



ABSTRACT

Family Welfare Programme – Conducting of Maternal and Death Audit Guidelines – Orders - Issued.

HEALTH AND FAMILY WELFARE (R1) DEPARTMENT

G.O. (Ms.) NO.223

Date: 9.7.2004

Read:

ORDER:

Maternal Death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not due to accidental or incidental causes.

2. The conduct of Maternal Death Audit helps to find out the causes and the specific circumstances that led to Maternal Death. The present system of conduct of Maternal Death Audit in the institutions alone may not provide an accurate picture of the causes of Maternal Death. The Government have decided that the system of Maternal Death Audit shall be strengthened. An Expert Team shall monitor the quality of conduct of Maternal Death Audit periodically.

The following guidelines are issued for the conduct of Maternal Death Audit:

3. A comprehensive format has been developed for conduct of verbal autopsy. The Deputy Director of Health Services (DDHS), District Public Health Nurses (DPHNs) and the Corporation Health Officers (CHOs) will be trained in the use of the new verbal autopsy format. In turn, they will train all the Medical Officers (MO) of Primary Health Centres (PHCs) / Municipal Health Officers (MHOs) / Medical Officers (MOs) of the Urban Health Posts / Woman Medical Officers (WMOs) of Maternity Homes and the field health functionaries in the investigation of maternal deaths by using the verbal autopsy format.

4. The Medical Officer of the concerned Primary Health Centre will ensure notification of all the maternal deaths of his/her area to the Deputy Director of Health Services, Director of Public Health and Preventive Medicine (DPH&PM), Commissioner Maternal, Child Health and Welfare (MCH & Welfare), District Collector and Secretary (Health and Family Welfare) within 24 hours of occurrence of death. He/ she will sensitize all the field health functionaries about reporting maternal deaths within 24 hours of occurrence.

5. The Municipal Health Officer shall be responsible for reporting maternal deaths in his/ her municipality to Deputy Director of Health Services by fax/ telegram/ E-mail with a copy marked to the Commissioner, Maternal, Child Health and Welfare. In the Municipalities where there is no post of Municipal Health Officer, the Municipal Commissioner is responsible for reporting the maternal deaths to Deputy Director of Health Services of the Health Unit District. Health Officer of the Corporation shall report the maternal deaths occurring within the six municipal corporation limits to the Corporation Commissioner, Commissioner, Maternal, Child Health and Welfare and Director of Public Health and Preventive Medicine within 24 hours of occurrence.

6. The Primary Health Centre – Medical Officer shall conduct a detailed investigation of every maternal death by personally visiting the various service providers and field health functionaries and meeting the relatives of the deceased. The Primary Health Centre – Medical Officer will use the verbal autopsy format for conducting the investigation. The investigation should be completed within 15 days of the occurrence of the maternal death. The Primary Health Centre – Medical Officer should personally conduct the investigation and should not entrust this responsibility to any paramedical functionary. The completed verbal autopsy investigation format should be sent to the Deputy Director of Health Services.

7. The Municipal Health Officer / Medical Officer of Urban Health Post / Woman Medical Officer of Maternity Home of the Municipalities and Municipal Corporations shall conduct a detailed investigation of every maternal death by personally visiting the various service providers and field health functionaries and meeting the relatives of the deceased. In case no Medical officer / Municipal Health Officer is available, in the municipality the Deputy Director of Health Services will nominate one Primary Health Centre Medical Officer to conduct the verbal autopsy. The Medical Officer of the Urban Health Post / Municipal Health Officer will use the verbal autopsy format for conducting the investigation. The investigation should be completed within 15 days of the occurrence of the maternal death. He/ she should personally conduct the investigation and should not entrust this responsibility to any paramedical functionary. The completed verbal autopsy investigation format should be sent to the Deputy Director of Health Services.

8. The Institution Heads including Private Hospitals should provide all details and case records of the Deceased Mothers/ Against Medical Advice / Absconded Cases who had attended their Institutions for the perusal of the Investigating Officers.

9. The Deputy Director of Health Services and District Public Health Nurse will scrutinize the verbal autopsy formats received from the Primary Health Centre – Medical Officer / Municipal Health Officer / Corporation Health Officer (CHO) / Municipal Commissioner and verify the quality and completeness of the investigation. They will discuss each case with the Primary Health Centers – Medical Officer / Municipal Health Officer / Corporation Health Officer / Municipal Commissioner and the concerned field health functionaries. A narrative case history will be prepared for each maternal death and the factors contributing to maternal death will be listed.

10. Maternal deaths occurring in the medical college hospitals and attached institutions shall be reported to the Deputy Director of Health Services, Director of Medical Education, Commissioner, Maternal, Child Health and Welfare by fax / telegram / e-mail by the Head of the Department of Obstetrics and Gynaecology within 24 hours of occurrence. The Superintendent / Chief Medical Officer of all District / Taluk / Non-Taluk Hospitals shall be responsible for reporting maternal deaths occurring in their hospitals to the Deputy Director of Health Services, Director of Medical and Rural Health Services, Commissioner, Maternal, Child Health and Welfare by Fax / Telegram / E-mail within 24 hours of occurrence. Deputy Director of Health Services will arrange to investigate these maternal deaths if not done already.

11. With regard to maternity cases discharged Against Medical Advice (AMA) and absconded from their institutions, the Dean / Superintendent / Chief Medical Officer of all Medical College Hospitals, District / Taluk / Non Taluk Hospitals should intimate the relevant details, including the complete address of the discharged patient, to the Deputy Director of Health Services of the District, immediately. The Deputy Director of Health Services will send the list of the maternity cases discharged against medical advice to the respective Medical Officers of the Primary Health Centres and the maternal deaths amongst those discharged Against Medical Advice (AMA), if not already investigated, shall be investigated by the Primary Health Centre- Medical Officer. These maternal deaths, if not already reported, shall also be notified immediately to the Commissioner, Maternal, Child Health and Welfare and Director of Public Health and Preventive Medicine.

12. The Deputy Director of Health Services on receipt of list of Against Medical Advice / Absconded Cases from urban areas will verify the cases through Municipal Health Officers, Medical Officers of Urban Health Posts, Urban Family Welfare Centres, Maternity Homes and Maternity Centres. The maternal deaths, if not notified earlier, will be notified by the Deputy Director of Health Services to the Commissioner, Maternal, Child Health and Welfare and Director of Public Health and Preventive Medicine immediately. The Medical Officer of the Urban Health Post shall investigate the maternal death and the investigation report will be sent to the Commissioner, Maternal, Child Health and Welfare.

13. Maternal deaths occurring in private health facility shall be immediately reported to the Deputy Director of Health Services of the concerned District by the management of the Private Health Institutions through Fax/Telegram/E-mail and a copy will be marked to the Commissioner, Maternal, Child Health and welfare. The Private Health Institutions will co-operate with the Government Officials in conducting the verbal autopsy as per the format. The Joint Director of Health Services (JDHS) / Deputy Director (Medical), DD (M) will arrange to inform the Private Hospitals in the Districts about the need for reporting maternal deaths and permitting the investigator to have an access to the medical records of such maternal deaths. Indian Medical Association will provide necessary support for the investigation process. The information collected from the Private Hospitals is of non statutory value.

14. A District Level Committee to review the maternal deaths shall be formed with the following members:

District Collector	-	(Chair person)
Deputy Director of Health Services	-	(Convenor)
Joint Director of Health Services / Deputy Director (Medical)	-	(Member)
Dean of the Medical College (wherever available)	-	(Member)
Regional Director Municipal Administration	-	(Member)
Obstetrician from the District Hospital	-	(Member)
Obstetrician of the Medical College hospital	-	(Member)
Chief Medical Officer/Superintendent of the Hospital	-	(Member)
District Public Health Nurse	-	(Member)

15. The District Committee will send a Detailed Report every month to Commissioner, Maternal, Child Health and Welfare and the Health Secretary about the corrective measures taken to minimize the Maternal Deaths. The number of Maternal Deaths in Tamil Nadu per year is around 1600. This works out to about 50 to 55 deaths per District per year on an average. The District Committee will have to review about four to five deaths per month. The Committee may meet fortnightly to carry out the audit. The Committee will discuss with the relatives of the deceased first to elicit their views on the factors contributing to Maternal Death including the quality and timeliness of service provision in the health facilities. A separate meeting will follow this with the various service providers including private service providers. The Committee will also hold discussions with Primary Health Centre-Medical Officer/ Urban Health Post Medical Officer who carried out the verbal autopsy. The various factors that led to the death of the mother will be reviewed and corrective measures taken to prevent Maternal Deaths.

16. A State Level Maternal Death Audit Committee consisting of the following members will be formed:

Secretary (Health and Family Welfare)
 Commissioner Maternal, Child Health and Welfare
 Commissioner Municipal Administration
 Director, Institute of Gynaecology
 Director of Public Health and Preventive Medicine
 Director of Medical and Rural Health Services
 Director of Medical Education
 Deputy Director, Institute of Public Health, Chennai
 Expert Resource Persons.

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

