Health Awareness

For Service Providers 2014

Tamil Nadu

Circular No. 11 / 2014

MMR - Special Maternal Death Review - Guidelines

NATIONAL HEALTH MISSION

State Health Society - TN

DMS Complex, Chennai

Circular No.11 / 2014

Roc No: 3543 / P5 / SHS / 2014,
Dated 24.06.2014

Dr.C.N.Mahesvaran, IAS.,
Mission Director

National Health Mission,
State Health Society-TN
DMS Complex, Chennai – 6

Circular No.11 / 2014

Roc No: 3543/P5/SHS/2014, Dated, 24.06.2014

"Women are not dying because of a disease we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving"

Sub: NRHM – TN - State Health Society – MDG – Reduction of MMR – Conduct of Special Maternal Death Review - Guidelines issued – regarding

I would like to invite your kind attention to the point mentioned in the subject above. Maternal Mortality Ratio of the State of Tamil Nadu is 90/100,000 Live births (SRS-2010-12). Based on the HMIS data, the State have recorded an MMR of 72.11 for the year 2013-14. Target suggested by the Government of India and State Government for the 12th Five Year Plan period is 45/100,000 Live births at the end of 2017. .

The following points are brought to your notice for kind consideration and effective implementations.

Community Based Maternal Death Audit (Verbal Autopsy)

- In 2004 itself, Government of Tamil Nadu have directed formation of District level Maternal Death Audit Committee with the District Collector as the Chairperson to conduct monthly reviews and State Level Committee to review the quality of Maternal Death reports received from the districts once in 2 months (Go.Ms.No.223 dt:09.07.2004- copy enclosed) .

- Based on the Government Orders, Community based MDR is ongoing in the State since 2004. As per the Government Orders, each of the Maternal Death has to be investigated by the concerned PHC Medical Officer / Municipal Health Officer / Medical Officer of the Urban Health Post / Woman Medical Officer of the Municipalities and Municipal Corporations within a period of 15 days of occurrence of Maternal Death.

- The State have also constituted a State Task Force on reduction of Infant Mortality Rate & Maternal Mortality Ratio under the Chairmanship of the Secretary to Government, Health & Family Welfare Department (G.O (2D) No.292 dt:10.08.2007) to further streamline the coordination between the different stakeholders and intensify the Infant Mortality Rate & Maternal Mortality Ratio reduction strategies.

- **Facility Based MDR through Video-Conferencing (SHS):** Facility Based MDR is being conducted since 2011 by State Health Society through video conferencing and Government MCH/DH/SDH maternal deaths are being reviewed on the fourth Thursday of every month.

- **Conduct of Special Maternal Death Review (State Health Society):** A proposal to intensify Maternal Death Review has been formulated by NRHM, Tamil Nadu and is being implemented in the State so as to investigate the Maternal deaths within 5 days of occurrence of the death.

GUIDELINES – SPECIAL MATERNAL DEATH REVIEW

The guidelines for the conduct of the Special Maternal Death Review is as follows:-

- A panel of experts have to be formed by the DDHS at each of the HUD consisting of renowned obstetricians and anesthetists in and around the district. The panel of specialists may include both Govt. (in service / retired) and Private Doctors. They may be, preferably, not below the rank of CCS / Professor of the speciality or equivalent.
- DDHS will have to be notified at once by the duty Medical Officer (both private and Govt.) when the admitted pregnant woman or delivered mother becomes dead. A delay of more than 15 minutes after declaration of death may amount to negligence of duty / responsibility of the Institution.
- DDHS will immediately alert the panel of experts and based on availability, will ensure that along with him, a team of 2 specialists visit the Institution (at which the death has occurred) at the earliest.
- The team will undertake visits to the place(s) from where referral was made (if the deceased mother is a referred case), Facility / facilities where AN registration and AN check-ups were undertaken (MCH/DH/SDH/PHC/HSC/ Urban Health Institutions / Private Institution / Any other) in and around the district and upto the house-hold level based on the merit of the case.
- All data pertaining to the deceased mother have to be presented to the MD audit team at the time of visit by all the Institutions (including private Hospitals) involved in the management of the deceased mother from AN-registration till Maternal Death.
- The Team will scruitinise the reports and case-sheets pertaining to the deceased mother and arrive at the plan of investigation and undertake them.
- The Team may prepare a report of the Maternal Death, with Xeroxed copy of details of AN registration, AN care, case-sheets, investigation reports (wherever applicable) in triplicate and send one copy to the State Health Society within 5 days of occurrence of Maternal Death. **A model reporting format by the team of specialists is attached.**
- The report has to present all the medical / social / economic causes and specify the areas of system failure if any in the occurrence of maternal death investigated by them.

- The Experts shall suggest measures to prevent occurrence of such Maternal Deaths in future.
- DDHS will disseminate the steps to be taken to address the preventable causes of maternal deaths in the monthly coordination meetings and facilitate their implementation in all the institutions of the HUD.
- The specialists have to be chosen from the institutions other than the institution where the MD occurred.
- The expenditure towards the conduct of enquiry will be paid as follows:

S.No.	Activity		Amount in Rs.
1	Honorarium for the Experts of the team	Rs.2000 per day x 2 days x 2 Experts	8000/-
2	Fuel expenses	Rs.500 per day x 2 days	1000/-
3	* Incidental expenses	Rs.500 per day x 2 days	1000/-
	Total		10000/-

* Incidental expenses to be incurred are for food and refreshments of the team, towards stationeries for preparation of reports and expenditure towards Xeroxing the needed documents.

- The DDHS of the district shall ensure that the payment to the specialists for the conduct of the Special MD Review team is paid at once on submission of the Special Review reports. Any delay in payment shall be avoided.
- Every month the report on the conduct of the Special MD Review shall be furnished to State Health Society in the following format.

REPORTING FORMAT FOR THE DISTRICT

1. LINE LISTING OF MATERNAL DEATHS THAT OCCURRED IN THE HUD IN THE MONTH (ALL CASES)					
Name of the deceased	Date of death	Period of Death AN/ IN/PN	Place of Death	Whether community verbal autopsy done or not?	Whether audited by special Audit team

NAME OF THE HUD:					
SPECIAL MATERNAL DEATH AUDIT					
Funds received from SHS/DHS	Teams formed? If yes, details	MONTH	No of Maternal Deaths occurred in the HUD	No of MD audited by Special MD audit team	Report communicated to SHS
		April			
		May			
		June			
		July			
		August			
		September			
		October			
		November			
		December			
		January			
		February			
		March			

Model Reporting Format for the Special Maternal Death Review Team

Name and designation of committee members:

Date and time of review:

Name of the deceased : Age :

Husband's name :

Address :

Obstetric Formula:

Time Line:

Date and time of admission at the centre where death occurred:

Date and time of delivery :

Date and time of death :

If delivery occurred in a centre other than the one where the mother died:

Date and time of admission at the centre where delivery occurred

Date and time of delivery :

Type of delivery:

L.Natural with/without episiotomy/ IVD/CS/ Hysterotomy /Undelivered

If CS/ Hysterotomy, indication for the same:

No. of facilities travelled by the mother before death occurred (To be filled if she was seen in more than one facility)

S.No	Name of the Facility	Duration of stay in the Facility	Reasons for referring	Transported by 108/ Hospital ambulance/ Pvt ambulance

Brief clinical history:

Lacunae in the management

Start from the facility where death occurred and go backwards (If she was seen in more than one centre)

Cause of Death: (As mentioned by the facility)
Final Cause of death: (as determined by the team):

Avoidable factors and missed opportunities: (From the facility where death occurred to social causes)

Signature of the committee members with date:

All the officers are requested to adhere the instructions and submit their report within time – SPM is requested to ensure whether all the above said instructions is carried out on time.

Sd/ ...
(Dr.C.N. Mahesvaran)
Mission Director,
National Health Mission-TN.

To

The All District Collectors
The Director of Medical Education
The Director of Medical & Rural Health Services
The Director of Public Health & Prevention Medicine
All Joint Directors in the District
All Deputy Director of Health Services
Medical Superintendent of Taluk & District Hospitals & Non-Taluk Hospitals
All Primary Health Center Medical Officers
Programme Officers and HOD's of Vertical Programme
Copy Submitted to Secretary to Government
Health & Family Welfare Department,
Secretariat, Chennai.

ABSTRACT

Family Welfare Programme – Conducting of Maternal and Death Audit Guidelines – Orders -Issued.

HEALTH AND FAMILY WELFARE (R1) DEPARTMENT

G.O. (Ms.) NO.223 Date: 9.7.2004

Read:

ORDER:

Maternal Death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not due to accidental or incidental causes.

The conduct of Maternal Death Audit helps to find out the causes and the specific circumstances that led to Maternal Death. The present system of conduct of Maternal Death Audit in the institutions alone may not provide an accurate picture of the causes of Maternal Death. The Government have decided that the system of Maternal Death Audit shall be strengthened. An Expert Team shall monitor the quality of conduct of Maternal Death Audit periodically.

The following guidelines are issued for the conduct of Maternal Death Audit:

A comprehensive format has been developed for conduct of verbal autopsy. The Deputy Director of Health Services (DDHS), District Public Health Nurses (DPHNs) and the Corporation Health Officers (CHOs) will be trained in the use of the new verbal autopsy format. In turn, they will train all the Medical Officers (MO) of Primary Health Centres (PHCs) / Municipal Health Officers (MHOs) / Medical Officers (MOs) of the Urban Health Posts / Woman Medical Officers (WMOs) of Maternity Homes and the field health functionaries in the investigation of maternal deaths by using the verbal autopsy format.

The Medical Officer of the concerned Primary Health Centre will ensure notification of all the maternal deaths of his/her area to the Deputy Director of Health Services, Director of Public Health and Preventive Medicine (DPH&PM), Commissioner Maternal, Child Health and Welfare (MCH & Welfare), District Collector and Secretary (Health and Family Welfare) within 24 hours of occurrence of death. He/ she will sensitize all the field health functionaries about reporting maternal deaths within 24 hours of occurrence.

The Municipal Health Officer shall be responsible for reporting maternal deaths in his/ her municipality to Deputy Director of Health Services by fax/ telegram/ E-mail with a copy marked to the Commissioner, Maternal, Child Health and Welfare. In the Municipalities where there is no post of Municipal Health Officer, the Municipal Commissioner is responsible for reporting the maternal deaths to Deputy Director of Health Services of the Health Unit District. Health Officer of the Corporation shall report the maternal deaths occurring within the six municipal corporation limits to the Corporation Commissioner, Commissioner, Maternal, Child Health and Welfare and Director of Public Health and Preventive Medicine within 24 hours of occurrence.

The Primary Health Centre – Medical Officer shall conduct a detailed investigation of every maternal death by personally visiting the various service providers and field health functionaries and meeting the relatives of the deceased. The Primary Health Centre – Medical Officer will use the verbal autopsy format for conducting the investigation. The investigation should be completed within 15 days of the occurrence of the maternal death. The Primary Health Centre – Medical Officer should personally conduct the investigation and should not entrust this responsibility to any paramedical functionary. The completed verbal autopsy investigation format should be sent to the Deputy Director of Health Services.

The Municipal Health Officer / Medical Officer of Urban Health Post / Woman Medical Officer of Maternity Home of the Municipalities and Municipal Corporations shall conduct a detailed investigation of every maternal death by personally visiting the various service providers and field health functionaries and meeting the relatives of the deceased. In case no Medical officer / Municipal Health Officer is available, in the municipality the Deputy Director of Health Services will nominate one Primary Health Centre Medical Officer to conduct the verbal autopsy. The Medical Officer of the Urban Health Post / Municipal Health Officer will use the verbal autopsy format for conducting the investigation. The investigation should be completed within 15 days of the occurrence of the maternal death. He/ she should personally conduct the investigation and should not entrust this responsibility to any paramedical functionary. The completed verbal autopsy investigation format should be sent to the Deputy Director of Health Services.

The Institution Heads including Private Hospitals should provide all details and case records of the Deceased Mothers/ Against Medical Advice / Absconded Cases who had attended their Institutions for the perusal of the Investigating Officers.

The Deputy Director of Health Services and District Public Health Nurse will scrutinize the verbal autopsy formats received from the Primary Health Centre – Medical Officer / Municipal Health Officer / Corporation Health Officer (CHO) / Municipal Commissioner and verify the quality and completeness of the investigation. They will discuss each case with the Primary Health Centers – Medical Officer / Municipal Health Officer / Corporation Health Officer / Municipal Commissioner and the concerned field health functionaries. A narrative case history will be prepared for each maternal death and the factors contributing to maternal death will be listed.

Maternal deaths occurring in the medical college hospitals and attached institutions shall be reported to the Deputy Director of Health Services, Director of Medical Education, Commissioner, Maternal, Child Health and Welfare by fax / telegram / e-mail by the Head of the Department of Obstetrics and Gynaecology within 24 hours of occurrence. The Superintendent / Chief Medical Officer of all District / Taluk / Non-Taluk Hospitals shall be responsible for reporting maternal deaths occurring in their hospitals to the Deputy Director of Health Services, Director of Medical and Rural Health Services, Commissioner, Maternal, Child Health and Welfare by Fax / Telegram / E-mail within 24 hours of occurrence. Deputy Director of Health Services will arrange to investigate these maternal deaths if not done already.

With regard to maternity cases discharged Against Medical Advice (AMA) and absconded from their institutions, the Dean / Superintendent / Chief Medical Officer of all Medical College Hospitals, District / Taluk / Non Taluk Hospitals should intimate the relevant details, including the complete address of the discharged patient, to the Deputy Director of Health Services of the District, immediately. The Deputy Director of Health Services will send the list of the maternity cases discharged against medical advice to the respective Medical Officers of the Primary Health Centres and the maternal deaths amongst those discharged Against Medical Advice (AMA), if not already investigated, shall be investigated by the Primary Health Centre-Medical Officer. These maternal deaths, if not already reported, shall also be notified immediately to the Commissioner, Maternal, Child Health and Welfare and Director of Public Health and Preventive Medicine.

The Deputy Director of Health Services on receipt of list of Against Medical Advice / Absconded Cases from urban areas will verify the cases through Municipal Health Officers, Medical Officers of Urban Health Posts, Urban Family Welfare Centres, Maternity Homes and Maternity Centres. The maternal deaths, if not notified earlier, will be notified by the Deputy Director of Health Services to the Commissioner, Maternal, Child Health and Welfare and Director of Public Health and Preventive Medicine immediately. The Medical Officer of the Urban Health Post shall investigate the maternal death and the investigation report will be sent to the Commissioner, Maternal, Child Health and Welfare.

Maternal deaths occurring in private health facility shall be immediately reported to the Deputy Director of Health Services of the concerned District by the management of the Private Health Institutions through Fax/Telegram/E¬mail and a copy will be marked to the Commissioner, Maternal, Child Health and welfare. The Private Health Institutions will co-operate with the Government Officials in conducting the verbal autopsy as per the format. The Joint Director of Health Services (JDHS) / Deputy Director (Medical), DD (M) will arrange to inform the Private Hospitals in the Districts about the need for reporting maternal deaths and permitting the investigator to have an access to the medical records of such maternal deaths. Indian Medical Association will provide necessary support for the investigation process. The information collected from the Private Hospitals is of non statutory value.

A District Level Committee to review the maternal deaths shall be formed with the following members:

District Collecter	-	(Chair person)
Deputy Director of Health Services	-	(Convenor)
Joint Director of Health Services / Deputy Director (Medical)	-	(Member)
Dean of the Medical College (wherever available)	-	(Member)
Regional Director Municipal Administration	-	(Member)
Obstetrician from the District Hospital	-	(Member)
Obstetrician of the Medical College hospital	-	(Member)
Chief Medical Officer/Superintendent of the Hospital	-	(Member)
District Public Health Nurse	-	(Member)

The District Committee will send a Detailed Report every month to Commissioner, Maternal, Child Health and Welfare and the Health Secretary about the corrective measures taken to minimize the Maternal Deaths. The number of Maternal Deaths in Tamil Nadu per year is around 1600. This works out to about 50 to 55 deaths per District per year on an average. The District Committee will have to review about four to five deaths per month. The Committee may meet fortnightly to carry out the audit. The Committee will discuss with the relatives of the deceased first to elicit their views on the factors contributing to Maternal Death including the quality and timeliness of service provision in the health facilities. A separate meeting will follow this with the various service providers including private service providers. The Committee will also hold discussions with Primary Health Centre-Medial Officer/ Urban Health Post Medical Officer who carried out the verbal autopsy. The various factors that led to the death of the mother will be reviewed and corrective measures taken to prevent Maternal Deaths.

A State Level Maternal Death Audit Committee consisting of the following members will be formed:

- Secretary (Health and Family Welfare)
- Commissioner Maternal, Child Health and Welfare
- Commissioner Municipal Administration Director,
- Institute of Gynaecology
- Director of Public Health and Preventive Medicine
- Director of Medical and Rural Health Services
- Director of Medical Education
- Deputy Director, Institute of Public Health, Chennai
- Expert Resource Persons.

The State Level Maternal Death Audit Committee will meet once in two months to scrutinize all the Reports received from the District Collectors, review the quality of Maternal Death Audit and take necessary follow up action.

The Government after careful consideration direct all Heads of Department and all other authorities concerned to follow the guidelines in this regard.

(By Order of the Governor)

SHEELA RANI CHUNKATH
SECRETARY TO GOVERNMENT

To
All the Heads of Department.
Commissioner, Maternal, Child Health and Welfare.
Commissioners of all Corporations.
All Municipal Commissioners.
All District Collectors.
Joint Director of Health Services.
Deputy Director (Medical).
Deputy Director of Health Services of all the Health Unit Districts.

/ Forwarded by order/