Training on Maternal Health and Maternal Death Review

November 28, 29 and 30th November, 2017

at

Regional Institute of Health and Family Welfare, Dhobiwan (Tangmarg)

Organized By

Common Health - Coalition for Maternal-Neonatal Health and Safe Abortion

In collaboration with

JKVHA, WHIPRO, PSA Kashmir, Ahsan Foundation J&K

&

Directorate of Health Services, Kashmir

Prepared by :- A.K. Wani (JKVHA), Rahi Riyaz Ahmed (Ahsan Foundation J & K) and (Journalist) Mohd Rafiq

Day 1 – 28th November 2017

(1) Introduction of Participants & Training Objectives :-

Mr. Rahi Riyaz Ahmed Chairman Ahsan foundation J&K introduced the resource persons and participants in the training programme. He said that 4 to 5 representatives from each of the ten districts of Kashmir valley have been invited to this training programme who will spread the message and use the techniques learnt from the resource persons who represent CommonHealth India, when they get back to their respective districts to complement their agenda on Health issues in the Rural and Urban areas.

(2) Welcome Address

Mr. A.K. Wani, Senior Programme Manager of JKVHA, while welcoming the guest speakers from CommonHealth and participants from the 10 districts of Kashmir valley, said that this training program will mainly be on maternal health and maternal death review with focus on neonatal health as well. He said that with the launch of JSY, the number of institutional deliveries has increased significantly but there are still 20 to 25% pregnant women who hesitate to access the health facilities. Home deliveries in the hill districts are still high due to difficult terrain and inclement weather conditions and the health volunteers, ASHAs and Anganwadi workers are expected to create enough awareness in this regard and ensure 100% institutional deliveries in all parts of J&K and to avail the benefits being provided under JSY and JSSK.

(3) Inaugural Address

Inaugurating the training program Dr. Subhashri, said that CommonHealth is a multi-state coalition of organizations and individuals whose vision is to create a society that ensures Maternal-Neonatal healthcare and Safe abortion for all women, especially in the marginalized communities of India. Its mission is to raise the visibility of unacceptably high mortality and morbidity among mothers and newborns and the lack of access to safe abortions. She said that the training program conducted by the local NGOs of central Kashmir in collaboration with Common Health India is a step towards this goal. She wished success of the training program in which grassroots level health workers, volunteers, ASHAs and Civil Society workers from various parts of Kashmir are participating.

Day 1 : First Session on 28-11-2017

This session was conducted by Dr Subhasri and the objective was experience sharing and grounding the workshop.

The participants were asked to share their experiences with regards to maternal health in the areas they worked in. The following issues came up.

- Several instances of poor quality maternal health care were shared. These included instances of patients not being seen on time, or not being seen at all, PPH not being picked up, birth asphyxia, home deliveries, etc.
- There is only one maternity hospital, Lal Ded Hospital in Srinagar catering to the whole valley; this means a lot of overcrowding and poor quality of care. Participants shared that newborn deaths were increasing because of this.
- There seemed to be a trend among both doctors and women to prefer caesarean delivery – this was seen with great concern.
- The issue of doctors in the public sector doing private practice and thus not being available on duty in public facilities was raised. This meant that often, no doctors were available in these facilities and only nurses managed patients.
- The effect of conflict on maternal health was stressed – the psychosocial effect of stress on pregnancy, conflict related access issues, the conflict having reduced the number of obstetricians in the valley, and the effect of conflict on mental disability in children were some of the issues brought up.
- There was also a perception among participants that miscarriages seemed to be increasing.

During her PowerPoint Presentation, the following points were highlighted by Dr Subhasri.

(a) The core principles of CommonHealth are to understand the current situation of Maternal-Neonatal health and Safe Abortion. Of course, it also involves adolescent health and family planning program. The situation has to be analysed both from policy and program perspective as well as understand the ground reality.

(b) Antenatal care and steps required are:-

(i) Aim of antenatal care is routine care, identification of women with special conditions and referral to higher centres if necessary for care.

(ii) Early detection of complications

(iii) Detailed history to detect complications and hereditary risks

(iv) <u>Clinical examination in which necessary things are</u>:

- Maternal height/weight
- Clinical examination for anemia
- Blood pressure measurement
- Abdominal examination for uterine height – for adequacy of fetal growth - and for position, lie and the fetal heart rate.

(v) Lab Tests necessary are:

- Haemoglobin
- Urine for protein
- Blood Group ABO and Rh

(vi) The essential components of antenatal care are :

- Medicines – Iron supplements
- Tetanus Toxoid
- Complete antenatal card

(vii) Instructions necessary on antenatal care :

- Birth preparedness including for emergency transport
- Danger signs and their explanation
- Contacts for emergencies

Education about maternity benefit schemes.

The feedback given by the participants on antenatal care on sharing the experiences was as under:

(1) There is a need to increase the demand generation through community mobilization to ensure community participation.

(2) Need to develop behavior change communication strategy in order to enhance knowledge and source of ANC, institutional delivery, child immunization and RTI treatment, group counseling of pregnant women and awareness programs on maternal and child health

through various activities like IEC material, print and electronic media to improve health check-ups.

(3) Concerns were expressed as to what can be done by the participants as lay persons. Who are we to interfere? Some of this was taken up in the discussion amongst the participants.

Day 1 – 2nd session

This session was conducted by Dr Sunil Kaul and the topic was "An overview of Maternal Mortality". The PowerPoint Presentation of Dr. Sunil covered the definitions, causes and the present policy of the maternal health and maternal death review. The definitions of maternal mortality and related issues were given under:-

Maternal Death:- As per the WHO definition, a maternal death is a death of woman during pregnancy or within 42 days after delivery or termination of pregnancy, irrespective of the duration and the site of pregnancy from any cause related to or aggravated by the pregnancy or its management though not from accidental or incidental causes.

Late Maternal Death:- A late maternal death is a death of a women from direct or indirect causes more than 42 days but less than one year after the termination of pregnancy.

Maternal Mortality Ratio:- The maternal mortality ratio is the number of maternal deaths per 100,000 live births.

Causes of Maternal Death

Direct:- Those resulting from obstetric complications of pregnancy state (pregnancy, labor and 6 weeks after childbirth) from interventions, omissions , incorrect treatment or from a chain of events resulting from any of the above.

Indirect:- Those resulting from previous existing disease or disease that developed during pregnancy and which was not due to direct obstetric causes but which was aggravated by physiologic effects of pregnancy.

Direct causes of maternal death are due to:-

- Hemorrhage
- Hypertension & Eclampsia
- Sepsis
- Unsafe abortion
- Obstructed labor
- Ectopic pregnancy
- Embolism
- Anesthesia complication

Indirect Causes are:-

- Anemia
- Heart Disease
- Accidents, etc.

Aim of CEmONC and BEmONC

- Comprehensive Emergency Obstetric – Neonatal care should be at all CHCs / SDHs / DHs. with surgical capability including Anesthesia and Blood transfusion.
- All Basic Emergency Obstetric – Neonatal care should be at all PHCs

Day 1 – 3rd session

This session was conducted by Dr Subhashri of CommonHealth by screening a film regarding the life of Mrs. X and her death because of delivering a dead baby and with less postpartum care (PPC). Mrs. X was shown to be from a poor family whose marriage had taken place at an early stage of her life, i.e., less than 18 years of her age. The society in which she was living with her husband was lacking health education. Mrs. X was shown as having third delivery with all health problems, anaemic and with less antenatal care. The film highlighted the social determinants behind a woman's death.

After watching the film participants observed the following deficiencies during her pregnancy and postpartum care:-

- Mrs. X had not maintained the spacing between the pregnancy periods.
- She was lacking family planning counseling and had no awareness of maternity benefit schemes.
- Being anemic and then due to pregnancies in succession, she suffered from serious health problems.
- Due to lack of health education she had gone to a medical institution away from her residence only once for antenatal checkup and had not followed the trimester schedule of her pregnancy.
- Because of the poverty, she and her husband had to work hard to earn their livelihood and as such the spacing and the birth plan was distant dream for them.
- Due to lack of resources she could not get the medicines to improve her health during pregnancy nor could she consult any doctor.
- There was no family or society support during her pregnancy and was discriminated on being anemic.
- Due to lack of health education, she could not plan properly for her delivery in the nearest health institution.
- She reached the hospital too late due to lack of transportation, of resources and the lack of attention of a trained birth attendant where she delivered a dead baby.
- The behavior of hospital attendants towards Mrs. X was not so good and it all happened because of her lack of health education, lack of family support, lack of antenatal care, lack availability of blood at the hospital and lack of proper attention from the hospital staff.
- There was no postpartum care of Mrs. X due to non-detection of problems and hence the delay in treatment too, because of which she lost the battle of her life for all reasons given above.
- The ASHAs, health workers and volunteers of various NGOs have to take note of all such problems and ensure timely health checkups during the pregnancy of a lady, proper planning of delivery in a sound health institution and proper postpartum care.

Day 2 : First Session on 29-11-2017

This session was conducted by Dr. Sunil Kaul who reviewed the earlier day proceedings by obtaining the feedback from the participants. The following points came up under observation with the collective feedback of participants:-

1. Infant mortality rate (IMR) is a sensitive indicator of health and Nutrition status of J&K. The IMR has fallen from 52 in 2006 to 34 in 2014 and TFR which indicates the number of children born to a woman during her entire reproductive period, has also come down to 1.7 from 2.3 in 2014.

2. Reducing MMR and IMR is the major objective of National Health Mission and is taken care properly in all hospitals of J&K. But still there are some incidents beyond control because of hilly and difficult terrain, lack of health awareness and timely transportation and referral.

3. In spite of the fact that J&K state has achieved 87% Antenatal care and 85% of the institutional deliveries, but there are still 15 to 20% of the pregnant ladies who still hesitate to access to health facilities in Govt. Health Institutions.

4. In spite of the fact that JSY and JSSY schemes have been launched in the Govt. Health Institutions in J&K, timely payment of the cash incentives to a pregnant woman who gives birth in these Health Institutions is still a million dollar question in view of non-availability of timely budget provisions. The fundamental aim of the cash incentive at the time of institutional delivery when it is needed, gets badly defeated.

5. Sanitation in rural areas offers formidable challenge to the health and well-being of rural population. The most challenging factor in rural sanitation comes from the habit of open area defecation and the women are facing a big challenge on this account.

6. Lack of proper disposal of domestic refuse is also a big challenge which adds to the health problems affecting women and children.

7. Marriage practices in adolescent age group i.e. before 18 years of age are a challenge in rural settings which needs proper education.

8. Cigarette and other tobacco products consumption in a family are absolutely bad for pregnant ladies and young ones which needs proper awareness.
9. Life skill education needs to be promoted among adolescent girls in and outside the Schools to inculcate healthy habits among them.

Day 2- Second Session

This session was conducted by Dr. Sunil Kaul and introduced Maternal Death Review (MDR)/Near-Miss review and the role of civil society. The topic was explained as under:-

- MDR is a study to learn why some women die while they are pregnant or soon after giving birth.
- Govt. of India has been reporting a steady decline in country's Maternal Mortality Ratio (MMR) over the last few years.
- The latest MMR figure of 178 per 100000 live births in 2010-12 is however far behind the fifth Millennium Development Goal (MDG) target of 109 per 100000 live births by 2015.
- Govt. of India has put in significant efforts to improve the maternal health situation in the country since the last decade.
- The primary focus of these initiatives has been to promote institutional deliveries.
- However the civil society networks like CommonHealth and Jan Swasthiya Abhiyan have been expressing concern over this exclusive push for institutional births and suggested that the maternal health policy should move away from the paradigm of institutional deliveries to that of "Safe Deliveries".
- Several efforts have been made in last few years to analyse the causes of individual maternal deaths and use such learnings to improve the health systems.
- In 2010, Govt. of India mandated MDRs at the district level across the country and published guidelines for the same.
- These reviews however suffer from several shortcomings including poor reporting, focus on medical causes rather than health systems, societal and family issues and the lack of transparency.

To illustrate the MDR, Dr. Kaul described the following main delays which cause maternal deaths:

I. 1st delay is on the part of mother, family or community not recognizing a life threatening delivery or not preparing well enough.

II. 2nd delay is in reaching a health care facility and may be because of road conditions, lack of transportation or location issues.

III. 3rd delay occurs at the health care facility upon arrival of a pregnant woman who receives inadequate care or insufficient treatment.

Conclusions:

After having the group discussion, the participants suggested the following measures to be taken by the Govt. authorities and the civil society members along with family members of the pregnant woman.

1. Antenatal care urgently needs to ensure monitoring of anemia and other risk factors like previous cesarean sections and obstructed labour.
2. Package of services to a pregnant woman like appropriate antenatal care, nutritional interventions and immunization needs to be ensured and monitored both by the family and at the nearest health care.
3. Birth preparedness and emergency readiness of the family including their close relatives needs to be made as a part of antenatal care.
4. Post-Partum care has to be strengthened at the nearest medical centers and the health providers should be trained on the need of effective postpartum care and in skills to quickly pick up and act in the event of postpartum complications.
5. Referral systems need to be made accountable and its auditing must be done by the higher authorities of the health department. This will decrease unnecessary referrals and improve the quality of referrals.
6. Free of cost emergency transport systems for obstetric complications must be ensured. Unlike many other states, J&K does not have a system like 108 for emergency transport, because of the conflict situation and security concerns involved in operating a call-in type of emergency transport system – this leaves patients to make their own arrangements for transport in case of emergency. Staff of State ambulances must be trained to recognize and transport women with complications to an appropriate facility that can manage them adequately. Instances were also

recounted of how ambulances refused to ply to certain places or in certain times because of conflict situation.

7. Civil society organizations and community based organizations including NGOs, Panchayats and village health and sanitation committees should be involved in the maternal death reporting process so as to increase the maternal death reporting.

8. Civil society organizations should be part of MDR committees at the district level so that they can take back the lessons from MDR analysis to the communities.

Day 2 – Second and Third Sessions

These two sessions were conducted by Dr. Subhashri in the forenoon and afternoon sessions on the object of introduction of MDR processes (familiarizing and working with tools in small groups) with coverage of experientially issues like sensitivity , consent and confidentiality .

The contents covered in these two sessions were:-

a) Safe abortion services

b) Delivery care

c) Referral

d) Postpartum care

e) Management of complications – postpartum hemorrhage.

f) Management of complications- obstructed care

g) Management of complications – sepsis

h) Anemia

i) Sickle cell anemia which is a genetic inherited blood disorder where hemoglobin is not normal. These sickle cells bunch up and cannot easily move through the vessels and causes blockage. This is more likely to happen when the person has lost a lot of fluids due to sweating, vomiting or does not have enough intakes of fluids during labour etc.

j) Sickle cell anemia and pregnancy

k) Tuberculosis – Pregnancy with TB causes risk of obstetric morbidity, higher miscarriage, eclampsia, intrapartum complications. There is a need to integrate MCH with RNTCP.

(A) Safe abortion services

The MTP act allows for termination of pregnancy on broad range conditions such as

1. Continuation of pregnancy would involve a risk to the life of the pregnant woman or it may cause grave injury to her physical or mental health.
2. Substantial risk that the child, if born, would be seriously handicapped due to physical or mental abnormalities.
3. Pregnancy is caused due to rape.
4. Pregnancy is caused due to failure of contraceptive in married woman or her husband.

The DLC may approve a private place to conduct termination up to 12 weeks or upto 20 weeks.

→ → Safe abortion services demands respectful care, privacy and confidentiality.

→→Unsafe abortions are very often kept confidential so complications and deaths are under reported.

When the session was opened out for discussion, there was a lot of debate about abortions – some women in the group of participants raised the issue that abortions were indeed happening, but for several reasons including religious ones, this was not something that was discussed in public, even among groups working on health. They also felt that the time was not conducive to bring up these issues as they were considered very sensitive, private and confidential.

The participants, while taking part in the discussion on the above objectives observed that while implementing the MTP Act, it is important to ensure:-

1. Women's access to safe abortion services is safeguarded and women are not forced to seek services from untrained providers posing risk to their lives, facing lifelong morbidities and even mortality.
2. There is health society in every district headed by deputy Commissioner with CMO as member secretary and NGOs should try to register with it.
3. NGOs should get involved in the system to improve accountability and transparency.
4. Interactive sessions should be held with women folk, ASHAs and Anganwadi workers on Maternal Health.
5. Programmes should be organized to spread awareness among adolescent girls about their reproductive health.

6. Voluntary blood donation camps should be organized to save the lives of the pregnant women who need it during the process of delivery in hospitals.
7. Role of media is very important in Maternal and Neonatal Health and their involvement in such programmes is necessary.
8. Private chemists are selling abortion pills without prescription which is a matter of concern as it leads to unsafe abortions.
9. This is the tendency in government officials to neglect social audit and maternal death review and as such we must pressurize state government to encourage such aspects.
10. In view of lack of quality services in government Hospitals, Private Hospitals are coming up efficiently in health care services including delivery of pregnancies which is a good sign.
11. Birth companion in a Labour Room is important and should be made mandatory for moral support and to avoid child thefts in hospitals.
12. Breast feeding should be made as a part of ASHA Training Programmes.
13. NGOs must plan a strategy what they can do in such scenario.

Day 3rd (Field Visit Session)

A field visit of the participants of the Training Programme from the 10 districts of Kashmir valley was organized and the main destination was Sub-District Hospital Magam which is some 4 to 5 kms from Regional Institute Dhobiwan. The team was also accompanied by the resource persons from CommonHealth. The visit was properly pre-fixed by the organizers with Dr. Tahir Block Medical Officer who took care of all medical Institutions of Medical Block Magam (District Budgam) including the Sub-District Hospital Magam. After introduction Dr. Tahir informed about the working of SDH Magam to the visiting team as under:-

1. The building of SDH Magam has come up under NHM funding and was occupied hurriedly after floods of 2014 after having maximum loss to the old building and equipments due to floods.
2. The building is still incomplete particularly as some lavatory points in operation theatre and Labour room are yet not adequately complete.
3. The BMO blamed political leaders of Magam area for their carelessness towards the problems faced by the SDH Authorities in performing their duties to the satisfaction of the people.

4. The main deficiency of the SDH was observed as non-heating system of the building on scientific lines due to which the patients are shivering during those winter days.

5. The SDH Magam among other Medical Staff has one Gynecologist, one Surgical Specialist and one Physician who are over burdened with the work load of the patients as most of the health facilities are provided free of cost including medicines.

6. In case of some scarcity of medicines, the same are purchased from the market in consultation with Hospital Development Fund Committee (HDFC).

7. As the District Hospital Budgam is at the tail end of Magam, as such the referral of the patients to SKIMS College Bemina and Lal Ded Gynae Hospital of Srinagar city is common. A proper referral note is prepared in which the deficiencies are recorded. The Hospital Authorities where the patients are referred to are informed well in advance.

8. The SDH Magam has different committees under different schemes like NHM, JSY, and JSSY etc. which are functioning properly and removing the bottlenecks if any as per agenda.

9. In addition to electric supply, the SDH has a solar plant.

10. The SDH Magam is reported to be conducting 30-40 delivery cases in a month including 25-30 caesareans a month(which is indeed very high!) and the abnormal delivery cases are referred to Government Lal Ded Gynae Hospital Srinagar along with Ambulance facility.

11. Arrangement for Blood Bank in the SDH Magam is in process.

12. Most of the tests of pregnant ladies are done in the hospital free of any cost.

13. The list of medicines available in the SDH Magam are displayed every day for information of patients visiting the Hospital.

14. The SDH Magam is having 30 beds, ANC registration room and one separate Gynae OPD.

15. The Operation theatre remains functional 5 days in a week.

16. While talking to some patients, they expressed their satisfaction for treatment within the limits of SDH and Hospital remains open for patients 24x7.

17. Magam being a populous town, there is lot of rush of indoor and outdoor patients as it caters to the needs of town as well as number of villages which fall under its area of operation.

18. No maternal death has taken place in this Hospital during the last three years.

19. All emergency drugs were reported to be available in the drug store for delivering purposes.

20. The performance of the Hospital was observed excellent but sometimes people demand such things which are beyond the system of a Sub-District Hospital and make hue and cry.

21. Some of the doctors were seen not with Apron and name plates and were in use of mobile phones during performing their duties with patients. This was brought to the notice of the BMO while discussing the observations made by visiting team.

Day 3 – Second Session

A thorough discussion on the observations made by the team during the field visit of SDH Magam was conducted with the resource persons at Regional Institute of Family Welfare at Dhobiwan

after lunch hour. In spite of high healthcare at SDH Magam for the patients by Doctors and other para-medical staff, all deficiencies which were raised by the patients and clarifications were sought from the BMO Magam and the resource persons.

Way Forward Future Plans

The resource persons of CommonHealth narrated that and maternal death review is a process of talking to people in community to learn why some women die while they are pregnant or during or soon after giving birth. CommonHealth has adopted a tool for this process which is regarding background of maternal death, her pregnancy history and her most recent events of pregnancy and even for her baby after delivery.

Some questions in the format may make the informer uncomfortable by talking about bad experiences. However, his/her participation will help to improve Maternal and newborn care for women and babies.

All information has to be kept confidential and the responses are assigned a code number and the name of respondent is not to be used in anyway. The participation of the respondent is strictly voluntary which will not affect whether they are or are not receiving subsequent service.

There was some discussion on this amongst participants. Based on feedback, it was decided that since most of the participants were engaging with maternal health for the first time, as a first step, it may be useful to start off with small studies documenting information of some of the areas that were identified as gaps in the previous two days' discussions.

Immediate steps required by the Participants/volunteers of NGOs for Survey

- In view of the fact "J&K Health Referral Transport service No.-102 " has been launched in J&K state, the participants of the various NGOs will start their survey on "Referrals and Transport services" in their respective areas of operation and see how far this effort of the J&K Health Deptt. is helpful for maternal health. This was supported by Dr. Afshana who is already in this very field.
- This has to be kept in mind that the main focus of referral transport service of J&K is to cater to the maternal and child health related emergencies, thereby augmenting institutional deliveries and reducing MMR and IMR. The existing fleet of approximately 800 basic life support ambulances is operating in J&K state under this scheme. In addition to this, 50 basic life support ambulances have been procured under NHRM and placed on national highway after every 30kms which are fitted with GPS devices.
- A format to be used for referral and ambulance services survey by the health workers of various NGOs is enclosed which will serve as first tool for the survey.

- In addition, it was decided that some data would be collected by participants in their own field areas on understanding h maternal health scenario in the communities and areas that they worked in. It was felt that some parts of the social autopsy tool could be adapted to collect information on the following:
    - Understanding the community's access to health care services – community level discussions would be held using the "issues at community level" section of the DWT tool.
    - Out of pocket expenditure for deliveries
    - Assessment of health facility – the relevant section of the DWT tool would be used to visit the health facilities in their area and understand what kind of services were available.

Day 3rd –Valedictory Function

In addition to the two resource persons namely Dr Subhashri and Dr Sunil Kaul from CommonHealth and the participants from the 10 districts of Kashmir valley, the presence of the following personalities in the valedictory function was of high illumination:

1. Dr Saleem-ur-Rahman , Director Health Services ,Kashmir
2. Dr Arshid Rafi , Principal RIHFW, Dhobiwan
3. Mr. G.N. Var, Chairman Private School Association Kashmir.
4. Dr. Tahir, Block Medical Officer Magam.
5. Representative of RCF Magam, a leading trading agency Magam.
6. Physician and Surgeon of SDH Magam.
7. Mr. Qadri, Chairman Development Council, Tangmarg

1. 

- **Dr. Saleem ur Rahman**, Director of health services Kashmir was formally welcomed by Shri A.K. Wani of JKVHA. He highlighted the activities being undertaken by JKVHA, WHIPRO and Ahsan foundation with special reference to mobilization of the community on following issues :
    - Tobbaco control
    - Tuberculosis control
    - Total Sanitation program
    - Maternal and neonatal health
    - BBBP
    - Drug addiction as It is hazardous and awareness for its control was essential

The patronage of DHSK in all such efforts has always been encouraging for us and helpful.

∞Mr. G.N. Var, Chairman Private Schools Association Kashmir appreciated the efforts being done by the NGOs in remote rural areas on various social issues and speeding the various health messages ensuring thereby health for all. He assured his possible help on behalf of private school association in mobilization of the community on various health issues.

∞ Mr. Var appreciated the work done by CommonHealth on maternal and neonatal health issues

∞ Dr. Subashri informed the Director Health Services Kashmir that CommonHealth is a 10 year old coalition working in the field of maternal-neonatal health and access to safe abortion services. It is a coalition of individuals and organizations. It is using all platforms to work proactively on these issues

∞ Dr. Subashri informed that CommonHealth has published a book named "Dead Women Talking" after documenting the maternal death reviews in 10 states of india.

She appreciated the support extended by voluntary organizations of Kashmir in making this Training Programme on Maternal Health and Death reviews a successful one and also thanked the DHSK for using the facilities available in RIHFW Dhobiwan for training programme.

She also handed over a copy of the Delhi statement of CH to the DHS to highlight the various demands of CH as related to maternal health.

∞ Mr. Rahi Riyaz Ahmad thanked all participants, resource persons of CommonHealth, Medical Staff of SDH Magam and RIHFW Dhobiwan for their active participation in the Training Programme. He offered special thanks to Dr. Saleem-Ur-Rehman DHSK for sparing his precious time inspite of all his pre-occupations and making this valedictory function illumine

Appreciation and comments of DR. Saleem-Ur-Rehman DHSK on the valedictory Function

After learning the efforts made by the organizations of the Training Programme on Maternal Health and Maternal death Review and the Resource persons of common health, DHSK expressed his views as under

∞ He honestly supports the efforts of the CommonHealth and local NGOs who have organized this training programme.

∞ He is always supportive to all those organizations who come forward for health awareness and its allied activists particularly when the focus is Mother and the child health.

∞If the representatives of various NGOs attending the Training Programme, identify schools for supply of multi vitamin tablets and de-worming tablets in consultation with medical professionals, his support is always with them.

∞As per SRS 2011, State's IMR was registered 41 as compared to national level of 44. Now the IMR of the state is showing a downward trend and is indicative of implementation of Child health related programmes and particularly the activities of NRHM since 2006. Now the IMR has fallen from 34 in 2014 to 26 in 2006. The TFR has also come down to 1.6 from 2.3

∞The institutional deliveries have remained 89.90% in 2015-16 as compared to 86.91% in 2012-13

∞The Department of Health has launched Skill Birth Attendant Programme.

∞The Health department is short of pediatricians.

The Govt. Hospitals do not go for unnecessary records. The referrals whenever done are audited.

∞The health department is providing free medicines to patients and diet to indoor patients.

∞The human blood is rare. The NGOs must register the donors and camps can be conducted at identified places as per need.

∞The NGOs can help in identifying drop outs who are in non-receipt of iron tablets.

By and large the DSHK is appreciative of all activities being done by CommonHealth in Maternal Health and Maternal Death reviews and assured his all help whenever approached.

The 3rd day of Training Programme ended with presentation of mementoes to DHSK and other dignitaries on the dais including to resource persons and presentation of certificates to participants of various NGOS including various journalists who covered the proceedings and published the same in local newspapers.


Three days training on mental health and maternal death review programme inaugurated at Dhobivan

Three days training on mental health and maternal death review programme inaugurated at Dhobivan kun

Rafeem ul Salam
Tangmarg: 30Nov
Today a three days training programme were inaugurated at Regional institute of Dhobivan kunzer,organized by common health (a national level organization in collaboration with Regional institute of health and family welfare dhobivan, Kashmir Humanity Foundation, JKVHA,WHIPRO,PSA,Kashmir,RCF magam, and ISHAN foundation jk,

Smt Dr Subhashri steering member of committee member common health accompanied with Rahi Reyaz AHSAN Foundation, Dr Hilal,Shree A k Wani,etc inaugurated the three days workshop,talking with media Dr Subhashri added that common health is a multi state coalition of organizations and individuals whose vision is to create "a society that ensures mental neonatal health care especially marginalized communities of India. It's mission is to raise visibility of unacceptably high morality and morbidity among mothers and newborn and lack access to safe abortion especially

among the disadvantage, she said that we have collectively to create a situation in which a healthy life for all is a reality and a situation which enables the flowers of people's talents and abilities to enrich each other and the people and guide the decisions that shapes lives.she further added that there is a need to create world-wide network of people organizations, NGO's,social activises health professionals academic and reachers to establish health and equitable development as top priority through primary health care and action on the social determinants of health and today's training programme conducted by common health organization in Kashmir is a step towards this goal she wishes success of the training programme in which gross root level health workers ,volunteers, ASHA'S and civil societies workers from various parts of Kashmir are participating.

Besides president ISHAN FOUNDATION Shree Rahi Reyaz added while introducing the programme that the resource persons and participants in this training programme he said that four to five representatives from each of ten Distt's.of Kashmir valley have been invited to this training programme who will spread the message given by common health resource in their representative districts.

A k Wani of JKVHA while welcoming the guests speaker's participants from all the Distt. Of Kashmir valley said that this training programme will mainly be on maternal and neonatal health he added that with the launch of JSY the number of institutional deliveries has increased significantly but there are still 20-25% pregnant women who still hesitate to access health facilities ASHA,s and angnanwdi workers are expecting to create enough awareness in this regard and ensure 100% institutional deliveries in all parts of j k and avail the benefits being provided under JSY and JSSK.

At last Dr Hilal thanked to all guests and workers.

Annexure

Questionnaire for referral and ambulance service to delivery cases availed by them, if any, during the process of delivery

1. Name of the woman who had a delivery during the last 2 months
2. Address _____

3. Age _____
4. No. of live children _____
5. Name of the first medical center where initial medical facility availed_____
6. Referral made by whom and reason there of _____
7. Name of the hospital where referred to for delivery
8. Whether ambulance service availed free of cost_____
9. Whether treatment at the place of delivery was satisfied _____
10. If not please mention the problem_____
11. Condition of the women after delivery _____
12. Health condition of the baby_____
13. Discharge from hospital after how many days _____
14. Whether any cash received as her provisions of JSY/JSSY or any other scheme_____
15. If yes _____ amount received _____
16. Any reason for non-receipt of amount_____
17. After delivery whether any transport service availed from the hospital_____
18. If not please give reason _____
19. After delivery and return to home please indicate the health condition of the woman and the baby_____

    Place _____

    Dated _____

Signature of the investigator / Health worker / ASHA

Name of NGO _____