders		0	0	0	0	0	
Incidental/accidental	0	0	0	1	1		
<b>Total</b>		0	0	0	3	3	
<b>TOTAL</b>		1	16	9	3	29	
		(3.4%)	(55.1%)	(31%)	(10.3%)		