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F. No. DFW-5/13/2025-SPO (MH-DFW)/ 5828–5853 **Dated:** 1-9-25

Minutes of Meeting

A meeting of the State Monitoring and Review Committee (SMRC) was held on 22nd July 2025 under the chairmanship of the Mission Director, DSHM.

The committee members and special invitees as per enclosed attendance sheet attended the meeting.

The meeting started with an introduction of all participants.

Following agenda were discussed:
Agenda 1: Actions taken on recommendations given by last SMRC-MDSR

S. No	Recommendation of 1st SMRC	Action Taken	Further action recommended
1.	Study strategies of Best performing countries/ states for adopting and implementing in Delhi	• Midwifery-Initiated • High risk pregnancy interventions-also being adopted(proposal submitted)	• Expedite Midwifery • Expedite proposed collaboration with ARMMAN
2	Maternal deaths referred from neighbouring States to be notified to DFW	Concerned hospitals were advised to inform details to referring hospitals, wherever applicable, and the same is being practised	• Letter to Mission Director (NHM) of concerned states by MD(NHM)
3	Districts to prepare individual plans of action for reduction of home deliveries especially for cluster areas(hubs) and monitor data on HMIS and Annual report. (CRS)	• Submitted and implemented by districts. • Latest data showing sustained decline. • Data alignment is a tough task and would require several stakeholders (efforts ongoing)	• Discussion on strategies for last mile. • Comparative data of 2024 from Department of Statistics and Economics as awaited to be compared and unified.
4	Preparation of a comprehensive checklist and constitution of teams to conduct supportive supervisory visits to all Delhi Govt. hospitals for achieving LaQshya and SUMAN standards.	• Completed except AN Hospital. • LNH, BMH, BJRM cleared state NQAS. • Also a mentoring plan prepared and experts assigned to remaining hospitals.	Hospitals to set timelines and complete by 3 months(State assessment at least) and followed by SUMAN.
5	Regular updation of MPCDSR Portal	• Meetings undertaken and advisories sent	• Further streamlining to go on.

		• Constant handholding on bottlenecks. • Achieved improvement in FBMDSR but CBMDSR is still pending. • Workshop planned for 29th July2025.	• Data must improve by the next meeting • Meetings of MDSR at facility, district and state must include triangulation of data so that all platforms speak to each other and project similar data.
6	Improvement in updation of HMIS portal by private health facilities	Gradual escalation in numbers of centres reporting (56 % of 1137 centres in Mar 24 to 81% in May 25)has been achieved through several joint efforts by MH section, NHC and HMIS section.	• Identify the remaining delivery points and coordinate with SPO (NHC) and SPO(DSHM) to achieve reporting by 100%registered private nursing homes.
7	Strengthening of PMSMA program and convergence with other departments.	Convergence meeting was conducted prior to WPD Campaign 2025, with themes of Unmet need and maternal mortality and promotion of utilization of PMSMA services was requested from all departments.	• All centres to be attached to nearby practitioners or private facilities and dedicate 2-3 hours as a goodwill gesture. • AOGD to promote in their monthly meetings.

Agenda 2: Issues and challenges related to maternal deaths in Delhi and Implementable solutions

Following was presented and discussed:

S. No	Challenge	Possible solution suggested/ being undertaken	Discussion & Recommendations
1.	Data multiplicity and mismatch between CRS and HMIS	• Meeting held with all stakeholders. • Weekly pilot planned with Registrar Birth & Death, MCD. Study of week -1 data of July to be put on file for further necessary action.	• Mr. Rajeev, NIC representative from MCD would help resolve the issue.

		• System should be developed through constant tripartite efforts (Discussion undertaken with Director, DES)	
2.	Urban Slums and Migratory Population	More ASHAs are being selected and better coverage is expected in near future as informed by SPO(ARC)	Identified pockets (High TFR, home delivery, mortality) to be prioritized by CDMOs
3	Referral system including for superspeciality needs. (Cardiac, Liver, renal, etc) referrals - currently only SJH, RML and GBPH, JPSS available and later 2 can't take cases (as no gynae deptt.), BSA (Urology only)	• Referring facilities should liaison before referring. • Re- organized Mapping, if required. • "0" denial	• In addition to advocacy, monitoring of denial and root causes of denial to be part of interventions • Mapping of superspeciality hospitals
4	Resource limitation wrt Maternity beds, ICU beds, Blood availability, HR(all categories)	System strengthening -Secondary,Tertiary centres & superspeciality hospitals.	• MCH Wings of 6 hospitals to be strengthened under "critical care blocks" initiative under PM ABHIM • AN Hospital to be strengthened and operationalized 24x7 -seek HR requirement
5	Overworked doctors	• Advocacy for task sharing(Low risk delivery by Nurses/Midwives) • Also Midwifery to be implemented as soon as possible	Strategies to be implemented
6	Free availability of logistics -MCP Card and IFA	Recent interruption of supply due to procurement issues	To be expedited (DSHM and CPA)

Agenda 3: Strategies for improvement of MDSR processes at all levels:

The SPO started with describing the recommended process of MDSR to be followed for home/transit/facility deaths through a flowchart highlighting the challenges(mainly portal related) and **gaps at different levels.**

Next, she informed of some **recent interventions** introduced to improve maternal health and reduce adverse events.

- Collaborating with ARMMAN(IHRPTM),NABET(Accreditation), IMMAST,other academic bodies(AOGD and NARCHI)
- Targeted interventions in the facilities with high maternal deaths.
- Near miss audits -and collating the observations for CAPA
- Expediting uptake of LaQshya Initiative
- MCH Wing (including skill labs) under development at 6-7 hospitals.
- Helpdesk and Grievance redressal system under SUMAN program
- Cluster meetings-an initiative to closely connect health care providers of referring and referral facilities with resolution of 2-way conflicts and challenges
- Collaboration with MOHFW for bottlenecks in reporting on portal and analysis eg. having segreg558ated causes in 'others'category and bringing RCH 2.0 in Delhi in first phase.
- Convergence meeting with allied departments (Themes of first meeting dated 13.06.25) was kept as maternal mortality and unmet need of contraceptives)
- MDSR Workshop planned on 29th July with hands-on series on filling MDR forms, updating MPCDSR portal, conduct of MDSR meetings, standard miniutization, etc.

Further, Steps for strengthening MDSR processes were advocated as follows:

- Regular monthly review meeting at hospital and district levels. Each death to be reviewed by DM also.
- Minutes of meeting to be visible on MPCDSR portal.
- DNB at more and more DHs(eg. Pt.MMH, RTRM,JPCH,BM,AAA,IGH,BH)

Agenda 4: Review of two selected maternal death cases (South and Shahdara districts)

Two cases of maternal mortality (1 each from South and Shahdara districts) were presented with respect to social and medical determinants and possible corrective and preventive actions (CAPA).

CASE 1

Presentation: Presented by Dr Rajesh Kumari from Safdarjung Hospital was a case of Primigravida with 35 weeks pregnancy with blood stained leaking with fever.

Cause of Death:

? Heat stroke

?? Dengue hemorrhagic fever

??? abruptio placenta

???? Septic shock.

Gaps/Challenges/Delays identified:

Delay 1: Delay in Decision to seek care by patient as delay in going to health centre despite fever and leaking.

Delay 2: Delay in reaching the tertiary facility as first she went to District hospital (transport arranged through CATS ambulance after initial resuscitative measures) .

Delay 3: Delay in taking up the case in OT at the Tertiary Hospital as it was busy and she had to wait for LSCS.

Corrective measures suggested:

- Health education of the woman to identify risk factors and seek timely services(self care)
- Capacity building of ASHA and Health Professionals(quality AN care)
- Easy Access of transport to the pregnant woman to the health facility and referral facility(CATS).
- Strengthened Referral Services.(Prompt and Pre informed)
- Referral centre to start appropriate antibiotic (at time of referral)
- Additional OT Tables in Tertiary centres.

CASE 2

Presentation:

Presented by Dr Priyanka from GTB Hospital as a case of Death due to high risk CS referred from private post operative events

2nd Gravida with 1 live issue with LSCS done for Postpartum Eclampsia (PPE) on 2nd post operative day with? aspirational pneumonitis.

Cause of Death

?PPE with aspiration pneumonitis.

Gaps/Challenges/Delays identified:

Delay 1:

- Failure to identify PIH/Pre-eclampsia in ANC period.
- Referral to higher centers
  without proper documentation of timely MgSO4 initiation or neuro assessment.

Delay 3:

- Late referral from private hospital after onset of altered sensorium and respiratory compromise
- No airway protection documented during seizure episode
- No time to escalate to ICU level interventions such as ventilator support, dialysis or neurological monitoring. (Late presentation (died in 7 hours after admission at GTB hospital left minimal scope for ICU intervention)
- At a private facility Quality of care and treatment protocol was inadequate as per the documents. The patient was in deteriorated condition without management and ventilatory support in the ambulance.

Corrective measures suggested:

- Post-op care management protocols of HRPW at private facilities must be in place and strengthened.
- SOPs for referral to tertiary care centers by the private facilities must also be in place and disseminated.
- Airway securing and loading dose of eclampsia drugs to precede transfer.
- These cases must be reviewed under DM to focus on Training Need Assessment and improve the Quality of Care of private facilities (Seizure drills for all engaged in high risk units). .
- Private centre which cater to high risk surgeries must have ICU.
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Summary of tasks decided to be accomplished

A. Short term tasks

S No.	Task	Timeline	Responsibility
1.	Registration of all delivery points among private registered Nursing Homes on HMIS and mandatory reporting .	10 days	• Nursing home cell and CDMOs to enforce • MH section and HMIS(DSHM) to coordinate.
3	MCP Card for universal use-Design and disseminate(Monthly meeting and bulk mail from AOGD Secretariat)	Before next AOGD meeting	MH section and AOGD President
4	Letter to MD, NHM of UP & Haryana	15 days	MH Section to draft
5	Checklist for DM & CDMO (monthly tasks) - progress to be submitted by CDMOs and DMO to Mission Director (NHM)	15 days	SPO(RCH) & SPO(HMIS)

Medium term tasks:

S NO.	Task	Timeline	Responsibility
1.	Attach Public Health facilities(Primary) with private practitioners/hospitals for voluntary services PMSMA day	Complete with 3 months	CDMO(All Districts)

Long Term tasks

S NO.	Task	Timeline	Responsibility
1	Strengthening of Delivery points/HDU through PM- ABHIM	Ongoing	Convergence any all stakeholders (Hospitals, DFW, DSHM, SPO-ABHIM)

This issues with prior approval of the Mission Director, DSHM

1/9/25

Dr. A.G. Radhika
Director

Encl: Attendance sheet

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Copy to:

1. **Director, DFW**
2. Representative of DGHS
3. SPO(RCH),DFW
4. SNO, Quality Assurance
5. Director, State Blood Transfusion Council (SBTC)
6. State Nodal officer, Nursing
7. All DPOs (RCH)/District Nodal Officers of Maternal Death Review
8. Representatives of AOGD
9. Chief Executive, Voluntary Health Association of India
10. Senior Program officers, Population Foundation of India
11. SNO, MDSR
12. DHA, MCD
13. Director, ESI
14. CDMO, South district
15. CDMO, Shahdara District
16. Facility Nodal Officer, GTB Hospital
17. Facility Nodal Officer, Safdarjung Hospital
18. National Program Officer, WHO
19. Representative from RBD (MCD)

Copy for information to:

1. PA to MD, DSHM
2. PS to Director, DFW
3. PS to Director, DGHS
4. Registrar, Nursing Council
5. CDMOs, All district
6. Executive Director, Population Foundation of India
7. President, AOGD

1/9/25

Dr. A.G. Radhika
Director