ANNEXURE 16

For official use only
CONFIDENTIAL

Facility Based Maternal Death Review Form

NOTE:

1. This form must be completed for all 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 (X) where applicable (? means unknown)
3. Attach a copy of the case records to this form
4. Complete the form in duplicate within 7 days of a maternal death. The original remains at the institution where the death occurred and the copy is sent to the person responsible for maternal health in the State

For Office Use Only:
FB-MDR no:

Year:

Please fill up form from below.

Address of Contact Person at District and State:

_____

Residential Address of Deceased Woman:

_____

Address where Died:

Name and Address of facility:

Block:

District: **State:**

2. DETAILS OF DECEASED

Inpatient Number:

Name:

Age(years) :

Gravida _____ Live Births_____Abortions ____No. Living children_____

Days since delivery/abortion: _____

Date of admission: Day____ Month_____Yr_____

Time of admission Hrs_____min_____

Date of Death: Day____ Month_____Yr_____

Time of Death Hrs_____min_____

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	DISTRICT HOSPITAL	MEDICAL COLLEGE/ TERTIARY HOSPITAL	PRIVATE HOSPITAL	PVT CLINIC	OTHER

Diagnosis at admission:

Abortion	Ectopic pregnancy	Not in labour	In labour	Postpartum

Diagnosis when died:

Abortion	Ectopic pregnancy	Not in labour	In labour	Postpartum

Duration from onset of complication 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

4. Antenatal Care

Did she receive ANC? Yes____ No_____ Don't know _____

If no, reason: Lack of awareness __ Lack of accessibility ___ Lack of funds____

Lack of attendee____ family problems_____

If Yes, Type of Care Provider (mark all): 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 _____

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

Comments on antenatal care - List any medication

5. DELIVERY, PUERPERIUM AND NEONATAL INFORMATION

Did she have labor pains? Yes_____ No _____ Don't know _____

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

In which phase of labor did she die?

?	Latent phase	Active phase	Second stage	Third stage	> 24 hrs after

Duration of labour: _____hrs _____mins

Delivery

Undelivered	Vaginal (unassisted)	Vaginal Vacuum/forceps	Caesarean section

Comments on labour delivery and puerperium

Details of Baby:

Baby Birth weight (g)				

Outcome

Stillborn	Neonatal death	Alive	Alive at 7 days

Needed resuscitation Y/ N
If yes, who gave ENBC? If died, probable cause

Comments on baby outcomes(in box below)

INTERVENTIONS (Tick appropriate box)

Early		Antenatal		Intrapartum		Postpartum		Other	
Evacuation		Transfusion		Instrumental del.		Evacuation		Anaesthesia - GA	
Laparotomy		Version		Symphysiot		Laparotom		Epidural	
Hysterectom				Caesarean		Hysterecto		Spinal	
Transfusion				Hysterecto		Transfusio		Local	
				Transfusion		Manual removal		Invasive monitoring	
						Other - specify		ICU ventilation	

7. CAUSE OF DEATH (See Guidelines):

Primary (underlying) cause of death: Specify:

Final cause of death: Specify:
Contributory (or antecedent) cause/s: Specify:

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 or admission				
	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				

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)**

11. **AUTOPSY:** Performed Not Performed ☐

12. If performed please report the gross findings and send the detailed report later

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

Form filled by:

Name
Designation
Institution and location
Signature and Stamp
Date:

ANNEXURE-17
MODULES

MODULE - I

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

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

MODULE - III

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

GENERAL INSTRUCTIONS

1. The 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. **CONFIDENTIALTITY:** 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. **NEUTRAL 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.

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

Kindly (√)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**	
1.9	Week of pregnancy If applicable			<16 weeks		17-28 weeks		>29 weeks	
1.10	Age at death								

2. FAMILY HISTORY

No.	Details	Deceased Mother	
2.1.	Age at marriage	<18 Yrs	
		19-25 Yrs	
		26-30 Yrs	
		31-35 Yrs	
		>36 Yrs	
2.2.	Religion	Hindu	
		Muslim	
		Christian	
		Others	
2.3.	Community	SC	
		ST	
		BC	
		MBC	
		OC	
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**	Alive	Dead	Newborn death	Still birth

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

MODULE - II

7. 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 also should be filled for all maternal deaths)

7.1	Did the mother had any problem during antenatal period?	Not known		No	
		Yes			
7.2	If yes, was she referred anytime during her antenatal period?	YES		NO	
		Don't know			
7.3	What was the symptom for which she sought care ?	Head ache Edema Anemia High blood pressure Bleeding p/v No foetal movements Fits Sudden excruciating pain High fever with rigor Others (specify)			
7.4	If YES, did she attend any hospital ?	YES		NO	
		Don't know			
7.5	In case of not seeking care from the hospital is it due to	Severity of the complications not known		Institution far away	
		No attender available		No money	
		believes and customs		Lack of transport	
		Others(specify)			

FOR ABORTION DEATHS FILL THE FOLLOWING QUESTIONS

7.6	Did she die while having an abortion or within 6 weeks after having an abortion?	Yes		No		Don't know	
7.7	If during an abortion, Was the abortion spontaneous or induced, including MTP?	Spontaneous				Induced	Don't know	
7.8	If the abortion was induced, How was it induced?	Oral medicine		Traditional vaginal herb application		Instrumentation	Don't know	
7.9	If the abortion was induced Where did she have the abortion?	Home		Government hospital (speci level)		Private clinic/center	Don't know	
7.10	If the abortion was induced Who performed the abortion?	Doctor		Nurse		Others (specify)	Don't know	
7.11	If induced, what made family seek care?	Bleeding started spontaneously				Wanted to terminate the pregnancy		
7.12	If the abortion was spontaneous, Where was the abortion completed?	Home		Government hospital (specify level)		Private clinic/center	Don't know	
7.13	How many weeks of pregnancy completed at the time of abortion							
7.14	Whether she had any of these symptoms after abortion?	High fever		Foul smelling discharge		Bleeding	Shock	

7.15	After developing complications following abortion, did she seek care?				
7.16	If yes, whom/where did she seek care?				
7.17	Date of spontaneous abortion/ date of termination of pregnancy				
7.18	Date of death				

MODULE - III

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

8. INTRANATAL SERVICES

8.1	Place of delivery	Home		Sub centre	
		CHC		PHC	
		Medical College		Dist. Hosp.	
		Sub dist. Hosp.		Pvt. Hosp.	
		Transit			
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)	Time __ __:__ __ _ _			
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 saree/inskirt soaked =500ml)	
		labour pain which disappeared suddenly		Inversion of the uterus	
		Retained placenta		Convulsions	
		Severe breathlessness /cyanosis/ edema		Unconsciousness	
		High fever		Others……..(specify)	
8.12	Did she seek treatment, if yes by whom and what was the treatment given by the ANM/Nurse/LHV/ / MO/others ? (give details)				
8.13	Was she referred?	YES		NO	
		Not known			
8.14	Did she attend the referral centre?	YES		NO	
		Not known			
8.15	In case of non compliance of referrals state the reasons	Intensity of complications not known		Institution far away	
		No attender available		No money	
		beliefs & customs		Lack of transport	
		Others			
8.16	Was there delay in	Decision making		Mobilizing funds	
		Arranging transport		Others	
8.17	Any information given to the relatives about the nature of complication from the hospital (describe)	Yes		No	
8.18	If yes describe				
8.19	Was there any delay in initiating treatment	Yes		No	
8.20	If yes, describe				

9. POST NATAL PERIOD

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	Onset of the problem	Date / /		Time __ __:__ __ _ _	
9.4	Specific problem during PN 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 behavior		Severe anemia	
		Others (specify)			
9.5	Did she seek treatment	Yes		No	
9.6	If yes, by whom	ANM		Nurse	
		LHV		MO	Others (specify)
	what was the treatment given (give details)				
9.7	Was she referred?	Yes		No	
		Not known		Not applicable	
9.8	Did she attend the referral center?	Yes		No	
		Not known		Not applicable	
9.9	In case of non compliance of referrals state the reasons	Intensity of complications not known		Institution far away	
		No attender available		No money	
		believes & customs		Lack of transport	
		Others			

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

11.Open history (Narrative format) (explore)

- Name and address of the facilities she went – decisions and time taken for action
- 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 spend at each facility and time spend at each facility before referrals were made and difficulties faced throughout the process
- Transportation method used
- Transportation cost? (at each stage of referral)
- Travel time – at each stage
- Care received at each facility?
- Total money spend by family
- How did the family arrange the money?

_____

_____

VERBAL AUTOPSY QUESTIONNAIRE FOR

INVESTIGATION OF MATERNAL DEATHS

NAME OF THE STATE	**J&K State**
NAME OF THE DISTRICT	
NAME OF THE BLOCK	
Name of the PHC	
NAME OF THE SHC	
NAME OF THE VILLAGE	
NAME OF THE PREGNANT WOMAN/ MOTHER	
DATE OF DEATH	
NAME & DESIGNATION OF THE INVESTIGATOR	
NAME & DESIGNATION OF THE INVESTIGATOR	
DATE OF INVESTIGATION	
PROBABLE CAUSE OF DEATH	

MDR CASE SUMMARY
(For every death of women between the age of 15 to 49 years)
To be filled by the block medical officer for each maternal death in the block after investigation by using the verbal autopsy format

Name of the Block PHC			
Particulars of the deceased	**Name:**		**Age:**
Name of the husband			
Gravida/Para			
Visitor/Resident			
Period of Death (tick the appropriate)	**Pregnancy**	**Delivery**	**42 days after delivery**
Community			
Place & Date of death			
Date of investigation			
Address			

1. Delay in Seeking Care
Not aware of danger signs
Neglect of complication
Problem not identified
Delay in decision making
No birth preparation
Beliefs and customs
Any other/specify

→ Fill in appropriate cause of Delay 1

2. Delay in receiving adequate care in facility
Delay in initiating treatment
Substandard care in hospital
Lack of blood, equipment & drugs
Lack of money
Any other/specify

→ Fill in appropriate cause of Delay 2

3. Delay in receiving adequate care in facility
Delay in initiating treatment
Substandard care in hospital
Lack of blood, equipment & drugs
Lack of money
Any other/specify

→ Fill in appropriate cause of Delay 3

Probable direct obstetric cause of death:_____

_____

Indirect obstetric cause of death:_____

_____

Contributory causes of death (may list them):_____

_____

Initiatives suggested:

_____

Signature and Name of Block Medical Officer (with stamp)

DRAFT

Monthly Maternal Death Review Line Listing Form for ANM/ASHA/other designated field staff

(To be compiled for every death of women aged 15 – 49 years)

Name of Sub Centre & village:_____
PHC:_____ Block:_____

District:_____ State: _____

Contact Person Name & Ph. #_____Date & month of submission:_____

Please submit a copy to PHC MO I/C and copy to Block MO , District CMO and Dist. Prog. Manager on or before the 5th of

every month (e.g. for report of March 2009, this copy must reach the above mentioned officers by the 5th of April 2009).

Sl.No	Name of deceased	Place of death			When did the death occur			Probable cause of death	Status of newborn (Death/ Alive)	Name of respondent who was interviewed	Name/designation and Date of visit to home of deceased
		Home	*Health facility*	*On the road*	*During pregnancy*	*During delivery*	*42 days after delivery*				

Name and designation of reporter:

Date: