Maternal Death Review - Country Perspective

WHO Multicountry Workshop, Bangkok, Thailand.
September 24-28, 2012

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Ministry of Health and Family Welfare
Govt. of India
Total Population: 1.2 Billion

Number of states, UTs: 35

Population of Largest State (UP)- 200 Million

About 30 million pregnancies per year

27 million births

56,000 maternal deaths
High Focus States:
- Uttar Pradesh
- Bihar
- Madhya Pradesh
- Rajasthan
- Orissa
- Chhattisgarh
- Jharkhand
- Uttarakhand
- Assam & N-E
- Jammu & Kashmir
- Himachal Pradesh
National Rural Health Mission (NRHM) is a sector-wide approach focusing on various aspects of health, including:

- **Community Mobilisation:** ASHAs
- **Health System Strengthening:**
  - Flexible financing
  - Human Resources
  - Infrastructure strengthening
  - Capacity Building
- **RCH (RMNCH+A):**
  - Maternal Health
  - Family Planning
  - Adolescent Health
  - Immunisation
  - Child Health

**Disease Control**

**National Rural Health Mission (NRHM)** aims to:

- Improve health outcomes
- Strengthen health systems
- Build capacity
- Enhance health services in rural areas
Under NRHM, focus on Poor Performing States and Districts: Bring in technical & managerial resources to states that lag behind

Higher resource allocation to 264 backward districts with poor indicators.
Releases and Expenditure are inclusive of State share.

<table>
<thead>
<tr>
<th>Year</th>
<th>Release</th>
<th>Exp.</th>
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<tbody>
<tr>
<td>2005-06</td>
<td>4,434</td>
<td>3,204</td>
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<tr>
<td>2006-07</td>
<td>5,774</td>
<td>4,519</td>
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<td>2007-08</td>
<td>8,509</td>
<td>7,010</td>
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<td>2008-09</td>
<td>10,941</td>
<td>10,565</td>
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<tr>
<td>2009-10</td>
<td>13,089</td>
<td>13,216</td>
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<tr>
<td>2010-11</td>
<td>14,669</td>
<td>16,113</td>
</tr>
<tr>
<td>2011-12</td>
<td>18,405</td>
<td>15,850</td>
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Releases have increased from 800 million US $ to 3.3 billion US $ in 7 years.
Key Challenges

1. Utilizing fully the NRHM funding for 2012-13

2. Doing it Well.......i.e. More Health for Money !!

3. Getting prepared to absorb the enhanced funding from next year onward
Trends in Maternal Mortality Ratio

- Two states: Kerala and Tamil Nadu have achieved the MMR goal, while Maharashtra is close.
- Four states are within striking distance.

These trends show a decrease in maternal mortality ratios over the years for different states in India.
MATERNAL MORTALITY RATIO (MMR)

Regional Disparities...

- Kerala and Tamil Nadu have achieved the NRHM goal, while Maharashtra is close.
- Andhra Pradesh, West Bengal, Gujarat and Haryana are within striking distance.
- EAG states and Assam would need to further intensify efforts.
Annual Health Survey -2010-11

MMR
(State; best and worst performing divisions)

Range: UK-7  Rj: 72  UP: 210  Bh:119  As: 88
Annual Health Survey 2010-11

MMR
(State; best and worst performing divisions)

Range: Jh-117
Os: 58
Cht: 69
MP: 125
Why conduct MDR?

- Reduce *Maternal mortality and severe morbidity*
- Improve quality of obstetric care
- Understand determinants of maternal death
- Provide stimulus for action at all levels
- Take corrective action to fill the gaps in service provision

A commitment to act upon the findings

Not for punitive action
MDR Process

Five approaches to help understand why women die...

• Maternal deaths in the community (CBMDR)

• Maternal deaths in facilities (FBMDR)

• Confidential enquiries into maternal deaths

• Learning from women who survived: “near miss” cases

• Evidence-based clinical audit
The maternal death surveillance cycle.

Identify cases → Collect information → Analyse results → Recommendations for action → Implement, evaluate and refine

No Punitive Action
Policy on Maternal Death Reviews ...spelt out in implementation framework of RCH II

Strengthen Monitoring/Records/Audit procedures

- Monitor State and Regional level MMR
- Introduce mother-child linked card
- Conduct audit of maternal deaths at the hospital and community levels
- Develop tools for maternal death auditing and reporting
Challenges... in rolling out MDR

• Resolving infrastructure and human resource issues
• Building partnerships between govt. systems and others (prof. bodies, tech. agencies, NGOs, CSOs)
• Resolving ethical issues
• Developing guidelines and simple implementable tools
• Orientation of a wide range of functionaries -- policy makers, programme officers, frontline HWs, community workers, PRIIs... capacity building of the states
• Mobilising communities and the health system
• Creating awareness in community... Need for effective BCC/IEC
Key Milestones..

• Multi-stakeholder workshop at PGIMER, Chandigarh in May 2009
• Developing simple tools and identifying programme requirements including operational framework for MDR
• Disseminating Guidelines and tools
• Upscaling Maternal Death Review to all states with a focus on high MMR States
• Institutionalising Maternal Death Review including facility based reviews in rural District Hospitals /high volume FRUs
• Advocating with State level policy makers and programme officers
• Capacity Building of states...district and field level workers
• NRHM State Plans... Resource Allocation
National Guidelines for Maternal Death Review (MDR)

Objectives

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

GUIDEBOOK
Key steps in MDR Implementation

- Implementation of MDR has to be supported by a State Govt. order
- Notification of Maternal Deaths
- **Facility based Review**
- **Community based Review**
- All health functionaries have a role in MDR
- District Collector (DM) to be involved in MDR with the relatives of the deceased and service providers
- *No punitive action against service providers*

ASHA and ANM have key roles in MDR
Maternal Death Review Process

Facility based review in high volume institutions

F1  F2  F3

DM

CMO

1

2

3

Community based review

ASHA

ANM

VASA  V2  V3
Facility Based Maternal Death Review Process

CMO & DNO
{Dt Level Maternal Death Review Committee Monthly}
(Community & Facility)

Hospital Maternal Death Review Committee (weekly)
Review of all MDs in the hospital

Nodal officer of the Hospital

Medical Officer on duty
MATERNAL DEATH IN THE HOSPITAL

Inform/send to DNO
• within in 24hrs (phone)
• Information report (Annex-6)
• FBMDR format within 24hrs

State cell
State Committee reviews once in 6 months

• Line listing of MDs (Annex-4)
• Approves FBMDR format and retains a copy

D. Magistrate
All MDs reviewed monthly

FBMDR format, Case sheet
Case summary, Mins of meeting
(Corrective measures taken)

FBMDR format
Case sheet

Intimation on MD to FNO
within 24hrs
Information report (Annex-6)
FBMDR done, reported within 24hrs
COMMUNITY BASED MATERNAL DEATH REVIEW PROCESS

**COMMUNITY**

- Telephonically informs about the maternal death within 24hrs to Block MO PHC

**BLOCK**

- Telephonically informs Dt Collector, Dt CMO and State DHS within 24hrs of receipt of information of maternal deaths

**DISTRICT**

- 2 relatives of the deceased attend

**STATE**

- DT Collector / Dt. Health Society
- DT Collector’s Monthly Review Meeting

**COMMUNITY BASED MATERNAL DEATH REVIEW PROCESS**

- Linelisting of maternal deaths, submitted to Block MO PHC by ASHA ( monthly)
  - Deploys LHV/BPHN/ Nurse/ other health personnel along with ANM of the subcentre(in whose area the death occurred) to visit the deceased woman’s house and conduct verbal autopsy
  - Confirmed death recorded at Block level and MO analyses and discusses the findings with the team

**State Review**

- Case summary sheet for every maternal death investigated sent to the Dt CMO
- Maternal death reports are reviewed by Dt MDR committee chaired by Dt CMO (monthly)
PROGRAMME MONITORING:
Monthly MDR Reports
## Status of Submission of MDR Reports by States/UTs

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<th>Criteria</th>
<th>April- Sept 2011 (6 months)</th>
<th>April 2011-March 2012 (one year)</th>
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<tr>
<td>Good</td>
<td>9 States/UTs</td>
<td>20 states/UTs</td>
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<tr>
<td>Satisfactory</td>
<td>15 States/UTs - Bihar,</td>
<td>13 states/UTs</td>
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<tr>
<td></td>
<td>Chhattisgarh, Jharkhand,</td>
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<td></td>
<td>Rajasthan, J&amp;K, Assam,</td>
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<tr>
<td></td>
<td>Haryana, Karnataka, Kerala,</td>
<td></td>
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<tr>
<td></td>
<td>W.Bengal etc</td>
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<tr>
<td>Poor/Defaulter</td>
<td>11 States/UTs (UP, HP,</td>
<td>2 states/UTs (Arunachal Pradesh,</td>
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<tr>
<td></td>
<td>Andhra Pradesh, Tamil</td>
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<tr>
<td></td>
<td>Nadu, Arunachal, Meghalaya,</td>
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<td></td>
<td>Mizoram, Nagaland, A&amp;N</td>
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<td></td>
<td>Islands, D&amp;N Haveli, Puducherry)</td>
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Maternal Death Review Reports... An Analysis
Maternal Deaths - Causes

- Haem. 38%
- Sepsis 11%
- Abortion 8%
- Obstructed Labor 5%
- Hypertensive Dis.ofPreg 12%
- Others 34%

Source: RGI-SRS 2001-03
Proportion of deaths Reported, Reviewed & Assigned Causes

- Deaths reported out of expected deaths: 18%
- Deaths reviewed by the MDR Committee of CMO: 67%
- Deaths reviewed by the MDR Committee of DM: 39%
- Deaths assigned causes: 92%
MDR: State Specific Initiatives

- **MP**: Developed state specific tools to monitor and analyse maternal deaths from each district.

- **Assam**: Compiled a “Maternal Death Directory for 2011-12” with information of all maternal deaths w.r.t. place of death, month and causes.

- **Punjab**: Detailed analysis of all maternal deaths reported in 2010-11 and 2011-12 and has started online reporting of maternal deaths ([www.pbnrhm.org/mdr.aspx](http://www.pbnrhm.org/mdr.aspx)).

- **Tamilnadu and Kerala**: Had established MDR processes for many years (Kerala doing Confidential Enquiry)...also have good Civil Registration Systems.
Current Challenges & Issues...implementation of MDR process

- **Under-reporting** (only 17.6% of total expected deaths reported).
- **Quality of Maternal death reviews** at District/facility level-
  - Restricted to identification of medical causes, rather than systemic gap analysis leading to corrective measures except in some states e.g. Orissa, MP, Punjab and Gujarat.
- **Focus on high case load facilities** in high mortality districts... need to prioritize on constitution of FBMDR Committees at High Case Load “Delivery Points”
- **Capacity building** of health care providers and community health workers
Way Forward..

- Complete Reporting through Web based Central HMIS ...sustainability
- Improving the MDR Process ... effective tool for enhancing Quality of Obstetric Care

- MDR Software (to be linked with MCTS) ...in process of development
Each maternal death is a tragedy.

Bigger tragedy, however, is failing to learn lessons from her death!!
Thank You!