GOVERNMENT OF KERALA

Abstract

Health & Family Welfare Department - Establishment - Medical Education Service - Guidelines for maternal death audit - [illegible] approved - District Level Monitoring Committee constituted - Orders issued.

HEALTH AND FAMILY WELFARE (B) DEPARTMENT

G.O(Rt.)No. 1108/2010/H&FWD. Dated, Thiruvananthapuram, 25.03.2010

Read: - Letter No.H5-30169/08/DME dated 10.11.2009 from Director of Medical Education, Thiruvananthapuram.

O R D E R

The Government have noticed that inspite of considerable mortality reduction in the State, maternal deaths continue to happen. The Clinical Epidemiology Resource and Training Centre under Thiruvananthapuram Medical College has prepared the guidelines for auditing Maternal Death, after holding discussion with subject experts and stake holders under Directorate of Medical Education (DME), Directorate of Health Services (DHS), National Rural Health Mission (NRHM) and Federation of Obstetrics & Gynaecology.

Maternal mortality reduction reflects the standards of services in a State. The millennium development goal targets reduction in maternal deaths by three quarters from the baseline. The Government reviewed the progress made in this regard and insists on practice of facility based death audit for achieving safe motherhood in the state.

Death of a woman while pregnant or within 42 days of termination of pregnancy is termed as maternal death. Death is a culmination of series of catastrophic clinical events. All maternal death should be reported without fail to the concerned authorities specified in the guidelines within 24 hours by the certifying physician or through head of the institution. This is to facilitate death audit which is not a fault finding exercise and is a fact finding or situation analysis process done in a practical and positive way to yield insight for effective action in the future. The whole process is strictly confidential. In order to improve the understanding and better health system functioning, all hospitals whether in private or public sector must do the audit process as per the guidelines.

Demographer

In the circumstances, Government are pleased to approve and append guidelines prepared by Clinical Epidemiology Resource and Training Centre. All hospitals in the State where women are admitted shall follow the guidelines scrupulously in the case of maternal death.

Government also order that a District Level Monitoring Committee is constituted consisting of District Medical Officer, Principal of the Government Medical College and Head of Department of Obstetrics & Gynaecology in the Medical College in the respective Districts, Reproductive and Child Health Officer, to ensure prompt reporting of all maternal deaths in Government as well as private hospitals. The Superintendent of concerned hospital in the district will also be a co-opted member. It is mandatory that the Committee shall meet once in two months and review the causes of death and make recommendations to Director of Medical Education and Director of Health Services.

The guidelines shall be distributed to all hospitals with colour coded forms by Director of Health Services.

(By Order of the Governor),

Dr. Usha Titus,
Secretary to Government.

To

The Director of Medical Education, Thiruvananthapuram
The Director of Health Services, Thiruvananthapuram
All District Collectors
State Mission Director, National Rural Health Mission, Thiruvananthapuram.
The Director, Clinical Epidemiology Resource and Training Centre, Thiruvananthapuram
All District Medical Officers.
All Principals, Medical Colleges.
All HoDs of Obstetrics & Gynaecology, Medical Colleges
All Reproductive Child Health Officers, O/o the District Medical Office.
All Superintendents of District and Taluk Hospitals. (Through DMO)
All Medical Officers of Community Health Centres and Primary Health Centres (Through DMO)
The Director of Public Relations Department, Thiruvananthapuram. (for press release)
Stock file/Office Copy.

Forwarded//By Order,

Section Officer.