



ABSTRACT

Family Welfare Programme – Maternal Death Audit – Improving and Streamlining the process of conducting Maternal Death Audit – Modified guidelines – Orders – Issued.

HEALTH AND FAMILY WELFARE (R2) DEPARTMENT

G.O.(Ms) No.389

Dated: 04.09.2018

திருவள்ளூர் ஆண்டு 2049

விளம்பி, ஆவணி - 19

Read:

1. G.O.(Ms) No.223, Health and Family Welfare Department, dated 09.07.2004.
2. The President, Tamil Nadu Government Doctors Association, Coimbatore, Representation dated 14.9.2017.
3. Government Letter No.34867/R2/2017-6, dated 05.08.2018.
4. From the Mission Director, National Health Mission Letter No.8051/P3/NHM/2018, dated 05.07.2018.
5. From the Director of Medical Education, Letter No.51177/ M&D.11/3/2018, dated 18.07.2018.
6. From the Director of Family Welfare, Letter No.6738/FW/D&E/D6/2018, dated 26.07.2018.
7. From the Director of Public Health and Preventive Medicine, Letter No.62318/MCH3/A2/2018, dated 28.07.2018.

ORDER:

Maternal Death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of duration and site of pregnancy for any cause related to aggravated by the pregnancy or its management but not due to accidental or incidental causes. The conduct of maternal death audit helps to find out the causes and specific circumstances that led to maternal death. It helps in knowing the preventable causes of maternal deaths in future and is not a fault finding exercise. The conduct of maternal death audit under guidelines issued vide G.O. first read above, among other interventions, has been instrumental in identifying preventive causes and reducing the maternal mortality rate in this State



from 114 per lakh live births during the year 2004 to 66 in 2014-2016, attaining the sustainable development goals. The systemic drivers of maternal mortality have also changed over the years, such as 8% of Higher Order Births accounting for 30% of mortality, heart disease complications, etc. It is now felt that the system of conducting maternal death audit should be strengthened with a view to identifying and mitigating the systemic issues to reduce the maternal mortality to the level of advanced countries.

2. In the references second read above, the Tamil Nadu Government Doctors Association has represented the Government to streamline and improve the maternal death audit. The heads of department, based on the recommendations of the technical expert committee of Obstetrician-Gynecologists and Public health experts have proposed modifications to streamline and improve the maternal death audit.

3. Based on the above proposals, in order to improve and streamline the process of conducting the maternal death audit, the Government after careful consideration direct that the following modifications be done in the system:

(a) Questionnaire based audit:

The maternal death audit questionnaire should be filled in detail prior to the audit and used as the basis for audit. The questionnaire can be circulated one week before the audit to take the views and allow the concerned doctors to fill up the details by contacting the relevant stakeholders, supplementing the present system of verbal autopsy.

(b) Level of maternal audit:

(i) Community level audit:

This should be undertaken by the PHC medical officer / Urban PHC medical officer wherein the maternal death audit can be conducted at the community level, as per the existing system supplemented by the questionnaire.

(ii) Technical Maternal Death Audit at District level:

A district technical committee for Maternal death is formed with the following members:-

1. Head of Department of Obstetrics and Gynecology from the Government Medical College in the district/adjacent districts.
2. District Nodal Officer for Maternal Death – Director of Public Health and Preventive Medicine side
3. Deputy Director of Family Welfare – Director of Medical and Rural Health Services side

This committee should take up for audit all maternal deaths and also cases of "near-misses" with a view to identifying and correcting the medical and non-medical reasons behind the case. The committee will screen all the cases to identify cases of lapse or preventable death, and will call for clarifications in the questionnaire format and then call for in-person enquiry of the treating doctors and allied health personnel.

The district technical committee will recommend specific cases (say 20%) to be taken up for audit by the district maternal audit committee. The district technical committee will also recommend such cases to be taken up at the State level.

(iii) District Level Maternal Death Audit by District Collector headed committee:

The existing district level committee will take up the select cases identified by the technical committee for greater scrutiny and to take definitive action where a holistic, co-ordinated and systemic response is needed. While the District Maternal Death Audit Committee will be free to call for the entire line list of maternal deaths and review all of them if necessary, care should be taken to review select cases only with a view for systemic improvement rather than a mechanical processing of cent per cent cases.

(iv) State Level Audit:

Based on the cases recommended by the district committee for a detailed State level audit, the existing State Committee should conduct the audit with a freedom to choose the cases not included in the list in case, it is felt that that greater scrutiny is needed. As in district level audit by the Collector, the cases being taken up for detailed scrutiny and tentative issues should be shared with the stakeholders in advance to allow greater participation.

4. The existing State Level Maternal Death Audit Committee will meet once in two months to scrutinise all the reports received from the District Collectors, review the quality of Maternal Death Audit and take necessary follow up action.

5. The following points should be kept in mind during the conduct of Maternal Death Audit:

i) The exercise should be one of fact finding and not fault finding.

(ii) In respect of the district maternal death audit, a separate discussion with patient attenders, medical and paramedical professionals should be done one-to-one in the District Collector's chamber. The discussion and findings should be discussed in an exclusive maternal audit meeting with the district technical committee and the community - based audit team, to ensure learning and feedback.

iii) State - level expert team will be sent to districts in cases of doubtful maternal death where conclusions need to be arrived. No penal action should be taken based on the findings, and the exercise should be of fact finding and systemic correction.

6. The questionnaire for Maternal Death Review is annexed to this order.

7. The Government after careful consideration direct all the Heads of Department and all other authorities concerned to follow the guidelines in this regard.

8. The Principal Secretary to Government, Health and Family Welfare Department is authorised to review the functioning of the above system and make necessary modifications after a period of three months, if required.

(BY ORDER OF THE GOVERNOR)

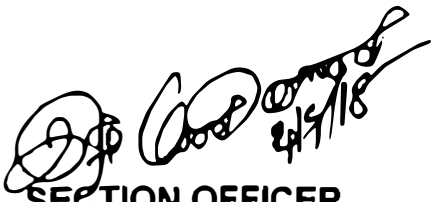
**J.RADHAKRISHNAN,
PRINCIPAL SECRETARY TO GOVERNMENT.**

To
All Heads of Department.
The Commissioner, Maternal Child Health and Welfare.
Commissioners of all Corporations.
All Municipal Commissioners.
All District Collectors.
All Joint Director of Health Services.
Deputy Director of Medical and Rural Health Services (Medical).
Deputy Director of Health Services of
all the Health Unit Districts.

Copy to:

The State Secretary, Tamil Nadu Government Doctors Association,
Coimbatore.
The Special Personal Assistant to Hon'ble Minister (Health and Family Welfare), Chennai-9.
The Principal Secretary to Principal Secretary to Government,
Health and Family Welfare Department, Chennai - 9.
The Health and Family Welfare (Data Cell) Department, Chennai-9.
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// FORWARDED BY ORDER //


SECTION OFFICER
23/11/18

Name of the Deceased Mother	Family	PHC	SDH & DH	MCH
Name of Husband / Father				
Age				
Antenatal Registration (PICME) <ul style="list-style-type: none"> • Booked Mothe • Unbooked Moth 				
LMP				
EDD <ul style="list-style-type: none"> • Gestational age /Preterm • Postdated mother • Date of delivery 				
Gravida <ul style="list-style-type: none"> • Multigravida • Bad Obstetric History • Too Close pregnancy 				
Para/Live <ul style="list-style-type: none"> • Living Children . 				
Abortion/Died <ul style="list-style-type: none"> • Spontaneous • Induced Abortion 				
AN checkup (at least 3 visits) <ul style="list-style-type: none"> • Number of visits 				
Height				
* Weight <ul style="list-style-type: none"> • Weight gain >10 kg during pregnancy • Inadequate weight • Rapid weight gain 				
* BP				

Postpartum Done/Report				
Date & time of death				
Cause of death				
Admission - Death Interval				
Delivery - Death Interval				

*** To entered at all facilities**

❖ Levels of failure identified

❖ Suggested steps to prevent in future

Signature of Medical Officer

Name:

Designation:

J. RADHAKRISHNAN
PRINCIPAL SECRETARY TO GOVERNMENT

// True copy //

[Handwritten Signature]
SECTION OFFICER
21/11/18