Ministry of Health – Sri Lanka

National Guidelines
Feto-Infant & Child Death Surveillance & Response

Sri Lanka has significantly reduced maternal, fetal and child mortality to lower levels on par with developed countries. A larger proportion of infant deaths are concentrated in the early neonatal period and a significant number of under – 5 year deaths are also reported. In such a context, feto-infant and under 5 year child deaths surveillance plays a crucial role in further improving maternal and child health service delivery and also reduction of fetal, infant and under – 5 year child mortality. It also contributes to the availability of solid data on feto-infant and child mortality.

Surveillance of feto-infant and child deaths involves the ongoing, systematic collection, analysis, and interpretation of data related to feto-infant and child deaths, essential to the planning, implementation and evaluation of public health practice, closely integrated with the dissemination of these data to those who need to know and linked to prevention and control of such deaths. Ministry of Health has introduced a feto-infant mortality surveillance mechanism, with Family Health Bureau (FHB), as the national nodal point in the year 2016. The system generated valuable data essential at policy, program and practice levels. The evolving health system dynamics demand further expansion and the addition of quality dimensions in the death surveillance systems. As such, several revisions are introduced to the existing death surveillance system from the year 2022.

Following guidelines should be adhered by all relevant healthcare institutions and officials in both government and private health sector.

1.0 Fetal and Child Death Classification and Definitions:

The following definitions are used in the surveillance system;

1.1 **Fetal death** is a death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy and which is not an induced termination of pregnancy. The death is indicated by the fact that after such expulsion or extraction, the fetus does not breathe or show any other evidence of life. Those that occur after the completion of 22 weeks gestation in which the developing fetus dies either in utero or upon delivery. They are classified as early (22-27 weeks gestation) or late (completed 28 weeks gestation or more) fetal deaths. A death that occurs prior to the completion of 22 weeks' gestation is classified as a spontaneous abortion

Stillbirth - A baby born with no signs of life at or after the completion of 28 weeks of gestation.
(Note: Intrauterine fetal deaths (IUDs) refer to babies with no signs of life in utero who are not yet delivered)

1.2 **Live Birth** is the complete expulsion or extraction from the mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes or shows any other evidence of life.

1.3 **Under 5 year Child Deaths** are those that occur before a child completes 5 years of age (4 years and 364 days). **Infant deaths** are those that occur during a child's first year (i.e. measured as Day 1 – the day of birth to Day 365). Infant deaths include both neonatal and post-neonatal deaths.

Neonatal deaths occur during the first 28 days of life. Neonatal deaths are further categorized as "early" (1 - 7 days) or "late" (8 -28 days). **Post-neonatal deaths** occur from day 29 through day 365 after birth.

Note: *A confusion is noted among some of the clinical teams with regard to the deaths of neonates born less than 28 weeks of gestation and not considering or notifying them as neonatal deaths. This may be due to misinterpretation of viability assessment and management of babies born preterm. Any baby born alive, at any stage of gestation, and who died within 28 days should be considered a neonatal death.*

1.4 **Perinatal deaths** include fetal deaths at the completion of 28 weeks gestation or more (or *weighing >1000 g),* and infant deaths of less than 7 days (early neonatal deaths).
Note: *WHO recommends the inclusion of fetuses and live born neonates weighing between 500 g and 1000 g in national statistics both because of its inherent value and also it improves the coverage of reporting at 1000 g and over. Therefore, all fetuses and infants weighing at least 500 g or* ***>22 weeks*** *of POG at birth, whether alive or dead, should be included in the statistics. (However, data on fetal deaths with POA < 22 weeks (500g) are collected only for information and not considered in statistical calculations).*

2.0 Procedure to be followed on Feto-infant and Under 5 year Child Deaths at Hospitals (Government and Private Sector)

All categories of hospitals in both the Government and Private Sector should ensure that all fetal (>=22 weeks of gestation completed) and under - 5 year child deaths are notified within 24 hours, investigated within 14 days, relevant data are entered into the relevant web-based systems and completed death investigation formats are sent in time to Family Health Bureau.
Figure - 1 schematically depicts the national feto-infant and child death surveillance and response mechanism.

2.1. Fetal deaths

All **fetal deaths** (Either >=22 weeks completed POG or >=500g weight) taking place in both government and private hospitals should be notified to the head of the institute by the medical officer confirming the death (at obstetric or gynaecological unit) using the **Hospital Fetal Death Case Abstraction Format (HS1)** within 24 hours under the guidance of relevant Obstetrician & Gynaecologist (or head of the hospital if no Obstetrician & Gynaecologist is posted). The completed format should be perused and approved by the relevant specialist. It is the responsibility of the relevant Obstetrician to ensure that HS1 forms are filled for notifiable fetal deaths.

The Sister / Nurse in Charge of the unit where the fetal death occurred, with the instructions from the Obstetrician & Gynaecologist (or head of the hospital if no Obstetrician & Gyanecologist is posted), should ensure that the format is completed by the relevant officers.

A copy of the HS1 should be kept with the Obstetrician & Gynaecologist (in specialized institutes) or the highest level of medical officer (in non-specialized / peripheral hospitals) for future reference and to be used at monthly hospital perinatal death audits.
The original copy should be forwarded to the Head of the Hospital for data entry into the web-based National Hospital Fetal Death Register.
The original HS1 format should be kept with the head of the hospital attached to the **Monthly Hospital Perinatal Mortality Surveillance Report** (HP2) for every month.

2.2 National Hospital Fetal Death Register

All the relevant variables of each Hospital Fetal Death Case Abstraction Format (HS1) should be entered into the web-based National Hospital Fetal Death Register.
Relevant weblinks, login details and system administration instructions should be obtained from the Child Morbidity & Mortality Unit of the Family Health Bureau by the head of the hospital.
At each hospital, the Medical Officer – Public Health (MO – PH) or a medical officer designated by the head of the institution should enter and maintain data in the on-line system.

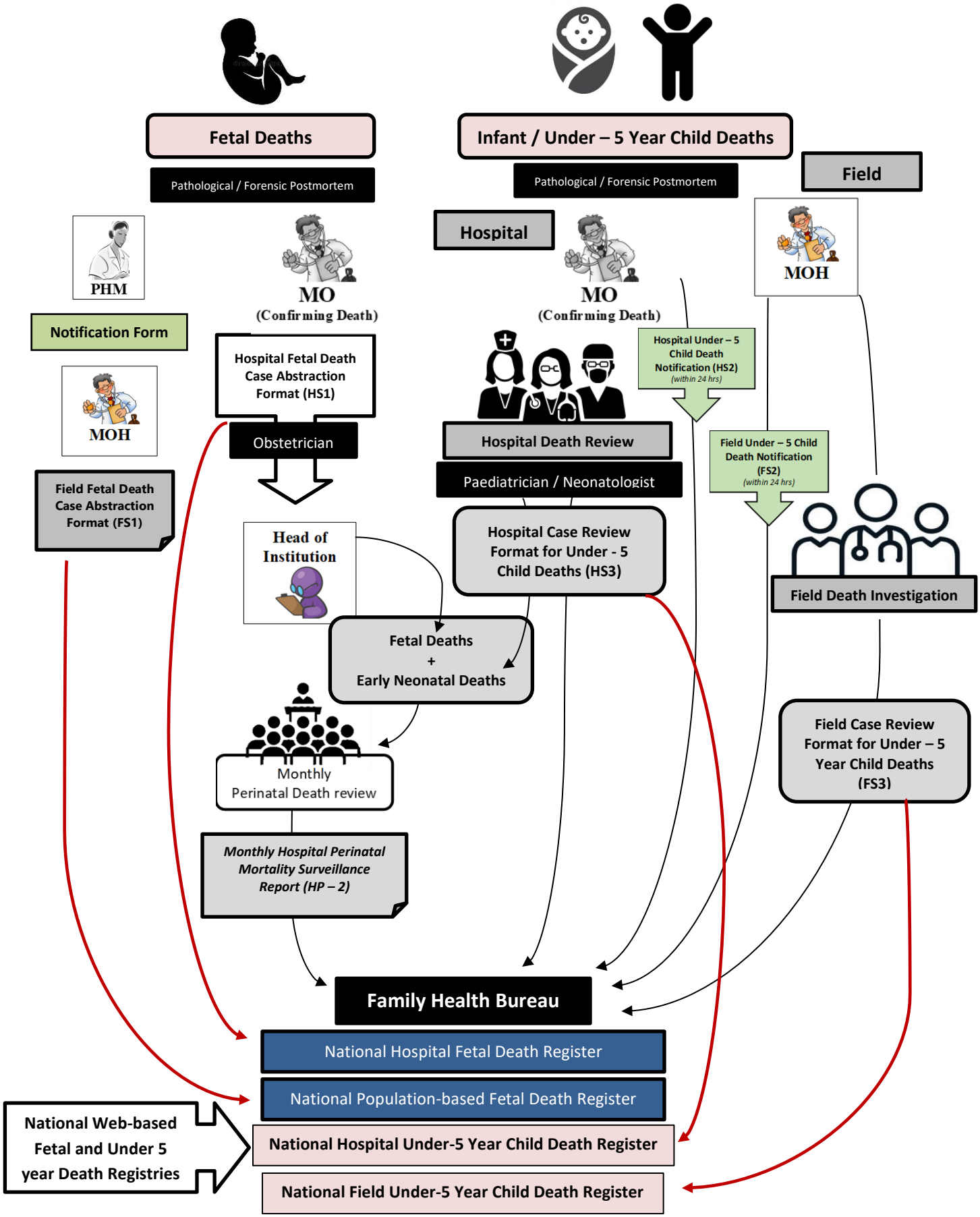

Figure – 1 : National Feto-Infant & Child Death Surveillance & Response Process

2.3 Under 5 year Child Death Notification

All under 5 year child deaths *(including all neonatal deaths and other infant deaths)* should be notified to the head of the institute by the medical officer confirming the death using the **Hospital Under – 5 Child Death Notification Format (HS2)** under the signature of the Paediatrician / Neonatalogist within 24 hours.
A copy of the form (HS2) should be kept with the Paediatrician / Neonatalogist (in specialized institutes) or the highest level of medical officer (in non-specialized / peripheral hospitals) for future reference.

Sister / Nurse in Charge of the unit should keep the blank copies of the notification format and with the instructions from the Consultant in charge of the unit / the highest level of medical officer, where the death occurred should ensure that the notification format is completed by the relevant medical officers and sent to head of the hospital.

The head of the hospital should notify all under 5 year child deaths within 24 hours by telephone, fax or email to the following officers;

1. Director – MCH (Family Health Bureau) / Child Morbidity & Mortality Unit
2. Heads of Institutions where the child was managed previously
3. MOH (of the deceased residence)

(Note: Residence of the mother of the deceased child is taken as the residence of the child.)

A copy of the completed & signed Hospital Under – 5 year Child Death Notification Format (HS2) should be used for notification of child deaths.

2.4 Custody of documents related to clinical management

Once a fetal or an under 5 year child death is reported in an institution (Government or private hospital), all the Head/s of the Institution/s where the index case was managed should take the custody of the bed head ticket (BHT), investigations, transfer forms and all other documentation related to the mother and/or baby within 24 hours. In case of a fetal death, this should be done at the end of inward management of the pregnant mother. All the pages should be numbered and the original document should be made available for the perusal of relevant officers (clinicians, JMOs and area MOH).

All relevant documents should be made available for the investigation procedures and review meetings. The BHT should not be reproduced. BHT should not be taken out of the office of the Head of the Institution and extraction of information from the BHT should be done within the office premises of the head of the institute only.

2.5 Conducting forensic postmortems or pathological post mortems

A judicial postmortem or pathological postmortem should be conducted in all cases of foetal and under 5 year child deaths when the cause of death could not be accurately determined.

Note: Please refer to the Guidelines on Conducting Pathological Post-mortems.

Special Notes on Foetal deaths: The placenta should be examined and the findings should be documented in the BHT and the placenta should be sent to the pathologist or JMO for further reporting.

2.6 Death Registration

2.6.1 Fetal Deaths

a. A **Certificate of Still Birth (B22)** should be filled by the medical officer confirming the death in triplicate for each foetal death completed 28 weeks of gestation: the first copy -is to hand over to parents, the second copy -is to be posted to Registrar General's Department and the third copy -to be kept as the office copy in the institution.
b. The head of the institute should send the second copy (Registrar General's copy) of the Certificate of Still Birth (B22) **by post directly to** the *Vital Statistics Unit, Registrar General's Department, Denzil Kobbekaduwa Mawatha, Battaramulla*

No person shall bury, cremate or otherwise dispose of, or cause to be buried, cremated or otherwise disposed of, the body of a still-born child delivered in a hospital unless there has been obtained a certificate from the appropriate registrar or relevant authority, stating that the occurrence of the still-birth was notified.

2.6.2 Under 5 year deaths (Neonatal deaths, Infant and other deaths)

a. For all babies born alive irrespective of the period of gestation and later died, registration of the birth should be ensured by sister / nursing officer in charge.
b. To facilitate the registration of the death, a **Declaration of Death (B 33)** form should be filled by the medical officer confirming the death for all babies born alive and later died.
c. The consultant in charge of the unit and the head of the hospital should ensure that a valid scientific cause of death is documented in the Declaration of Death (B33).

No person shall bury, cremate or otherwise dispose of, or cause to be buried, cremated or otherwise disposed of, the body of a child born alive and later died in a hospital unless there has been obtained a certificate from the appropriate registrar or relevant authority, stating that the occurrence of the death was notified.

2.7 Case Abstraction and Unit level investigation of Under 5 year Child Deaths

A fact-finding ward/unit level child death technical investigation should be performed for each under 5 year child death *(including all neonatal and other infant deaths)* by the Consultant in charge of the unit where the death occurred.

The investigation should be conducted as a form of a meeting within 14 days of the occurrence of the index death as this would enable to identify precisely the circumstances that led to the death with fresh information. The lead clinician, obstetrician (where relevant), other clinicians involved in the management of the child, Forensic Pathologist / Pathologist, medical officers and relevant nursing officers should participate at the investigation meeting.

All the clinical, pathological and post-mortem records should be perused and reviewed during the investigation meeting. The circumstances of the death should be discussed in detail with the intention of identifying preventive measures.

The medical officer who confirmed the death of the child (or a medical officer nominated by the Consultant in charge of the unit) should complete the **Hospital Case Review Format for Under - 5 Year Child Deaths (HS3)** under the guidance of the Consultant in charge of the unit.

A copy of the properly filled Hospital Case Review Format for Under - 5 Year Child Deaths (HS3) should be forwarded to the head of the hospital under the signature of the Consultant in charge of the unit. The original should be kept with the Consultant in charge of the unit to add more information once the Perinatal Mortality or Institutional Child Death Review meetings is conducted.

The Sister / Nurse in Charge of the unit should keep the blank copies of the case abstraction format. With the instructions of the Consultant in charge of the unit or the highest level of medical officer, Sister / Nurse in Charge of the unit should ensure that the relevant format is completed by the assigned medical officer and sent to the head of the hospital.

3.0 Review of Fetal and Under 5 year Child Deaths

3.1 Hospital Perinatal Mortality Surveillance Meetings

These meetings should be conducted by every specialized institution (including the private sector) providing perinatal care once a month on a fixed date (may be in the second week of the month). The Head of the institution with consultants (Obstetricians, Pediatricians, Neonatologists and other related specialists) should organize the meetings.

All perinatal deaths (fetal deaths > 22 weeks of gestation and early neonatal deaths) reported during the previous month should be reviewed at this meeting.

Data of the index cases should be collated from the Hospital Fetal Death Case Abstraction Format (HS1), Hospital Case Review Format for Under - 5 Year Child Deaths (HS3), BHT and other clinical records. A structured format could be used for presenting the data at the meeting by the Medical Officers attached to the relevant obstetrics unit or SCBU/NICU under the guidance of the head of the unit/ward (Obstetrician, Pediatrician, Neonatalogist and other relevant Specialists).

The participation of the following categories of health care teams is <u>mandatory</u> with relevant information;

- Head of the Institution
- Obstetrician, Pediatrician, Neonatalogist and other relevant Specialists (Intensivists / Surgeons / Anesthesiologists / Pathologists / Microbiologist etc)
- Forensic Pathologist / Judicial Medical Officer
- Medical Officers from Obstetric and Neonatal Units
- MO /MCH and MOOH from the catchment area
- Medical Officer /Public Health
- Matron / Sister in Charge / Grade I Nursing Officer /Nursing Officer in Charge of the ward/ labour room
- Medical Record Officer (MRO)
- Other relevant healthcare officials

Note: *Head of the Institution is authorized to invite any other healthcare official relevant for the review of the index cases for the meeting.*

The index cases should be discussed in detail based on the three-delay model in order to identify deficiencies associated with seeking medical care, reaching the hospital and management of the mother and/or the neonate at the hospital.

The perinatal death audit process should be a no-fault finding exercise of the healthcare workers involved in the management of the pregnant mothers or infants. The review process should focus on establishing if circumstances represent system issues that require change, developing recommendations for change and assisting in the implementation of change at hospital level and field level. The recommendations should be formulated in the SMART format (Specific, Measurable, Achievable, Relevant, and Time-Bound). The Head of the Institution is responsible to ensure the implementation of the corrective actions within the hospital without delay as decided at the meeting.

Maintenance of confidentiality: The whole process of the review should be confidential and each participant of the institutional review should sign the confidentiality agreement (F-4) prior to the review meeting.

3.2 Reporting of Perinatal Mortality Surveillance meetings

The Head of the hospital should designate a medical officer to document the proceedings and the recommendations of the meeting.
Additional information/data on index deaths generated at the meeting should be added to the relevant fetal or child death case abstraction formats (HS1 or HS3) by relevant medical officers under the guidance of respective specialists (Obstetrician / Paediatrician / Neonatologist etc).
The completed **Monthly Hospital Perinatal Mortality Surveillance Report (HP-2)** should be sent within one week after conducting the meeting to the Director (MCH), FHB by the head of the institute.

3.3 Entering perinatal death data into the national database

The Head of the hospital should ensure that all individual perinatal death data are entered in the web-based **National Hospital Fetal Death Register** and **National Hospital Under-5 Year Child Death Register** by the time HP-2 is sent to Family Health Bureau.

Institution-specific login details should be obtained from the Child Morbidity & Mortality Unit of the Family Health Bureau.

3.4 Institutional review of Under 5 year deaths (excluding early neonatal deaths)

- A fact-finding institutional child death review meeting should be performed by <u>all hospitals in both government and private sector</u> depending on the number and the frequency of the under 5 year child deaths reported.
- Early neonatal deaths are reviewed at Monthly Hospital Perinatal Mortality Surveillance meetings. If feasible, all neonatal deaths may be discussed at the Perinatal Mortality Surveillance meeting.
- *Under 5 year Child Death reviews may be conducted as an extension of the monthly perinatal mortality surveillance meeting.*
- Conducting the institutional child death review is the responsibility of the Head of the Institution. All clinicians (neonatologists or paediatricians), obstetricians, other clinicians involved in the management of the child, Forensic Pathologist / Pathologist, medical officers and relevant nursing officers other clinicians and medical officers involved in the management of the cases should comply with the instructions of the head of the institution.

The participation of the following categories of healthcare workers at the institutional child death review meeting is <u>mandatory</u>.

- Head of the Institution (Director/MS/DMO/MO-IC) as the team leader
- Consultant Paediatrician / Neonatologist or the relevant specialist (eg. Anaesthetist / Intensivist / Cardiologist / Surgeon etc) of the hospital unit in which the death occurred (acting consultant in his/her absence) and all other relevant consultants who managed the mother & the baby (Obstetrician, Surgeon, Anaesthetist, Pathologist, Microbiologist etc)
- Medical officer/s who attended the deceased infant / child (DMO, MO/IC, senior house officer, MO-PBU, MO-NICU, house officer etc.)
- Judicial Medical Officer / Forensic Pathologist
- Matron / Sister / Grade I Nursing Officer /Nursing Officer In Charge of the Ward / Unit / labour room - when relevant
- Heads and relevant clinicians of the hospitals where the patient was managed before the transfer

- Medical Officers Maternal and Child Health (MO-MCH) of the districts where the mother is resident and where the hospital is situated
- Medical Officer of Health (MOH) from the mother's area of residence
- Public Health Midwife (PHM) from the mother's area of residence
- Other relevant healthcare officials

Note: *Head of the Institution is authorized to invite any other healthcare official relevant for the review of the index cases for the meeting.*

3.5 Institutional Review Process of Under 5 year Child Deaths *(excluding early neonatal deaths)*

- All original documents related to the healthcare services delivered or clinical management of the index children from both field and hospital/s and postmortem or necropsy reports should be reviewed at the death investigation.
- The index cases should be reviewed in detail based on three-delay model in order to identify deficiencies associated with seeking medical care, reaching the hospital and management of the child at the field and hospital level. Efforts should be taken to establish if circumstances represent system problems that require change, develop recommendations for change and assist in the implementation of change at the hospital level and field level. The recommendations should be formulated in the SMART format (Specific, Measurable, Achievable, Relevant, and Time-Bound).
- The review process should be a no-fault finding exercise of the healthcare workers involved in providing filed health services or clinical management of the child.
- The whole process of the review should be confidential and each participant of the institutional review should sign the **Confidentiality Agreement (F-4)** prior to the review meeting.
- The institutional child death review meeting should be coordinated by the medical officer (public health) or a medical officer designated by the head of the institution.
- The Head of the Institution is responsible to ensure the implementation of the corrective actions within the hospital without delay as decided at the institutional review.

3.6 Reporting the findings of the institutional child death review

- **Hospital Case Review Format for Under - 5 Year Child Deaths (HS3)** should be updated with the additional information generated during the death review by responsible medical officers under the guidance of respective specialists (Paediatrician / Neonatologist etc).
- The relevant specialist should peruse, ensure the completeness and approve the completed format prior to forwarding the same to the head of the hospital.
- The completed and signed original case review formats should be sent to the Director (MCH) within 7 days of the child death review by the head of the hospital.

3.7 Entering child death data to the national database

- Head of the hospital should ensure that all individual child death data are entered in the web-based **National Hospital Under-5 Year Child Death Register** by the time case review formats **(**HS3) are sent to Family Health Bureau.
- Institution-specific login details should be obtained from the Child Morbidity & Mortality Unit of the Family Health Bureau.

4.0 Feto-Infant and Child Death Surveillance at Field Level

4.1 Public Health Midwife level

All foetal deaths (either >= 22 completed weeks of gestation or >=500g) and under 5 year child deaths should be notified to the respective medical officer of health (MOH) by the area Public Health Midwife (PHM) or acting PHM using the relevant format (Field Fetal Death Case Abstraction Format or Field Under – 5 Year Child Death Notification Format) within 24 hours.

4.2 Notification of Under 5 year Child deaths

MOH should notify all under 5 year child deaths (birth to 5th birthday) within 24 hours by telephone, telegram, fax or email using the Field Under – 5 Year Child Death Notification Format (FS2) to the following officers;

Director – MCH (Family Health Bureau)
RDHS

The MOH may also receive an Under 5 year Child death notification directly from the head of the institution at which the death occurred or from the RDHS/MOMCH of the district to whom the death was notified.

In case of the death of a child whose mother was temporarily resident in a MOH area, the area MOH should notify the death to the MOH of the area from where the mother came from (& where she was registered as an eligible female). In cases of deaths within one week of discharge from a hospital, the MOH should notify the index death to head/s of the previously managed institution/s

MOH should also ensure that all foetal & deaths are reported through H 509 (Quarterly Maternal and Child Health Return).

4.3 Custody and safety of under 5 year child death documentation

All the relevant records of the mother & child (H512A, H512 B, Child Health Development Record - CHDR) should be taken over & kept safely in the MOH office till the investigations & case review meetings are over.

- The MOH is responsible for the safe custody of the all the documentation related to all under 5 year child deaths
- MOH should hand over all the documents related to under 5 year death investigations and reviews to the next MOH appointed on his/her transfer or retirement.

4.4 Field death investigation procedure for under 5 year child deaths

a. The purpose of the field child death investigation is to understand how a wide array of social, economic, health, educational, environmental and safety issues related to the child loss on a local level and in turn utilize that information to improve community resources and systems of care to reduce child mortality.
b. MOH (of the area where the mother is registered in the eligible family register or the MOH area where the deceased child mostly received field care) is the responsible officer for the field death review. In case of an absence of the relevant MOH, the acting MOH/AMOOH or MO-MCH should take the responsibility of conducting the field child death investigation.
c. The investigation should be done as a team comprising MOH, all AMOHs, all PHNS, all SPHM and PHM/acting PHM of the area. All the MOH and AMOHs should jointly investigate the child death.
d. Investigation should commence as early as possible and should be completed within fourteen (14) days of the occurrence of the child death.

e. Record review: The team should visit the office of the area PHM and examine all the relevant documents starting from the Eligible Family Register, Pregnant Mother's Register, pregnancy records (H512B), family planning field records, Birth & Immunization register, Hospital Records, CHDR, PHM diary, weighing records, notes on home visits, advance programme, previous supervision reports on the area PHM etc.
   The team should also review birth and death certificates, post-mortem / coroner's reports, and records from other health and social service agencies.
f. The field health staff should contact parents through phone calls or other communication channels and/or home visits soon after the child death.
g. The review team should physically visit the relevant household. The staff should provide emotional support, information, and referrals to other services that assist parents and families where necessary prior to the death investigation.
h. Maternal (or guardian) interview -After family support has been initiated, the mother (or the guardian) should be invited to participate in an interview. The interview should allow the mother's voice to be heard and provides her with the opportunity to share her experiences before, during and after the pregnancy and the child death. Other family members may also be interviewed by the investigation team in order to obtain relevant information.
i. The care received by the mother (antenatal, postnatal) and the child prior to admission to the hospital should be assessed. The case should be reviewed in detail based on three-delay model in order to identify deficiencies associated with seeking medical care, reaching the hospital and management of the infant / child at the field and hospital levels. Efforts should be taken to establish if circumstances represent system problems that require change, develop recommendations for change and assist in the implementation of change at the field level and also at the hospital level.
j. The investigation process should be a no-fault finding exercise of the parents, healthcare workers involved in providing filed health services or clinical management of the child. The whole process of the investigation should be confidential and each participant of the field investigation should sign the **Confidentiality Agreement (F-4)** prior to the death review.
k. In the case of a hospital death, MOH should participate as a member in the hospital investigation meeting. If the institutional investigation is delayed, the MOH should visit the hospital and obtain relevant information from the hospital (from health care staff and the BHT) with the permission of the head of the institution.
l. After the field child death investigation, the MOH should implement the necessary corrective actions at the field level, and the implementation of these should be discussed at the next monthly conference.
m. A collective supervision of the area PHM by all the supervisory staff (MOH, AMOH, PHNS, SPHM) should be undertaken. They should follow up the work of the PHM until the deficiencies (if any) at the field level are rectified.
n. If the child death investigation has been done by the previous MOH, the present MOH should do a fresh field visit to the PHM office and the home of the deceased child and be thorough with the details.

4.5 Reporting the field infant / child investigation

The information obtained during the field death investigation should be entered in the Field Case Review Format for Under - 5 Year Child Deaths (FS3) in triplicate (Office Copy / RDHS / FHB)
On completion, the format should be sent to the RDHS and Director (MCH) within 14 days of the occurrence of the child death.

MOHs are advised not to delay sending the FS3 just because a few data are not available. The completed format could be sent pending such data and the unavailable data can be sent separately in a letter once they are obtained.

4.6 Role of the MO-MCH

- The Medical Officer – MCH at the district level should compile all feto-infant and under 5 year child mortality data received from area MOHs and hospitals (Notifications/death investigation reports / post-mortem reports / perinatal death audit reports).
- MOMCH should maintain a feto-infant and under 5 year child mortality database at the district level
- A quarterly summary of all feto-infant and under 5 year child deaths should be sent to the PDHS and Family Health Bureau.
- MOMCH should participate at field and hospital child death investigations where feasible.
- He / She should organize the district and national perinatal and child mortality review meetings
- He / She should ensure that corrective actions are taken under the guidance of RDHS

5.0 District and National Feto-Infant and Child Mortality Reviews

At the end of each half year, the MOMCH should prepare a summary of all feto-infant and under 5 year child deaths notified during each half year and send the same to the Director (Maternal and Child Health) and PDHS.

National Program Manager (Child Morbidity & Mortality) will also prepare a feedback summary of the deaths notified from each district and institution at the Family Health Bureau at the end of each quarter and annually. These data will be disseminated to each district and institution for verification.

District and National Feto-Infant and Child Mortality Reviews are an important aspect of Feto-Infant and Child mortality surveillance since it provides a forum to discuss and learn lessons out of Feto-Infant and child deaths at the district level. It also gives an opportunity to identify service deficiencies and to formulate preventive strategies to further reduce Feto-Infant and child deaths taking local contexts of the district in to consideration. Data gaps with regard to each death could be filled at district reviews. Each reported death should be discussed at these reviews with the aim of identifying circumstances of death in order to prevent such deaths in future. The circumstances which led to the death should be identified at the district review using three delay model.

Two half yearly District Reviews should be organized by MO-MCH on behalf of RDHS according to the following schedule.

First half yearly review	-2nd week of July
Second half yearly review	-2nd week of January (following year)

District Feto-Infant and Child Mortality Review Team should comprise of the following officers;

PDHS/ RDHS (chairperson)
Provincial or District Consultant Community Physician/s
All Head/s of the Institution/s in the district (including peripheral hospitals)
MO-MCH
All Paediatricians/ Neonatologists /VOGG and other relevant consultants
Judicial Medical Officers
Pathologists
Senior registrars / SHOO / MOO –who were involved in the management of the deceased infant / child or the pregnant mother
All MOOH, all AMOOH, all PHNS, SPHM, relevant area PHMM

The participation of all relevant officers is compulsory at these review meetings.

Preventive strategies should be generated to improve the availability, accessibility, utilization & quality of field health care services and essential newborn/ paediatric /obstetric services and steps should be taken to initiate the preventive activities which could be implemented at the district level.

At the end of the review the MOMCH should prepare a minute (deficiencies identified and action to be taken/ already taken) and it should be sent to the following health authorities by RDHS.

- PDHS
- Director (Maternal and Child Health)
- Heads of Institutes / Clinicians (Paediatricians/ Neonatologists /VOGG)
- Sri Lanka College of Paediatricians / Sri Lanka College of Obstetricians & Gynaecologists
- All MOOH

These minutes should be taken for discussion to assess the progress at the next district review of Feto-Infant and Child deaths.

6.0 National Feto-Infant and Child Mortality Review (NFICMR)

a. National Feto-Infant and Child Mortality Review is a process that brings together key stakeholders of the healthcare community from both national and district level to review data on fetal and infant / child deaths in order to identify factors associated with those deaths, establish if they represent system problems that require change, develop recommendations for change, assist in the implementation of change at national and district levels.

b. Annual reviews are conducted on a district basis to review all the deaths which occurred in a particular district in the previous year with the participation of experts from the national level.

c. Director/Maternal and Child Health (D/MCH) in collaboration with the Provincial Director of Health Services will organize the annual review of Feto-Infant and Child deaths in a district with the participation of representatives from professional colleges including Sri Lanka College of Obstetricians & Gynaecologists, Sri Lanka College of Paediatricians, Sri Lanka College of Community Physicians, Sri Lanka College of Forensic Pathologists and Sri Lanka College of Pathologists.

d. Director General of Health Services (DGHS) or in his absence the PDHS will chair this meeting. In the absence of the DGHS, a ministry official nominated by the DGHS should participate at the NFICMR to represent the DGHS.

e. The participation of following categories of health care teams is <u>mandatory</u> at the NFIMR;
   - PDHS, RDHS and Deputy RDHS
   - Provincial and District Consultant Community Physician/s
   - All Head/s of the hospitals in the district
   - MO-MCH
   - All MOOH, all AMOOH, all PHNS, SPHM, relevant area PHMM
   - All Paediatricians/Neonatologists &VOGG and other relevant consultants
   - Judicial Medical Officers
   - Pathologists
   - Senior registrars / SHOO / MOO –who were involved in the management of the pregnant mothers &/or deceased infants / children

f. The RDHS, MOMCH, RSPHNO, all Paediatricians/Neonatologists, all VOGG, MOOH and AMOOH, all heads of the institutions and the relevant consultants, all the DMOO / MOO-IC of the district hospitals and peripheral units (whether or not Feto-Infant deaths occurred in their institutions) should participate at the annual review.

g. All the reported deaths for the year are taken for discussion by an expert panel consisting of the DGHS (or a representative of the DGHS), PDHS, Director/Maternal & Child Health, other relevant officials from the Ministry of Health, representatives of the SLCOG, SLCOP and other professional bodies.
h. The relevant presentation of the Feto-Infant and Child death should be done by the MOMCH (District Statistics), Head of Institutions (Institutional statistics), VOG (Obstetric Unit statistics and details) Paediatrician/Neonatologist (Neonatal unit & Paediatric unit statistics and details) and MOH (field care) based on the presentation formats prepared by the FHB.
i. Following the review, minutes will be prepared by Director (Maternal and Child Health) / National Program Manager (Child Morbidity & Mortality). Such minutes will be sent to the relevant national, district and provincial officers. The RDHS will then send the copies of the minutes to the relevant curative institutions and MOOH.
j. Final decisions regarding the type of death, preventability, preventive measures that should be taken at the national level will be decided during the annual review by the panel of experts.

7.1 Follow up action to NFICMR

Following the NFICMR the MOMCH should organize a meeting for all MOOH / heads of institutions and other relevant officers to implement the corrective actions decided at the NFICMR. This meeting will be chaired by the RDHS.
Head of the institution should call for a separate meeting at the institutional level to discuss these minutes with the relevant consultants/ SHOO/ and other relevant staff in order to implement these activities.

MOMCH should report the progress of these activities after 3 months to the DGHS/ PDHS/ RDHS/ D/MCH. At the annual review of the next year the MO/MCH should present the status of implementation of preventive measures suggested at the previous year's annual review.

Director (Maternal and Child Health) should carry out regular discussions with the DGHS, relevant DDGG and other officials regarding issues which need departmental intervention. Issues identified at NFICMR should be taken up at Advisory Committees on Child & Newborn Health, Maternal care & Family Planning and National Committee on Family Health.

8.0 National Feto-infant and Child Mortality database

All the important variables of feto-infant mortality information are entered in a National Feto-Infant and Child Mortality Database maintained by Child Morbidity and Mortality Unit of FHB. Director – Maternal and Child Health and National Program Manager on Child Morbidity & Mortality will act as database custodians.

Each MOH and hospital will be issued of login details by FHB.

When all the NFICMR meetings are over, the national statistics on Feto-Infant and Child mortality should be compiled and issued by the Family Health Bureau before the end of the next year.

For further details or clarifications:

Child Morbidity & Mortality Unit – Family Health Bureau 0112692745