B. Guidance Note for Child Death Audit and Review (Annexures 5 to 8)

Child mortality is one of most important public health concern. Although Maharashtra has shown substantial decline in child mortality, intrastate variation still warrants the attention to strengthen the preventive measures. About 75 percent of the child deaths occur due to preterm birth, birth asphyxia, infections and birth defects. Most of these complications are observed during first month of life and are preventable or treatable.

Child death review (CDR) helps in identifying the gaps in the existing health care delivery systems, prioritize and plan for intervention strategies and to strengthen the child health services.

This document is intended to assist district officials/programme managers to conduct child death audit effectively with the objective of reducing child deaths due to preventable causes.

This guidance templates should be used to analyse sample of child deaths (atleast 5 cases) every month to identify the multifaceted underlying causes, gaps in health care service delivery, level of delays. It consists of 4 Annexures which will assist in making effective action plan to address the identified gaps.

Annexure 5- Gap analysis at community, health system, monitoring and policy level
Annexure 6- Gap analysis as per Three-delays model
Annexure 7- Line list format for child death review at district level
Annexure 8- Plan of action and compliance report of child death review meeting

Details of annexures is given in following sections.

Annexure 5- Gap analysis at community, health system, monitoring and policy level

- This sheet has some pointers for identification of gaps pertaining to most important causes of child deaths i.e. Prematurity / low birth weight, Sepsis / Pneumonia, Birth Asphyxia and also regarding deaths occur at home or during transit
- For above mentioned causes of death, some questions are suggested which are to be asked in each child death case regarding previous history, gaps at community/individual level, health system land service delivery level, monitoring of programs and policy level.
- This will help in finding gaps at various levels, program implementation, monitoring etc.
- This analysis should be done to identify underlying gaps which can be attributed to the child death for a sample of 6 child deaths every month.

Details regarding underlying causes / areas of gaps is as follows-

1. **Previous History –** For each child death case, previous history is to be asked in detail for the cause of death as given in template.

2. **Community, Society or family Gaps:** Enlist the causes existing among the community or at individual level which are related to particular cause of child death. For example, following questions may be asked

    i. If there are any misconceptions?
    ii. What is the awareness level of the bereaved family?
    iii. Are the family members resistant to seek institutional help?
    iv. If there any geographic or infrastructural constraints?

3. **Gaps in health service delivery:** Explore the gaps in service delivery which would have been proved beneficial in preventing the child death.

For example, following questions should be asked to assess the gaps in service delivery for death due to Prematurity or Low birth weight

- Was maternal weight gain monitoring done during ANC period by ASHA/CHO?
- Was Inj Dexa (antenatal steroids) given to mother for premature delivery before 34 weeks
- Was counselling for KMC done during home visits by ASHA under HBNC?

4. **Gaps on health policies :** Committee should review the policies which could have addressed the child death. Committee can also suggest the policies needed to address such events.

Sample questions which can be asked in case of child death due to Sepsis/Pneumonia are

- Any policy for referral linkage for transfer of sick newborn?
- Any policy on CHO involvement in management of newborn and child diseases?

5. **Gaps in monitoring and implementation of health programmes:**

Ongoing national and state health programmes should be reviewed for their implementation in the concerned area / health facility.

Also, monitoring and follow up of the child and high-risk pregnant women should be analysed.

Following sample questions should be considered to review the monitoring and implementation of the health programmes related to cause of child death –

E.g., For child death due to Birth Asphyxia

- Was high risk ANC monitoring done or not?
- Was health facility preparedness monitored to tackle cases of birth asphyxia or prevent cases of birth asphyxia
- Was monitoring of referral of labor cases monitored or not?
- Was regular skill assessment of staff working in labor room monitored?

6. **Identification of facilities/areas/blocks/PHCs:** Investigate about the trends of the child deaths in the given area/facility for at least 3 years. It will guide the committee to identify hotspots of poor child health service coverage. If the concerned area has repeated events of child deaths, then review the maternal and child health care services. Plan the supportive supervision visit to concerned area/hospital to review the field level activities.

7. **Programs which address these problems/gaps:** Identify the ongoing national and state programmes which are attributed in reducing child deaths. For example, investigate about the implementation status of SNCU, NBSUs, JSSK, HBNC, Home Based KMC, RI and identify the programme which need to be strengthen for higher impact in reduction of maternal mortality.

8. **Status of programs in the field/facility:** Further, investigate about the benefits of the ongoing health programmes received by the deceased child. Analyse and identify the gaps in receiving the benefits of the health programmes which are intended to reduce maternal mortality.

9. **Action Points:** After analysing the causes, the action points should be suggested to prevent future deaths with defined roles of responsibilities of concerned health workers/officials.

10. **Compliance on action plan:** Take follow up of suggested action points in next meeting. Analyse the bottlenecks in implementing the action points for example shortage of human resources, lack of trained staff, supervision visits etc.

Template for analysing the causes of child death for finding the gaps has been given in **Annexure No 5**. It can be used for finding the gaps and making action plan for various causes of maternal death.

Annexure 6- Three-delays model for preparing action plan to reduce maternal deaths

The 3-Delays Model helps in the identification of barriers in accessing the child health services. It identifies the causes at household, community and health system levels which are responsible for the child death.

Identify the level of delay responsible for the child death. Three delays in accessing the health care services as given as-

i. First Delay- Delay in the decision to seek care

ii. Second Delay- Delay in identifying and reaching the health facility

iii. Third Delay- Delay in receiving treatment at the facility

1. **Enlist the reasons behind level of delay responsible for the child death for each area** i.e. Society/Individual area, Health service delivery in facility/field, Policies and Monitoring of programs.

For example in case of child death at home, for level 1 delay, question in related to society or family level can be asked eg. Family members do not know about danger signs in child, Family didn't call for ambulance etc.

2. **Common areas/facilities:** Assess that whether the identified reasons for the delay is the common phenomenon in the concerned area. Investigate whether the concerned area / facility is prone to identified reasons. This will give a high priority area for child deaths.

3. **Programs to tackle delays:** Identify the ongoing programmes which would address the identified delays and its reasons.

4. **Status of program implementation in these areas/facilities:** Also assess the implementation status of these programs useful to tackle various levels of delay and to strengthen the related programmes.

5. **Action Plan:** After identifying and assessing the delays and its reasons and related programmes, committee should suggest action points to address the child mortality t

6. **Compliance on suggested action plan:** All the suggested action points must be followed up in next monthly meeting.

Annexure No 6 can be used as template to investigate the delays and making action points to address them.

Annexure 7- Line list format for Child deaths reviews at district level

- Annexure-4 is designed for the summarizing child deaths at district level meeting
- Enlist the child deaths with details of causes of deaths, reasons for the cause leading to deaths, type of delays and its reasons and proposed corrective measures.
- This format can also be used to present the maternal and child death information to District collector and CEO.
- This format will give brief information about the cause of deaths in the given month which will help to prioritize the preventive measures.

Annexure 8 - Summary points of Child death review

- Summarize the meeting minutes reviewing child deaths at district level meeting in separate sheet
- Summarize common preventable reasons leading to deaths, common problems identified with service delivery and common areas involved. Also identify programs for the said reasons.
- Based on these inputs, prepare common preventive measures for reducing child deaths and activities to be implemented in the district.
- Also take follow up of action plan prepared in the last meeting of child death audit and actions taken for the same.
- Mention about any improvement in the programs/indicators based on actions implemented as per last meeting.