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சுவசிரிபாய

SUWASIRIPAYA

මගේ අංකය)
எனது இல) FHB/EH/01/2016
My No.)

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Your No. :)

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திகதி) 09.03.2016
Date)

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சுகாதார, போசணை மற்றும் சுதேச வைத்திய அமைச்சு
Ministry of Health, Nutrition & Indigenous Medicine

All Provincial Directors of Health Services
All Regional Directors of Health Services
All Heads of Health Institutions
All Heads of the Private Health Institutions
Director - Private Health Sector Development
Directors – National Institute of Health Sciences / National Blood transfusion Services
Chief Medical Officer - Colombo Municipal Council

Implementation of the National Maternal Severe Morbidity Surveillance System

Sri Lanka reports a low level of maternal mortality (112 deaths with a MMR of 32.03 per 100,000 live births in 2014). The information received from review of maternal deaths is limited in further reduction of maternal mortality and improving service delivery to pregnant women. Maternal near-miss surveillance is a best practice advocated by World Health Organization (WHO) for countries with similar situations.

In 2011, the survey was conducted by Family Health Bureau estimated a number of 1400 – 1500 maternal near-miss cases per annum. Several stakeholder meetings were conducted on introducing a Maternal Severe Morbidity Surveillance mechanism and data formats. Ministry of Health has introduced a National Maternal Severe Morbidity Surveillance System, with Family Health Bureau (FHB), as the national nodal point and expertise contributions from professional colleges.

Surveillance of maternal near-misses involves the ongoing, systematic collection, analysis, and interpretation of data related to such cases, essential to the planning, implementation and evaluation of public health practice, closely integrated with the dissemination of these data to those who need to know and linked to prevention and control of such incidents. The objectives of the surveillance is to make available quality severe maternal morbidity data, to utilize such data effectively at different levels (field, hospital, district and national levels) and to translate lessons learnt in to practice by dissemination to all stakeholders of maternal health.

The implementation of the maternal near-miss surveillance will commence with immediate effect both in the hospitals and in the field levels. All maternal near-miss cases that occurred in the hospitals (both in government and private sector) since 1st January 2016 should be included in the maternal severe morbidity surveillance.

Key components of the surveillance mechanism are as follows;

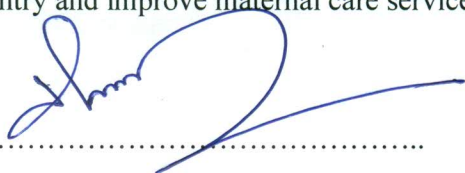
1. *Maternal near-misses occurred in all hospitals (both government and private sector) and reported from the field are subjected to maternal severe morbidity surveillance.*

2. *The WHO Maternal Near-miss criteria (see below) is used to capture cases. 'A woman presenting any of such life-threatening conditions and surviving a complication during pregnancy, childbirth or within 42 days of termination of pregnancy is considered a maternal near-miss case'.*
3. *All heads of hospitals should introduce a mechanism within the hospital to capture possible maternal near-miss cases (especially from Obstetric, Gynaecology & Post-partum units, Intensive Care Units, Surgical Theatres, High Dependency Units, Blood Banks, Medical & Surgical wards etc). All relevant healthcare staff should be made knowledgeable about the need for capture and notification of maternal near-miss cases in time.*
4. *All probable maternal near-miss cases of both government and private hospitals should be notified to the head of the institute by the lead clinician (eg. Obstetrician & Gynaecologist / Anaesthetist / Physician / Pulmonologist / Transfusion Specialist / Microbiologist etc) using the **Hospital Maternal Near-miss Notification Form** (attached) within 24 hours. Upon receipt of such a notification, the head of the institute should forward the same to Director (MCH), Family Health Bureau within 2 days.*
5. *A fact-finding institutional Maternal Near-miss review with the participation of all the categories of healthcare staff involved in the management should be conducted within 14 days and the completed **Maternal Near-miss Reporting Format** (attached) should be sent to Director (MCH) by the head of the institute.*
6. *In the **field** settings (eg. home visits by public health midwives and field clinic care by medical officers of health), relevant field healthcare workers should be vigilant on possible maternal near-miss cases managed at hospitals. A recent hospital stay during pregnancy or post-partum period should alert for in-depth exploration (eg. Perusal of clinical notes and/or diagnosis cards) and checking for maternal near-miss criteria. All relevant field healthcare staff should be made knowledgeable about the need for capture and notification of maternal near-miss cases by the Medical Officers of Health.*
7. *All probable maternal near-miss cases reported from the **field** should be notified using **Field Maternal Near-miss Notification Form** (attached) within 24 hours to Director (MCH) by the Medical Officer of Health.*
8. *All heads of hospitals and Medical Officers of Health should take all efforts to translate lessons learnt into actions at relevant settings with the objective of improving maternal care.*

All heads of all levels of hospitals (both in the government & private sector) and all medical officers of health (MOOH) are advised to facilitate the implementation of National Maternal Severe Morbidity Surveillance System by establishing the information flow with the help of relevant staff involved. You are also advised to make sure the availability of all data collecting formats at each level.

You are instructed to copy this letter to all relevant officials and/or institutions for the successful implementation of the system.

I trust that all officers concerned would comply with these guidelines and make every effort to successfully implement the National Maternal Severe Morbidity Surveillance System in the entire country and improve maternal care service provision.



Dr. P G Mahipala
Director General of Health Services

Cc: Secretary Health – Ministry of Health
Additional Secretary – Medical Services & Public Health Services

DDGs – Medical Services I & II, ET & R

DDG – PHS II

Directors (MCH / TCS / MS / Nursing)

Presidents - Sri Lanka College of Obstetricians & Gynecologists / College of Anaesthesiologists and Intensivists of Sri Lanka / Ceylon College of Physicians / Sri Lanka Heart Association / Sri Lanka College of Pulmonologists / College of Community Physicians of Sri Lanka / Perinatal Society of Sri Lanka / Sri Lanka College of Pathologists / College of Surgeons of Sri Lanka / Sri Lanka College of Administrators / Sri Lanka Medical Association / College of Transfusion Specialists.

For further clarifications, you may contact MCMMS Unit of FHB: 0112692745

The WHO Near Miss criteria:

-a woman presenting any of the following life-threatening conditions and surviving a complication during pregnancy, childbirth or within 42 days of termination of pregnancy should be considered a near miss case

Dysfunctional system	Clinical criteria	Laboratory markers	Management based proxies
Cardiovascular	Shock (a) Cardiac arrest (b)	pH<7.1 Lactate>5 mEq/mL	Use of continuous vasoactive drugs (i) Cardio-pulmonary resuscitation
Respiratory	Acute cyanosis Gasping (c) Respiratory rate >40 or <6 bpm	Oxygen saturation < 90% for ≥ 60 minutes PaO ₂ / FiO ₂ <200 mmHg	Intubation and ventilation not related to anaesthesia
Renal	Oliguria non responsive to fluids or diuretics (d)	Creatinine ≥300μmol/l or ≥3.5 mg/dL	Dialysis for acute renal failure
Haematologic/Coagulation	Failure to form clots(e)	Acute severe thrombocytopaenia (<50,000 platelets/ml)	Transfusion of ≥ 5 units of blood / red cells
Hepatic	Jaundice in the presence of preeclampsia (h)	Bilirubin>100 μmol/l or >6.0 mg/dL	
Neurologic	Any loss of consciousness lasting >12h (f) Stroke (g) Uncontrollable fit / status epilepticus Total paralysis		
Alternative severity proxy			Hysterectomy following infection or haemorrhage

- (a) Shock is a persistent severe hypotension, defined as a systolic blood pressure <90 mmHg for ≥60 minutes with a pulse rate at least 120 despite aggressive fluid replacement (>2L)
- (b) Cardiac arrest refers to the Loss of consciousness AND absence of pulse/heart beat
- (c) Gasping is a terminal respiratory pattern and the breath is convulsively and audibly caught
- (d) Oliguria is defined as an urinary output <30ml/hr for 4 hours or <400ml/24hr
- (e) Clotting failure can be assessed by the bedside clotting test or absence of clotting from the IV site after 7-10 minutes
- (f) Loss of consciousness is a profound alteration of mental state that involves complete or near-complete lack of responsiveness to external stimuli. It is defined as a Coma Glasgow Scale <10 (moderate or severe coma)
- (g) Stroke is a neurological deficit of cerebrovascular cause that persists beyond 24 hours or is interrupted by death within 24 hours
- (h) Pre-eclampsia is defined as the presence of hypertension associated with proteinuria. Hypertension is defined as a blood pressure of at least 140 mm Hg (systolic) or at least 90 mm Hg (diastolic) on at least two occasions and at least 4–6 h apart after the 20th week of gestation in women known to be normotensive beforehand. Proteinuria is defined as excretion of 300 mg or more of protein every 24 h. If 24-h urine samples are not available, proteinuria is defined as a protein concentration of 300 mg/L or more (≥1 + on dipstick) in at least two random urine samples taken at least 4–6 h apart
- (i) For instance, continuous use of any dose of dopamine, epinephrine or norepinephrine.