Maternal Health in Gujarat: Realities and Challenges

Report of a State level consultation
April 9 - 10, 2014
Organized by
Jan Swasthya Abhiyan (Gujarat)
Hosted by
CHETNA at Samvaad Conference Center, Ahmedabad

Working Group on Maternal Health
SEWA Rural, SAHAJ, CHETNA, ANANDI
Introduction

Gujarat is among the four states in India which are close to achieving the Millennium Development Goal 5. The Maternal Mortality Ratio is estimated at 122 per 100,000 live births (SRS 2013) which has decreased by 26 points from 148 in 2007-09. However, improvement in the nutritional status of women continues to be a challenge with every second adolescent and more than half of the women (55%) in reproductive age group suffering from anemia. Pregnancy anemia is almost universal.

Besides implementation of national programmes such as the National Rural Health Mission and schemes such as the Janani Shishu Suraksha Yojana; Janani Suraksha Yojana, Chiranjeevi Yojna, Kasturba Poshan Sahay Yojana, etc are some of the state innovative ‘missions’ to bring about an improvement in the health status of women and children in the state. These efforts are welcome and indicative of the state’s attention for maternal and infant mortality reduction. However, translating these efforts into action has given rise to several concerns.

Field level observations and experiences of JSA members indicate inequities in terms of access to information about the state initiative-schemes and services; coverage of services particularly among poor, tribal and social vulnerable groups leading to exclusion of the most vulnerable and the marginalised. There are also concerns related to the policy and programme approach which is vertical and without an inclusive, broader and comprehensive framework. The states’ policy for promotion of deliveries in institutions is a single point intervention for reducing maternal and infant mortality with inadequate attention to continuum of services from pre pregnancy to post partum phase; scheme such as Chiranjeevi which engage private sector but as various studies show its limited influence on MMR and reaching out to the most vulnerable section; recently there is a push for deliveries in public sector without considering the capacities. Community participation and voice in public health system is limited and there is often no scope for choice. There are concerns related to quality and accountability. While a system of maternal death review has been institutionalised, information is not available in the public domain.

Several NGOs and civil society organisations also strive hard to improve health conditions in difficult areas of the state. Several members of Jan Swasthya Abhiyan are working on Maternal Health issues. The Indian Institute of Public Health Gujarat, organised an international conference of Inequities in Maternal Health during October 2013. The 5th Right to Health Convention during 1-3rd March 2014 in Sanand also drew attention to the state of nutrition and health in Gujarat. More than a 100 organisations accredited as Mother NGOs have been working to increase access to maternal and child health services in underserved areas.

This is the report of a State Consultation on Maternal Health, organised on the eve of National Safe Motherhood Day (April 11). Specific Objectives of the Consultation are:

Objectives

1. Review the current maternal health and nutrition scenario in Gujarat state
2. Share experiences and strategies adopted by JSA members for improving maternal health and nutrition sharing of/showcasing micro level innovations.
3. Dialogue with state health officials and media on emerging issues.
4. Develop an action plan to work towards improved maternal health in the state.
About the Participants

45 JSA Gujarat members, Academic Institution-IIPH – Gandhinagar, representatives from 6 state and national networks and 23 organizations from 22 districts of Gujarat participated in the consultation. (For a list of Participants please refer Annexure 1).

Welcome and Introduction

Ms Renu Khanna from SAHAJ welcomed the participants and a brief round of introduction by all the participants followed.

Vd. Smita Bajpai from CHETNA, also extended a welcome to all the participants. She commenced the day with a reminder of where we stand on indicators of Maternal Health. As per the statistics, Gujarat was doing quite well, one of the four states in India to have been close to achieving MDG 5. She also mentioned that this two day consultation would be a good time to share insights on Maternal Health situation from areas across Gujarat. While the overall situation in Gujarat looked positive, there were pockets which were deprived and needed attention. This consultation therefore is being organised at a very critical stage where the National Health Mission is being initiated, the Reproductive Maternal Neonatal Child Health+ Adolescents(RMCH+A) approach is being promoted and the nation is going to elect its Government. The two day consultation will be useful in drawing out an action plan for JSA in the next phase.

SESSION 1: OVERVIEW OF MATERNAL HEALTH SCENARIO IN GUJARAT

The consultation began with sharing of maternal health field realities by representatives from tribal areas of Gujarat by Ms Anita Shah from Anjali, Sabarkantha; Mr. Harish Patel from SARTHI, Dahod and Ms Lakshmi Bhatt from ARCH, Valsad. Their sharing revealed that:

- In different districts the situation of Mamta Divas had improved, with the day being observed at least once a month. However, the issue was that it was observed that once a month observation was not adequate to provide complete and continuum of maternal health and nutrition services to women.

- Iron Folic Acid tablets were distributed, Haemoglobin was checked and TT injection was given, however, health education during pregnancy was not imparted, neither were the risk factors explained, abdominal check -ups were also not done, characterizing poor quality of ANC on the whole.

- Take home rations are to be given to the pregnant women during the Mamta Divas, however, it has also been observed that it is also consumed by the staff at the Anganwadi centre.
In implementation of Kasturba Poshan Sahay Yojana the cheques are not released unless there is extra payment by the claimant in some areas.

There have been instances wherein even the 108 is known to have charged. The fact that (108) ambulance is only available during the trip from home to the hospital, and not on the return, is another issue.

Birth plans are not prepared.

Antenatal care along with post natal care, both is either absent or inadequate.

There were issues related to reporting of maternal deaths or a conscious attempt at hiding them.

2.2 Inequity in Maternal Health in the State of Gujarat: Reasons and Actions - Presented by Dr. Dilip Mavalnakar from IIPH, Gandhinagar.

The Objective of the IIPH study was to investigate the determinants of inequity in maternal health using existing data with specific focus on State of Gujarat.

Methodology: A three-fold methodology was followed-

A Review of grey literature was conducted which included Multiple Indicator Cluster Survey (MICS, dissertations from medical colleges in Gujarat, Reports and Monograms published by various NGOs, government reports. Secondary data analysis of District Level Household Survey (DLHS/3)2007-2008 was done. Experiences were drawn from the ICMR funded pre term birth study: Inequity in Maternal health care, by IIPH-Gujarat.

Results

Findings indicate that in the general population, post natal care is the weakest link. Majority receive at least one ANC but fewer receive recommended three ANC visits. Institutional deliveries are increasing, out of which majority are conducted by private providers.

Inequities exist with regards to disadvantaged population, defined as those from rural areas, urban slums, SC, ST, illiterate, lowest wealth quintile. These people were almost 5 times less likely to receive ANC services in comparison to the non poor in urban areas, or non poor in the same caste category or upper castes. Family Planning services are reaching even the marginalized groups in comparison to the 3 ANCs and institutional deliveries.

Findings (from all sources)

In Gujarat poverty is the greatest factor for inequity. Social class is also a source of inequity in the non poor. Such inequity is less severe in utilization of Family Planning services. The ICMR study showed that 69.17 % people were hiring a vehicle in order to reach a health care centre while only 18.7% people used (108) ambulance for transportation. 89.2% had normal delivery, while 10.8% had undergone caesarean operation.

Reasons behind existence of Inequities despite schemes
- Low coverage of most of the schemes. Eg Chiranjeevi covers only 30% poor and ST.
- Managerial capacity is limited at State and District level for MCH.
- No close monitoring of inequity - only overall numbers given.

Dr. Malvankar stated that the **Recommendations** that emerged from their work were that:

1. Focus on poor in the policies should be strengthened.
2. Inequities should be monitored.
3. Evidence should be reviewed and data analysed before policy formulation.

**Discussion**

- The discussion began with attitudes of nurses and went to highlight how nurse education and training is still very lecture oriented and not skill oriented. There are instances of nurses not having done a single delivery even after a 3 year nursing course. Dr. Malvankar emphasized that biased attitudes of service providers like ANM, Nurse, teachers, etc on gender and caste needs to be changed.

- Dr. Malvankar expressed how institutional deliveries are considered as deliveries anywhere except home. There are deliveries that happen in transit too. There are many examples where women die after a few days or hours after delivery. So instead of focussing merely on institutional deliveries, the focus should be on Quality Institutional deliveries.

- He pointed out that In India we still don’t have an independent cadre of midwives. This is a very serious debate globally, and this issue is unfortunately neither addressed by the government, nor advocated by the women’s organizations.

- Participants pointed out that anaemia and nutritional status was not covered in any of the surveys and data sets and these are important determinants of maternal health. Participants also felt that mere reach or implementation of certain schemes should not make us happy. Mindsets need to change; we need to focus more on micro level issues.

- There was a round of discussion on universal access to health, and within this targeted interventions for better service delivery for those in greatest need, including those in remote/ interior areas where services generally do not reach.
SESSION 2 AND 3: CHALLENGES IN MATERNAL HEALTH IN DIFFERENT AREAS of Gujarat

Five regional groups were formed to discuss two key issues 1. Situation of maternal health and 2. Matters of concern and inequities, their discussions highlighted the following issues:

**BOX 1**

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<tr>
<th>A Summary of the above presentations brings to light the following issues:</th>
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<tr>
<td><strong>a. Difficulty in accessing schemes:</strong> Although many schemes exist for the vulnerable groups, it is very difficult for them to access these schemes. Reasons for this are: lack of awareness, unsatisfactory dissemination of information on schemes, issue of too many ID cards/proofs and other documents, corruption and bribery, all these factors make the process of availing benefits lengthy and expensive.</td>
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<td><strong>b. Gender Issues and its impact on women’s health:</strong> Issue of ‘Taruni’ (adolescent girls) being excluded from health care services, issue of women’s decision making due to her secondary status, problem of female foeticide, poor dietary practices have all led to higher rates of malnutrition and anemia among women, thereby adversely impacting over maternal health scenario.</td>
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<td><strong>c. Poor quality of ANC and PNC:</strong> These are apparent across all districts. Unavailability of instruments, poor quality of Mamta Divas services such as BP check up, abdominal check up, etc, lack of health education or birth preparedness, no nutrition demonstrations—all these aggravate the vulnerability of pregnant women. Post Natal care is very poor as neither women go for check up post delivery nor is there any follow up from the system. Abortion care after MTP is nil.</td>
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<td><strong>d. Problems prevalent at the PHC/ sub centres:</strong> Problem of human resources, poor state of infrastructure and equipments, unhygienic conditions, problem of storage at Anganwadis, medicine stock-outs, persistent referrals and inefficient (108) service have largely contributed to the maternal deaths in various district across Gujarat.</td>
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<td><strong>e. Monitoring Issues:</strong> Lack of clarity in job responsibilities and roles of frontline workers, lack of strict supervision and monitoring of various services and service providers, along with irregular and problematic social audits have adversely impacted the quality of health care services at the grass roots, thereby impacting Maternal Health.</td>
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| **f. Inequities:** Health care should be a right guaranteed to all citizens irrespective of social, economic, caste backgrounds. However, those residing in remote, inaccessible areas are often excluded from the purview of health services. These generally constitute the SC/ST
SESSION 4: CURRENT SCENARIO OF MATERNAL HEALTH IN GUJARAT

This panel had three presentations which were a summary of the process, findings and learning from studies conducted either by individual organizations in collaboration with partners or research studies conducted as JSA. These studies were not for the purpose of research, but to serve as a tool for advocacy. The intent of these studies revolved around issues of Maternal Health such as studying situation of government schemes, access to services, as well as situation of maternal health in an urban scenario.

4.1 Monitoring of JSSK in Gujarat by JSA members – Presented Dr. Dhiren Modi

The duration of the study was from 15/09/2013 to 31/10/201. The Data was collected by 6 NGOs-Anjali, Gram Seva Trust, Sewa Rural, JNPCT, Deepak Foundation, and PTRC

Objective- To study the status of JSSK scheme in Gujarat

Study findings- Out of a total of 717 deliveries, 171(24%) were govt. institutional deliveries. 59 (34.5%) had to pay some expenses for their delivery for which the amount varied from Rs. 50 to Rs. 4000/- Expenses were incurred on transportation (especially return journey), medicines, food, reward to health staff etc.

No expenses were incurred on medical services

Suggestions

- Drop back services are required
- More advertisements of the scheme are required to increase knowledge in community and among health staff

Feedback and Suggestions from Deepak Foundation
In many areas JSSK grant is not utilized completely hence food expenses can be borne by health department.

- Travel for blood can also be included under JSSK
- There are no clear guidelines regarding the JSSK expenses hence they should be made available

4.2 Access to Maternal Health Services in Santrampur / Adesar blocks of Gujarat - CHETNA, SARTHI and AWAG - Presented by Vaidya Smita Bajpai, CHETNA

The second presentation in this panel was an advocacy initiative coordinated by CHETNA in 28 villages under 2 PHCs - Chuthan Na and Muvada in Santrampur and Adesar blocks of Gujarat State.

**The Objective of the study was** To empower women to claim their right to continuum of quality health services by engaging women and Gram Sanjeevni Samiti, for monitoring women’s access to maternal health services from the public health system.

Methodology: village meetings were held to understand women’s concerns and assessment of functioning of Village Health Sanitation and Nutrition Committees. An Information Awareness campaign followed which also included orientation of VHSNC members collect information on women’s access to maternal health services using a pictorial tool. A total of 237 women who delivered during January-June 2013 were interviewed.

**Study findings**

- Out of 237 women who were interviewed, 56% of the women were from BPL families - (43/76) from Chuthana Muvada and (44/78) Adesar.
- Total registration was good but early registration was less than 50%.
- On an average, 81.4% of the total deliveries were institutional deliveries.
- 16% of the women received three ANC checkups. Adesar region was characterized by poor services and less care given in last 3 months of pregnancy.
- 58% (76/130) women from Chuthana Muvada and 73% (78/107) from Adesar Kutch shared they incurred expenses during delivery on transport/ medicines/ lab tests/ in public as well as private facilities. From this majority of the women spent money on transportation, especially on their return journey. Their expenses ranged from Rs.500 to Rs.13000/-

Jansamwad was arranged and few changes were seen

- Three new nurses were appointed at Adesar PHC
- Medical officer and laboratory technician were appointed at Chuthana Muvada PHC
- JSY entitlements were disbursed.

4.3 Challenges in Urban slums - SAHAJ- Presented by Sangeeta Macwan

Sangeeta spoke about the challenges of maternal health for urban poor women. Between August 2012 and July 2013, deliveries were tracked in 12 bastis of Vadodara, whose findings are as under:

**Profile**
Majority of the women were in the age bracket of 21-35 years, belonging to the low income group. They were either illiterate or had acquired up to five years of schooling. More than 80% were tribal. Majority lived in Kutcha houses and none of them had BPL cards.

**Findings**

Out of 117 deliveries recorded, 14 were home deliveries and most of these were from two bastis- Subhash nagar and Sanjay nagar 8 of them were registered in the 3rd trimester of pregnancy, while only 3 women received complete ANC. 50% of the deliveries were home deliveries by experienced family members.

**Issues identified**

The urban slums are characterized by lack of hygiene, very unclean surroundings, which coupled with the biased behaviour/ attitude of the service providers, lack of knowledge of schemes, lack of knowledge on birth preparedness, financial constraints, etc all contribute towards accelerating maternal deaths or impairing access to health care.

Besides these, there are issues of encroachment since slums comprise a huge chunk of migrant population who are not beneficiaries of many of the services/ schemes, language issues faced by these migrants is yet another matter of concern.

**Suggestions**

- To have ante natal check-ups at the ward level.
- Training of service providers and behaviour change communication.
- To impart education to communities on birth preparedness.
- It needs to be found out whether this was the first, second or third delivery of the women, where were the earlier deliveries and where had the woman/ family actually planned to have this delivery.

**4.4 Social Autopsies of Maternal Deaths - Report from select areas in Gujarat - CHETNA-RRC, SAHAJ, SEWA Rural, Tribhovandas Foundation**

Dr. Pankaj Shah introduced the session comparing the maternal mortality factors known to us as the tip of the iceberg, wherein a host of causes and determinants need a lot of work at the ground to get to its depth. There have been various National schemes such as JSSK, JSY and state missions such Chiranjeevi Yojana, Kasturba Poshan Sahay, as well as initiatives by the Health Department such as four wheel drive, inter facility transfer, essential drugs and technical up gradation to prevent maternal deaths. However these interventions were not widely publicized, plans of districts were not shared and there were serious gaps in implementation.

SEWA Rural, CHETNA Regional Resource Centre and SAHAJ in collaboration with ANANDI and Tribhuvandas Foundation have been doing maternal death reviews in their own work areas.

The **Objectives** of doing the social autopsies of Maternal Deaths are:
• To determine the pathways leading to maternal death and identifying the health system and social factors contributing to these deaths.
• To suggest ways to prevent such maternal deaths in the future.

Methodology
This study draws from an analysis of 46 maternal deaths identified and documented from January 2012 to December 2013. Purposive and non-representative sample from 11 districts across Gujarat was collected.

SAHAJ in collaboration with ANANDI and Tribhuvandas Foundation used the social autopsy tool. SEWA Rural - since 2003-04, recorded deaths through a surveillance system where link workers report a death, used the tool by NAMHR. CHETNA RRC, as a Regional Resource Center - initiated tracking of Maternal Health Services in underserved areas in 2008 through MNGO scheme, tracked deaths of women in the age group of 15-49, used tool by NAMHHR and ARROW.

This study was designed not as a research study, rather a tool for advocacy. Data collection was done by health activists and not researchers. Total 46 deaths from select districts were reviewed and the findings are as under:

• The Baria block reported maximum number of deaths, i.e. 19 deaths
• 19 out of 46 deaths were of women below the age of 25 years.
• 27 out of 46 deaths, i.e. more than half were SC/ST women
• Nearly 50% of the women who died were illiterate.
• Most women had multiple responsibilities along with domestic chores: 23 were agricultural/wage labourers, 9 migratory workers.
• Out of 46, 14 women were primies, while 13 were in the 2nd gravida.
• The place of death for 14 women was at home, 24 in institute and 8 in transit. Out of 24 in institute 10 died in public hospitals while 14 in private ones.
• Out of 46, more than 50%, i.e. 28 women died in the post partum period, while 14 died in the ante natal period and 4 died during delivery.
• As per the data available, around 16 women (nearly one third) were reported to have complications in their previous pregnancy.
• The medical causes of death constituted:
  - Direct causes- 15% APH, 4.3%PPH, eclampsia 8%, pulmonary embolism 6.5%.
  - Indirect causes- 17.4% anaemia, 4.3% sickle cell disease.
  - In 10.8% of deaths, the cause of death could not be ascertained. While in 20 cases, more than one cause of death was identified.

Discussions

• Number of mortalities should be compared to total number of deliveries.
• Majority of deliveries where mortality occurred are in government facilities and then transferred to private or other institutions. Referrals are provided even when the condition of the woman is very critical and delay caused accelerates deaths. These studies reflect poor care in government setup which is worrisome.
• Inequities in services are apparent as majority of the women who were died were SC/ST.
• Apathy of govt towards antenatal and post natal care is worrisome. Govt promotes institutional deliveries only in their agenda to decrease maternal mortality, while quality of
the institutional deliveries is never questioned. Even quality of ANC is poor due to which high risk factors are never identified.

- Anaemia, high workload, gender discrimination and malnutrition lead to poor maternal health and most of these factors are cultural factors.
- Peripheral government setup needs strengthening along with active community involvement.
- Verbal autopsies done by Deepak Foundation in Vadodara district too show that 31% deaths occurred in antenatal period, while 34% in post natal period. This shows that preventive antenatal care and post natal care are as important as institutional and safe delivery.

5. ACTIVITY SESSION

After a very enriching day with interesting insights and discussions through presentations on research studies and action researches, group work between participants and experts from various NGOs working on Maternal Health across Gujarat, the participants assembled post dinner, after a break of two hours, for an activity session titled “The Show and Tell Session” which comprised of sharing of resources on Maternal Health such as videos, games, charts, tools, etc by various organizations.

5.1 SEWA Rural

- Video screening

The informal evening session began with the screening of videos that are being used by SEWA Rural as a part of the ImTECHO project to impart awareness about antenatal check-ups, nutritional intake during pregnancy, health education and so on. These videos were available online and accessible on mobile phones.

- Hb Colour Scale

This is a very cost effective tool developed by the WHO to measure one’s haemoglobin level. It is not precise in terms of the number, however; it is effective in showing the range such as 10-12, 8-10, etc for Hb. This was displayed practically by Dhiren Modi from SEWA Rural by asking participants to volunteer for this exercise. He took the blood using the set and then tried matching the colour of the blood with the shades in the tool, with each shade having the range mentioned on their side. The one that was the closest to the shade in the tool was matched, and one could determine the range of Hb from this scale.

In the next round, one of the participants tried this on another participant. We were informed that this exercise was to be done in day light and also one had to wait for about a minute after collecting the blood sample, in order for it to dry and assume its colour. It was also important that this blood sample was round in shape, so that it would fit the empty circles in the tool. A sample that was not round or small would leave white gaps in the tool, and hence make it difficult to determine the exact shade.

- Chart showcasing nutrition levels
This was yet another simulation exercise and participants enjoyed undergoing this exercise. A chart displaying various levels of nutrition—ranging from malnourished to healthy, using different colours like red, green, white, etc was spread out on the floor. The chart displayed weight on the X axis and age on the Y axis. The participants were assigned weight and age, and were asked to stand on the point in the chart as per their weight and age. After all the participants took their respective positions, a dialogue would begin between them, wherein the healthy one would tell the malnourished ones about the kind of care he/she took in the diet.

This exercise has been found to be very effective in the community with women standing on different points on the chart along with their children. The women with healthy children would tell the other mothers, what she fed her child and in this manner a healthy discussion facilitated learning for these women.

5.2 SAHAJ- Board Game

A board game on Maternal Health and Emergency Obstetric Care was demonstrated by the team of SAHAJ along with other members. This board game was basically designed as a revision tool after a training programme, particularly for the health workers and the questions in it could be changed with regards to target population who were seeking the training.

The game comprised of a board with numbers written in a circular grid, a dice, a number of cards which were either statements or questions, and four members playing it. At the throw of dice the players would move forward, and pick up a card and read out the statement. In case of the grid displaying a question mark, they would pick up a question card and would be able to move forward only if the question was answered correctly. With each card, discussion is generated and this helps the players and observers to understand and reuse concepts such as ANC, PNC, EMoC and so on. In this way, this game could be effectively used as a revision tool post any training session.

5.3 Gram Seva Trust- Video on nutritional intake and healthy diet
A video shot by Gram Seva Trust regarding components of a balanced diet and the nutritional intake of women during pregnancy, was screened for participants. Besides this, it also highlighted that need for frequent check-ups including BP, weight, sonography, feeling the baby’s position from the stomach, etc were integral part of quality antenatal check-ups.

The activity session indeed demonstrated fun and learning together and also made us realize how innovative approaches incorporating games, videos, stories, simulation exercises, etc can be very effective during community intervention in order to elicit participation of community women as well as convey various kinds of information to them.

VI. NEW AND INNOVATIVE EFFORTS AND TECHNOLOGIES

6.1 Women Friendly Hospital- Presented by Dr. Shobha Shah

This was presented by Shobhaben from SEWA Rural. She began the presentation by a discussion with the audience on what aspects they thought would comprise a women friendly hospital. Some of the answers were:

- A Hospital that would help in restoring the respect and dignity for the woman: This would entail providing the women with privacy when needed, where there would be no discrimination meted out to her in terms of her caste, linguistic, cultural, and economic or any other background, wherein the woman is carefully heard and also provided counselling when necessary.

- A fully equipped hospital: A hospital with the infrastructure, staff and facilities required to address maternal and other health issues of women, including arrangements for blood storage, mechanisms and systems to handle emergencies as well as facilities for transportation.

- Environment: A hospital with a hygienic environment that would provide appropriate, timely, accessible and affordable health care

- Accountability: A hospital where the doctors and staff exhibit responsible behaviour towards the pregnant women, and where patients would be provided the needed information and treatment without being misguided.

- Space for family members: A hospital where the children of the woman would be taken care of, as well as where the relatives could wait comfortably.

- Post Natal Care: A hospital that has good mechanism in place to address post natal issues.

After the discussion, there was a slide show of the various facilities available at the SEWA Rural Hospital set up in Jhagadia block of the Bharuch district and how they have endeavoured to create a women friendly hospital. The hospital addresses majority of the above mentioned aspects and its ultimate objective remains health and empowerment of women from the marginalized section. She also spoke of how the maternal admissions and deliveries have increased steadily in the last decade,
while there have been variations in the maternal mortality ratio (MMR) as well as the neonatal mortality rate (NMR) over the years, with a rise and fall.

6.2 CEmONC at Jambugam CHC – Presented by Dr. Nandini Srivastava

The presentation was made by Nandini Srivastava on behalf of Deepak Foundation. The public private partnership at the Jambugam CHC was initiated to serve as a comprehensive emergency medical unit for maternal and newborn care for nine lakh tribal populations in 5 tribal blocks of Chota Udaipur, with a focus on addressing the third delay. Besides this its aim was to provide for immediate care to the emergency obstetric cases referred from PHC as well as provide timely referral of complicated cases to a tertiary level hospital. After a brief presentation about the facilities available and services provided there, Nandini mentioned about their interventions: Behaviour Change Communication, Emergency Transport Facility, Capacity Building of frontline health workers, and so on.

Nandini then spoke of the inevitable challenges they faced in terms of finding committed doctors who would be willing to relocate to a small tribal town and also the issues and delays in equipment procuring since it was a public private partnership, which lengthened the process.

6.3 Gram Seva Trust- Presented by Dr. Harsha Shah

Dr. Harsha Shah briefed the participants about the Gram Seva Trust. They began intervention in 1994 addressing an area with around 65% tribal population, gradually expanding their services from 22 nearby villages to about 100 villages currently. Their mission was to provide healthcare, education and employment opportunities, for all village communities. Situation of maternal health in 1995 around these villages was characterized by lack of anganwadis, incomplete ANCs, severe anemia, majority deliveries by untrained dais, high percentage of malnourished pregnant women as well as LBW and premature babies.

The team realized that in order to holistically address maternal health, merely clinical services were not enough to address issues of maternal health and that community involvement was necessary. Some of the milestones that GST has achieved are -

- Clinical: full time obstetric and gynaecologist services, ultra sound facilities, free ANC clinic 4 times a week, benefit of government schemes such as Chiranjeevi, Balsakha Yojana, etc., PNC clinic, Ambulance, SNGO Project, ICTC Centre, Mamtaghar,

- Community Based: Menstrual tracking and early registration, home visits, follow up and referral, health education to adolescents as well as family, telephone services in remote areas, training of ANMs, ASHAs and RCH workers, coordination with govt departments and liasoning for govt schemes .

Besides, Sharmishtha also spoke of the cultural challenges faced while working with a tribal population such as explaining dangers of teenage pregnancy and its implications for maternal health to women, since teenage pregnancy were culturally acceptable here. Commitment, collective efforts and shared responsibility were imperative to reach goals in order to reduce MMR. Since 2008 GST is recognized as an FRU. The percentage of institutional deliveries has gradually gone up since 2008, with about 97.7% institutional deliveries in 2012-2013.
Discussion Post Presentations

Q. What are the challenges faced by the NGOs running such hospitals?

Challenges:

a. Commitment of the doctors is an issue. Most doctors come and stay for two years and are then ready to move on.

b. Payment is a challenge as what they would be paid here annually could be their monthly income in the corporate health sector.

c. There is a need to prepare the local people for sustainable interventions

d. Freedom to function is very important- working with the government, being a part of their schemes, results in some loss of autonomy.

Q. These three models that have been spoken of right now are examples of work happening both at a clinical level as well as a community level. How can the effort be taken forward without replication of the model??

Pankaj Bhai: Committed human resource is a very important requirement and this is what we need to build. Irrespective of the model adopted, challenges are prevalent even today but the question to address is within the given system how we create spaces for questioning the government.

Renuben: These experiments by various organizations are very important, since demanding such efficiency from the government then becomes valid. The standards set up by these voluntary hospitals can be useful for recommendations, as well as for formulating rules and regulations. These JSA members should be a part of sub committees set up by the government to take the experiences from such hospitals and make recommendations to the government for the Clinical Establishment Act.

Pallavi Ben: Apart from National level advocacy; we can also take the learning forward and replicate on a much micro level. Small changes can be adopted at a State level, and approaches can be documented and taken forward on the individual, State as well as National level.

6.4 IMTECHO (Innovative Mobile phone Technology for Community Health Operations) — presented by Dr. Dhiren Modi

This began as a pilot project in 2 PHCs of Jhagadia Block of Narmada District since May 2013, jointly being implemented by SEWA Rural and local health staff. This technology can be used for patient management, BCC, Performance improvement, support and motivation, reporting, documentation, supervision etc.

Benefits

1. Useful from making work plan to monitoring of the project.
2. Helps in strengthening capacities of ASHAs and motivating them by determining a probable diagnosis instantly, automatically upgrading malnutrition levels, videos for counselling families, helpful in early registration and tracking.
3. Helps to eliminate human errors in data collection and entry.
4. Helps in enhancing IEC material and BCC.

Limitations
1. Expensive at the moment.
2. Needs intensive training of ASHAs.
3. Can become a very mechanical approach without human emotions and feelings.
4. Cannot be used where mobile coverage is not available

6.5 Varli Madi- Monitoring tool - presented by Pradeepa
This is a 25 page pictorial monitoring tool in local language to be used by village level link workers. This is to be filled in the 8th month of pregnancy and within 15 days of the delivery. It has served as a valuable instrument for increasing awareness of pregnant women and their families of their maternal health entitlements and standards prescribed for quality of maternal health. Report cards exhibiting quality of maternal health care have been produced by compiling the data in the warli madis. These report cards have then served as a basis for dialogue with the PHC, MOs, staff and the THO.

6.6 Interactive Voice Message- presented by Pallavi Patel
This is a form of mobile technology and is used in schools, anganwadis, govt offices, etc for sensitization and counselling of youths towards girl child education. It can be used for other issues as well such as health, employment, etc. In the beginning FGDs were conducted with the villagers in various groups to explore reasons behind lack of education for girls, or not sending them to schools. Their families, teacher, nurses, govt officials and everyone’s numbers from the system were taken and fed into the software. Twelve different types of messages were created, and in a week, the same message was sent twice to every mobile number in the software. Many times, questions come back and answers are forwarded to everyone.

Benefits
1. Inexpensive
2. About 80 % beneficiaries benefit
3. Any type of phone can be used

Limitations
Inevitably about 20% of the population remains left out as the messages do not reach due to several reasons or numbers change.

Suggestions by audience post all three presentations:
- Touch monitors can be also used for interactive IEC sessions in community
- Mobile and other technology can be used for monitoring work plan, training, etc.

VII Learning about Alliances and Networks
Members from various State and National Alliances and Networks are also members of JSA, and were present during the workshop. One member from each alliance briefed the audience about their objectives, activities, action researches and what they expect from JSA as a forum, as well as what they can contribute to JSA.

1. **DAG: Disability Action Group-Presented by Ms Neeta Panchal**

The Disability Action Group (DAG) was constituted two years ago with a purpose to inform advice and advocate on issues of people living with disabilities such as accessibility (physical and digital), employability and assistive technology. Ms Neeta Panchal, Coordinator at DAG, Ahmedabad explained how DAG as an alliance advocated for all kinds of challenges and disabilities- physical as well as mental. While explaining their objectives, she also spoke of how the disabled population is generally excluded and how majority of the approaches even within the development sector are not inclusive, for example, power point presentations which cannot be viewed by the visually impaired or material and reports which are generally not documented in Braille.

She also mentioned about how Maternal Health needs to incorporate a perspective of the disabled. For example, there has been a constant mention of improving the quality of ANC, however, nobody mentioned the difficulties that women on crutches, or wheel chairs face while weight was being recorded during pregnancy. She spoke of the various fears and challenges faced by the disabled population and requested JSA as a body to incorporate this perspective in every endeavour, and make this one of the priority issues for advocacy.

2. **Right to Food Campaign- Presented by Ms Sejal Dave**

The “Right to Food Campaign” is an informal network of organisations and individuals committed to the realisation of the right to food in India. They consider that everyone has a fundamental right to be free from hunger and that the primary responsibility for guaranteeing basic entitlements rests with the state. The National Food Security Act has been passed since 7 to 8 months; however, the Gujarat Government has not yet begun intervention on it. Not just women but children also need to be included with regards to advocating for Right to Food. The statistics claim that there has been significant reduction in the proportion of malnutrition; however, the reality as revealed by a study conducted jointly by various NGOs of Gujarat is very different. Some of the questions addressed by the study were: Whether malnourished children are identified on ration cards, do they have Mamta cards, rate of malnutrition as identified by age, are they being referred for services, do they receive take home rations and so on.

Sejal from Anna Suraksha Abhiyaan briefed about the campaign and explained how maternal health and overall woman’s health was impacted by what she consumed. The tribal and dalit population especially was deprived from ICDS services in various ways. We cannot look at this as a one-time approach, rather as a life cycle intervention, with collective efforts of the civil society, NGOs as well as various government departments which should work in coordination in order to achieve this. She gave simple examples, like how an emphasis on cereals in ICDS can be replaced by proteins to benefit the malnourished children and pregnant women better.

3. **CommonHealth - Presented by Ms Renu Khanna**
CommonHealth (The Coalition for Maternal-Neonatal Health and Safe Abortion) is a membership-based network of individuals and organisations from across the country. It is a 9 years old coalition, is unregistered, and has approximately 75 members. Maternal Health not only comprises maternal deaths but also includes components of family planning, morbidity, ANC and so on. The goal of Common Health is to advocate for better access to and quality of maternal-neonatal health and safe abortion services. They engage with issues of women’s gender and reproductive health and rights through a broad-based advocacy strategy to bring together and mobilise citizens, health providers, researchers, administrators, policy makers and others to identify significant gaps that exist in maternal-neonatal health and safe abortion.

There is an artificial boundary between departments that address women’s and children’s issues and both need to work in sync in order to reduce MMR as well as neonatal deaths. Ms Renu Khanna from CommonHealth explained how while talking of maternal and neonatal health, somehow abortions is still not talked about. There is a difference between “Garbhpat” (miscarriage) and “Garbh Samapan” (abortion) and the questions that need to be addressed are who are these women, why do they abort and where? Sex selection and determination is unethical and wrong and there are no two sides to it. However, there is a difference between the PC PNDT Act (Pre-conception and pre-natal diagnostic techniques Act) and the MTP (Medical termination of pregnancy) Act and the two should not be confused.

Besides that, the Government of India has made MDRs mandatory. However, in Gujarat and various other States, we still see Maternal Deaths are not reported; hence a maternal death review is out of question. Also the MDRs that have been documented are very clinical in nature with a lack of focus on social determinants and victim perspective towards the community.

4. Mother NGO scheme – Presented by Vd. Smita Bajpai

The International Conference on Population and Development (ICPD) organised at Cairo in 1994 was a milestone in bringing Reproductive Rights to the global agenda. The Reproductive and Child Health Programme was initiated by the Government of India in 1997. To ensure civil society participation in the effective implementation of Reproductive and Child Health (RCH) program, the Ministry of Health and Family Welfare, Government of India initiated the Mother NGO (MNGO) Scheme in the year 2000. The objective of the MNGO scheme is to improve the Reproductive and Child Health status in the underserved areas.

Since October 2004, the Ministry of Health and Family Welfare, Government of India, has accredited CHETNA as a Regional Resource Centre (RRC) for Gujarat State and the Union Territories of Diu, Daman and Dadra Nagar Haveli. The role of RRC is to strengthen the technical and managerial competencies of MNGOs to facilitate implementation of RCH activities through field NGOs and Coordinate with the National/State and District Health Department. A total of 21 Mother NGOs (MNGOs), 76 field NGOs (FNGOs) and 3 Service NGOs (SNGOs) have been identified for the intervention by RRC in 23 districts of Gujarat State.

5. National Alliance for Youth - Presented by Ms Pallavi Patel
Youth Alliance represents the National Alliance for Young People towards a Healthy Future. It promotes concerns of young people (10-24 years) and offers an interactive space to all those working towards their development. It is an open platform that encourages sharing of experiences across different parts of the country and updated information for better communication with young people, organizations and individuals. The main aim is to enable young people to voice their needs and actively participate in creating greater awareness and empowerment for issues relating to health, nutrition, education, employment, gender equality and reproductive and sexual health rights.

6. NAMHHR (National Alliance for Maternal Health and Human Rights) - Presented by Vd. Smita Bajpai
National Alliance for Maternal Health and Human Rights (NAMHHR) was started on 20th January 2010. Several civil society organizations from seven states of India got together and agreed on the need to strengthen maternal health as an issue of women's human rights, given the sheer scale of the problem at seventy to eighty thousand women dying each year in India of preventable causes related to maternity. Vd. Smita Bajpai, A Steering Commitee member of NAMHHR shared that the group recognizes that there is an urgent need for women's organizations, health organizations, and groups working on law and human rights, and mass-based organizations to come together on this issue. Strong rights-based strategies are needed to build greater accountability for these thousands of preventable deaths among women in India.

The Alliance currently has 33 members from 11 states of India, as well as expert advisors working on research, Right to Food, public health, right to medicines and budget accountability.

7. WRAI (White Ribbon Alliance - India)
White Ribbon Alliance is a global network of maternal health advocates campaigning for more resources and the right policies to prevent the deaths of women in pregnancy and childbirth, while holding governments and politicians to account for their promises of action. It unites citizens to demand the right to a safe birth for every woman, everywhere. CHETNA has initiated and is the Secretariat of the White Ribbon Alliancece-Rajasthan which is called SUMA.

The session concluded with a note to work collectively and interact with other networks to build solidarity among civil society members.

VIII. Action plan for JSA-Gujarat

Before lunch break, all the members were divided into groups based on their respective regions of intervention, and in each group participants were asked to brainstorm on 3 to 4 priority issues which they recognized as a group in order to work upon as JSA and also other small thematic areas in order to make suggestions/ recommendations to the Health Department. Members were told that the
priority issues need not be too many, as it should to be something which we can collectively work towards as JSA, in a decided time frame.

GANDHINAGAR REGION

Issues
- The services provided to pregnant are not catered to suit the challenging geographical realities; hence women residing in far flung tribal areas and the migratory population do not get access to services of Mamta Divas and other health services.
- Quality of ante natal care is very poor marked by lack of health as well as nutrition based education, no BP check-ups, no abdominal check-ups and birth plans are not prepared.
- There is a lack of awareness and services for miscarriages. (Kasuvavad). Pills are given without understanding the implicit dangers.
- The locals do not have awareness about the structure and hierarchy of the government health systems – PHC- CHC- Civil/ Private hospital

Action
- The village level committees like Rogi Kalyan Samiti and VHNSC need strengthening.
- A distinction should be made between Mamta Diwas and Mamta Taruni Diwas in order to reach out to the adolescent girls.

VPSS, VALSAD, NAVSARI REGION

Issues
The issues identified in this region relate to lack of Infrastructure/equipments/staff at the PHC/CHC, issues with the lack of clarity of role of health workers as well need for their training, neglect towards the needs of the disabled population and lastly neglect of women who have undergone a miscarriage/abortion.
Suggestions

- A deep need perceived for training of frontline health workers as well as Dais, especially for reaching out to women in remote areas. JSA members could take this responsibility. Regular training and practical exams for nurses are also needed.
- To impart awareness and education on health rights- this can be done through various mandals/ local groups at the village, by educating children at school, as well as women during Mamta Divas.
- To strengthen members of Gram Sanjivni Samiti- to be able to impart knowledge about the various government schemes, and bear responsibility for the same.
- To ensure home visits by ASHA/ Nurse to women who have undergone miscarriage/ abortion.
- The health department should have predetermined guidelines for different kinds of deliveries, place to be fixed, and each health worker should be informed of this.
- Special privileges should be guaranteed for the disabled population, such as facility for a wheel chair for a crippled woman.
- Advocacy and dialogue by JSA members with the Health department over issues identified.

AHMEDABAD REGION

Issues
The issues identified in this region relate to prevalence of various addictions in the adolescent age group as well as pregnant women, misuse of funds and corruption while accessing benefits of any schemes, exclusion of the disabled population, as well as the inactive and dormant presence of various village level samitis that do not function.

Suggestions

1. To strengthen Rogi Kalyan Samiti and Sanjeevi Samiti by trying to analyze and understand the situation of the samiti, to provide regular training inputs for up gradation of skills, to ensure regular reporting and monitoring, creating a mechanism wherein efficient samitis are awarded.
2. To prepare a village level plan and present it in the Gram Sabha.
3. To ensure judicious utilization of funds.
4. Focus on de addiction through awareness campaigns via street plays, exposure visits, as well as video screening.
5. To create accessible documents that incorporate perspective of the disabled population, so as to enable the disabled population to have knowledge about various government schemes.

SAURASHTRA, KUTCH REGION (Rajkot, Jamnagar, Devbhoomi, Dwarka)

Issues

- Absence of complete staff at PHC has been a pertinent issue.
• There are issues with the services of PHC for which training of RKS is perceived as necessary in order to regularize those services.
• Visibility of the village level issues is still a problem and they are not adequately addressed at the block level.
• Strict monitoring of GSS members during the Mamta Divas is needed.

Suggestions
• To attempt to reduce the workload of the female health worker.
• To have strict monitoring mechanisms for the sub centres as well as PHC.
• Block level meetings should be conducted to address problems of PHC

VADODARA REGION (Deepak Foundation, SAHAI, ANANDI, SEWA Rural, SARTHI)

Issues were identified in the following areas

• Mamta Divas - Mamta Divas was conducted in a manner which was devoid of quality such as incomplete Mamta Cards, no HB testing, scattered settlements, limited reach of the services of Anganwadi, thereby depriving the houses that are far flung.
• PNC – In spite of majority deaths occurring within a few hours post delivery, quality of post natal care is very poor.
• Government schemes - In spite of introduction of so many schemes there are procedural difficulties in accessing the benefits due to too many documents, problem of too many cards for each scheme which leads to confusion, issues of corruption and bribing within these schemes in order to procure cheques and largely the issue of lack of awareness about the various schemes.
• PHC- Functioning at the PHC is hampered with issues like lack of infrastructure, lack of staff, lack of medicines, and it does not remain open 24/7.
• ASHA- There are serious concerns with regards to accountability of the work of ASHAs such as inaccurate data about institutional deliveries, incomplete Mamta Cards, no documentation of maternal deaths, flaws in the implementation of various schemes, no clear division of responsibilities of health workers at the village level, absence of audits and lack of training and monitoring.

Suggestions
• A number of suggestions arose of out of the discussion on issues prevalent in Mamta Divas such as time scheduling of work in order to improve quality, clear division of responsibilities of frontline workers, to celebrate the Mamta Divas separately for each Anganwadi, supervision of the Mamta Divas, incentives for the Dai, monitoring of Mamta Divas by NGOs and reporting the same to the government.
• Maternal Death Reviews need to be conducted with CBOs and NGOs playing an active role in the review process.
• Social Audit of Maternal Deaths as well as Child Deaths should be conducted.
Three visits should be made mandatory as part of Post Natal Care and there should be strict monitoring of the same.

Training for ASHAs, ANMs, GSS, RKS should be taken up collectively and more actively.

XII. WAY FORWARD - SUGGESTIONS AND RECOMMENDATIONS

- The discussion commenced with a follow up of the JSSK study which was a compilation of data provided by various NGOs, however, very few organizations had sent in their data on time in order for it to be incorporated.
- So there was further deliberation over when the remaining NGOs could send in their data. Also it was mentioned that this could comprise of a few villages or an entire district depending on the organization’s capacity and discretion.
- As per the outcome of the group presentations, it was unanimously decided that issues pertaining to Mamta Divas were prevalent everywhere and this needs to be addressed seriously on a policy level. One of the suggestions was that monitoring of Mamta Divas could be taken up as a study by all the NGOs together. SAHAJ has agreed to take the responsibility for sharing the monitoring tool that they are using in Anand and Panchmahals and Baria districts.
- It was collectively decided that there would be no limit fixed on the number of villages to be surveyed for this study. There was discussion over fixing a timeline for this study, as also a day, time and place for presenting this to the government.
- For this study on observation of the Mamta Divas, the tool is already ready. Dhiren bhai and Pankaj bhai from SEWA Rural have agreed to take the responsibility for refining the tool, as well as for doing the analysis of the compiled data.
- It was also collectively felt that besides refining the tool, it was also important to do a training of the field workers along with the staff to understand in depth the quality issues of the Mamta Divas.
- It was also decided that a report of this two day JSA workshop, held at Ahmedabad would be compiled within the next 10 days, (by the 20th of April) and could be presented as a memorandum on issues of concern as well as suggestions/ recommendations to the government (Health Secretary/ Health Minister) after the elections, preferably after the 15th of May.
- Besides the above, a press note was prepared for the two day workshop in Gujarati and English and read to the participants for feedback, which was incorporated on the spot.

The note has been attached as Annexe 4.

Participants’ Feedback
1. **Situation of Maternal Health in the State**: Through the discussion and presentations we realized that not just our own district but various districts all over Gujarat were poor in terms of maternal health.

2. **Newer insights**: Insights from various studies/researches was a new learning for us.

3. **Aspects that require more focussed efforts**: As per discussion there were some prominent deterrents in way of reducing maternal mortality, which required more attention.

   a. Lack of knowledge of one’s rights is also a deterrent in reducing maternal mortality.

   b. Adolescents need more focus and need to be incorporated in policy decisions

   c. Post natal care is another area which requires a lot of work on.

   d. As recognized on an international level, a focus on the third delay in India is imperative.

   e. Involving the community was perceived as necessary for effective collaborative efforts towards reduction of maternal mortality.

   JSA Action plan for Maternal Health: Members collectively felt that JSA should not just be a forum for discussion of issues but these insights should be taken forward to the policy level. In spite of these workshops and campaigns, it was felt that more efforts were needed to be made in order to increase the visibility of the issues.
# ANNEXE 1

## LIST OF PARTICIPANTS

<table>
<thead>
<tr>
<th>SR NO</th>
<th>NAME</th>
<th>ORGANIZATION</th>
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<tbody>
<tr>
<td>1.</td>
<td>Chauhan Vashishta</td>
<td>Gram Vikas Trust, Dwarka</td>
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<tr>
<td>2.</td>
<td>Pradeepa Dube</td>
<td>ANANDI</td>
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<td>3.</td>
<td>Badiya</td>
<td>ANANDI</td>
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<td>4.</td>
<td>Sejal Dave</td>
<td>ANANDI</td>
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<td>5.</td>
<td>Narendra Makwana</td>
<td>Kutch Mahila Vias Sangathan</td>
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<td>6.</td>
<td>Dr. Lakshmi Bhatt</td>
<td>ARCH, Valsad</td>
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<td>7.</td>
<td>Anita Shah</td>
<td>Anjali</td>
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<td>8.</td>
<td>Smita Bajpai</td>
<td>CHETNA</td>
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<td>9.</td>
<td>Savita Dangi</td>
<td>CHETNA</td>
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<td>10.</td>
<td>Arpita Suthar</td>
<td>CHETNA</td>
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<td>11.</td>
<td>Pallavi Patel</td>
<td>CHETNA</td>
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<td>12.</td>
<td>Harishkumar L Patel</td>
<td>SARTHI</td>
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<td>13.</td>
<td>Pasma Hebadoo</td>
<td>SEWA Ahmedabad</td>
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<td>14.</td>
<td>Kazi Rehanabanan</td>
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<td>Suresh Chavda</td>
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<td>Darshana</td>
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<td>18.</td>
<td>Alpita Kapadia</td>
<td>FRHS</td>
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<td>19.</td>
<td>Dr. Harsha Shah</td>
<td>Gram Seva Trust, Navsari</td>
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<td>Dr. Sharmishtha Patil</td>
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<td>21.</td>
<td>Sunita Macwan</td>
<td>KSSS, Ahmedabad</td>
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<td>22.</td>
<td>Yasmin Shaikh</td>
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<td>23.</td>
<td>Dr. Pankaj Makwana</td>
<td>SEWA Rural, Jhagadia</td>
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<td>24.</td>
<td>Dr. Dhiren Modi</td>
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<td>Dr. Shobha Shah</td>
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<td>Jasubhai</td>
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<td>Rajpara Jayanti</td>
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<td>Gandhi Dipesh Kumar</td>
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<td>Chetan Patel</td>
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<td>31.</td>
<td>Nandini Srivastava</td>
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<td>Renu Khanna</td>
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<td>Dileep Malvankar</td>
<td>IIPH, Gandhinagar</td>
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<td>Kotecha Ketan</td>
<td>Sava, Jamnagar</td>
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<td>Ramesh Kshatriya</td>
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<td>42.</td>
<td>Girish Bhadiyar</td>
<td>FRHS Ahmedabad</td>
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<td>Neeta Panchal</td>
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## SCHEDULE FOR THE STATE LEVEL CONSULTATION OF JAN SWASTHYA ABHIYAN, GUJARAT.

<table>
<thead>
<tr>
<th>Time</th>
<th>Day 1</th>
<th>Speaker/ Presenter</th>
<th>Coordinator</th>
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<tbody>
<tr>
<td>11:00 to 11:30</td>
<td>Welcome, Introduction</td>
<td>Vd. Smita Bajpai</td>
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<tr>
<td>11:30 to 12:30</td>
<td><strong>Current Scenario of Maternal Health in Gujarat Session I</strong></td>
<td>Renu Khanna</td>
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<td></td>
<td>Testimonies highlighting different aspects of Maternal Health, Overview presentation ‘Inequities of MH in Gujarat’</td>
<td>Dr Dileep Mavlankar IIPHG</td>
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<td>12:30 to 1:15</td>
<td>Group Work - Challenges in MH in different regions of Gujarat</td>
<td>Smita Bajpai</td>
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<td>1:15 to 2:00</td>
<td><strong>Lunch Break</strong></td>
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<tr>
<td>2:00 to 3:00</td>
<td>Presentations, discussion, summary based on the group work</td>
<td>Smita Bajpai</td>
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<td>3:00 to 4:15</td>
<td><strong>Current Scenario of Maternal Health in Gujarat Session II</strong></td>
<td>Anita Shah</td>
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<td>JSSK Study, Access to Maternity Entitlement- Kutch and Mahisagar</td>
<td>Dr. Dhiren Modi, RRC/Smita Bajpai</td>
<td>Anandi/ Sejal Dave</td>
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<td>Malnutrition in Gujarat</td>
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<td>4:15 to 4:30</td>
<td><strong>Tea Break</strong></td>
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<td>4:30 to 5:30</td>
<td><strong>Current Scenario of Maternal Health in Gujarat Session III</strong></td>
<td>Dr. Pankajbhai</td>
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<td>Social Autopsies of Maternal Deaths - Report from select areas in Gujarat</td>
<td>Mahima/ Pradeepa/ Sunanda /Smita</td>
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<td>5:30 to 8:30</td>
<td><strong>Break and Dinner</strong></td>
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<td>8:30 to 10:00</td>
<td>Show and Tell –sharing of resources on MH (Hb colour scale, community growth - SEWA Rural, Game - SAHAJ, others from participants)</td>
<td>All participants will be asked to bring their resources.</td>
<td>Mahima/Sangeeta/ Dhiren Modi</td>
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**Day 2**

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ANNEXE 2
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<tr>
<th>Time</th>
<th>Session Description</th>
<th>Presenter(s)</th>
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<tbody>
<tr>
<td>9:00 to 10:00</td>
<td><strong>Innovation and best practices I</strong></td>
<td>DHIREN MODI/SHOBHA SHAH, NANDINI HARSHA SHAH, PALLAVI PATEL</td>
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<td>Mother Friendly Hospital- SEWA Rural, CHC- Jabugam - Deepak Foundation Gram Sewa Trust , Kharel</td>
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<td>10:00 to 11:00</td>
<td><strong>Innovation and best practices II</strong></td>
<td>DHIREN MODI, PALLAVI PATEL, PRADEEPA</td>
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<td>11:00 to 11:15</td>
<td><strong>Tea Break</strong></td>
<td>GVHA</td>
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<td>11:15 to 1:00</td>
<td><strong>Brief Introduction of Networks/alliances/campaigns</strong></td>
<td>Smita Bajpai</td>
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<td></td>
<td>Identifying Issues for dialogue with state: JSA members and other campaigns/networks</td>
<td>PANKAJ SHAH</td>
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<td>2.30 - 3:00</td>
<td><strong>Closure and Lunch Break</strong></td>
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ANNEXURE-III REGION WISE ISSUES

Ahmedabad Region

1. **Issues with government schemes:** Lack of awareness about entitlements, corruption, too many documents act as barriers to availing benefits of any scheme.

2. **Gender issues and women’s health:** Malnutrition and anaemia in girls and women are serious concerns, adolescent girls and boys are left out of the purview of most interventions—absence of Tarunis in the Mamta Taruni Divas, behaviour change is a perceived necessity, issue of decision making among women is prevalent due to their secondary status, issue of female foeticide due to family pressure is very serious in terms of its consequent impact women’s health, there is a need to include men as ASHAs, ANMs, etc so as to reduce burden on women both on the personal and professional front.

3. **Anganwadi/PHC/CHC level problems:** Problem of human resources, inadequate infrastructure/ equipments/ space problems, problem of storage at Anganwadi, problem of unhygienic toilets during delivery, inadequate transport facilities - all these impact the quality of services delivered.

4. **Monitoring issues:** Irregular and problematic social audits, along with inadequate monitoring by supervisors create accountability issues.

5. **Lack of training**- Untrained dais, nurses, ANMs, lack of skilled health workers, inactive RKSs and VHNSCs act as barriers to Gramin Development. The various samitis/ local groups should be utilized for Gramin development.

Gandhinagar Region

1. **Geographical issues:** Maternal Health services are not available/ accessible in many areas. Migratory population/ salt pan workers, etc who are away for 4-5 months are generally not tracked. Health staff is unable to provide services in tribal areas, hilly regions, wadis and other interior areas. Those places where services are available, they lack in quality.

2. **Quality of ANC:** Instruments are not are available or not in working condition, birth plans are not prepared, health education and nutrition education is not given , post natal care and abortion care after MTP is not given

3. **Lack of awareness and accountability on part of government officials:** People are not aware of the roles and responsibilities of health functionaries. Doctors are not available 24 hours, and there’s no visiting gynaecologist, referrals are given during critical situations without any explanation

4. **Problems with government schemes and utilization of funds:** There is a lack of knowledge in community about health structure, government schemes like JSY, JSSK, etc. VHSNC and RKS funds are unutilized as the members have no knowledge about the use of these funds.
Vadodara Region

1. **Problems faced with regards to government schemes:** Access to govt schemes is difficult—beneficiaries do not receive money, there is a lack of knowledge in communities regarding the benefit of these schemes, paperwork and collection of documents for these schemes is difficult and repetitive, and beneficiaries face corruption. Private Doctors give commissions to ASHAs to bring patients to them.

2. **Issues at PHC level:** Poor Infrastructure at PHC and sub-centres, non-availability of 24 hour services in PHCs, unavailability of medicines or medicine stock-outs, incomplete and fabricated information filled in the Mamta cards, incorrect or fabricated Hb estimations filled in the form—all these characterize the situation at PHCs.

3. **Problems of monitoring:** Job responsibility of health staff is not defined clearly due to which many pregnant women do not receive health services. There are problems with documentation and reporting such as staff reports are not seen, no MDR is done in community, child deaths and maternal deaths are neither reported nor reviewed. No social audits are done and nutrition programs are characterized by poor implementation. There is pressure on ASHAs to show increase in institutional deliveries.

4. **Inequities:** Those in interior and difficult areas have no access to Mamta diwas services. Access to health care should be a right guaranteed to all irrespective of one’s economic and social background. High rates of anaemia and malnutrition present in SC and ST population is neglected; only Family Planning is emphasized. If Polio campaigns are religiously conducted, why not gynaec campaigns?

Jamnagar Region

1. **Issues at PHC/ sub centres:** Situation at PHC is characterized by lack of staff and infrastructure/ equipments, most of the times there is no staff at the sub centres and most sub centres are non functional. There are fewer deliveries in public hospitals.

2. **Mamta Divas:** Beneficiaries do not receive appropriate counselling during Mamta Divas, days for Mamta Divas are not fixed and many a times change as per the convenience of the staff, quality issues in Mamta divas also exist due to the heavy burden of work and reports of FHWs.

3. **ANC:** Ante natal check-ups lack in quality, BP is not checked, abdominal check-ups are not done, and there is a delay in registration of deliveries.

4. **Cultural factors:** Prevalence of teenage marriage and pregnancies is still high among the tribal population, alcohol and/or tobacco addiction is present in women, superstitions, culture specific dietary practices as well as migration—all affect the overall situation of maternal health. Malnutrition and anaemia are very high among women and adolescent girls.

**Inequities:** Behaviour of health workers towards beneficiaries is not good, high poverty and illiteracy exists, interior areas do not receive health services
Navasari Region

1. **Adolescent girls:** Both adolescent boys and girls are malnourished and anaemic, there is caste based discrimination, girls receive food packets from Anganwadi but recipes are not demonstrated, IFA consumption is poor and irregular- girls throw away tablets and stock is not available many a times, school dropout rate is high after 8th std, teenage marriages and pregnancies are still high in interior areas.

2. **Antenatal health:** Mamta diwas is conducted regularly but quality of services are poor, health staff cannot identify high risk pregnant women, health education is not given during mamta diwas or in home visits, nutrition demonstrations are not done, beneficiaries are unaware about govt schemes, paper work is difficult and talatis are not available regularly, if pregnant women wish to go for better antenatal care outside their village, it is expensive, and transport is difficult, migratory population have no access to health services due to language difficulties, lack of sensitivity in health staff is evident- all these factors culminate in very poor maternal health.

3. **Delivery services:** About 40 percent home deliveries are in interior areas, there is lack of infrastructure in PHCs for emergency care and delivery, cleanliness and hygiene are not maintained in PHCs, behaviour of health staff is rude, health staff lacks training in delivery, women do not have the right to choose place of delivery- they are often forced to deliver in PHCs, health staff not available 24 hours in PHC hence patients are referred in evenings, ambulance drivers are not available in evenings in interior areas, 108 travels 20 to 25 kms in interior areas to reach beneficiary and back to the hospital. Hence many deliveries happen before 108 reaches home or on the way.

4. **Post natal care:** No post natal visits are conducted by health the staff, ASHA is not trained enough to conduct good quality PNC visits. Women neither go for back for PNC, nor does anyone follow up from the health system.

5. **New born and infant care:** Old beliefs still prevail eg. Branding , pre lacteal feeds given etc, 25 to 30 % LBW babies, lack of intensive care for LBW and premature babies in PHC, no NICUs in PHC, such babies are referred to private setups which are very expensive, vaccination coverage is good except in migratory population, 45 to 50 percent malnutrition in children is present.

6. **Women’s health:** Gender discrimination is seen in some areas, gynec services are not available in PHC, lack of awareness in women regarding their health problems, lack of care by women herself and her family due to secondary status. Women’s decisions are made either by the family or by the health system. There are no Chiranjeevi Yojana forms, Dai training has been stopped, there are no specialized referral services, there are huge delays in (108) ambulance.
ANNEXE 4

PRESS RELEASE

Observing National Safe Motherhood Day-Kasturba’s Birthday

NGOs in Gujarat share Concerns and Solutions for Maternal Health in Gujarat

To commemorate the National Safe Motherhood Day on April 11, 45 representatives from 25 Voluntary Organisations from 22 districts of Gujarat met in Ahmedabad on April 9 and 10 to share their concerns and solutions about maternal health. The meeting was organised by Jan Swasthya Abhiyaan, Gujarat which is the state chapter of the National body.

The members appreciated the fact that the Maternal Mortality Ratio of the state has come down to 122 per 100000 live births (SRS 2013) from 148 in 2007-09. However there is still inequities in Maternal Health in Gujarat and Dr. Dileep Mavalankar from IIPHG presented the findings of three studies which identified economic and social factors resulting in inequity. Members shared and expressed that although the government has launched a number of innovative schemes, like the Chiranjeevi Yojana, Kasturba Gandhi Poshan Yojana, Bal Sakha Yojna, it is still a challenge for migrating, marginalised women and their families to avail the benefits of these schemes. Disability groups spoke about their difficulties in accessing health services and urged the state to ensure accessible health services.

In addition members also shared that migrating women and families face difficulties in accessing ante natal services, institutional deliveries and post natal checkups. While Mamta Divas is being somewhat regularly held the services provided are incomplete and not of appropriate quality, for example – haemoglobin levels are not being assessed despite the fact that more than 50% of pregnant women are anemic (NFHS 3), blood pressures are not being measured accurately despite the fact that high blood pressure may become life threatening for many women. This was a universal observation by the members present.

An analysis and stories of 372 maternal deaths was shared by Deepak Foundation, SAHAJ, ANANDI, SEWA Rural and CHETNA. While the 108 service has been quite a revolution in bringing mothers to nearest facility, multiple referrals have been a problem - many of the women who died were taken to upto three health facilities before they died. It is not uncommon for women to be referred from public health facilities to private institutions. There is an urgent need to strengthen and operationalise First Referral Units, civil hospitals, district hospitals and medical college hospital as emerging from these stories.

Representatives from ANANDI, SEWA Rural, Gram Seva Trust, CHETNA and SAHAJ shared various innovative approaches for improving maternal health - use of pictorials by community to monitor health services, use of colour scale method for haemoglobin testing and use of mobile phone technology for empowering ASHAs, Interactive Voice Based Messaging for adolescent education etc. Members from SEWA Rural, Deepak Foundation, Gram Seva Trust and Anjali also shared their experiences of providing hospital based maternal care services establishing quality standards and protocols.

Now when the government of Gujarat has taken a lead in identifying 77 high priority talukas for intensifying various services, JSA members resolved to draw the attention of the health department to the following issues of concern: quality of ante natal and post natal care at the field level; addressing issues of migrant women in terms of portability of entitlements and services; making the institutions
responsive and mother friendly, ensuring availability of blood in situations of emergency, eliminating out of pocket expenditures for maternity care and making the process of maternal death review more meaningful.

The meeting concluded by members expressing renewed commitment to continue to observe, monitor and complement maternal health services across the state and to develop and demonstrate innovative alternatives to strengthen their grassroots work to reach the excluded groups.

(For more details, contact Dr. Dhiren Modi - 94284416785, Smita Bajpai - 9426010938, Renu Khanna - 9427054006, Nandini Srivastav - 9825511652)
REPORT PREPARED BY

INDIVIDUAL SESSION RAPPORTEURS

Day 1: Dr. Sharmishtha Patil and Pallavi Saha
Day 2: Pallavi Saha and Dr. Sharmishtha Patil

Gujarati – Sejal Dave

First Draft compiled by Pallavi Saha

Reviewed and Finalised by Smita Bajpai and Renu Khanna