

ACTION PLAN OF CHILD DEATH AUDIT

One of the prime objectives of NRHM is to reduce the Infant Mortality Rate (IMR). Various attempts are being made to reduce Infant Mortality by improving quality of child health care delivery through strengthening of Facility Based Newborn Care Units, introduction of Home Based Newborn Care Programme and stepping up monitoring.

However, it has been felt that prompt reporting and review of child deaths (0-59 months) can provide insight into:

- Identify the bottlenecks in delivery of maternal and child health services by investigating and recording the sequence of events leading to child deaths and drawing inferences from the data generated locally.
- Analysis would guide the programme managers at all levels to recognise the key gap areas for service delivery and institute corrective measures.
- Data on causes of neonatal and child deaths are also useful for health planners, administrators, and medical professionals to evaluate trends in causes of mortality over time and thus assess the impact of the on-going health programmes and to make a decision on allocation of resources for different strategies to prevent and manage neonatal and childhood illnesses.

Key Steps in Child Death Review

- All deaths among children in the age group 0-59 months will be reviewed and reported irrespective of the place it takes place: at home, in health facility or in transit.
- The review processes will remain the same for all children; however the details to be investigated will vary in neonates (0-28 days) and children (29 days-59 months).
- Child Death Review will be undertaken at two levels:
 - Community level
 - Facility level

COMMUNITY BASED CHILD DEATH REVIEW

Step 1: Notification of child death

1. Done by ASHA/ AWW/ ANM/ Link worker/Panchayat member. They will visit the family of the deceased child and fill the **Notification Card** in duplicate, one copy of the notification card will be submitted for record to be maintained in the Sub centre and the other handed over to the family to be shown to persons of health department if anyone asks. The Block Medical Officer should be informed of the death within 24 hours through SMS (where such facility is available). If the SMS facilities are not yet established in the state or district, informant will post the message in a standard format printed on an inland letter.
2. Block Medical Officer (BMO) will maintain line-listing of all deaths in his/her area. The line list will be transmitted to the District Nodal Officer (MOH) at the end of

each month. BMO will also inform concerned ANM to further investigate the death, using a structured format.

3. Incentives: Where ASHA is the primary informant, she may be given Rs. 50/- per child death reported.

Step 2: Investigation of death

1. First Brief Investigation:

- a) Will be conducted for **all** child deaths by the **ANM** of the area, by interviewing parents/ close caregiver of the deceased, who were present at the time of death. **First Brief Investigation Form in Annexure 2** should be filled. ANM may be paid incentive of Rs. 100/- per child death investigation carried out by her. FBI should be done and report submitted to Block Medical Officer within one month after notification of the death. These should be kept on record at the office of the Block Medical Officer. Reports should be compiled monthly and sent to **District Nodal Officer (MOH)**.
- b) **District Nodal Officer (MOH)** is the person designated by the State as the overall 'in charge' for the planning and implementation of the Child Death Review process in the district.
- c) Detailed investigation is undertaken by performing a **Verbal Autopsy** (an investigation of train of events, circumstances, symptoms and signs of illness leading to death through an interview of the relatives or associates of the deceased) and **Social autopsy** (identifying social, behavioural, and health systems contributors to neonatal and child deaths). It should be completed within 1-2 months of the death.
- d) The investigating team should comprise of at least 2 persons: one from medical (PHC Medical Officer, Public Health Nurse, LHV, Staff Nurse or Nursing Tutor) and other from non-medical background (Block Supervisor, LHV, ASHA Facilitator, NGO facilitator or any other person).
- e) A minimum sum of Rs. 250/- will be given to each member of the team for each death investigated. In addition Rs.100/- may be provided to cover the cost of travel to the household and back.
- f) Maintenance of records: One copy of the Verbal Autopsy Format of all child deaths investigated in the block will be kept on record at the office of the Block Medical Officer. The original format will be sent to District Nodal Officer within one week of receiving the report.

Step 3: Data transmission and analysis

1. BMO will compile reports and send to District Nodal officer every month.
2. District Nodal Officer will forward the compiled report from all the health facility of the district to the State Nodal Officer each month in **Format Two**
3. The deaths reported from district /states through the Child Death Review must also be reported in the HMIS, starting right from the Subcentre level.
4. The State Nodal Officer will compile reports from all districts for onward transmission to the national programme managers **every two months**.

Step 4: Feedback for improved planning and institution of corrective measures

- Same as facility based child death review

FACILITY-BASED CHILD DEATH REVIEW

Step 1: Notification of child deaths

For all deaths occurring in the hospital, Medical Officer/Specialist on duty at the time of death should fill in the Notification Card and send it to the office of the Facility Nodal Officer (FNO) within 24 hours of death. The office of the FNO (MS/ Principal/ SMO incharge) should inform the child death to the District Nodal Officer (MOH) within 48 hours of the occurrence of death.

Step 2: Investigation

The Facility Based Child Death Review (FBCDR) Form should be filled for each child death by the Duty Medical Officer with details of the medical cause of death and add any other information that s/he has regarding the social factors and delays associated with the death. Medical cause of death is to be ascertained based on SRS coding for causes of death and recorded in the Death Certificate. The completed form should be submitted to the Facility Nodal Officer within one week of the occurrence of death in duplicate. One copy of the form will be sent to the MOH within one month of death and the second copy retained in the hospital for records. All children treated, and died, in departments other than the Paediatrics department, must also be reported and investigated.

Step 3: Data Flow & Analysis

The office of the FNO will prepare a line list of all child deaths (0-59 months) that have taken place at the hospital and get data entered using pre-coded *Facility Based Child Death Review* format during the month and information will also be electronically transmitted to the District Nodal Officer for information and compilation in the Format Three. These reports will also be compiled and analysed at the district level and key findings and recommendations included in the report to be presented to District Child Death Review Committee, from now onwards FBMDR committee will also functional as FBCDR committee with additional members from Pediatrics.

Step 4: Feedback for improved planning and instituting corrective measures

The reports from First Brief Investigation reports and the Detailed Investigation should be reviewed at the block and district level and definite actions to address the delays and causes of death should be identified. The analysis of causes of death will facilitate fine-tuning of programmes locally in the district. An Annual Child Death report should be prepared and disseminated to all stakeholders. It should also be used for the purpose of formulating Annual State and District programme Implementation plans.

DISTRICT CHILD DEATH REVIEW COMMITTEE

The Maternal and CDR Committee should be assigned the responsibility of reviewing Child Death Reports, plus additional members are suggested:

1. District Magistrate/District Collector (Chairperson)
2. Chief Medical Officer (Member Secretary)
3. District Nodal Officer (for Child Death Review)
4. Paediatrician/ MD Paediatrics degree holder from the district, one or two in number
5. District Project Officer for ICDS
6. Representative/s from recognised professional bodies (Indian Academy of Paediatrics, National Neonatology Forum, IAPSM)
7. Expert from medical college/development agency (if present/located in the district)
8. Any other official or person deemed important for providing a specific technical input (at the discretion of the Chairperson)

The Child Death Review meeting should be conducted simultaneously with the Maternal Death Review, every month, with the purpose of reviewing the causes and trend of child deaths in the district.

State Level Taskforce: A single **State Level Taskforce** will be constituted for review of both maternal and child deaths. The meeting of the taskforce is to be convened every 6 months.

Members

1. Principal Secretary Health & Family Welfare
2. Mission Director
3. Commissioner Health
4. Director General of Health Services
5. Deputy Director/ Director Child Health under NRHM
6. State Nodal Officer, Child Death Review
7. Paediatricians and Public Health Experts from State Govt. and Private Medical Colleges (Maximum 3)
8. Obstetric Specialists from State Govt. and Private Medical Colleges (Maximum 1)
9. State ICDS Officer
10. Deputy Director/ Director Nursing
11. Deputy Director/ Director MSD (materials/ supplies and disposables)
12. Any other expert, official , person deemed important for discussion on a particular issue (at the discretion of the Chairperson)

The implementation of the Child Death Review requires that a nodal person is identified at Block, District and State to support and monitor the processes, ensure quality of data collected and compiled and transmit data to the next level. One key person /Nodal officer should be designated at each level.

Block Nodal Officer

The Block Medical Officer or the Block Programme Manager can be designated as the Block Nodal Officer (BNO) for the Child Death Review by the official order issued by the District CMO. The BNO will be responsible for the CDR process at the block, and will also act as a supervisor for the teams for carrying out the verbal autopsy.

Roles and Responsibilities

1. Maintain line-list all child deaths in the block
2. Select cases for detailed investigation; delegate teams for conduct of Verbal Autopsy; ensure the timely reception of all formats (facility and community based death review) every month.
3. Assign the medical cause/s of death with local assistance.
4. Ensure quality of data and timely reporting to the district
5. Transmit data to district in the agreed time frame and formats/s.
6. Participate in the meetings of the District Child Death Review Committee and present the block report (when asked to do so) ; follow up of the recommendations specific to the block

Facility Nodal Officer (FNO) /Medical Superintendent of the hospital

1. Inform the District Nodal Officer and State Nodal Officer on the occurrence of child death in the hospital within one week of occurrence of death.
2. Notify all deaths in the facility to the District Nodal Officer and maintain line list of facility based child deaths
3. Review the FBCDR format and approve it for onward transmission;
4. Prepare Facility Based Child Death Review Report every quarter;
5. Participate in the meetings of the District Child Death Review Committee; follow up on specific recommendation pertaining to specific health facility or those under his/her jurisdiction

District Nodal Officer (DNO) / District MOH Officer is the District Nodal Officer

1. Maintain line list of facility based deaths and community based deaths in the district; facilitate the data entry and analysis of the CBCDR and FBCDR at the district level
2. Prepare the District Child Death Review Report for presentation in the meeting of the District Child Death Review Committee Meetings
3. Timely transmission of information from all blocks and the district to state level; overall responsibility for quality of CDR undertaken in the district
4. Organize the quarterly District Child Death Review Committee Meetings under directions of the Chief Medical Officer, maintain minutes of meetings ; follow up action to be taken ; prepare Action Taken Report
5. Participate in the meetings of the State Level Taskforce; follow up of any recommendation/s specific to the district
6. Share the district and state child death review reports with the key stakeholders and the communities to create awareness and initiate action at village level

Trainings

Trainings will be imparted to various personnel involved in the process. These include:

1. ASHA/Primary Informant
2. ANM
3. Block Nodal Officer
4. Investigation Teams for Verbal Autopsy
5. District Nodal Officer
6. State Nodal Officer
7. Block , District and State Data Managers (and /or Data Entry Operators)

Selected institution/s /agency/ies will conduct trainings at the state level for the following personnel:

- Orientation of the Primary Informants
- Training of ANMs for conducting first brief investigation, reporting and record keeping
- Training of Data Managers (Block, District and State) on compilation of information in standard formats, maintaining data base and transmission of information to the next level. (Three days training at District / State level)
- Training of Block and District Nodal Officers on review of brief and detailed investigation formats, assigning medical causes of death and identifying socio-cultural and systemic factors, reporting, checking the quality of data, preparing reports (for districts/state), use of data and reports for feedback and corrective measures. (Three days training at District/State level)
- Training of investigation teams/investigators: Orientation on the Verbal Autopsy formats, processes and guidelines (Three days training at District level).
- Training of Medical Officers on assigning causes of death based on SRS: At least two medical officers should be trained in each district for assigning the "Most Probable Causes of Death" using the SRS coding for the based on Verbal Autopsy.
- Training of Facility Nodal Officers and Specialists (Paediatric and others dealing with children): Orientation on the FBCDR formats, processes and guidelines, data analysis and interpretation, use of data to improve services at the facility (Two days training at District/State level)

These trainings will be imparted by the organisation with expertise in the field. Trainings will be skill based and each trainee will be required to achieve a satisfactory level of proficiency.

In order to plan the roll out of CDR, each state should work out the district wise training load of various personnel. At least two –three teams per block should be available to conduct investigation for 10 deaths each month. The training load of the investigators will however vary from state to state. Some states having low child mortality will need fewer teams and the planning process should take this into account.

Trainings should be budgeted under IDR/CDR under the NRHM/CH component.

Monitoring

The BMO will ensure timely reporting and investigation through regular feedback to the ANMs and investigating team. S/he will be responsible for scrutiny of the filled up formats and provide handholding support to the block investigation team to improve quality of investigation. The BMO as a supervisor of the block team will also participate in the field level investigation himself/herself, as the time permits.

The District Nodal Officer and the Chief Medical Officer (as Secretary of the District Child Review Committee) will monitor the process and provide feedback to the blocks regarding the quality of data as well as the analysis. S/he will also give feedback on the quality of investigation through scrutiny of filled up formats to FNO. The DNO and CMO will also inform and follow up with the blocks/ health facilities on implementation of specific response plan/s.

The State Nodal Officer will monitor the information received from various districts and accordingly provide feedback to districts regarding the completeness of reporting, timeliness and quality of investigation, regularity of review meetings and development of response plans.

In addition to the designated nodal officers, agencies located at block/district /state level can also be assigned the task of monitoring the Child Death Review. Medical Colleges (Departments of Paediatrics and Community Medicine) can also be brought in for this purpose. The objective is to provide support through experts for streamlining of the process, enhancing the quality of reports generated from the data and implementing the key recommendations made by the District Committee and the State Level Taskforce.

Process indicators

1. Child deaths reported / estimated number of child deaths (District-wise)
2. Detailed Child Death Investigation (Verbal Autopsy) Formats submitted / child deaths selected for detailed investigation (Data to be computed district wise)
3. Proportion of child deaths investigated (denominator: All child deaths taking place in public health facilities) (Data to be computed district wise)
4. No. of districts conducting meetings of the District Child Death Review Committee as per plan
5. No. of State Level taskforce Meetings held / numbers planned