Study on "Data Quality of Social Audit of Maternal Deaths and Analysis of the Cause of Delays in Obstetric Care by Applying the Theory of Three Delay Model"

IIHMR UNIVERSITY

unicef

BACKGROUND

A *'three delays'* model identifies the cause at which delays can occur in obstetric care. A detailed analysis of these delays can help health personals design a Programme to reduce maternal mortality. The first delay occurs when a woman, or her family avoid seeking care which may be because of social obstacles, low perceived susceptibility, low perceived benefit, low perceived severity or affordability of care. The second delay occurs when she cannot reach appropriate care in time because of inadequate transportation mode or elusive routes to health facility. The third delay is delay in receiving care at health facilities. This involves factors within the health facility, including organization, quality of care, and availability of staff and equipment. Unless all three delays are addressed, no safe motherhood Programme can turn out as planned.

WHAT IS SOCIAL AUDIT ?

Government of Rajasthan has introduced social audit of maternal deaths for deaths happening at community level since 2014 September. A team of health professionals (that includes medical officer, a nurse, ASHA/ANM/AHW) visit the community and take history of the maternal death case to deduce the cause of maternal death. Apart from this they also conduct group discussions where all pregnant women, their husbands, mother in laws and panchayat head are involved. They are counselled for safe motherhood and also a discussion is carried out where the reasons of maternal deaths are put forward. The possible ways to prevent these deaths are discussed e.g. if a woman died be cue of non – availability of transport , then the group discussion carried by social audit team helps the community to figure out that if in future such an event occurs then who shall bethe one to carry the patient to health facility by his conveyance.

METHODOLOGY

STUDY SETTING

Every year Rajasthan has ANC and we encounter maternal deaths per year.

Review of 90 maternal deaths over the period of 4 months (September 2014 to December 2014) in 33 districts of Rajasthan is done.

REVIEW TOOL & DATA COLLECTION

Secondary data from social audit of maternal deaths as given by Department of National Health Mission was taken.

DATA ANALYSIS

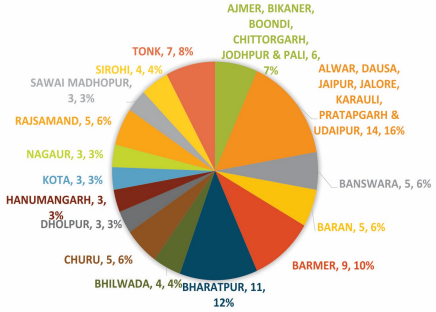
First the data was checked for completeness and consistency, then after cleaning the data coding was done. It was categorized into major causes of delay after which it was analyzed using appropriate statistical methods in Microsoft excel.

RECOMMENDATIONS

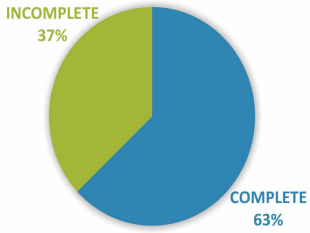
1. Early registration of pregnancy shall be encouraged
2. Education for the benefits of institutional deliveries to all
3. ASHA & ANM should help in registration of pregnancy and encourage ANC visits during pregnancy, moreover a vigilance over their productivity should be there.
4. Well-equipped ambulatory services for referred cases should be there
5. Timely decision making for referrals to higher centers.
6. Training for handling emergency obstetric services to all health professionals at all levels of healthcare.

RESULTS : Total maternal deaths recorded during 4 months (September 2014 to December 2014) are 90. The data describes the summary of deaths for many cases. Summary of 54 entries abide by the three delays that occur during obstetric care.

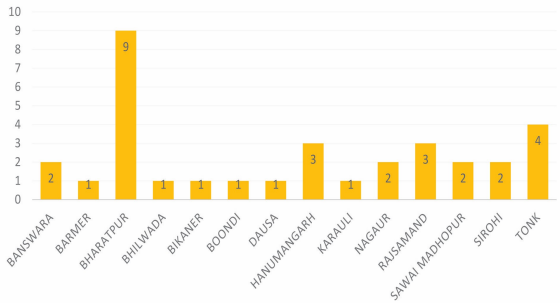
DISTRICT WISE DISTRIBUTION



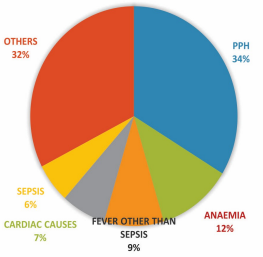
COMPLETENESS OF DATA



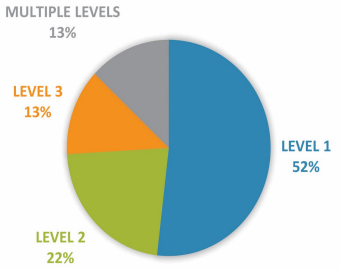
DISTRIBUTION OF INCOMPLETE DATA DISTRICT WISE



CAUSES OF DEATH



LEVELS OF DELAY



Presented By : *Dr. Shruti Kohli*