

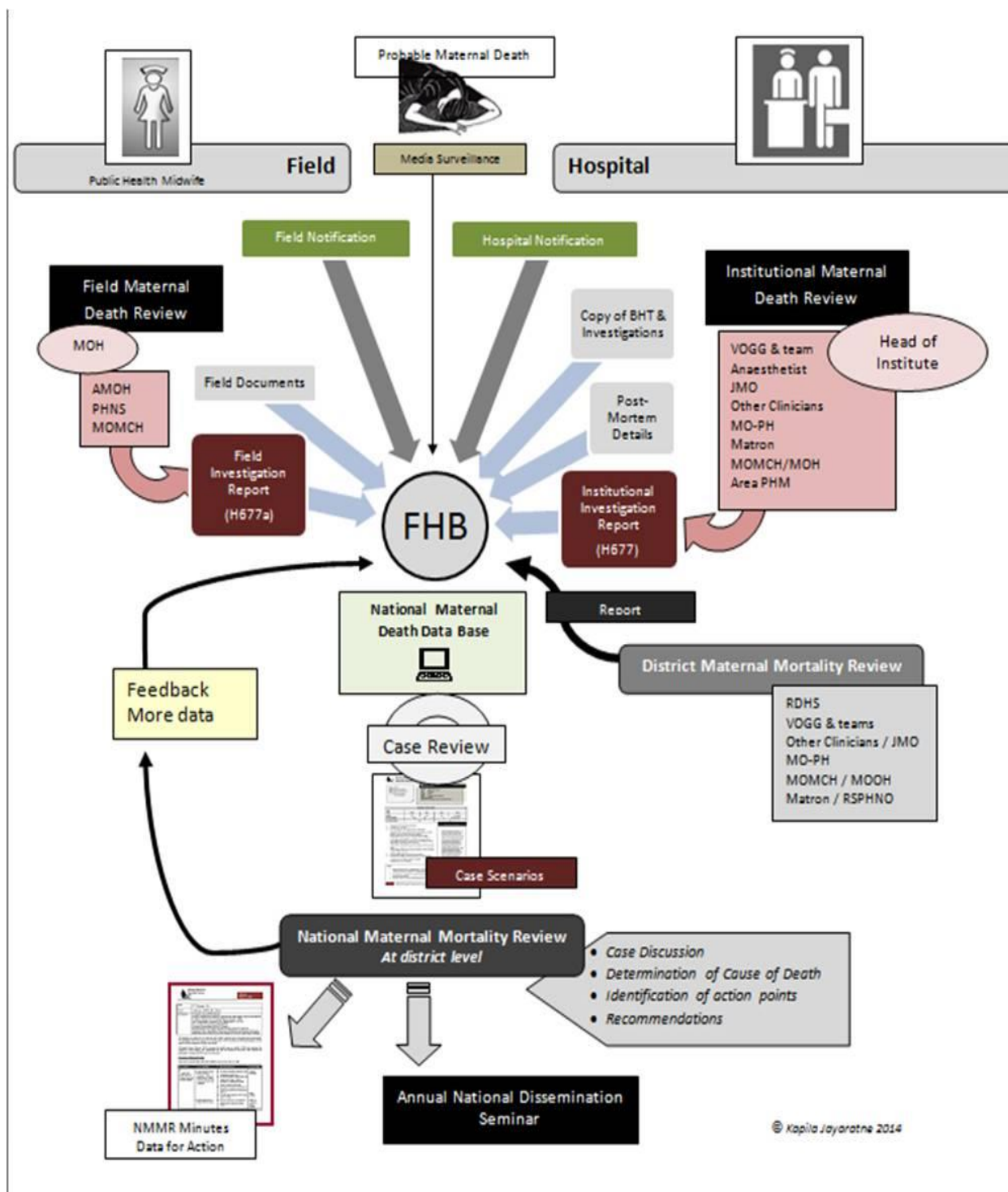
Maternal Death Surveillance & Response System – Sri Lanka

Guidelines for Hospital & Filed Healthcare Workers

Family Health Bureau (FHB), Ministry of Health has set up a single island-wide surveillance system to capture maternal deaths occurring throughout the country since 1987.

Surveillance of maternal deaths involves the systematic collection, collation, analysis, interpretation and dissemination of all information related to maternal deaths. Figure 1 outline the present national maternal mortality surveillance system in Sri Lanka.

Figure 1



© Kapila Jayaratne 2014

Based on the WHO guidelines, Sri Lanka adopts following approaches in maternal death review process;

- **Verbal autopsy** (community level) – A **field investigation** is carried out by all the relevant field healthcare workers (MO-MCH, MOH, PHNS, PHM) as a method of finding medical causes of death and ascertaining personal, family and community factors that may have contributed to the death in women who died both in a health institute and outside of a medical facility. A structured field investigation report format (H677a) covering all the information as well as views/comments and follow up activities carried out is in place.
- **Facility-based MDR** – An **institutional** maternal death review is conducted as an in-depth investigation of the causes and circumstances surrounding maternal deaths occurring in health facilities with the participation of all the health care workers (Obstetricians, Anaesthetists, Physicians, other medical officers, nursing officers and paramedics) involved in the management of the deceased woman. Forensic Pathologist who conducted the post-mortem and public health workers from the mother's residential area also participate at this review meeting. A structured institutional investigation report format (H677) covering all the information as well as views/comments and follow up activities carried out is in place.
- **Clinical audit** – A modified clinical audit process is adopted at the national maternal mortality review with the participation of multitude of experts (Obstetricians, Anaesthetists, Physicians, Forensic Pathologists, Health Administrators, Community Physicians etc) as a quality improvement process. This is conducted as a systematic review of care against standard protocols already available at local level with due consideration to available facilities.

The implementation of maternal mortality surveillance is governed by the general circular issued in the year 1996. The previously issued instructions on maternal mortality surveillance are currently under review considering the recent changes in the maternal care service delivery.

The maternal mortality review is also recognized as a continuous quality improvement process of maternal and newborn health services.

No-fault finding concept

A no-name no-blame with total confidentiality strategy is adopted in all the steps of maternal mortality surveillance in the country. All the healthcare workers are assured of non-revelation of information included in investigation formats or district and national mortality reviews to third parties.

1.0 Definitions

Following definitions are used to capture maternal deaths in the country;

Maternal death -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 from accidental or incidental causes. (*Ninth version of the International Classification of Diseases*)

Maternal deaths are subdivided into two groups;

Direct maternal deaths -Deaths resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above.
Eg. Deaths due to septic abortions, post partum haemorrhage, pregnancy induced hypertension, amniotic fluid embolism and suicide due to post partum psychosis etc.

Indirect maternal deaths -Deaths resulting from previous existing disease or disease that developed during pregnancy and not due to direct obstetric causes, but aggravated by the physiologic effects of pregnancy are classified as
Eg. Deaths due to pregnancy complicated with medical disorders such as heart disease, anaemia, pneumonia, hepatic diseases etc.

Late maternal death -Death of a woman between 42 days and one year after termination of pregnancy, following direct or indirect maternal causes.
Eg: Death of a mother on the 90th day due to renal failure following eclampsia.

Pregnancy related death -Death of a woman while pregnant or within 42 days of termination of pregnancy irrespective of the cause of death.
This category includes all maternal deaths, incidental deaths and accidental deaths.
Eg: Deaths due to food poisoning during pregnancy, murder during pregnancy.

2.0 Notification of maternal deaths

Notification of maternal deaths has been made a legal requirement by issuing a gazette notification that all practitioners providing care to women in the country, both at institutional and field levels, are legally bound to notify maternal death events to Family Health Bureau – the focal point in maternal death surveillance.

Notification involves informing of all deaths which fulfill the notification criteria to the relevant authorities, in a uniform manner and without delay for necessary action.

2.1 Notification criteria

- All deaths (*irrespective of cause*) of women in reproductive age group (15 – 49 years) during the pregnancy period and until one year after termination of pregnancy

This includes; all confirmed maternal deaths, late maternal deaths, pregnancy related deaths and other reproductive age group female deaths. Such a wider notification range will ensure that all probable maternal deaths are captured by the surveillance system.

3.0 Maternal Death Surveillance at Institutional Level

- Once a maternal death occurs in an institution (Government or private hospital), the Head of the institution should take the custody of the bed head ticket (BHT) and all the documentation of management details of the deceased mother. All the pages should be numbered and the original document should be made available for relevant officers /review meetings for investigation procedure. The BHT should not be reproduced. BHT should not be taken out of the office of the Head of the Institution and extraction of information from the BHT should be done within the office premises only.
- A copy of the BHT and other relevant documents related to the management of the index case should be sent to Family Health Bureau when requested.
- It is compulsory to conduct a post mortem in all cases of maternal deaths as per the circular issued by the Secretary to the Ministry of Justice and Law reforms dated 2008.10.02 to all coroners and letter issued by director general of health services (DGHS) on 2011.01.12.
- A representative (VOG / VP or Registrar / SHO) from the relevant unit of the hospital should participate at the post-mortem examination. Relevant JMO should inform the index unit the time of the post-mortem examination through the head of the institute.
- A copy of the post mortem report should be issued by JMO to DGHS, Director – FHB and Head of the hospital where maternal death occurred

3.1 Notification procedure of maternal deaths to be followed at institutional level

- Immediately after the occurrence of a death which fulfils above notification criteria (2.1) the relevant staff should report it to the head of the institution.
- JMO should also notify such deaths to the head of the institution after the post mortem.
- Coroners should also be requested to notify such deaths to the RDHS and the head of the institution after inquiry into sudden deaths.
- The head of the institution will then notify the death within 24 hours by telephone, telegram, fax or email to the following officers;
 - Director – MCH (Family Health Bureau) Tel/Fax: 0112692745
 - PDHS and RDHS (where the institution located)
 - PDHS and RDHS (deceased residence)
 - MOH (deceased residence)
 - Head/s of the previously managed institution/s
- A sample format of **Intimation of Maternal Deaths** can be downloaded from the FHB website: www.familyhealth.gov.lk/ under submenu “Forms”.
- Whenever the death of such a mother transferred from another institution occurs, the receiving institution should notify the head of the previously managed institution of the death.

3.2 Institutional Investigation procedure of a maternal death (Government and private hospitals)

- Separate institutional investigations should be performed by each institution involved in the management of the deceased mother.
- The investigation should be conducted within 14 days of occurrence of a maternal death as this would enable to identify precisely the circumstances that led to the death with fresh information. The circumstances of the death should be discussed in detail with the intention of identifying preventive measures.
- The institutional investigation is the responsibility of the Head of the Institution.
- Investigation should be carried out as a team which should comprise of the following officers;

- Head of the Institution (Director/MS/DMO/MO-IC) as the team leader
 - Consultant Obstetrician and Gynaecologist or the relevant Specialist of the hospital unit in which the death occurred (acting consultant in his/her absence) and all other relevant consultants who managed the mother (Physician, Surgeon, Anaesthetist, Psychiatrist etc)
 - Medical officer/s who attended the deceased mother (DMO, MO/IC, senior house officer, house officer etc.)
 - Judicial Medical Officer
 - Medical officer – blood bank – when relevant
 - Grade I Nursing Officer /Nursing Officer In Charge of the ward/ labour room - when relevant
 - Head of the Institution of hospitals where the patient was managed before transfer
 - Medical Officers Maternal and Child Health (of the districts where the mother is resident and where the hospital is situated)
 - Medical Officer of Health from the mother's area of residence
 - Public Health Midwife from the mother's area of residence
- The institutional investigation should be coordinated by the medical officer (preventive health) on behalf of the head of the institution.

3.3 Immediate Response to identified service deficiencies:

- The Head of the Institution is responsible for the immediate implementation of the corrective actions within the hospital without delay as decided at the institutional review. Please include all the actions taken in the H677.

3.4 Reporting the institutional investigation

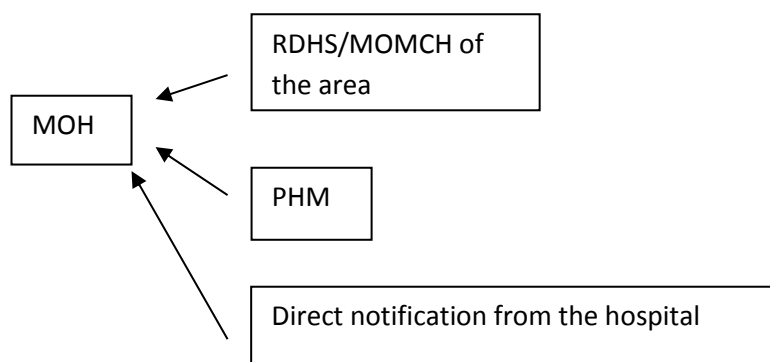
- The information obtained during the investigation should be entered in form H 677 in triplicate. A copy of the latest version of H677 should be obtained from the MOMCH or downloaded from the FHB website: www.familyhealth.gov.lk/ under submenu “Forms”.
- Consultant Obstetrician and Gynaecologist or the relevant Specialist of the hospital unit in which the death occurred and Head of the Institution should ensure the completeness of the format.
- The completed format (H 677) should be sent to the following institutions within 14 days of occurrence of the maternal death.
- Head of the institution should also ensure that these deaths are reported through H830 (Monthly Report on Maternal Statistics) and Quarterly Indoor Morbidity and Mortality Returns sent to the relevant sectors. Also he/she should ensure that pregnancy and/or childbirth should be mentioned as an underlying cause of death when the death declaration is given.

4. Maternal Death Surveillance at Field Level

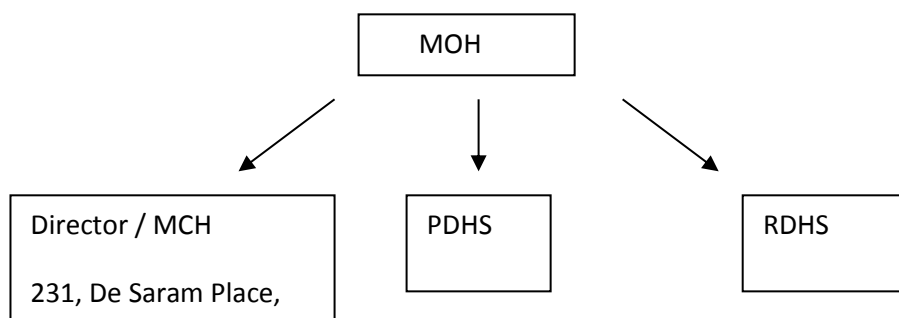
4.1 Notification procedure of maternal deaths to be followed at field level

When a notifiable death occurs in her area, the area PHM should immediately notify it to the MOH. Notification by the PHMM can be considered as the single most important step in maternal death surveillance as this is the means which could have the highest notification rate.

The MOH may receive a maternal death notification directly from the head of the institution at which the death occurred or from the RDHS/MOMCH of the district to whom the death was notified.



- MOH should notify such a death to the following places by telephone, telegram, fax or email



- The telegram or telephone message should be confirmed by a letter containing the following information:
(Name of the deceased mother, address, PHM area, MOH area, RDHS area, date of death, place of death, tentative cause of death, name and designation of the informant, date informed)
- A sample format of **Intimation of Maternal Deaths** can be downloaded from the FHB website: www.familyhealth.gov.lk/ under submenu “Forms”.
- In case of the death of a mother who is temporarily resident in a MOH area, the area MOH should notify the death to the MOH of the area from where the mother came from (& where she was registered as an eligible female)
- MOH should also ensure that all deaths are reported through H 509 (Quarterly Maternal and Child Health Return).

4.2 Field investigation procedure for maternal deaths

- MOH (of the area where the mother is registered in the eligible family register) is the responsible officer for the field investigation. In case of an absence of the relevant MOH,

the acting MOH or MO-MCH should take the responsibility of carrying out the field investigation.

- Investigation should be done as a team comprising of MO-MCH, MOH, all AMOH, all PHNS, SPHM and PHM of the area. MO-MCH and MOH should jointly investigate the maternal death.
- In case of the death of a mother who is temporarily resident in another MOH area, the MOH of that area should also investigate the case as a team comprising of PHNS and PHM and send that report to the MOH of the area of mother's residence (i.e. where the mother was registered in the eligible couple register) who will then prepare the final investigation report.
- Investigation should commence as early as possible and should be completed within fourteen (14) days of occurrence of the maternal death.

The team should visit the office of the PHM and examine all the relevant documents.

Start with the eligible family register

Special attention should be paid to promotion of Family Planning and relevant documents

Supervisions carried out by different supervising officers

- The care received by the mother (antenatal, postnatal) prior to the admission to the hospital should be assessed.
 - The family members should be interviewed by the investigation team in order to obtain relevant information.
 - All the relevant records (H512, H512 B, FP records and other relevant documents) should be taken over & kept safely in the MOH office till the investigations & review meetings are over.
 - In the case of a hospital death, MOH should participate as a member in the hospital investigation team. If the institutional investigation is delayed, the MOH should visit the hospital and obtain relevant information from the hospital (from health care staff and the BHT) with permission of the head of the institution, which information should go into H 677a.
- ➔ Mothers treated by GP –MOH should visit concerned GP and obtain necessary information
 - ➔ Obtain also details of care received from Traditional healers / TBAs
 - ➔ Collect coroner information and death registration –Obtain a copy of the Death Certificate issued by the death registrar from the relatives
 - ➔ Evaluate for social circumstances –Please obtain a client perspective from the relatives

Field team should decide on a tentative underlying cause of death considering the details they obtained.

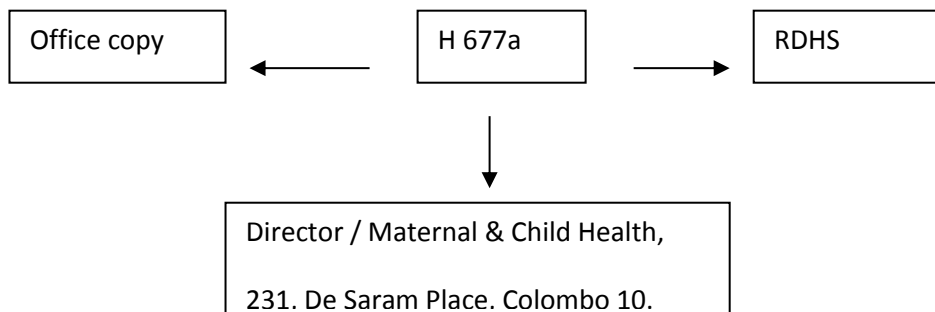
- Identify deficiencies –contemplate corrective actions / forward suggestions for higher authorities
- After the maternal death investigation the MOH should implement the necessary corrective actions at field level, and the implementation of these should be discussed at the next monthly conference.
- The relevant area PHM should be supervised by SPHM / PHNS /MOH consecutively for 3- 6 months

4.3 Immediate Response to identified service deficiencies:

- Chief MOH is responsible for the immediate implementation of the corrective actions within the MOH level without delay as decided at the field maternal death review. Please include all the actions taken in the H677a.

4.4 Reporting the field investigation

- The information obtained during the investigation should be entered in form H 677a in triplicate. A copy of the latest version of H677 should be obtained from the MOMCH or downloaded from the FHB website: www.familyhealth.gov.lk under submenu “Forms”.
- MOMCH of the district should ensure the completeness of the format.
- The completed format (H 677a) should be sent to the following institutions within 14 days of occurrence of the maternal death.



- For deaths occurring in the field (intra partum / post partum home death) MOH should fill the H 677 format (institutional format) which includes the details regarding the delivery. For the field investigation the same procedure should be adhered (as given in section 3.2) and H 677a format should be filled by the MOH.
- Copies of the H512, H512B, FP records, copy of the page of eligible family register, death certificate (issued by the death registrar) and other relevant documents related to the care of the index case should be sent to Family Health Bureau along with field investigation report.

5. District Maternal Mortality Reviews (DMMR)

District Maternal Mortality Reviews are an important aspect of maternal mortality surveillance since it provides a forum to discuss and learn lessons out of maternal deaths at the district level. It also gives an opportunity to identify service deficiencies and to formulate preventive strategies to further reduce maternal deaths taking local contexts of the district in to consideration. Data gaps with regard to each death could be filled at DMMRs.

District Maternal Mortality Review Team should comprise of the following officers

PDHS/ RDHS (chairperson)
Provincial or District Consultant Community Physician/s
All Head/s of the Institution/s (where labour rooms are available)
MO-MCH
All MOOH, all AMOOH, all PHNS, SPHM, relevant area PHMM
All VOGG and other relevant consultants
Judicial Medical Officers
Senior registrars / SHOO / MOO –who were involved in the management of the deceased from the hospital where the death occurred.

The relevant presentation of the maternal death should be done by the MOH (field part) and VOG or the relevant Specialist (institutional part) from the hospital where the death occurred. It is the responsibility of the head of the institution and the specialist of the unit where mother was managed to ensure that a detailed presentation is made at the DMMR.

6. National Maternal Mortality Review (NMMR)

Annual reviews are conducted on a district basis to review all the deaths which occurred in a particular district in the previous year with the participation of experts from the national level.

Director/maternal and Child Health, Department of Health in collaboration with the Provincial Director of Health Services will organize the annual review of maternal deaths in a district with the participation of representatives from professional colleges including Sri Lanka College of Obstetricians & Gynaecologists / Anaesthetists, College of Physicians, Sri Lanka College of Community Physicians.

The responsibility of organization of the meeting lies with the RDHS / MOMCH of the district with instructions from FHB.

DGHS or in his absence the PDHS will chair this meeting. In the absence of the DGHS a ministry official nominated by the DGHS should participate at the NMMR to represent the DGHS.

The participation of following categories of health care teams is mandatory at the NMMR;

- PDHS
- RDHS and Deputy RDHS
- Provincial and District Consultant Community Physician/s
- All Head/s of the Institution/s where labour rooms are available)
- MO-MCH
- All MOOH and AMOOH
- All VOGG and other relevant consultants
- Judicial Medical Officers
- Senior registrars / SHOO / MOO –who were involved in the management of the deceased from the hospital where the death occurred.

The DPDHS, MOMCH, RSPHNO, all VOGG, MOOH and AMOOH, all heads of the institutions and the relevant consultants (VOG, Anaesthetist, VP, Consultant JMO) of the units where maternal deaths have occurred, all the DMOO / MOO-IC of the district hospitals and peripheral units (whether or not maternal deaths occurred in their institutions) should participate at the annual review.

MOMCH under the guidance of RDHS should present the situation analysis of MCH care in the district in the index year and the progress of the implementation of the recommendations of NMMR of the previous year.

The relevant presentation of the maternal death should be done by the MOH (field part) and VOG or the relevant Specialist (institutional part) from the hospital where the death occurred. The JMO should present the post-mortem details to facilitate the determination of the cause. It is the responsibility of the head of the institution and the specialist of the unit where mother was managed to ensure that a detailed presentation is made at the NMMR.

Final decision on causality and category of maternal deaths are decided at the NMMR. Cases are analyzed based on 3 –delay model (whether there is a deficiency in seeking, reaching or treating) and preventability and family planning unmet need are assessed following consensus of the expert team.

MOMCH should take minutes of the NMMR and note down relevant recommendations for the district for implementation at district level.

A detailed NMMR minute will be prepared by the MCMMS Unit of FHB and the same will be disseminated to all the stakeholders of maternal care in the country for maximum utilization of the findings.

For any clarification of these guidelines, please contact Maternal and Child Morbidity and Mortality Surveillance Unit of Family Health Bureau.



**National Maternal Mortality
Surveillance System**

Phone / Fax : 0112962745