



**NATIONAL RURAL HEALTH MISSION**

# **MATERNAL DEATH REVIEW**

**Department of Health and Family Welfare  
Government of Punjab**

**(JULY 2010)**

**GUIDELINES FOR ROLLING OUT**

# MATERNAL DEATH REVIEWS (Facility and Community Based)

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# CHAPTER – 1

## MATERNAL DEATH REVIEW – A Perspective

### 1.1 Background and Introduction

Each year in India, roughly 28 million women experience pregnancy and 26 million have a live birth. Of these, an estimated 67,000 maternal deaths and one million newborn deaths occur each year. In addition, millions more women and newborns suffer pregnancy and birth related ill-health. Thus, pregnancy-related mortality and morbidity continues to have a huge impact on the lives of Indian women and their newborns.

***Maternal death** is defined as the death of a woman who dies from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy or child birth or within 42 days of termination of pregnancy, irrespective of duration and site of the pregnancy.*

***Maternal Mortality Ratio (MMR)** is the number of women 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, per 1,00,000 live births.*

Maternal Mortality Ratio (MMR) in India has shown an appreciable decline from 398/100,000 live births in the year 1997-98 to 301/100,000 live births in the year 2001-03 to 254/100,000 live births in the year 2004-06 as per the latest RGI-SRS survey report, released in April 2009. However, to accelerate the pace of decline of MMR in order to achieve the NRHM and MDG Goal of less than 100 per 100,000 live births, there is a need to give impetus to implementation of the technical strategies and interventions for maternal health. Levels of maternal mortality vary greatly across the regions, due to variation in underlying access to emergency obstetric care, antenatal care, anemia rates among women, education levels of women, and other factors. About two-thirds of maternal deaths occur in a handful of states – Bihar and Jharkhand, Orissa, Madhya Pradesh and Chattisgarh, Rajasthan, Uttar Pradesh and Uttarakhand and in Assam, all these states being among the 18 high focus states under NRHM.

*Maternal Mortality Ratio in Punjab showed a decline from 199 in the year 1997-98 to 178 in the years 2001-03 but again rose to 192 per 1,00,000 live births in the years 2004-06 as per the latest RGI-SRS survey report, released in April 2009.*

Maternal Death Review (MDR) as a strategy has been spelt out clearly in the RCH –II National Programme Implementation Plan document. It is an important strategy to improve the quality of obstetric care and reduce maternal mortality and morbidity. The importance of MDR lies in the fact that it provides detailed information on various factors at facility, district, community, regional and national level that are needed to be addressed to reduce maternal deaths. Analysis of these deaths can identify the delays that contribute to maternal deaths at various levels and the information used to adopt measures to fill the gaps in service. MDR has been conducted as an established intervention for the last few years by some states like Tamil Nadu, Kerala and West Bengal which have also shared their experiences while these guidelines and tools were being framed. However, in most of the other states the efforts in this area have been at best fragmented. Recognising the need for sharing of and learning from experiences of different stakeholders, MOHFW organized a two day workshop to finalize the MDR strategy at PGIMER, Chandigarh, in May 2009, with the objective of developing a road map and also guidelines and tools, which the states could use and implement easily. During the workshop, participants from various states shared their experiences in initiating maternal death reviews in facilities and also in community settings.

## **1.2 Guidance Note**

The present note is based on the inputs and deliberations held during the above workshop. The purpose of this guidance note is to provide a roadmap to the State and District Programme Managers for conducting MDR. The tools for MDR have been developed with the objectives of identifying gaps and the reasons for maternal deaths, for taking corrective actions to fill such gaps and improve service delivery. The process of MDR should not be utilized for taking punitive action against service providers.

The **objectives** of the guidelines are:

- a. To establish operational mechanisms/modalities for undertaking MDR at selected institutions and at community level
- b. To disseminate information on data collection tools, data/information flow and analysis
- c. To develop systems for review and remedial follow up actions

*Maternal Death Review is contemplated to be implemented in two forms – **Facility Based Maternal Death Review (FBMDR)** and **Community Based Maternal Death Review (CBMDR)**, which are defined as below:*

***FBMDR** is a process to investigate and identify causes, mainly clinical and systemic, which lead to maternal deaths in the health facilities; and to take appropriate corrective measures to prevent such deaths.*

*CBMDR is a process in which deceased's family members, relatives, neighbours or other informants and care providers are interviewed, through a technique called Verbal Autopsy, to elicit information for the purpose of identification of various factors – whether medical, socio-economic or systemic, which lead to maternal deaths; and thereby enabling the health system to take appropriate corrective measures at various levels to prevent such deaths.*

The note will be useful for programme managers, Medical Superintendents, officers in charge and district programme managers who are routinely engaged in delivery of maternal health interventions. For ease of reference this document has been organized separately for facility and community based reviews and has a section on MDR at District and State level. Private sector providers may also find this useful in instituting maternal death reviews/ audits.

While implementing interventions on MDR, a one day sensitization cum training of trainers for the states will be conducted at the national level at the National Health System Resource Centre (NHSRC) with participation of national level programme officers from Ministry of Health and Family Welfare. Similarly, district CMOs will be trained at the state level and all block and PHC level MOs will be trained for one day at the district level. Each Block/PHC MO will conduct a similar training for all paramedical staff / other field functionaries. Simplified process flow charts and formats for both CBMDR and FBMDR alongwith Annexures comprising of detailed questionnaires and other tools for both types of MDR are also enclosed with this Guidance Note which will facilitate the training. Printing of these materials shall be done through the State Health Society and this must be reflected in the budget of the state PIPs.

The conduct of these reviews and meetings shall be **supported by a State Government Order.**

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## CHAPTER – 2

### MATERNAL DEATH REVIEW – METHODOLOGY AT A GLANCE

#### FACILITY BASED MATERNAL DEATH REVIEW

<b>FACILITY BASED</b>
<p><b>INFORMATION</b></p> <p>1. In case of any maternal death in the Facility, <b>MO on duty</b> immediately telephonically informs Facility Nodal Officer MDR. (Ref: Para 3.6)</p> <p>2. Facility Nodal Officer MDR immediately (within 24 hours of the maternal death) informs <b>CS, DC and DFW</b> telephonically and also in the Format for Primary Informer as per Annexure-6. (Ref: Para 3.6)</p>
<p><b>INVESTIGATION</b></p> <p>3. Completion of <b>Facility Based MDR Form (Annexure-1)</b> in duplicate for every maternal death within 24 hours of its occurrence by the <b>MO on duty in consultation with Facility Nodal Officer</b> and signed by both. (Ref: Para 3.7)</p>
<p><b>MONTHLY REVIEW</b></p> <p>4. <b>Monthly review meeting of the Facility MDR Committee</b> on a prefixed date of the following month to review all the maternal deaths occurred in the Facility during the month and implementation of the suggested corrective measures. (Ref: Para 3.8 &amp; 3.12)</p> <p>5. Every maternal death occurring in the facility is given a <b>yearly serial number</b>. The findings of the review for all the maternal deaths during the month and corrective actions taken are <b>reported to the Civil Surgeon</b> by the Facility Nodal Officer MDR, along with a duly filled copy of the <b>Facility Based MDR Form ( Annexure-1)</b> &amp; a copy of the case sheet of the deceased, in a sealed cover marked 'CONFIDENTIAL'. (Ref: Para 3.9 &amp; 3.10)</p>
<p><b>KEEPING RECORD OF MATERNAL DEATHS</b></p> <p>6. A register as per the format at <b>Annexure-6A</b> shall be maintained in the facility by the Facility Nodal Officer to keep a yearly serial record of all the maternal deaths occurring in the facility. (Ref: Para 3.9)</p>

#### COMMUNITY BASED MATERNAL DEATH REVIEW

<b>COMMUNITY BASED</b>
<p><b>INFORMATION</b></p> <p>1. In case any maternal death takes place, <b>ASHA/AWW</b> telephonically informs <b>SMO Block PHC &amp; ANM</b> of the area immediately. (Ref: Para 4.6)</p> <p>2. <b>ANM</b> ensures that every maternal death in her area is reported to the <b>SMO Block PHC</b> immediately telephonically within 24 hrs of its occurrence, and simultaneously she also gives information to the SMO Block PHC in the format for primary informer as per <b>Annexure-6</b>. (Ref: Para 4.6)</p> <p>3. <b>SMO Block PHC</b> informs this maternal death immediately within 24 hours of receipt of information from ASHA/AWW/ANM to the <b>CS, DC and DFW telephonically</b>, and also in the format for primary informer as per <b>Annexure-6</b>. (Ref: Para 4.11)</p>
<p><b>LINE LISTING OF ALL DEATHS OF WOMEN OF AGE 15-49 YEARS</b></p> <p>4. <b>ASHA/AWW</b> line lists all deaths of women of age 15 to 49 years during the month, irrespective of cause or pregnancy status, and she submits the monthly report as per <b>Annexure-4</b> to the ANM she is attached to by 5<sup>th</sup> of the following month. In addition, she informs every such death to the ANM telephonically also within 24 hours of its occurrence. (Ref: Para 4.7)</p> <p>5. The ANM cross checks every death line listed by ASHA/AWW as per <b>Annexure-4</b> and submits the final report to the SMO Block PHC by 10<sup>th</sup> of the following month. (Ref: Para 4.8 &amp; 4.9)</p>
<p><b>INVESTIGATION</b></p> <p>5. <b>SMO Block PHC</b> on receipt of information of the maternal death deposes the designated <b>investigation team</b> for Community Based Investigation (Verbal Autopsy) as per format at <b>Annexure-2</b> to be completed within 3 weeks of the death. (Ref: Para 4.12)</p> <p>5. <b>SMO Block PHC</b> discusses and analyses the findings of every maternal death investigated with the Investigation Team, completes the Case Summary Sheet (<b>Annexure-3</b>) in duplicate for every confirmed maternal death during the month and sends the <b>report in Annexure-3 to the Civil Surgeon</b> within four weeks of the occurrence of the death while keeping one copy of <b>Annexure-3</b> for record. (Ref: Para 4.13)</p>
<p><b>KEEPING RECORD OF ALL DEATHS OF WOMEN OF AGE 15-49 YEARS</b></p> <p>8. All the deaths of women of age 15-49 yrs, irrespective of the cause of death or pregnancy status line listed by the ASHA/AWW every month and submitted by ANMs after cross checking, are serially recorded at Block PHC by the SMO Block PHC in the <b>Community Based MDR Register</b> as per <b>Annexure-5</b> ( including the confirmed maternal deaths). (Ref: Para 4.10)</p>

<b>FACILITY BASED</b>
<p><b>PARTICIPATION IN THE MEETING OF DISTRICT MDR COMMITTEE</b></p> <p>7. In case a maternal death is reported to the District MDR Committee during the month, <b>a member is nominated by the Facility MDR Committee</b> to participate in the monthly review meeting of the District MDR Committee chaired by the Civil Surgeon in the following month. <b>(Ref: Para 3.13)</b></p>

<b>COMMUNITY BASED</b>
<p><b>PARTICIPATION IN THE MEETING OF DISTRICT MDR COMMITTEE</b></p> <p>9. In case a maternal death review report (in Annexure-3) is submitted to the District MDR Committee by the Block PHC during the month, in that case the <b>SMO Block PHC participates</b> in the monthly review meeting of the District MDR Committee chaired by the Civil Surgeon in the following month. <b>(Ref: Para 4.14)</b></p>

<p><b>DISTRICT LEVEL MATERNAL DEATH REVIEW BY CIVIL SURGEON (Ref: Para 3.14, 4.4, 4.14 &amp; Chapter-5)</b> (FBMDR + CBMDR)</p> <p>(Civil Surgeon will constitute the <b>District MDR Committee</b> comprising of ACS, MO (Obs. &amp; Gynae.), Anaesthetist, Officer I/c blood bank/blood storage centre, a Senior Nurse and invited members from Facilities/Block PHCs as Members, and District Nodal Officer MDR (DFWO) as Member Secretary of the Committee).</p> <p><b>Monthly review meeting of the District MDR Committee chaired by Civil Surgeon and convened by District Nodal Officer every month on a prefixed date.</b></p>
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<p><b>MATERNAL DEATH REVIEW BY DISTRICT HEALTH SOCIETY UNDER THE CHAIRMANSHIP OF DEPUTY COMMISSIONER (Ref: Para 3.15, 4.15 &amp; Chapter-6)</b> (FBMDR + CBMDR)</p> <p>(The review meeting will be attended by all the members of the District Health Society or a selected group of DHS members as deemed fit by the Deputy Commissioner. The other members to attend will be the District MDR Committee members and any other member incorporated/suggested by the DC which may include the family members of the deceased who were present with the mother during the treatment of complications or at the time of death).</p> <p><b>Monthly review meeting chaired by DC, convened by the Civil Surgeon and assisted by the District Nodal Officer (2 relatives of the deceased to attend).</b></p>
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<p><b>STATE LEVEL MATERNAL DEATH REVIEW BY STATE LEVEL TASK FORCE (SLTF). (Ref: Chapter-7)</b> (FBMDR + CBMDR)</p> <p><b>Review meeting once in 3 months chaired by PSHFW.</b></p>
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**CHAPTER - 3**  
**PROCEDURE FOR FACILITY BASED MATERNAL DEATH REVIEW**  
**(FBMDR)**

- 3.1 Objective** - The objective of this process is to identify various delays causing maternal deaths in the health facilities and to enable the health system to take corrective measures at various levels. Identifying maternal deaths would be the first step in the process of review, the second step would be the investigation of the causes which led to the maternal death mainly clinical and systemic and the third step would be to take appropriate and corrective measures.
- 3.2 Identification of Institutions - Civil Surgeon** will identify and notify names of institutions which will take up MDRs in the district. In the first phase, this exercise will be limited to Government facilities and the facilities run by Public Sector Undertakings (PSUs). Government facilities of the level of Medical College Hospitals, District Hospitals and high volume sub district level FRUs (having an Expected Annual Delivery Load of about 360 deliveries) will initially be taken up for MDRs. Facilities run by PSUs will include all the institutions in the district controlled by Corporations, Boards, ESI Scheme etc. having an Expected Annual Delivery Load of about 360 deliveries.
- 3.3 Appointment of Nodal Officer for every Facility** - MS/SMO/Officer In charge of each facility will identify the **Facility Nodal Officer MDR** for the facility. The Facility Nodal Officer MDR will be responsible to convene the review meeting of the Facility MDR Committee every month to be chaired by the MS/SMO/Officer In charge of the facility, to organise necessary documentation for review by the Committee and to keep a record of follow up actions initiated. He will be responsible for proper maintenance of all records related to Maternal Death Reviews in the facility.
- 3.4 Orientation meetings** - A one day orientation meeting will be organised by the State Nodal Officer MDR at State level for orienting the MS/SMO/Officer In charge and Facility Nodal Officer of identified facilities in the data collection tools and processes. Similarly, a one day orientation training of all MOs of the identified Facilities, focussed on the processes to be adopted and formats to be used, will be organised by the District Nodal Officer MDR at the district level.
- 3.5 Facility MDR Committee** - MS/SMO/Officer In charge of the facility will constitute a **Facility MDR Committee**. The members of this committee would be staff members from Obstetrics & Gynaecology, Anaesthesia, Nursing, Blood Bank and any other relevant departments. The Facility Nodal Officer will be the **Member Secretary** of this committee. The Facility MDR Committee shall meet on a prefixed date in the first week of every month to review the maternal death reports of the preceding month.
- 3.6 Intimation regarding maternal death** - For each case of maternal death, the **MO on duty/MO In charge Ward/Emergency** will immediately inform the **Facility Nodal Officer** on telephone and the Facility Nodal Officer will immediately telephonically within 24 hours of occurrence of the death inform the **Civil Surgeon, Deputy Commissioner and the State Director Family Welfare** about the maternal death and simultaneously also in the format for Primary Informer as per **Annexure-6**.
- 3.7 Investigation of maternal death** - For each case of maternal death, the **Facility Based MDR Form** at **Annexure-1** will be completed in duplicate by the MO on duty /Medical

Officer In charge Ward/Emergency within 24 hours of occurrence of the death, in consultation with the Facility Nodal Officer. **Hospital Case Sheet** available with respect to the deceased will be referred to while filling this form and a copy of the Case Sheet will also be attached with this form to discourage any post facto recording/entry in the case sheet. After the form is filled in duplicate and duly signed by both these officials and a copy of the Case Sheet is attached with each, it will be kept in a sealed envelope with the Facility Nodal Officer of the MDR committee who in turn will put up the cases to the Facility MDR Committee during its scheduled meetings.

**3.8 Monthly review by MDR Committee** - The Facility MDR Committee formed above (Para 3.5) will have the responsibility of reviewing all the MDR forms filled and collected during the month. The implementation of the suggested corrective measures which emerge as an outcome of this review will be the responsibility of the Medical Superintendent/SMO/Officer In charge of the facility through the respective department. The recommendations of the committee shall be confidential and known only to the MS/SMO/Officer In charge and the relevant department/officials who will act on the recommendations. The minutes of each monthly review meeting will be recorded in a register and shall be kept confidential in the safe custody of the Facility Nodal Officer. **The findings from the review shall not be used as a tool for punitive action against service providers.**

**3.9 Register of maternal deaths** - Every maternal death occurring in the facility will be given a yearly serial number and a yearly serial record of all the maternal deaths in the facility will be maintained at the facility by the Facility Nodal Officer in the **Maternal Death Record Register** as per the format in **Annexure-6A**.

**3.10 Report to District MDR Committee** - The findings of the review for each maternal death and the corrective actions taken during the month, along with a duly filled copy of **Facility Based MDR Form at Annexure-1** and a copy of **Hospital Case Sheet** of the deceased shall be sealed in an envelope marked '**CONFIDENTIAL**' and reported every month by the Facility Nodal Officer to the **District MDR Committee** headed by the Civil Surgeon **on or before 10<sup>th</sup> of the following month**. If no maternal death takes place during the month, a '**Nil**' report will be submitted to the District MDR Committee by the due date.

**3.11 Death on referral / LAMA** - In those cases in which death occurs immediately after the woman is referred to another Institution or the woman leaves against medical advice (**LAMA**), these maternal deaths shall be captured at the facility itself and reviewed.

**3.12 Terms of reference for Facility MDR Committee** - The terms of reference (**TOR**) for the Facility MDR Committee review will be as follows:

**Committee will meet and review the following:**

- a. Circumstances under which the death took place
- b. Cause of maternal death: Direct obstetric, indirect obstetric and non obstetric cause.
- c. What steps are required to prevent such deaths in future:
  - i. Action related to infrastructural strengthening

- ii. Action required to augment human resource availability
- iii. Action required to strengthen protocols and competence of staff
- iv. Supplies and Equipment
- v. Demand-side Interventions to address first and second delays
- vi. Management interventions
- vii. Other interventions based on the findings of MDR

**3.13 Participation in District MDR Committee meetings** - In case a maternal death is reported to the District MDR Committee during the month, **Facility MDR Committee** will nominate a member to participate in the monthly review meeting of the **District MDR Committee** chaired by the Civil Surgeon in the following month.

**3.14 Review by District MDR Committee** - The District MDR Committee (**please see Chapter-5**) will map any particular pattern in occurrence of deaths in the facility such as:

- a. Deaths occurring in/on particular weeks/months/days
- b. Any pattern in timing of deaths: day/night
- c. Any pattern in relation with staff deployment
- d. Others

**3.15 Review by Deputy Commissioner** - A monthly MDR review meeting to take stock of the situation and corrective measures will be **chaired by the Deputy Commissioner (please see Chapter-6)**. This MDR review meeting will be attended by all the members of the District Health Society or a selected group of DHS members as deemed fit by the Deputy Commissioner. The other members to attend will be the District MDR Committee members and any other member incorporated/suggested by the DC which may include the family members of the deceased who were present with the mother during the treatment of complications or at the time of death. The meeting will be convened by the Civil Surgeon and assisted by the District Nodal Officer MDR.

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**PREPARATORY STEPS TO INITIATE FBMDR – ACTIVITIES FLOW CHART**

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<b>Activity</b>	<b>Level</b>	<b>Responsibility</b>
1. Identification of facilities for MDR (Ref: Para 3.2)	District	Civil Surgeon
2. Appointment of Facility Nodal Officer MDR (Ref: Para 3.3)	Facility	MS/SMO/ Officer in charge of the Facility
3. Orientation Training of the MS/SMO/Officer In charge of the facility & Facility Nodal Officer MDR (Ref: )	State	State Nodal Officer MDR

<b>Para 3.4)</b>		
4. One day orientation training of all MOs of the facilities identified for FBMDR (Ref: Para 3.4)	District	District Nodal Officer MDR
5. Constitution of Facility MDR Committee at the facility (Ref: Para 3.5)	Facility	MS/SMO/ Officer in charge of the Facility

## PROCESS FLOW CHART FOR IMPLEMENTATION OF FBMDR

<u>Facility Level</u>	<u>Time Line</u>	<u>Responsibility</u>
1. Information of the maternal death to the Facility Nodal Officer. (Ref: Para 3.6)	Immediately telephonically	MO on Duty/MO in charge Ward/ Emergency
2. Information of the maternal death to <b>Civil Surgeon, Deputy Commissioner and Director Family Welfare</b> telephonically and simultaneously in the format for primary informer (Annexure-6). (Ref: Para 3.6)	Immediately, within 24 hrs of maternal death	Facility Nodal Officer MDR
3. Completion of <b>Facility Based MDR Form (Annexure-1)</b> in duplicate for every maternal death within 24 hours of its occurrence by the MO on duty in consultation with the Facility Nodal Officer and signed by both. (Ref: Para 3.7)	Immediately, within 24 hours of the occurrence of death.	MO on duty in consultation with the Facility Nodal Officer and signed by both.
4. Monthly meeting to review all maternal deaths occurred during the month by Facility MDR Committee. (Ref: Para 3.8 & 3.12)	Monthly review meeting on a prefixed date of the following month.	Chaired by MS/SMO/ Officer in charge of the Facility and convened by Facility Nodal Officer.
5. Implementation of the suggested corrective measures as outcome of the monthly review by the MDR Committee. (Ref: Para 3.8)	Monthly implementation	MS/SMO/ Officer in charge of the Facility through respective departments/ officials.
6. A yearly serial record of all the maternal deaths occurring in the facility to be maintained at the facility by the Facility Nodal Officer in <b>Maternal Death Record Register</b> as per the format at <b>Annexure-6A</b> . (Ref: Para 3.9)	Yearly serial recording	Facility Nodal Officer MDR.
7. Findings of the review of every maternal death and the corrective actions taken during the month, along with a duly filled copy of <b>Facility Based MDR Form (Annexure-1)</b> and a copy of the case sheet of the deceased, to be reported every month to the District MDR Committee in a sealed cover marked ' <b>CONFIDENTIAL</b> '. (Ref: Para 3.10)	Monthly report on or before 10 <sup>th</sup> of the following month ('nil' report to be sent by the due date in case no death occurs during the month).	Facility Nodal Officer MDR.
8. Nomination of a member of the Facility MDR Committee to participate in the monthly review meeting of the District MDR Committee. (Ref: Para 3.13)	When a maternal death takes place in the reporting month, participation in the following month.	Facility MDR Committee.

## CHAPTER - 4

### PROCEDURE FOR COMMUNITY BASED MATERNAL DEATH REVIEW (CBMDR/Verbal Autopsy)

- 4.1 Verbal Autopsy** - The verbal autopsy is a technique whereby family members, relatives, neighbours or other informants and care providers are interviewed and asked for a narrative to elicit information on the events leading to the death of the mother, during pregnancy/ abortion/ delivery/ within 42 days after delivery, in their own words in order to identify the medical and non medical (including socio-economic) factors for the cause of death of the mother.
- 4.2 Purpose** - The main purpose of **CBMDR** is to identify various delays and causes leading to maternal deaths, to enable the health system to take corrective measures at various levels. Identifying maternal deaths would be the first step in the process, the second step would be the investigation of the factors/causes which led to the maternal death – whether medical, socio-economic or systemic, and the third step would be to take appropriate and corrective measures on these, depending on their amenability to various demand side and communication interventions.
- 4.3 District Nodal Officer** - The District will be the unit for undertaking Community based MDR. **District Family Welfare Officer shall be the District Nodal Officer MDR.**
- 4.4 Role of District Nodal Officer** - The District Nodal Officer MDR will be responsible for convening and organizing the review meeting of the District MDR Committee to be chaired by the Civil Surgeon every month. He will also be responsible for organising necessary documentation for review by the committee and keeping a record of follow up actions initiated. He will be responsible for proper maintenance of all records related to Maternal Death Reviews by the Civil Surgeon at district level. The District Nodal Officer will also assist in the conduct of Maternal Death Reviews by the Deputy Commissioner.
- 4.5 Orientation Meetings** - Following orientation meetings/ trainings will be conducted:
- i. A one day orientation meeting will be organised by the State Nodal Officer MDR at State level for orienting the **Civil Surgeons and District Nodal Officers MDR** in the data collection tools and processes.*
  - ii. The District Nodal Officer MDR will organise a one day orientation programme for **all SMOs/ MOs of the primary health care institutions in the district**, focussed on the processes to be adopted and formats to be used for data collection.*
  - iii. **The SMO of Block PHC will orient** all Health Workers including LHV, PHNs, Staff Nurses, ANMs etc., on the processes and data collection tools etc. Other functionaries like AWWs, AWSs, leaders of Self help groups, PRI members, representatives of departments of Social Security and Women and Child Development, Rural Development, ICDS, etc. should also be involved in the orientation.*
  - iv. **MOs in charge of all PHCs** in the block will also orient the ASHAs, ANMs and other functionaries ( as enumerated above) in scheduled monthly meetings*

*about line listing of all deaths of women in the age group of 15-49 years irrespective of the cause of death or pregnancy status. Line listing format as enclosed at Annexure-4 will be explained and adequate copies should be made available in local language for monthly reporting to the ANM/ ASHA.*

- 4.6 Reporting maternal deaths to SMO Block PHC** - In case of any maternal death, telephonic intimation to the SMO Block PHC and ANM of the area will be made immediately by ASHA/ AWW within 24 hours of the occurrence of the maternal death. The ANM will immediately inform the SMO Block PHC telephonically and simultaneously, also in the format for Primary Informer at **Annexure-6**. ANM will ensure that every **maternal death** is reported to the SMO Block PHC within 24 hours of its occurrence. *(Note: It is made clear that all deaths of women in the age group 15-49 years are reported every month in Annexure-4 by ASHA/AWW to the ANM and by ANM to the SMO Block PHC. If any death appears to be maternal then ASHA/AWW would immediately inform SMO Block PHC and ANM on telephone, and the ANM would also immediately telephonically inform the SMO Block PHC, and simultaneously would send information in the format for primary informer as per Annexure-6 to the SMO Block PHC).*
- 4.7 Line listing of all deaths of women in age group 15-49 years** - The line listing format as per **Annexure-4** for all deaths of women of age 15-49 years during the month, irrespective of the cause of death or pregnancy status, duly filled by ASHA/AWW will be submitted to the ANM of her area **on or before 5<sup>th</sup> of the following month**. In addition, she will inform the ANM about each death telephonically also within 24 hours of its occurrence. In case no such death occurs during the month in the area under ASHA/ AWW, she will submit a '**Nil**' report to the ANM for that month by the due date in the Line Listing Form. *(Note: Basically, ASHA will be responsible for reporting maternal deaths and line listing of all deaths of women of age group 15-49 years. But in case ASHA is not performing as expected or an area is not represented by ASHA, in that situation the SMO Block PHC, on written recommendation of the ANM of the area, may authorise AWW or any other suitable link worker of the area for reporting and line listing under the MDR scheme).*
- 4.8 Cross check by ANM** - The ANM will cross-check every death listed in the monthly line listing formats (**Annexure-4**) submitted to her by ASHAs/ AWWs of her area and make amendments, if any discrepancies are found. If the ANM detects any unreported maternal death during cross checking, she will immediately send the information to SMO Block PHC telephonically as well as in **Annexure-6**.
- 4.9 Submission of monthly line listing report to SMO Block PHC** - After completing the cross checking, the ANM will countersign the line listing formats (**Annexure-4**) of her area and submit these to the SMO Block PHC **on or before 10<sup>th</sup> of the following month**. Even if the women death report is 'Nil' during the month, the Line Listing Forms will be submitted to the SMO Block PHC by the due date.
- 4.10 Register of all deaths of women of age group 15-49 years** - All the deaths of women of age 15-49 years (line listed by ASHA/ AWW and submitted after cross checking by ANM) will be recorded serially in the **Community Based Maternal Death Review Register** (including the confirmed maternal deaths) to be maintained at Block PHC as per format at **Annexure-5** and linked with the reporting in the HMIS.

- 4.11 Reporting maternal deaths to District/ State HQ** - Once the report of the maternal death reaches the concerned **SMO In charge, Block PHC**, he will immediately send information of this death by telephone within 24 hours of the receipt of information from ASHA/AWW/ANM to the **Civil Surgeon, Deputy Commissioner** and the **Director Family Welfare** and also in the format for Primary Informer at **Annexure-6**.
- 4.12 Deputing Investigation Team** - SMO Block PHC will simultaneously depute the designated **investigation team** (a three member investigation team comprising of a **female Medical Officer, one LHV/PHN and the ANM of the area** where maternal death takes place) to further investigate and conduct a Community Based Investigation (**Verbal Autopsy**) by visiting the deceased woman's house in order to collect complete information relating to the death as per the Questionnaire at **Annexure-2** which has three modules which will be completed for data collection. **Module-I** refers to general background information about the deceased. **Module-II** pertains to maternal deaths during Ante-natal period and **Module-III** refers to death during intra partum and post natal period. It is advised that such investigations should ideally be completed within 3 weeks of receiving information from ASHA/AWW/others. These visits should be made to the house of the deceased as per the convenience of respondent/s and taking into consideration the period of mourning for the family.
- 4.13 Sending the Investigation Report to District MDR Committee** - After completing the Community Based Investigation (Verbal Autopsy) Questionnaire at **Annexure-2**, it should be immediately submitted to SMO Block PHC who will discuss and analyse the findings with the investigation team and complete the **case summary form for confirmed maternal deaths** as per **Annexure-3 in duplicate** and allocate a Yearly Serial Number to every confirmed maternal death. This would then be sent (within 4 weeks of the occurrence of maternal death) in a sealed cover marked '**CONFIDENTIAL**' to the Civil Surgeon for review in the monthly meeting of the District MDR Committee chaired by Civil Surgeon and a copy of it will be retained at the Block PHC for record purpose.
- 4.14 Participation in District MDR Committee meeting** - In case a maternal death report (in **Annexure-3**) is submitted to the District MDR Committee by a Block PHC during the month, in that case the SMO of that Block PHC will participate in the monthly review meeting of the District MDR Committee in the following month.
- 4.15 Review by Deputy Commissioner** - A monthly MDR review meeting to take stock of the situation and corrective measures will be **chaired by the Deputy Commissioner** (please see **Chapter-6**). This MDR review meeting will be attended by all the members of the District Health Society or a selected group of DHS members as deemed fit by the Deputy Commissioner. The other members to attend will be the District MDR Committee members and any other member incorporated/suggested by the DC including the family members of the deceased who were present with the mother during the treatment of complications or at the time of death. The meeting will be convened by the Civil Surgeon and assisted by the District Nodal Officer MDR.

## PREPARATORY STEPS TO INITIATE CBMDR - ACTIVITIES FLOW CHART

Activity	Level	Responsibility
<ul style="list-style-type: none"> <li>One day orientation training of Civil Surgeons and District Nodal Officers MDR. <b>(Ref: Para 4.5-i)</b></li> </ul>	State	State Nodal Officer MDR
<ul style="list-style-type: none"> <li>One day orientation of MOs/SMOs of the Primary Health Care Institutions of the district. <b>(Ref: Para 4.5-ii)</b></li> </ul>	District	Civil Surgeon (organised by District Nodal Officer MDR)
<ul style="list-style-type: none"> <li>One day orientation training of all Para Medical Staff of the Block on the processes and data collection tools etc.  Other Block level functionaries/representatives of departments like Social Security and W &amp; C Welfare, Rural Development, ICDS, PRI, Leaders of local SHG etc. should also be involved in the orientation. <b>(Ref: Para 4.5-iii)</b></li> </ul>	Block PHC	SMO Block PHC
<ul style="list-style-type: none"> <li>Orientation training of all ASHAs and ANMs on line listing of all deaths of women of age 15-49 years, irrespective of the cause of death or pregnancy status, during scheduled monthly meetings of PHCs. <b>Line Listing Format (Annexure-4)</b> would need to be explained to ASHAs/ANMs and adequate copies of this format in Punjabi language will be made available to all ASHAs for reporting to the ANM she is attached to. <b>(Ref: Para 4.5-iv)</b>  Other PHC level functionaries/their representatives like AWWs, AWSS, Panchayat members/Sarpanch, leader of local SHG etc. should also be involved in the orientation. <b>(Ref: Para 4.5-iv)</b></li> </ul>	All PHCs	PHC MOs
<ul style="list-style-type: none"> <li>Constitution of Investigation Team for community based investigation (verbal autopsy) of the maternal death. The Investigation Team to comprise of 3 members namely – one female Medical Officer, one LHV/PHN, and the ANM of the area where death takes place. <b>(Ref: Para 4.12)</b></li> </ul>	Block PHC	SMO Block PHC
<ul style="list-style-type: none"> <li>Printing of Line Listing forms as per <b>Annexure-4</b></li> </ul>	State	State Nodal Officer MDR
<ul style="list-style-type: none"> <li>Constitution of District MDR Committee. <b>(Ref: Chapter-5)</b></li> </ul>	District	Civil Surgeon

## PROCESS FLOW CHART FOR IMPLEMENTATION OF CBMDR

ASHA/ANM/Block PHC Level	Time Line	Responsibility
<p><b>1. ASHA/AWW</b> to inform every maternal death immediately telephonically to SMO Block PHC and ANM of the area. <b>(Ref: Para 4.6)</b></p>	Immediately on occurrence of maternal death	ASHA/AWW
<p><b>2. ANM</b> to ensure that every maternal death in her area is reported to the SMO Block PHC telephonically within 24 hrs of its occurrence and simultaneously, also to send information to the SMO Block PHC in the format for primary informer as per <b>Annexure-6. (Ref: Para 4.6)</b></p>	Immediately on receipt of telephonic information from ASHA/AWW	ANM
<p><b>3.</b> SMO Block PHC to inform this death by telephone to <b>CS, DC and DFW</b> within 24 hours of the receipt of information from ASHA/AWW/ANM and also to send information in the format for Primary Informer (<b>Annexure-6. (Ref: Para 4.11)</b>)</p>	Immediately, within 24 hours of the receipt of telephonic information of maternal death from ASHA/AWW/ANM.	SMO Block PHC
<p><b>4.</b> SMO Block PHC to simultaneously depute the designated investigation team for <b>Community Based Investigation (Verbal Autopsy)</b> as per Questionnaire at <b>Annexure-2. (Ref: Para 4.12)</b></p>	Community Based Investigation (Verbal Autopsy) to be completed by the investigation team within three weeks of the occurrence of maternal death.	SMO Block PHC
<p><b>5.</b> Case summary sheet (<b>Annexure-3</b>) for every maternal death investigated and confirmed during the month is completed in duplicate, one copy is sent to the Civil Surgeon in a sealed cover marked 'CONFIDENTIAL' and a copy is retained at the Block PHC for record. <b>(Ref: Para 4.13)</b></p>	Within 4 weeks of occurrence of the maternal death.	SMO Block PHC
<p><b>6.</b> Line listing of all deaths of women of age 15-49 years, irrespective of the cause of death or pregnancy status, during the month by ASHA/AWW as per <b>Annexure-4</b> and submission of monthly report to ANM, along with information of each such death to ANM telephonically within 24 hours of the death. <b>(Ref: Para 4.7)</b></p>	Monthly report of line listing to be submitted on or before 5 <sup>th</sup> of the following month & telephonically of each death within 24 hrs.	ASHA/AWW
<p><b>7.</b> The ANM cross checks every death line listed by ASHA/AWW in <b>Annexure-4</b> and submits the final report to the SMO Block PHC. <b>(Ref: Para 4.8 &amp; 4.9)</b></p>	On or before 10 <sup>th</sup> of the following month	ANM
<p><b>8.</b> All deaths of women of age 15-49 yrs. irrespective of the cause of death or pregnancy status, are serially recorded at Block PHC (including the confirmed maternal deaths) in the <b>Community Based Maternal Death Review Register</b> as per the format at <b>Annexure-5. (Ref: Para 4.10)</b></p>	Every month immediately after submission of line listed formats (Annexure-4) by the ANMs.	SMO Block PHC
<p><b>9.</b> In case a maternal death review report is submitted to the District MDR Committee by the Block PHC during the month, in that case the <b>SMO Block PHC participates</b> in the monthly review meeting of the district MDR Committee in the following month. <b>(Ref: Para 4.14)</b></p>	Participation only when a maternal death review report is submitted from the Block PHC.	SMO Block PHC

<b>District Level (Civil Surgeon):</b>	<b>Time Line</b>	<b>Responsibility</b>
<b>10.</b> Meeting of District. MDR Committee to review all the maternal deaths reported in the previous month (FBMDR +CBMDR). <b>(Ref: Para 3.14, 4.4 &amp; Chapter-5)</b>	Every month	Convened by District Nodal Officer MDR & <b>chaired by Civil Surgeon</b>
<b>District Level (Deputy Commissioner) :</b>		
<b>11.</b> District level monthly review of maternal deaths by Deputy Commissioner. <b>(Ref: Para 3.15, 4.15 &amp; Chapter-6)</b>	Every month	Convened by the Civil Surgeon, <b>chaired by the Deputy Commissioner</b> (and assisted by the District Nodal Officer MDR)
<b>State Level :</b>		
<b>12.</b> State review by State Level Task Force (SLTF) to make recommendations to Government for policy & strategy formulations. <b>(Ref: Chapter-7)</b>	Once in 3 months	<b>Chaired by PSHFW,</b> Convened by State Nodal Officer MDR
<b>13.</b> Dissemination meeting/ workshop to sensitize various service providers & managers. <b>(Ref: Chapter-7)</b>	Annual	<b>Mission Director, NRHM</b>

## CHAPTER – 5

### CONDUCTING MATERNAL DEATH REVIEW AT DISTRICT LEVEL BY THE CIVIL SURGEON

**5.1 District MDR Committee** - Every district will have a committee for maternal death review, the District MDR Committee. District Family Welfare Officer (DFWO) shall be the Nodal Officer for this Committee. The District MDR Committee will review all the maternal deaths in the District once every month on a pre-fixed date. In case, a district level committee under quality assurance exists, then the same committee can be extended by nominating additional relevant members and utilised for maternal death review or a new committee could be formed.

**5.2 Two types of MDR reports** - The District MDR Committee will receive two types of MDR reports :

- i. Community based maternal death reports from the SMOs of Block PHCs.
- ii. Facility based maternal death review reports from the identified Facilities.

**5.3 Constitution of the committee** - The District MDR Committee will be chaired by Civil Surgeon and District Family Welfare Officer will be the Member Secretary of the District MDR Committee. The Civil Surgeon will constitute the District MDR Committee. The existing quality assurance committee or a newly formed committee should have following members:

- |  |                           |
|--|---------------------------|
| • Civil Surgeon  | Chairperson               |
| • District Nodal Officer MDR (DFWO)  | Member Secretary/Convener |
| • Assistant Civil Surgeon  | Member                    |
| • Medical Officer (Obstetrics & Gynaecology)   | Member                    |
| • Anaesthetist   | Member                    |
| • Officer I/c of blood bank/blood storage centre   | Member                    |
| • Senior Nurse nominated by Civil Surgeon  | Member                    |
| • Invited member(s) from the Facilities/SMO Block PHCs where a maternal death has taken place/reported in the previous month | Member(s)                 |

Frequency of Meetings : Once every month

**5.4 Meetings** - The District Nodal Officer MDR will convene the meeting of the District MDR Committee once every month on a pre-fixed date and will put up for review of the committee all the maternal death reports relating to the preceding month received from Block SMOs (under CBMDR) and from MS/SMO/Officers in charge of identified Facilities (under FBMDR).

**5.5 Role of the Committee** - The Committee will have following responsibilities:

- i. To conduct a detailed review and analysis of all the FBMDR reports received from the Facilities and all the CBMDR reports from Block PHCs, and spell out the remedial follow-up actions (refer to **Para 3.14** also). Minutes of each monthly review meeting to be recorded in a register and kept confidential in the safe custody of District Nodal Officer MDR.
- ii. Maintain a yearly serial record of all the confirmed maternal deaths reported and investigated in the district under FBMDR and CBMDR in the **Maternal Death Record Register** as per the format at **Annexure-6A** and link it with the reporting in the **HMIS**.
- iii. Prepare reports in the form of **Case Summaries** (in the format at **Annexure-1A for FBMDR reports** and **Annexure-3A for CBMDR reports**) of all the confirmed maternal deaths reviewed by the committee to share the findings with the Deputy Commissioner. The Deputy Commissioner will have the option of reviewing in detail a sample of these deaths in a monthly meeting. The District Nodal Officer of the District MDR Committee will assist the Deputy Commissioner in these monthly review meetings.
- iv. Record the minutes of the DC's monthly review meeting in a register with specific corrective measures and monitor the implementation of these in line with the timelines.
- v. A report in the form of **District level FBMDR and District level CBMDR Case Summaries** (**Annexure-1A & Annexure-3A** respectively), along with the minutes of the DC's monthly review meeting with specific corrective measures planned or implemented if the case has been reviewed by the DC, will be sent in a sealed cover marked 'CONFIDENTIAL' to the State Director Family Welfare every month. One copy of the **Case Summaries** (**Annexure-1A & Annexure-3A**) is to be retained at the District for record)

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**Note:** *Based on the findings of the MDRs no disciplinary action is to be initiated against any of the service providers. The key principle to be adopted during the entire process of reviewing is not to blame or find fault with anybody. The purpose of the discussion is to identify gaps at different levels and to take appropriate corrective measures and to sensitize the service providers to improve the accountability.*

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## CHAPTER-6

### MATERNAL DEATH REVIEW BY DISTRICT HEALTH SOCIETY UNDER THE CHAIRMANSHIP OF DEPUTY COMMISSIONER

**6.1 Objectives** - The objectives of the District level review by the District MDR Committee under Civil Surgeon and at the level of Deputy Commissioner are :-

- To sensitize the service providers to improve their accountability
- To find out the system gaps including the facility level gaps to take appropriate corrective measures with time line
- To allocate funds from the district health society for the interventions.
- To monitor the implementation of the corrective measures.
- To disseminate the findings of the district maternal death review in the next medical officers review meeting by the Deputy Commissioner.
- To institute measures to prevent maternal deaths due to similar reasons in the district in future.

**6.2 Review by Deputy Commissioner** - All the maternal death reports compiled by the District MDR Committee after review as district level case summaries (**Annexure-1A and Annexure-3A** for deaths reviewed under FBMDR & CBMDR respectively) will be put up to the Deputy Commissioner, who will have the option of reviewing a sample of these deaths, which will be representative of deaths occurring at home, at facilities and in transit.

**6.3 Meeting** - The Civil Surgeon of the district in consultation with Deputy Commissioner will fix up the date for the review meeting once every month. The review meeting will be attended by all the members of the District Health Society or a selected group of DHS members as deemed fit by the Deputy Commissioner. The other members to attend will be the District MDR Committee members and any other member incorporated/suggested by the DC which may include the family members of the deceased who were present with the mother during the treatment of complications or at the time of death. The participants in the maternal death review meeting at the Deputy Commissioner level will be as follows :-

• Deputy Commissioner	Chairperson
• Civil Surgeon	Convener
• Members/ A Selected Group of Members of District Health Society	Members
• Members of the District MDR Committee	Members
• Any other member(s) incorporated/suggested by the D.C. (This may include the relatives/ family members who were with the deceased during the treatment of complications or were family members who were with the deceased)	Special Invitee(s)

The **District Nodal Officer MDR** will assist the Deputy Commissioner in conduct of these monthly review meetings.

- 6.4 Relatives of the deceased to participate in the meeting** - The Civil Surgeon through the ANMs will arrange to bring two relatives of the deceased to attend the Maternal Death Review meeting. Only relatives who were with the mother during the treatment of complications or at the time of death may be invited for the meeting. Relatives attending the meeting (up to two members) will be paid Rs.200/- each to compensate the wage loss and to meet the travel cost out of the RKS funds from the district hospital at the end of the meeting.
- 6.5 Conduct of meeting** - The relatives of the deceased will first narrate the events leading to the death of the mother in front of the Deputy Commissioner and all service providers. The case history of each of the selected maternal death will be heard separately. After the deposition and getting clarifications from the relatives they will be sent back. Then the various delays – the decision making at the family, getting the transport and institutional delays would be discussed in detail. The provision of antenatal, post natal care will also be discussed. The outcome of the meeting will be recorded as minutes in a register and corrective actions will be listed with time line to prevent similar delays in future.
- 6.6 Grouping of corrective measures** - The corrective measures will be grouped into three categories with time lines :
- i. Corrective measures at the Community level.
  - ii. Corrective measures needed at the Facility level.
  - iii. Corrective measures for which State support is needed.
- 6.7 Report to be sent to the State** - After the maternal death review meeting, the minutes of the meeting with corrective measures planned or implemented will be sent to the State Level Task Force on maternal mortality reduction.
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## CHAPTER-7

### CONDUCTING MATERNAL DEATH REVIEW AT STATE LEVEL

7.1 A State Level Task Force (SLTF) for maternal death reviews will be formed at the State level with the following composition:

- |   |                  |
|---|------------------|
| • PSHFW   | Chairperson      |
| • Mission Director (NRHM)   | Vice chairperson |
| • Managing Director (PHSC)  | Member           |
| • Director Family Welfare   | Member           |
| • Director Health Services  | Member           |
| • Director Health Services (ESI)  | Member           |
| • Director Research and Medical Education   | Member           |
| • Head of the Department of Gynaecology and Obstetrics<br>(Of a Govt. Medical college in the State) | Member           |
| • Sr. Obstetrician and Gynaecologist, IMA   | Member           |
| • Sr. Obstetrician and Gynaecologist, FOGSI   | Member           |
| • Any other member(s) nominated by the Government   | Member(s)        |

Frequency of meetings : Once in three months.

7.2 The SLTF will meet once in 3 months under the chairmanship of Principal Secretary Health & Family Welfare to discuss the actions taken on the minutes of the last meeting and make recommendations to Government for policy and strategy formulations.

7.3 A serial record of all confirmed maternal death reports received from all districts during the calendar year will be kept in the **Maternal Death Record Register** to be maintained in the office of the Director Family Welfare as per the format at **Annexure-6A** and will be linked with the reporting in the **HMIS**.

7.4 Every year an annual maternal death report for the State will be prepared and a dissemination workshop will be organized to sensitise various service providers and managers. The annual report may contain interesting maternal death case studies which may be used during the training of medical and para medical functionaries.

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**CHAPTER-8**  
**TIME LINES & INCENTIVES**

<b>Activity</b>	<b>Time line</b>	<b>Incentive/Transaction Cost payment</b>	<b>Source of funding</b>
Reporting death of women (15-49 years) by ASHA/AWW and submission of monthly line listing form (Annexure-4) to the ANM	Within 24 hours of occurrence of death by phone and monthly line listing report by 5 <sup>th</sup> of the following month	Rs.50 per death reported for ASHA/AWW/Other Link Worker	Sub-centre untied fund
Submission of the monthly line listing report (Annexure-4) after cross checking by ANM to SMO Block PHC	On or before 10 <sup>th</sup> of the following month	Rs.100 per monthly line listing report for ANM	Sub-centre untied fund
Reporting maternal death of woman by Block SMO to the Civil Surgeon, Deputy Commissioner and the Director Family Welfare	Within 24 hours of receipt of information of death on phone from ASHA/AWW/ANM	No incentive	-
Field verification of maternal death and community based investigation by the Investigation Team	Within 3 weeks of occurrence of death	Rs.100 per person to a maximum of three persons	Sub-centre untied fund
Submission of report by SMO Block PHC to Civil Surgeon in the prescribed form (Annexure-3)	Within 4 weeks of occurrence of death	No incentive	-
Submission of report by Facility Nodal Officer MDR to Civil Surgeon in the prescribed form (Annexure-1)	On or before 10 <sup>th</sup> of the following month	No incentive	-
Reporting deaths of women by Facility Nodal Officer to the Civil Surgeon, Deputy Commissioner and the Director Family Welfare	Within 24 hours of occurrence of death by phone	No incentive	-
Conduct of facility based review meetings and preparation of district MDR report for all deaths in district by the District committee (chaired by the CMO)	Every Month for the deaths reported in previous month.	No incentive	-
Conduct of MDR meeting chaired by Deputy Commissioner	Once in a month	Incentive of Rs.200 each for two persons of the deceased family	District hospital RKS fund

## CHAPTER-9

### ORIENTATION TRAININGS

For implementing interventions on MDR, following **orientation trainings** will be undertaken.

- 9.1 One day sensitization cum **training of trainers (TOT) for the State level resource persons** will be conducted **at the National level** at the National Health System Resource Centre (NHSRC) with participation of National level programme officers from MOHFW.
- 9.2 One day orientation training of **Civil Surgeons, District Nodal Officers, MS/SMO/MO In charge of the facilities and Facility Nodal Officers at State level.**
- 9.3 One day orientation training of all **MOs of the Primary Health Institutions** in the district **at District level.**
- 9.4 One day orientation training of all **MOs of the Facilities** identified for FBMDR **at District level.**
- 9.5 One day orientation training of all **ASHAs and ANMs on line listing** of all women deaths (age 15-49 years) **by PHC MOs** during monthly meetings at PHCs and provide them with adequate **line listing formats in local language.**
- 9.6 One day orientation training of **all paramedical staff/other field functionaries AWWs, PRI members, leaders Self Help Groups etc.** by **Block SMOs/PHC MOs.**

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## CHAPTER-10

### LIST OF REGISTERS TO BE MAINTAINED AT VARIOUS LEVELS

- 10.1 Community Based MDR Register** at the Block PHC as per the format at **Annexure-5** to keep serial record of all the deaths of women of age 15-49 years, irrespective of the cause of death or pregnancy status, occurred in the Block during the calendar year.
- 10.2 Maternal Death Record Register** at the **Facility, District** (in the offices of **Civil Surgeon & Deputy Commissioner**) and office of **Director Family Welfare** as per format at **Annexure-6A** to keep a serial record of all the confirmed maternal deaths during the calendar year.
- 10.3 Registers** to be maintained at the Facility and District (Civil Surgeon & Deputy Commissioner) levels to record the minutes/proceedings/other details of monthly MDR review meetings.

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CONFIDENTIAL

**Facility Based Maternal Death Review Form**

(To be conducted and filled by Medical Officer on duty and Facility Nodal officer)

**NOTE:**

1. *This FBMDR Form must be completed in duplicate for all maternal deaths, including abortions and ectopic gestation related deaths, in pregnant women or within 42 days after termination of pregnancy irrespective of duration or site of pregnancy.*
2. *Mark with an (✓) where applicable (mark with '?' when uncertain).*
3. *Attach a copy of the case sheet/records of the deceased with this form.*
4. *Complete the form in duplicate within 24 hours of a maternal death. The original remains at the institution where the death occurred and the copy is sent to the District MDR Committee for district level monthly review.*  
*(Ref. Chapter 3, para 3.7 & 3.10 of MDR guidelines)*

Yearly Serial No: \_\_\_\_\_ . Calendar Year: \_\_\_\_\_

(Refer to Para 3.9 of the MDR Guidelines)

**Please fill up the proforma given below**

**1. GENERAL INFORMATION**

**Contact Person:**

Name & Address:.....

.....

Telephone/Mobile No. : .....

Relationship with the deceased: .....

**Name, Age & Residential Address of deceased woman:**

.....

.....

**Address where Died:**

Name and Address of facility: .....

.....

Block: ..... District: .....

## 2. DETAILS OF DECEASED

Inpatient Number:..... Name:..... Age (years) :.....

Gravida  Live Births  Still Births  Abortions

No.of Living children

Days since delivery/abortion:

Day Month Year Hrs min

Date of admission:    Time of admission

Day Month Year Hrs min

Date of death:    Time of death:

## 3. ADMISSION AT INSTITUTION WHERE DEATH OCCURRED OR FROM WHERE IT WAS REPORTED (tick where appropriate)

Type of facility where died:

PHC	24x7 PHC	SDH/RURAL HOSPITAL/CHC	DISTRICT HOSPITAL	MEDICAL COLLEGE/TERTIARY HOSPITAL	PRIVATE HOSPITAL	PVT CLINIC	OTHER
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Stage of pregnancy/delivery on admission:

Abortion	Ectopic pregnancy	Not in labour	In labour	Postpartum
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Stage of pregnancy/delivery when died:

Abortion	Ectopic pregnancy	Not in labour	In labour	Postpartum
----------	----------------------	---------------	-----------	------------

Duration of time from onset of complications to admission:  Hrs  mins

**Condition on Admission:**  Stable  Unconscious  Serious  Brought dead

**Referral from another centre?**  Yes  No  Don't know

**If yes, how many centres?**   Specify type of centre(s):

**4. ANTENATAL CARE**

**Did she receive ANC?** Yes  No  Don't know

**If no, reason(s):** Lack of awareness  Lack of accessibility  Lack of funds   
Lack of attendee  Family problems

**If Yes, Type of Care Provider (mark one or more):** S/C ANM  M/O PHC   
M/O CHC  Specialist SDH  Specialist D/H  Specialist College/Tertiary Hosp   
Private Hosp  (Please Specify Type of Doctor/Nurse):

**If yes, was she told she has risk factors?** Yes  No  Don't know

**Complications:**

Type of Complication	Yes	No	Don't know	Comments if any
Previous C/Section				
Abnormal Presentation/lie				
Anaemia				
Glycosuria				
Hypertension with Proteinuria				
Hypertension				
Twins etc				
APH				
Ectopic/pain in abdomen				
Other ( Please specify)				

Comments on antenatal care and list medication, if any:

--

**5. DELIVERY, PUERPERIUM AND NEONATAL INFORMATION**

Did she have labour pains?    Yes     No     Don't know

If Yes, was a partograph used?    Yes     No     Don't know

In which phase of labour did she die?

Latent phase	Active phase	Second stage	Third stage	> 24 hrs after delivery
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Duration of labour:     hrs     mins

**Delivery:**

Undelivered	Vaginal (unassisted)	Vaginal(assisted) Vacuum/forceps	Caesarean Section
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**Puerperium** (Tick  ):    Uneventful / Eventful: **PPH** / **Sepsis** / **Others** (Specify):

Comments on labour, delivery and puerperium:

--

**Details of Baby:**

Baby Birth Weight(gms)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Apgar Score	<input type="text"/>	Outcome	Still born	Alive at birth	Died immediately after birth	Alive at:	
											7 days	28 days

Needed resuscitation: Yes / No

If yes, who gave ENBC:

If died, probable cause:

Comments on baby outcomes( in box below)

**6. INTERVENTIONS: (Tick appropriate box)**

Early pregnancy	Antenatal	Intrapartum	Postpartum	Other
Evacuation	Transfusion	Instrumental del.	Evacuation	Anaesthesia - GA
Laparotomy	Version	Symphysiotomy	Laparotomy	Epidural
Hysterectomy		Caesarean section	Hysterectomy	Spinal
Transfusion		Hysterectomy	Transfusion	Local
		Transfusion	Manual removal	Invasive monitoring
Any Other – specify:				ICU ventilation

**7. CAUSE OF DEATH :**

**Probable direct obstetric (underlying) cause of death: Specify:**

**Indirect Obstetric cause of death: Specify:**

<p><b>Other Contributory (or antecedental) cause/s: (Specify)</b></p>
---

**8. IN YOUR OPINION WERE ANY OF THESE FACTORS PRESENT?**

System	Example	Y	N	?	Specify
Personal/Family	Delay in woman seeking help				
	Refusal of treatment				
	Refusal of admission in facility				
Logistical Problems	Lack of transport from home to health care facility				
	Lack of transport between health care facilities				
	Health service - Health service communication breakdown				
Facilities	Lack of facilities, equipment or consumables				
	Lack of blood				
Health personnel problems	Lack of human resources				
	Lack of Anesthetist				
	Lack of Surgeons				
	Lack of expertise, training or education				

**Comments on potential avoidable factors, missed opportunities and substandard care:**

--

9. **AUTOPSY:** Performed  Not Performed

**If performed please report the gross findings** (and send the detailed report later):

10. **CASE SUMMARY:** (please supply a short summary of the events surrounding the death)

**Form filled by:**

Name:

Designation:

Name & address of the Facility:

Block/Tehsil:

District:

Signature and Office Seal:

Date & Time:

**Facility Nodal Officer:**

Name:

Designation:

Signature:

Date & Time:

## DISTRICT LEVEL FBMDR - CASE SUMMARY

District level FBMDR-Case Summary, for every maternal death reported by the Facilities, to be completed in duplicate by the District Nodal Officer after review by the District MDR Committee and reports compiled to be put up to the Deputy Commissioner for monthly review & to State Director Family Welfare for monthly report (Ref: MDR Guidelines-Para 5.5-iii, 5.5-v and 6.2)

(Fill / tick (√) in appropriate boxes)

Yearly Serial No. : \_\_\_\_\_ . Calendar Year: \_\_\_\_\_

### General Information:

Name of the Facility/ District:					
Particulars of the deceased:		In-Patient No.	Name		Age
Husband's name & address:					
Gravida	Para	Still births	Live Births	Abortions	No.of living children
Timing of Death :		Pregnancy	Delivery	Within 42 days after delivery	
Religion:		Caste		Sub-caste/Community	
Date & Time of admission:					
Date & Time of Death:					

1. **Stage of pregnancy/delivery on admission:** Abortion /Ectopic Pregnancy /In labour / Postpartum

2. **Stage of pregnancy/delivery when died:** Abortion / Ectopic Pregnancy / In labour / Postpartum

3. **Duration from onset of complications to admission:**   Hrs   min

4. Condition on Admission:  Stable  Unconscious  Serious  Brought dead

5. Complications:

Type of Complication	Yes	No	Don't know	Comments, if any
Previous C/Section				
Abnormal Presentation/lie				
Anaemia				
Glycosuria				
Hypertension with Proteinuria				
Hypertension				
Twins etc				
APH				
Ectopic/pain in abdomen				
Other ( Please specify)				

6. In which phase of labour did she die:

Latent phase	Active phase	Second stage	Third stage	> 24 hrs after birth
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7. Duration of labour: Hours: \_\_\_\_\_, Minutes: \_\_\_\_\_.

8. Delivery:

Undelivered	Vaginal (unassisted)	Vaginal(assisted) Vacuum/Forceps	Caesarean Section
-------------	----------------------	----------------------------------	-------------------

9. Details of Baby:

Baby Birth Weight (gms)	<table border="1"> <tr><td></td><td></td><td></td><td></td></tr> </table>					Apgar Score	<table border="1"> <tr><td></td></tr> </table>		Outcome	Still born	Alive at birth	Died immediately after birth	Alive at:	
7 days	28 days													

10. Interventions: (Tick appropriate box)

Early pregnancy	Antenatal	Intrapartum	Postpartum	Other
Evacuation	Transfusion	Instrumental del.	Evacuation	Anaesthesia - GA
Laparotomy	Version	Symphysiotomy	Laparotomy	Epidural
Hysterectomy		Caesarean section	Hysterectomy	Spinal
Transfusion		Hysterectomy	Transfusion	Local

	Transfusion	Manual removal	Invasive monitoring
Any Other – specify:			ICU ventilation

**11. Probable direct obstetric cause of death:**

**12. Indirect obstetric cause of death:**

**13. Contributory causes of death:**

**14. In your opinion were any of these factors present?**

System	Example	Y	N	?	Specify
Personal/Family	Delay in woman seeking help				
	Refusal of treatment				
	Refusal of admission in facility				
Logistical Problems	Lack of transport from home to health care facility				
	Lack of transport between health care facilities				
	Health service - Health service communication breakdown				
Facilities	Lack of facilities, equipment or consumables				
	Lack of blood				
	Lack of OT availability				
Health personnel problems	Lack of human resources				
	Lack of Anesthetist				
	Lack of Surgeons				
	Lack of expertise, training or education				

**15. Comments on potential avoidable factors, missed opportunities and substandard care:**

**16. If autopsy performed, please report the findings :**

**17. Findings of the review by the Facility MDR Committee and corrective actions taken:**

**18. Remedial follow up actions spelled out by the District MDR Committee: (Add extra page if required):**

**(Signatures of District Nodal Officer MDR)**

(Office Seal)

**Name:**

**Date:**

**(Signatures of Civil Surgeon)**

(Office Seal)

**Name:**

**Date:**

**Note: For details, refer to Annexure-1 on FBMDR**

**COMMUNITY BASED MATERNAL DEATH REVIEW FORM**  
**COMMUNITY BASED INVESTIGATION (Verbal Autopsy) QUESTIONNAIRE FOR**  
**INVESTIGATION OF MATERNAL DEATHS**

*(To be filled by investigation team, ref: para 4.12 & 4.13 of MDR guidelines)*

Name of District: ..... Block: .....

<b>NAME OF THE SUB CENTRE</b>	
<b>NAME OF THE VILLAGE</b>	
<b>NAME &amp; AGE OF THE PREGNANT WOMAN/ MOTHER (DECEASED)</b>	
<b>ADDRESS</b>	
<b>NAME OF HUSBAND/OTHER (FATHER/MOTHER)</b>	
<b>PLACE OF DEATH (Home/Institution/In transit/Village/Town etc.) Specify:</b>	
<b>DATE &amp; TIME OF DEATH</b>	
<b>NAME &amp; DESIGNATION OF THE INVESTIGATOR(S)</b>	
<b>DATE OF INVESTIGATION</b>	
<b>PROBABLE CAUSE OF DEATH</b>	

## MODULES

### **MODULE - I**

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**Page No. 1 - 2**

Should be used for collection of general information for all maternal deaths irrespective of whether deaths occurred during antenatal or intranatal or postnatal period or due to abortion.

### **MODULE - II**

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**Page No. 3 - 4**

Should be used for the deaths occurring during the antenatal period including abortion

### **MODULE - III**

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**Page No. 5 - 8**

Should be used for the deaths occurring during delivery or postnatal period

# GENERAL INSTRUCTIONS

1. *The Community Based Investigation (Verbal Autopsy) is a technique whereby family members, relatives, neighbors or other informants and care providers are interviewed to elicit information on the events leading to the death of the mother during pregnancy/ abortion/ delivery / after delivery in their own words to identify the medical and non medical (including socio-economic) factors for the cause of death of the mother.*
2. *It is preferable to give advance information about the purpose of visit to the relatives of the deceased who were with the mother from the onset of complications till the death, and obtain their consent.*
3. **CONFIDENTIALITY:** *After the formal introduction to the respondents, the investigating official should give assurance that the information will be kept **confidential**.*
4. *Throughout the interview, the interviewer should be very polite and sensitive questions should be avoided.*
5. *Make all the respondents seated comfortably and explain to them that the information that they are going to provide will prevent death of mothers in future.*
6. *Allow the respondents to narrate the events leading to the death of the mother in their own words. Keep prompting until the respondent says there was nothing more to say.*
7. *Wherever needed, the investigating official should encourage the respondents to bring out all information related to the event.*
8. *Please also write information in a **narrative form***
9. **NEUTRALITY AND IMPARTIALITY:** *The interviewer should not be influenced by the information provided by the field health functionaries, doctors or by the information available in the mother care register, case sheets etc.*
10. **Maternal Death** *is defined as the death of a woman who dies from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy or child birth or within 42 days of termination of pregnancy, irrespective of duration and site of the pregnancy.*

## MODULE - I

Contains general information, information about previous pregnancies wherever applicable. It should be used for all the maternal deaths irrespective whether occurred during antenatal, delivery or postnatal period including abortion)

### I. BACKGROUND INFORMATION

Tick ( ✓ ) the correct answer for each question:

1.1	Resident / Visitor death								
1.2	Type of death	Abortion		Antenatal		Delivery death		Post natal	
1.3	Place of death	Home		Sub Health Centre					
		CHC		PHC					
		Medical college Hosp.		Dist. Hosp.					
		Sub Dist. Hosp.		Pvt. Hosp.					
		Transit/ on the way		Others ( specify)					
1.4	Specify the name and place of the institution or village where death occurred								
1.5	Onset of fatal illness			Date / /		Time ___:_____			
1.6	Admission in final institution (if applicable)			Date / /		Time ___:_____			
1.7	Death			Date / /		Time ___:_____			
1.8	Gravida			1	2	3	4	5 & more	
1.9	Weeks of pregnancy If applicable			<16 weeks		16-28 weeks		>28 weeks	
1.10	Age at death								

### 2. FAMILY HISTORY

No.	Details	Deceased Mother	
2.1	Age at marriage	<18 Yrs	
		18-25 Yrs	
		26-30 Yrs	
		31-35 Yrs	
		>35 Yrs	

2.2.	Religion	Sikh	
		Hindu	
		Muslim	
		Christian	
2.3.	Community	SC	
		ST	
		BC	
		OBC	
		Others	
2.5.	Occupation	House Wife	
		Agri. Labourer	
		Cultivator	
		Non-Agri. daily wages	
		Govt. Employee	
		Private employee	
		Self employed	
		Business	
Others (Specify)			

### 3. INFANT SURVIVAL

3.1	Infant status:	Still Birth	Live Birth	Died immediately after birth	Alive at 7 days	Alive at 28 days
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### 4. AVAILABILITY OF HEALTH FACILITIES, SERVICES AND TRANSPORT

(4.1 & 4.2 to be filled by the investigator before the interview)

4.1	Name and location of the nearest government / private facility providing Emergency Obstetric Care Services		
4.2	Distance of this facility from the residence		
4.3	Number of institutions visited before death (in the order of visits)		
4.4	Reasons given by providers for the referral	No explanation given	Lack of blood
		Lack of staff	Others (specify)

### 5. CURRENT PREGNANCY

(To be filled from the information given by the respondents)

5.1	Antenatal Care	YES		NO	
5.2	If yes, Place of Antenatal checkup	Sub Centre		PHC/ CHC	
		Govt. Hosp.		Pvt. Hospital	
		VHND		Govt. & Pvt. hospital	
5.3	Number of antenatal check ups	Nil	4 and above	1-3	Not known

## MODULE - II

### 6. DEATHS DURING THE ANTENATAL PERIOD

(This module to be filled for the maternal deaths that occurred during the antenatal period including deaths due to abortion. In addition to module-II, module-I should also be filled for all maternal deaths)

6.1	Did the mother had any problem during antenatal period?	Not known			No
		Yes			
6.2	If yes, was she referred anytime during her antenatal period?	YES			NO
		Don't know			
6.3	What was the symptom for which she sought care ?	Headache			
		Edema			
		Anemia			
		High Blood Pressure			
		Bleeding p/v			
		No foetal movements			
		Fits			
		Sudden excruciating pain			
		High fever with rigor			
		Others (specify)			
6.4	If YES, did she attend any hospital?	YES			NO
		Don't know			
6.5	In case of not seeking care from the hospital is it due to	Severity of the complications not known			Institution far away
		No attendant available			No money
		beliefs and customs			Lack of transport
			Others(specify)		

**7. FOR ABORTION DEATHS FILL THE FOLLOWING QUESTIONS**

7.1	Did she die while having an abortion or within 6 weeks after having an abortion?	While having an abortion	Within 6 weeks after having an abortion		Don't Know
7.2	If abortion, was the abortion spontaneous or induced, including MTP?	Spontaneous	Induced	MTP	Don't know
7.3	If the abortion was induced, how was it induced?	Oral medicine	Traditional vaginal herbal application	Instrumentation	Don't know
7.4	If the abortion was induced, where did she have the abortion?	Home	Government hospital (specify level)	Private clinic/center	Don't know
7.5	If the abortion was induced, who performed the abortion?	Doctor	Nurse	Others (specify)	Don't know
7.6	If induced, what made family seek care?	Bleeding started spontaneously		Wanted to terminate the pregnancy	
7.7	If the abortion was spontaneous, Where was the abortion completed	Home	Govt. Hospital (Specify level)	Private Clinic/centre	Don't Know
7.8	How many weeks of pregnancy completed at the time of abortion				
7.9	Whether she had any of these symptoms after abortion?	High fever	Foul smelling discharge	Bleeding	Shock
7.10	After developing complications following abortion, did she seek care?				
7.11	If yes, whom/where did she seek care?				
7.12	Date of spontaneous abortion/ date of termination of pregnancy				
7.13	Date & time of death				

## MODULE - III

(To be used for the deaths occurring during delivery. For these deaths, Module-I should also be filled)

### 8. INTRANATAL SERVICES (Tick 'v' wherever applicable)

8.1	Place of delivery	Home		Sub centre	
		CHC		PHC	
		Medical College		District Hospital	
		Sub district Hospital		Private Hospital	
		Transit		Any other place (specify):	
8.2	Admission (not applicable for home delivery and transit)	Date    /    /	Time ____:____		
8.3	Delivery	Date    /    /	Time ____:____		
8.4	Time interval between onset of pain and delivery (in hours)	Hours: _____			
8.5	Who conducted the delivery- if at home or in private institution (Not applicable for transit delivery)	ANM		Staff Nurse / M. Asst.	
		Doctor		Dai	
		Quack		Others	
8.7	Type of delivery	Normal		Assisted	
		Caesarean			
8.8	Outcome of the delivery	Live birth		Still birth	
		Multiple births			
8.9	During the process of labour/delivery, did the mother have any problems?	Prolonged labour Primi >12 hrs Subsequent deliveries >8 hrs		Severe bleeding/ bleeding with clots- (one salwar/saree/skirt soaked =500ml)	
		labour pain which disappeared suddenly		Inversion of the uterus	
		Retained placenta		Convulsions	
		Severe breathlessness /cyanosis/ oedema		Unconsciousness	
		High fever		Others (specify):	

8.10	Did she seek treatment, if yes by whom and what was the treatment given by the ANM/Nurse/LHV/ MO/others ? (give details)		
8.11	Was she referred?	YES	NO
		Not known	
8.12	Did she attend the referral centre?	YES	NO
		Not known	If yes, time interval between admission & delivery (if delivered)
8.13	In case of non compliance of referrals, state the reasons	Intensity of complications not known	Institution far away
		No attendant available	No money
		Beliefs & customs	Lack of transport
		Others	
8.14	Was there delay in	Decision making	Mobilizing funds
		Arranging transport	Others
8.15	Any information given to the relatives about the nature of complication from the hospital	Yes	No
8.16	If yes, describe		
8.17	Was there any delay in initiating treatment	Yes	No
8.18	If yes, describe		

**9. POST NATAL PERIOD (Tick ' v ' wherever applicable)**

9.1	No. of Postnatal checkups	Nil	< 3 checkups
		>/= 3 checkups	Don't know
9.2	Did the mother had any problem following delivery	YES	NO
		Not known	
9.3	Time interval between detection of complication & death (in hours/minutes)		
9.4	Specific problem during Post Natal period	Severe bleeding	Severe fever and foul smelling discharge
		Sudden chest pain & collapse	Unconsciousness/ visual disturbance
		Bleeding from multiple sites	Severe leg pain , swelling
		Abnormal behaviour	Severe anemia
		Others (specify)	
9.5	Did she seek treatment	Yes	No
9.6	If yes, by whom	ANM	Nurse
		LHV	MO Others (specify)
9.7	What was the treatment given (give details)		
9.8	Was she referred?	Yes	No
		Not known	Not applicable
9.9	Did she attend the referral center?	Yes	No
		Not known	Not applicable
9.10	In case of non compliance of referrals, state the reasons	Intensity of complications not known	Institution far away
		No attendant available	No money
		Beliefs & customs	Lack of transport
		Others (specify):	

**10: REPORTED CAUSE OF DEATH**

10.1	Did a doctor or nurse at the health facility tell you the cause of death?	Yes		No	
		Don't know			
10.2	If yes, what was the cause of death?				

**11. OPEN HISTORY (In narrative form): (explore)**

11.1	Name and address of the facilities she went – decisions and time taken for action	
11.2	How long did it take to make the arrangements to go from first centre to higher centers and why those referrals were made and how much time was spent at each facility and time spent at each facility before referrals were made and difficulties faced throughout the process	
11.3	Transportation method used	
11.4	Transportation cost? (at each stage of referral)	
11.5	Travel time – at each stage	
11.6	Care received at each facility?	
11.7	Total money spent by family	
11.8	How did the family arrange the money?	
11.9	Any other	

**Investigator – 1**

**Investigator – 2**

**Investigator – 3**

(Signature)  
 Name:  
 Designation:  
 Place of posting:  
 Date:

(Signature)  
 Name:  
 Designation:  
 Place of posting:  
 Date:

(Signature)  
 Name:  
 Designation:  
 Place of posting:  
 Date:

**COMMUNITY BASED MDR -CASE SUMMARY**  
**(BLOCK PHC)**

**Case Summary Form to be filled in duplicate by the SMO Block PHC for each confirmed maternal death in the block after investigation and to be sent to District MDR Committee within 4 weeks of occurrence of the death (Ref: MDR Guidelines-Para 4.13)**

Yearly Serial No. (Refer to Para 4.13 of the Guidelines): \_\_\_\_\_.

<b>Name of the Block PHC/ District</b>					
<b>Particulars of the deceased</b>		<b>Name:</b>		<b>Age:</b>	
<b>Husband's name &amp; address</b>					
<b>Gravida</b>	<b>Para</b>	<b>Live births</b>	<b>Sill births</b>	<b>Abortions</b>	<b>No. of living children</b>
<b>Visitor/Resident: Address</b>					
<b>Timing of Death</b>		<b>Pregnancy</b>	<b>Delivery</b>	<b>Within 42 days after delivery</b>	
<b>Religion/Caste/Community</b>					
<b>Place, Date &amp; Time of death</b>					
<b>Date of investigation</b>					

**Fill in appropriate cause(s) of delay:**

**1. Delay in Seeking Care:**

Not aware of danger signs	
Problem not identified/identified and neglected	

Delay in decision making	
No birth preparedness	
Beliefs and customs	
Any other (specify)	

**2. Delay in reaching first level facility:**

Delay in getting transport	
Delay in mobilizing funds	
Not reaching appropriate facility in time	
Difficult terrain	
Any other (specify)	

**3. Delay in receiving adequate care in facility:**

Delay in initiating treatment	
Substandard care in hospital	
Lack of blood, equipment & drugs	
Lack of adequate funds	
Any other (specify)	

**Probable direct obstetric cause of death:**

--

**Indirect obstetric cause of death:**

--

**Contributory causes of death (may list them):**

**Initiatives suggested:**

**Date:**

**(Signatures of SMO Block PHC)**

**Name:**

(Office Seal)

**Note: To facilitate investigations (Verbal Autopsy /Community Based MDR), for detailed questions refer to Annexure-2 on CBMDR**

**DISTRICT LEVEL CBMDR - CASE SUMMARY**

District level CBMDR-Case Summary, for every maternal death reported by the Block PHCs, to be completed in duplicate by the District Nodal Officer after review by the District MDR Committee and reports compiled to be put up to the Deputy Commissioner for monthly review and to the State Director Family Welfare for monthly report (Ref: MDR Guidelines-Para 5.5-iii, 5.5-v and 6.2)

Yearly Serial No. \_\_\_\_\_ . Calendar Year: \_\_\_\_\_

**1. General Information:**

Name of the Block PHC/ District:					
Particulars of the deceased:		Name:			Age:
Husband's name & address:					
Gravida	Para	Live births	Still births	Abortions	No. of living children
Visitor/Resident Address:					
Timing of Death:		Pregnancy	Delivery	Within 42 days after delivery	
Religion/Caste/Community:					
Place, Date & Time of death:					
Date of investigation:					

**2. Fill in appropriate cause(s) of delay:****a. Delay in Seeking Care:**

Not aware of danger signs	
Problem not identified/identified and neglected	

Delay in decision making	
No birth preparedness	
Beliefs and customs	
Any other (specify)	

**b. Delay in reaching first level facility:**

Delay in getting transport	
Delay in mobilizing funds	
Not reaching appropriate facility in time	
Difficult terrain	
Any other (specify)	

**c. Delay in receiving adequate care in facility:**

Delay in initiating treatment	
Substandard care in hospital	
Lack of blood, equipment & drugs	
Lack of adequate funds	
Any other (specify)	

**3. Probable direct obstetric cause of death:**

**4. Indirect obstetric cause of death:**

**5. Contributory cause(s) of death:**

**6. Initiatives suggested by SMO Block PHC:** (Add extra page if required)

**7. Remedial follow up actions planned or implemented:** (Add extra page if required)

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**(Signatures of District Nodal Officer MDR)**

(Office Seal)

**Name:**

**Date:**

**(Signatures of Civil Surgeon)**

(Office Seal)

**Name:**

**Date:**

**Note: To facilitate investigations (Verbal Autopsy /Community Based MDR), for detailed questions refer to Annexure-2 on CBMDR**

### Community Based Maternal Death Review

**Line Listing Form to be filled by ASHA/AWW/Others (Ref: Para 4.6, 4.7, 4.8 & 4.9 of MDR Guidelines)**

*(To be compiled for all deaths of women aged 15 – 49 years irrespective of cause of death or pregnancy status)*

Name of village: \_\_\_\_\_ Sub Centre: \_\_\_\_\_ PHC: \_\_\_\_\_

Block: \_\_\_\_\_ District: \_\_\_\_\_ State: \_\_\_\_\_

Contact Person's Name, address & Telephone No. : \_\_\_\_\_

Report for the Month of: \_\_\_\_\_ Date of submission of report: \_\_\_\_\_

*Please submit a copy to the ANM of the area on or before 5<sup>th</sup> of every month (e.g. for report of March, this copy must reach the ANM by 5<sup>th</sup> of April).*

*Even if there is no death of women of age 15-49 years, submit 'NIL' report by the due date.*

Sl. No.	Name, age, husband's name & address of deceased	Place of death			When did the death occur				Probable cause of death	Status of newborn (dead/alive)	Name & Tel No. of the person interviewed	Date & time of visit to home of deceased
		Home	Health facility (Name)	Others	During pregnancy	During delivery	Within 42 days after delivery	Others (Non-maternal death)				

Name of ASHA: ..... Village: ..... Mob/Tel No: ..... Signatures : .....

**Note:** 1. For every death of women of age 15-49 years, inform the ANM of the area telephonically within 24 hours.

2. In case a Maternal Death is detected, inform the SMO Block PHC and the ANM of the area IMMEDIATELY TELEPHONICALLY.

**Maternal Death** is defined as the death of a woman who dies from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy or child birth or within 42 days of termination of pregnancy, irrespective of duration and site of the pregnancy.

**COMMUNITY BASED MATERNAL DEATH REVIEW REGISTER**

**To be maintained at Block PHC level (Ref: Para 4.10 of the MDR Guidelines)**

**(To be compiled for all deaths of women aged 15 – 49 years irrespective of cause of death or pregnancy status)**

**Name of Block PHC:** \_\_\_\_\_

**Block:** \_\_\_\_\_

**District:** \_\_\_\_\_

**State:** \_\_\_\_\_

**[ Fill separate page(s) for every month from the Line listing and CB-MDR forms]**

**Year:** ..... **Month:** .....

Sr. No.	Name of deceased	Age	Date of death	Address	Husband's Name	Cause of death (tick ✓)		Primary information (line list) provided by	Date of field investigation	If died due to maternal causes, specify reasons	Action taken
						Maternal (Mention Yearly Serial Number)	Non-Maternal				

**Name of the SMO Block PHC:** ..... **Signatures:** ..... **Date:** .....

**Note:** Maternal death is defined as the death of a woman who dies from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy or child birth or within 42 days of termination of pregnancy, irrespective of duration and site of pregnancy.

**Maternal Death Information Report****Format for Primary Informer**

*(To be compiled for reporting Maternal Deaths to Civil Surgeon, Deputy Commissioner & the State Director Family Welfare by the Primary Informer i.e. by Facility Nodal Officer in case of FBMDR and by SMO Block PHC in case of CBMDR. Also by ANM to SMO Block PHC in case of CBMDR )*

1	Name of District	
2	Name of Block	
3	Report under FBMDR or CBMDR	
4.	Name, age & address of the deceased woman	
5.	Name of husband	
6.	Date and time of death	
7.	Place of death	
	Home	
	Health Facility (Specify name and address of the Facility)	
	Others (Specify):	
8.	When did death occur	
	During pregnancy	
	During delivery	
	Within 42 days after delivery	
9.	Name of reporting person & mobile/telephone no.	

Signature of reporting person:

Designation:

Name of the Sub-centre/Facility/Block PHC:

Date & Time:

## MATERNAL DEATH RECORD REGISTER

(FACILITY / DISTRICT / STATE)

*To be maintained at Facility, District and State level to keep record of all the reported/ confirmed 'Maternal Deaths' (Ref: Para 3.9, 5.5.ii & 7.3 of MDR Guidelines)*

Sr. No.	1 Name of District / Block	2 Name of Block PHC/ Facility	3 Report under FBMDR or CBMDR	4 Name, age & address of the deceased woman	5 Name of husband	6 Date and time of death	7 Place of death			8 When did death occur			9 Name & designation of reporting person & mobile/telephone no.	10 Date & time of receipt of information on telephone	11 Date & time of receipt of information in Annexure-6	12 Outcome of the investigation (Tick ✓ in the appropriate box)	
							Home	Health Facility (Specify name and address of the Facility)	Others (Specify)	During pregnancy	During delivery	Within 42 days after delivery				Confirmed Maternal Death (mention Yearly Serial Number)	Non-maternal Death
1																	
2																	
3																	
4																	
5																	

**NOTE:** Column No. 12 will be completed after report of verification/ investigation is available.