A Rapid Appraisal on
Functioning of Janani Suraksha Yojana
In South Orissa

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PREFACE

Despite significant improvements made in the past few decades, the public health challenges are not only so huge but are also growing and shifting at an unprecedented rate in our country. The concerns shown by the organisations at the global level indicate that in view of the resurgence of various epidemics, both infectious and non-infectious, the situation can be handled only through a public health management approach. This urgency was realised and expressed in the Public Health Conference as the "Calcutta Declaration", which called for creating appropriate structure for public health professionals and promoting reforms in public health education and training.

The National Institute of Health & Family Welfare initiated a Public Health Education and Research Consortium (PHERC) with the objective of networking and engaging in partnerships with public health institutions in the country to enhance their research capacity. As the nodal agency for imparting in-service training to health personnel and conducting research under the NRHM, the Institute is an ideal partner to bring the Department of Community Medicine in medical colleges, nursing colleges and other public health education and training institutions in the healthcare delivery system into the mainstream healthcare system, and also to provide a platform for building networks for capacity building in these institutions.

Currently, under the National Rural Health Mission many innovations have been introduced in the states to deliver healthcare services in an effective manner. State programme managers would wish to know how well these innovations are performing so that in case of gaps they could take corrective measures to achieve the stated objectives. There has been an increasing recognition for incremental improvements in the programme delivery system by undertaking quick and rapid health systems research and engineering the feedback into the processes. An impending need was discerned to develop a cluster of institutions and strengthen their capacities on rapid appraisal methodologies for generating programme relevant information at local and regional levels.

The Rapid Assessment of Health Interventions (RAHI), a collaborative effort with the United Nations Population Fund (UNFPA), is a unique initiative taken under the wider umbrella of the 'Public Health Education and Research Consortium (PHERC)' of the National Institute of Health and Family Welfare to develop partnerships with different organisations working in the field of health and family welfare. The project objective is to accelerate programme implementation in the identified states by providing them with timely and appropriate research inputs for addressing priority implementation problems. The specific objectives of this initiative are to develop a network of state/regional institutions for conducting health systems research and to provide technical support for

steering locally relevant research based on the specific issues identified by the state/district programme managers.

During the first phase of the RAHI Project, the UNFPA India Office supported 12 health system research projects. In this phase, five low-performing states, viz. Madhya Pradesh, Jharkhand, Chhattisgarh, Uttar Pradesh and Orissa, were included. Initially, proposals were invited from medical colleges, NGOs and other health institutions. After rigorous screening of the proposals by the Technical Advisory Committee (TAG) consisting of eminent public health experts, 12 projects were finalised in a national workshop conducted at the NIHFW. The faculty of the NIHFW provided technical support for the finalisation of tools, training to investigators, planning and monitoring of data collection. A quality assurance mechanism was developed in consultation with the members of TAG and experts from the UNFPA. The progress of the projects was reviewed by the TAG from time to time. A draft report entitled **"A Rapid Appraisal of the Functioning of Janani Suraksha Yojana in South Orissa**" by the Department of Community Medicine, MKCG Medical College, Berhampur, Orissa, was finalised by the Institute in consultation with the UNFPA.

It is envisaged that the findings and recommendations of this study would trigger a series of follow-up measures by the programme managers concerned in the state. We also feel strongly about continued need for optimum engagement of available human resources in community medicine, paediatrics, obstetrics, and gynaecology departments of the medical colleges in such assessments. Such initiatives by the programme managers will end the current isolation of medical colleges and will be conducive for incorporating such public health interventions during undergraduate and post graduate training.

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ABBREVIATIONS

ADMO	Additional district medical officer
ANC	Antenatal check-up
ANM	Auxiliary nurse midwife
ASHA	Accredited social health activist
AWW	Anganwadi worker
BCC	Behaviour change communication
BCG	Bacillus Calmette Guerin
BMO	Block medical officer
BPL	Below poverty line
CDMO	Chief district medical officer
CHC	Community Health Centre
CS	Caesarean section
DLHS	District level health survey
FGD	Focus group discussion
FRU	First referral unit
HSR	Health system research
IDI	In-depth interview
IIPS	International Institute of Population Studies
IPHS	Indian Public Health Standards
JSY	Janani Surakhya Yojana
LB	Live births
LPS	Low-performing states
LSCS	Lower segment Caesarean section
MKCG	Maharaja Krushna Chandra Gajapati
NE	North-Eastern
NFHS-2	National Family Health Survey-2 (1998-99)
NFHS-3	National Family Health Survey-3 (2005-06)
NRHM	National Rural Health Mission
NIHFW	National Institute of Health and Family Welfare
PHC (N)	Primary Health Centre New
PHC	Primary Health Centre
PNC	Postnatal check-up
PRI	Panchyati Raj Institution
RAHI	Rapid assessment of health interventions
RA	Research associates
RCH	Reproductive and child health
SB	Still births
SBA	Skilled birth attendant
UGPHC	Upgraded Primary Health Centre
UNFPA	United Nations Population Fund
UPA	United Progressive Alliance
Ku	Kukudakhandi block in Ganjam district
Kh	Khallikote block in Ganjam district
Mo	Mohana block in Gajapati district
Go	Gosami block in Gajapati district
Tk	Tikabali block in the Kandhamal district
Ck	Chakapadi block in Kandhamal district

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EXECUTIVE SUMMARY

The National Rural Health Mission (NRHM), under implementation since 2005, is aimed at providing accessible, affordable and quality healthcare services to the rural population. The National Institute of Health & Family Welfare, in collaboration with the UNFPA, has undertaken a rapid appraisal of the various health interventions under the NRHM with the concurrence of Government of India. These rapid appraisals are conducted in five low-performing states, namely Madhya Pradesh, Uttar Pradesh, Orissa, Jharkhand and Chhattisgarh, to critically examine the implementation process of various schemes and innovations under the NRHM.
The JSY Scheme was under implementation in Orissa since April 2006 and cash assistance was provided to the users with the changing rules at different times and mode of fund disbursement. In Orissa, the total number of JSY beneficiaries till December 2007 was 3,62,087 and the total number of ASHAs appointed were 34,178 and the total trained ASHAs were 30,992 (90.7%).

Issues related with procedural constraints in JSY implementation and inadequate feedback from the community are the primary concerns, which necessitated this study in Orissa.

General Objectives

The objectives of this study are to review the operational mechanism and usage status of the scheme, reasons for non-usage, perception and awareness of beneficiary and non-beneficiary mothers and the involvement of ASHAs, ANMs along with district and block officers in the implementation of the Janani Suraksha Yojana so as to furnish a set of recommendations to senior programme managers in light of study findings.

Methodology

Two blocks from each district, one close to the district headquarters and the other remotely located from the district headquarters were chosen for the study. Thus, six blocks from three districts were selected for the study. From each block, five or more villages were selected randomly.

Programme Implementers: Chief Medical Officers/ADMOs of the districts concerned (3) and Block Medical Officers (6) qualified as respondents. One ASHA from each block (6) and one ANM from each block (6) were selected randomly. One group of

PRI members and ASHAs were also selected on the basis of their availability for FGDs from each block. This constituted the sample respondents.

Beneficiaries and Non-beneficiaries: A list of beneficiaries who underwent institutional deliveries and availed of the JSY services in the past six months was procured from five selected villages under each block. Also, through feedback from key informants, a list of non-beneficiaries was prepared who gave birth in the past six months but did not avail of the JSY services. From each village, four users and four non-users were randomly selected for the study.

Primary data were collected from both beneficiary and non-beneficiary mothers and other stakeholders of the Janani Surakhya Scheme. Secondary data were collected from available reports and records at district and block levels regarding the operational mechanism and usage of the scheme. Data were also collected from various respondents using semi-structured schedules, in-depth interviews and focus group discussions.

Salient Findings

- The knowledge imparted in the ASHA training provided by the government is considered useful by the majority. But majority feel that further training is required for resolving practical problems they face in the field. However, the lack of orientation of the health staff other than ASHAs on JSY is a significant finding emerging from this study.
- Less than half of both beneficiary as well non-beneficiary mothers knew about the various aspects of the JSY scheme like provision for escort by ASHA, stay during hospital delivery and cash assistance. In approximately three-fourths of the beneficiaries, the first contact of ASHA with the mother was for ANC in between the third and sixth month of the pregnancy. The ASHAs also played a major role in motivation for institutional deliveries in two-thirds of the beneficiaries.
- The JSY scheme has a continuum of services to be availed of by the mothers. Services like three ANCs are perceived as useful by the majority of beneficiaries but some of non-beneficiaries do not perceive so. However, the need for 100 IFA tablets figure low in the perception of all the respondents.
- Majority of the stakeholders perceive monetary assistance as a big advantage for mothers and consider that the JSY scheme has made the health staff more helpful and friendly towards the people such as making frequent contacts, issuing of JSY cards and motivating prospective mothers to avail of the JSY benefits.
- Most of the beneficiaries are of the view that there is a lack of transparency in money distribution as they are forced to induce the staff for getting the JSY Card or getting the cash assistance. Nearly all, except the district officials, feel that the JSY assistance

comes late, mostly because of the complicated procedures of filling in and sending out forms or due to interruption of money flow to the PHC.

- Most of the respondents feel that there are problems of communication and transport. Hiring transport at odd hours, high cost of transportation and even being denied by transporters are some of the barriers in availing of the JSY services. Non-availability of 24x7 health centres and lack of staff are also other major deterrents for prospective mothers in accessing the JSY services.
- There is very little or no involvement of PRI members in the scheme. So is the case with community leaders, women groups and local NGOs.

Key Recommendations

- The policy-level suggestions include streamlining of the flow of funds from the states to PHCs, creation of core banking system, release of cash assistance under the scheme on the day of the delivery on the pattern of the Rajasthan Axis Bank Model and simplifying the paper work for releasing of payment
- The process of making JSY Card should be made simpler and should be issued as soon as possible. The JSY Card issued in one state should be accepted in other states as this is a Centrally-sponsored scheme.
- There is a need to accredit more private and charitable hospitals under the scheme at the block levels on the pattern of the Chiranjeeve Scheme. Due to higher out-of-pocket expenditure in case of Caesarean sections more assistance should be considered in the scheme.
- Thrust should be given on improving the quality of services and institutional capacity building for better performance
- There is an urgent need to intensify EC activities, focusing on the benefits of the scheme with special attention to clearing the myths and misconceptions about the scheme
- All recruited ASHAs should be trained within a time frame and post-training field appraisal should be done and thereafter refresher trainings should be imparted in a planned manner. Training of other categories of health staff on the scheme should be planned so that that the services to expecting mothers are more user friendly.
- Service centres should be provided with better infrastructure and supplies to provide round-the-clock services and to avoid unnecessary referrals and out-of- pocket expenses
- To increase involvement of PRIs, community leaders, women's groups and local NGOs for enhancing coverage of the scheme. Villagers should be informed through ASHAs about the 24x7 services available nearest to the village.

CHAPTER 1

INTRODUCTION

The National Rural Health Mission (NRHM) was launched by Prime Minister Manmohan Singh on April 12, 2005 with a mandate to provide/improve equitable, affordable, accountable and effective primary healthcare to the rural masses, especially the poor women and children. It aims to provide effective healthcare to people living in rural areas across the country, with special focus on the rural populations in 18 states with poor health achievements. The mission plans to take an integrated view of health by ensuring complementarities with family welfare, sanitation and hygiene, nutrition and provisioning of safe drinking water. (1)

The Janani Surakhya Yojana (JSY) is a safe motherhood intervention with the objective of reducing maternal and neonatal mortalities by promoting institutional deliveries. It is a 100% Centrally-sponsored scheme that integrates cash assistance with anntenatal and postnatal care. The scheme has ASHA as a key functionary for providing services and functioning as a link between healthcare delivery systems and the pregnant women. Each beneficiary registered under the scheme receives cash assistance for institutional delivery irrespective of parity and socioeconomic status. The ASHA also gets cash assistance for accompanying the pregnant women to the institution (referral transport) and cash incentive after postnatal visit and BCG immunization of the child.

The NRHM has shown significant gains since its inception. Reports from the states indicate noteworthy increase in institutional deliveries. From 6 lakh JSY cases in 2006, the number reached 21 lakh in 2007. (4) More than 4.35 lakh ASHAs have been selected under the NRHM who are mobilising people to avail of the services from CHCs/sub-district/district hospitals to improve institutional deliveries.

Operationalisation in the State

The JSY scheme has been under implementation in the Orissa since April 2006 and the cash assistance is being given to the users with the changing rules at different times and mode of operation of funds. Total number of JSY beneficiaries in Orissa till December 2007 was 36,2087. The total number of ASHAs appointed are 34,178 out of which 30,992 (90.6%) are trained.

Initially, only BPL families were entitled for the JSY assistance. Also, assistance was granted to mothers for the first two children. Several problems such as delayed release and poor management of funds, poor maintenance of accounts and non-involvement of

PRI members are reported as barriers in effective implementation of the project. Inadequate awareness on the part of different stakeholders, including community representatives, is also acted as a hindrance to proper implementation.

Rationale

Limited studies on procedural constraints in JSY implementation and inadequate feedback from the community are the major factors that necessitated this study. Therefore, a cross-sectional rapid assessment of the functioning of JSY has been conducted in southern Orissa.

General Objective

To assess the functioning of JSY in south Orissa.

Specific Objectives

- To review the operational mechanism of JSY
- To review the usage status and the reasons for non-usage in the districts
- To assess the perception and awareness of scheme by beneficiaries and non-beneficiaries
- To assess the involvement of ASHAs/ANMs and district/block officers in JSY implementation
- To make recommendations in light of the study findings.

CHAPTER II

METHODOLOGY

Study Area

Ganjam, Gajapati and the Kandhamal districts of Orissa.

Study Design

Type of Study: Cross Sectional design

Study Subjects

The following stakeholders are the subjects of this study:

- User mothers
- Non-user mothers
- ASHAs
- ANMs
- BMOs
- CDMOs
- PRI members.

Sampling Design

Multistage Random Sampling Design

The study was conducted in three priority districts in southern Orissa based on their poor performance on maternal and child health indicators last year. From each district, two blocks – one close to the district headquarters and other remote, were randomly selected. From each block, five or more villages were selected randomly.

Selection of Blocks and Villages

Two blocks from each district, one close to the district headquarters and the other remotely located, were chosen for the study. Thus, six blocks fro m three districts were selected. From each block, five or more villages were selected randomly. The lists of districts, blocks and villages in the study are given in Table 1.

Table-1: Selected Districts, Blocks and Villages under Study

Sl. No.	District	Block and villages	
		Proximal	Remote

1.	**Ganjam**	**Kukudakhandi** • Ratanpur • Anksushpur • Krupasindhipur • Balipada • Sihala	**Khallikote** • Kanka • Bikrampur • Manikpur • Birnarasinghpur • Khajapalli
2.	**Gajapati**	**Mohana** • Jodamaba • Dhadiamba • Nuasahi • Kidasingi • Gabariguda	**Gosani** • Labanyagada • Sariapalli • Garabandha • Gurandi • Rautpur
3.	**Kandhama**l	**Tikabali** • Totagudu • Barapalli • Pasara • Raipada • Gurusahi • Mundagoan	**Chakapada** • AMCS colony • Chatijhar • Kaltimendi • Kedarsahi • Gumalmendi • Tiparigoan

The following sample of the respondents were selected from the identified districts, blocks and villages:

Programme Implementers: Chief Medical Officers/ADMOs of the districts concerned (3) and Block Medical Officers (6) qualified as respondents. One ASHA from each block (6) and one ANM from each block (6) were also selected randomly. One group of PRI members and ASHAs were also selected on the basis of their availability for FGDs from each block. This constituted the sample respondents on the implementers' side.

Users[1] and Non-users[2]: A list of users who underwent institutional deliveries and availed of the JSY services in the last six months was selected from five selected villages under each block. Also, with the feedback from key informants, a list of non -users was prepared who gave birth in the last six months but without availing of the JSY services. From each village, four users and four non-users were randomly selected. If sufficient number of respondents was not available in the village, then the nearby village was considered to complete the sample. The total numbers of respondents from the beneficiary side were 120 users and 120 non-users.

[1] A mother/household having a child < 6months and availed the JSY cash assistance

[2] A mother /household having a child < 6months child who has not availed of JSY cash assistance

Study Duration

The duration of the project was 12 weeks and data collection was done between last week of October to the last week of November 2007.

Data Collection and Field Work

Primary data were collected from user mothers and non-user mothers and other stakeholders of the scheme. Secondary data were collected from available reports and records at district and block level regarding the operational mechanism and usage of the scheme. Data were also collected from various respondents using semi-structured schedules, in-depth interviews and focus group discussions. All IDIs and FGDs were recorded with consent from respondents and transcribed. One FGD for ASHAs and PRIs in each block was included in the study sample. All the data collected were triangulated to have a clear idea of the findings at the time of analysis.

The workload for each block was two FGDs, four IDIs and 40 interviews using semi-structured schedule. To ensure data quality, PI/Co-PI conducted FGDs and IDIs with district authorities, while the research associates (RAs) conducted remaining IDIs and interviews with the **users** and non-users along with investigators. The latter were entrusted to carry out semi-structured interviews and organise the FGDs. A team of two investigators and two RAs worked in one district for 20 days. Given the shortage of time for appraisal, separate teams worked simultaneously to cover the three districts. The research staff were provided two days of hands-on training on research guidelines, tools and research issues which were pretested on the third day before the commencement of the actual field work.

Table No.2: Sample covered, tools and techniques used for data collection

Stakeholder	Number	Data Collection method and Tools
JSY User mothers JSY Non user mothers	120 (4 users from each of 5 villages per block from 6 blocks ie 4 users X5 villagesX6 blocks) 120(4 users from each of 5 villages per block from 6 blocks ie 4 usersX5 villagesX6 blocks))	Interview-semi structured schedule

Stakeholder	Number	Data Collection method and Tools
CMOs/District nodal officers BMOs ASHAs ANMs	3 (1 per district) 6 (1 per block) 6 (1 per block) 6(1 per block)	In-depth interview checklist
ASHAs PRI/Community leaders	1 Per Block 1 Per Block	FGDs -FGD Checklist

Quality Assurance

The entire project was monitored and supervised by the Principal Investigator (PI). The PI monitored the quality of data collection in the field by being present in 10% of the interviews at the block level. Also, the PI personally conducted the FGDs and in -depth interviews of district officials. Central monitoring team from the NIHFW closely monitored the training, field activities, data analysis and report writing.

The data collected in form of recorded interviews was coded and each interview was transcribed with the help of field notes and further translated by the RAs on the same day of the field study. Each interview was given an ID number to eliminate bias. The PI and the Co-PI supervised the data handling and data analysis.

Data Analysis Plan

Quantitative data were analysed after generating frequency tables for users and non -users using SPSS 13 software. For qualitative data, semi -quantification was done by coding the responses for different stakeholders and merging into different headings using adjectives as the guidelines provided by the NIHFW.

Adjectives used in the study for qualitative data

Proportion of respondents	Adjectives used
<10 %	Very few
10-24 %	Some
25-49 %	Approximately half
50-74 %	Majority/Over half
75-89 %	Most
>90 %	Almost all

Ethical Clearance

The project structure was examined and cleared by the Ethical Committee of the Institution Review Board at NIHFW for ethical considerations.

CHAPTER III

FINDINGS AND DISCUSSION

Secondary Data

The secondary data from six blocks of three districts of southern Orissa -- Ganjam, Gajapati and Kandhamal -- reveals an increasing trend in institutional deliveries from 2005 to 2007 which may be attributed to the implementation of the JSY scheme. The total number of people benefited from the scheme and the total number of deliveries expected in a year in each block (as per the state birth rate of 22.7 per 1,000) show that there is a long road to meet 100% JSY coverage. For example in Kukudakhandi block, expected versus recorded JSY deliveries in 2006-07 were 3,254/1,237 (38%), in Gurandi 1,715/1,010 (58.9%), in Tikabali 1,064/874 (82%) and in Chakapada block it was 1,003/330 (33%). However in two blocks, the recorded JSY deliveries exceeded the expected number of deliveries as in Khallikote it was 2,696/3,472 (129%) and in Mohana it was 1,465/2,875 (196%). This extra achievement under the scheme needs to be carefully examined.

Also, the recorded delivery data for 2004-05 from some of the blocks are incomplete thus making it difficult to analyse the achievement status of the subsequent years. Considering the population of the block, the total reported deliveries recorded by the district authorities versus the expected deliveries are grossly mismatching during 2004-05. For example, in Kukudakhandi block, expected versus recorded deliveries in 2004-05 were 3,254/261, in Gurandi 1,715/947, in Tikabali 1,064/596 and in Chakapada it was 1,003/108. It indicates a need to improve the registration mechanism of the vital events in the area. However, in Khallikote it was 2,696/3,017 and in Mohana 1,465/2,198 indicating over-reporting.

With the total expected deliveries in the state in 2006-07 being 8,35,466, as per the JSY data in Orissa, the total beneficiaries registered were just 2,27,204 (27% of the expected numbers). Out of those, 70,814 (31%) were assisted by ASHAs. The institutional deliveries out of total deliveries registered under JSY scheme were 1,51,921 (67%) and home deliveries were 75,283 (33%). In spite of the launch of JSY in Orissa in 2006, selection of ASHAs is still in progress. Training is also not complete for selected ASHAs in all the six blocks, which may be a reason for low ANC coverage and predominance of home deliveries. This is particularly true among tribal populations of Mohana and Gurandi blocks in Gajapati district where home deliveries were the norm.

Table 3: Secondary Data of JSY in six blocks of three sample districts over last three years

Performance Indicators	Ganjam			Gajapati	Kandhamal	
	Kukudakhandi	**Khallikote**	**Mohana**	**Gurandi**	**Tikabali**	**Chakapada**
Total Population (Census-2001)	1,43,329	1,18,756	64,547	75,543	46,875	44,169
Recorded deliveries Nov 04-Oct 05 Home deliveries Institutional deliveries	261* 186(71%) 75(29%)	3017 2,039(67%) 978(33%)	2198 2,082(95 %) 116(5%)	947 910(96%) 37(4%)	596 310(52%) 286(48%)	108 100(92%) 08(8%)
Total JSY beneficiary Nov 05-Oct06 Home deliveries Institutional deliveries	268* 178(66%) 90(34%)	3034 2,090 (69%) 944(31%)	2567 2,429 (94%) 138(6%)	968 898(93%) 70(7%)	889 436(49%) 553(51%)	158 125(79%) 33(21%)
Total JSY beneficiary Nov 06-Oct-07 Home deliveries Institutional deliveries	1237 195(16%) 1,042(84%)	3,472 1,432(41%) 2,040(59%)	2,875 2,630(91 %) 245(9%)	1010 830(82%) 180(18%)	874 393(45%) 481(55%)	330 232(70%) 98(30%)
No of ASHA's selected	124	136	120	70	85	64
% of ASHA's trained fully till Oct 07	39(31%)	45(33%)	68(57%)	30(43%)	32(38%)	24(38%)

Sources: Records from three PHCs of six blocks in study districts
*A-available NA-Not available

Socio-Demographic Characteristics

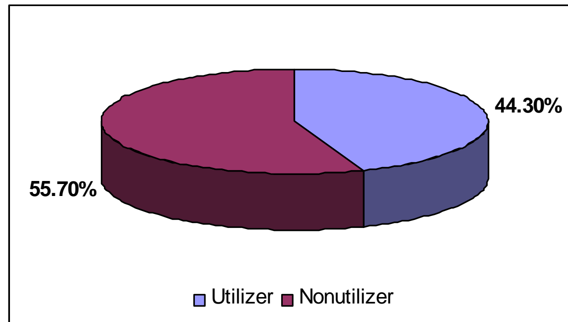
Most of the respondents (both users and non-users) are in the age group 19-25 years, majority are illiterate or just literate and most of them are housewives by occupation. The age of marriage is 16-18 years showing an early marriage trend. Around half of the users are illiterate or just literate and 82% of the non-users are housewives in comparison to 78% in users category. The age of mothers during birth of first child is between several 19-25 years in 68% of respondents. About 44.3% of the users and 55.7% of the non-users are BPL cardholders. This brings to notice that while most (44.3%) of the expected BPL population of the users category (Orissa BPL Population: 47%, Census 2001) are availing of JSY services, there is a special need to propagate the scheme amongst the non-users where still a big part (55.7%) are BPL mothers, who are deprived of JSY services.

Table 4: Distribution of Socio-Demographic and other characteristics of user/non-user mothers under study

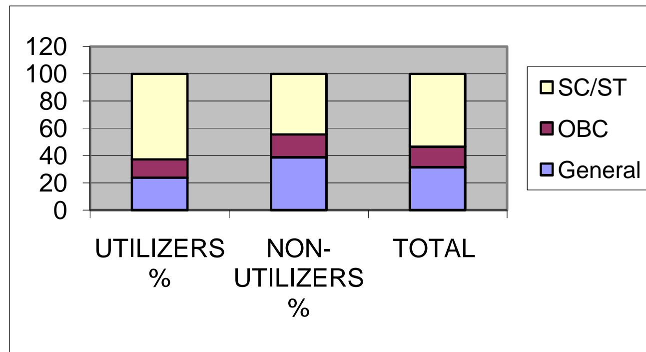
Variable	Users(120) Number (%)	Non-users (120) Number (%)	Total(240) Number (%)
Literacy			
Illiterate	40(33.3)	44(36.4)	84(35.0)
Just Literate	19(15.8)	25(20.7)	44(18.3)
Primary education	33(27.5)	25(20.7)	58(24.1)
Secondary and above	28(23.4)	26(21.6)	54 (22.5)
Age			
16-18 yrs	9(7.5)	10(8.3)	19 (7.9)
19-25	83(69.2)	82(67.8)	165 (68.7)
> 25 yrs	28(23.3)	28(23.1)	56 (23.3)
Caste			

Variable	Users(120) Number (%)	Non-users (120) Number (%)	Total(240) Number (%)
General	29(23.8)	47(38.9)	76 (31.6)
OBC	16(13.5)	20(16.8)	36 (15.0)
SC/ST	75(62.7)	53(44.3)	128 (53.4)
Religion			
Hindus	78(64.7)	86(72.0)	164 (68.3)
Muslims	12(10.2)	14(11.3)	26 (10.8)
Christians/others	30(25.1)	20(16.7)	50 (20.8)
Occupation			
Housewives	94(78.3)	99(82.5)	193 (80.4)
Labourers	17(14.2)	12(10.0)	29 (12.0)
Agriculture	7(5.8)	7(5.9)	14 (5.8)
Skilled workers	2(1.7)	2(1.6)	4 (1.6)
Age of marriage			
< 16 yrs	9(7.5)	14 (11.6)	23 (9.5)
16-18 yrs	81(67.5)	78(65.0)	159 (66.2)
19-25 yrs	30(25.0)	28 (23.3)	58 (24.1)
BPL Card Holders	50(44.3)	63(55.7)	113(47.0)

Graph-1 BPL Card holders among user/non-user mothers



Graph 2: Distribution of JSY Users by SC/ST, OBC and General Castes



Service Usage Pattern

About 84% users had, three or more ANC check -ups, which are expected with the enhanced coverage and support provided by JSY. However, in non -users the percentage of women who underwent three or more ANCs dropped to 63.3%.

The IFA tablets usage is average in JSY users (59.1%) and very poor in non -users (17.5%). Considering the importance of this component a special effort is required by ASHAs to enhance acceptance of IFA uptake.

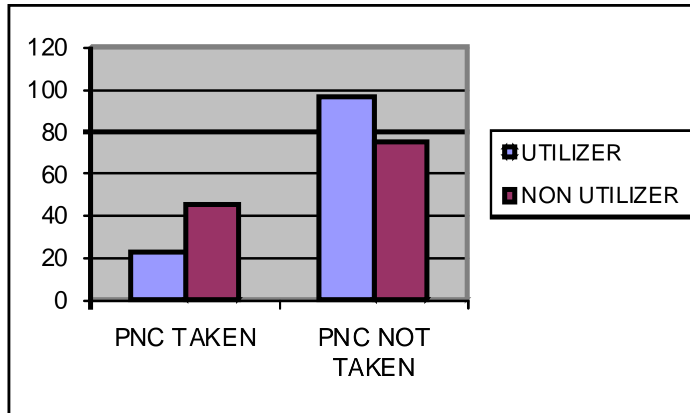
Usage of TT is good with two doses being taken by 88% of both users and non-users.

For 94.2% users, the place of delivery was government health institutions and very few deliveries happened at home. Notably, no delivery took place at accredited private clinics and charitable hospitals. But when it comes to non -users, as many as 57.5% deliveries happened at home, while a few (20.9%) went to private clinics and charitable hospitals. A significant finding is that 21.6% of the non -users delivered in government hospitals but did not receive JSY compensation. This was pr imarily because of the non-availability of JSY Card with these mothers.

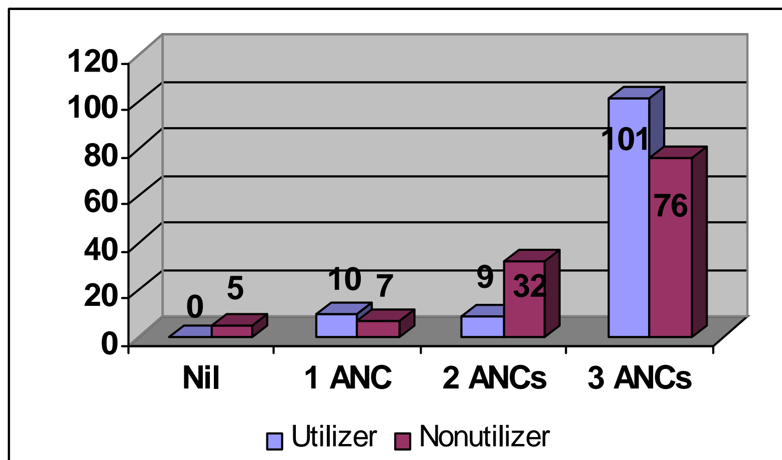
Among the majority of users, the ASHA was the accompanying person for delivery but among non-users, only family members accompanied for delivery. For both the categories

PNC check-up was quite low (28.3 %). The ASHAs facilitated three PNCs in 19.1% of the user-women and private parishioners did 37.5% PNCs in non -users. Since PNC is an important component of the service continuum, a special thrust is required to enhance its uptake.

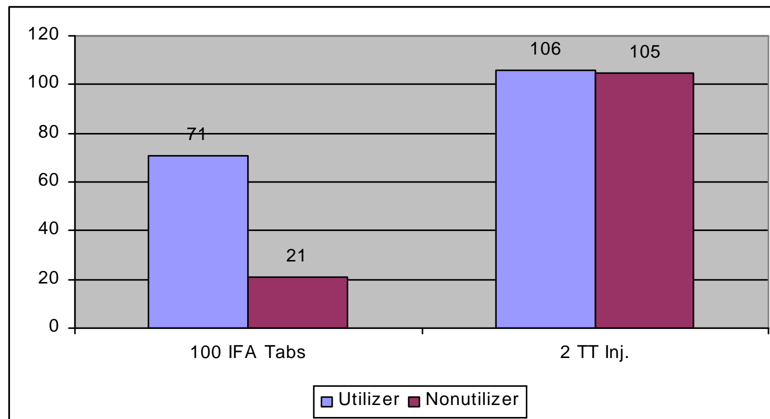
Graph-3 Antenatal services received by user and non -user mothers



Graph-4 IFA Tablet intake and TT injection of user/non -user mothers



Graph 5: Graph of PNC services availed by users and non -users



First Contact for ANC Usage

When the actual usage levels of JSY are analysed, it is found that the first contact was made by ASHAs with 70% of the respondents for ANC during 12-24 weeks of pregnancy. This is the right time during pregnancy for proper antenatal check-up, detection of complications and planning for an institutional delivery. In around half (49%) of the cases, ANC was performed by the medical officer.

Motivation for Institutional Deliveries

The ASHAs play a major role (65% of users) in motivating the women for institutional delivery, which indicates that ASHAs are well-accepted by the community and are able to reach out to pregnant women and successfully motivate them for undergoing institutional delivery.

Issue of JSY Card

The role of ASHAs in assisting the pregnant women in registering and obtaining a JSY Card during the early stages of pregnancy is important as early registration provides sufficient time before delivery for interaction with women to create awareness, provide ANC and promote institutional delivery. In 51.6% of the cases, the JSY Card was made in 3-6 months of pregnancy, providing sufficient time for the mothers to obtain information about the JSY scheme from the ASHAs and also undergo ANC. However, in 48.4% of the users, registration was delayed beyond 6 months, thereby reducing the time available to ASHAs to interact with the potential beneficiary and initiate ANC check-ups.

Table 5: Programme Usage by Beneficiary Mothers

Performance Indicators	Values

Ist contact/ANC	12-24 wks in 70%
Motivation for ANC by ASHA	65%
ANC done by Medical Officer	49.2%
Motivation for institutional delivery by ASHA	62%
Time of getting JSY card	<3 months in 3.3% 3-6 months in 48.3% 6-9 months in 39.1% > 9 months in 9.1%

Programme Management

Funds Flow

Less than half (36.7%) of the users in the study area got payments within one week, while 40% of them got between a week and a month, and for the remaining 23.3% it took over a month to avail of the cash assistance.

To enable local availability of money, ANMs are given advance money which is kept in a joint account with the Sarpanch or the Naib Srapanch whoever is a woman. This money is replenished on time-to-time basis on submission of bills and vouchers of the last round of disbursements. Two out of three CDMOs and four out of six BMOs inform that most of the times the funds flow at various levels (from state to district and below) are interrupted because of delayed submission of bills and vouchers. This delay results in lack of money at operational levels which in turn affects the release to money to ASHAs and eventually to the beneficiaries. All the money required should be planned in advance depending on the expected number of deliveries at each level of institutions and necessary amounts should be parked in the budget for them in one go so that the operationalising on the scheme does not get blocked due to lack of money at the ANM level.

Now, the payments are given through cheques, therefore an effort should be made to link the flow of money with the e-governance financial reporting systems, which are used in the Treasuries of many states so that it becomes more transparent and quick. A core banking system with its own dedicated computerised reporting network can create space for the JSY financial system as well. This will enable the senior programme managers in assessing and understanding the fund requirement and payment situations at central levels so that early curative action can be taken. A core banking system will solve these problems .Since one of the major benefits that the scheme offers is cash assistance to mothers, these delay/difficulties may act as a disincentive for other prospective users. Also, since ASHAs are the link and interface between the beneficiaries and health

services, any delay in providing cash assistance to user may lower their credibility in the community thereby decreasing their effectiveness in the very first years of the work.

'Tanka jetebele thik time re asu nahin loke mane amaku biswas karu nahanti au gali karuchanti," averred an ASHA.

"[When money flow is interrupted the mothers lose faith and hold us responsible for delay in money disbursement."]

"Amaku to bank jibaku paduchi, bank re jagibaku hebe,choto pila sahito heyrano hoi jaichu"

'["We have to go the bank to receive the money but this is difficult with a new born to take care off."], said a mother.

Table 6: Time taken in receipt of JSY payment by the Users

Time Taken	Ganjam(n=40) number/(%)		Gajapati(n=40) number/(%)		Kandhamal(n=40) number/(%)		Total (120) number/(%)
	Khall	Kukud	Mohan	Guran	Tikab	Chakap	
<7 Days	4(20)	10(50)	5(25)	9(15)	8(40)	4(20)	40(33.3)
7 Days to 1 Month	2(10)	9(45)	9(45)	8(40)	8(40)	9(45)	45(37.6)
>1 Month	10(50)	1(5)	4(20)	3(15)	3(15)	7(35)	28(23.3)
Not received yet	4(20)	0	2(10)	0(0)	1(5)	0	7(5.8)
Total	20(100)	20(100)	20(100)	20(100)	20(100)	20(100)	120(100)

Awareness of Programme for Managers/Providers

Human resources are a major necessity for any scheme to operate smoothly. On analysing the provider's perspective on awareness about implementation arrangements for the JSY, majority of BMOs and CDMOs are aware of the various processes involved in running the scheme. However, as lead-managers of the scheme, every one of them should be fully aware of it. This draws attention towards the need of instituting a mechanism for periodic orientation and updating of personnel at this level. Another significant observation is that only two out of the six ASHAs are aware of the functional aspects of the scheme. This is a major gap as ASHAs are the principal front line functionaries who are expected to provide complete and accurate information to prospective users. This is a priority area for intervention for long-term sustainability of the scheme.

Orientation of the health staff other than ASHAs on the JSY scheme is another major finding emerging from the study. No respondent from across the CDMOs, BMOs and ASHAs know whether health staff other than ASHAs are trained and oriented for the

scheme. Since the success of the JSY scheme depends on team w ork with various tasks undertaken by different type of functionaries, it is essential that all frontline health staff are trained/oriented on the JSY scheme to enhance service coverage as well as to increase their ownership of the program.

"ASHA didi to ama pakhare rahuchi, kichi asuvidha hele hospital nei jiba"
["The ASHA stays near our house and if some health problem arises, she will take me to the hospital," confirms a mother.

Training of ASHAs

The ASHAs play a pivotal role in motivating and faci litating users for antenatal services, institutional delivery, postnatal care, and care of the newborn. Therefore for the smooth running of the scheme, they need to be adequately trained. The ASHAs in the six blocks have been assessed for various aspects o f the JSY training such as extent and utility of training, and need for further training.

"Amaku training au tike bhalla bhabare dele hal hoi thanta, jemeti ki TV re dekhiye thile amkau bhala bhabare bujhi parantu"
[" Training would have been good if gi ven with some visual aids like television or computer,"] complains an ASHA.

In the FGDs with the ASHAs, training was done for approximately half of them in Ganjam and the Kandhamal districts and most of them in Gajapati district received training. Knowledge imparted by the training is considered useful by most of the ASHAs; also most of them are of the view that further training is required focusing on feedback and discussions about practical problems they face in the field. There should be refresher training on a regular basis. But the majoriy have been given only the government guidelines regarding implementation of the scheme during the training.

Most of the PRIs and community members are aware of the implementation of JSY and have a favourable attitude towards the ASHAs. Most of them say that they are doing a good job and are trained well and that an ASHA is the link person who is well accepted by the community as she is well-known in the community and is easily accessible to mothers.

"Eka thare manne ruhane amaku majhi majhi re training dele bhala hoi thanatha."
["We don't remember all things. Training has to be given from time to time (re -training) for better performance," says an ASHA.

Perception of Stakeholders on the Advantages of JSY Scheme

The JSY scheme has many advantages if the perceptions of all the respondents including users, ASHAs, ANMs, BMOs and PRI members, are to be believed. Majority of them agree that cash assistance is important to mothers as it is used during delivery and for postdelivery care like food and medicines for both the mother and the child.

The fund is used for the mother's nutrition during the postpartum period as many of the poor women are deprived of nutritious food essential for them to breast -feed the child.

"JSY tnaka re jaha hohu maa ro bhala khaibha hoye paruchi jaha ki maa tara khira pila ku piyaye paruchi" i.e.
["The JSY money is useful for the mother so that she can take nutritious food and can feed the baby,"] opines an ASHA.

"Jaha hohu sarkar ama maa ma nakna payin kichi bhal yojana karichi,ama gariba loke pain tanka bahut sahajya re laguchi" i.e.
'Thank god, the government has at least thought about the poor women and the scheme of getting money is quite useful for the poor mothers," opines a mother.

But another mother has a different view, and says: "Sarkar jo tanka daychu amkau to adhika tanka kharca hoyi jayucahi,doctorkhana re to ayushadha patra re kharch hoye jahuchi." [The money which the government gives us is totally used for the medicines and hospital costs."]

Almost all of the user mothers feel that the scheme has made the peripheral health staff such as ASHAs and ANMs more helpful and friendly in terms of making frequent contacts, in promptly issuing the JSY Cards and motivating prospective m others to avail of the benefits of the scheme.

While monetary benefits of the scheme as well as increased friendliness of the heath staff is increasing the number of JSY users in the state, the service delivery is not found attractive by the users. Majority of them are of the opinion that lack of 24 -hour services, absence of staff at hospitals, dirty conditions, poor supplies of medicines and rough attitude of the clinical staff, referrals to higher centres, and tests from outside as major problems. It is pertinent to focus more towards the institutional and technical capacity as well as quality components of each service to enhance coverage both in the short - and long-term.

Perception of Stakeholders on Reasons for Non -Users

Finance related: Most non-users have informed that money disbursement is delayed, quoting ANMs and ASHAs who tell them that payments are late because of interruptions at the higher level. The delay is normally due to complicated procedure of filling of forms, vouchers and cards resu lting in the interruption of fund flow from the district to the PHC.

"Paisa nothile amkku doctorkhana jiba aisbia re tanka kharch hoyi jayuchi aue jane loko jai jabiba paduchi maa sahita"
["When money is not available at the PHC, the money we spend on going to the PHC goes waste. Moreover, since the beneficiary mother herself must be present to receive the money, someone in the family has to accompany her," says a family member of a non-user.

Most of the non-users see also lack of transparency on the part of the health staff in the money distribution, as well as in issuance of the JSY Card.
"Chaudhasa tanaka ru to hospital staff to adha magiki neyi jayuchanti, ama pakhare au kana rahila"

'Out of Rs. 1,400, the hospital staff will ask for half the mo ney and take it from us; what is left with us after that," complains a mother.

Another major problem, seen particularly in Ganjam and other bordering districts of the state is of temporarily shifting maternity homes to neighbouring states like Andhra Pradesh. In Gajapati district that is bordering Andhra, the JSY guidelines and registration cards are different. The different set of rules in the bordering state creates hurdles in getting cash assistance to users who are registered in Orissa but deliver in the neighbouring states.

"Andhra lo maku yi card icharu mari aa card ikada ledu anatarnaru"
["We got this JSY card from Andhra Pradesh, but in Orissa the health staff tells this card is not a JSY Card and asked us to make another card,' complained a moth er**.**

Mixed Opinion Among Community: Poverty and illiteracy compound the problem. Most of the non-users are reluctant to go for institutional delivery for fear of expenses. Another major fear is that there will either be referral or some surgical procedure to be done. This indicates the need for a more strengthened referral network. It also reveals the reluctance of field staff to take up cases and their tendency to shift cases to the next level to avoid work. Also, there is a tendency of family members to go in for home delivery. Most of the ASHAs say that the decision to go in for institutional delivery or

not, doesn't depend on the in-laws, husbands and other elder family members but it is decided by the local *dais* if complications arise.

Another major reason behind their reluctance for institutional delivery is the embarrassment of being assisted by a male doctor.

"Amaku laja laguchi purusha doctor agare prasaba karibaku,stri doctor hoi thiel bhala hoi thanta"
"We feel shy to deliver in the presence of male doctors it would be better if female doctors are available," says a Tribal mother.

Poor Accessibility: Nearly all the stakeholders report poor accessibility to hospitals due to lack of communication and transport. The blocks of Mohana and Gurandi in Gajapati district are hilly areas far away from the hospital. Here the problem of transport to the hospital is acute. This may be the reason for more than 80% home deliveries in Mohana and Gurandi blocks in 2006-07 under JSY in comparison to other study blocks where institutional deliveries dominate. The condition is worse when a woman is to be brought to the hospital at night. Poor communication systems hamper the usage of the JSY services. Major reasons for poor transport cited by the stakeholders are nonavailability of means of tranport, high cost demanded by transporter, refusal to carry patients to far away places and their non-availability in night.

"Rati re hospital aniba gotiye garbhabati maa ku bahut kasta,rasta re kana haba kahi hebe nahin"
["At night taking a pregnant woman to a hospital is a very difficult task and we don't know what will happen on the way,"] **says a** PRI member.

The ASHAs do not have advance money with them and in some cases where they have to bear the cost of transport from their own pocket it often results in a personal loss to them, thereby discouraging them to extend help in future.

Hospital-Related Expenses: Though, all the services in government hospitals are free, majority of the non-users say that they hear that users often incur more expenses than what they get through the JSY cash assistance, also at times are forced to pay for services that are promised free. Majority of the non-users think that hospital services are costly and the JSY assistance is insufficient in meeting delivery expenses. Most of these expenses, according to non-users, are purchase of drugs, IV fluids and other hospital materials, lab tests etc.

"Amaku to kahile free re delivery hobe hee jete bele prasab ku nele amku doctor ayusadha, injection sabu lekhidel antibaku"

[“They told us the delivery will bear no costs but when they took my wife to the labour room the doctor wrote a big prescription of injections and medicines,”] avers a father.

Poor Availability of Health Staff/Logistics: Majority of the non-users and PRI members state that non-availability of 24x7 health centres and lack of staff in treatment centres are major deterrents for prospective mothers in accessing the JSY services. Also, according to approximately half of the BMOs and majority of PRIs, poor institutional facilities and inadequate supply of essential materials like drugs, IV fluids and surgical materials are major roadblocks. Majority of the non-users say that the unavailability of ASHAs and ANMs as escorts at the time of need creates apprehension amongst mothers in negotiating or communicating with the health staff.

Available programme data indicate that ASHAs are yet to be posted in many villages. Many are still not trained and therefore are unable to work effectively. Doctors and staff are sometimes not present at the hospitals, thereby leaving the quality services poor. Most of the PRI members and some of the ASHAs and ANMs state that government hospitals are not clean and patient friendly.

“Hospital re to kichi jinish,staff nahintne,khali quality service boli training dele ama kan karibu.Operation theatre au specialist ro subudha nahin”
[“ In our hospitals there is no adequate staff. We also neither we have an operation theatre nor specialists available with us. So how can we provide quality service,” argues a block medical officer.

Inadequate number of doctors and staff in the health facility is one major reason for lack of quality services. The increase in demand for institutional delivery on account of the JSY scheme is putting additional burden on rural health facilities.

Inadequate IEC: Approximately half of the ANMs, ASHAs and PRI members feel that lack of awareness about the scheme is one of the reasons for non-usage of the JSY scheme.
To make the scheme more widely accepted and transparent, the target community should be made aware of the various components of the scheme. It has been found that less than half of non-users have knowledge about what the JSY offers, such as, registration, issue of JSY Card, institutional delivery, provision of escort (ASHA), cash assistance, PNC and immunization, etc. This point towards the need for wider and better dissemination of information about the JSY scheme to ensure wider acceptance and usage as well as to ensure transparency in the whole programme.

Poor Coordination: There is very little involvement of PRI members in the scheme. So is the case with community leaders. Women groups are also poorly involved with it,

which may be the reason behind poor awareness of the scheme among the community members. Involvement of local NGOs has been observed in some places where they are actively working.

Majority of ASHAs, ANMs and BMOs cite lack of regular meetings, inadequate briefing about the programme, work overload and financial expectations by civil society organisations as the principal reasons for the weak inter-sectoral coordination. The JSY programme managers should encourage involvement of such sectors for meeting the JSY objective of communitisation as well as better uptake of the services under the scheme.

CHAPTER IV

RECOMMENDATIONS

Areas of Concern	Actions Recommended
Policy Issues ▪ Slow release of funds to the operational units is creating delay in passing on the assistance to users on the day of delivery ▪ Old system of filling and delivering vouchers and bills ▪ Slow selection of ASHAs is delaying rapid scale-up of the programme ▪ Lack of availability of committed transport facilities as and when required, is making people opt for home deliveries ▪ Private health facilities are still a choice for many prospective mothers ▪ Migration to the bordering state for delivery blocks the release of assistance due to different type of JSY card, different norms and rules prevailing in that state	▪ Funds flow from state to districts and then to PHC should be streamlined. Proactive attempts should be made to ensure its release to users on the day of delivery. Money distribution should be more transparent to avoid allegations of inducements. ▪ The financial information flow should be on the e-financial system used by treasuries in many states to ensure quick flow of information and funds ▪ An attempt to recruit remaining ASHAs as early as possible should be put in place in a time-bound manner ▪ Transport is a major barrier to access JSY services. A mechanism to ensure committed availability of transportation in the vicinity of prospective users like the Andhra Pradesh model, especially in the remote areas should be planned ▪ Since some people still access private facilities to undergo institutional deliveries, more private and charitable hospitals at block level should be accredited for JSY scheme and list should be made available to ASHAs ▪ Crossing of state boundaries to avail JSY benefits should not hamper release of cash assistance and services to the users as it is a Centrally- sponsored scheme. A smart card model like that being used for HIV treatment can be considered.
Programme Level Issues ▪ Deliveries through Caesarean section entail more expenses and longer hospital stay, therefore, more assistance is required for such cases. ▪ Programme managers' knowledge on implementation guidelines, steps, components and modifications not complete which impacts flow of adequate knowledge down below ▪ Delay in issuing JSY Card obstructs early uptake of	▪ Since mothers having Caesarean section incur additional costs on medicines, surgical items and spend more time in the health facilities leading to higher wage losses and the JSY money falls short of meeting these expenses, it is required that they should get more money in assistance ▪ Programme guidelines should be clearly explained to the implementers and providers and they should be informed and updated about modifications in the scheme in a regular manner. This will avoid confusion regarding the processes in the minds of functionaries at all levels and bring about a unified and coherent schematic response. ▪ The JSY Card is the entry point of the JSY

the services ▪ The increase in number of functionaries under the NRHM is not matched up by better institutional infrastructure and enhanced treatment quality ▪ ASHAs expect regular interactive sessions with seniors to solve field level problems	scheme. Attempts should be made to ensure early issue of these cards and also It should be ensured that there are no cumbersome procedures for issue and use of the JSY Card. ▪ Since quality in services and institutional capacity provide sustainability to the efforts, a specific mechanism of enhancing quality in treatment and enhancement in institutional infrastructure should be ensured to guarantee less referrals, friendly hospital environment and supportive attitude of staff ▪ A fully functional two-way communication system will lead to effective decision-making and modification in field strategies for better utilization of JSY, therefore, a periodic activity to clear field level queries of ASHAs should be planned for every district on regular basis
IEC ▪ Poor PNC uptake hurting the continuum umbrella under the JSY scheme ▪ Strong and fixed beliefs and myths reduce uptake of services	▪ Intensification of IEC activities in the community especially focusing at the PNC component of the scheme are required to ensure uptake of the continuum of services offered by the scheme ▪ Awareness campaign focussed to dispel misconceptions and myths and clarifying various components of the scheme should become an integral part of the IEC campaign
Training • Training of ASHAs is still not complete which impacts their quality and confidence • Re-training sessions, specially focussing on emerging training needs based on field experiences still not conducted • No JSY orientation to health staff other than ASHAs may convert JSY into an ASHA-owned and ASHA-operated standalone intervention with no lateral support	▪ A proactive attempt to complete the incomplete trainings of ASHAs should be attempted to ensure that they approach the clients with full knowledge and confidence and provide right services to them ▪ Quality in training should be enhanced, post-training field appraisal should be done and refresher trainings should be provided after conducting training need appraisals ▪ Orientation of appropriate health staff other than ASHAs on JSY should be done to enhance their ownership of the scheme and to provide additional support to ASHAs
Logistics • Lack of essential supplies and infrastructure like	• Supplies at hospitals should be enhanced to meet the increasing number of clients and ensuring that these are provided to mothers free of cost

testing services at institutions, which compel mothers to make high out of pocket expenses, are dissuading them and others from users of the scheme • Lack of availability of adequate staff on 24-hour basis is reducing users' confidence on assured services under the scheme	• Provision of more infrastructure facilities to manage high risk cases to avoid unnecessary referrals to be ensured • Positioning of more staff to provide quality services should be undertaken and assurance of round the clock services should be done
PRI/community level issues • Lack of adequate intersectroral coordination with PRI members, womens groups and NGOs is affecting enabling environment and proper mobilisation for the scheme	• Involvement of PRI members/community leaders in decision-making is a must and should be targeted • Involvement of women groups and local NGOs is to be assured

Limitations of the Study

- The study duration was quite less therefore a large sample could not be attempted
- The study area could have been extended to a wider geographical area to have a representable population
- Involvement of men in JSY cannot be ruled out therefore further studies should incorporate husbands as study subjects.

Future Directions of Research

With the increasing number of users coming to the scheme, a study to access the preparedness of the health systems in meeting the enhanced demand of services is the appropriate area of future research. Other aspects of the NRHM like the District Health Plan, Rogi Kalian Samiti and NREG schemes should also be studied in the Orissa to have an all-round impact of implementation of the NRHM Programme in southern Orissa.

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