Annexure-1

CONFIDENTIAL

Facility Based Maternal Death Review Form

(To be conducted and filled by Medical Officer on duty and Facility Nodal officer)

NOTE:

1. ***This FBMDR Form must be completed in duplicate for all maternal 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 (√) where applicable (mark with '?` when uncertain).***
3. ***Attach a copy of the case sheet/records of the deceased with this form.***
4. ***Complete the form in duplicate within 24 hours of a maternal death. The original remains at the institution where the death occurred and the copy is sent to the District MDR Committee for district level monthly review.***

(Ref. Chapter 3, para 3.7 & 3.10 of MDR guidelines)

Yearly Serial No: _____ . Calendar Year: _____

(Refer to **Para 3.9** of the MDR Guidelines)

Please fill up the proforma given below

1. GENERAL INFORMATION

Contact Person:

Name & Address:……....

……

Telephone/Mobile No. : ……..

Relationship with the deceased: ……

Name, Age & Residential Address of deceased woman:

…….....

.....

Address where Died:

Name and Address of facility: ……..

……

Block: …….. District: …….

2. DETAILS OF DECEASED

Inpatient Number:..... **Name:**..... **Age (years) :**.....

Gravida ☐☐ **Live Births** ☐☐ **Still Births** ☐☐ **Abortions** ☐☐

No.of Living children ☐☐ **Days since delivery/abortion:** ☐☐

	Day	Month	Year		Hrs	min
Date of admission:	☐☐	☐☐	☐☐	**Time of admission**	☐☐	☐☐

	Day	Month	Year		Hrs	min
Date of death:	☐☐	☐☐	☐☐	**Time of death:**	☐☐	☐☐

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

Stage of pregnancy/delivery on admission:

Abortion	Ectopic pregnancy	Not in labour	In labour	Postpartum

Stage of pregnancy/delivery when died:

Abortion	Ectopic pregnancy	Not in labour	In labour	Postpartum

Duration of time from onset of complications 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 of centre(s):

4. ANTENATAL CARE

Did she receive ANC? Yes☐ No ☐ Don't know ☐

If no, reason(s): Lack of awareness ☐ Lack of accessibility ☐ Lack of funds☐

Lack of attendee☐ Family problems ☐

If Yes, Type of Care Provider (mark one or more **)**: 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 ☐

Complications:

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

Comments on antenatal care and list medication, if any:

5. DELIVERY, PUERPERIUM AND NEONATAL INFORMATION

Did she have labour pains? Yes☐ No ☐ Don't know ☐

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

In which phase of labour did she die?

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

Duration of labour: ☐☐hrs ☐☐mins

Delivery:

Undelivered	Vaginal (unassisted)	Vaginal(assisted) Vacuum/forceps	Caesarean Section

Puerperium (Tick √ **):** Uneventful / Eventful: **PPH / Sepsis / Others (**Specify**):**

Comments on labour, delivery and puerperium:

Details of Baby:

Baby Birth Weight(gms)					Apgar Score		Outcome	Still born	Alive at birth	Died immediately after birth	Alive at:	
											7 days	28 days

Needed resuscitation: Yes / No

If yes, who gave ENBC:

If died, probable cause:

Comments on baby outcomes(in box below)

6. INTERVENTIONS: (Tick appropriate box)

Early pregnancy		Antenatal		Intrapartum		Postpartum		Other	
Evacuation		Transfusion		Instrumental del.		Evacuation		Anaesthesia - GA	
Laparotomy		Version		Symphysiotomy		Laparotomy		Epidural	
Hysterectomy				Caesarean section		Hysterectomy		Spinal	
Transfusion				Hysterectomy		Transfusion		Local	
				Transfusion		Manual removal		Invasive monitoring	
Any Other – specify:								ICU ventilation	

7. CAUSE OF DEATH :

Probable direct obstetric (underlying) cause of death: Specify:

Indirect Obstetric cause of death: Specify:

Other Contributory (or antecedental) 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				
	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				
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)

Form filled by:

Name:

Designation:

Name & address of the Facility:

Block/Tehsil: District:

Signature and Office Seal: Date & Time:

Facility Nodal Officer:

Name:

Designation:

Signature:

Date & Time:

Annexure 1-A

DISTRICT LEVEL FBMDR - CASE SUMMARY

District level FBMDR-Case Summary, for every maternal death reported by the Facilities, to be completed in duplicate by the District Nodal Officer after review by the District MDR Committee and reports compiled to be put up to the Deputy Commissioner for monthly review & to State Director Family Welfare for monthly report (Ref: MDR Guidelines-Para 5.5-iii, 5.5-v and 6.2)

(Fill / tick (√) in appropriate boxes)

Yearly Serial No. : _____ . **Calendar Year:**_____

General Information:

<table>
<tr><td colspan="2">Name of the Facility/ District:</td><td colspan="4"></td></tr>
<tr><td colspan="2">Particulars of the deceased:</td><td colspan="2">In-Patient No.</td><td>Name</td><td>Age</td></tr>
<tr><td colspan="2">Husband’s name & address:</td><td colspan="4"></td></tr>
<tr><td>Gravida</td><td>Para</td><td>Still births</td><td>Live Births</td><td>Abortions</td><td>No.of living children</td></tr>
<tr><td colspan="3">Timing of Death :</td><td>Pregnancy</td><td>Delivery</td><td>Within 42 days after delivery</td></tr>
<tr><td colspan="3">Religion:</td><td colspan="2">Caste</td><td>Sub-caste/Community</td></tr>
<tr><td colspan="3">Date & Time of admission:</td><td colspan="3"></td></tr>
<tr><td colspan="3">Date & Time of Death:</td><td colspan="3"></td></tr>
</table>

1. **Stage of pregnancy/delivery on admission:** Abortion /Ectopic Pregnancy /In labour / Postpartum

2. **Stage of pregnancy/delivery when died:** Abortion / Ectopic Pregnancy / In labour / Postpartum

3. **Duration from onset of complications to admission:** ☐☐ Hrs ☐☐ min

4. **Condition on Admission:** ☐Stable ☐Unconscious ☐Serious ☐Brought dead

5. **Complications:**

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

6. **In which phase of labour did she die:**

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

7. **Duration of labour:** Hours: _____ , Minutes:_____ .

8. **Delivery:**

Undelivered	Vaginal (unassisted)	Vaginal(assisted) Vacuum/Forceps	Caesarean Section

9. **Details of Baby:**

Baby Birth Weight (**gms**) | | | | |

Apgar Score | |

Outcome

Still born	Alive at birth	Died immediately after birth	Alive at: 7 days	Alive at: 28 days

10. **Interventions: (Tick appropriate box)**

Early pregnancy		Antenatal		Intrapartum		Postpartum		Other	
Evacuation		Transfusion		Instrumental del.		Evacuation		Anaesthesia - GA	
Laparotomy		Version		Symphysiotomy		Laparotomy		Epidural	
Hysterectomy				Caesarean section		Hysterectomy		Spinal	
Transfusion				Hysterectomy		Transfusion		Local	

	Transfusion		Manual removal		Invasive monitoring		
Any Other – specify:					ICU ventilation		

11. Probable direct obstetric cause of death:

12. Indirect obstetric cause of death:

13. Contributory causes of death:

14. In your opinion were any of these factors present?

System	Example	Y	N	?	Specify
Personal/Family	Delay in woman seeking help				
	Refusal of treatment				
	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				

15. Comments on potential avoidable factors, missed opportunities and substandard care:

16. If autopsy performed, please report the findings :

17. Findings of the review by the Facility MDR Committee and corrective actions taken:

18. Remedial follow up actions spelled out by the District MDR Committee: (Add extra page if required):

(Signatures of District Nodal Officer MDR) **Name:**

(Office Seal) **Date:**

(Signatures of Civil Surgeon) **Name:**

(Office Seal) **Date:**

Note: For details, refer to Annexure-1 on FBMDR

Annexure -2

COMMUNITY BASED MATERNAL DEATH REVEIW FORM

COMMUNITY BASED INVESTIGATION (Verbal Autopsy) QUESTIONNAIRE FOR INVESTIGATION OF MATERNAL DEATHS

(To be filled by investigation team, ref: para 4.12 & 4.13 of MDR guidelines)

Name of District: ..... **Block:** .....

NAME OF THE SUB CENTRE	
NAME OF THE VILLAGE	
NAME & AGE OF THE PREGNANT WOMAN/ MOTHER (DECEASED)	
ADDRESS	
NAME OF HUSBAND/OTHER (FATHER/MOTHER)	
PLACE OF DEATH (Home/Institution/In transit/Village/Town etc.) Specify:	
DATE & TIME OF DEATH	
NAME & DESIGNATION OF THE INVESTIGATOR(S)	
DATE OF INVESTIGATION	
PROBABLE CAUSE OF DEATH	

MODULES

GENERAL INSTRUCTIONS

1. *The Community Based Investigation (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. ***CONFIDENTIALITY:*** *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. ***NEUTRALITY 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.*

10. ***Maternal Death*** *is defined as the death of a woman who dies from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy or child birth or within 42 days of termination of pregnancy, irrespective of duration and site of the pregnancy.*

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

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 & more**
1.9	Weeks of pregnancy If applicable			<16 weeks		16-28 weeks		>28 weeks	
1.10	Age at death								

2. FAMILY HISTORY

No.	Details	Deceased Mother	
2.1	Age at marriage	<18 Yrs	
		18-25 Yrs	
		26-30 Yrs	
		31-35 Yrs	
		>35 Yrs	

2.2.	Religion	Sikh	
		Hindu	
		Muslim	
		Christian	
		Others	
2.3.	Community	SC	
		ST	
		BC	
		OBC	
		Others	
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 status:	**Still Birth**	**L ive Birth**	**Died immediately after birth**	**Alive at 7 days**	**Alive at 28 days**

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

MODULE - II

6. 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 should also be filled for all maternal deaths)

6.1	Did the mother had any problem during antenatal period?	Not known		No	
		Yes			
6.2	If yes, was she referred anytime during her antenatal period?	YES		NO	
		Don't know			
6.3	What was the symptom for which she sought care ?	Headache			
		Edema			
		Anemia			
		High Blood Pressure			
		Bleeding p/v			
		No foetal movements			
		Fits			
		Sudden excruciating pain			
		High fever with rigor			
		Others (specify)			
6.4	If YES, did she attend any hospital?	YES		NO	
		Don't know			
6.5	In case of not seeking care from the hospital is it due to	Severity of the complications not known		Institution far away	
		No attendant available		No money	
		beliefs and customs		Lack of transport	
		Others(specify)			

7. FOR ABORTION DEATHS FILL THE FOLLOWING QUESTIONS

7.1	Did she die while having an abortion or within 6 weeks after having an abortion?	While having an abortion	Within 6 weeks after having an abortion		Don't Know
7.2	If abortion, was the abortion spontaneous or induced, including MTP?	Spontaneous	Induced	MTP	Don't know
7.3	If the abortion was induced, how was it induced?	Oral medicine	Traditional vaginal herbal application	Instrumentation	Don't know
7.4	If the abortion was induced, where did she have the abortion?	Home	Government hospital (specify level)	Private clinic/center	Don't know
7.5	If the abortion was induced, who performed the abortion?	Doctor	Nurse	Others (specify)	Don't know
7.6	If induced, what made family seek care?	Bleeding started spontaneously		Wanted to terminate the pregnancy	
7.7	If the abortion was spontaneous, Where was the abortion completed	Home	Govt. Hospital (Specify level)	Private Clinic/ centre	Don't Know
7.8	How many weeks of pregnancy completed at the time of abortion				
7.9	Whether she had any of these symptoms after abortion?	High fever	Foul smelling discharge	Bleeding	Shock
7.10	After developing complications following abortion, did she seek care?				
7.11	If yes, whom/where did she seek care?				
7.12	Date of spontaneous abortion/ date of termination of pregnancy				
7.13	Date & time of death				

MODULE - III

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

8. INTRANATAL SERVICES (Tick ' √ ' wherever applicable)

8.1	Place of delivery	Home		Sub centre	
		CHC		PHC	
		Medical College		District Hospital	
		Sub district Hospital		Private Hospital	
		Transit		Any other place (specify):	
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)	Hours: __ ____ __ _ _			
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 salwar/saree/skirt soaked =500ml)	
		labour pain which disappeared suddenly		Inversion of the uterus	
		Retained placenta		Convulsions	
		Severe breathlessness /cyanosis/ oedema		Unconsciousness	
		High fever		Others (specify):	

8.10	Did she seek treatment, if yes by whom and what was the treatment given by the ANM/Nurse/LHV/ MO/others ? (give details)		
8.11	Was she referred?	YES	NO
		Not known	
8.12	Did she attend the referral centre?	YES	NO
		Not known	If yes, time interval between admission & delivery (if delivered)
8.13	In case of non compliance of referrals, state the reasons	Intensity of complications not known	Institution far away
		No attendant available	No money
		Beliefs & customs	Lack of transport
		Others	
8.14	Was there delay in	Decision making	Mobilizing funds
		Arranging transport	Others
8.15	Any information given to the relatives about the nature of complication from the hospital	Yes	No
8.16	If yes, describe		
8.17	Was there any delay in initiating treatment	Yes	No
8.18	If yes, describe		

9. POST NATAL PERIOD (Tick ' √ ' wherever applicable)

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	Time interval between detection of complication & death (in hours/minutes)				
9.4	Specific problem during Post Natal 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 behaviour		Severe anemia	
		Others (specify)			
9.5	Did she seek treatment	Yes		No	
9.6	If yes, by whom	ANM		Nurse	
		LHV		MO	Others (specify)
9.7	What was the treatment given (give details)				
9.8	Was she referred?	Yes		No	
		Not known		Not applicable	
9.9	Did she attend the referral center?	Yes		No	
		Not known		Not applicable	
9.10	In case of non compliance of referrals, state the reasons	Intensity of complications not known		Institution far away	
		No attendant available		No money	
		Beliefs & customs		Lack of transport	
		Others (specify):			

10: REPORTED CAUSE OF DEATH

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

11. OPEN HISTORY (In narrative form): (explore)

11.1	Name and address of the facilities she went – decisions and time taken for action	
11.2	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 spent at each facility and time spent at each facility before referrals were made and difficulties faced throughout the process	
11.3	Transportation method used	
11.4	Transportation cost? (at each stage of referral)	
11.5	Travel time – at each stage	
11.6	Care received at each facility?	
11.7	Total money spent by family	
11.8	How did the family arrange the money?	
11.9	Any other	

Investigator – 1	**Investigator – 2**	**Investigator – 3**
(Signature)	(Signature)	(Signature)
Name:	Name:	Name:
Designation:	Designation:	Designation:
Place of posting:	Place of posting:	Place of posting:
Date:	Date:	Date:

Annexure-3

COMMUNITY BASED MDR -CASE SUMMARY

(BLOCK PHC)

Case Summary Form to be filled in duplicate by the SMO Block PHC for each confirmed maternal death in the block after investigation and to be sent to District MDR Committee within 4 weeks of occurrence of the death (Ref: MDR Guidelines-Para 4.13)

Yearly Serial No. (Refer to Para 4.13 of the Guidelines**):** _____.

Name of the Block PHC/ District						
Particulars of the deceased			**Name:**			**Age:**
Husband's name & address						
Gravida	**Para**	**Live births**	**Sill births**	**Abortions**	**No. of living children**	
Visitor/Resident: Address						
Timing of Death			**Pregnancy**	**Delivery**	**Within 42 days after delivery**	
Religion/Caste/Community						
Place, Date & Time of death						
Date of investigation						

Fill in appropriate cause(s) of delay:

1. **Delay in Seeking Care:**

Not aware of danger signs	
Problem not identified/identified and neglected	

Delay in decision making	
No birth preparedness	
Beliefs and customs	
Any other (specify)	

2. **Delay in reaching first level facility:**

Delay in getting transport	
Delay in mobilizing funds	
Not reaching appropriate facility in time	
Difficult terrain	
Any other (specify)	

3. **Delay in receiving adequate care in facility:**

Delay in initiating treatment	
Substandard care in hospital	
Lack of blood, equipment & drugs	
Lack of adequate funds	
Any other (specify)	

Probable direct obstetric cause of death:

Indirect obstetric cause of death:

Contributory causes of death (may list them):

Initiatives suggested:

Date: **(Signatures of SMO Block PHC)**

Name:

(Office Seal)

Note: To facilitate investigations (Verbal Autopsy /Community Based MDR), for detailed questions refer to Annexure-2 on CBMDR

Annexure-3A

DISTRICT LEVEL CBMDR - CASE SUMMARY

District level CBMDR-Case Summary, for every maternal death reported by the Block PHCs, to be completed in duplicate by the District Nodal Officer after review by the District MDR Committee and reports compiled to be put up to the Deputy Commissioner for monthly review and to the State Director Family Welfare for monthly report (Ref: MDR Guidelines-Para 5.5-iii, 5.5-v and 6.2)

Yearly Serial No._____ . **Calendar Year:** _____

1. General Information:

Name of the Block PHC/ District:					
Particulars of the deceased:		**Name:**			**Age:**
Husband's name & address:					
Gravida	**Para**	**Live births**	**Still births**	**Abortions**	**No. of living children**
Visitor/Resident Address:					
Timing of Death:		**Pregnancy**	**Delivery**	**Within 42 days after delivery**	
Religion/Caste/Community:					
Place, Date & Time of death:					
Date of investigation:					

2. Fill in appropriate cause(s) of delay:

a. Delay in Seeking Care:

Not aware of danger signs	
Problem not identified/identified and neglected	

Delay in decision making	
No birth preparedness	
Beliefs and customs	
Any other (specify)	

b. Delay in reaching first level facility:

Delay in getting transport	
Delay in mobilizing funds	
Not reaching appropriate facility in time	
Difficult terrain	
Any other (specify)	

c. Delay in receiving adequate care in facility:

Delay in initiating treatment	
Substandard care in hospital	
Lack of blood, equipment & drugs	
Lack of adequate funds	
Any other (specify)	

3. Probable direct obstetric cause of death:

4. Indirect obstetric cause of death:

5. Contributory cause(s) of death:

6. **Initiatives suggested by SMO Block PHC:** (Add extra page if required)

7. **Remedial follow up actions planned or implemented:** (Add extra page if required)

(Signatures of District Nodal Officer MDR) **Name:**

(Office Seal) **Date:**

(Signatures of Civil Surgeon) **Name:**

(Office Seal) **Date:**

Note: To facilitate investigations (Verbal Autopsy /Community Based MDR), for detailed questions refer to Annexure-2 on CBMDR

Annexure- 4

Community Based Maternal Death Review

Line Listing Form to be filled by ASHA/AWW/Others (Ref: Para 4.6, 4.7, 4.8 & 4.9 of MDR Guidelines)

(To be compiled for all deaths of women aged 15 – 49 years irrespective of cause of death or pregnancy status)

Name of village:_____**Sub Centre:**_____ **PHC:**_____

Block:_____**District:**_____ **State:** _____

Contact Person's Name, address & Telephone No. :_____

Report for the Month of:_____ **Date of submission of report:**_____

Please submit a copy to the ANM of the area on or before 5th of every month (e.g. for report of March , this copy must reach the ANM by 5th of April).

Even if there is no death of women of age 15-49 years, submit 'NIL' report by the due date.

Sl. No.	**Name, age, husband's name & address of deceased**	**Place of death**			**When did the death occur**				**Probable cause of death**	**Status of newborn (dead/ alive)**	**Name & Tel No. of the person interviewed**	**Date & time of visit to home of deceased**
		Home	***Health facility*** *(Name)*	***Others***	***During pregnancy***	***During delivery***	***Within 42 days after delivery***	***Others (Non-maternal death)***				

Name of ASHA: …… **Village:** …… **Mob/Tel No:**…… **Signatures :** ……

Note: 1. For every death of women of age 15-49 years, inform the ANM of the area telephonically within 24 hours.

2. ***In case a Maternal Death is detected, inform the SMO Block PHC and the ANM of the area IMMEDIATELY TELEPHONICALLY.***

Maternal Death is defined as the death of a woman who dies from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy or child birth or within 42 days of termination of pregnancy, irrespective of duration and site of the pregnancy.

Annexure- 5

COMMUNITY BASED MATERNAL DEATH REVIEW REGISTER

To be maintained at Block PHC level (Ref: Para 4.10 of the MDR Guidelines)

(To be compiled for all deaths of women aged 15 – 49 years irrespective of cause of death or pregnancy status)

Name of Block PHC: _____

Block: _____

District: _____

State: _____

[Fill separate page(s) for every month from the Line listing and CB-MDR forms]

Year: …… **Month:** ……

Sr. No.	Name of deceased	Age	Date of death	Address	Husband's Name	Cause of death (tick √)		Primary information (line list) provided by	Date of field investigation	If died due to maternal causes, specify reasons	Action taken
						Maternal (Mention Yearly Serial Number)	Non-Maternal				

Name of the SMO Block PHC: …… **Signatures:** …… **Date:** ……

Note: ***Maternal death is defined as the death of a woman who dies from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy or child birth or within 42 days of termination of pregnancy, irrespective of duration and site of pregnancy.***

Annexure- 6

Maternal Death Information Report

Format for Primary Informer

(To be compiled for reporting Maternal Deaths to Civil Surgeon, Deputy Commissioner & the State Director Family Welfare by the Primary Informer i.e. by Facility Nodal Officer in case of FBMDR and by SMO Block PHC in case of CBMDR. Also by ANM to SMO Block PHC in case of CBMDR)

1	**Name of District**	
2	**Name of Block**	
3	**Report under FBMDR or CBMDR**	
4.	**Name, age & address of the deceased woman**	
5.	**Name of husband**	
6.	**Date and time of death**	
7.	**Place of death**	
	Home	
	Health Facility (Specify name and address of the Facility)	
	Others (Specify):	
8.	**When did death occur**	
	During pregnancy	
	During delivery	
	Within 42 days after delivery	
9.	**Name of reporting person & mobile/telephone no.**	

Signature of reporting person:

Designation:

Name of the Sub-centre/Facility/Block PHC:

Date & Time:

Annexure – 6A

MATERNAL DEATH RECORD REGISTER

(FACILITY / DISTRICT / STATE)

To be maintained at Facility, District and State level to keep record of all the reported/ confirmed 'Maternal Deaths' **(Ref: Para 3.9, 5.5.ii & 7.3 of MDR Guidelines)**

	1	2	3	4	5	6	7			8			9	10	11	12	
							Place of death			When did death occur						Outcome of the investigation (Tick √ in the appropriate box)	
Sr. No.	Name of District / Block	Name of Block PHC/ Facility	Report under FBMDR or CBMDR	Name, age & address of the deceased woman	Name of husband	Date and time of death	Home	Health Facility (Specify name and address of the Facility)	Others (Specify)	During pregnancy	During delivery	Within 42 days after delivery	Name & designation of reporting person & mobile/telephone no.	Date & time of receipt of information on telephone	Date & time of receipt of information in Annexure-6	Confirmed Maternal Death (mention Yearly Serial Number)	Non-maternal Death
1																	
2																	
3																	
4																	
5																	

NOTE: **Column No. 12 will be completed after report of verification/ investigation is available.**