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Editorial

SPECIAL ISSUE FROM CHIEF EDITOR ON PREVENTION OF MATERNAL DEATH

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Mr. SB lost his wife due to eclampsia at the age of 19 years leaving behind one child. Mr. SA 30 years, lost his wife who had h/o home delivery died spontaneously without any professional help. Mr. SR, 27 years, lost his wife at the age of 18 years due to sepsis caused by illegal abortion. Mrs. AR, 20 years, delivered a baby at road- side on way to hospital died due to retained placenta.

All these preventable unwanted catastrophes and mourning of their families echo in my heart for the last 30 years. "Why Mother Die"? Whether it is due to delay to seeking treatment or delay to reach the hospital or delay on the part of the doctor to start treatment or lack of transportation due to bad road condition.

During my tenure (5yrs) as chairman of IMA standing committee initiative of safe motherhood

{2021 and chairman of safe mother hood committee of fogsi [2000 - 2005] and as a vice-president, FOGS [1998] I, I have visited most of the parts of rural area of India. While visiting the rural area, I was so much depressed to see the pathetic situation of some of the pregnant women because of lack of commitment by some of the obstetricians, nursing staff, and health providers or due to lack of the eco-socio-political commitment.

Women are dying their long journey of 280 days during pregnancy period without antenatal checkup, investigation and treatment. Every minute of a women dies as a result of pregnancy or child birth somewhere in the world may be due to – a) Teenage pregnancy, physically not fit to deliver the baby leading to obstructed labor, sepsis, eclampsia and anaemia etc. b) Due to want of blood or drug, c) Elderly women from low socio-economic resources going for illegal abortion.

Such tragic picture still existing in many states of India excluding Nagaland, skim, Kerala, Mizoram [death rate is as per report by SRS, RGI 2016 -18.] low etc. Maternal death review is not done in many states till date. No CME on MMR in many places. Government (state and central) in good faith started National Rural Health Mission (NRHM) by spending a lot of fund but no positive result to prevent MMR so far. [DR DILIP KUMAR DUTTA, INSIGHT MATERNAL MORTALITY – AN INDIAN FACE BOOK, FOGSI PUBLICATION, PULISHED BY JAYPEE, PAGE37 TO171, 2012]

Idea to publish this issue is to high light the different causes of maternal death in different states and strategies to prevent such death and valuable suggestions given by experts from Assam, Manipur, Meghalaya, Bengal, Orissa, Delhi, Punjab and Andaman and nicober too.

A) SILCHAR MEDICAL COLLEGE & HOSPITAL (ASSAM) REPORTED BY
PROF ASHISH KUMAR BHATTACHARYA
Prof and hod, obstt. And gynae deptt. SMC

As silchar medical college and hospital is the only tertiary center serving whole Barak valley, North cachar hill district, part of Tripura, southern part of Meghalaya, part of Manipur and entire Mizoram, so all the critically ill patients are referred here. Unfortunately, most of the cases arrive very late to several reasons including distance and road condition. Reduction of maternal mortality not only depends on the service provided by the O and G

department but also depends on other department like – pathology, radiology, pediatrics, neurology, hematology, medicine and last but not the least anesthesiology. [Insight Maternal Mortality-An Indian Facebook, 2012 page 38 -42, publish by Jaypee brothers] Facility of ICU with multidisciplinary approach need to be present in the department of O and G exclusively.

Maternal mortality also reflects several socioeconomic and other aspects which need to be addressed by appropriate experts in order to reduce its incidence. Improvement of only medical care facility may not be able achieve the targeted goal at least in this part of the country.

Measurement taken so far:

a) Number of doctors on emergency duty have been increased with the existing staff to the maximum.
b) Patients and attendance are motivated for voluntary blood donation, contraception and for sterilization operation in appropriate cases.
c) Patients are motivated for regular antenatal check – up.
d) Two ICU beds commissioned near labor room for care of critical cases.

Scope for improvement:

a) Creating awareness for regular antenatal checkup remain to be addressed at the periphery.
b) While institutional delivery is promoted, more doctors at junior level (Medical Officers), nurses and paramedics are needed to tackle increased burden of the department of offer optimum patient care.
c) Construction of full-fledged ICU with staff within the O and G department.

Measured Suggested:

a) Good antenatal care at the periphery.
b) Timely detection and referral of high-risk patients.
c) Raising the nutritional status (correct anaemia in particular) of childbearing mother.
d) Quick transportation of critical cases with medication prior to transfer (eclampsia, hemorrhage)

Low risk /routine cases to be tackled at PHC/FRU or Civil hospital to reduce the workload of tertiary care center.

Suggestions to improve overall scenario:

a) Creation of awareness among population regarding maternal health problems.
b) Improvement of PHC system.
c) More functioning FRUs.
d) Better treatment facility with improvement of road facility.

Safe motherhood is a vital, cost-effective economic and socio investment …….. Even one woman dying is too many women dying.

B) DIBRUGARH MEDICAL COLLEGE & HOSPITAL (ASSAM) REPORTED BY: -
DR PRANAY PHUKAN,
Professor,
DR SWATI JAIN
Asst. prof

Improving women's health requires a strong and sustained government commitment, a favorable policy environment, and well-targeted resources. The government's strategy should include balancing the role of the public and private sectors to maximize resources and to extended care to women whom government programs do not reach. [Insight Maternal Mortality-An Indian Facebook, 2012 page 43 - 48, Jaypee brothers]

The unacceptably high maternal mortality rate in India can be reduced by making concerted efforts along the following lines:

a) Allocation of sufficient funds to all the health institutions including primary health centers.
b) Construction of better roads and transport facilities especially in the rural areas.
c) Periodic training programs for local dais and female health workers.
d) Early registration of antenatal cases.
e) Health education of couples to make them understand the importance of antenatal

checkups, hospital deliveries and small family norms.

f) Wide spread availability of iron-folic acid tablets and fortified food to remote areas.

g) Prevention and early treatment of infection, antepartum and postpartum hemorrhage.

h) Treatment of concomitant illnesses like diabetes, tuberculosis and malaria.

i) Emphasizing the importance of observing proper aseptic measures while conducting deliveries.

j) Providing facilities for hospital deliveries for high-risk cases like severe anemia, diabetes and heart disease.

k) Accountability in case of the unfortunate event of any maternal death. Taking appropriate remedial measures for preventing lapses noted in the management of these cases will be of immense value in reducing the maternal mortality.

Maternal mortality is a global problem facing all those involved in women's care. Strong health system is needed to analyze the cause for these deaths. Women living in rural areas or those belonging to low socioeconomic class have the highest risk of dying and carry most of the burden. We need to target specific interventions for specific populations and engage health care providers as well as policy makers f we are to meet the challenge set maternal mortality by 75% by the year 2015.

"Safe motherhood is a vital, cost-effective, economic and social investment……. Even one woman dying is too many women dying".

C) GUWAHATI MEDICAL COLLEGE: A TERTIARY CARE HOSPITAL (ASSAM)
REPORTED BY: -
SASWATI SANYAL CHOUDHURY
Prof Gauhati medical college

Gauhati

Maternal deaths due hypertensive disorders are found to be highest in Guwahati Medical College and consist of 26% of all deaths. Next cause is sepsis and it consists of 25% and which is a cent percent preventable cause. Maternal death due to hemorrhage is less and consists of 19% as transfusion facility is improved due to the presence state of art transfusion center. Anemic heart failure as a direct cause of death was found to be 12.85% and which is also a cent percent preventable cause by the existing facilities and simple measures of iron supplementation and deworming and malaria prevention, considering the area to be endemic for malaria. [Insight Maternal Mortality-An Indian Facebook, 2012 Page 49-52, Jaypee Brothers]

Rupture uterus and obstructed labor is another preventable death consisting of 7.84%. Petrographic management of labor in all cases with institutional delivery can prevent these deaths. So, it has been seen that almost 72% deaths are preventable if regular antenatal check-up to pick up all hypertensive cases as early as possible and iron supplementation with cent percent institutional delivery for sepsis prevention and provision for safe abortion service. To reduce the highest incidence of hypertension regular antenatal check-ups with blood pressure measurements are very important and achievable by simply training ANMS to check blood pressure and referring her in case of hypertension. Assuring iron tablets intake by pregnant mother is another area where ASHA and ANM can play a vital role.

Government of Assam has already taken measures to save lives of these poor mothers and one project to give free IV iron sucrose injection in mothers with severe anaemia is already been started recently in September 2011. With some more social changes of more female literacy, improvement of road conditions with better connectivity, full ANC and cent percent institutional delivery can definitely bring down MMR to MDG 5 goal very soon.

D) MATERNAL MORTALITY IN MEGHALAYA
Prof A SANTA SINGH director,
Associate prof S PANDA

The causes of maternal mortality are multiple, interrelated, complex and almost always preventable. "Delayed referral, poor transport facilities, underutilization of health facilities, and poor socioeconomic status are all

responsible for the high rate of maternal deaths.

The reasons for death of a woman in pregnancy and childbirth are many layered. Behind the medical causes are logistic causes, failure in the healthcare system, etc. And behind these are the social, cultural and political factors which together determine the status of women, their health, fertility, and health seeking behaviour.

In India, the use of maternal health care services is directly or indirectly associated with women's socioeconomic status. A17 In terms of delivery assistance, antenatal check-up and place of delivery, there appear to be a big gap according to the standards of living. Women from poorer section of the population are less likely to avail maternal health care services than rich women. Poor families do not find themselves in a position to be able to bear the cost of delivery care service." Health care is a public right, and it is the responsibility of the government to provide this care to all people equally. There should be a proper health policy by the government to decrease maternal mortality and it should be declared as a priority public health issue. Health budget should be increased and available resources should be mobilized to its fullest extent. Some useful steps include developing educational programs on health maintenance and prenatal care within the community, disseminating information through the news media and the internet, educating all women of reproductive age on the benefits of family planning, and promoting research in areas of woman health, cultural competency, and maternal mortality.

We can take the example of Sri Lanka where in 1948; its maternal mortality ratio at 630 was comparable to that of India, The MMR in Sri Lanka has shown a marked decline and as per estimates for the year 2000 is pegged at 57.0 Other indicators of maternal health are equally impressive, 96% of deliveries are attended by trained personnel and 92% of all live births take place in government hospitals. These gains have been achieved through improving both geographic and economic access to institutional health services, availability of emergency obstetric care and no health strategies like female education and woman empowerment."

The first referral hospital should be situated in areas where the MMR is high so as to avoid delay in transporting patients in obstetric emergencies. Poor road infrastructure and lack of telecommunication in the rural areas are major areas of concern. It is a very good idea to establish either maternity homes or maternity villages, close to the district hospital so that high risk cases from the remote areas can come and stay for 10-15 days prior to the onset of labour. Essential and emergency obstetric care should be available in primary health centre (PHC) level throughout the day. There should be a network of organized blood bank services. Basic amenities like ambulance services, blood pressure apparatus, weighing machine, haemoglobin meter, test tubes and acetic acid for routine urine examination for protein must be avail- able at PHC level. Good co-ordination between maternal and child health field staff and doctors can help a great extent in reducing maternal deaths. Since complications are not predictable, all women need care from skilled health professionals, especially at birth, when rapid treatment can make the difference between life and death. For instance, severe bleeding after birth can kill even a healthy woman within two hours if she is unattended. Data shows that less than two thirds (62%) of women in developing countries receive assistance from a skilled health worker when giving birth. [Insight Maternal Mortality-An Indian Facebook, 2012 page 53 -60, 168-170, jaypee brothers]

Training of the nursing staff is not up to the mark in our country. In our teaching program of nursing staff, they only have six months of rotational midwifery posting where they do not have sufficient exposure. In contrast, in Sri Lanka there is specific two-year course for midwifery where their MMR is less than 100. Medical officer should be trained to tackle obstetric emergency so that they can help at PHC level. Institutional delivery should always be encouraged and the schemes like “Janani Surakshya Yojana” should always be welcome. Nongovernmental Organizations (NGOS) should also be responsible for public awareness about women health, family planning and safe

motherhood. We should acknowledge the role of trained birth attendants and accredited social health activists (ASHAS) and support their training and integration with health care system. We should coordinate with women's organizations to promote women's health, social and economic development.

Analysing maternal mortality in Meghalaya and various steps taken by the government. Most of the mothers died because of indirect causes in 2009, mainly anaemia and malaria. These two indirect causes of maternal death are preventable. Anaemia can be due to poverty and illiteracy and poor knowledge about health. In order to prevent deaths due to malaria weekly chloroquine prophylaxis can be incorporated in iron and folic acid prophylaxis during ante-natal period. Lack of proper infrastructure and adequate man power are obstacles in public health. There are various steps taken by Meghalaya government to reduce maternal mortality and to improve general obstetric care, Steps have been taken to ensure access to skilled birth attendants and increase safe delivery to 45% by 2010. Encouragement for institutional delivery and by trained birth attendants and ASHA at village level is also done. Training co-coordinators are already appointed to train birth attendants, staff nurse and auxiliary nurse midwives (ANMS). Steps are taken to ensure supply of essential drugs and other commodities needed for skilled birth attendants in subcenters, PHCS as well as at CHCS. Steps are taken to strengthen subcenters with second ANM and provision of emergency obstetric care (EmOC) as a fall-back mechanism. Initiation has been taken for redeployment of medical officers, nurses and additional ANMS and other preclinical staff like laboratory technicians and pharmacists, etc. Strategy has been planned out to ensure round the clock services in the PACS and emergency obstetric care in the first referral units (FRUS). Many CHCS are commissioned as FRUS for comprehensive emergency obstetric care. Government is hiring skilled specialist doctors in specialty like Gynaecology, Paediatrics, and Anaesthesia. Steps are already taken to improve the infrastructure starting from PHC, CHC and civil hospitals with blood storage facility in CHCS. Reproductive and child health (RCH) consultants are appointed for Commissioning of FRUS along with the Director (Maternal and Child Health and Family Welfare), on behalf of government of Meghalaya. Government is coordinating with various NGOS to promote health education, sanitation and to prevent malaria. Government is also running 108 ambulance services for safe referral of emergency patients. North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences (NEIGRIHMS) is a tertiary health care centre situated in Shillong and established by the Ministry of Health and Family Welfare, Government of India. It is almost fully functional at present and will soon be able to reduce maternal mortality in Meghalaya to some extent.

Maternal mortality is not only a health-related medical issue but also a socioeconomic issue. It remains a major challenge to health systems worldwide. Reliable information about the rates and trends in maternal mortality is essential for resource mobilization, and for planning and assessment of progress towards millennium development goal (MDG), the target for which is a 75% reduction in the maternal mortality ratio (MMR) from 1990 to 2015. Therefore, all the health workers, media person, NGOS and the government should work together in a well-coordinated way to make the millennium development goal a success.

E) MATERNAL MORTALITY AND ITS CAUSES IN RIMS: A TERTIARY CENTER IN MANIPUR REPORTED BY: -

KHUMANTHEM PRATIMA DEVI,
NG NABAKISHORE SINGH,
CHANAM MANGLEM SINGH

RIMS IMPHAL MONIPUR.

Globally maternal deaths are a manifestation of an enormous health inequality of our time.

Individual and family level: Every girl child should be given special care from childhood and proper education to be given. Every woman should plan for pregnancy after reaching a certain age and in good physical as well as in

mental health. Every pregnancy must be given good diet, nutrition, and proper rest and health facilities. Male involvement is mandatory. [Insight Maternal Mortality-An Indian Facebook, 2012 page 61-67 Jaypee brothers]

Health service level: Easy access should be there for basic antenatal, intranasal and postnatal care to all women. There must be 100% delivery by trained birth attendant. Strong, quick and functioning referral system is a must. Emergency obstetric care is to be provided at the door step of a pregnant woman or prefer- ably at the first referral unit (FRU). Safe abortion services are to be provided to prevent unwanted pregnancies.

Community level: Regular health education program involving all people must be arranged. There should be proper communication, roads and transport facilities. We must change social and cultural bad norms.

Policy maker and Government: Maternal mortality reduction should be the top priority among all problems and every country should reform laws in relation to women's health.
What is tragic is that most of these deaths are preventable. Maternal deaths are still high in comparison with developed countries. Sustained reductions in maternal mortality will only be possible if modern high-quality obstetric care is made available to all women through a system of professional midwifery and referral hospital care in the context of political commitment arid accountability of health providers.
A recent systemic review of the causes of death stressed the need for increased emphasis on prevention and treatment of obstetric haemorrhage and noted that most postpartum deaths should be avoidable by appropriate management. "Much needs to be done for maternal health care in rural areas, as most of the deaths reported are referral from peripheral centres. Concentrated efforts are required to obtain the missing data by improvising better and accurate data collection. Heath education of masses along with good quality health care and transport facilities can prevent many deaths.

F) MKCG MEDICAL COLLEGE, BERHAMPUR, ORISSA REPORTED BY: Prof RITANJALI BEHERA

SUGGESTION FOR DECEASING MMR AT OUR AREA:

As our most of death are due to haemorrhage and eclampsia

a) Universal antenatal care is the first step to diagnose and screen high risk cases for PIH and PPH.
b) Every FRU should be well-equipped and posted with an Obstetrics and Gynaecology specialist who should be trained with anticonvulsant therapy and its toxicity.
c) Care should be taken for Hb% concentration of patient either by oral/ parenteral iron therapy, so she can withstand PPH.
d) Healthcare providers should properly be trained for prophylaxis and treatment of PPH by oxytocics like use of syntocinon and misoprostol and more important is they should well experience with PPH drill.
e) Every PHC/FRU should be given all management protocol and to work accordingly.
f) Early diagnosis and timely referral can save the other.
g) Proper instrumental delivery for right patient should be chosen to avoid traumatic PPH.
h) TBA and PHC doctors should trained time to time interval for updating the knowledge.
i) Fixing an accountability of Medical Officer In-Charge.
j) Good transport facility can save the PPH patient as they need early intervention.
k) Last but not the least to establish a multidisciplinary patient safety team for PPH and eclampsia and septicaemia.
l) Lastly, our institution should improve with a critical obstetric care unit.

CONCLUSION:
Maternal mortality is a human right issue. Most maternal death are preventable by health education of masses, adequate healthcare in the community and good transport facilities. As safe

motherhood is a women's right, maternal mortality prevention is a great challenge. Effective reduction of maternal mortality requires long-term effort as it requires strengthening of the healthcare system. [Insight Maternal Mortality-An Indian Facebook, 2012 page- 166 -167, jaypee brothers]

G) MATERNAL MORTALITY IN A TERTIARY CARE HOSPITAL IN CENTRAL INDIA (MADHYA PRADESH) REPORTED BY:

Prof LAXMI MARU,
Asso.prof ANUPAMA DAVE

Why do these women die? (3 delays model)

a) Delay in decision to seek care:
-- Lack of understanding of complications, acceptance of maternal death, low status of women, sociocultural barriers to seeking care
b) Delay in reaching care:
-- Mountains, islands, rivers -- poor organization c) Delay in receiving care:
-- Supplies, personnel, poorly trained personnel with punitive attitude, finances.

Problems Faced at Grass Root Levels:

It is not possible to predict which mother will develop complication, most com- plication cannot be prevented by good antenatal care. Once major obstetrics complication, which can cause death develop, even a trained TBA or a nurse cannot do much at home.

Problems Faced at Tertiary Level:

Late referral, lack of obstetric ICU, lack of sufficient nursing staff, lack of emergency drugs and equipment's, too much work load and scarcity of medical staff.

Current Situation:

a) Many interventions are not implemented properly
b) Lack of specialists and trained staff in rural areas
c) Delegation of EmOC functions not done weak monitoring of implementation-FRU's operationalization, deliveries and EmOC care, maternal deaths.
d) Lack of integration and coordination of inputs.
e) Lack of monitoring of outputs and weak supervision.
f) Many problems in design
g) Availability of blood remains as a problem - not many blood storage units started.
h) Referral transport money not much used.
i) Too many activities and programs -no focus on EmOC or delivery care. No large scale or systematic evaluation.
j) FRU's still not functional - no monitoring.

Lessons and Future Directions:

a) Key objectives are improving availability, utilization and quality of EmOC.
b) Stepwise improvements.

Recommendations Steps to be taken:

a) Eradicate extreme poverty and hunger.
b) Achieve universal primary education.
c) Promote gender equality and empower women.
d) Reduce child mortality.
e) Improve maternal health.
f) Combat HIV/AIDS malaria and other diseases.
g) Ensure environmental sustainability.
h) A global partnership for development.

Benefits of Obstetrics ICU:

Prevention and early recognition of problems, prompt management, peripartum monitoring, residents - training, non-invasive monitoring, invasive, medical application, foetal monitoring. India can reduce MMR. But needs political and societal commitment. [Insight Maternal Mortality-An
Indian Facebook, 2012 page 117-122, 164, jaypee brothers]

"Maternal mortality is a neglected tragedy and it has been neglected because those who suffer are neglected people with least power and influence, they are poor, the rural peasants and above all women".

H) MMR SGRD IMS AND R AMRITSAR (PUNJAB) REPORTED BY:
Prof MADHU NAGPAL

a) Improving infrastructure for maternity services at every step including training of all paramedics even transport vehicle drivers to act swiftly in case of emergency.
b) More emphasis on emergency obstetrical care with round the clock availability of specialists in primary/secondary healthcare.
c) Mandatory antenatal booking with institutional delivery being emphasized.
d) Team work for critical care obstetrics, availability of HDU, CCU beds and NICU facilities for improving maternal and perinatal outcome.
e) Ensuring availability of blood and its components whenever required in emergency situations.
f) Anaemia prevention is an important aspect keeping in view the prevalence in pregnancy.
g) Promoting the use of contraception to limit family structure which will improve women's health in general.
h) During postgraduate teaching - emergency obstetrics, critical care, mock drills for shoulder dystocia, PPH, eclampsia management, step wise devascularisation should be essentially taught.
i) Implementation of national programs in true spirit is in woman's benefit.
Overall inculcation of will to work attitude will help a lot. [Insight Maternal Mortality-An Indian Facebook, 2012 page -167-168, jaypee]

I) MATERNAL MORTALITY IN ANDAMAN AND NICOBAR ISLAND REPORTED BY:
Prof **MK SAHA,**
Prof **INDU CHAWLA,**
Prof **ANIS AKHTARKHAVARI**

POSITIVE CONTRIBUTORS TO LOWER MATERNAL MORTALITY IN ANDAMAN AND NICOBAR ISLANDS:

a) Ninety-eight percent registration/booking of antenatal cases.
b) Eighty-eight percent institutional deliveries.
c) High level of motivation of blood donors.
d) Efficient transportation system.
e) Deliveries being conducted by nurses who have years of experience.

Shortcomings:

a) Inadequate postoperative monitoring which requires services of resident doctors/trained house surgeons round the clock.
b) No availability of swift access to life-saving technology.
c) Despite very good antenatal coverage 16.66% maternal mortality was due to intractable heart failure secondary to severe anaemia. A matter of grave concern.
d) Geographical constraints arising out of scattered Islands.
e) Lack of blood bank facility in any place other than Port Blair.
f) Reluctance of specialists to join Andaman and Nicobar Islands.

Remedial Measures that have been taken Over the Years

a) Training of medical officers in emergency obstetrics: 2 doctors trained so far.
b) Training of staff nurses in skilled birth attendants (SBA): 54 nurses trained already and the training process is ongoing.
c) Reproductive and child health (RCH) training to nursing personnel: 111 staff nurses, 3 PHN, 27 LHV, 182 ANM and 29 AANM have already been trained.
d) Provision of kits at several health centres for testing blood for HIV and HbsAg to facilitate transfusion in remote areas in cases of postpartum haemorrhage.
e) Provision of Pitocin, Methergin and magnesium sulphate to all sub enters and all these plus injectable prostaglandins to all PHCS and CHCS to combat PPH.
f) Contacting the Gynaecologist, posted at GB Pant Hospital, by mobile phone in cases of obstetric emergencies requiring evacuation has been made mandatory, of late.
g) Ministry of Health and Family Welfare, Government of India has been deputing specialists to Andaman and Nicobar Islands on short-term duty from central health services for 90 days on rotation to overcome the perpetual shortage of specialists in Andaman and Nicobar Islands.

Summary:

Andaman and Nicobar Islands is situated some 1200 Kilometres away from mainland India. But the presence of a dense network of health infrastructure, strewn all over the Islands, in the form of one referral hospital, five urban health centres, four community health centres, twenty primary health centres and one hundred and fifteen subsidiary health centres speaks for itself how carefully designed the healthcare delivery system is. The presence of so many health institutions in such a small Union Territory does defy the Indian public health standards (IPHS) though, but it is certainly for the betterment of the Islanders. The ANC registration rate of 98% is perhaps the best in the country and so is the institutional delivery rate of 88%. The ten-year average maternal mortality ratio for the entire Andaman and Nicobar Islands of 86.7% is yet another milestone for this Union Territory. But against the backdrop of such glorifying vital statistics there are matters of serious concerns. The islands healthcare sys- tem is riddled with a perpetual manpower crisis. The specialists from mainland India are not too keen to come and serve in such remote places. Out of 51 sanctioned posts of specialists presently only 09 posts are filled up by MOH and FW. This is one of the constraints that this Union Territory is grappling with all these years. The others are: inspite of 98% ANC registration, and a large number of antenatal patients attending over ten ANC visits, as many as five maternal deaths (16.66%) took place due to intractable heart failure as a result of severe anaemia. This clearly speaks of serious lacuna in the manner in which antenatal care is provided.

Detailed scrutiny of case records revealed that most of these patients did not turn up for routine ANC after initial registration. In any case, this is an important shortcoming that we are looking into. The other serious setback is three maternal deaths (10%) took place in GB Pant hospital itself as a result of late detection of intraperitoneal bleeding following caesarean section. These deaths could have easily been avoided had these patients been carefully monitored in the Postoperative period. The labour ward is generally managed by a general duty medical officer with no special knowledge in obstetrics. The number of specialists is far too few to look after every admitted patient on a regular basis. Moreover, in all these three cases caesarean sections were performed by general duty medical officers (CHS Cadre) with postgraduate qualifications who were posted on a short-term rotation basis by MOH and FW to overcome the manpower crises here but they did not have much experience in performing caesarean section before coming to this place. They were initially trained and later on allowed to do caesareans by themselves. Subsequently, however, posting of specialists, exclusively, by MOH and FW has indeed changed the scenario greatly. There has been no such death thereafter. However, if there were regular junior residents or house surgeons in obstetrics and gynaecology things would have been different altogether, particularly in terms of monitoring the postoperative cases. Regular refresher training to ANMS and strict supervision of antenatal care by trained personnel can make a significant difference in the overall maternal health scenario in this island territory. We are striving hard to accomplish this. A series of measures, as highlighted above, has already been taken in a bid to reduce maternal mortality further. These coupled with the extraordinary importance that the Ministry of Health and Family Welfare, Government of India is paying in recent times, by tracking every antenatal mothers and critically analysing every single maternal deaths that occurs anywhere in India, both in the form of community based review as well as the facility based review, to know the exact cause of such deaths and the measures that can be taken to prevent its recurrence, will certainly bring down MMR to a respectable level. Such extraordinary measure will surely bear fruit if we all act conscientiously with the conviction that our profession demands. [Insight Maternal Mortality-An Indian Facebook, 2012 page 105 to 113 jaypee brothers]

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