**Annexure 6-** Child death review- Gap analysis as per Three-delays model

| SN | Reasons | % of deaths | Common / Repeated Delay type | Reasons for Delay | Underlying Reasons | Frequency (Common occurance or isolated incidence) | Common area/village/ pada/hopsital | Progrms which address these problems | Status of These programs in these areas, taluks and district | Sugested Actions | What actions actually implemented in the district |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | **Home Death/ Transit** | | Type One<br><br>**Type Two** | **Individual / family / Societal cause**<br><br>**Health Care delivery**<br><br>**Policies**<br><br>**Monitoring**<br><br>**Health Care delivery**<br><br>**Policies Monitoring** | 1.Do not know about danger signs<br>2.Do not know high risk Status of child<br>3.Gone to local faith healer<br>4.No hope for survival of the child<br>5.Didn't call to ambulance services<br>6.Didn't think that illness is serious<br>7.No faith in modern medicine/Govermemnet hospital<br>8.No one advised to visit facility/No visit by ASHA or ANM as per HBNC or other program<br>9.Do not know nearby delivery point or health facility<br>10. Not willing to go to government hospital<br>11. No good experience | | | 1.JSSK<br>2. ANC Care<br>3. IEC<br>4. DP / FRU<br>5. JSSK<br>6. 102/108 | | | |

| S N | Reasons | % of deaths | Common / Repeated Delay type | Reasons for Delay | Underlying Reasons | Frequency (Common occurance or isolated incidence) | Common area/village/ pada/hopsital | Progrms which address these problems | Status of These programs in these areas, taluks and district | Sugested Actions | What actions actually implemented in the district |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | with Govt hopsitals/services<br>12. No policy on awareness/health seeking behaviour<br>13. No policy for engagement of faith healers<br>14. No monitoring of home deaths - areas wise<br>15. No monitoring of refusal families/communities by field level staff/PHC/Block level officers<br>16. No nearby Delivery point or FRU<br>17. Delay in ambulance services due to - No Govt ambulance available/Ambulance driver was not available/Private ambulances not identified in case of emergency | | | | | | |

| SN | Reasons | % of deaths | Common / Repeated Delay type | Reasons for Delay | Underlying Reasons | Frequency (Common occurance or isolated incidence) | Common area/village/ pada/hopsital | Progrms which address these problems | Status of These programs in these areas, taluks and district | Suggested Actions | What actions actually implemented in the district |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | 18. Referral not done timely<br>19. JSSK IEC Not done in remote areas<br>20. No policy for any alternat ive transport arrangement<br>21. DP mapping not done considering remote/hard to reach areas<br>22. No monitoring of 24 *7 ambulance availability<br>23. No monitoring of driver availability<br>24. No monitoring of performance of ambulances | | | | | | |
| **2** | **Birth Asphyxia** | | **Type One** | 1.Individual / family / Societal cause<br>2.<br>3.Health Care delivery | 1. Do not know about danger signs/high risk status eg. Eclampsia, PROM<br>2. Gone to local faith healer/No faith in Govt institute/No | | | 1. JSSK /ANC care<br>2. IEC<br>3. DP FRU<br>4. SNCU<br>5. NBSU<br>6. IEC | | | |

| S N | Reasons | % of deaths | Common / Repeated Delay type | Reasons for Delay | Underlying Reasons | Frequency (Common occurance or isolated incidence) | Common area/village/ pada/hopsital | Progrms which address these problems | Status of These programs in these areas, taluks and district | Suggested Actions | What actions actually implemented in the district |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | **Type Two**<br><br>**Type Three** | 4.Policies<br>5.Monitoring<br>6.Individual / family / Societal cause<br>7.Health Care delivery<br><br>**8. Policies**<br>9.<br>10. Monitoring<br>11. Health Care delivery | faith in modern medicine<br>3. No hope for survival of the child<br>4. Didn't think that illness is serious<br>5. Do not know nearby delivery point or health facility<br>6. No good experience with Govt hopsitals/services/not willing to go to governement hospital<br>7. Home birth not attended by trained birth attendent<br>8. No counselling regarding health facility availability/High risk status /hospital delivery<br>9. No policy for IEC for awareness<br>10. No monitoring in refusal families or resistant areas | | | 7. Monitoring and Review<br>8. JSSK / IEC<br>9. DP / FRU<br>10. JSSK<br>11. Referral Transport Guidelines<br>12. TRAINING<br>13. ANC Care<br>14. Dakshata<br>15. LaQshya MusQan<br>16. NBCC<br>17. FRUs/ DP<br>18. IPHS<br>19. Training<br>20. SNCU<br>21. Training<br>22. DP FRU<br>23. Monthly Meetings<br>24. LaQshya MusQan<br>25. LaQshya MusQan | | | |

| S N | Reasons | % of deaths | Common / Repeated Delay type | Reasons for Delay | Underlying Reasons | Frequency (Common occurance or isolated incidence) | Common area/village/ pada/hopsital | Progrms which address these problems | Status of These programs in these areas, taluks and district | Sugested Actions | What actions actually implemented in the district |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | 11. Do not know whom to contact for ambulance<br>12. No nearby Delivery point or FRU<br>13. No Govt ambulance available/Ambulance driver was not available/Private ambulances not identified in case of emergency<br>14. Referral not done timely<br>15. Referral transport guidelines not followed - prereferral stabilisation, commuication with higher hospital<br>16. Referal points not mapped so inappropriate referral or multiple referalas.<br>17. JSSK IEC Not done in remote areas<br>18. DP mapping not done considering | | | | | | |
| | | | | 12. Policies<br>13. Monitoring | | | | | | | |

| S N | Reasons | % of deaths | Common / Repeated Delay type | Reasons for Delay | Underlying Reasons | Frequency (Common occurance or isolated incidence) | Common area/village/ pada/hopsital | Progrms which address these problems | Status of These programs in these areas, taluks and district | Sugges ted Actions | What actions actually implemented in the district |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | remote/hard to reach areas<br>19. No policy for any alternative transport arrangement<br>20. No monitoring of 24 *7 ambulance availability<br>21. No monitoring of driver availability<br>22. No monitoring of performance of ambulances<br>23. Staff not trained on SBA or Dakshata / NSSK<br>24. Delay in identification of prolonged or obstructed labor<br>25. Birth Companion policy not followed in specific facilities or area - block/district<br>26. Staff not trained on management of preeclampsia or eclampsia<br>27. Partograph | | | | | | |

| S N | Reasons | % of deaths | Common / Repeated Delay type | Reasons for Delay | Underlying Reasons | Frequency (Common occurance or isolated incidence) | Common area/village/ pada/hopsital | Progrms which address these problems | Status of These programs in these areas, taluks and district | Suggested Actions | What actions actually implemented in the district |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | and Safe Child birth checklist not used for monitoring labor<br>28. Lack of esesntial newborn care<br>29. No NBCC at Delivery point or NBCC not maintained properly<br>30. No specialist available at FRU/high risk delivery not attended by Pediatrician<br>31. Staff in SNCU not trained on NSSK<br>32. In SNCU, management of Birth Asphyxia not done as per treatment protocol<br>33. Not attended by specialist on time<br>34. No intimation to facility prior to referal so delay in starting treatment<br>35. No training policy - priority | | | | | | |

| S N | Reasons | % of deaths | Common / Repeated Delay type | Reasons for Delay | Underlying Reasons | Frequency (Common occurance or isolated incidence) | Common area/village/ pada/hopsital | Progrms which address these problems | Status of These programs in these areas, taluks and district | Suggested Actions | What actions actually implemented in the district |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | for FRU staff training, reorientation on important topic etc<br>36. No policy of DP or FRU identification and revision in facilities<br>37. No policy for non rotation of staff in LR, SNCU<br>38. Perinatal management preparedeness monitoring is not regularly monitored at institutional level<br>39. Audit is not being conducted regularly at facility level<br>40. Refered in management time lag need to be monitored | | | | | | |
| **3** | **Sespis / Penumonia** | | **Type One** | **Individual / family / Societal cause**<br><br>**Health Care delivery** | 1. Not aware about danger signs of Sepsis / Penumonia<br>2. Exlcusive breastfeeding not followed<br>3. Did not think that the illness was serious<br>4. Gone to local faith healer/No faith in Govt institute/Not aware about health facility | | | 1.ASHA Program<br>2.<br>3. Routine Immunisation,VHSND<br>4. SNCU<br>5. NBSU<br>6.IEC | | | |

| S N | Reasons | % of deaths | Common / Repeated Delay type | Reasons for Delay | Underlying Reasons | Frequency (Common occurance or isolated incidence) | Common area/village/ pada/hopsital | Progrms which address these problems | Status of These programs in these areas, taluks and district | Suggested Actions | What actions actually implemented in the district |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | **Type Two**<br><br>**Type Three** | **Policies Monitoring**<br>**Societal cause**<br>**Health Care delivery**<br>**Policies Monitoring**<br>**Health Care delivery (Facility and field)**<br>**Policies Monitoring** | 5. No hope for survival of the child<br>6. Didn't call to ambulance services<br>7. Migrated parents<br>8. PCV, MR Penta vaccines refusal<br>9. No examination in HBNC/No PNC visits<br>10. Health worker not able to identify high risk signs<br>11. Not done awareness about disease and treatment facilities available<br>12. SAM children not refered to NRC or CTC<br>13. Specific awareness policy<br>14. No specific monitoring of refusal families or resistant areas<br>15. No monitoring of HBNC/PNC visits | | | 7. IEC<br>8. JSSK IEC<br>9. JSSK IEC<br>10. Referral Transport guidelines<br>11. SAANS<br>12. IMNCI F IMNCI<br>13. HBNC HBYC<br>14. Training<br>15. CHO<br>16. SAANS<br>17. HBNC | | | |

| S N | Reasons | % of deaths | Common / Repeated Delay type | Reasons for Delay | Underlying Reasons | Frequency (Common occurance or isolated incidence) | Common area/village/ pada/hopsital | Progrms which address these problems | Status of These programs in these areas, taluks and district | Suggested Actions | What actions actually implemented in the district |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | 16. No awareness about JSSK scheme<br>17. Beneficiaries not informed about 102/108 services<br>18. ASHA/ANM didn't refered on time<br>19. Non availability of ambulance/delay in reaching ambulance/No response from ambulance services/Ambulance driver was not available/Diesel not available at the time of referral<br>20. Private ambulances not identified in case of emergency<br>21. CHOs not oriented on appropriate referral protocol of sick children<br>22. No policy for any alternative transport arrangement<br>23. No monitoring | | | | | | |

| S N | Reasons | % of deaths | Common / Repeated Delay type | Reasons for Delay | Underlying Reasons | Frequency (Common occurance or isolated incidence) | Common area/village/ pada/hopsital | Progrms which address these problems | Status of These programs in these areas, taluks and district | Suggested Actions | What actions actually implemented in the district |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | of 24 *7 ambulance availability<br>24. No monitoring of performance of ambulances<br>25. No pre-referral treatment given by ASHA / ANM / SN at facility<br>26. Referral transport guidelines not followed - pre-referral stabilisation, commuication with higher hospital<br>27. Delay in identification of sepsis / pneumonia signs by ASHA/ANM / CHO or at facility<br>28. Staff / ASHA ANM not trained on SAANS treatment protocols<br>29. Facility Staff do not know treatment protocols<br>30. Medicines not | | | | | | |

| S N | Reasons | % of deaths | Common / Repeated Delay type | Reasons for Delay | Underlying Reasons | Frequency (Common occurance or isolated incidence) | Common area/village/ pada/hopsital | Progrms which address these problems | Status of These programs in these areas, taluks and district | Sugges ted Actions | What actions actually implemented in the district |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | available with frontline workers or health facilities<br>31. No appropriate antibiotic protocols in SNCU / Health Facility<br>32. Not attended by MO/Specialist on time<br>33. No policy of CHO involvement in newborn and chld disease management<br>34. No monitoring of drugs and logistics at facility and field level<br>35. No monitoring of Sepsis cases and deaths in SNCU/ward<br>36. No daily monitoring rounds by ACS/Metron to SNCUs/Pediatric wards | | | | | | |
| 4 | **Prematurity and LBW** | | Type One | **Individual / family / Societal cause** | 1. Not aware about danger signs , delivery conducted by local untrained dai<br>2. Gone to | | | IEC<br>ANC CARE<br>ASHA PROGRAM<br>VHSND RI SESSIONS | | | |

| S N | Reasons | % of deaths | Common / Repeated Delay type | Reasons for Delay | Underlying Reasons | Frequency (Common occurance or isolated incidence) | Common area/village/ pada/hopsital | Progrms which address these problems | Status of These programs in these areas, taluks and district | Suggested Actions | What actions actually implemented in the district |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | local bhumaka/padiyal/ faith healer | | | MusQan | | | |
| | | | | **Health Care delivery** | 3. Did not think that the illness is significant | | | ASHA Program | | | |
| | | | **Type Two** | **Policies** | 4. No one advised to visit facility | | | | | | |
| | | | | **Monitoring** | 5. Not aware about health facility /Not willing for taking government hospital help/No faith/No trust on modern medicine | | | JSSK Referral Transport | | | |
| | | | **Individual / family / Societal cause** | | | | | CHO PROGRAM HWC Referral Transport - JSSK | | | |
| | | | **Type Three** | **Health Care delivery** | | | | VHSND | | | |
| | | | | **Policies** | 6. No good experience with Govt hopsitals/services/staff | | | AMB NHM GB EC MEETING | | | |
| | | | | **Monitoring** | | | | | | | |
| | | | | **Health Care delivery (Facility and field)** | 7. Delivery conducted by untrained personnel | | | | | | |
| | | | | | 8. No visit by ASHA or ANM as per HBNC or other program | | | | | | |
| | | | | | 9. No policy for engagement of faith healers in such areas | | | | | | |
| | | | | **Policies** | | | | | | | |
| | | | | **Monitoring** | 10. No propoer IEC/SM | | | | | | |

| S N | Reasons | % of deaths | Common / Repeated Delay type | Reasons for Delay | Underlying Reasons | Frequency (Common occurance or isolated incidence) | Common area/village/ pada/hopsital | Progrms which address these problems | Status of These programs in these areas, taluks and district | Sugges ted Actions | What actions actually implemented in the district |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | strategies for refusal families<br>11. No monitoring in refusal families or resistant areas or Home deliveries<br>12. Not aware about health facility/taken to local healer<br>13. No road/communication network/cut off villages/pada<br>14. ASHA/ANM didn't refered on time<br>15. Non availability of ambulance/delay in reaching ambulance/No response from ambulance services/Ambulance driver was not available/Diesel not available at the time of referral<br>16. Private ambulances not identified in case of emergency<br>17. CHO not | | | | | | |

| SN | Reasons | % of deaths | Common / Repeated Delay type | Reasons for Delay | Underlying Reasons | Frequency (Common occurance or isolated incidence) | Common area/village/ pada/hopsital | Progrms which address these problems | Status of These programs in these areas, taluks and district | Suggested Actions | What actions actually implemented in the district |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | oriented on referral management protocol of sick children<br>18. No policy of CHO involvement in sick newborn and children referral and disease management<br>19. No Monitoring of Ambulances working or not/No monitoring of performance of ambulances<br>20. Health care worker visisting home delivery is not trained in management of prematurity and LBW babies/Essential newborn care not done after delivery<br>21. Health facility is not initimated while refering for receipt of baby<br>22. No treatment given | | | | | | |

| S N | Reasons | % of deaths | Common / Repeated Delay type | Reasons for Delay | Underlying Reasons | Frequency (Common occurance or isolated incidence) | Common area/village/ pada/hopsital | Progrms which address these problems | Status of These programs in these areas, taluks and district | Sugges ted Actions | What actions actually implemented in the district |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | by Medical officer as per protocol/ baby not attended by MO or pediatrician.<br>23. Unavailability of Specialist / check up by specialist at health facility<br>24. Treatment protocols not available at facility level - sncu/nbsu/other facilities<br>25. Capacity building<br>26. No policy on referral linkage<br>27. No monitoring of high risk ANCs admitted by Specialists<br>28. No monitoring of drugs and logistics at facility and field level<br>29. No monitoring of LBW babies in wards<br>30. Premature discharge from SNCU<br>31. No monitoring of KMC practices in SNCU/NBSU/PNC ward<br>32. No monitoring of breastfeeding practices in LR/SNCU/PNC wards | | | | | | |