Making Pregnancy Safer- Intentions and Challenges

Report of a meeting held in Ranchi, 4-5 May, 2012

CommonHealth

Coalition for Maternal-Neonatal Health and Safe Abortion

www.commonhealth.in

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"Making Pregnancy Safer- Intentions and Challenges"
Ranchi, 4-5 May, 2012

CommonHealth - Coalition for Neonatal Health and Safe abortion held a two day meeting in Ranchi on "Making Pregnancy Safer – Intentions and Challenges" during 4th & 5th May, 2012. Dr Lindsay Barnes and Dr TK Sundari Ravindran of CommonHealth's Steering Committee and Dr Dinesh Singh of JHPIEGO (came as member of CommonHealth?) steered the two day meeting. Logistical support was provided by Child In Need Institute (CINI), Ranchi and organising support by various members of the *Jharkhand Women's Health Network*. The meeting was organised in two parts. The first day of the programme deliberated on the poor state of maternal health in the state. The focus was on sharing experiences from the ground on challenges related to maternal health and gaps in maternal health care, and coming up with recommendations to be presented to government authorities. There were also a few technical updates on various aspects of maternal health care of importance to Jharkhand. On the second day, in which officials from the government, from the medical college hospital and from international agencies participated, recommendations of the group were presented and discussed with them. Annex-1 presents the agenda for the two days.

The meeting was attended by 75 participants including more than 60 activists and organisations from nearly 15 districts of Jharkhand working in the area of maternal health. Annex-2 contains the list of participants.

DAY 1

The meeting started with welcome and purpose of the meeting by Lindsay Barnes, followed by self-introduction by participants. CommonHealth's vision and mission and activities were then shared with the group by TK Sundari Ravindran. She also walked participants through CommonHealth's website and the various resources that could be accessed from it. Lindsay Barnes then set the stage for the meeting by presenting an overview of the maternal health situation in Jharkhand.

Maternal health situation in Jharkhand compared poorly with national averages. Only 19% of deliveries in the state took place in health facilities as compared to 41% in India, according to NFHS-3 data. The maternal mortality ratio of Jharkhand was 261/100,000 live births, as compared to 212 for India. While medical causes of death were well known, the many social causes were not be overlooked. Poverty, lack of transportation, lack of information, gender discrimination, low health status and severe malnutrition among women, poor quality or non availability of health services- were only a few of the many underlying factors that made women vulnerable to the medical conditions that claimed their lives.

The majority of maternal deaths (61%) took place after delivery, of which 45% happened within 24 hours of delivery. A quarter (24%) of the deaths occurred during pregnancy and 15% occurred during delivery. Interestingly, an almost equal proportion of maternal deaths

took place in health facilities and in homes: 42% and 41% respectively. Thirteen percent of the women died on their way to a facility while 4% are reported to have died in 'other' places (according to analysis of 142 deaths through the MAPEDIR process by UNICEF).

Neonatal mortality rate in Jharkhand – at 49/1000 live births- was also higher than the all-India average of 44/1000 live births. A third of all neonatal deaths occurred on the first day, while three-quarters occurred within the first week.

Government's response to the situation has been to introduce *Janani Suraksha Yojana,* srat? training of Skilled Birth Attendants, introduce Sahayas (women community health workers) to provide education and first-level care at the domiciliary level; and the Mamta Vahan for providing transportation to women to reach a health facility for delivery. And JSSK. The effectiveness of these measures in addressing the maternal health situation in the state, and the gaps in these were to be deliberated in the meeting.

'*Voices from the Ground*' was the next session. There were presentations from Godda, Noamundi, Madhupur, West Singhbum and Bokaro in Jharkhand, and also by two CommonHealth members from Orissa.

Soumik Banerjee reported on 23 maternal deaths of 3150 births in Sunderpahari and parts of Poreyahat block of Godda district during April 2011 – March 2012. This works out to an MMR of 761/100,000 live births, ~ 3 times the State figures of 261/100,000. The majority of women (70%) in this area have below-normal BMI and 78% are severely anaemic with haemoglobin levels of between 7 and g/dl.?

Of the women who died, all were from economically weaker sections, 74% were from indigenous communities (Santhals), and 85% had never attended school. Many were very young - 61% were in the 18-22 age group and 43% died in their first pregnancies. Just over half (56%) of the deaths were post-natal. Maternal deaths also resulted in newborn deaths, only three children survived their mothers.

Forty eight percent (48%) of the deaths occurred at home, 35% at hospital and the rest in transit. This was despite the fact that 80% of the villages were motorable. Thirteen percent received no medical care, and 65% approached local practitioners first. This was because of the long distances to functional facilities. Mean Time taken to reach the nearest functional facility from home since appearance of symptoms was 7.5 hours; mean time taken for referral between CHC to DH to Bhagalpur was 7 hours and the nearest FUNCTIONAL EmOC facility- Jawaharlal Nehru Medical College and Hospital was in Bhagalpur in the neighbouring state of Bihar, located 70 km from the district headquarters. Mean out of pocket expenses incurred was Rs 4478 and ranged between Rs 400 and Rs 10,000.

The families of many women reported abusive and insensitive behavior by staff in health facilities even at the time of serious emergencies (See Box p.4).

- *Go and put up in the verandah, I have to close the ward*---ANM telling woman having convulsions at CHC
- *Do not step in my vehicle if you don't have money*--------Driver of Mamta Wahan telling husband of woman going for delivery
- *Why have you come here, nothing can be done, take the mother to Bhagalpur*------- Doctor telling woman's family at District Hospital
- *Pay up! Throw the baby in the ditch and get lost*------Nurse yelling at a woman who had just delivered at stillborn baby.
- *Then you call the person whom you gave money and let her do the delivery*-------ANM telling family members to pay her even after they had already paid Rs 300 to the previous ANM on duty
- *You illiterate brats, pay up else we will thrash you*-------Nurse telling woman who had delivered a stillborn baby

Soumik went on to describe an intervention his organization had undertaken in Paharia villages (17 ICDS & 2 HSCs). The activities they undertook included

- Complete Monthly ANC
- Third Trimester Camps
- Post Natal Home visits
- 24x7 Emergency Referral System
- Awareness Programs
- Malaria prevention & control
- Training of Community Resource Persons

Even with these simple interventions, huge changes were already visible. There had been no maternal deaths in the project area from Oct 2008 till date. Neonatal mortality dropped by 15%. There was a 7% drop in cases of severe malnutrition. The Slide Positivity Rate –SPR of malaria dropped by 15% between 2010-11 & 2011-12. Kala-Azar incidence dropped below 5 annually from 126 in 2006.

The next presentation was by Pani Lahori from Naomundi in West Singhbum. She highlighted the near-absence of health services in their area which covered 18 panchayats. Transportation was very poor in these villages surrounded by three huge coal mines (I think they are iron ore mines). No deliveries were being done in the PHCs. The doctors came for 1-2 hours in a day and left. ANMs came once a month for antenatal care and Village Health and Nutrition Day. Only the Sahaya knew about the Mamta Vahan and how to get in touch with it. Women in the community knew about JSY but preferred to deliver at home because of the huge distances (30kms upwards) to the government hospital where normal delivery was conducted. In this hospital, Magnesium Sulphate, Oxytocin and Misoprostol were unavailable

and there were no blood transfusion facilities, which meant that women had to go even farther in case of emergencies.

Kalyani Meena of Prerana Bharti spoke about the situation in Chakulia Block of E.Singhbum. Some PHCs here had been upgraded to CHCs, but without investing in additional manpower, equipment and facilities. This meant that it could not function as a first referral unit (FRU) catering to obstetric emergencies. For EmOC the nearest functioning facility was in the neighbouring state of W.Bengal, to which Jharkhand's Mamta Vahan would not take the women. One of her major concerns related to severe malnutrition among pregnant women. At present they were given inadequate rations erratically – may be 3-4 times during their entire pregnancy rather than monthly. The rations were hardly sufficient to feed a family for a single day. The scheme was not serving its purpose of improving the nutritional status of pregnant women and improving pregnancy outcome. Another concern related to the VHND having become a mere distribution of Take-Home-Ration event. Time had to be allocated to complete the whole range of antenatal care services, and especially for providing counselling and health education to pregnant women on danger signals during pregnancy and delivery and self-care.

Nirmala Nair of Ekjut spoke about the work they had been doing since 2005 in West Singhbhum, Saraikela-Kharsawan & Keonjhar and which had resulted in a significant reduction in maternal mortality. The population included a number of tribal communities and non-tribal communities. Between 2005 and 2011, the MMR in the target population had come down from 720 per 100,000 live births to 327, a reduction of 393 points in 5 years, or 80 in a year on average. In Jharkhand, the MMR had declined from 312 to 261 in 3 years, or 17 points on average per year. What had brought about this change? One contributing factor may be that the NRHM had made significant investments in improving access to health services. But this could not be the only reason or even the major reason, because the increase in institutional deliveries had been modest . According to data for 8 districts in which Ekjut now works, proportion of institutional deliveries increased from about 32% to 45% during 2008-2011. However, the decline in maternal deaths in these 8 districts was steep: from 38 to 18 deaths. Ekjut's interventions in the community had contributed significantly to the decline. The strategy consisted of:

- Empowerment of women through women's groups – 20 000 women meet every month
- Shaping community norms for building delivery?? Meaning?
- Increase in problem solving skills and decision making
- Peer learning
- Reducing first & second delays
- Accessing appropriate place, facility and birth attendant

Nirmala concluded her talk by highlighting that community mobilization + improved health services could make a significant dent in bringing about a decline in maternal deaths. System strengthening is a slow process hence there was need for hastening the process with other interventions such as Ekjut's. Issues that still loomed large and required immediate attention

and investment were addressing early marriage and childbearing and prevention and early detection and treatment of malaria in pregnancy.

The next voice from the ground was that of Kajol from *Jan Chetna Manch* in Bokaro. Kajol talked about the absence of emergency obstetric facilities in the areas where her organisation worked. The PHCs and CHCs did not have Magnesium Sulphate, Oxytocin or Misoprostol. While normal deliveries were conducted in PHCs, women were often sent home straight from the labour table. Nurses in PHCs were frequently unable to handle even minor problems. For example, a woman who developed perineal tear could not be stitched up and had to seek care from a private referral facility, incurring an expenditure of Rs 18,000. Such experiences discouraged other women from opting for institutional deliveries. She also narrated that no emergency obstetric care is available in any of the government hospitals that Mamta Vahan transports women to. The nearest government hospital for EmOC is in Purulia, West Bengal. Kajol was also concerned about the severe malnutrition among pregnant women. She felt that the rations now being given were meagre in quantity: 700g of rice, 250 g of oil and 400 g of dal for a woman per month. This was often not given monthly and even when given, was usually consumed by the entire family and not benefiting the severely malnourished woman. A much better way to tackle sever malnutrition in pregnant women may be to give them *chana sattu*, a local food supplement of high nutritional value 9or similar preparations) which the pregnant woman will directly consume.

The next two presentations were by CommonHealth members from Orissa. Madhusmita Panda who works for UNICEF in Mayurbhanj district of Orissa made a presentation on the Maternal Death Review Process adopted in Orissa. Jeevan Krishna Behera of Society for Development Action (SODA) made a brief intervention drawing attention to unsafe abortions as a contributor to maternal deaths. The high proportion of deaths in pregnancy (about 24% reported in some instances) needed to be examined to verify if unsafe abortion may have been responsible. Advocacy for availability of and access to safe abortion services free of cost to the woman was highlighted by him.

The first half of the afternoon consisted of technical sessions. The first was on the three government schemes for maternal health: *Janani Suraksha Yojana*, *Janani Sishu Swasthya Karyakram* and Mamta Vahan (Annex-3). The second presentation was on three life-saving drugs in delivery and post-partum: Oxytocin, Magnesium Sulphate and Misoprostol. This was followed by a session on malaria in pregnancy and prevention measure. The last technical presentation was on preventing sex-determination and promoting access to safe abortion as part of the same agenda of challenging gender discrimination. The content of the last three presentations are available as CommonHealth fact sheets which will soon be uploaded into its website.

During the last session of the day, participants deliberated on recommendation to be made to the government around five themes: gaps in government programmes; malaria in pregnancy; anaemia and malnutrition; antenatal and post-natal care; and access to safe abortion services. The day ended after completion of the discussions and drafting of recommendations.

DAY2

The first part of the second day was spent on presentations by the thematic groups of their respective recommendations and discussion and agreements on a final set of recommendations. Officials from the government, from the medical college and from international agencies joined us following this.

Shubhra Singh from UNICEF shared with participants the Maternal Death Review Process by UNICEF (MAPEDIR) in selected districts of Jharkhand. This was followed by a talk by Mr Balram –advisor to Supreme Court and human rights advocate on the Right to Food and Health.

Recommendations from the group were then presented to the officials present (see next page). Dr BP Sinha, State RCH Officer, Dr Sumant Mishra of MCHIP, Dr Rajan Kumar, State Programme Manager, Dr Kiran Trivedi from RIMS, Dr Madhulika Jonathan from UNICEF were among those present. The officials stayed through the entire day, gave a patient hearing to all the recommendations and the discussions on these, and responded to many queries related to the issues. The representatives from government assured participants that a high-level committee will consider the recommendations and after due deliberations, take effective action to rectify the gaps in the system. The aim of the government was to protect the life and wellbeing of women in pregnancy and childbirth, they assured all participants.

The meeting ended on a high note with the felicitation, on the occasion of International Day of Midwives, of three midwives – Kajol Devi, Raimoni Boipai and Kiran Tiru - who have rendered yeoman service to ensure safe delivery to the poorest women in under-served districts of Jharkhand.

Recommendations from the meeting

1. Enabling government schemes for maternal health to reach women effectively

Mamta Vahan

Mamta Vahan now brings women from villages to PHC. But this is a limitation. The Rs 500 provision for referral transport is not useful because distances vary. Second and further referral should have timely and cashless transfer till the woman reaches a place where she gets definitive treatment. Cashless transportation for referral should be available to go to the nearest functional EmOC facility, irrespective of whether the hospital is a private one, or whether it is located in a bordering state. The ultimate purpose is saving the woman's life. The point that I had made was that – in order to reduce delays in accessing emergency care for complicated deliveries – private accredited (under JSY) hospitals (which includes some missionary hospitals located in remote areas) should also be included in Mamta Vahan.

If the vehicle does not reach within 30 minutes then the family should be reimbursed for expenses incurred on any vehicles at the same rate as compensated for Mamta Vahan.

Another barrier to availability of Mamta Vahan is difficulties in phone connectivity to Mamta Vahan Call Centres. Call Centres should be given mobile phones with adequate credit so that they are contactable at all times to be able to effectively provide transportation for delivery care.

Janani Sishu Swasthya Karyakram

Under this programmes, seven entitlements are guaranteed to any pregnant woman and the newborn seeking health care from government health facilities, throughout the pregnancy period up until one month after delivery. These include:

- Free delivery services
- Free c-section delivery services
- Free drugs
- Free diagnostic tests
- Free food (for 3 days after normal delivery and 7 days after c-section),
- Free blood (if transfusion is required), and
- Free transportation (from home to health centre and back)

Should any of these entitlements not be available in a government facility then reimbursement should be given for services sought from the nearest private health facility that can provide these services.

Currently cashless transfer is mentioned only from home to a health facility and back. Facilities for referral cashless transfer should be available for second and further

transfers, to the nearest health facility capable of providing emergency care, till one month postpartum for the mother and the newborn.

Government health facilities

- Infrastructural facilities in PHCs and CHCs need to be improved to enable women's stay in health centres till 48 hours after delivery. One reason why women do not stay back is lack of awareness which needs to be addressed, but another reason is the lack of facilities for stay, toilet etc of care-givers.
- Cleanliness in health facilities is a major concern. Swift action needs to be taken to ensure adequate standards of cleanliness and to protect people from hospital-based infections.
- It would be useful to have a checklist of essential facilities, drugs and equipments that are required to be kept in every health facility. The availability of these should be monitored and reported on a three-monthly basis, and reported. Special attention should be given to ensuring the availability of three essential drugs for saving maternal lives – Oxytocin, Magnesium Sulphate and Misoprostol.
- Information on doctors and health providers on duty should be put up in every health facility.
- Government doctors may be given Non-practicing allowance and strict prevention of private practice should be brought about.
- The practice of demanding under-the-table and informal payments should be strictly controlled and disciplinary action taken. There are instances when patients who refuse to pay are referred to private facilities to teach them a lesson.
- There should be a suggestion box in all health institutions providing public services. These should be opened every week by the authorities and suitable action taken. Information on actions taken based on the suggestions received could be displayed prominently next to the suggestion box as a means of accountability.
- At the level of PHC and Health Sub-centre there are at present no mechanisms such as the *Rogi Kalyan Samiti* in which local people can participate and voice their feedback and opinions. *Rogi Kalyan Samitis* should have greater participation of members of the local community and especially women and those from socially marginalised groups.

Other public institutions/mechanisms

- *Village Health and Sanitation Committees* should function as resource centres for giving information on entitlements related to social welfare and health. It should also have information on where women should go for which kind of obstetric emergencies, where blood bank is available, where C-section is available etc.
- In the case of *National Maternity Benefit Scheme* for giving maternity benefits for home deliveries there should be no differences across population groups and no limitations by parity or BPL status. There is a Supreme Court Ruling specifying this and this may be taken cognisance of. Absence of conditionalities is now true for Janani Suraksha Yojana, and should also be true for home deliveries.

- Under the Janani Suraksha Yojana, when women utilise delivery care from accredited private facilities, they have to pay for services including high costs of c-sections, although they do receive the Rs 1400/- which they are entitled to. The costs of care in accredited private facilities often make women and their families hesitate seeking EmOC in a private facility even when it is the only functioning facility available. (Or force the family to seek government health care in the neighbouring states of West Bengal/Orissa/Bihar which are further away) Delivery care services including c-sections in accredited facilities should be made available free of cost to the patient, government may reimburse the concerned facility.

2. Effective prevention and control of malaria in pregnancy

- At the community level, cleaning of water-logged pockets, spraying and other mosquito control measures need to be implemented regularly
- Every pregnant woman should be given long lasting insecticide treated mosquito nets and widespread awareness campaigns should be carried out to bring home the importance of sleeping within it.
- IEC materials need to be produced and widely disseminated – including as prominent displays in public places – that a pregnant woman with fever should immediately get tested for malaria because malaria in pregnancy can be fatal for women
- Drugs for malaria should be available in every village
- Every Sahiyya should be trained repeatedly on malaria testing and treatment and given adequate supplies of the Rapid Diagnostic Test kits.
- Medical officers need training on the treatment protocols for falciparum and vivax malaria in complicated and uncomplicated malaria in women
- Regular reporting on the incidence of malaria in pregnant women and treatment outcomes

3. Prevention of anaemia and malnutrition in women and girls

One of the fundamental challenges in improving maternal health is the prevention and control of anaemia and malnutrition in women and girls overall with special additional measures for pregnant women.

- Rations for pregnant women should be available every month and the quantities of food supplies provided need to be increased to a level that will enable the woman to overcome anaemia and malnutrition. Attention to the nutritional value of the diet provided so that it is balanced with adequate protein and suitable and culturally acceptable food. One suggestion is to give all pregnant women *channu sattu*, a locally acceptable food supplement, along with antenatal care.

- The VHSC should participate in ensuring proper functioning of ICDS, in purchasing food items for the centre and deciding on a locally suitable and appropriate diet.
- The IGMY Scheme is currently being piloted in a few districts in Jharkhand. This Scheme is meant to improve the nutritional status of pregnant women. In its current form, there are many conditionalities imposed for availing benefits from this

Scheme: for example it is not available for women of parity above two, and for those who have not been immunised. Such conditonalities should be removed because they run the risk of excluding women who need the nutritional support most. The Scheme may follow the same norms as those prescribed by the Supreme Court of India for the NMBS, and should be available to all women, and expanded to all districts as soon as possible.

- Anaemia tests need to be carried out on all girls and women at the community level as well as in schools. These be carried out properly, so that results are valid.
- There are reports from communities of non-availability of IFA tablets in some pockets. Systems should be put in place to make sure that IFA tablets are universally available
- Sahayas may be given proper training on diagnosing and treating anaemia and malnutrition.
- Women with severe anaemia should be kept in the health facility longer than 48 hours after delivery, and given appropriate diet and drugs in the hospitals till severe anaemia is resolved.
- Community-based nutrition rehabilitation centres need to be created according to the number of malnourished children in every community and adequate investments have to be made to cover all malnourished children

4. **Enhancing the availability, coverage and quality of antenatal care and postnatal care**

- Antenatal care has come to mean merely providing pregnant women with tetanus toxoid immunisation in the second and third trimester of pregnancy. There is an urgent need to ensure that when TT injections are given, height/weight is taken, urine and BP tests are carried out on a priority basis, necessary treatment provided and appropriate follow-up action taken.
- HMIS should track whether all tests were carried out in ANC, this data should be compiled and reviewed at all levels starting from subcentre upwards.
- During the Village Health and Nutrition Day all the stipulated tasks should be carried out, including counselling and health education, rather than be a Take-Home Ration distribution event. The government should mobilise adequate human resources to do so.
- TBAs have been marginalised under NRHM. However, since 60% women in the state deliver at home, TBAs visit women for 6 days post partum, and evidence is available that training TBAs can reduce neonatal mortality, the training and involvement of TBAs needs to be taken up.
- Sahayas may be required to make at least three visits to all mothers postpartum: within 24 hours, on 3-4 day and between 7-10days respectively. They may be given a checklist on essential services for the mother and the newborn in the postnatal period, including weighing of the baby; identifying danger signs in the mother and child; counselling on immunisation, breastfeeding, nutrition for self and family planning. Sahayas may be given suitable incentives for delivering complete PNC. Supervisors should ensure that all these services are provided. Sahayas need to be trained and equipped adequately for doing this.

- Danger signs in mother and newborn in the immediate postpartum period should be known to the Sahiyya and she should have an emergency drug kit for immediate first aid including for e.g. Cotrimoxazole paediatric; paracetamol; anti-malarials and gentian violet. Immediate referral should also be ensured.
- Information on where to go for emergency care in the postpartum period for women and emergency neonatal care and contact details of such places should be available at the sub-centre level. Such information may also be prominently displayed within the community so that no time is lost in timely referral.
- If neonatal care for seriously ill newborns is not available in the government health system, reimbursement should be made to the family if they access care from the private sector. Mamta Vahan should also be clearly instructed not to bring such babies to the government PHC/CHC if NICU is not available.

5. Ensuring access to safe abortion services

- Awareness-raising and IEC on legal status of abortion and indications for which Medical Termination of Pregnancy is provided lawfully should be carried out not only among community members but also among Panchayati Raj Institution members, health providers, policy makers
- Medical abortion and Manual Vacuum Aspiration (MVA) need to be made available from the PHC level to tertiary care hospitals
- Comprehensive Abortion Care provided need to be of a technically high quality as well as humanely provided. Counselling may be made an integral part of these services, including post abortion counselling and services for family planning
- There should be no refusal by health providers for any MTP legal under the law in any certified MTP facility. Should services be refused, the concerned woman should have recourse to complaints and redressal procedures
- Visible sign boards on availability of MTP services in all MTP facilities may be made mandatory. Further, in government facilities, the sign board should also announce that MTP services areprovided free of cost.
- In order to increase the availability of MTP service delivery points, District MTP committees may be formed where they do not exist; and their effective functioning to inspect, license and monitor MTP service delivery be facilitated by the Department of Health and Family Welfare
- Adequate budgetary allocation may be made in district and state PIPs for MTP training, equipment, drugs at all levels of facilities from PHC upwards. This may be followed by regular reporting as part of NRHM on actual expenditure of the allocated amount and activites carried out
- Regular reporting on MTP services provided may be made an integral part of NRHM monitoring activities.
- PCPNDT committees may be constituted in all district where these do not as yet exist, and their efficient functioning facilitated in order to prevent sex determination

Annex-1

Agenda for 4 May 2012

Time	Subject	Person	Facilitator
9 -10	Registration		
10 - 11	Welcome & Introduction & Agenda for 2 days	All the participants	Lindsay Barnes
11- 11.15	About CommonHealth	Sundari Ravindram	
11.15 - 11.30	Maternal & Neonatal Health Scenario in Jharkhand		Dinesh Singh
11.30 - 13.00	Panel Presentations: Voices from the field: • Godda • Noamundi • Madhupur • Singhbhum • Bokaro • Orissa	Soumik Pani Kalyani Nirmala Kajola Madhusmita Jeevan	Sundari
13.00 - 13.45	Lunch		
13.45 - 14.15	Schemes for improving maternal health (JSY/JSSK/Mamta Vahan)	Rajan Kumar	Gurjeet Singh
14.15 – 14.45	Essential Lifesaving drugs during childbirth: Factsheets 3 Drugs: Oxytocin, Magnesium Sulphate & Misoprostal	Dinesh Singh	Sundari Ravindram
14.45 – 15.15	Malaria in Pregnancy	Suranjeen Prasad	Kalyani Meena
15.15 - 15.30	Tea break		
15.30 - 16.00	MTP & PCPNDT Acts access to safe abortion & declining sex ratio	Sundari Ravindram	
16.00 - 18.00	Group discussions: Topics: Gaps in the system Malaria Malnutrition & anaemia ANC & PNC Safe abortion	Group facilitators: Dinesh Gurjeet Suranjeen Lindsay Sundari	

Agenda for Meeting on 5th May, 2012 at Hotel Green Horizon

Time	Subject	Person	Facilitator
9.30 – 11.00	Presentations and Conclusions from group discussions	Representatives from thematic groups	Lindsay
11.00 – 11.30	Tea break		
11.30 – 12.30	Maternal Death Audit: UNICEF and MAPEDIR	Shubra Singh, UNICEF	
12.30 – 13.00	Constitutional provisions: Rights to life, food, etc	Balram	
13.00 – 14.00	Presentation of recommendations to government officials and discussions	Lindsay Barnes	
14.00 – 14.30	Lunch		
14.00- 15.00	Responses	SPM, SRCHO	Dinesh Singh
15.00- 15.30	Felicitation of midwives on occasion of International Midwives Day		
15.30- 16.00	Way Forward		

Annex-2 List of participants				
1	Manju Raj	Mahila Jagruti Trust, Gomia	9939174968	-
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5	Usha Kumari	Jagruti Mahila Samiti, Jamtada	9955542842	
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11	Raimoni Boipai	--do--		
12	Jasmathi Bodhara	--do--		
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14	Mary Honhaga	--do--	9534102012	
15	Priya Kunkal	Josh Jamshedpur	9204306841	
16	Pano Hansda	--do--	9204542512	
17	Pushpa Kispota	Jharkhand mahila samakhya Society E Singhbum	9234672688	
18	Malti Murmu	--do--	9835311766	
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23	Mamta	--do---		

	Hagesia			
24	Heeramani Kerai	--do--		
25	Suchitra Devi	Vikas Bhairavi Mahila	9693991244	
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34	Parvati Tudu	--do--		
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39	Thakur Soren	JOSH, Jamshedpur	8409260725	
40	Lois Dull	Spring of Joy		loisdull@gmail.com
41	Banita Marjee	--do--	8294663406	banitamarjee@gmail.com
42	Daniel Malarek	Roche	8757460119	dmalarek@yahoo.com
43	Soni Sapna	Ekjut	9661952489	sonisapna.ekjut@gmail.com
44	Swati Sarbari Roy	Ekjut		swati.ekjut@gmail.com
45	Dinesh Singh	JHPIEGO	9234601953	dsingh@jhpiego.net
46	Shampa Roy	PHRN	9431635305	shampa4roy@gmail.com
47	Gurjeet Singh	JSA, Jharkhand	9431120534	gurjeetgvs@gmail.com

48	Suranjeen Prasad	CINI	9431707728	suranjeen@gmail.com
49	Balram		9430753201	
50	Shakti Pandey	CINI	9934109575	shaktipandey.shakti@gmail.com
51	Lindsay Barnes	JCMB	9431128882	janchetnamanch@rediffmail.com
52	Kajol Devi	--do--		
53	TK Sundari Ravindran	CommonHealth	9447757974	ravindrans@usa.net
54	Nirmala Nair	Ekjut	9931546260	nirmala.ekjut@gmail.com
55	Praveer Peter	Solidarity Centre	9430367949	praveer.peter@gmail.com
56	Ajitha George	Omon Mahila Sanghatan	9431960442	ajithasg@gmail.com
57	Gobind Mahto	Dayasagar	9955171325	
58	Malti Kumari	Anupam Mahila Chetna Samiti	9031563319	
59	Nitu Kumari	CINI		
ONLY 5 MAY				
60	Akay Minz	JRHMS	9204751662	akay.minz@gmail.com
61	Deoki nandan Paswan	Nagrik Kalyan Samiti, Jharkhand	9471183107	
62	Kumar Manoj	AAJ	9430116134	kumarmanoj119@yahoo.com
63	Dr BP Sinha	State RCH Officer	9204780378	srho.jharkhand@gmail.com
64	Dr. Sumant Mishra	MCHIP	9431108383	sumant@mchip.in
65	Rajan Kumar	State Programme Manager NRHM	9204788912	spmjharkhand@gmail.com
66	Rachana Dwivedi	Visiting from UK		dwiver28@gmail.com
67	Nutan Mishra	--do--		nutanmishra@hotmail.com
68	Shubhra Singh	UNICEF Extender, MAPEDIR, Ranchi	9430955125	shubhravin@gmail.com
69	Madhulika Jonathan	UNICEF, Ranchi		
70	Rajkumar	AJ, Ranchi		
PRESS				
71	Manoj Kumar	SANMARG	9431372038	
72	Puspgeet	DAINIK SAMACHAR		puspgeet.ranchi@gmail.com

73	Sunil KR	JHARKHAND NEWSLINE		sunil_ver77@yahoo.com
74	Manoj Lakra	PRABHAT KHABAR		manojplakra@gmail.com
75	Sunita Prasad	NAXATRA NEWS		sunita.jsr@gmail.com

Annex-3

ममता वाहन

जननी शिशु सुरक्षा कार्यक्रम के अन्तर्गत झारखण्ड सरकार द्वारा गर्भवती माताओं को घर से स्वास्थ्य केन्द्र तक रेफरल सुविधा देने एवं प्रसव उपरांत उन्हें घर तक निःशुल्क पहुंचाने हेतु सभी जिलों में ममता वाहन का संचालन पब्लिक प्राइवेट पार्टनरशिप मोड में किया जा रहा है। इसके अन्तर्गत सभी जिलों में एक कॉल सेंटर की स्थापना की गई है।

इस योजना का लाभ लेने के लिए ममता वाहन कॉल सेंटर का नम्बर डॉयल करना होगा जहां अपना पता बताने से कॉल सेंटर के द्वारा निकटतम स्थित कोई ममता वाहन गर्भवती महिला के घर अविलम्ब भेज दिया जाएगा। यह वाहन गर्भवती महिला को प्रसव के लिए प्राथमिक स्वास्थ्य केन्द्र या निकटतम सरकारी अस्पताल पहुंचाएगा। प्रसव के बाद भी यह वाहन मां और बच्चे को अस्पताल से घर तक पहुंचाएगा। यह सेवा बिल्कुल मुफ्त में मिलेगी। ममता वाहन के उपयोग के लिए किसी तरह का कोई किराया नहीं लगेगा।

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जननी शिशु सुरक्षा कार्यक्रम

जननी शिशु सुरक्षा कार्यक्रम भारत सरकार की एक महत्वाकांक्षी कार्यक्रम है जिसका उद्देश्य गर्भवती माताओं एवं नवजात शिशुओं को निःशुल्क स्वास्थ्य सेवाएं उपलब्ध कराना है। इसके तहत सरकारी स्वास्थ्य सुविधाओं के लिए अस्पताल में आने वाले प्रत्येक गर्भवती महिलाओं को प्रसव के दौरान सम्पूर्ण व्यय एवं नवजात शिशु के एक माह तक होने वाले खर्च का वहन सरकार द्वारा किया जाएगा। गर्भवती महिला से किसी प्रकार की कोई राशि नहीं ली जाएगी। इस कार्यक्रम के तहत गर्भवती महिला को मिलने वाले लाभ निम्नलिखित है -

1. निःशुल्क प्रसव 2. निःशुल्क सिजेरियन प्रसव 3. निःशुल्क दवाएं
4. निःशुल्कजांच (रक्त, पेशाब एवं अल्ट्रासोनोग्राफी आदि)
5. निःशुल्क भोजन (सामान्य प्रसव में तीन दिनों तक, सिजेरियन प्रसव में सात दिनों तक)
6. निःशुल्क रक्त की व्यवस्था 7. निःशुल्क रेफरल सुविधा (घर से स्वास्थ्य केन्द्र तक एवं वापस घर तक)

कुपोषण उपचार केंद्र

गंभीर रूप से कुपोषित 0-6 वर्ष के बच्चों को कुपोषण उपचार केन्द्र में इलाज के लिए आंगनबाड़ी केन्द्र से रेफर किया जाता है। इसके पूर्व आंगनबाड़ी केन्द्र में बच्चों की शारीरिक जांच की जाती है। इसमें वृद्धि निगरानी तालिका, BMI एवं MUAC फीता को आधार बनाया जाता है। आंगनबाड़ी केन्द्र में बच्चों के कुपोषण के स्तर को मापने की यह नियमित प्रक्रिया होती है।

कुपोषण उपचार केन्द्र में भरती के बाद बच्चों को 15 दिनों तक निःशुल्क इलाज की सुविधा मिलती है। इस दौरान कुपोषण उपचार केन्द्र में पदस्थापित ANM बच्चे को उचित पोषण की खुराक देती है, साथ ही उसकी नियमित जांच भी करती हैं।

बच्चे के साथ MTC में ठहरने वाले उसके एक परिजन को प्रतिदिन 100 रुपये की दर से भुगतान किया जाता है। साथ ही बच्चे को MTC लाने और ले जाने के लिए सहिया को 100 रुपये की प्रोत्साहन राशि दी जाती है।

जननी सुरक्षा योजना

लाभार्थी गर्भवती महिला को

कुल 1400 रूपये का भुगतान संस्थागत प्रसव के बाद – संस्थान द्वारा

सहिया

कुल 150 रूपये – प्रसव के समय 24 घंटे तक गर्भवती महिला की देखरेख करनी वाली सहिया को संस्थान के चिकित्सा पदाधिकारी द्वारा जहां संस्थागत प्रसव हुआ हो।

कुल 200 रूपये – प्रसव के पहले दिन से 7 दिन तक प्रतिदिन जच्चा एवं बच्चा को देखभाल करने तथा बच्चे को बी.सी.जी. का टीका लगवाने के बाद सहिया को – प्रभारी चिकित्सा पदाधिकारी द्वारा

कुल 250 रूपये – घर से स्वास्थ्य केंद्र/अस्पताल तक ले जाने के लिए (यातायात मद में) सहिया/लाभार्थी को संस्थान जहां से संस्थागत प्रसव हुआ हो – प्रभारी चिकित्सा पदाधिकारी द्वारा

मुख्यमंत्री जननी शिशु स्वास्थ्य अभियान (अधिसूचित शहरी क्षेत्र)

लाभार्थी को

कुल 1000 रूपये – संस्थागत प्रसव के बाद – संस्थान द्वारा/चिकित्सा पदाधिकारी द्वारा जहां संस्थागत प्रसव हुआ हो

सहिया को 200/– रूपये संस्थागत प्रसव के बाद देखभाल करने के लिए

इस योजना का लाभ किसे मिलेगा

1. सभी ग्रामीण एवं शहरी क्षेत्र की महिलाओं को जो संस्थागत प्रसव कराती हैं
2. घर में प्रसव कराने की स्थिति में क्या प्रावधान है।

ग्रामीण क्षेत्र		कुल	शहरी क्षेत्र		कुल
गर्भवती महिला पैकेज	सहिया पैकेज	रुपये	गर्भवती महिला पैकेज	सहिया पैकेज	रुपये
1400	600	2000	1000	200	1200

Annex-4

Press coverage

SANMARG 6/5/12

सुरक्षित गर्भावस्था और प्रसव पर कार्यशाला

गर्भवती जहां चाहें, वहीं ले जायें ममता वाहन

सन्मार्ग @ वरीय संवाददाता

रांची : एक महिला गर्भवती थी। उसके साथ सिर्फ उसका पति था। सामान्य परिवार था। पति ने प्रसव के लिए पांच हजार रुपये का इंतजाम कर रखा था। प्रसव के एक महीना पहले उसने अपने एक संबंधी महिला को मदद के लिए भी बुला लिया था। महिला को प्रसव वेदना शुरू हुई। पति ने एक गाड़ी बुलायी। गाड़ीवाले ने उससे तीन सौ रुपये लिये और प्राथमिक स्वास्थ्य केंद्र पहुंचाया। वहां उस महिला का प्रसव नही हुआ। उसे सामुदायिक स्वास्थ्य केंद्र भेज दिया गया। गाड़ीवाले ने पचास रुपये लेकर उसे वहां पहुंचाया। वहां भी उस महिला का प्रसव नहीं हुआ और उसे आगे रेफर कर दिया गया। महिला की जिला अस्पताल पहुंचते-पहुंचते रास्ते में ही मौत हो गयी। यह सिर्फ एक कहानी नहीं बल्कि हकीकत है। शनिवार को

कार्यशाला में उपस्थित विशेषज्ञ।

राजधानी के होटल ग्रीन होराइजन में सुरक्षित गर्भावस्था और प्रसव : सोच एवं चुनौतियां विषय पर आयोजित कार्यशाला में यह हकीकत बयां की गयी। कॉमन हेल्थ संस्था ने दो दिवसीय कार्यशाला का आयोजन किया था। दूसरे दिन कहा गया कि प्रसव के लिए गर्भवती महिलाओं को इतने चक्कर लगाने पड़ते हैं कि कभी-कभी रास्ते में ही उनकी मौत तक हो जाती है। राज्य में चल रहे ममता वाहन भी गर्भवती महिलाओं को प्रसव के लिए पहले पीएचसी, फिर सीएचसी और उसके बाद जिला अस्पताल ले जाते हैं। सभी ने कहा कि ऐसा नहीं होना चाहिए। गर्भवती महिला जहां चाहे उसे वहीं ले जाना चाहिए। यह भी कहा गया कि ममता वाहन प्रसव के लिए निजी अस्पतालों में नहीं ले जाते हैं। जबकि इसका भी प्रावधान किया जाना चाहिए। कार्यशाला में स्वयंसेवी संस्थाओं के प्रतिनिधि और स्वास्थ्य विभाग के अधिकारी भी शामिल हुए। दोनों ने ही एक दूसरे के ऊपर दोषारोपण किया। एनजीओ के प्रतिनिधियों ने कहा कि सरकार सिर्फ योजनाएं बना देती है, लेकिन उसकी मॉनिटरिंग नहीं करती है। अस्पतालों में जीवनरक्षक दवाएं और सुविधा उपलब्ध नहीं रहती हैं। इसके लिए निगरानी कमेटी बननी चाहिए। जबकि सरकार के पदाधिकारियों ने कहा एनजीओ अपना रोल सही से अदा नहीं कर रहे हैं। वे इस मामले में लोगों को जागरूक नहीं कर रहे हैं। कार्यशाला में कॉमन हेल्थ की चेयरपर्सन टीके सुंदरी रविंद्रन, लिंडसे बार्न्स, यूनिसेफ की शुभ्रा सिंह, राज्य कार्यक्रम अधिकारी राजन कुमार, आरसीएच पदाधिकारी बीपी सिन्हा के अलावा दिनेश सिंह, बलराम, कल्याणी, अजिथा और सुरजन प्रसाद सहित विभिन्न स्वयंसेवी संस्थानों के प्रतिनिधि शामिल हुए।

सुविधा से ही घटेगी मातृत्व मृत्यु दर

DAINIK BHASKAR 5/5/12

एचआरडीसी में 'सुरक्षित गर्भावस्था एवं प्रसव : सोच व चुनौतियां' पर कार्यशाला

भास्कर न्यूज | रांची

आप चाहे कितना भी संस्थागत प्रसव का ढोल पीट लें। जब तक पीएचसी, सीएचसी में प्रसव कराने की समुचित व्यवस्था नहीं होगी, मातृत्व मृत्यु दर में कमी नहीं आएगी। इसमें ममता वाहन, जननी सुरक्षा योजना भी कारगर नहीं है। ममता वाहन से मां तो अस्पताल पहुंच गईं, लेकिन, जब वहां प्रसव की बुनियादी सुविधा मसलन अल्ट्रासाउंड जांच, जीवन रक्षक दवाएं, ब्लड की व्यवस्था, सिजेरियन की व्यवस्था नहीं होगी, माताएं दम तोड़ती रहेंगी। इसमें भी सबसे आवश्यक है 24 घंटे डॉक्टरों की मुस्तैदी। ये बातें शुक्रवार को गोस्सनर कंपाउंड स्थित एचआरडीसी में 'सुरक्षित गर्भावस्था एवं प्रसव : सोच व चुनौतियां' पर आयोजित कार्यशाला में उभरीं। आयोजन कॉमन हेल्थ संस्था ने किया था।

कार्यशाला में स्वास्थ्य के क्षेत्र में काम कर रही कई संस्थाओं के प्रतिनिधि शामिल हुए। पांच मई को कार्यशाला होटल ग्रीन हॉरिज़न में होगी। यहां सरकार के साथ वार्ता भी होगी। इस मौके पर डॉ. दिनेश सिंह, द. छोटानागपुर के एएसओ दिग्विजय नारायण, अजीता जार्ज, कल्याणी मीना, डॉ. निर्मला नायर और डॉ. विपिन मौजूद थे।

वर्कशॉप में सुरक्षित प्रसव पर विचार रखतीं सुंदरी रवींद्रन और अन्य।

माता का एंटीनेटल चेकअप जरूरी

कॉमन हेल्थ की अध्यक्ष सुंदरी रवींद्रन ने कहा कि गर्भ ठहरने के बाद से ही माताओं का एंटीनेटल चेकअप जरूरी है। आयरनयुक्त भोजन की व्यवस्था होनी चाहिए। अधिकतर माताएं काफी एनिमिक होती हैं। इसमें प्रसव के दौरान लापरवाही होने पर मौत तय है।

ममता वाहन अच्छा पर सुविधा मिले तब

जनचेतना मंच की जिंसी बोस ने कहा कि ममता वाहन अच्छा है, लेकिन गांव से अस्पताल पहुंचने पर माताओं को सुविधा मिलेगी तब ना। अभी देखा जाता है कि वहां प्रसव कराने की सुविधा नहीं है। अनसेफ डिलेवरी में प्रति एक लाख पर 312 माताओं की मौत हो रही है, जो दुखद है।

महिलाओं का सुरक्षित प्रसव सरकार का उद्देश्य

सुरक्षित गर्भावस्था व प्रसव पर कार्यशाला का समापन

PRABHAT KHABAR 6/5/12

संवाददाता ■ रांची

सुरक्षित गर्भावस्था व प्रसव : सोच व चुनौतियां विषयक दो दिनी कार्यशाला का समापन शनिवार को होटल ग्रीन होराइजन में हुआ. इसमें स्वास्थ्य व्यवस्था की कमियां, प्रसव पूर्व व प्रसव के बाद देखभाल, मलेरिया, अनीमिया, कुपोषण व असुरक्षित गर्भपात विषय पर चर्चा हुई. इसमें सुप्रीम कोर्ट कमिश्नर के राज्य सलाहकार बलराम, आरसीएच ऑफिसर डॉ बीपी सिन्हा, डॉ सुमंत मिश्रा, डॉ रंजन कुमार, डॉ किरण त्रिवेदी, यूनिसेफ की डॉ मधुलिका जोनाथन व अन्य पदाधिकारी मौजूद थे.

सुविधाएं बढ़ें, जानकारी की कमी न हो : चर्चा के दौरान कई सुझाव सामने आये. गर्भवती महिलाओं को आपात स्थिति में यातायात की सुविधा सुनिश्चित कराने, सरकारी संस्थाओं में सुविधा की कमी, गर्भवती महिलाओं का मलेरिया से बचाव, प्रसव पूर्व सभी जरूरी जांच कराने और सहिया व दाइयों को प्रसव के बाद होनेवाली समस्याओं से अवगत कराने की जरूरत रेखांकित की गयी.

इसके अतिरिक्त स्वास्थ्य केंद्रों में सुरक्षित गर्भपात की व्यवस्था दुरुस्त कराने की आवश्यकता भी बतायी गयी. पदाधिकारियों ने आश्वासन दिया कि उच्चस्तरीय समिति सुझावों की समीक्षा करेगी और कमियों को दूर करने का प्रयास करेगी. उन्होंने कहा कि सरकार गर्भवती महिलाओं की सुरक्षा व सुरक्षित प्रसव चाहती है.

काजोल, रायमनी व किरण सम्मानित : इंटरनेशनल डे ऑफ मिडवाइव्स के अवसर पर दाई (प्रसाविका) काजोल देवी, रायमनी बोइपाई व किरण तिडू को सम्मानित किया गया. इन तीनों ने सबसे कमजोर तबके की महिलाओं को सुरक्षित प्रसव में मदद दी थी.

माताओं को अस्पताल चुनने का अधिकार

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रांची . गर्भवती महिलाओं को अपने सुरक्षित प्रसव के लिए अस्पताल चयन का अधिकार मिलना चाहिए। वह अपने निकटतम सरकारी अस्पताल चाहे जिला अस्पताल ही क्यों न हो। उक्त विचार सुरक्षित गर्भावस्था व प्रसव : सोच व चुनौतियां पर आयोजित कार्यशाला में उभरे। यह कार्यशाला कॉमन हेल्थ की ओर से होटल ग्रीन हॉरिजन में आयोजित था। इस अवसर पर कॉमन हेल्थ की चेयरपर्सन सुंदरी रविंद्रन, जनचेतना मंच की लिंडसे बार्न्स, स्टेट आरसीएच अफसर डॉ. बीपी सिंह आदि मौजूद थे।

Annex-5

Felicitation of midwives