Role of National Rural Health Mission in Promoting Institutional Delivery Services in Rural Uttar Pradesh, India: An Assessment of 'Janani Suraksha Yojana'

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INTRODUCTION

An important neglected problem in the h**e**alth care delivery systems of most developing societies is maternal mortality (Hartfield 1989; Rosenfield, 1989; WHO 1999, 2010; UNFPA, 2010). The clustering of maternal deaths during delivery makes the care during this period the most important (Filippi et al., 2006). Campbell and Graham (2006) provide evidence to show that the best intrapartum care strategy is likely to be one in which women routinely choose to deliver in a health institution. 'The Millennium Development Goal for maternal health (MDG-5) - to reduce maternal mortality by two-thirds by 2015 - will best be achieved by adopting a core strategy of health centre-based intrapartum care' (Costello et al., 2006, p.26). This statement echoes the recommendations of the WHO (2005), and indicates wisdom in safer motherhood policy. International commitment for increasing the institutional births is also India's concern and is reflected in some of the initiatives taken by the Indian government for safe motherhood. According to RGI (2006), to achieve the target set by the MDG of reducing the maternal mortality, rapid expansion of institutional deliveries with skilled attendance would be needed. Further the report highlights that states having higher percentage of institutional deliveries have lower maternal mortality. Realizing the importance of institutional deliveries GOI has launched Janani Suraksha Yojana (JSY) on 12th April, 2005 under the overall umbrella of NRHM for bringing down the high maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women.

JSY seeks to promote institutional delivery by providing a cash incentive to mothers who deliver their babies in a health facility. There is also a provision for cost reimbursement for transport and incentives to Accredited Social Health Activists (ASHA) for encouraging mothers to opt for institutional delivery services. The scheme is fully sponsored by the Central Government and is implemented in all states and Union Territories (UTs). There is provision for roping in the private sector by giving accreditation to willing private hospitals/nursing homes for providing delivery services. The scheme focuses on the poor pregnant woman with special dispensation for states having low institutional delivery rates namely the states of Uttar Pradesh, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa, and Jammu and Kashmir. While these states have been named as Low Performing States (LPS), the remaining states have been named as High performing States (HPS).

As rural Uttar Pradesh is the study area, we have specifically discussed the scenario of JSY in the state since the inception of the scheme. Initially when the scheme was started on 31st August, 2005, it was directed that the benefits will be given to pregnant women belonging to BPL households, fulfilling the eligibility criteria of the age of 19 years or above, up to two live births and in case of third live birth if the mother, on her own accord chooses to undergo

sterilization in the health facility where she has delivered, immediately after the delivery. On 11th October, 2006, Uttar Pradesh government removed all the above mentioned eligibility criteria. At present the benefit is given to all the pregnant women. Further on 24th November, 2006 the government has increased the cash assistance given to beneficiary from Rs. 700 to Rs. 1400 in rural areas and from Rs. 600 to Rs. 1000 in urban area. In addition a cash reward is given to ASHA. In rural areas per beneficiary ASHA is given Rs. 600 (Rs. 250 for arranging transport, Rs. 150 for cost incurred on fooding etc. during her stay in the health facility with the beneficiary woman and Rs. 200 as reward) and in urban places Rs. 200 for encouraging women and bringing them to health facility for delivery.

The success of the scheme can be assessed by the increase in institutional deliveries. In our study area (rural Lucknow) as per the two rounds of District level household survey (DLHS) conducted in 2002-2004 and 2007-08 the level of institutional deliveries were 14.1 percent and 33.2 percent, respectively which increased to 65.0 percent in 2010. The level of institutional deliveries in the rural areas as observed in two rounds of DLHS was quite low compared with the estimates provided by the present study. The pace of increase in the proportion of institutional deliveries is higher during the period when JSY has been implemented. This clearly brings out the effect of the JSY in promoting institutional deliveries.

OBJECTIVES

The objectives of the study is to presents an assessment of JSY in terms of awareness of the scheme, increase in institutional deliveries, JSY beneficiaries by background characteristics, place of delivery (public/private health facility), distance and use of transport facility by beneficiaries, payment of cash incentives and quality of care. This paper also intends to investigate the shortcoming of the JSY scheme.

STUDY AREA

Worldwide India accounts for the highest number of maternal deaths (WHO, 2010) with the highest number of deaths occurring in the state of Uttar Pradesh (RGI, 2009). Uttar Pradesh is the most populous state in India with a population of over 199.5 million people as of 1 March 2011 (Census of India, 2011). Fertility and mortality are higher in Uttar Pradesh as compared to many other states. Fertility in Uttar Pradesh is second highest among all the states. The infant and under-five mortality rate in Uttar Pradesh is the highest of any state in the country. Fertility and mortality in rural areas of Uttar Pradesh is much higher than in urban areas of the state (IIPS and Macro International, 2007).

Relative to other states maternal health in Uttar Pradesh, however, is characterized by both low uptakes of antenatal and delivery services. In Uttar Pradesh two-thirds received

antenatal care (IIPS and Macro International, 2007). Four out of every five births in Uttar Pradesh take place at home (IIPS and Macro International, 2007).

The Janani Suraksha Yojana focuses on the states having low institutional delivery rates and these states have been named as Low Performing States (LPS). Uttar Pradesh is one of the LPS. Because of the above mentioned reasons Uttar Pradesh has been selected as the study area.

DATA SOURCE & METHODOLODY

This study is based on primary data analysis. Primary data has been collected from the study of randomly selected 600 currently married women (15-49) who have given their last birth during 2007-2009. The sampling area chosen for the study is the Lucknow district of Uttar Pradesh. Lucknow district is situated in the center of the state and is also the state capital. Therefore, Lucknow district may give us the true characteristics of Uttar Pradesh. In order to cover the diversity of contexts in terms of access to services and infrastructure least and most developed block of Lucknow district were selected on the basis of the value of composite index of development. Chinhat is the most developed and Mal is the most backward block of Lucknow district. Mal is around 55 kilometers (in the north) and Chinhat is approximately 15 kilometers (in the east) away from the Lucknow city. Respondents were identified from the villages of least and most developed block. Villages in each of the blocks were selected on the basis of their distance from the Primary Health Center. 87 villages under the jurisdiction of three PHCs in least developed block and 34 villages served by two PHCs in most developed block were divided into three categories on the basis of their distance from the PHCs. These three categories were: less than 5 kms, 5-10 kms and more than 10 kms. Sample villages for the present study were identified from these three categories.

RESULTS

The findings of the study show that 96.0 percent of the women are aware about JSY. They reported having obtained this knowledge mainly from the ASHAs (77.8 percent) and from their friends and relatives (9.2 percent). The awareness levels among the mothers about the various components of JSY and objective of the scheme are high. More than half of the women who had institutional deliveries, have availed the benefits of JSY. Majority of the JSY deliveries were conducted in the government hospitals, followed by Community Health Centers (CHC) and Primary Health Centers (PHC). One in every ten beneficiary of JSY delivers her child in an accredited private health institution.

Present study has investigated the background differentials among JSY beneficiaries. Slight differentials among women having different demographic characteristics have been noticed. As far as socio-economic characteristics are concerned a lower proportion of Non-Hindus and OBC women have taken the benefits of scheme. As expected, a higher percentage of

illiterates, women belonging to low standard of living and those who have no exposure to mass-media are beneficiary than their counterparts. Health status and health-seeking behavior also influences the utilization of the benefits of JSY. There are marked differentials in taking the advantage of JSY based on development of the block and distance from the place of delivery.

The findings of this study inform us about the distance of the health institution from the beneficiaries' place of residence and mode of transport used by them to travel to facility. One-fourth (29.6 percent) of the mothers are living within a radius of 5 kms or less from the institution. For about one-third of the mothers, the distance of the institution in which they have delivered range from 5 to 10 km, one-quarter travelled more than 10 kms and 8.9 percent travelled more than 20 kms. Bullock-cart, rickshaw, bus etc. and four-wheel drive are most commonly used by the respondents. In majority of the cases, the mode of transport is a hired one and average cost of hiring the vehicle is Rs. 177.6. A majority of the mothers (85.7 per cent) reported that the transport cost was not reimbursed to them.

Analysis shows that half of the respondents within 15 minutes of their arrival to the health facility were attended by the health personal. A delay of 1 hour or more was reported by 17.8 per cent of mothers. A majority of the deliveries were conducted by doctors (77.8 percent) followed by nurses (21.2 percent). The C-section and episiotomy rates are 5.9 percent and 4.9 percent, respectively. One-fifth of the women (21.2 percent) reported that they were immediately attended to after the delivery of their child. One-third (33.5 percent) were attended within an hour of the birth. Post-natal check-up in a majority of the deliveries were conducted by doctors (68.5 percent). Slightly less than one-third of the women (32.5 percent) stayed for 2 days, one-quarter (25.1 percent) stayed only for a day or less in the institution after the delivery. An overwhelming proportion of the mothers rated toilet facility is reasonable (70.9 percent) and 10.3 percent rated this facility as poor.

Among the mothers who are eligible for receiving the incentives, 85.7 percent received the money. One-third of the women received the money at the time of discharge from the institution. Majority of the mothers were paid money within a week or before 4 weeks after the delivery (53.1 percent). However, one-tenth of the women received the money after 4 weeks of the delivery of their child. Three-quarter (78.3 percent) of the beneficiaries who delivered in an institution received full payment of cash incentive. Regarding experiences in receiving the incentive is concerned, 14.9 percent of the women had made several contacts to obtain the money. Majority of the women (90.6 percent) received the cash incentive from the institution in which they had delivered and rest from other sources such as ASHA, ANM etc.

CONCLUSION AND POLICY IMPLICATIONS

An important programmatic factor that is, JSY has promoted the utilization of institutional delivery services among rural women. Institutional deliveries increased from 14.1 percent (2002-2004) to 33.2 percent (2007-2008) to 65.0 percent (2010). This improvement in the utilization of

institutional delivery services is a major step in reducing high maternal mortality rates. In spite of the fact that all the women delivering in a health institution are technically eligible for availing the benefits of JSY, half of the rural women who have delivered in health facility were given JSY incentives. Therefore, measures should be taken to ensure that each and every rural woman who delivers in a health facility should be provided the benefit of JSY.

A majority of the JSY deliveries were conducted in the government hospitals, followed by CHCs and PHCs. During FGD and in-depth interviews, women and village level health workers revealed that health centers especially PHCs are under-equipped and lack life-saving medicines and staff. Thus, women surpass CHC/PHC and visit hospitals. Therefore, government should guarantee the availability of life saving equipments and drugs required for effective delivery in health centers. Ensuring obstetric services in CHC/PHC will help pregnant women not to travel to far away located hospitals for delivery. Further availability of obstetric services in CHC/PHC can facilitate safe normal vaginal delivery and effective management of emergency cases before referring them to hospitals. This will also reduce the burden of institutional delivery case in government hospitals, which has tremendously increased after the launch of JSY. Results show that even after the accreditation of private hospitals under this scheme merely one-tenth of the women have given birth to their child in an accredited private health institution. Thus, efforts should be made to increase the level of awareness among poor rural women about the inclusion of this clause in JSY and ASHA workers should facilitate the utilization of this provision.

A higher percentage of illiterates, women belonging to low standard of living and those who have no exposure to mass-media are beneficiaries of JSY. But at the same time a matter of concern is that a higher proportion of women who suffer delivery complications do not avail the benefits. Thus, ASHA and other health workers should inform, motivate, encourage and facilitate utilization of benefits of JSY among this high risk group of women. There are also marked differentials in having the incentives of JSY based on development of the block and distance from the place of delivery: a lower proportion of women belonging to least developed block and residing away from health institutions are JSY beneficiary than their counterparts. Under JSY transport cost is reimbursed and one ASHA assist pregnant women to travel to health institutions. Therefore, ASHA should provide special attention to women belonging to least developed block and those residing far away from health facility in reaching health institutions.

Among the mothers who are eligible for receiving the cash incentives, a high percentage has not been provided the JSY money. However, among those who have received cash incentive, one-tenth mentioned that the money was provided after four weeks of the delivery of their child, one-fifth received less than the full payment of cash benefit. As far as their experiences in receiving this incentive are concerned, a large number of women reported facing problems and making several contacts to obtain the money. A majority of the women received the cash incentive from the institution in which they had delivered and rest from other sources such as ASHA and ANM. During FGDs women mentioned about the few instances in which ASHA and health personal demanded bribe from the JSY beneficiaries. Therefore, government should

ensure the timely and definite payment of JSY cash reward and strictly check the corrupt practices of demanding bribery from the beneficiaries. Practice of bribery at all levels in health facilities should be stopped through effective supervision and punitive measures against those involved. Grievance cells should also be set up to look into the complaints related to non-payment of beneficiaries.

JSY is not about promoting institutional deliveries alone. Program objectives for reduction of maternal mortality and morbidity will be achieved when women coming to facilities receive quality delivery and post partum care services. In the absence of corresponding inputs for human resources, additional labour rooms and post-natal beds, drugs and other supplies, quality of services, etc. have been a major casualty. In many instances providers may not adhere to the evidence-based guidelines. Hence, it has been proposed to monitor the quality of facilities as an integral component of JSY monitoring so that service providers and program managers also appreciate the importance of the focus in the quality of services provided and don't see their role merely as distributors of money.

A long-term commitment is needed to fuel sustainable change of reducing maternal mortality. The aim must be to ensure that all pregnant women should deliver in health facilities. Child-delivery in a fully equipped health institution under the supervision of a trained doctor can achieve MDG-5 of reducing the maternal mortality by three-fourth by 2015.

Acknowledgement

This study is based on data collected for the Doctoral work of the author which was supported by the Parkes Foundation, Department of Biological Anthropology, Cambridge, U.K. The author wishes to express her gratitude to the trustees of Parkes Foundation.
http://www.parkesfoundation.org.uk/awardees.html.