Government of West Bengal
Department of Health & Family Welfare
Swasthya Bhawan
GN-29, Sector-V, Salt Lake, Kolkata – 700 091

No.177(4)-Secy(HFW)/2022 Date :19/07/2022

From : Secretary
Health & Family Welfare Department

To : 1. The Commissioner, KMC
2. The District Magistrate (All Districts)
3. The Chief Medical Officer of Health (All districts)
4. SFWO, Health & FW Deptt.

Sir/Madam,

1.0 Preventing occurrence of maternal death and ensuring proper healthcare of new born by ensuring proper early childhood care, a multi-pronged approach is essential. The Order of the Chief Secretary vide No 3209-SW/O/3S-69/19 (Part II) dated 27.6.2022 (copy enclosed as Annexure A) elaborates upon the need for the convergence between the Frontline workers of H& FW Department and that of the WCD & SW Department. It is essential that convergence at three levels i.e.

- Structural Convergence: Synchronized catchment areas and tagging of AWC with Sub Centres in a hub and spoke formation as well as joint review by CHO, ANM, ASHA and AWW.
- Data and Reporting Convergence: On the basis of real time data collected in Annual Household Survey the Supushti mobile app and Marima Portal will be the digital platform with common linked cohort tracking facilities.
- Activity Convergence: Identification of at-risk pregnant women and malnourished children as "Red Cohort" and review by the core team at least once in a month and identification of action points such as further investigations, counselling, closer follow up, referrals etc. The HWC team- including the Community Health Officer (CHO), 1st & 2nd ANMs, ASHAs and all AWWs within a (HWC) / SC area will participate in the meeting, under the leadership of the CHO. Supervisors can also participate and provide their inputs. The meeting will be convened by CHO every third Saturday of the month at the Health & Wellness Centre.

2.0 Details of the deliberations to be undertaken during the monthly meetings between Health & ICDS team at HWC and the protocol for identification of high-risk beneficiaries and for management and follow up is enclosed as Annexure B.

i. Data exchange & tracking, for identifying and reviewing list of high-risk beneficiaries (those in red or yellow category).

ii. Formulating Action plans/Management plans for the high-risk beneficiaries.

iii. Identification of drop out by the beneficiary- the action will be to Follow-up and mobilization to bring them back into the system. If they have shifted to some other location in the state, it will have to be ensured that the beneficiary is located and service provided at the new place.

iv. For those beneficiaries who develop complications (including growth failure and faltering) /are at higher risk of developing complications- e.g., cut off blood pressure level to diagnose pregnancy induced hypertension or cut-off Hb level to diagnose anaemia in pregnancy or cut-off weight to diagnose underweight.

v. Fixing roles & responsibilities for actions among the HWC & AWC team members for providing care to the high-risk beneficiaries - As a general rule but not restricted to, actions related to mobilization, service utilization, behaviour change for RMNCHA household level practices etc will be responsibility for ASHAs; those related to nutrition, growth monitoring, supplementary nutrition, IYCF etc will be responsibility of AWWs and those related to service delivery from the SC/HWC and data entry in software will be responsibility of ANMs & CHO.

vi. Documentation of the meeting and updating list of high-risk beneficiaries in portal - Preparation of updated list of high risks (Red & Yellow categories) which will be uploaded in the Matrimaa portal after the meeting. Document improvement or lack of improvement in the condition of each of the beneficiaries and determining whether each of them is now eligible to be moved out of the Red /yellow Cohort.

vii. Roles and responsibilities of each category of FLW viz. CHO, ANM, ASHA and AWW are provided as Annexure -C.

3.0 You are requested to ensure that the instructions in the Order of Chief Secretary are followed and the action taken are reviewed at your level regularly. In addition to these, from the point of view of Health & Family Welfare, proper Care at the institution level is essential in ensuring safe and complication free childbirth is of critical importance not only in preventing maternal death and healthy new-born. In order to ensure the same, following points are suggested for your regular monitoring and review.

i. Operationalisation of 'C' Section audit and corrective & preventive actions for ensuring that 'C' Sections are undertaken judiciously in those cases having robust clinical indications.

ii. Reduction in surgical site infection rate in the Maternity OT. Proper Biomedical Waste Management to be ensured. All labour rooms and Maternity OTs should take microbiological samples from defined areas every month.

iii. Real-time Partograph generation including shift to electronic partograph & usage of safe birth check-list & surgical safety check-list.

iv. Presence of Birth companion during delivery, respectful maternity care and enhancement of patients' satisfaction.

v. Assessment, Triage and timely management of complications including strengthening of referral protocols.

vi. Management of Labour as per protocols including AMTSL & rational use of Oxytocin.

vii. Essential and emergency care of new-born & Pre-term babies including management of birth asphyxia and timely initiation of breast feeding as well as KMC for preterm new-born.

viii. Review of Maternal Death:

a) The place of origin (district, block etc) of the mothers dying at Medical Colleges particularly in Kolkata should be identified in all cases.

b) Districts must also focus on improving reporting from private tertiary level institutions with the help of regulatory mechanisms such as the Clinical Establishment Act. In 2021-22 about 88 per cent of reported maternal death occurred at institutions, 4 per cent deaths occur at home and 8 per cent during transit.

c) It is observed that 81 per cent maternal deaths have been reviewed at the end of CMOH and 9 per cent by the District Magistrates.

d) The district and block teams should monitor the number of deaths occurring during transit and the mechanism for reporting of deaths occurring during transits (both for private and government vehicles).

e) The referral mechanism should be strengthened to ensure that referral requiring long transit are avoided to the extent possible, and referral is done only after the bed at destination hospital is ensured.

f) Review of each and every maternal death should be done at 3 levels as mentioned below with the level of analysis as mentioned.

A. Block – When a death is reported, review has to be done to identify the factors responsible with a focus on the three delays in a mother receiving care for a complication. (A) First delay - decision making process, not recognizing or understanding the danger signs, using traditional home care or informal service providers. Low education and poverty could aggravate this. B) Second Delay – lack of transport, poor roads, long commute to the nearest health facility, or delay in organizing funds if they have to pay for it. (C) Third Delay – lack of medicines, blood, consumables, skilled manpower, etc. and arriving at the cause of death and contributory factors that have played a role in that particular case, the reports are sent to district level. In the monthly meeting of the block, the analysis/ discussion on the death focus on gaps at the level of Family/ Community, ASHA, ANM, transport/referral, availability of services and possibly the care given at institutional level. The common problems that can happen at Family/ Community involves late detection of danger signs, not choosing appropriate facility for treatment, which contributes largely by way of no ANC or poor-quality ANC etc. Gaps at ASHA/ANM level involves birth preparedness, conveying health schemes, services and benefits available at public institutions.

B. Institution – since a health professional has taken care of the mother an analysis into the detailed clinical causes and gaps in providing appropriate care after the mother has reached health institution is possible. Though delay 1 and delay 2 can be one of the contributory factors leading to death of mother, the institutional review prioritizes in identifying delay 3. It is also possible that gaps exist at the time of initiation of treatment or the line of management adopted for care of mother. Data flow from private sector can be ensured only if some form of registration & regulation system for private hospitals are in place (e.g., Clinical Establishments Act).

C. District – at the district level, both reviews one under the chairmanship of CMOH as well as review by the District Collector is crucial. The review by the CMOH should focus on the technical issues and the action points relating to all healthcare providers / community structures. At the district level, comparison of functionality across various blocks is available for analysis. If an issue is common across many blocks, probably the action is required at district level. This review should undertake a case wise analysis focusing on detailed narration with an objective to arrive at action points for the district. The review by the District Magistrate should prioritize action on social determinants of health where mandate is not limited to health department and where interdepartmental coordination is required. Resources to be mobilized for effecting reforms in the district and any policy recommendation for the State would be essential in the report generated by the district. The DM should also review whether the action points identified in the previous meetings have been complied with by the appropriate authorities/ person responsible.

4.0 Action Points:

1. Review the implementation of Order of Chief Secretary regarding convergence between FLWs of H & FW and W & CD and SW departments.
2. Identification of high-risk mothers including those "always red" having pregnancy induced hypertension, gestational diabetes, post-caesarean section, teenage pregnancy etc and follow up on action taken. Area wise concentration as well as individual line-list are available in the Matri-Maa portal.
3. Monitoring of the performance of hospitals and medical colleges in terms of performance parameters given in Annexure D.

You are requested to accord a priority to the above referred suggestions and ensure proper implementation of primary health care initiative in your district.

Yours faithfully,

19/7/2021

Secretary
Health & Family Welfare Department