

Has Janani Suraksha Yojana Stimulated Institutional Delivery?

A Study in Una District of Himachal Pradesh

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CHAPTER

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INTRODUCTION

Himachal Pradesh (HP) is one of the states in India with high economic growth with the second highest per capita income in spite of over 90 percent population living in rural areas. Adjoined by the states of Jammu and Kashmir and Punjab, Himachal enjoys good socio-economic indicators with a population 27 times less than the most populous state of Uttar Pradesh. It also has a good literacy rate which ranks it among the first five most literate states in the country. The overall literacy rate is 76 percent — 85 percent for males and 67 percent for females. The infrastructure available to the state is also at par with some of the most developed states in India and the state has many health facilities despite being located in a hilly region.

However, the economic and literacy indicators did not lead to better status of women, especially poor women in the state. The constraints and problems faced by women in Himachal are not very different from other parts of the country. The women not only face a high degree of domestic violence but also have limited access to health facilities which are otherwise available to their male counterparts.

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The access to health services is determined by many factors like the cultural belief system as well as the secondary position of women in society. The taboos and cultural practices also get strengthened by the fact that health services are not of good quality, especially for maternal care.

Maternal mortality and infant mortality are the touchstones for a public health delivery system. Among the various tools for achieving the goal of low maternal mortality and infant mortality, the most important one is ensuring an institutional delivery, i.e., a medically supervised environment at the time of childbirth. The government has made this a crucial part of its health delivery effort. Under the overall umbrella of the National Rural Health Mission (NRHM), the Reproductive and Child Health programme Phase II (RCH-II) was launched in the year 2005. RCH-II aims to improve access for rural people, especially from the underprivileged sections, to equitable, affordable, accountable and effective primary healthcare. The cornerstone of this ambitious programme has been the Janani Suraksha Yojana (JSY). JSY is a cash benefit scheme under the RCH-II to promote institutional deliveries with a special focus on women living below the poverty line and SC/ST pregnant women. Janani Suraksha Yojana is being implemented in all states and Union Territories.

The JSY is implemented in Himachal Pradesh where women are entitled for a cash incentive of Rs.700 if they go for institutional delivery and Rs.500 for women who belong to the Below the Poverty Line (BPL)/Scheduled Caste or Scheduled Tribe community even if they choose not to go for institutional delivery. This maternal benefit is given only if women register themselves with the ICDS¹ worker available in each village as ASHAs are not yet appointed in the state under JSY. Implementing JSY will be an additional responsibility on these ICDS workers, and there is still lot of confusion in the state as to how to go about it. These ICDS workers do not take full responsibility for providing health assistance to pregnant women as their core responsibility lies in another

About JSY

- JSY is a 100% centrally sponsored scheme. The scheme focuses on poor pregnant woman with special dispensation for states having low institutional delivery rates namely, the States of Uttar Pradesh, Uttrakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Orissa, Rajasthan and Jammu & Kashmir. Besides providing for maternal care, the scheme provides cash assistance to all eligible mothers for delivery care.
- The Yojana has identified the Accredited Social Health Activist (ASHA) as an effective link between the government and poor pregnant women in the ten low performing States. Her main role is to facilitate pregnant women to avail services of maternal care and to arrange referral transport.
- Janani Suraksha Yojana has built-in incentives for both ASHA and the mother. The mother's package in the target states is Rs.1,400 and ASHA gets Rs.600 for various services in promoting institutional delivery. The Yojana subsidized the cost of Caesarean Section or for the management of Obstetric complications, upto Rs.1,500 per delivery to the government institutions, where government specialists are not available.
- In Low Performing States (LPS) and High Performing States (HPS) all pregnant women falling in Below Poverty Line (BPL) category and aged 19 years and above, are entitled to a cash assistance of Rs.500 per delivery, up to two live births even if they prefer to deliver at home.
- The incentive that is offered is supposed to help women by providing assistance for nutritional food supplements as well as to take care of the transport charges if they go for institutional delivery.

programme. However, without even appointing ASHAs the state is expecting to increase the rate of institutional deliveries by way of providing cash incentives.

CONTEXT

With this background, a rapid assessment of the JSY implementation at Gagret Block of Una district was conducted

by ANKUR Welfare Association, an organization working in the area. It was felt that there was a need to know the experiences of women who had accessed the JSY incentive and to analyze those experiences in the light of the quality of maternal healthcare and services. To know the experiences of women is important not only from the perspective of whether they received the assistance on time or not but also from the perspective that this incentive is meant for the very poor and marginalized communities which generally have difficulty accessing government facilities and schemes. Additionally, keeping in view, women and their social status, it was also important to know how this benefit has been utilized (or not) by the women.

Una district consists of two sub-divisions (Una and Amb), three tehsils (Bangana, Amb and Una) and two sub-tehsils (Haroli and Bharwain) with five blocks (Una, Bangana, Gagret, Amb and Haroli).

Gagret block has total population of nearly 79,000 according to 2001 census.

TABLE 1. Profile of Una District

Geographical Area	1559 sq. kms.
Population	447,967
Male	224,299
Female	223,668
Sex Ratio	997/1000
Density of Population	291/per person/sq. km.
Literacy Rate — Male	88.49%
— Female	73.85%
B.P.L Families	15,429
Hospitals	2
First Referral Units	2
PHCs	19
Community Health Centres	5
Sub-Centres	131
Sanctioned Bed Strength	369

Source: Census 2001 and H.P. Health Deptt

THE OBJECTIVES

To know whether the introduction of the JSY programme has brought about a change in the health status of the women who have accessed and availed health facilities and incentives under the JSY scheme for the year 2008–09.

Specific Objectives

- To understand the factors that motivate women to move from home to institutional delivery and vice versa.
- To assess communities' confidence in government health facilities.
- To understand the dynamics of women's decision-making in choosing between the public and private health systems.
- To formulate suggestions for modifications and improvements relating to JSY policy implementation.

METHODOLOGY

Selection of the Study Area

The study area was selected on the basis of convenience as our organization has a presence in and familiarity with the area as well as the community. The organization conducting the study has a long history of working in the area and had access to women for data collection. In addition to this, Gagret block in Una district was chosen based on availability of human resources to carry out the study. From the block, two PHC areas, namely Gagret and Daulatpur, having a large proportion of Scheduled Caste and BPL families, were selected for the study since the scheme is supposed to benefit a particular class and section of a community. Then from each PHC area, 10 villages were selected on the basis of majority of the population belonging to the Scheduled

Caste and BPL categories. These 20 villages were spread over two sub-centres of Daulatpur PHC and three sub-centres of Gagret PHC.

The Sample

The sample consisted of all the 291 women from five SC communities who had delivered. From these 291 women, 69 women had availed JSY and of them only six were institutional deliveries.

Data Collection Methods

The study used both quantitative and qualitative methods for data collection. The method used in the study was to survey all women who had delivered in the last one year. Besides survey, five separate FGDs were conducted with women who had availed the JSY services to get additional information about various aspects of the JSY implementation. In addition, focus group discussions were held with health practitioners and service providers including doctors, ANMs, dais and RMPs.

To conduct FGDs, a FGD guideline was developed for each set of respondents. In addition to this, a checklist was also developed to help in the in-depth interviews. The FGDs were conducted in local languages and notes were taken. It was not feasible to record the interviews or FGDs as the respondents were sensitive to the use of electronic instruments and using recording devices would have been disruptive to the process.

Limitations of the Study

The results of the study may vary from location to location because the study was done with a particular caste and population in a specific area and hence the study cannot be generalized for the whole state.

FINDINGS

Findings of the Survey

Utilization of public health facilities: The fact that women fear of spending more money if they go for institutional delivery was also evident from the fact that out of 291 women, 77 percent belonging to labourer families opted for home delivery compared to 61 percent women whose husbands were in government jobs opting for institutional delivery.

Care provision at JSY: As regards after-delivery care, it was found that 80 percent women who delivered at the institution came back home the same day. Only 18 percent women stayed there for more than three days, which might be due to complications or caesarean cases. But this is also an indicator of the poor healthcare that is being offered at the public health facilities.

Private services have not been designated by the government: There is a provision under the JSY scheme of NRHM that if the public health facilities are not equipped with emergency obstetric care or do not have sufficient staff to take care of emergencies, they can take the services of private doctor/clinic/nursing homes. But to-date the government has not designated any private nursing home/doctors/clinic to provide such facilities to poor women. In the study area, there are two nursing homes that provide such facilities, but these institutions are not accredited for these facilities. Women informed that because these private facilities were not accredited, women were bound to go to public health facility which is very far from their houses. In some cases, women even delivered on the way while trying to reach a PHC for emergency care. In this scenario, it would have been very useful if some private doctors/clinics were also accredited so that women could reach out to them much easily and timely.

Findings from FGD

Women who Delivered at Home

Feeling of safety at home: We found that women who delivered at home expressed that they felt safe and secure at home for delivery. This is evident from the fact that only six women availed the JSY benefits for institutional delivery. Most of the women were of the view that unless there is nobody at home to look after or there is some complication it is not advisable to go to hospital for delivery. One woman shared her experience of one of her earlier pregnancies for which she went to the PHC, where she was put in a store room as suddenly an accident case arrived and all doctors rushed to attend that case and she was left all alone in a filthy store room. She said that “such things don’t happen at home; there are always elder women and relatives to take care of them.”

Lack of confidence in health institutions: Another important attitude that women shared in the FGD was the lack of confidence in the public health system. Women who delivered at home were of the strong opinion that unless you have a friend or acquaintance in the hospital, the treatment by the staff is very poor. To get proper attention and treatment, it is important to know some staff personally who can help in getting respectable treatment at the PHC or any other public health facility. They also felt that the staff at the institution lacked sensitivity towards their pain and need. They expressed that the only reason they would go for institutional delivery is if there is a complication, which the dai (Traditional Birth Attendant) is unable to handle.

Antipathy of the system: The cash benefits provided under JSY are also eluding women and during the FGD women expressed their deep anger towards the hostility of the system. One of the women said that, “We (poor women) are treated like beggars at these PHCs” when they approach PHC for JSY money.

Women narrated how they were kept waiting for hours, as the person concerned was busy in some other work.

Actual cost is more: Women expressed that Rs.500 or 200 that they might get as JSY cash incentive if they go for institutional delivery is inadequate and actual cost is far more than the reimbursement that they would eventually get. Women also opined that though under the JSY scheme there is a provision for free medicine to the BPL families, at the time of emergency, the doctors prescribe costly medicine and there is no provision for the reimbursement of this amount.

Unable to use JSY incentives: Women also reported that they have heard of JSY beneficiaries having difficulty in obtaining the cash incentive. They cited that in the absence of any bank account and required documents, women are forced to open a joint account with other family members, and therefore lose control over the spending of the monetary incentive for their own nutrition or treatment. They said that there are so many cases where the amount is being utilized for other purposes, mainly by the men folk of their families without the consent of the women. "Money is used to get household items. There were also some cases where the husbands used the JSY money to buy liquor."

Referral without support: In case of emergencies, women told that they were referred to the higher institutions without any support of ambulance or other transport facility. They said that poor women generally are not prepared for this emergency and thus often opt to go back to their homes.

Women who Delivered at Institutions

Most of the women expressed that they had negative experiences with the public health system and strongly felt that

they liked to have home delivery instead of institutional delivery. When they were asked about their experience of delivering at the health facility, four out of six said “ok,” which actually meant not really good as was evident from their tone and body language, and two categorically said that they were treated badly and sometimes health staff used abusive language.

The women in the FGDs were asked the reason of choosing institutional delivery over home delivery inspite of negative experience and the responses received were mostly generic in nature. They are summarized below:

- Nuclear and migrant families are more inclined to use hospital facilities because they are alone and have no one to support at home.
- If the delivery is “precious,” that is, when a woman is expecting a boy after a girl/many girls — this is done by testing at the early stages of pregnancy or if it is a selected one (if woman is not able to bear children or had episodes of miscarriages etc.). In these cases, the family prefers to have a delivery in the institution they are in consultation with since conception.
- Women who had bad experience with the TBA or ANM, or experienced complications at home in their past pregnancies also go for a health facility delivery. For instance, in one case, where the ANM failed to remove the placenta and the woman had to be rushed to the health facility with bleeding, was found advising other women participating in the discussion for institutional delivery and narrated her story how she was able to save her life during that tense situation.

Women also said that when, after all the constraints, they decide to go for institutional delivery, many choose private facilities over public healthcare institutions. They shared that not only their negative experiences of using

public health services encouraged them to choose private clinics over public health facility but ANMs also motivate women to go for private institutions. Women said that ANMs, for reasons unknown to them, discourage women from opting public health system. Women having faith in their regular ANM, then choose the facility as per her recommendations.

Perceptions of the Government Health Functionaries

Perceptions of about the systems: Health practitioners expressed that the JSY failed to deliver as the administration could not decide between ASHA and AWW as to who would be the accredited activist under this scheme. The main purpose of appointment of the ASHA was to develop a vital link between the health facilities and the beneficiaries. The ANM posted at the sub-centre level covers a population of more than 4,000. However, this functionary is also not available during the odd hours as she is not locally posted. Appointment of ASHA or AWW would have solved the problem.

Limited knowledge of doctors about JSY: Most of the doctors at the public health facilities admitted that their knowledge about the JSY is limited to its monetary benefits. They also mentioned that there was no special staff to maintain cash flow of JSY money and it is an extra burden on them.

Perceptions about the cause behind home deliveries: Doctors at the PHCs reported that the major factor affecting women's decision for not coming for institutional delivery is that the health facilities are not equipped with the emergency obstetric care. If the institutions are equipped for emergency care, trust will be developed among the villagers towards the institution. They said that facilities need to be equipped with all medicines, blood bank and trained staff.

Communication gap between beneficiaries and the service providers: In absence of ASHA, there is no one at the field level to ensure timely delivery of health services specific to maternal health needs as specified in the JSY. This becomes more important in the context of emergency cases as there is no support system available at the village level to deal with such cases.

Cumbersome process for getting incentives: The flow of cash from the Block Medical Officer (BMO) to the beneficiaries is also very time-consuming and cumbersome. Doctors informed that the beneficiary had to fill in a form at the sub-centre level and the payment was made at the Block level. The amount spent on travelling to get the reimbursement often exceeds the amount they receive under the JSY. The mechanism specified in the JSY guidelines that the amount shall be paid through ANM in cash before the last days of delivery is not practiced.

Perceptions of the Private Practitioners

The study found that none of the eight private health practitioners knew anything about the JSY scheme. According to them, the scheme has neither affected their practices nor have they been benefited. When they were told about the accreditation of private practitioners/nursing homes under this programme, they were of the opinion that if this happens, they would certainly get benefited and the confidence in them among the local people will increase. The institutional delivery will also increase, as local poor people will get quality health facilities at their doorstep.

CONCLUSION

This study again brought forth the issue of good policy and a bad implementation. The findings reveal that none of the

291 women who delivered cited that the JSY provisions motivated or even contributed to their choice of home delivery. Leaving aside the fact the cash incentive given under JSY is much lower than what woman spent when they go for institutional delivery and that the reimbursement process is very cumbersome, the bad quality of care received by people at public health institutions is the major hindrance that the government needs to address if it wants to make delivery safe through institutional care and achieve the goals set by the government in the MDGs or in various other health policy documents.

Providing monetary incentives only at the point of birth does little to address the health needs of mothers. When money is scarce, women are less likely to take care of their health and health needs take a low priority in terms of household expenditure. Instead of stop-gap arrangements like monetary incentive after institutional delivery as provisioned under the JSY, what is needed is a long-term commitment to quality public healthcare and nutritional services.

Another issue is gender discrimination in terms of delivery care received by women in the area that needs to be addressed. Women informed that generally they go for institutional delivery if they are expecting a male child and do not want to take risk of any kind. This means sex-selection, and prenatal diagnostic test for knowing the sex of the child, is taking place in the area. Since the issues are getting reported around these situations, there is urgent need to institute an enquiry and probe this issue at the district level to control those who do the sex selection.

Recommendations

Based on the study findings, the following recommendations are made:

- Quickly appoint ASHA to ensure timely delivery of health services.

- Develop training programmes to ensure sensitive, well-trained and adequate staff at government health centres.
- Provide adequate equipment at the government health centres for emergency obstetric care.
- Better implementation of the ICDS for better food and nutrient intake for women during pregnancy and lactation.
- Provision for the regular and good quality capacity-building programmes for AWWs and ANMs to make them skilled enough to address women's maternal needs.
- Appoint more women doctors, particularly gynaecologists, in the public health system which might motivate women for institutional delivery.
- Enhance facilities for safe abortions in government hospitals as unsafe abortions are an important cause for maternal mortality.
- Develop better mechanism to ensure that the monetary incentive of the JSY is used for timely maternal care.

NOTES

1. Integrated Child Development Scheme (ICDS) is another centrally sponsored scheme that is being run to help poor families provide additional nutrition to the children below 6 years of age.