How does NRHM help Tribal Women?

A Study of Financial Incentives for Maternal Health Services in Heggadadevanakote Taluk, Mysore District, Karnataka

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BACKGROUND

The National Rural Health Mission (NRHM) was introduced in April 2005 with the goal to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children. In order to promote institutional deliveries and reduce maternal and infant mortality, the Government of India introduced Janani Suraksha Yojana (JSY) as a 100% centrally sponsored Conditional Cash Transfer (CCT) scheme to promote institutional delivery among women living below the poverty line (BPL). The target group for JSY in Karnataka (a non-high focus state) is all poor women above the age of 19 years and up to two live births. Women are entitled to a cash incentive of Rs.700/- for delivery in institutions and Rs 500/- for home delivery. Under the JSY, women are also entitled to a support of Rs.1500/- for caesarean section.

The Karnataka Government also introduced a special programme called Prasuti Aarike (PA) for pregnant women belonging to BPL, schedule caste (SC) and schedule tribe (ST) families. Under this scheme, pregnant women are to receive a financial incentive of Rs.1000/- during the second and third trimesters in order to encourage rest, nutrition and medical care during the antenatal period. Subsequently, PA was altered to give beneficiaries Rs.1000/- in the third trimester and Rs.1000/- after delivering in a government hospital. This benefit is also limited to the first two live births.

Earlier studies like National Family Health Survey have indicated a comparatively poorer health status among STs. There is also a relative paucity of data about health status of the tribal populations across India. This makes planning for these marginalized people more difficult. NRHM identifies women belonging to STs as one of the most vulnerable sections of society. The present study has been undertaken to understand the availability and access to cash incentive programmes that have been introduced under NRHM and the Government of Karnataka to improve the health of women of Jenu Kuruba (JK), Kadu Kuruba (KK), Soliga and Yerava communities who in this study are also identified as Forest Based Tribes (FBT).

STUDY OBJECTIVES

1. To understand the levels of awareness of FBT women about the JSY and PA financial incentive schemes introduced as part of NRHM or by the State Government.
2. To identify the gaps, if any, in availability and accessibility of these financial incentives for the FBT women and the reasons for these gaps.
3. To document the purposes for which these monies were utilized by the tribal women.

STUDY SETTING

The study was conducted in H. D. Kote Taluk of Mysore district in the state of Karnataka. Mysore district has a population of 2,994,744 according to Census 2011. The district stands as 7th out of the 29 districts in the state in terms of income, but is 14th in the Human Development Index (HDI) as per district HDI of Karnataka (2009). The total population of FBT communities is 14,530 (6.17% of population of the taluka). Some of the health indicators of Mysore district as indicated in the Karnataka NRHM Programme Implementation Plan (2009- 10) are as follows: institutional delivery rate of 93%, IMR of 18 and MMR of 213 per 100,000 live births, 85% of women registered in their first trimester of pregnancy and 92% had at least 3 antenatal care visits during their last pregnancy (the figures for rural and urban areas being 82% and 93% respectively). Data specific to the tribal population was not provided in this document.

METHODOLOGY

Sample: The study is descriptive in nature, employing a mix of both qualitative and quantitative methods. Information was collected from FBT women as well as the providers who are responsible for providing them maternal health services. FBT communities live in small colonies called *Haadis* (tribal hamlets), separate from the non tribal villages. There are 109 *Haadis* in the Taluka and of these 30 *Haadis* were selected by cluster sampling method using probability proportional to size (PPS) technique of sampling.

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Data collection: A household survey was conducted in these 30 *Haadis* and 98 FBT women were identified who had delivered between 1st October 2009 to 30th September 2010. All these women were entitled for JSY and PA schemes. However, during the interview only 61 women from 20 *Haadis* could be interviewed because the others had migrated. The second category of informants included Medical Officers (MOs), ANMs and ASHAs. 7 MOs, 8 ANMs and 11 ASHAs working in the *Haadis* and the sub-centres and PHCs servicing these *Haadis* were interviewed.

The study design was reviewed by the Institutional Ethics Committee of School of Public Health at SRM University and all interviews were conducted after obtaining informed consent. Interview schedules (IS) for different categories of respondents were prepared, translated, piloted and revised before they were used. The interviews of the FBT women, ANMs, ASHAs were conducted by a trained field researcher. The MOs were interviewed by the principal investigators. The quantitative data was analysed using SPSS and the qualitative data was analysed manually.

FINDINGS

Profile

A majority (42/61) of the women were from the Jenu Kuruba tribe. Their age varied from 18 to 28 years with a mean age of 22 years. The mean age at marriage was 17.5 years, but 36 (60%) women had been married before the age of 18 years and 21 (36%) before the age of 16 years. 16 (26%) women were illiterate and 18 attended school till class 8 or more. A majority of women worked as daily wage farm labourers. Almost 70% (42) of the women belonged to families earning less than Rs.1,500/- per month and the average reported annual income of the families was less than Rs.17,000/-. Around 40% (25) of the families did not possess a ration card.

An accessibility score was developed to assess the accessibility of the *Haadis* taking into consideration factors like proximity to or lying within forest areas, availability of transportation, type of road and so on. According to this scoring system, only 44% (21) of the women were residing in *Haadis* which were easy to access and the rest were from difficult to access *Haadis*.

Service delivery to *haadis*:

- 3 out of 8 tribal sub-centers in the Taluka had vacancies compared to 19 out of 24 of non tribal sub-centers
- 17 out of 61 women lived in *Haadis* without an ANM, 15 were from difficult to reach *Haadis*
- 29 out of 61 women lived in *Haadis* without ASHA, 27 of these were from difficult to reach *Haadis*
- 15 women lived in *Haadis* without either ASHA or ANM, all were from difficult to reach *Haadis*.

Awareness

Awareness among the FBT women about Incentives: Around 46% (28) of the study respondents had heard about these programmes with 43% (26) able to name JSY, and 10% (6) able to name PA. Only 38% (23) of the women knew how much money they were entitled to. A majority (31) of the women living in difficult to access *Haadis*, without a fulltime ANM, had not heard about these schemes. The major sources of information about financial incentive schemes were the ANMs, while some mentioned ASHAs, NGOs and family members as their sources of information.

Awareness among the health functionaries and ASHAs about FI: Though most (5 out of 7) of the MOs said that the tribal status of these women was itself an eligibility criterion for financial incentives, ANMs and ASHAs were not similarly informed. Only one of the ASHAs mentioned this as a criterion. Fifty percent of the ANMs interviewed indicated that the woman needed to have an institutional delivery to be eligible for any incentive. There was confusion among ANMs and ASHAs about documentary evidences required and eligibility criteria for receiving CIs.

Table 1
Status of ANC registration and place of delivery by place of residence (All numbers refer to nummber of women)

Details of ANC and institutional delivery	Women from difficult to access *Haadis* (n=40)				Women from easy to access *Haadis* (n=21)				Total (n=61)
	Total	Village had...			Total	Village had...			
		ANM + ASHA (n=13)	ANM or ASHA (n=12)	Neither ANM/ASHA (n=15)		ANM+ ASHA (n=17)	ANM or ASHA (n=4)	Neither ASHA/ANM (n=0)	
1st trimester	20 (50%)	8	7	5	14 (67%)	12	2	-	34 (56%)
2nd trimester	16	5	2	9	6	4	2	-	22 (%)
3rd trimester	2	0	1	1	0	-	-	-	2
3< visits	28	11	7	10	17	15	2	NA	45
No ANC	2	0	2	0	1	1	-	-	3
Institutional deliveries	22	11	7	4	14	10	4	NA	36

Utilization of maternal health services

ANC registration: Almost all women (58 out of 61) were registered for ANC, irrespective of the remoteness of their *Haadi*. Table 1 provides details regarding ANC and place of delivery. Around 34 (56%) women were registered in their first trimester and overall 74% of women were registered. The commonest reason for not registering was *"ANM not regular"*. Other reasons included, *"not aware should register with ANM"* and *"ANM did not give card for one visit"*. Thus, accessibility of the *Haadi* and availability of ANMs were factors influencing early ANC registration.

Table 1 also indicates that for women living where there is either an ASHA or an ANM, the chances of ANC are higher.

Institutional deliveries: Around 59% of the women delivered in an institution and 41% delivered at home. Even among women living in remote *Haadis*, 89% who had early ANC registration and 3 or more visits delivered in an institution. Thus, encouraging early and regular ANCs would go a long way in ensuring institutional deliveries. In difficult to access *Haadis*, where both ASHA and ANM were absent, institutional delivery was 26%, when one of them was present it was 58% and when both were present it was 84%. Thus, presence of ASHA/ANM in these *Haadis* increased the rate of institutional deliveries.

Access to Financial Incentives (FI)

Financial incentives: All women who registered with the ANM are considered registered under JSY. They are expected to give documentary proof of eligibility for cash incentives. A total of 39 women applied for FIs by giving documentary evidence. Among those who had given documentary evidence and delivered in an institution, nearly a third (12) did not receive their money (Table 2). Only 6 women received either full or partial (Rs.1000/-) money under the state government scheme of PA.

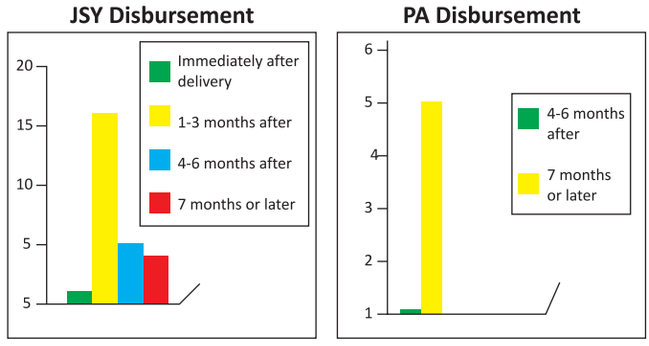
Table 2
Number of FBTW who received cash incentives by place of residence, Heggadadevanakote, 2011

Details	Difficult access *Haadis*			Easy access *Haadis*			Total
	Institution	Home	Total	Institution	Home	Total	
Provided documentary evidence required	20	4	24	12	3	15	39
Received JSY	16	2	18	8	1	9	27
Received full amount Under PA	4	0	4	0	0	0	4
Received partial amount under PA	2	0	2	0	0	0	2

Out of the 39 who had applied, 16 (43%) said they received help for applying from ANM or ASHA and another 5 (12%) said they received help from a local NGO. Receiving help from ANM or NGO helped women in actually receiving the amount (19 out of 21). All the women who received cash received the full entitlement of Rs.700 under the JSY. One woman who had undergone caesarean section also received Rs.700/-.

Difficulties faced in availing FIs: The application for the incentives were made from 3 months before to 4 months after delivery, majority being after delivery. According to NRHM, the women are deemed to have registered for JSY the moment ANM identifies and registers them. In the sample, 45 women had registered with ANM but it took the women many days and multiple visits to the SC/PHC to get their documents accepted. Thirty one (51%) women had difficulties in applying. Fifty percent of these women said *'ANM not available'* and *'procuring documentary evidences'* as difficulties. The ANMs and ASHAs are expected to help them procure documentary evidences if the women are not in a position to do so. In a community as socially and economically marginalized as the forest based tribes, with their low levels of awareness on most issues, this support was expected to be higher. In practice, the burden of establishing proof rests on the women, especially in absence of ASHA/ANM.

Fig. 1 : **Graph showing the Timeliness of Disbursement of JSY and PA to the FBTW**



The mean time after delivery for receipt for money was 3.8 months for JSY and 9.8 months for PA.

The graph (Fig. 1) shows that there is huge delay in getting the money, negating the very purpose of supporting better care during pregnancy and delivery. Reduction in time gap in applying and receiving funds would be very important in realizing the vision of NRHM.

Reasons for not getting FIs under JSY: Around 34 women did not get any cash incentives under JSY. Twenty two of these women had delivered at home and 12 in an institution. A majority of the women who did not receive it said so either due to lack of funds or because they delivered at home. Other reasons mentioned were lack of documents or because they delivered in a hospital outside the state. Since H.D. Kote is a border Taluk, people living near the border, find it much easier to go to Kerala, the neighboring state. Eleven who delivered at home did not have any ration card.

The ASHAs, ANMs and MOs said delay in fund release, lack of funds (for PA), lack of awareness among FBT women and difficulty in procuring necessary documents were the major barriers for these women not getting the promised incentives. However, most of the medical officers agreed that they could certify the tribal status if the women lacked the necessary documents. The JSY and PA funds related data collected from PHCs indicated a mismatch in time when funds were required and funds received. For PA, there was a large gap between the time and amount of funds required and received.

Utilization of financial incentives

Most of the MOs said that the money was not being spent by the FBT women for the purpose it was meant. ANMs said that delays in fund disbursement meant the money was being used for other purposes. All the ASHAs and ANMs also felt that the entire money or at least a part of it was being used by the husbands. On enquiring from women, it was learnt that nearly half of the women (16) said they spent major part of fund on buying household rations. Three women said they used it to travel to the hospital to treat the sick baby or to buy nutrition supplements. The rest of the women who got the money late said they spent the money to buy jewels or household utensils. Only one woman said her husband took away the money.

CONCLUSION AND RECOMMENDATIONS

The study reveals that awareness about financial entitlements under NRHM is low among FBT women. This is more so among women who live in remote *Haadis* and who are less educated. There is lack of clarity among ASHAs and ANMs about the eligibility criteria for such incentives under NRHM. This makes access to financial incentives very difficult for the tribal women. Due to delay in getting the money the purpose is lost as most of the women from this very poor group utilized the financial incentives for food and necessary health care of their children. This has tremendous policy implications as providing adequate and timely funds are crucial for the success of the programme.

Based on the findings, the following recommendations are made:

1. All tribal women must be included under financial incentive schemes. Having age or parity related criteria for JSY benefits leads to the disqualification of a significant number of women from accessing regular maternal health services. These criteria also add a layer of complication related to the documentation necessary to prove eligibility.
2. Funds for financial incentives should be released in advance to the PHCs; there should be a mechanism to monitor the disbursement of the FIs including the timeliness. Innovative methods like cash disbursement by NGOs should be explored.
3. Filling of vacancies of ANM in remote areas needs to be given priority. ANMs in remote areas may be covered under soft loan schemes to help procure vehicle for easy mobility.
4. There should be a separate "Tribal ASHA scheme" with higher incentive money for ASHAs. This would encourage tribal women in remote areas to work as ASHAs and provide women with the necessary health care support for improved maternal health care including institutional deliveries.

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About the Organization: Swami Vivekananda Youth Movement (SVYM), Mysore, Kartanakata is a development organization, engaged in building a new civil society in India through its grassroots to policy-level action in Health, Education and Community Development sectors since 1984.

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