EXECUTIVE SUMMARY

State has made substantial improvement in the reducing the number of maternal and child deaths since the start of National Health Mission in 2005. However many preventable maternal and child deaths still occur because of lack of quality of care, socioeconomic issues, gaps in health delivery especially in remote, rural and tribal areas of the State. In order to reduce the number of maternal and child deaths further, State needs to improve quality of care given around birth and address the modifiable factors that contribute to majority of deaths.

Understanding the circumstances and the modifiable of factors that lead to maternal or child death can prevent these deaths. Audit and review of maternal and child deaths is an important tool for identifying gaps in health service provision at facility or community level. This also helps in identification of socioeconomic factors which are directly or indirectly leading to mortality. This identification of gaps in service delivery can help in planning various interventions to improve the quality of care in health facilities and in communities. This is also essential for identifying new health interventions and reforms in health system at local and State level.

For this purpose, all public health facilities providing services to pregnant women and children need to establish an effective system for maternal and child death reviews. Also, at block and district level, committees on maternal and child death review need to have regular monitoring and review of maternal and child deaths. Maternal and child death audits along with reviews provide in detail information regarding how a similar death may be avoided in the future.

This document helps in providing guidance to district and block level health functionaries for establishing and conducting maternal and child death reviews as part of improvement in overall quality of care provided at facility and in community.

The guidance note describes in detail the key parameters of maternal and child death audit and review at facility and district level. The steps in the death audit and review are: (i) Notification of Death, (ii) Investigation of Death (First Brief Investigation and Detailed Investigation including verbal autopsy, Identifying the causes of death and potentially modifiable factors) (iii) Data Transmission iv) Analysis of data and recommending solutions or actions, (v) implementing an action plan (vi) monitoring the implementation of action plan.

This guidance note includes forms for notification, investigation of death. This also includes template to identify gaps in society/family, health service delivery, monitoring and policies for major causes of maternal and child deaths. Also, a short summary brief information on major causes of deaths, definition, risk factors associated, diagnosis and preventive actions is given for districts to plan interventions.

The annexures in the guideline provide forms for notification of death, brief and detail investigation of deaths for assigning cause of death, templates for asking key questions for major causes of maternal and child deaths regarding gaps in different areas (society/family, health service delivery, monitoring and policies) and level of delays, summary line list format for death review meeting and summary action plan format for preparation of action plan along with compliance.

CHAPTER 1: BACKGROUND AND PURPOSE

BACKGROUND

Reducing maternal and child mortality is one of the key goals under National Health Mission. There are various programs implemented to prevent maternal and child mortality. Over the years there has been decline in maternal and child deaths. Maharashtra has already achieved SDG goals for maternal and child mortality. However, there are some variations in urban and rural areas as per SRS surveys. So, to reduce mortality further down focus has to be given on areas, age groups where mortality is high. For this purpose, specific interventions are to be made for major causes of maternal and child mortality. This requires identification of gaps in health service delivery, monitoring of programs and issues related to socioeconomic conditions.

Districts are required to undertake this in-depth analysis for identification of gaps and formulation of local context specific implementation plan on key maternal and child health strategies identified based on mortality patterns. This will be possible if special efforts are made to investigate maternal and child death in depth for identification of information required to prepare plans specific to districts. This kind of analysis will help district and State program managers to identify key gaps for health service delivery at facility and community level.

The objectives of maternal and child death audit are

- To report all maternal and child deaths
- To ensure that each death is assigned a cause or causes
- To ensure to identify preventable causes and areas of improvement
- To investigate in detail about health services provided and whether they are provided as per guidelines and treatment protocols
- To identify 3 types of delays in each case of death as well as reasoning for these delays and to identify the actionable actions to reduce these delays.
- To investigate the social, family and individual related risk factors for any death;
- To identify gaps in health service delivery, monitoring of programs and policies
- To identify geographical areas having high mortality
- To identify possible modifiable factors in all such areas
- To plan interventions to change modifiable factors to improve the quality of care and avoid similar deaths in future
- The death audit also shall be used as tool for monitoring the implementation of activities/program to reduce the maternal and child death
- The ultimate aim of death audit is to improve the quality of care, to prevent maternal and child deaths.

Purpose of this document

State has already issued guidelines for conducting maternal and child death audit. This document suggests the possible approach towards doing maternal and child death review which will help district level officers to identify gaps for major reasons of maternal and child deaths in various areas like societal/family issues, health service delivery, monitoring of programs and policy level gaps. Also, template will help to identify reasons behind level of delay related to above areas.

This document will help district officers to prepare action plan based on identified gaps and monitoring of plan to achieve desired results.

The purpose of this document is to;

- To enlist the steps for MDR and CDR at the health facility and community levels.
- To identify specific cause related gaps in individual or societal issues, health service delivery, monitoring of programs and policies along with causes for level of delay in these areas.
- To prepare plan based on identified gaps and monitoring of action plan by district level committee.
- To provide guideline related to notification, investigation and data transmission under MDR and CDR programs.