Chapter 4: Use of Guidance Templates – MDR and CDR

The booklet and contents are to be used as a guidance note for child and maternal death review. The format is to guide how to approach the maternal and child death individually as well as a cumulative analysis. The causes, reasons mentioned are not in any way exhaustive and committee need to go into identifying the preventable causes as well as systemic failure which can be corrected. These guidelines are developed to facilitate committee as well as district administration to formulate district specific action plan to reduce maternal as well as child death. Committee is expected to approach the death review from hospital as well as community point of view and also with broader view of developing implementable action plan and evidence-based action plan.
The committee and district are at complete liberty to explore the data in more comprehensive way to achieve this goal.

A. Guidance Template for Maternal Death Audit and Review (Annexure No. 1 to 4)

Maternal deaths occur as a result of complications during and following pregnancy and childbirth. Most of these complications develop during pregnancy and most are preventable or treatable. In some cases, complications may exist before pregnancy but are worsened during pregnancy.

Definition: The maternal death is the defined as the death of the woman who die from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy.

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

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

This guidance templates should be used to analyse each of the maternal deaths 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 1- Gap analysis at community, health system, monitoring and policy level
Annexure 2- Gap analysis as per Three-delays model
Annexure 3- Line list format for maternal death review at district level
Annexure 4- Plan of action and compliance report of maternal death review meeting

Details of annexures is given in following sections.

Annexure 1- Gap analysis at community, health system, monitoring and policy level

- This sheet has some pointers for identification of gaps with respect to most important causes of maternal deaths i.e. APH/PPH, PIH, Sepsis, Abortion, Anemia and also regarding home / transit deaths
- For above mentioned causes of death some questions are suggested which are to be asked in each maternal death case regarding previous history, gaps at community/individual level, health system and 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 for each cause of maternal death.

A) Details regarding underlying areas of gaps is as follows-

1. Previous History: Detail previous history before the maternal death is to be investigated.

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

- If there are any misconceptions?
- What is the awareness level of the bereaved family?
- Are the family members resistant to seek institutional help?
- 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 to the deceased mother.

For example, following questions should be asked to assess the gaps in service delivery.

- Was the deceased mother visited by ASHA/ANM for ANC?
- Was the ambulance available in that particular area?
- Were the due services given to deceased mother as per her high-risk status?

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

Sample questions-

- Presence of IEC/BCC policy which is covering the misbeliefs and resistance in the area
- Is there any policy which is engaging local healers in providing health services?
- Is there need of any policy which will provide the special health services to migrated or floating population?
- Is there need of any human resource policy modifications?

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. **Also, monitoring and follow up of high-risk mothers should be analysed.**

Following sample questions should be considered to review the monitoring and implementation of the health programmes.

- What is the status of PMSMA services in the concerned area?
- Is there proper monitoring of high-risk mothers going on?
- Are ASHA home visits being monitored?
- Is line list of high-risk mothers being maintained?

6. Identification of facilities/areas/blocks/PHCs: Investigate about the trends of the maternal deaths in the given area/facility for at least 3 years. It will guide the committee to identify hotspots of poor maternal health service coverage and high maternal deaths. If the concerned area / facility has repeated events of maternal deaths, then review the maternal and child health care services at these facilities. 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 involved in reducing maternal deaths. For example, investigate about the implementation status of JSSK, PMSMA and identify the programme which need to be strengthened for reduction of maternal mortality.

8. **Status of programs in the field/facility:** Review the maternal health programme implementation status in the given areas of maternal deaths. Further, investigate about the benefits of the ongoing health programmes received by the deceased. 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 maternal death for finding the gaps has been given in **Annexure No 1.**
It can be used for finding the gaps and making action plan for various causes of maternal death.

Annexure 2- Three-delays model for preparing action plan to reduce maternal deaths

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

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

i. First Delay- Delay in the decision seeking care
ii. Second Delay- Delay in identifying and reaching the health facility
iii. Third Delay- Delay in receiving treatment at the facility

Each maternal death should be analysed for each level of delay and gaps need to be identified. Questions should be asked in each maternal death case for each level of delay for following areas

1. **Enlist the reasons behind level of delay responsible for the maternal 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 maternal death due to APH, for level 1 delay question in the area of society or family level can be asked regarding misconceptions about bleeding during ANC or no belief on government services

2. **Common areas/facilities:** Assess that whether the identified reasons for the level of delay is the common phenomenon in the concerned area or facility. Investigate whether the concerned area / facility is prone to identified reasons. This will give a high priority area for maternal 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 delays leading to the maternal mortality.
6. **Compliance on suggested action plan:** All the suggested action points must be followed up in next monthly meeting.

Annexure No 2 can be used as template to investigate the delays and making action points to address

them.

Annexure 3- Line list format for maternal deaths reviews at district level

- Annexure-3 is designed for the summarizing maternal deaths at district level meeting
- Enlist the maternal 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 4 - Summary format for maternal death review meeting at district level

- Summarize the meeting minutes reviewing maternal 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 maternal deaths and activities to be implemented in the district.
- Also take follow up of action plan prepared in the last meeting of maternal death audit and actions taken for the same.
- Mention about any improvement in the programs/indicators based on actions implemented as per last meeting.