Maternal Death Audit in Tamil Nadu: Its impact of health system

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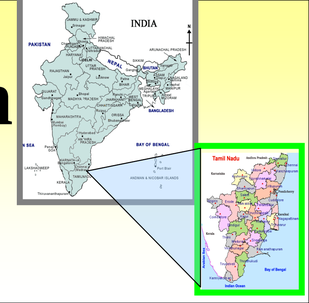


Key health indicators of Tamil Nadu and India

	Tamil Nadu	India
Total population (Census 2001) (in million)	62.41	1028.61
Decadal Growth (Census 2001) (%)	11.72	21.54
Crude Birth Rate (SRS 2007)	15.8	23.1
Crude Death Rate (SRS 2007)	7.2	7.4
Total Fertility Rate (SRS 2007)	1.6	2.7
Infant Mortality Rate (SRS 2007)	35	55
Maternal Mortality Ratio (SRS 2004 - 2006)	111	254
Sex Ratio (Census 2001)	987	933
Population below Poverty line (%)	21.12	26.10
Schedule Caste population (in million)	11.86	166.64
Schedule Tribe population (in million)	0.65	84.33
Female Literacy Rate (Census 2001) (%)	64.4	53.7

Rationale, Objectives and Methodology

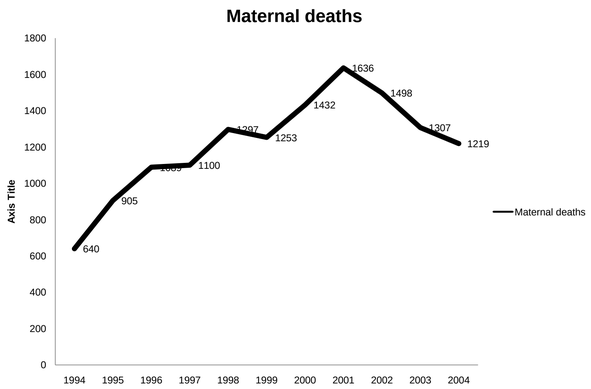
•Tamil Nadu is the first state in India which has setup a system to register all maternal deaths and developed maternal death audit

•Objective is to describe how maternal death audit system was developed and its impact

•Secondary literature review including government reports, interviews with key officials and presentations made by them

How Maternal Deaths are reported

1. Compulsory reporting of maternal deaths within 24 hours from public and private facilities
2. Official orders were issued in 2004
3. Government health system staff report home and institutional maternal deaths to the district health office



Reported maternal deaths from 1994-2004

Other interventions for MH

- Increase in institutional deliveries
- Certification of CEmOC to CEmNOC
- Cash payment to poor mothers
- 3 staff nurse poster at PHCs for 24/7 services

Process of Maternal death review

1. Health officials conduct Verbal autopsy for each maternal death
2. Audit reports are prepared and placed before the district collector
3. District collector invites relatives of the deceased women for further investigation of social and governance factors

Factors identified for maternal deaths through audit

1. Shortage of staff at the facility
2. Delay in transportation
3. Multiple referrals
4. Facilities not ready for EmOC
5. Blood not available
6. Illegal payments demanded

Impact on health system

1. Hiring contractual staff nurses
2. Contracting private anesthetist and obgyns for emergency C-section
3. Contracting with private partners for Ambulances
4. Certification of CEmNOC centers for making the facility accountable for EmOC functions
5. Reduction of MMR

Conclusions

- Maternal death audit helped in improving health systems leading to reduction in maternal mortality
- Maternal mortality reduced from 167 in 1997-2003 to 111 in 2007
- Increased accountability of staff and health system