

A Rapid Appraisal of Organization and Utility of Health Melas in Uttar Pradesh

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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 NIHF. The faculty of the NIHF 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 **“An Assessment of the Health Status in Select Districts of U.P.”** by the Department of Hospital Administration, C.S.M. Medical University, Lucknow, 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

AIDS	Acquired immuno deficiency syndrome
AYUSH	Ayurveda, Unani, Siddha, and Homeopathy
BPHC	Block primary health centre
CHC	Community health centre
CMO	Chief Medical Officer
DAVP	Department of Audio Visual Publicity
ENT	Ear, nose and throat
HIV	Human immunodeficiency virus
IEC	Information, education and communication
IMA	Indian Medical Association
MoHFW	Ministry of Health & Family Welfare
MO	Medical Officer
MO I/c	Medical Officer In-charge
NIHFW	National Institute of Health and Family Welfare
NGO	Non-Government Organisation
NRHM	National Rural Health Mission
NSV	Non-scalpel vasectomy
OT	Operation theatre
PHC	Primary health centre
PI	Principal investigator
RCH	Reproductive and child health
STI	Sexually transmitted infections

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EXECUTIVE SUMMARY

Popularly known as the “Parivar Kalyan Avam Swasthya Mela”, these Health Melas are an instant and massive awareness campaign on public health services being rendered by the Government and non-government organisations and disseminate information on preventing various diseases. The uniqueness of these Mela as an approach is to provide composite healthcare facilities such as laboratory services, consultation, treatment and medicines under one roof, being provided with the help of specialised doctors and other healthcare professionals who come forward from various reputed medical colleges/institutions from across the country. The Health Melas have been organised in various parts of Uttar Pradesh as one of the RCH–II activities under the National Rural Health Mission. With a view to provide the target communities with opportunities to disseminate current ideas on health issues, these Melas usually are of three days and are being organised with the guidance of the MPs in their respective Parliamentary constituencies.

General Objective

To assess the Implementation and Utility of Health Melas in order to understand the socio-demographic characteristics of the beneficiaries, services available, the extent up to which the guidelines of the Government of India are being followed, the referral mechanisms and to identify the problems and challenges in organising these Melas.

Specific Objectives

- To provide quality healthcare services with converging and integrated delivery of services for all segments of population
- To sensitise people by putting a number of options before them in terms of different systems of medicine like Allopathy, Homeopathy, Ayurveda and Unani
- To comprehend the linkages between preventive, promotive, curative and rehabilitative healthcare as well as between the primary, secondary and tertiary health sectors, and
- To sensitise people about the roles of Central and state governments, elected local bodies, NGOs and professional organisations play in this.

METHODOLOGY

Study Area

This study was undertaken in the nine districts of Uttar Pradesh such as Banda, Jalaun, Unnao, Hardoi, Aligarh, Moradabad, Azamgarh, Basti and Sonbhadra.

Study Design: A rapid analysis of the Health Mela was conducted by a team which underwent vigorous training for collecting qualitative and quantitative information about the Melas. A cross-sectional design was adopted for the study.

Study Subjects

- Chief Medical Officers
- Mela Health Officers
- Health Care Providers at Health Melas
- Patients availing of Mela services
- Local leaders/PRI members/NGOs.

Sampling: To capture the variability amongst districts in the state, two districts each from the four geographical regions-- eastern, central, western and Bundelkhand, and one district from the Tribal belt were selected randomly. A total of nine Melas were studied in the state in about two months.

At each Mela site, exit-interviews of the beneficiaries and in-depth interviews of Mela in-charges were conducted. In addition, in-depth interviews of CMOs/District Nodal Officers, healthcare providers at the Mela site and of local leaders/PRI members/NGOs/CBOs were also taken. Records of previous Melas organised in these districts were also analysed.

SALIENT FINDINGS

- Ayurvedic, Allopathic and Homeopathic doctors are available at all Mela sites
- Staff nurses, paramedics and volunteers were available at all Melas in sufficient numbers
- More than 70.4% of the beneficiaries who visited the Melas are of more than 31 years of old
- Hand bills were the main source (18.9%) of information to the community about the Melas
- Majority (60.4 %) of beneficiaries visit the Melas to get the free medicines. In Moradabad and Azamgarh districts, the purpose is just to walk around (30% each).
- Majority (32.4%) of local leaders/PRI members/NGOs/CBOs get the Mela information from the media.
- Overall about 73.5% of the stakeholders are of the opinion that services provided at the Melas are better than at health centres
- Referral services are available at all the Melas studied
- Accessibility/approach to the Mela site is good at all places, however cleanliness is only good to satisfactory at various Melas
- The general enquiry and registration counters are available in almost all Melas and drug distribution is central at all the Melas under observation.

KEY RECOMMENDATIONS

- The Health Melas should preferably be organised in remote areas where accessibility to health services is difficult or is not available
- The Mela sites and dates should be fixed for every year in advance by the Government of India and should not change every year
- The referral services should be strengthened and be more effective
- Care should be taken for follow up of cases especially after surgery
- A strong communication strategy to motivate community to utilise the services at the Melas.

CHAPTER I

INTRODUCTION

The National Rural Health Mission (NRHM) promotes the Janani Suraksha Yojana (JSY) across the country to improve the proportion of institutional deliveries by providing cash incentives to the mothers who deliver in the institutions. The JSY is a safe motherhood intervention under the NRHM being implemented with the objective of reducing maternal and neonatal mortalities by promoting institutional delivery among the poor women and is being implemented across the country, but with special focus on the five low-performing states. It is a 100% Centrally-sponsored scheme and it integrates cash assistance with delivery and post-delivery care. One of the indicators of its success is to increase in institutional delivery among the poor families.

Madhya Pradesh has designed an innovative strategy to supplement this scheme known as the Vijaya Raje Janani Kalyan Bima Yojana (VRJKBY), which covers the BPL families and has a provision of delivery in private institutions; partially compensate the cost on Caesarean sections, abortions along with insurance in case of death following the delivery.

Operationalisation of VRJKBY

The state initiated an innovation in the JSY scheme in the form of VRJKBY since May 2006. The intention is to promote institutional deliveries and eventually reducing maternal mortality. As per the RGI estimates, MMR in the state was 379 in 2003. The main reason identified for high maternal deaths is high proportion of home deliveries by unskilled birth attendants in rural areas. The other reasons are low acceptance of ANC services and lack of timely identification of complications during the pregnancy. The scheme was applicable to all BPL women residing in the state.

The beneficiaries are offered the following services under this scheme:

- Rs 1,000 discount on Caesarean sections on a prefixed price in private hospitals
- Rs 1,000 in case of deliveries in government hospitals
- Compensation of Rs 50,000 in case of death during delivery or causes related to pregnancy/delivery
- Expenses for abortion of more than 16 weeks up to a maximum of Rs. 1,000.

If the patient wishes to avail of the services in private institutions, the scheme is available in only those hospitals which are accredited by the government and the beneficiary is required to present an ANC card verifying at least three ANC check -ups.

The scheme is being implemented by United India Insurance with its nodal office at Bhopal. The agency with its 100 field-level offices has ensured that the claims are settled in a timely manner. The state office is responsible for issuing the policy. The state government bears the cost of premium of Rs. 11 per family.

Rationale

Though the state has reported improvement in the proportion of institutional deliveries since the implementation of the VRJKBY, there is no recorded evidence for the same. Therefore, this study has been planned to assess the functioning of the VRJKBY so as to understand the influence of this scheme on the level and status of institutional deliveries and also to know the client satisfaction and other operational issues associated with the scheme with the following objectives:

General Objective

To analyse the process and performance of the VRJKBY.

Specific Objectives

- To assess the implementation of scheme against the laid down guidelines
- To identify the challenges faced in the implementation of the VRJKBY
- To assess the perception of the stakeholder towards the scheme
- To assess the trends in institutional deliveries over the past three years to capture the performance of the scheme, and
- To document the good practices, if any, under this scheme.

CHAPTER II

METHODOLOGY

Study Area

Gwalior and Guna districts of Madhya Pradesh.

Study Design

Study Type: A cross-sectional study design

Study Subjects

- Planners, (state officer in-charge);
- Policymakers and implementers- District Chief Medical and Health Officers (CMHOs), Block Medical Officers (BMOs), Medical Officers (MOs) of a Primary Health Centre, ANMs and AWWs;
- Community and PRI members, and
- Beneficiaries¹ and non-beneficiaries.

To elicit the perspective of the service providers, the state and district officials involved in the programme/implementation have also been selected for in-depth interviews.

The perspectives of the community has been assessed by a series of focus group discussions (FGDs) with the members of the Panchayati Raj Institutions (PRIs) and also of community leaders. A set of FGDs have also been conducted with the AWWs involved in the implementation of the scheme. The detailed break -up of the interviews and FGDs of CHCs in rural area is as follows:

Table 1: Detailed Break-up of IDIs and FGDs

Method	Target Population					
	Single District					
		Block 1	Block 2	Block 3	Urban	Total
In-depth Interviews	BMOs/Health facility in charge	1	1	1	1	4
	ANMs	2	2	2	-	6
	AWWs	2	2	2	-	6

Method	Target Population					
	Single District					
	Block 1	Block 2	Block 3	Urban	Total	
Beneficiaries	25	25	25	25	100	
Community leaders	-	-	-	2	2	
Non-beneficiaries	25	25	25	25	100	
Total	55	55	55	53	218	
FGD	PRI members	1	1	1	-	3
	Community leader	1	1	1	-	3
	AWW	1	1	1	-	3
Total FGD	3	3	3	-	9	

Duration

The study was conducted from August 2007 to December 2007.

Sampling Design

We have adopted a purposive sampling for this study.

Gwalior and Guna districts have been selected as representative of the population of M.P. While, the Gwalior district has relatively well-placed healthcare delivery system and infrastructure, high literacy etc., Guna does not have major health facilities with health indicators on the lower side.

In urban areas; one urban health facility located nearest to one urban poor habitation has been selected.

Data Collection Methods and Organisation of Field Work

Quantitative Method: A pre-tested semi-structured interview schedule has been designed for in-depth interviews. There have been separate sets of proformas for beneficiaries, non beneficiaries, planners, policymakers, implementers and community leaders. The FGD guidelines have been also prepared for smooth and organised functioning of the FGDs.

Quantitative Method:

(i) A desk review of the state and district specific -indicators institutional deliveries, ANCs etc have been adopted

(ii) Detailed study of the VRJKBY followed by the review of the policy framework for maternal healthcare and healthcare delivery in the state.

Quality Assurance

There are various measures for quality control of this study. The external experts and observation team have been present at the time of training of the data collection team. This team has been given hands-on practice too. At the time of data collection, almost 20% data collection have been supervised by the PI/Co PI at the field level. All the information collected has been cross checked for completion.

Data Analysis Plan

The data collated ha been analysed in following steps:

(I) The first step has been the analysis of the responses to a particular question to obtain a range of responses for all open-ended questions in the schedules. The process has been repeated for each categories.

(II) In the second step, a specific code has been given to every response. The code is given on the basis of the type of the response and under which category of question, it is falling.

(III) In the third step, all entry responses have been regrouped t o the code allotted of a response. There have been a few response not related to any study objective, and such response have been rejected and not included in the trial analysis.

(IV) The fourth step has seen the inclusion of quotes as general/common comme nts as and where appropriate.

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 Consideration

The Institutional Ethical Approval Committee of the NIHFV has approved the project.

CHAPTER III

FINDINGS AND DISCUSSION

As many as 436 IDIs and 18 FGDs have been conducted for the study. The necessary arrangements for interviewees are made prior to starting the interview. Therefore all participants have agreed for the interviews after informing them about the study and reason behind the in-depth interviews.

A data check for completeness has been done and none of the interviews has been rejected for lack of appropriateness.

Table 2: Total Data Collected

	Block 1	Block 2	Block 3	Urban	Total	Total 2
Beneficiaries	25	25	25	25	100	200
Non-Beneficiaries	25	25	25	25	100	200
AWWs/ANMs	4	4	4	-	12	24
MOs	1	1	1	1	4	8
Community Leaders	-	-	-	2	2	4

Awareness about the Scheme

Approximately half of the beneficiaries never heard about the VRJKBY. Almost all of the non-beneficiaries are unaware of the scheme. Although they are given the money at the health facilities, since there is another scheme of JSY running in the area, majority of the beneficiaries are concerned about getting some more financial incentives but they are not aware under what scheme, this money is being distributed.

Less than half of the AWWs/ANMs also do not know the scheme. Since they are the frontline workers who motivate the patients to avail of the benefits under any new scheme, their ignorance is discouraging because this is resulting into poor knowledge levels of both the beneficiaries and non-beneficiaries.

Table 3: Awareness about the scheme amongst the study participants

	Beneficiaries (25)	Non- Beneficiaries (25)	AWWs/ANMs (4)	MOs (1)	Total (55)
Gwalior					
Mihona	14 (56)	02 (8)	3 (75)	1 (100)	20 (36.4)

	Beneficiaries (25)	Non- Beneficiaries (25)	AWWs/ANMs (4)	MOs (1)	Total (55)
Bhitarwar	17 (68)	00 (0)	2 (50)	1 (100)	20 (36.4)
Dabra	16 (62)	00 (0)	2 (50)	1 (100)	19 (34.5)
Urban	11 (44)	01 (4)	-	1 (100)	13 (23.6)
Guna					
Bamhori	11 (44)	02 (8)	3 (75)	1 (100)	17 (31)
Badhera	09 (36)	04 (16)	4 (100)	1 (100)	18 (32.7)
Aron	14 (50)	02 (8)	2 (50)	1 (100)	19 (34.5)
Urban	15 (60)	02 (8)	-	1 (100)	19 (34.5)

Figure in parenthesis indicate percentages.

When the awareness about the provisions in the VRJKBY amongst stakeholders has been assessed, it has been found that the majority of the beneficiaries, ANMs/AWWs and MOs are aware of the cash provision, while only a few respondents across all categories are aware about the other benefits provided under this scheme. None of the beneficiaries interviewed in their project has taken advantage of any other benefits provided under this scheme.

Source of Information

The AWWs and ANMs are the main source of information for the beneficiaries. However, a limited number of people have got the information from doctors, newspapers and television etc because the AWWs/ANMs after receiving their incentives used to contact the expectant mothers early in the pregnancy. However, this has been more prevalent under the JSY scheme as the BRJKBY does not offer any additional benefit/incentive to the promoter for bringing in beneficiaries to the scheme resulting into poor dissemination of information at the end-user level.

Other major informants of the scheme are the health staff at PHCs and CHCs. However, there is very poor information dissemination through PRI members which shows that either they are not oriented on the scheme in a systematic and comprehensive manner or the scheme has been in operation only for a very short period resulting in limitations.

Table 4: Source of information for the beneficiaries in Gwalior district

District	Gwalior				
Block	Mihona (25)	Bhitarwar (25)	Dabra (25)	Urban (25)	Total (100)
AWWs/ANMs	22 (88)	20 (80)	23 (92)	14 (50)	79

District	Gwalior				
PHCs/Health Facilities	11 (44)	15 (60)	12 (48)	19 (76)	57
Neighbours	5 (20)	3 (12)	4 (16)	2 (8)	14
PRI/Community Members	2 (8)	4 (16)	6 (24)	4 (16)	16
Media	7 (28)	2 (8)	3 (12)	8 (32)	20
Others	12 (48)	5 (20)	11 (44)	15 (60)	43

*Multiple responses

Table 5: Source of information for the beneficiaries in Guna district

District	Guna				
Block	Bamhori (25)	Badhera (25)	Aron (25)	Urban (25)	Total (100)
AWWs/ANMs	22 (88)	24 (96)	21 (84)	17 (68)	84
PHCs/Health Facilities	08 (32)	11 (44)	12 (48)	15 (60)	46
Neighbours	5 (20)	02 (8)	06 (24)	02 (8)	15
PRI/Community Members	3 (12)	4 (16)	8 (32)	4 (16)	19
Media	3 (12)	5 (20)	5 (20)	11 (44)	24
Others	14 (50)	12 (48)	16 (64)	15 (60)	57

* Multiple responses.

Human Resources and Training

According to the implementers there has been no scarcity of manpower, though they are of the opinion that there is an urgent need for giving training to the health staff. The implementers also opine that since it's a government programme it involves a lot of paperwork and so it would be better if a separate post of a clerical staff is created to handle this.

The training component in this scheme is grossly missing. Even the staff are not fully aware of the benefits and provisions of the scheme resulting in their poor convincing powers with the prospective clients. Therefore, the staff feel that it would be better if an orientation training programme can be arranged before the scheme is being rolled out.

Similarly, there is major lack of knowledge about the scheme amongst both PRI members and community leaders, and they confuse with this scheme with the JSY scheme. At best they have heard the name of the scheme. Nearly all the community

leaders and PRI members feel that even they should be actively involved in the planning of implementation of this scheme and should be given necessary training.

The implementation guidelines are made available at all the health facilities. However, none of ANMs/AWWs interviewed have ever seen such documents.

Target Group Discussions and their Management

There are a lot of difficulties in the identification and mobilisation of the beneficiaries for this scheme. Almost all of the health staff at each level feel that a number of pregnant mothers in the community, who are actually very poor, cannot be given the benefits under this scheme as they do not have the BPL cards or are either not issued or are in the process of making it. Almost all the community leaders have complained that the BPL cards are not being issued to a lot of people who are actually poor.

Since the BPL card is a “must” criterion for eligibility to avail of the scheme and the cards are not issued to many BPL families a majority of the community members and non-beneficiaries suggest that the criteria be either SC/ST population or the scheme introduce some alternative criterion for selecting the beneficiaries. as the benefit of this scheme is not reaching to many real BPL people.

Coordination

Due to the provision of cash incentives to the promoters under the JSY scheme, there are some incidences/reports of quarrel between ASHAs/AWWs because both claim to have worked as promoter for single beneficiary. The coordination at the village level is missing and this is reflected in the VRJKBY too. However, there is smooth facilitation of the deliveries under the scheme at the health facility level.

Inter-sectoral Coordination

The health staff at the facilities are often overwhelmed by the number of ANC clinic attendees and deliveries at the health facility. There is often no separate discussion about this scheme as this is considered to be a part of the JSY only. Some beneficiaries also have complained of the staff demanding money before releasing the cash incentives under this scheme.

Social Mobilisation and Communication Efforts

The awareness in the society about this scheme is missing. Even AWWs in some areas are not aware of the scheme. And what is more disheartening is that no special efforts have been to do the IEC campaigns to promote it. Community members (both

beneficiaries and non-beneficiaries) feel that there should be better information dissemination to the community so that more number of people can utilise this scheme and they suggest that wall paintings could be used for this as this is one of the most effective promotional media in villages.

Community Participation

The Panchayati Raj Institution members are largely not aware of this scheme. Their participation is limited or almost nil in the scheme. There is no involvement of NGOs or any other SHGs/CBOs also in the scheme. Community members, whosoever are aware of the scheme promoted the beneficiaries to go for institutional delivery.

Client Perspective

The majority of the clients used to get full information about the scheme only when they reach the health facilities. Occasional contacts are made by AWWs, however, even during their visits, the emphasis is on the institutional deliveries.

The villagers are also not also unaware of the other benefits/facilities provided under this scheme. A few of the mothers have complained that health facility where delivery facility is available is far away from their home, however, adding that the availability of the Janani Express Yojna vehicle has simplified the issue.

Majority of the clients report that a lot of money is spent on various transport related and health issues related expenditure on the mother.

Positive Reasons

The majority of the beneficiaries are given the monetary benefit under this scheme. They also do not have any knowledge about other benefits. Almost everybody says money as the best provision under this scheme.

“We get money, which is useful for the expenditure related to the mother,” said a woman.

There are cases when family has taken some debt for pregnancy -related expenditure. This debt is repaid once they get money from the scheme.

“It’s good, definitely, we should be given money,” said another woman.

Amount of money disbursed

The beneficiaries have admitted to receiving cash/cheque in the range of Rs. 1,000 to 2400, from both the VRJKBY and the JSY going on in the area. More important, the whole amount is given in one go.

Therefore, we could not clarify under what head this money has been given. However, simple variation in the amount of money distribution (as different people received dissimilar amount of money Rs. 1,000, Rs. 1,100, Rs. 1,300, Rs. 1,400, Rs. 1,700, Rs. 2,000 and Rs. 2,400 reflects that there has been no problem or discrepancy in the distribution of money.

“We got only Rs. 1,300, while a women in our area received Rs. 2,000,” complained a woman.

Table 6 : Amount of money given to beneficiaries

Amount of money	Gwalior (100)	Guna (100)	Total (200)
1,000	28	13	41
1,001-1,299	06	14	20
1,300-1,599	11	39	50
1,600-1,899	10	07	17
1,900-2,199	03	02	05
2,200-2,400	42	25	67

The mode of distribution is either cash or cheque. The cheque used to be issued by the MO and could be encashed at specified nationalised bank. There is no need of having an account in the bank as cheques is not an account payee one. The time period for the distribution of money is at the time of discharge to one month. The median time in the process is one week.

Funds Flow

The money used to be sent to the person concerned from the office of the State Directorate of Health Services. The CMHOs used to allocate these funds to the respective CHCs and then to the PHCs concerned.

The performance of the scheme is dependent on the funds availability. At one PHC in Gwalior, Rs. 30,000 only has been allocated under this scheme. Therefore, the benefits of the scheme were given to first 30 eligible women till mid -September 2006. Even though,

the scheme was running in the state, the beneficiaries could not be enrolled from that PHC after that period as there were no funds available.

Similarly at another PHC, where the scheme was running, the MOI/c distributed the fund from “flexi pool” available expecting that government would repay the amount. However, the funds were not reimbursed by the government and he had to give explanation on why money was spent in this scheme, when funds were not available.

Utilisation of the Money by Beneficiaries

The money disbursed was kept by the women herself, in majority of the cases in rural areas. However, this money was kept by husband and in-laws in some cases. Most of such cases came from urban sites.

Table 7: Who used the Money?

	Gwalior		Guna	
	R	U	R	U
Self	3+	3+	1+	2+
Husband	<1+	1+	2+	1+
Others	1+	<1+	1+	1+

The beneficiaries reported of having this money spent on the medicines and treatment of common illnesses for both mothers and the newborn. Only a few utilised money for family purpose or saved it for the future. The most common use of the money on medicines and on the treatment followed by the diet and nutrition of the mothers.

Table 8: Utilisation of money received by beneficiaries

	Gwalior		Guna		Total	
	R	U	R	U	R	U
Diet of the mother	3+	4+	3+	3+	3+	3+
Medicines	<1+	1+	1+	1+	1+	1+
Debt Service	2+	2+	3+	1+	3+	2+
Saving	4+	2+	3+	2+	3+	2+
Grocery	<1+	1+	1+	1+	1+	1+

*There were expenditures on multiple heading.

Negative Reasons

The people got tired of the paper work involved in the scheme and the number of repeated visits for collecting the money. Following are some quotes from the beneficiaries of this scheme:

“One woman didn’t get any money in spite of the Anganwadi worker running here and there for money and having made lots of efforts. ”

“If documents were complete then only the money was given. However, if documents were not complete, only a part of the money was given. Moreover, they deducted money.”

“Too many documents were required and the beneficiaries had to wander here and there for signatures. ”

“If the BPL card was not there, no money was provided despite the mother being in the BPL family. ”

“The cash incentive promoted more pregnancies amongst Tribals. If they got money the pregnancy rate would increase in that area. ”

“The Government was giving money to the poor but functioning of scheme was not being done properly. ”

“Rich people were having BPL cards but the poor don’t. Moreover, we had to spend around Rs. 400 - 500 to get the card issued. ”

Reasons for Non-utilisation

The study helped in the review of the performance of this scheme in the two districts. Although, the scheme was time-bound in design, the process also helped in understanding of the problems and constraints in this scheme.

The majority of the non-beneficiaries could not utilise it because the possible beneficiaries were not aware about this scheme. Other common reason was non-availability of the BPL card with the targeted beneficiaries. The third reason was that although the mother was registered at the health facility, the delivery happened at home, during the night or when there was nobody to accompany her to the health facility.

Table 9: Reasons for Non-utilisation

Reason	Gwalior (n=100)	Guna (n=100)	Total (N = 200)
No information about scheme	82%	68%	74%
Deliveries happen at home	15%	9%	12%
Non-available of the BPL Card	34%	44%	39%
Hospital is far away	15%	21%	18%
Delivery in private hospitals	08%	03%	10.5%
Non-availability of doctors at PHCs	02%	04%	03%

*Multiple responses.

Implementer Perspective

The AWW/ANM was supposed to have played key role in the implementation of this scheme. However, only a limited few were aware of the scheme. And those who knew about the scheme, their knowledge was restricted to the cash incentives and the insurance plan. Nearly all of them were confused regarding the JSY and VRSKBY. Though they mentioned about the insurance, they could not provide any information about this component. This lack of information about the scheme prevented them from giving any useful suggestions for the improvement in the scheme.

Monitoring and Supervision

The monitoring of the programme was integrated with other health programmes. There were no separate efforts to ensure to record the performance of the programme.

Programme Performance

The information about the total number of ANC registration, institutional deliveries and total beneficiaries under VRJKBY was also collected for the preceding year and in the year in which the scheme was implemented. The information was collected in monthly format. It was noticed that there was only slight increase in the number of total registrations and institutional deliveries in all the four study sites in both the districts. However, this difference was not found to be of statistical significance. It might have happened as the JSY was already going on prior to the start of the VRJKBY and the

most of the eligible beneficiaries were already included under the JSY. The overall institutional delivery rate had already increased by the ongoing JSY, and hence the VRJKBY did not bring any significant change.

CHAPTER IV

RECOMMENDATIONS

Policy

The VRJKBY was a good scheme, targeted at the BPL population to increase the institutional delivery. It was well-recognised and realised that the underserved and the marginalised people should be given extra benefits to increase their participation in the health schemes.

Programmatic Implications

Health Schemes

The VRJKBY was good scheme where BPL population was being given additional benefits besides the package in the JSY. This kind of schemes should be promoted. But there should not be two separate schemes on the similar pattern. Both the schemes had cash incentives. However, the VRJKBY could not be promoted as the target population could not be delivered correct and complete information about the scheme. The aim should be awareness generation amongst the target population.

Planning

- The planning should be done with all stakeholders including the possible beneficiaries
- There should be sufficient budgetary allocation for IEC for any such scheme. The planning of IEC activities and mode to reach to the targeted population should be the part of the implementation plan
- For all such schemes, and non-initial orientation training should be given to the scheme implementers. Community leaders, PRI members and NGOs should also be an integrated part of such schemes.
- The monitoring and evaluation components are often missing from government programmes. This should be inbuilt into the scheme.
- The review of the planning should be done on monthly and quarterly basis. There are examples in the VRJBKY, where the allocated funds for a PHC finished within three months of the programme implementation. After that the scheme was going on in that area but the eligible people did not get the stipulated benefits. After the review, the remedial measures must be taken.

Demand side/Community/PRI level issues

The community leaders and PRIs should be involved in the planning and awareness generation about the scheme. However, the community perspective shows that the PRI should have limited role in implementation.

Issues related to Sustainability

The BPL card as an eligibility criterion is a big hurdle in the implementation of the scheme. People who are actually poor, do not have the BPL card due to various reasons and hence care automatically excluded from the ambit of the scheme. This criterion should either be made according to socioeconomic conditions irrespective of the ownership of BPL card or any alternate mechanism for identification of the BPL population should be devised.

There should be transparency in the disbursement of the money to beneficiaries.

Limitations in the design or conduct of the study

Since this is a community-based cross-sectional study with purposive sampling, an in-built mechanism for evaluation may provide better understanding of the programme.

Future Directions of Research

With the increasing number of people coming to avail of the benefits of the JSY, a study to assess health systems preparedness in meeting the enhanced demand of services is the appropriate area of future research.

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