ANNEXURE 1

MDSR Formats

Form 1

Notification form

Format to be filled by Primary informant for all Women's Death (15-49) years

S. No.		Place of Current Residence	Native Place
1	**Name of State**		
2	**Name of District**		
3	**Name of Block**		
4	**Name of village/ Description of location**		
5	**Name of the deceased woman**		
6	**Name of Husband**		
7	**Name of Father**		
8	**Age of the woman**		
9	**MCTS ID**		
10	**Mobile No**		
11	**Date and time of death**	Date ....DD/ MM/ YYYY Time ________:_________am/pm	
12	**Place of death**	Yes	No (tick)
	I. Home		
	II. Health Facility		
	III. Transit		
	IV. Others		
13	**When did death occur**	Yes	No (tick)
	a. During pregnancy		
	b. During delivery		
	c. Within 42 days after delivery		
	d. During abortion or within 6 weeks after abortion		

If either a, b, c, d, =yes in Q 13: ***Suspected maternal death***
If all- a, b, c, d, =no in Q13 ; ***Non- maternal death***

Name of reporting Person: ______________________________

Designation: ______________________________

Signature of reporting person:

Date:

Verification by ANM of the respective Sub-center that death of women occurred during pregnancy or within 42 days of delivery/abortion:

Name of the sub center:

Signature: ____________________

Name: ____________________

Date: ____________________

Form 2

Block Level MDR Register for All Women's Death (15-49 years)

(Fill in one form for every month)

Name of Block ______________________

District ____________________________ State ______________________________

Month ______________________________ Year ______________________________

S. No.	Name of deceased	Age	Date of death	Address	Husband's name	Cause of death (tick √)		Name/ designation of Primary informant (Annex 6)	Date of field investigation	If died due to maternal causes, specify reasons	Action Taken
						Maternal	Non-maternal				
1.											
2.											
3.											
4.											
5.											

Signature of MO I/C of the block with date:

Form 3

MDR Line Listing Form for All Cases of Maternal Deaths

Line listing for use by ANM, BMO, FNO and DNO

District____________________ **State**____________________

FB MDR: Name of facility: ____________________ **or** **CB MDR:**

SHC/Block____________________

S. No.	Date of death	Name of deceased	Place of death			When did the death occur				Probable cause of death	Status of newborn (Delivery outcome)	Name of investigator/ date of interview
			Home	Health facility	In transit	During pregnancy	During delivery	During abortion or within 6 weeks after the abortion	Within 42 days after delivery			

Name of reporting person: ____________________ ***Signature:*** ____________________

Designation: ____________________ ***Date of reporting:*** ____________________

Form 4

Confidential

Facility Based Maternal Death Review Form

Name and Type of Health Facility (specify)________________________________

Address____

Name of Nodal Person ______________________ Contact No______________

FOR OFFICE USE ONLY

FBMDR No. (Specific to the Place) ☐☐☐☐

MCTS No ☐☐☐☐☐☐☐☐☐☐☐☐☐

Month ☐☐

Year ☐☐☐☐

Please fill up the Performa given below

NOTE:

- **MDR Number must be put serially 0001 & so on.**
- **This form must be filled for all Maternal Deaths.**
- **Mark with √ wherever applicable.**
- **For Date use Day/Month/Year format. For time use 24 hours clock format.**
- **Complete within 24 hrs.**
- **Make 2 photocopies & send original to MRD, a copy to DNO, and one retained with Nodal Officer for further action0**

Background information of deceased Mother

Full Name______________________ Age ________ Inpatient No____________

Medico-legal admission: Yes ☐ No ☐

Complete Address ____

Contact/ Mobile No____________________

Education: Illiterate ☐ Upto 5th class ☐ 6th to 12th class ☐ Beyond 12th class ☐

Below Poverty Line: BPL Certified ☐ Self certified BPL ☐ Not BPL ☐

1\. a. Date and Time of admission: Day☐☐ Month☐☐ Yr.☐☐ at Hours☐☐ Min.☐☐

b. Date and time of Death: Day☐☐ Month☐☐ Yr.☐☐ at Hours☐☐ Min.☐☐

c. Duration of Hospital stay: ☐☐Days ☐☐Hours

d. Duration of ICU stay: Days ☐☐ Hours ☐☐ if any

	Days	Hrs.	N.A.	DNK
e. Admission- delivery interval:	☐☐	☐☐	☐☐	☐
f. Admission – death interval	☐☐	☐☐	☐☐	☐

g. Outcome of pregnancy:

1) Abortion ☐	2) Ectopic ☐	3) Live birth ☐
4) Still birth ☐	5) Undelivered ☐	

2. On Admission

a. Complaints at time of admission: ______________________________

b. Obstetric formula on admission **M F**

1. Gravida ☐☐ 2. Para ☐☐ 3. Abortions ☐☐ 4. No. of Living children ☐☐

c. Period of gestation:

1) Before 22 weeks ☐	2) Antenatal 22-34 weeks ☐	3) Antenatal ≥34 weeks ☐	4) Intrapartum ☐
5) Post- Partum up to 24hrs ☐	6) Post-natal 24hrs- 1 week ☐	7) Post-natal- More than 1 week to 42 d ays ☐	

3. Condition on Admission: 1) Stable ☐ 2) Semi conscious responds to verbal commands ☐ 3) Semi conscious responds to painful stimuli ☐ 4) Unconscious ☐ 5) Brought dead ☐

a. **Referral**: If referred from outside: i. No. of places visited prior ☐

b. Please fill the table below for the details on transport, referral and type of care given

Place	Home/ Village	Facility 1	Facility 2	Facility 3
Date (DD/MM/YY)				
Time of onset of complication or onset of labour				
Time of calling/ arrival of transport				
Transport used/type				
Time to reach				
Money spent on transport (Rs.)				
Name of Facility/ Level of referral				
Attended by Doctor/ nurse/ other staff/none				

Place	Home/ Village	Facility 1	Facility 2	Facility 3
Reason for referral				
Referral slip (given or not, if yes, attach)				
Treatment given				
Money spent on treatment/ medicine/ Diagnostics				
Time spent in facility				

4. Diagnosis at time of admission:

(Please make sure to fill the table with underlying cause given for each condition)

S. No.	Diagnosis →	Underlying Cause	
1.	**Hemorrhage** ☐	**I. Abortion** ☐ **II. Ectopic Pregnancy** ☐ **III. Gestational Trophoblastic Disease** ☐	
		IV. Antepartum Bleeding	**a) Placental causes-** Placenta Previa ☐ - Placental abruption ☐ **b) Late pregnancy Bleeding other than placental causes-** - Scar dehiscence ☐ - Rupture uterus ☐ - Others, ☐ Specify_________
		V. Intrapartum Bleeding	
		VI. Postpartum bleeding- Atonic ☐ Traumatic ☐ Mixed ☐	
2.	**Hypertensive disorders of pregnancy** ☐	i. Gestational Hypertension ☐ ii. Pre-eclampsia ☐ iii. Eclampsia ☐ iv. Others ☐	
3.	**Labour related Disorders** ☐	i. Normal labour ☐ ii Prolonged / Obstructed labour ☐ iii. Inversion of Uterus ☐ iv. Retained placenta ☐ v. Any other ☐	
4.	**Medical Disorders** ☐	i. Anaemia ☐ ii. Heart disease ☐ iii. TB ☐ iv. Diabetes ☐ v. Others ☐	

<table>
<tr><th>S. No.</th><th colspan="2">Diagnosis → Underlying Cause</th><th></th></tr>
<tr><td>5.</td><td>Infection ☐</td><td>I. Post abortal ☐
II. Antepartum ☐
III. Intrapartum ☐
IV. Post-partum ☐</td><td>a) Viral such as Hepatitis/HIV AIDS/ Others, ☐
b) Malaria, ☐
c) Dengue, ☐
d) Lower Respiratory Tract Infection, ☐
e) Other infections, ☐
Specify_______________</td></tr>
<tr><td>6.</td><td colspan="2">Incidental/ Accidental Disorders E.g. Surgical including Iatrogenic, Trauma, Violence, Anaesthetic complications, ☐</td><td>Specify</td></tr>
<tr><td>7.</td><td colspan="2">Any other, ☐</td><td>Specify</td></tr>
</table>

2. Abortion (to be filled if applicable)

a. Spontaneous ☐ Induced ☐

i. If spontaneous, - Complete ☐ Incomplete ☐

ii. If induced -Legal ☐ Illegal ☐

b. What was the procedure adopted? Medical methods ☐ MVA ☐ D&E/ S&E ☐ Extra Amniotic Installation ☐ Hysterotomy ☐ Others ☐

c. Post Abortal Period Uneventful ☐ Sepsis ☐ Hemorrhage ☐ Others ☐

d. Was the termination procedure done in more than one center Yes ☐ No ☐

(If yes, specify the centres visited before coming to this facility)..

....

3. Antenatal Care

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

b. If Yes, Type of Facility: SC ☐ PHC ☐ CHC ☐ SDH ☐ DH ☐ Medical College ☐ Private hospital ☐ Others ☐ specify_______________________________

c. Services provided by: ANM ☐ MO ☐ Obstetrician ☐ AYUSH ☐ Nurse ☐ Other specialists, ☐ specify_______________

d. If yes, was she told about any disorder/complication? Yes ☐ No ☐ Don't know ☐

e. If yes, what was the risk factor identified?

1. Abortion ☐	2. Ectopic pregnancy ☐	3. Vesicular Mole ☐	4. APH ☐
5. Hydramnios / Oligohydramnios ☐	6. Short stature ☐	7. PIH/PE ☐	8. Previous C section ☐

9. Multiple pregnancy ☐	10. Grand multi ☐	11. Abnormal presentation/ position ☐	12. Big baby ☐
13. Anemia ☐	14. Diabetes/ GDM ☐	15. Medical conditions (Specify______) ☐	16. Others (Specify___) ☐

4. DELIVERY, PUERPERIUM AND NEONATAL INFORMATION

If applicable

a. **Did she have labour pains**? Yes ☐ No ☐

b. **If yes, was a partograph used to monitor labour** ?

i.) Past facility: Yes ☐ No ☐ Don't know ☐

ii.) Current facility: Yes ☐ No ☐

c. **Complications during labour**:

1. Eclampsia/ pre-ecclampsia ☐	2. Prolonged labour ☐	3. Obstructed labour /Rupture Uterus ☐	4. Intra partum Hge ☐
5. Inversion of Uterus ☐	6. IP sepsis ☐	7. Others ☐ Specify ______________	

d. Mode of Delivery

1. Undelivered	☐
2. Vaginal	a. Normal ☐ - With episiotomy ☐ b. Assisted ☐ - Forceps ☐ - Vacuum ☐ c. Breech ☐ d. Multiple Pregnancy ☐
3. Caesarean Section	Elective ☐
	Emergency ☐
4. Laparotomy	Rupture uterus ☐
	*Ectopic Pregnancy ☐
5. Indication (CS/Instrumental) ☐	

* Although in Ectopic pregnancy woman does not deliver but fetus may be removed during Laparotomy

e. Anaesthesia (any adverse reaction):

a) General Anaesthesia ☐	b) Reg- Epidural / Spinal ☐	c) Local ☐

f. In which phase of labor did she develop complications?

a) First stage ☐	b) Second stage ☐	c) Third stage ☐	d) Post Birth ☐		
			a. Within ≤ 6 hrs. of birth ☐	b. > 6 - ≤ 24 hrs. of birth ☐	c. > 24 hrs. after birth ☐

g. Neonatal Outcome: Alive ☐ Fresh Still birth ☐ Macerated still birth Neonatal death ☐

h. If baby died, probable cause of death:

1. Birth Asphxia ☐	2. Respiratory distress ☐	3. Aspiration including MAS ☐	4. Sepsis ☐
5. Cong Anomalies ☐	6. Preterm ☐	7. Others ☐ Specify________	

i. Postnatal period: - Uneventful Eventful ☐

- If Eventful, specify probable cause of death: ☐

1. PPH ☐	2. PE / Eclampsia ☐	3. CVA/Pulmonary Embolism ☐	4. Sepsis/ ARDS ☐
5. Anemia ☐	6. Post op complication ☐	7. Medical conditions Specify________ ☐	8. Others Specify________ ☐

5. INTERVENTIONS (Tick appropriate box), Specify other in the last row

Early pregnancy	Antenatal	Intrapartum	Postpartum	Anaesthesia/ ICU
1. Evacuation ☐ 2. Trans-fusion ☐ 3. Laparotomy/ laparo-scopy ☐ 4. Hyster-ectomy ☐	1. Trans-fusion ☐ 2. Version ☐ 3. Other surgeries ☐	1. Instrumental del. ☐ 2. Caesarean section ☐ 3. Hyster-ectomy ☐ 4. Manual removal of placenta ☐ 5. Conservative surgery ☐ 6. Trans-fusion ☐	1. Removal of retained POC ☐ 2. Laparo-tomy ☐ 3. Hyster-ectomy ☐ 4. Trans-fusion ☐	1. Anaesthesia -GA ☐ 2. Spinal ☐ 3. Local ☐ 4. Epidural ☐ 5. ICU monitoring ☐

a. Blood transfusion given? Yes ☐ **No** ☐

b. If yes, No of units——☐☐☐☐ Whole Blood ☐ /PRBC ☐ /FFP ☐/Platelets /Cryo ☐

c. Specify if any transfusion reaction occurred?: Yes ☐ **No** ☐

6. Primary diagnosis/condition leading to death______________________________

7. CAUSE OF DEATH:____

Part 1: Antecedent causes (Please mention the cause of death from Box below)

a. Due to or as a consequence of ___________________________________

b. Due to or as a consequence of ___________________________________

c. Due to or as a consequence of ___________________________________

8. IN YOUR OPINION WERE ANY OF THESE FACTORS PRESENT?

System	Example	Y	N	Not known
Personal/ Family	Delay in woman seeking help			
	Refusal of treatment or admission			
	Refusal of admission in previous facility			
Logistical Problems	Lack of transport from home to health care facility			
	Lack of transport between health care facilities			
	Lack of assured referral system			
Facilities	Lack of facilities, equipment or consumable			
	Lack of blood/ blood products Lack of OT availability			
Health personnel problems	Lack of human resources Lack of Anesthetist Lack of Obstetricians			
	Lack of expertise, training or education			

9. AUTOPSY: Performed ☐ Not performed ☐

- If performed please report the final diagnosis and send the detailed report later

____

____

10. CASE SUMMARY (please supply a short summary of the events surrounding hospital stay and the death of the patient)

Form filled by the MO on duty

Name & Signature

Designation

Stamp & Date:

Nodal Officer of the Hospital:

Name& Signature

Address of the Institution

Form 5
Verbal Autopsy Questionnaire

FOR INVESTIGATION OF MATERNAL DEATHS

NAME OF THE STATE	
NAME OF THE DISTRICT	
NAME OF THE BLOCK	
NAME OF THE PHC	
NAME FO THE SHC	
NAME OF THE VILLAGE	
NAME OF THE PREGNANT WOMAN/ MOTHER	
NAME OF THE HUSBAND/OTHER (FATHER/MOTHER)	
DATE OF DEATH	
NAME & DESIGNATION OF THE INVESTIGATOR(S)	
NAME & DESIGNATION OF THE INVESTIGATOR(S)	
DATE OF INVESTIGATION	
PROBABLE CAUSE OF DEATH	

(For investigation of maternal deaths at community level)

General Instructions

1. **CONFIDENTIALITY:** After the formal introduction to the respondents, the investigating official should give assurance that the information will be kept **confidential**.
2. Throughout the interview, the interviewer should be very polite and sensitive questions should be avoided.
3. Make all the respondents seated comfortably and explain to them that the information that they are going to provide will help to prevent such deaths of mothers in future.
4. 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.
5. Do not ask questions which are not in the interview schedule.
6. Wherever needed, the investigating official should encourage the respondents to bring out all information related to the event.
7. Please also write information in a **narrative form.**

8. **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.

The format is divided into three modules:

MODULE - I

This form will be used for collection of general information about the deceased woman in case of all maternal deaths

MODULE - II

This form should be used to collect details about maternal death during antenatal period or due to abortion

MODULE - III

This form should be used to collect details about deaths during delivery or postnatal period

VERBAL CONSENT FORM

Instructions to Interviewer: Please ask the respondent to acknowledge her/his consent to be interviewed by checking the response below. The interviewer should sign and put date below. If the respondent does not consent to the interview, thank her/him for their time and terminate the conversation.

My name is [say your name]. I am a _____/_____ at the _____ center/hospital, and an interviewer for Maternal Death Review. I have been informed that a woman (name) in your household has died recently. I am very sorry to hear this. Please accept my condolences.

The purpose of our visit is to collect information about causes of death of the woman (name) so that we can work on improving health care services which will help prevent death of other women because of similar reasons/ circumstances.

Your participation will help to improve maternal and newborn care services for women and babies in your area. We would like to talk to the person in your house who took care of [say the woman's name] before death.

We will ask questions about the woman (name) who recently died. We will ask about her background, pregnancy history and events during her most recent pregnancy. We assure you that any information you or your family provide will be kept confidential and your name will not be used in any way.

Your participation in this interview is voluntary and refusal to participate will not affect you in any manner. You may discontinue participation at any time or choose to not answer any question.

The interview will take approximately one hour.

At this time do you want to ask me anything about the interview?

Answer any questions and address respondents concerns

Do you agree to participate in this interview? YES NO

Respondent

Name ______________________ Signature ______________________

Interviewer

Name ______________________ Signature ______________________

Date ______________________

Respondent's relationship with the deceased woman

General Information

(Enclose the Primary informant form with this format)

NAME & DESIGNATION OF THE INVESTIGATOR 1	
NAME & DESIGNATION OF THE INVESTIGATOR 2	
NAME & DESIGNATION OF THE INVESTIGATOR 3	
DATE OF INVESTIGATION	

Signature of reporting person:

Designation:

Date:

MODULE I

The form is intended to capture general information and information about previous pregnancy history, wherever applicable. It should be used for all the maternal deaths irrespective whether the death occurred during antenatal, delivery or postnatal period including abortion)

I	BACKGROUND INFORMATION			
1.	Name of the respondent			
2.	Name of the deceased woman			
3.	Relationship of the respondent/s with the deceased woman			
4.	Age of the deceased woman at the time of death	____________yrs		
5.	***Period of Death***	**Yes**	**No (tick)**	
	a) During pregnancy	☐	☐	
	b) During delivery	☐	☐	
	c) Within 42 days after delivery	☐	☐	
	d) During abortion or within 6 weeks after abortion	☐	☐	
6.	Place of Death **(tick)**			
	a) Home………………………………………1	b) Sub-District Hospital……………2		
	c) Sub-Health Centre……………………3	d) District Hospital……………………4		
	e) PHC…………………………………………5	f) Private Hospital……………………6		
	g) CHC…………………………………………7	h) In-transit………………………………8		
	i) Others, (Specify__________________________________)…………………………9			
7.	Specify the name and place of the institution or village /urban area where death occurred			
8.	Date & Time of Death	Date:___DD/__MM/____YYYY Time: _____:______ am/ pm		
9.	Did the doctor or nurse at the health facility tell you the cause of death?	Yes………………………………………1 No………………………………………2 Not applicable……………………3		**Go to sec II** (No, Not applicable)
10.	If yes, what was the cause of death?			
II	**Profile of deceased woman**			
	Age at marriage	___________years/ Not married		
	Religion	a) Hindu……………………………………1		
		b) Muslim…………………………………2		
		c) Christian………………………………3		
		d) Others (Specify……………….)……4		

	Caste	a) SC……………………1		
		b) ST……………………2		
		c) OBC……………………3		
		d) General……………………4		
	BPL Status	a) BPL……………………1		
		b) Non-BPL……………………2		
	Education status			
	a) Illiterate……………………1	b) Completed 5th std……………2		
	c) Completed 8th std……………………3	d) Completed 12th std…………4		
	e) Graduate……………………5	f) Others (Specify____)…………6		
III	**Availability of health facilities, services and transport**			
	Name and location of the nearest government / private facility providing Emergency Obstetric Care Services			
	Distance of this facility from the residence			
	Mode of transport available to reach this facility			
IV	**Write 'GPLA-Gravida, Para, Live Births, Abortions)**			
1.	Gravida			
2.	Para			
3.	Live Births			
4.	Abortions			
V	**Current pregnancy** (To be filled from the information given by the respondents and MCP Card)			
1.	Infant Survival			
	a) Alive……………………1	b) New born death……………………2		
	c) Still birth……………………3	d) Not applicable……………………4		
	Antenatal care received	Yes……………………1 No……………………2 Do not know……………………3	} Go to Q6	
3.	If yes, write number of antenatal checkups received	______________________		
4.	Place of antenatal check-ups (Multiple responses possible)			
	a) VHND……………………1	b) Sub Health Centre……………………2		
	c) PHC……………………3	d) CHC……………………4		
	e) District Hospital……………………5	f) Pvt. Hospital/clinic……………………6		
	g) 7	h) Don't know……………………8		
	i) Not applicable……………………9	j) Others, (specify____________)..10		

5.	Services received during ANC (multiple response possible)	a) Tetanus Toxoid Injection..........1 b) Blood Pressure measurement...2 c) Hemoglobin test.......................3 d) Abdominal Examination............4 e) Iron Folic Acid provided...........5 f) Don't know 6	
6.	Did the deceased woman have any problem during the antenatal period?	Yes...1 No..2 Not known.....................................3	Go to Module II
7.	What were the symptoms she had?		
	a) Head ache...................................1	b) Edema..2	
	c) Anemia...3	d) High blood pressure.................4	
	e) Bleeding p/v...............................5	f) No foetal movements.................6	
	g) Fits...7	h) Sudden excruciating pain..........8	
	i) High fever with rigor 9	j) Others (specify__________)......10	
8.	Did she seek care for these symptoms?	Yes...1 No..2 →	Go to Q 10
9.	Where did she seek care?		
	a) Sub Health Centre.........................1	b) PHC...2	
	c) CHC...3	d) District Hospital...........................4	
	e) Pvt. Hospital/clinic.......................5	f) Quack..6	
	g) Don't know....................................7	h) Not applicable..............................8	
	i) Others, (specify____________________)................9		Go to Module II
10.	What were the reasons for not seeking care? *(Multiple responses possible)*		
	a) Severity of complication not known...1	b) Health facility was very far...........2	
	c) Lack of transport...........................3	d) Financial reasons.........................4	
	e) Family reasons 5	f) Faith in local healers / dai............6	
	g) Disrespectful behaviour of the providers...7	h) Beliefs and customs.......................8	
	i) Others (Specify__________________)..................9		

Note: Education status categories may be as: a. Illiterate b. up to 5^{th}st c. 5th to 8^{th}st d. 8th to 12^{th}st e. completed 12^{th}st f. Graduate g. Others (Specify......)

MODULE - II

This module is to be filled for the maternal deaths that occurred during the antenatal period or if the deaths due to abortion related causes.

VI	**No. of weeks of pregnancy completed at the time of death?** *(Help the respondent in estimating weeks of pregnancy)*	______________________**weeks**	***If less than 6 weeks go to sub section VIII***
VII	**Death during Antenatal Period**		
1.	What was the problem that the deceased woman had at the time of death?		
2.	What were the symptoms?		
	a) Head ache..................................1	b) Edema.......................................2	
	c) Anemia.......................................3	d) High blood pressure...............4	
	e) Bleeding p/v...............................5	f) No foetal movements..............6	
	g) Fits..7	h) Sudden excruciating pain.......8	
	i) High fever with rigor 9	j) Others (specify________)......10	
3.	Was she referred at that time?	Yes..1 No..2 Not known.....................................3	} Go to Q 6
4.	Did she seek care for these complications?	Yes..1 No..2	If yes, fill the table no. 1 for referral transport If no skip to Q 6
5.	If yes, where did she seek care?		Go to Sec VIII
	a) PHC..1	b) CHC...2	
	c) District Hospital.........................3	d) Pvt. Hospital/clinic..................4	
	e) Quack..5	f) Don't know..............................6	
	g) Others, (specify__________________)......................7		

6.	In case of not seeking care from the hospital, what were the reasons for not seeking care *(Multiple responses possible)*		
	a) Severity of complication not known...1	b) Health facility was very far........2	
	c) Lack of transport..............................3	d) Financial reasons.........................4	
	e) Family reasons.................................5	f) Faith in local healers / dai........6	
	g) Beliefs and customs..................7	h) Disrespectful behaviour of the providers...8	
	i) Others (Specify________________________________)...................9		
VIII	**Abortion related Death**		
1	Did the deceased woman (name) die while having an abortion or within 6 weeks after having an abortion?	Yes...1 No..2 Not known.....................................3	
2	Type of abortion	a) Spontaneous...............................1 b) Induced ....2 c) Don't know..................................3	If induced Go to Q. 5
3	Date of spontaneous abortion/ date of termination of pregnancy	DD___/ MM_____/ _______YYYY	
4	If the abortion was spontaneous, where was the abortion completed?		Go to Q 9
	a) Home..1	b) PHC...2	
	c) CHC...3	d) DH...4	
	e) Private hospital/clinic..............5	f) Don't know....................................6	
	g) Others (Specify_____________________________)........................7		
5	If the abortion was induced, how was it induced?	a) Oral Medicine............................1 b) Traditional Vaginal Herbal Medication...............................2 c) Instrumentation.......................3 d) Don't know.................................4	
6	If the abortion was induced, where did she have the abortion?		
	a) Home..1	b) PHC...2	
	c) CHC...3	d) DH...4	
	e) Private hospital/clinic..............5	f) Don't know....................................6 g) Others (Specify------) 7	
7	If the abortion was induced, who performed the abortion?		
	a) Allopathic Doctor.....................1	b) AYUSH doctor.........................2	
	c) Nurse..3	d) Quack...4	
	e) Dai...5	f) Don't know...............................6	
	g) Other (Specify___________________________)..............7		

<table>
<tr><td>8a</td><td colspan="2">What was the reason for inducing abortion?</td><td colspan="2">a) Medical Condition/Bleeding started spontaneously..............1
b) Wanted to terminate the pregnancy..2
c) Don't know...................................3</td><td></td></tr>
<tr><td>8b</td><td colspan="2">Describe the reasons for inducing the abortion</td><td colspan="2"></td><td></td></tr>
<tr><td rowspan="4">9</td><td colspan="4">What were the complications/ symptoms that the woman had after abortion?</td><td rowspan="4"></td></tr>
<tr><td colspan="2">a) High fever..................................1</td><td colspan="2">b) Foul smelling discharge..........2</td></tr>
<tr><td colspan="2">c) Bleeding......................................3</td><td colspan="2">d) Shock.......................................4</td></tr>
<tr><td colspan="2">e) None..5</td><td colspan="2">f) Don't know.............................6</td></tr>
<tr><td>10</td><td colspan="2">After developing complications following abortion, did she seek care?</td><td colspan="2">Yes...1
No..2
Not applicable..................................3</td><td>Go to Q 12</td></tr>
<tr><td rowspan="5">11</td><td colspan="4">If yes, where did she seek care?</td><td rowspan="5">If the answer is any facility, also fill the table 1below for referral transport</td></tr>
<tr><td colspan="2">a) SHC...1</td><td colspan="2">b) PHC...2</td></tr>
<tr><td colspan="2">c) CHC...3</td><td colspan="2">d) DH...4</td></tr>
<tr><td colspan="2">e) Private hospital/clinic..............5</td><td colspan="2">f) Quack.......................................6</td></tr>
<tr><td colspan="2">g) Don't know..................................7</td><td colspan="2">h) Others
(Specify_____________)........8</td></tr>
<tr><td rowspan="6">12</td><td colspan="4">In case of not seeking care from the hospital, what were the reasons for not seeking care</td><td rowspan="6"></td></tr>
<tr><td colspan="2">j) Severity of complication not known...1</td><td colspan="2">k) Health facility was very far.......2</td></tr>
<tr><td colspan="2">l) Lack of transport.......................3</td><td colspan="2">m) Financial reasons......................4</td></tr>
<tr><td colspan="2">n) Family reasons...........................5</td><td colspan="2">o) Faith in local healers / dai........6</td></tr>
<tr><td colspan="2">p) Beliefs and customs...................7</td><td colspan="2">q) Disrespectful behaviour of the providers.........................8</td></tr>
<tr><td colspan="4">r) Others (Specify______________________________)....................9</td></tr>
</table>

Please fill the table below for the details on transport, referral and type of care given				
Table 1				
Place	**Home/ Village**	**Facility 1**	**Facility 2**	**Facility 3**
Date (DD/MM/YY)				
Time of onset of complication or onset of labour				
Time of calling/ arrival of transport				
Transport used				
Name of Facility/ Level of referral		**Facility 1**	**Facility 2**	**Facility 3**
Time to reach				
Money spent on transport				
Reason for referral				
Referral slip (given or not)				
Treatment given				
Money spent on treatment/ medicine/ diagnostics				
Time spent in facility				

MODULE - III

This module is to be filled for the maternal deaths that occurred during delivery or if the death occurred during postnatal period (after delivery of placenta)

IX	INTRANATAL SERVICES		
1	Place of delivery		In case of institution delivery also fill table 2 after completion of this form
	a) Home……………………………1	b) SHC……………………………2	
	c) PHC……………………………3	d) CHC……………………………4	
	e) DH……………………………5	f) Private hospital…………………6	
	g) Transit……………………………7	h) Don't know……………………8	
	i) Others (Specify________________________)…………………9		
2	In case of home delivery, what were the reasons for home delivery?		Skip in case of non-home delivery
	a) Family's preference…………………1	b) Village Dai is good…………2	
	c) No transport facilities………………3	d) Cost of transport is high..4	
	e) No information given about need for institutional delivery……………5	f) Services not available at the nearest health facility……………………6	
	g) High expenses……………………7	h) Bad experience at institution……………………8	
	i) No complication so no need…….9	j) Home is more comfortable……………………10	
	k) Others (Specify____________________)……………………………11		
3	No. of completed pregnancy weeks at time of delivery	______________weeks	
4	Date and Time of delivery	Date : Time _ _:_ _ _ _ am/pm	
5	Date and Time of death	Date: Time _ _:_ _ _ _ am/pm	
6	Who conducted the delivery?		
	a) Allopathic doctor……………………1	b) AYUSH doctor………………2	
	c) ANM……………………………3	d) Staff nurse……………………4	
	e) Dai……………………………5	f) Quack……………………………6	
	g) Relatives……………………………7	h) Don't know……………………8	
	i) Others (specify____________________________)……………9		
7	Type of delivery		
	a) Normal……………………………1	b) C- section……………………2	
	c) Assisted……………………………3	d) Unattended…………………4	
	e) Don't know……………………………5		

No.	Question	Response	Skip
8	Outcome of the delivery (write numbers in each column) Or not applicable if not delivered but died in labour	Live births: ____ Still births: ____	
9	What were the complications that the deceased woman (name) had during labour/ delivery?		
	a) Prolonged labour (Primi>12 hrs / Subsequent deliveries >8 hrs)........................1	b) Severe bleeding/ bleeding with clots- (one saree/in skirt soaked =500ml)..........2	
	c) Labour pain which disappeared suddenly.......................................3	d) Inversion of the uterus.....................................4	
	e) Retained placenta........................5	f) Convulsions......................6	
	g) Severe breathlessness /cyanosis/ edema..7	h) Unconsciousness..............8	
	i) High fever.......................................9	j) Not applicable.................10	
	k) Other (specify________________________)..11		
10a	***In case of institutional delivery,*** what was the treatment provided at the health facility?	a) Received IV drip...............1 b) Blood transfusion.............2 c) Oxygen was given............3 d) Don't know.......................4 e) Others (specify______________)....5	
10b	See the hospital records if available and fill details of treatment received.		
10c	Any information given to the relatives about the nature of complication from the hospital	Yes...1 No..2	If no, Go to Q 10e
10d	If yes, please describe		
10e	Was there any delay in initiating treatment	Yes...1 No..2 Not known.............................3 Not Applicable......................4	Go to Q 12
10f	If yes, please describe		Go to Q 12
11a	In case of home delivery, did the woman seek care?	Yes...1 No..2	If yes, Go to Q11c

11b	In case of not seeking care, what were the reasons for not seeking care		Go to Sec X
	a) Severity of complication not known.......1	b) Health facility was very far.......2	
	c) Lack of transport.......3	d) Financial reasons	
	e) Family reasons.......5	f) Faith in local healers / dai.......6	
	g) Beliefs and customs.......7	h) Disrespectful behaviour of the providers.......8	
	i) Others (Specify____________)..........9		
11c	Where did she seek care?		
	a) SHC.......1	b) PHC.......2	
	c) CHC.......3	d) DH.......4	
	e) Private hospital.......5	f) Quack.......6	
	g) Don't know.......7	h) Others (Specify________)........8	
11d	Any information given to the relatives about the nature of complication by the care provider?	Yes.......1 No.......2	If no, Go to Q 11f
11e	If yes, please describe		
11f	Was there any delay in initiating treatment	Yes.......1 No.......2 Don't know.......3 Not applicable.......4	Go to Q 12
11g	If yes, please describe		
12	Was the deceased woman referred – from the place of delivery in case of institutional delivery	Yes.......1 No.......2 Not known.......3	
13	In case of home delivery, was the deceased woman referred from first point of seeking care for complication?	Yes.......1 No.......2 Not known.......3	
14	Did she attend the referral centre?	Yes.......1 No.......2 Not known.......3	Also fill table 2 given below for information on referrals

15	In case of not seeking care from the hospital, what were the reasons for not seeking care		
	s) Severity of complication not known..1	t) Health facility was very far..2	
	u) Lack of transport..............................3	v) Financial reasons..............4	
	w) Family reasons..................................5	x) Faith in local healers / dai...6	
	y) Beliefs and customs.......................7	z) Disrespectful behaviour of the providers..............8	
	aa) Others (Specify________________________)....................9		
16	Any information given to the relatives about the nature of complication from the hospital	Yes...1 No..2	If no, Go to Q.18
17	If yes, please describe		
18	Was there any delay in initiating treatment	Yes...1 No..2 Don't know..............................3 Not Applicable.......................4	Go to Sec XI
19	If yes, please describe		
	If the death happened after delivery of placenta then fill section X also- as it would be classified as death during post natal period		
X	**POST NATAL PERIOD**		
1	Did the deceased woman (name) have any problem following delivery	Yes...1 No..2 Don't know..............................3	Go to Q 10
2a	Date and time of onset of the problem	Date – DD __/MM___ / YYYY___ Time __ __:__ __ _ _	
2b	Duration of onset of problem after delivery	______________hrs ______________days	

3	What was the problem during post natal period?		
	a) Severe bleeding……………………1	b) High fever and foul smelling discharge…………………………2	
	c) Unconsciousness/ visual disturbance……………………………3	d) Bleeding from multiple sites ……………………………………4	
	e) Severe leg pain, swelling ………5	f) Abnormal behaviour…………6	
	g) Severe anemia……………………7	h) Sudden chest pain & collapse…………………………………8	
	i) Don't know…………………………9	j) Others (Specify____________)……..10	
4	Did she seek treatment	Yes……………………………………………1 No………………………………………………2	If yes, also fill table 2 If no Go to Q No. 7
5	If yes, where did she seek treatment		
	a) SHC……………………………………1	b) PHC…………………………………2	
	c) CHC……………………………………3	d) DH……………………………………4	
	e) Private hospital/clinic…………5	f) Quack…………………………………6	
	g) Don't know…………………………7	h) Others (Specify_____________)……8	
6a	What was the treatment provided at the health facility?	a) Received IV drip………………1 b) Blood transfusion………………2 c) Oxygen was given………………3 d) Don't know…………………………4 e) Others (specify___________)……..5	
6b	See the hospital records if available and fill details of treatment received.		
7	Was she referred?	Yes……………………………………………1 No………………………………………………2	If no, Go to Q.10
8	Did she attend the referral center?	Yes……………………………………………1 No………………………………………………2	If yes, also fill table 2
9	In case of not seeking care from the hospital, what were the reasons for not seeking care		
	a) Severity of complication not known…………………………………………1	b) Health facility was very far……………………………………2	
	c) Lack of transport…………………………3	d) Financial reasons…………4	
	e) Family reasons…………………………5	f) Faith in local healers / dai…………………………………………6	
	g) Beliefs and customs………………7	h) Disrespectful behaviour of the providers……………8	
	i) Others (Specify______________________________)…………………9		

10	Did she receive any postnatal check ups	Yes……………………………………1 No……………………………………2	If no, *end of the questionnaire*
11	No. of post natal check ups received	______________________	
12	Who did the post natal check ups		
	a) Doctor………………………………1	b) ANM…………………………………2	
	c) ASHA………………………………3	d) Dai……………………………………4	
	e) Quack………………………………5	f) Don't know……………………………6 g) Others (Specify-----) ………7	

Please fill the table below for the details on transport, referral and type of care given				
Table 2				
Place	**Home/ Village**	**Facility 1**	**Facility 2**	**Facility 3**
Date (DD/MM/YY)				
Time of onset of complication or onset of labour				
Time of calling/ arrival of transport				
Transport used				
Name of Facility/ Level of referral		**Facility 1**	**Facility 2**	**Facility 3**
Time to reach				
Money spent on transport				
Reason for referral				
Referral slip (given or not)				
Treatment given				
Money spent on treatment/ medicine/ diagnostics				
Time spent in facility				

XI. Open history (Narrative format) (explore)

XII. According to you, what could have been done to prevent the death of the deceased mother?

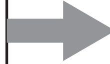
Form 6

MDR Case Summary

<table>
<tr><td>Name of the Block/PHC/District OR/Name of facility</td><td colspan="6"></td></tr>
<tr><td>Particulars of the Deceased Woman</td><td colspan="2">MCTS ID ______________</td><td colspan="2">Name ________________
Age:</td><td>Religion:</td><td>Caste:</td></tr>
<tr><td>Address (when death occurred)</td><td colspan="4">Place of Residence:</td><td colspan="2">Native Place:</td></tr>
<tr><td>Place of Death</td><td colspan="6"></td></tr>
<tr><td>Date and Time of death</td><td colspan="6">D D / M M / Y Y Y Y At H H : M M AM/PM</td></tr>
<tr><td>Timing of Death</td><td>Pregnancy</td><td>During or within 6 weeks of abortion</td><td colspan="2">In labour or during Delivery</td><td>Within 1 week after delivery</td><td>7- 42 days after Delivery</td></tr>
<tr><td rowspan="2">Obstetric History</td><td rowspan="2">Gravida</td><td rowspan="2">Para</td><td colspan="2">Previous Abortions</td><td>Infant outcome</td><td>Number of alive children</td></tr>
<tr><td>Spontaneous</td><td>Induced</td><td></td><td></td></tr>
<tr><td>Investigation</td><td>Date of interview</td><td>Date of Interview-2 (if second visit made)</td><td colspan="4">Name and contact details of main respondents:</td></tr>
</table>

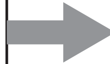
1. Delay in seeking care

- Unawareness of danger signs
- Illiteracy & Ignorance
- Delay in decision making
- No birth preparedness
- Beliefs and customs
- Lack of assured services
- Unawareness about services available in nearby facility
- Any other, specify__________



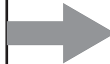
2. Delay in reaching health facility

- Delay in getting transport for first facility
- Delay in mobilizing funds
- Not reaching appropriate/ referral facility in time
- Difficult terrain
- Any other, specify__________



3. Delay in receiving adequate care in facility

- Delay in initiating treatment
- Substandard treatment in hospital
- Lack of blood, equipments and drugs
- Lack of adequate funds
- Any other, specify__________



Probable direct obstetric cause of death: ____________________

____

____

Indirect obstetric cause of death: ____________________

____

____

Contributory causes of death: ____________________

____

____

Initiatives suggested: ____________________

____

Name and designation of investigation team:

1. Name:____________________ Designation: ____________________

2. Name:____________________ Designation: ____________________

3. Name:____________________ Designation: ____________________

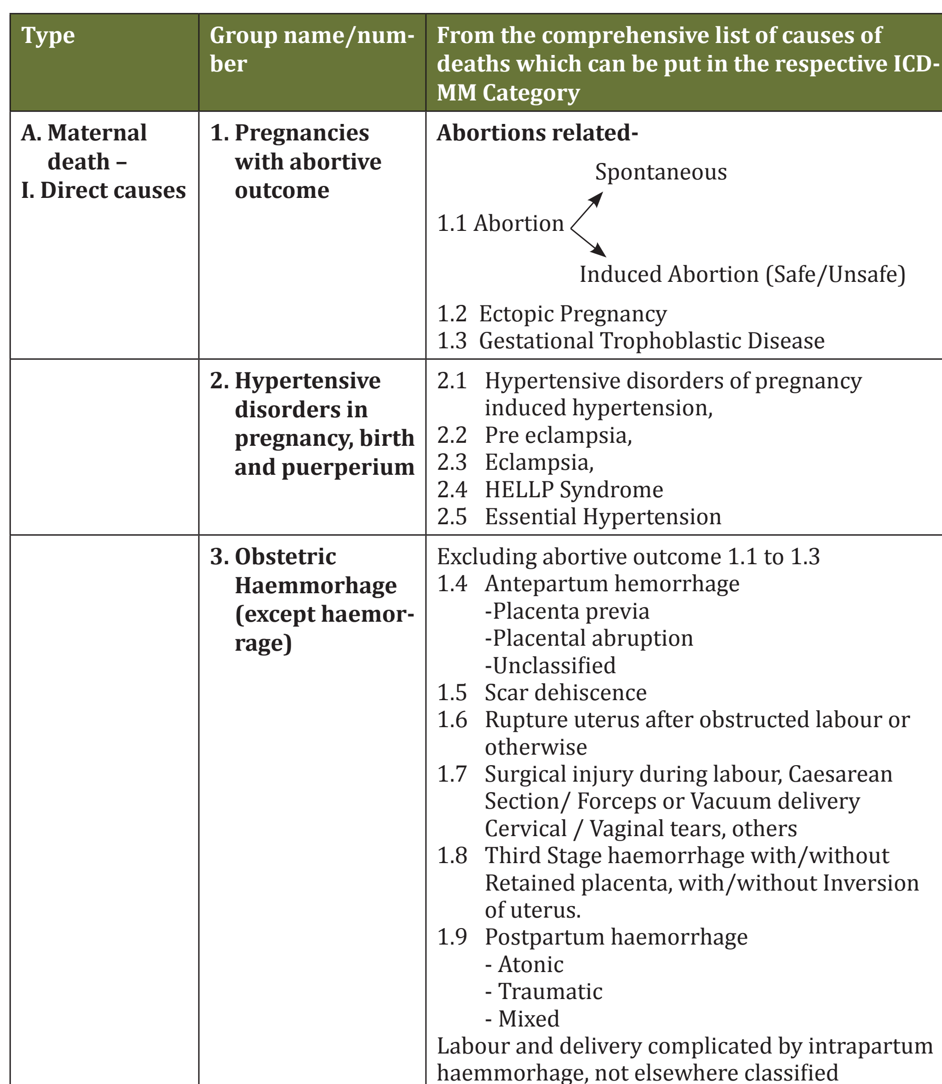
Signatures and Name of Block Medical Officer/Facility Nodal Officer (with stamp)

ANNEXURE II

The Who Application of ICD-10 to Deaths During Pregnancy, Childbirth and the Puerperium: ICD-MM

For Filling in MDR Tool ICD-MM

Groups of underlying causes of death during pregnancy, childbirth and the puerperium in mutually exclusive, totally inclusive groups.



Type	Group name/number	From the comprehensive list of causes of deaths which can be put in the respective ICD-MM Category
A. Maternal death – I. Direct causes	**1. Pregnancies with abortive outcome**	**Abortions related-** 1.1 Abortion → Spontaneous / Induced Abortion (Safe/Unsafe) 1.2 Ectopic Pregnancy 1.3 Gestational Trophoblastic Disease
	2. Hypertensive disorders in pregnancy, birth and puerperium	2.1 Hypertensive disorders of pregnancy induced hypertension, 2.2 Pre eclampsia, 2.3 Eclampsia, 2.4 HELLP Syndrome 2.5 Essential Hypertension
	3. Obstetric Haemmorhage (except haemorrage)	Excluding abortive outcome 1.1 to 1.3 1.4 Antepartum hemorrhage -Placenta previa -Placental abruption -Unclassified 1.5 Scar dehiscence 1.6 Rupture uterus after obstructed labour or otherwise 1.7 Surgical injury during labour, Caesarean Section/ Forceps or Vacuum delivery Cervical / Vaginal tears, others 1.8 Third Stage haemorrhage with/without Retained placenta, with/without Inversion of uterus. 1.9 Postpartum haemorrhage - Atonic - Traumatic - Mixed Labour and delivery complicated by intrapartum haemorrhage, not elsewhere classified

Type	Group name/number	From the comprehensive list of causes of deaths which can be put in the respective ICD-MM Category
	4. Pregnancy related infection	3.1 Excluding abortive outcome 3.2 Chorioamnionitis without or with obstructed labour / prolonged labour 3.3 Puerperal sepsis 3.4 Post surgical procedures (E.g. evacuation, Cesarean section, laparotomy, manual removal of placenta , others) Infections of genito urinary tract Infection of obstetric surgical wound following delivery Infections of breast associated with child birth Pyrexia of unknown origin following delivery 3.5 Others like breast abscess 3.6 Unknown
	5. Other Obstetric complications	4.1 Amniotic Fluid Embolism 4.2 Uterine Inversion 4.3 Hepatorenal failure due to vomiting during pregnancy 4.4 Unexplained
	6. Unanticipated complications of management	**Unanticipated complications of management**
A . Maternal death **II. Indirect causes**	**7. Non obstetric complications**	**1. Anaemia** 1.1 Iron/Folic Acid Deficiency 1.2 Sickle cell Disease 1.3 Thallasemia 1.4 Aplastic Anaemia **2. Cardiac disorders** 2.1 Cardiomyopathy (antepartum, peripartum postpartum) 2.2 Rheumatic heart disease 2.3 Congenital heart disease 2.4 Aortic aneurysm 2.5 Myocardial infarction 2.6 Others **3. Liver Disorders** 3.1 Acute fatty liver of pregnancy 3.2 Acute hepatic failure 3.3 Cirrhosis of liver with portal hypertension 3.4 Infective hepatitis (A,B,C,E) 3.5 Others **4. Respiratory Disorders** 4.1 Tuberculosis 4.2 Pneumonia 4.3 Asthma 4.4 Adult respiratory distress syndrome 4.5 Pulmonary embolism

Type	Group name/number	From the comprehensive list of causes of deaths which can be put in the respective ICD-MM Category
		5. Renal disorders 5.1 Acute renal failure 5.2 Nephritis 5.3 Medico renal disease e.g chronic/acute renal failure 5.4 Renal artery stenosis 5.5 Collagen disorder 5.6 Transplant complications **6. Endocrinal Disorders** 6.1 **Diabetes** Gestational diabetes mellitus Diabetes mellitus 6.2 **Thyroid Disorder** Thyrotoxicosis **6.3 Pheochromocytoma** **7. Neurological Disorders** 7.1 Epilepsy 7.2 Cortical vein thrombosis 7.3 Cerebral embolism (stroke) 7.4 Meningitis 7.5 Enhephalitis **8. Infections/ Infestations** 8.1 Malaria 8.2 Dengue 8.3 H1N1 viral Disease 8.4 HIV/AIDS 8.5 Scrub typhus 8.6 Other
A. Maternal death **III. Unspecified**	**8. Unknown causes-**	**8. Maternal death during** Pregnancy, childbirth and the puerperium where the underlying cause is unknown or was not determined.
B. Death during pregnancy, child birth and puerperium	**9. Coincidental /Incidental causes**	**B Death during pregnancy, child birth and the puerperium due to external causes**