

# AN APPRAISAL OF JANANI SAHYOGI YOJANA IN MADHYA PRADESH

## Chief Investigator

Prof. Deoki Nandan  
Director  
National Institute of Health & Family Welfare

## Study Team

NSCB Medical College, Jabalpur, M.P.

Dr. D. K. Pal  
Dr. Neelam A. Toppo

National Institute of Health & Family Welfare

Dr. Y.L. Tekhre  
Prof. J. K. Das  
Mrs. Vandana Bhattacharya  
Dr. S. Menon



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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 feed back 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 NIHFWS. The faculty of the NIHFWS 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 Appraisal of Janani Sahyogi Yojana in Madhya Pradesh”** by the Department of Community Medicine, Netaji Subhash Chandra Bose Medical College, Jabalpur, M.P. 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.

Dr. Dinesh Agarwal  
National Programme Officer, UNFPA

Prof. Deoki Nandan  
Director, NIHFWS

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We are grateful to the Dean of NSCB Medical College, Jabalpur for giving us permission and all the necessary support in conducting this study. Also, we express our gratitude to all our colleagues and Postgraduate students who participated and extended their help to finish this task. We are also grateful to our respondents in this research without whose cooperation the study would not have seen its completion.

Dr. D. K. Pal  
Professor and Head  
Department of Community Medicine  
NSCB Medical College, Jabalpur, M.P.

## ABBREVIATIONS

NC	Antenatal check up
ASHA	Accredited social health activist
AWW	Anganwadi worker
BCC	Behaviour change communication
BPL	Below poverty line
CMHO	Chief Medical and Health Officer
CS	Caesarean section
CMES	Centre for Maternal Emergency Services
FA	Field associates
IDI	In-depth interview
IMR	Infant mortality rate
IFA	Iron folic acid
JSY	Janani Sahyogi Yojana
MCH	Maternal and child health
MMR	Maternal mortality rate
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
NHP	National Health Programme
PSP	Private Service Provider
PNC	Postnatal check-up
PRI	Panchyati Raj Institution
PI	Principal investigator
RAHI	Rapid Assessment of Health Interventions
RGI	Registrar General of India
SRS	Sample Registration System
T.T.	Tetanus Toxoid
UNFPA	United Nations Population Fund

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## EXECUTIVE SUMMARY

The Janani Sahyogi Yojana (JSY) was implemented in Madhya Pradesh to understand the public-private partnership as a viable option to increase institutional deliveries and thereby reduce the prevailing high maternal mortality rate.

### General Objective

To assess the functioning of the JSY scheme in the four districts of the state and to review the operational mechanism and usage status of the scheme.

### Methodology

#### Study Area

An appraisal of the JSY scheme was done in the four districts of Bhopal, Indore, Jabalpur (with Katni) and Chhindwada (with Betul) in M.P.

#### Sample Size

From each district one CMHO, eight private service providers (PSPs) and 25 beneficiaries were selected for the study sample. Thus the total study sample was four CMHOs, 32 PSPs, and 100 beneficiaries of the scheme. As there were less than eight functioning PSPs in Jabalpur and Chhindwada districts, hence the adjoining districts of Katni and Betul were included to complete required the sample size of 8 PSPs.

Structured interview schedules were designed for each stakeholder. The field work was completed in two months.

### Key Findings

The data show that majority of PSPs fulfilled the accreditation criteria under the JSY. However, in some PSPs, particularly in rural areas, some relaxation was given for provision of laboratory services, blood banks and emergency care for sick children. Specialists (e.g. paediatricians, or gynaecologists or anaesthetists) were not full-time in PSPs but their services were availed of by PSPs as and when required.

Most of the beneficiaries are in the 21-25 age group (54%), less educated (primary 24%, middle 24% and illiterate 19%) and belong to the socio-economic class IV (48%). Almost all (97%) of beneficiaries are satisfied with the quality of services (87%) provided by PSPs.

### The salient findings of the study are the following:

- Performance of PSPs under the scheme ranges from poor to very good. The PSPs who adopted multiple motivational strategies like meetings with ASHAs/ AWWs, offering

free OPDs for BPL patients, publicity through media etc. are successful in getting more cases compared to those who did not adopt such strategies. Moreover, publicity through patients themselves as per their experiences must have contributed to the success of some PSPs in some districts.

- In Bhopal and Indore districts motivation charges for institutional deliveries (as paid in JSY) are also being given to ASHAs/AWWs. This strategy has been very effective in increasing the institutional deliveries in private hospitals, thus meeting the objective of the scheme.
- Caesarean section rate among BPL patients is not higher than non-BPL group thus indicating that BPL patients are not unnecessarily being forced for Caesarean sections for the want of money.
- However, the percentage of Caesarean sections in most of the districts is higher than the accepted average of 8%. This may be indicative either of a high percentage of the patients opting for elected Caesarean sections or a very high percentage is driven by bigger monetary benefits to PSPs if they carry out surgical procedures on these patients.

### **Key Recommendations**

- The scheme should continue in future as it has expanded the choice and accessibility of services for the BPL people. More effort should be made to encourage private sector participation in the scheme so that it can bring about an increase in institutional deliveries and thereby decrease maternal mortality rate.
- Provision for motivational benefit to motivators (ASHAs/AWWs), establishment of call centre initiatives including ambulance services to emergency maternity services, relaxation in the criteria to select rural PSPs to cater to the needs of rural people and if a rural PSP doesn't have Caesarean section services, in such cases they should be recognised only for normal deliveries and MTP services.
- Improve the dialogue/communication between CMHOs and PSPs to strengthen the partnership as well as help in identification and rectification of the problems faced by PSPs.
- Efforts should be made to increase the awareness of the scheme among the targeted beneficiaries by the government as well as the PSPs through appropriate IEC strategies.
- Develop a specific scheme monitoring tool for its effective implementation.
- Develop behaviour change communication strategies to about bring positive and sustainable change among BPL beneficiaries.
- Necessary modifications like re-evaluation, should be done on every three years periodicity to improve the effectiveness of the scheme.

# CHAPTER-1

## INTRODUCTION

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

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

### Operationalisation in the State

The JSY has been going in the state since October 15, 2006 with the objective of increasing the availability of delivery and newborn care services through PSPs for BPL families.

### Essential Features

Private and non-government hospitals are invited to render services in delivering safe motherhood and child healthcare to the BPL families under the Reproductive and Child Health Programme II.

### PSPs<sup>1</sup> Selection Criteria

- Availability of gynaecologist, anaesthetist, paediatrician.
- Minimum bed strength of 20-30, and 10-12 beds for remotely located and inaccessible places.
- Fully equipped and functional operational theatre.
- Well equipped labour room.
- Separate area for newborn care and delivery room and ward.
- Functional pathological laboratory where essential tests may be performed.
- Round the clock availability of water.
- Availability of power for running operation theatre, labour room and cold chain.
- Availability of inverter/generator for uninterrupted power supply.

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<sup>1</sup> Private Service Provider (PSP): A private hospital accredited under the Janani Sahyogi Yojana as per its guideline and functioning since last 6 months.

- Telephone.
- Ambulance (owned/rented).
- Blood storage facility (desirable).

Initially the accredited hospitals were remitted for the following services:

### **Delivery Services**

- Normal delivery: Rs. 800.
- MTP/spontaneous abortion: Rs. 300.
- Caesarean Section: Rs. 4,530.
- Blood transfusion: Rs. 500.

### **Newborn Care Services**

- Baby warmer: Rs. 50/day
- Phototherapy: Rs. 50/day
- Paediatric care: Rs. 50/day
- Low birth weight/pre-term baby: Rs. 250/day

Initially, the scheme was intended for BPL families through rural PSPs, but due to being a few in number or their complete absence or not fulfilling the criteria of accreditation, urban PSPs were included in the scheme. Monetary compensation was provided to the beneficiaries with changing rules at different times and modes of operation of funds.

**The accredited hospitals are now remitted for the following services (Present charges):**  
**Delivery Services**

- Normal delivery: Rs. 1,200
- MTP/Spontaneous abortion  
Up to 8 week: Rs.500  
Up to 8– 12 weeks: Rs. 750
- Caesarean Section: Rs. 5,500
- Blood transfusion : Rs. 750 per unit

### **Newborn Care Services**

- Baby warmer: Rs 50/day
- Phototherapy: Rs. 50/day
- Paediatric care: Rs. 50/day
- Low-birth weight/pre-term baby: Rs. 250/day

Initially, when the scheme was started, there was only a provision for reimbursement for the services provided to BPL beneficiaries. However, later, monetary compensation was also started for institutional deliveries in private hospitals. To improve participation of the private

sector i.e. Bhopal and Indore, motivation charges were also given to ASHAs/AWWs for motivating BPL beneficiaries for institutional deliveries in PSPs.

When started, the JSY was targeted at BPL beneficiaries who had only two children. But now, this has been revised and the benefit is given to all beneficiaries irrespective of parity. Again, there was no provision for providing advance money to PSPs initially, but now against a bank guarantee, advance money can be given to PSPs. Initially complicated delivery (Eclampsia, Breech delivery, cord prolapse, forceps delivery etc.) was included but discontinued later.

### **Need for the Study**

This study was planned to assess the outcome of the JSY and to identify the operational bottlenecks so as to understand whether public-private partnership is a means to increase institutional deliveries and to decrease maternal mortality rate. This study would enable timely modifications in the processes of this scheme.

### **Study Objectives**

#### **General Objective**

To assess the functioning of the scheme in the four districts of M. P.

#### **Specific Objectives**

- To assess the proportion of PSPs fulfilling the selection criteria.
- To assess the proportion of BPL families out of total deliveries conducted at PSPs.
- To determine the Caesarean section rate among BPL families and compare it with non-BPL families.
- To analyse adequate coverage of ANC and PNC care under the JSY.
- To understand the mechanism of payment to PSPs as well as to beneficiaries under this scheme.
- To assess the satisfaction level among BPL families who avail of PSPs for delivery.

## **CHAPTER-II**

### **METHODOLOGY**

#### **Study Area**

Bhopal, Indore, Jabalpur (with Katni), Chhindwada (with Betul) in M.P.

#### **Study Design**

#### **Type of Study**

Descriptive Study

**Study Subjects:** The following stakeholders are the subjects of this study:

#### **4 Districts\*:**

1. 32 PSPs from six districts (2 neighbouring districts have been added to complete the sample of 32 PSPs, 25-50% PSPs).
2. Six CMHOs.
3. 100 beneficiaries availed or availing of services from PSPs.

(\* A district is characterised where at least eight PSPs are functioning, in case of less than eight functioning PSPs in the district, the adjoining district is included to complete eight accredited PSPs)

#### **Sampling Design**

#### **Selection of District<sup>2</sup>:**

The JSY was initiated in all 48 districts of M.P., but due to lack of sufficient accredited private hospitals under this scheme, only those districts were selected which has PSPs been functioning for at least six months.

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<sup>2</sup> District: A district means where at least 8 PSPs are functioning, in case there less than 8 functioning PSPs the adjoining district is included to complete 8 accredited PSPs.

### **Selection of CMHOs/District Nodal Officers**

Chief Medical and Health Officers/ADMOs of the districts concerned qualified as respondents.

### **Selection of PSPs**

Thirty-two PSPs from six ( two neighbouring districts were added to complete the sample of 32 PSPs) districts of MP (25-50% PSPs). Out of 32, eight PSPs which have been functioning since last six months were selected from each district.

### **Selection of Beneficiaries<sup>3</sup>**

A list of beneficiaries who underwent institutional deliveries and availed of services from accredited PSPs under JSY in the last one year were selected randomly from the six selected districts so as to have 25 beneficiaries per district and 100 beneficiaries from six districts.

**Table 1: Sample Size, Tools and Techniques used for Data Collection**

<b>Stakeholders</b>	<b>Number</b>	<b>Data Collection Method and Tools</b>
Beneficiaries of JSY	100 ( 25 per districts)	Interview - structured schedule
CMOs/District Nodal Officers	6 ( 1 per district)	Interview- In-depth interview checklist
PSP in-charge	32 ( 8 per district)	Interview-In-depth interview checklist  Desk review of selected 32 PSPs– Checklist

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<sup>3</sup> Beneficiaries: Women in the reproductive age group (15-45 years) who availed of the benefits of JSY

**Table 2: Selected Districts and PSPs under Study Area**

<b>Sl. No.</b>	<b>District</b>	<b>PSPs</b>
1.	<b>Bhopal</b>	<ul style="list-style-type: none"><li>• Metro Hospital</li><li>• Faith and Hope Hospital</li><li>• Peoples' Hospital</li><li>• Mayo Hospital</li><li>• Niramay Hospital</li><li>• Paliwal Hospital</li><li>• Tripti Hospital</li><li>• Surya Clinic</li></ul>
2.	<b>Indore</b>	<ul style="list-style-type: none"><li>• Amol Hospital</li><li>• Roberts' Hospital</li><li>• Geeta Bhawan Hospital</li><li>• Radha Bhawan Hospital</li><li>• Khandelwal Hospital</li><li>• Aastha Hospital</li><li>• Asha Deep Hospital</li><li>• Life Care Hospital</li></ul>
3.	<b>Jabalpur</b>	<ul style="list-style-type: none"><li>• Hindustan Hospital</li><li>• Prachi Bhatnagar Hospital</li><li>• Jamdar Hospital</li><li>• Anant Hospital</li></ul>
4.	<b>Katni</b>	<ul style="list-style-type: none"><li>• Bajaj Hospital</li><li>• Gupta Nursing Home</li><li>• Shree Hospital</li><li>• MGM Hospital</li></ul>
5.	<b>Chhindwada</b>	<ul style="list-style-type: none"><li>• Khadatkar Nursing Home</li><li>• Sukri Mission Hospital</li><li>• Mamta Maternity Hospital</li><li>• Vansh Nursing Home</li><li>• Sthapak Heart</li></ul>
6.	<b>Betul</b>	<ul style="list-style-type: none"><li>• Padhar Mission Hospital</li><li>• Maternity and Hurgical Hospital</li><li>• Arogya Niketan Nursing Home</li></ul>

## Study Duration

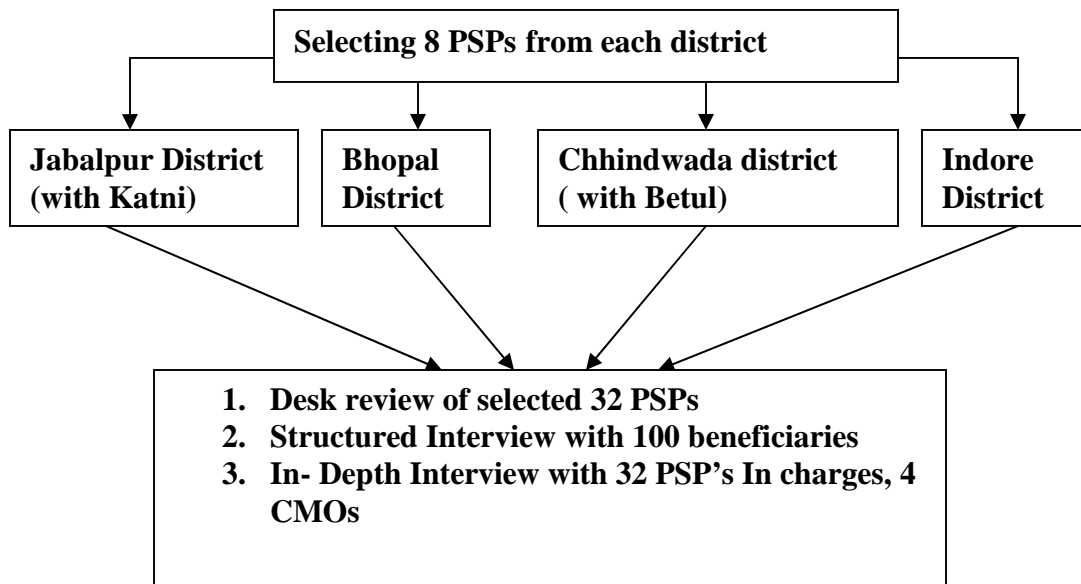
September to November 2007.

## Data Collection Methods and Field Work

### Plan for Data Collection

Developed the questionnaire guide

Training of the team members on interview techniques



Nine IDIs with eight PSPs and one CMO/District Nodal Officer and 25 beneficiaries conducted in each district. To ensure the quality of data, two teams of two investigators and a supervisor were formed. Each team was responsible for two districts. Each team covered one district in 10 days. The principal investigator and Co-PIs were responsible for monitoring the quality of the collected data along with a central monitoring team.

Both primary as well as secondary sources were used for data collection. Primary data were collected from beneficiaries of the scheme, PSPs in-charge and CMHOs, while the secondary data were collected from available reports and records at PSPs and CMHO' office at district level regarding the operational mechanism and usage of the scheme.

All the data collected were triangulated to have a clear idea of the findings at the time of analysis.

## Quality Assurance

The entire project was monitored and supervised by the principal investigator (PI) and Co - PIs. They monitored the quality of the collected data in the field by being present in 50% of the interviews at all levels. The PI and Co-PI personally conducted the IDIs of CMHOs and PSPs in-charge. The central monitoring team from NIHFV closely monitored the field activities and provided all guidance on data analysis and report writing.

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

## Data Analysis Plan

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

### 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 Review Board of the Ethical Committee of NIHFV for ethical considerations.

## CHAPTER-III

### FINDINGS AND DISCUSSION

The collected data were analysed as per the objectives of the study using various statistical techniques. Some univariate and multivariate tables were generated using the SPSS 13 software. Results were used to interpret the findings which may be useful for the programme.

**Table 3 : Distribution of PSPs in study areas**

S.no.	Districts	Urban		Rural		Total	
		No.	%	No.	%	No.	%
1	Bhopal	34	94.44%	2	5.55%	36	100%
2	Indore	20	86.95%	3	13.04%	23	100%
3	Jabalpur	8	100%	0	0%	8	100%
4	Katni	6	100%	0	0%	6	100%
5	Chhindwada	5	71.42%	2	28.57%	7	100%
6	Betul	2	66.66%	1	33.33%	3	100%
	<b>Total</b>	<b>75</b>	<b>90.36%</b>	<b>8</b>	<b>9.63%</b>	<b>83</b>	<b>100%</b>

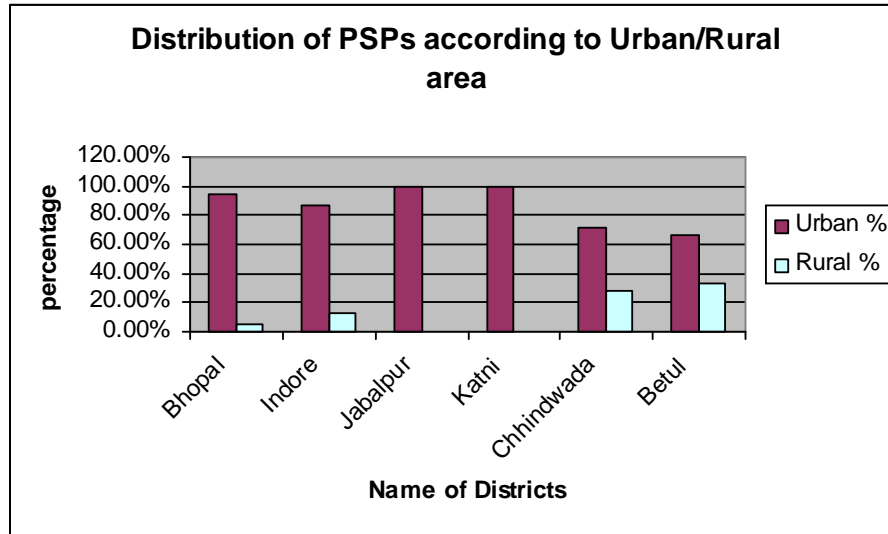


Table indicates that total the number of PSPs in the districts are 83, out of this, 75 (90.36%) are urban and 8(9.63%) are rural. Though this scheme was intended to increase institutional deliveries among BPL population and majority of BPL population live in rural areas, there are very few PSPs in the rural belt. The reason may be that rural PSPs are not fulfilling the eligibility criteria of the scheme and some might have withdrawn in between. For better participation of rural PSPs further relaxation in selection criteria may be required.

## Proportion of PSPs fulfilling the criteria of selection

**Table 4: PSPs fulfilling the criteria for mandatory services**

S.No.	Mandatory Services under the Scheme	PSPs Fulfilling the Criteria		PSPs not Fulfilling the Criteria	
		No.	%age	No.	%age
1.	ANC /PNC care	32	100%	0	0%
2.	Routine Immunization for pregnant women and children	23	71.87%	9	28.12%
3.a.	24 hrs. normal delivery services	32	100%	0	0%
3b.	24 hrs. assisted delivery services	32	100%	0	0%
4a.	Parental antibiotics for management of common obs. Care	31	96.87%	1	3.12%
4b.	Parental oxytocines	32	100%	0	0%
4c.	Parental sedatives/anticonvulsants	32	100%	0	0%
4d.	Manual removal of placenta	32	100%	0	0%
5.	Early and safe abortion services	27	84.37%	5	15.62%
6a.	IUD insertion	17	53.12%	15	46.87%
6b.	Provision of OCP, condom, Emergency Pill	30	93.75%	2	6.25%
6c.	T.T	27	84.37%	5	15.62%
6d.	V.T.	29	90.62%	3	9.37%
6e.	T/t of RTI/STI	19	59.37%	13	40.62%
7.	Newborn care	32	100%	0	0%
8.	Emergency care of sick children	26	81.25%	6	18.75%
9a.	Hb Estimation	27	84.37%	5	15.62%
9b.	Blood grouping and testing	27	84.37%	5	15.62%
9c.	BT, CT	27	84.37%	5	15.62%
9d.	Urine albumin and sugar	27	84.37%	5	15.62%
10.	Caesarean section and laprotomy	31	96.87%	1	3.12%
11.	Blood transfusion services	20	62.5%	12	37.5%

In all the PSPs the delivery related services are found to be adequate. But critical ANC services like pathological testing is absent in around 15% of the PSPs. Routine immunization of the mother and child are not available in 28% of the PSPs. Ready and available blood transfusion services which are required in majority of complicated deliveries and constitute a major of reason for high percentage of maternal mortality are missing in 37.5% of PSPs. Similarly, safe abortion facilities are also missing in 15% of the PSPs. Absence of services like IUD insertion, which is of national priority, are missing in as much as 46% of the PSPs and RTI/STI treatment is also missing in around 46% of the PSPs.

Since even in the relatively bigger hospitals, essential pathological tests are generally outsourced, a similar arrangement in accredited PSPs can solve the problem of lack of

testing. Critical maternal mortality drivers like lack of blood transfusion services and lack of safe abortion facilities can be overcome by linking these PSPs to district blood banks. Training to service providers in PSPs on D&C as well as small grants for essential abortion equipments, if required, can be considered on case to case basis. The IUD insertion can be enhanced by provisioning of free latest CopperTs to the facilities along with training for STI/RTI treatment facilities, the service providers can be trained on syndromic management guidelines by NACP III functionaries in these districts.

**Table 5: PSPs fulfilling the criteria for mandatory infrastructure facilities**

S.No.	Mandatory Infrastructure Facilities under the Scheme	PSPs Fulfilling the Criteria		PSPs not Failing the Criteria	
		No.	%	No.	%
1.	Minimum bed strength (20-30)	32	100%	0	0%
2a.	Table	32	100%	0	0%
2b.	Oxygen cylinder	32	100%	0	0%
2c.	Anaesthetic boyles	27	84.37%	5	15.62%
2d.	Vain circuit	25	78.12%	7	21.87%
2e.	Nitrous cylinder	26	81.25%	6	18.75%
2f.	suction Machine	31	96.87%	1	3.12%
2g.	Ambu beg	32	100%	0	0%
2h.	Endotracheal tube	32	100%	0	0%
2i.	Laryngoscope	32	100%	0	0%
2j.	spinal needle	32	100%	0	0%
2k.	Hand warmer	25	78.12%	7	21.87%
2l.	Vantous	16	50%	16	50%
2m.	USG	24	75%	8	25%
2n.	Pulse oxymeter	28	87.5%	4	12.5%
3.	Labour room with toilet	31	96.87%	1	3.12%
4.	Wards with toilet	32	100%	0	05
5.	Area ear marked for newborn care in labour room (Warmer, infant feeding tube)	30	93.75%	2	6.25%
6.	Regular 24 hrs water supply	32	100%	0	0%
7.	Functional lab facility	29	90.62%	3	9.37%
8.	Regular electricity supply with backup (Inverter/generator)	32	100%	0	0%
9a.	OT table	32	100%	0	0%
9b.	OT light	32	100%	0	0%
9c.	Suction machine for baby and mother	32	100%	0	0%
9d.	Boyles apparatus	31	96.87%	1	3.12%
9e.	Autoclave	32	100%	0	0%
9f.	Sterilised gown	32	100%	0	0%
9g.	Gloves	32	100%	0	0%
9h.	Linen	32	100%	0	0%
9i.	Baby resuscitation kit	32	100%	0	0%

9j.	Baby warmer	31	96.87%	1	3.12%
9k.	Endotracheal tube	32	100%	0	0%
9l.	Oxygen cylinder	32	100%	0	0%
9m.	Laryngoscope	32	100%	0	0%
9n.	Drugs for resuscitation	32	100%	0	0%
9o.	Coutery	31	96.87%	1	3.12%
9p.	Scissors	32	100%	0	0%
9q.	Portable sonography machine	22	68.75%	10	31.25%
9r.	Vantouse	14	43.75%	18	56.25%
10a.	OT table	32	100%	0	0%
10b.	OT light	32	100%	0	0%
10c.	Suction machine for mother	32	100%	0	0%
10d.	Boyles apparatus	31	96.87%	1	3.12%
10e.	Autoclave	32	100%	0	0%
10f.	Sterilised gown	32	100%	0	0%
10g.	Gloves	32	100%	0	0%
10h.	Linen	32	100%	0	0%
10i.	Resuscitation kit	32	100%	0	0%
10j.	Endotracheal tube	32	100%	0	0%
10k.	Oxygen cylinder	32	100%	0	0%
10l.	Laryngoscope	32	100%	0	0%
10m.	Emergency laprotomy facility	32	100%	0	0%
10n.	Blood availability	16	50%	16	50%
10 o.	Donors list for blood donation	10	31.25%	22	68.75%
11.	Telephone connection	32	100%	0	0%
12.	Ambulance (owned or locally hired)	31	96.87%	1	3.12%
13.	Proper arrangement for waste disposal	28	87.5%	4	12.5%
14.	Blood storage facility (optional)	16	50%	16	50%

The table shows that most of the PSPs are fulfilling most of the criteria for mandatory infrastructure requirements. However, availability of blood and absence of blood storage facilities in 50% of the PSPs and lack of lists of the voluntary donors near the facility in 68% of the units is very significant and needs urgent intervention by the planners.

**Table 6: PSPs fulfilling the criteria for mandatory supplies and equipments**

S.No.	Mandatory Supplies and Equipments	PSPs Fulfilling the Criteria		PSPs not Fulfilling the Criteria	
		No.	%	No.	%
1a.	(Normal delivery kit) Disposable needle	32	100%	0	0%
1b.	Syringe no. 3-5	32	100%	0	0%
1c.	Intra cath	32	100%	0	0%
1d.	IV set	32	100%	0	0%
1e.	IV fluid	32	100%	0	0%

1f.	Drugs(oxytocin, methergin, prostogin and antibiotics	32	100%	0	0%
2a.	(Equipment for assisted vaginal delivery) forceps	29	90.62%	3	9.37%
2b.	Vantouse	16	50%	16	50%
3a.	(standard surgical set for episiotomy) Episiotomy trolley containing 10 chromic gut	32	100%	0	0%
3b.	Needle holder	32	100%	0	0%
3c.	episiotomy scissors	32	100%	0	0%
3d.	Xylocain, forceps	32	100%	0	0%
3e.	IV needle	32	100%	0	0%
3f.	Ventouse small towel for draping the baby	20	62.5%	12	37.5%
4.	Equipment of MVA a. MVA syringes and canula	23	71.87%	9	28.12%
5.	Equipment for MTP	28	87.5%	4	12.5%
6.	Equipment for newborn care and neonatal resuscitation	32	100%	0	0%
7a.	(IUCD insertion kit) vaginal speculum	32	100%	0	0%
7b.	Vaginal wall retractor	32	100%	0	0%
7c.	Vulsalum	32	100%	0	0%
7d.	Uterine sound	32	100%	0	0%
7e.	Small scissors	32	100%	0	0%
8a.	(Equipment for sterilization operation) Retractors	32	100%	0	0%
8b.	Cat gut and Vicryl	32	100%	0	0%
9.	Equipment/reagents for essential lab investigation	27	84.37%	5	15.62%
10.	Stock of contraceptive material	29	90.62%	3	9.37%
11.	Standard surgical set	31	96.87%	1	3.12%
12.	Cold chain maintenance facility (refrigerator)	25	78.12%	7	21.87%

The mandatory requirement for cold chain equipment is a refrigerator. It is required for proper maintenance of vaccines and short-term storage of blood. This is found missing in 21% of the facilities. Also, the reagents and equipment for pathological testing are not present in 15% of PSPs.

Another important observation is that though IV fluid, transfusion sets are included in the essential supplies criteria, blood transfusion sets are missing from this list. This brings the focus back on reassessment of the strategy of assuring blood transfusion services in the accredited PSPs.

**Table 7: PSPs fulfilling the criteria for Mandatory Manpower**

S.No.	Mandatory Manpower Under the Scheme	PSPs Fulfilling the Criteria		PSPs not Fulfilling the Criteria	
		No.	%age	No.	%age
1.	Gynaecologist	32	100%	0	0%
2.	Paediatrician	32	100%	0	0%
3.	Anaesthetist	31	96.87%	1	3.12%
4.	Surgeon	31	96.87%	1	3.12%
5a.	(Paramedical support staff) staff nurse (minimum 4)	32	100%	0	0%
5b.	Lab technician-1	27	84.37%	5	15.62%
5c.	Radiographer -1	26	81.25%	6	18.75%
5d.	Compounder -1	28	87.5%	4	12.5%
5e.	Dresser -1	29	90.62%	3	9.37%
5f.	Cleaning staff	31	96.87%	1	3.12%

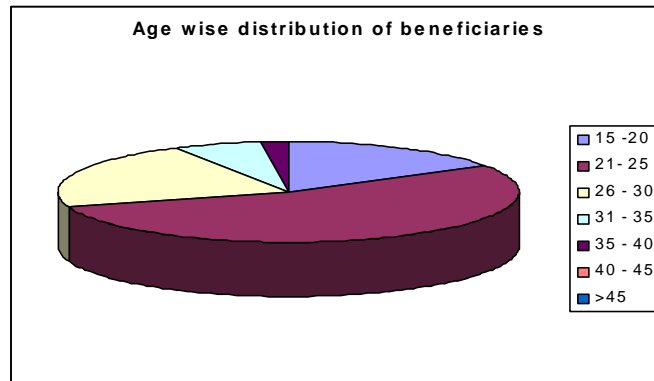
The table shows that all the PSPs have gynaecologists and paediatricians, and only in one hospital anaesthetist and surgeon are not available. Complete paramedical support staff is also not present in all hospitals though more than 80% PSPs are fulfilling the criteria. If on-call doctors are available then an attempt to relax norms of accreditation should be made, to incorporate larger number of PSPs into the scheme.

**Socio-demographic characteristics of beneficiaries**

**Table 8: Age-wise Distribution of Beneficiaries**

Age interval (in years)	No. of Beneficiaries	%age of Beneficiaries
15 -20	16	16%
21- 25	54	54%
26 – 30	22	22%
31 – 35	6	6%
35 – 40	2	2%
40 – 45	0	0%
>45	0	0%
Total	100	100%

The table shows that the maximum number of beneficiaries is in the 21 -25 age group i.e. (54%) followed by in 26-30 years i.e. (22%) and in 15-20 years age group (16%).



**Table 9: Distribution of Beneficiaries According to Education**

<b>Educational status</b>	<b>No. of Beneficiaries</b>	<b>%age of Beneficiaries</b>
Illiterate	19	19%
Just literate	7	7%
Primary	24	24%
Middle	24	24%
high school	14	14%
Higher secondary	6	6%
College	6	6%
<b>Total</b>	<b>100</b>	<b>100%</b>

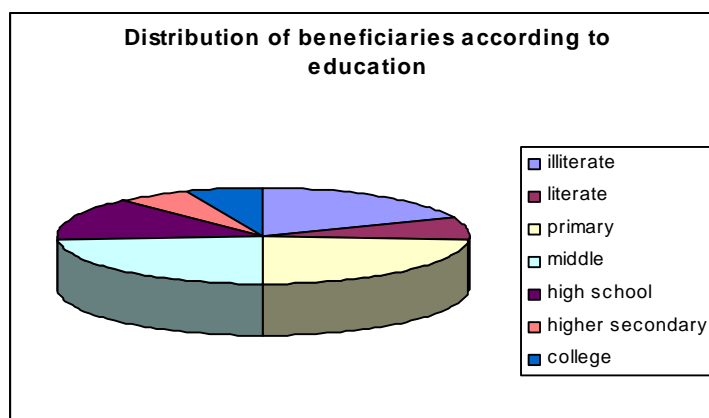
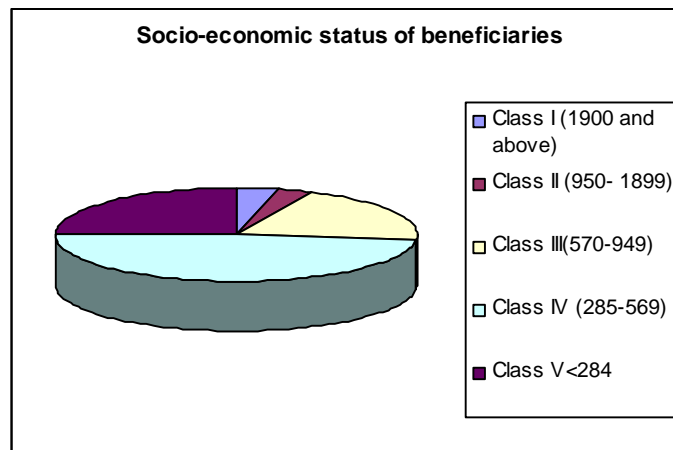


Table indicates that almost half of the beneficiaries have just primary education (24%) and middle (24%) followed by illiterate i.e. 19%.

**Table 10: Socio economic status of Beneficiaries as per Modified Prasad Classification**

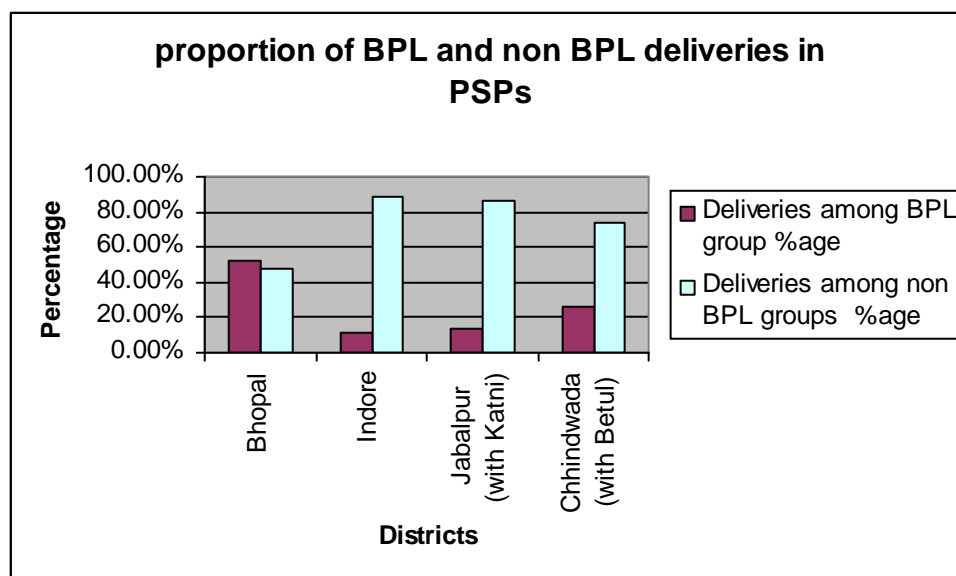
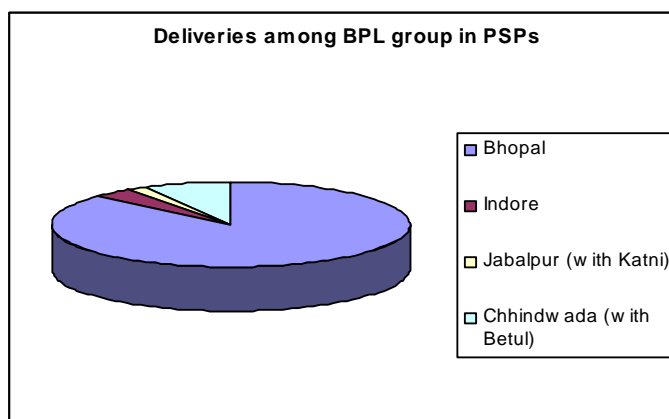
Social Class based on per month	No. of Beneficiaries	%age of Beneficiaries
Class I (1900 and above)	4	4%
Class II (950-1899)	3	3%
Class III(570-949)	20	20%
Class IV (285-569)	48	48%
Class V <284	25	25%
<b>Total</b>	<b>100</b>	<b>100%</b>



According to above table maximum beneficiaries' socio - economic status is in class IV (48%) followed by class V (25%) and class III (20%), which also indicates the BPL status of beneficiaries.

**Table 11: Secondary Data on the Proportion of BPL Deliveries out of total deliveries in PSPs ( October 2006 – September 2007 )**

Districts	Deliveries among BPL group		Deliveries among non BPL groups		Total Deliveries	
	No.	%age	No.	%age	No.	%age
Bhopal	1640	52.09%	1508	47.90%	3148	100%
Indore	69	11.75%	518	88.24%	587	100%
Jabalpur (with Katni)	40	14.13%	243	85.86%	283	100%
Chhindwada (with Betul)	146	26.59%	403	73.4%	549	100%
<b>Total</b>	<b>1895</b>	<b>41.49%</b>	<b>2672</b>	<b>58.50%</b>	<b>4567</b>	<b>100%</b>



As per the NFHS III, institutional deliveries in urban areas is (60%), in rural areas it is (20%) and the total institutional deliveries is 30% in M.P. In the present study, the overall percentage of BPL deliveries in 32 PSPs of the six districts under study is 41.5%. It ranges

from 11.75% in Indore to 52.09% in Bhopal. Before the implementation of the JSY, there were hardly any BPL beneficiaries as per statement of PSP in-charges. Increase in BPL deliveries to over one-third of the total institutional deliveries within a year of the JSY implementation clearly indicates that private sector can be very well involved for the benefits of the BPL section.

### **Methods used for Disseminating Information for Recruiting PSPs**

To identify and motivate PSPs to participate in this scheme, all CMHOs placed ads in newspapers and organised meetings for PSP in-charges and also contacted them telephonically.

#### **A Case Study:**

The Bhopal CMHO motivated the maximum number of P SP in-charges through ads and personal letters to each of them. Failing to get a good response, meetings were called with the PSP in-charges who expressed their apprehension of the lot of paper work under the scheme and less monetary benefits.

Then the CMHO called some interested doctors who worked on the financial aspect ensuring that the hospitals will not incur losses and the money provided is sufficient. Presentations were made to the new and existing PSPs to motivate them further.

The result was that at presently there are 33 private hospitals which are accredited and many more are in their way for accreditation.

### **Various Strategies adopted by PSPs to Increase Participation of BPL Beneficiaries**

**Table 12: Type of Promotional strategies used by Implementers**

<b>Strategies</b>	<b>PSPs In-charge</b>
Meeting with AWWs/ASHAs	68.8%
Publicity through print media	28.1%
Free OPD for BPL women	3.1%
Through hoardings	31.3%
Not applicable	31.3%

To promote the programme there was no specific guidelines and strategies. In spite of th at over two-thirds (68.8%) of PSP in-charges developed their own strategies to implement this programme and almost all of CMHOs too planned some innovative strategies to make the programme a success. The most common strategy was meeting with Anganwadi and ASHA workers and displaying JSY material in private hospitals for creating awareness on the benefits of this scheme.

**Table 13: Table showing Performance of PSPs in Relation to Strategies to Promote this scheme**

Names of PSPs	Meeting with AWWs/ASHAs	Publicity through print media	Free OPD for BPL women	Using hoardings	Total no. of BPL institutional deliveries
Metro Hospital	√	√	√	√	133
Faith and Hope Hospital	√	√	-	√	55
Peoples' Hospital	√	-	√	√	262
Mayo Hospital	-	-	-	-	20
Niramay Hospital	√	√	√	√	277
Paliwal Hospital	√	√	√	√	204
Tripti Hospital	√	√	√	√	538
Surya Hospital	√	-	-	√	110
Amol Hospital	-	-	-	-	0
Roberts' Hospital	-	-	-	-	0
Geeta Bhawan Hospital	-	-	-	-	5
Radha Mohan Hospital	√	√	-	-	36
Khandelwal Hospital	√	√	-	-	8
Astha Hospital	√	√	-	-	11
Asha Deep Hospital	√	√	-	-	5
Life Care Hospital	√	√	-	-	4
Hindustan Hospital	√	√	√	√	21
Prachi Bhatnagar Hospital	-	-	-	-	2
Bajaj Hospital	-	-	-	-	5
Jamdar Hospital	-	-	-	√	7
Gupta Nursing Home	-	-	-	-	3
Shree Hospital	-	-	-	-	3
MGM Hospital	-	-	-	-	0
Anant Hospital	-	-	-	-	0
Khatatkar Nursing Home	-	√	-	-	3
Sukri Nission Hospital	√	√	-	-	44
Mamta Maternity Hospital	-	-	-	√	10
Arogya Niketan Nursing Home	-	-	-	√	5
Padhar Mission Hospital	√	√	-	√	89
Maternity and Surgical Hospital	-	-	-	√	0
Vansh Nursing Home	-	-	-	-	0
Sthapak Heart	-	-	-	√	0

The PSPs which adopted all possible strategies had maximum number of beneficiaries in comparison to those who adopted either no or a few strategies. It has been observed that PSPs which were involved since the past six months, did not cater to even a single BPL patient indicating the need to have a comprehensive, cross-cutting communication strategy and intensive demand generation activities for adequate programmatic achievements.

**Table 14: Information Regarding JSY Scheme to Beneficiaries**

	<b>Frequency</b>	<b>Percent</b>
<b>Through local health workers</b>	64	64%
<b>Through PROs of other Hospitals</b>	2	2%
<b>By Neighbours</b>	7	7%
<b>By Family Members</b>	10	10%
<b>By any Other</b>	17	17%
<b>Total</b>	100	100%

As much as 64% beneficiaries were informed about the scheme by the local health workers and 56% of the beneficiaries were accompanied by ASHAs /AWWs to PSPs. It indicates that ASHAs/AWWs were the key players in client mobilisation.

Majority of PSPs developed some strategies for target group management. Over half of these PSPs had meetings with local health workers to inform the beneficiaries of the benefits of the JSY which is evident from the findings of the beneficiaries, majority of whom were informed by the local health workers about this scheme.

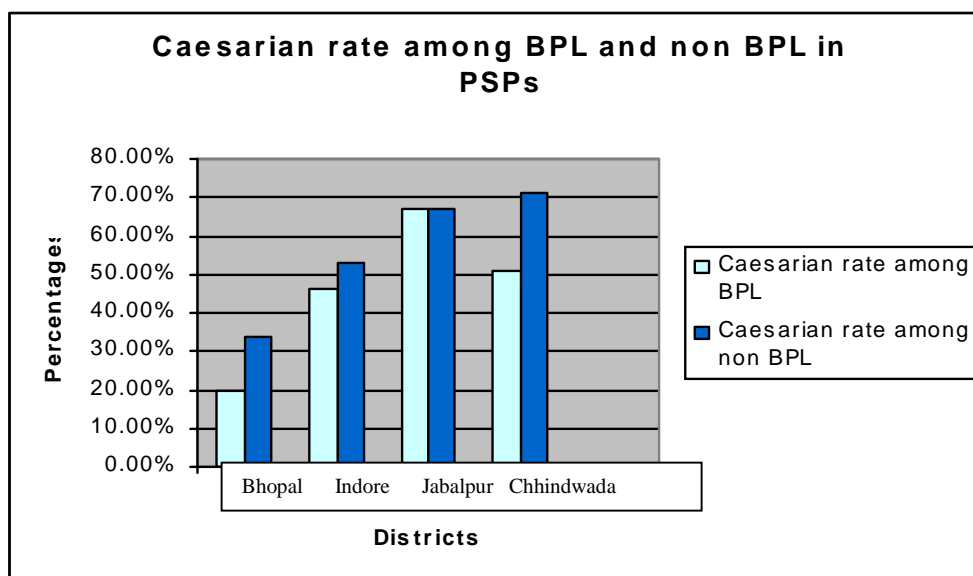
**Table 15: Did you come to this hospital by your own or accompanied**

	<b>Frequency</b>	<b>Percent</b>
<b>Own</b>	44	44.0
<b>Accompanied by ASHAs/AWWs</b>	56	56.0
<b>Total</b>	100	100.0

*The Caesarean section rate among BPL families covered under this scheme and compare with non BPL families.*

**Table 16: Secondary Data Showing Caesarean Section rate among BPL and non - BPL beneficiaries ( October 2006 to September 2007)**

<b>Districts</b>	<b>No. of C.S. among BPL</b>	<b>Total deliveries in BPL (Normal + C.S.)</b>	<b>Caesarean section rate among BPL</b>	<b>No. of C.S. among Non BPL</b>	<b>Total deliveries in BPL (Normal + C.S.)</b>	<b>C.S rate among non-BPL</b>
Bhopal	322	1641	19.62%	508	1507	33.7%
Indore	32	69	46.37%	275	518	53.08%
Jabalpur (with Katni)	27	40	67%	162	243	67%
Chhindwada (with Betul)	79	155	51%	297	416	71%
<b>Total</b>	<b>460</b>	<b>1905</b>	<b>24.14%</b>	<b>1242</b>	<b>2684</b>	<b>46.27%</b>



**Table 17 : Distribution of Beneficiaries According to their Deliveries**

Districts	Normal Delivery		Caesarean Section		Spontaneous abortion		Total
	No.	%	No.	%	No.	%	
Bhopal	15	60%	10	40%	0	0%	25
Indore	14	56%	7	28%	4	16%	25
Jabalpur (with Katni)	11	44%	14	56%	0	0%	25
Chhindwada (with Betul)	11	44%	10	40%	4	16%	25
<b>Total</b>	<b>51</b>	<b>51%</b>	<b>41</b>	<b>41%</b>	<b>8</b>	<b>8%</b>	<b>100</b>

The over all percentages of the Caesarean section deliveries in the BPL group is not higher than the percentages of Caesarean section deliveries in non-BPL groups which indicates that BPL group is not being unnecessarily forced for Caesarean sections for monetary benefit. However the percentage of Caesareans sections in most of the districts is higher than the accepted average of 8%. This may be indicative either of a high percentage of the patients opting for elected Caesarean Sections or a very high percentage of complicated deliveries due to poor ANC coverage or this high percentage is driven by bigger monetary benefits to PSPs.

It is, therefore, required that a separate study on this high percentage of Caesarean section should be conducted to understand its reasons and take remedial measures accordingly and also concurrently to understand a state average of normal vs. Caesarean section like in Gujarat to create an inbuilt discouragement mechanism for unnecessary surgeries by PSPs as well as for better financial planning of the scheme in the coming years.

‘Maximum patients come with complications after getting trial in government hospitals and at home. That’s the reason they need Caesarean sections,’ defended the PSP in-charge at Katni

‘Hospital authorities demanded Rs. 20,000 for a Caesarean section. As she was unable to pay such a big amount they refused to discharge her. Then they arranged Rs. 12,000 and requested the hospital to discharge her and they did,’ said a patient from Chhindwada.

### Payment Mechanism to PSPs and to beneficiaries under this scheme

#### Information to stakeholders about various components of financial management

**Table 18: Knowledge about Payment Mechanism**

Response Category	Mechanism of Reimbursement/Advance Payment			
	CMHOs		PSP In-charges	
Respondent categories	No.	Percentage	No.	Percentage
Advance money	6	100%	23	71.9%
Reimbursement	6	100%	27	84.4%

Almost all CMHOs know about the advance payment to all PSPs as well as the reimbursement claim under this scheme, though only over a half of the PSP in -charges have enough knowledge about the same. This shows lack of full information on the possible payment mechanisms to the PSPs reducing their chance to exercise the best option suited to them and it needs special attention while disseminating the scheme to PSPs at the time of their recruitment.

**Table 19: Mode of Payment to PSPs**

Payment mode	PSPs’ response towards Payment	
	No.	%age
Cash	1	3.1
Cheque	27	84.4
Not applicable *	4	12.5%
<b>Total</b>	<b>32</b>	<b>100.0</b>

The maximum number of PSPs (84.4%) received payment through cheque, followed by cash at 3.1%. Since cash as a mode of financial transaction is strongly discouraged in the government sector, it should be ensured that such practices are discouraged in future.

\*Not applicable are the PSPs where one did submit their claim but till date of our survey they did not get their money reimbursed. And three are the number of PSPs where they did not get any cases after their accreditation with the scheme.

**Table 20: Fund Availability to PSP from CMHOs**

Periodicity	Received Advance money (n=32)		Received Reimbursement (n=32)		Verification (n=32)	
	No.	%	No.	%	No.	%
Weekly	0	0%	0%	0%	0	0%
Monthly	0	0%	5	15.62%	23	71.9%
Quarterly	0	0%	0	0%	0	0%
Yearly	0	0%	0	0%	0	0%
Random/no fixed schedule	16	50%	6	18.75%	6	18.75%
Not yet	0	0%	5	15.62%	3	9.37%

A large majority of (71.9%) PSPs informed that monthly verification by record check was done by the CMHO office. And according to 18.75% PSPs, reimbursement is done whenever they submitted their claim on monthly basis, while 50% PSPs said that they got advance money whenever they required it. It indicates that reimbursement is being done timely and there is no delay from the CMHO office.

As per the original guideline by state Public Health and Family Welfare Department, all the claims should be submitted to CMHO office before 5<sup>th</sup> of every month. After the verification of the claim and services provided by PSPs, reimbursement will be done within a week. But later these guidelines were changed where advance money is being provided against a bank guarantee.

**Table 21: Reasons for not taking advance money**

S.No.	Reasons	PSPs who opted reimbursement (multiple answers were accepted) N= 32	
		No.	Percentage
1.	Finding problem in giving bank guarantee	11	34.37%
2.	No delay in getting reimbursement money	3	9.37%
3.	Very few BPL cases so advance not needed	6	18.75%

Approximately half of the PSPs which opted for reimbursement expressed that they were finding problems in giving bank guarantees. Some told that as they were not getting many BPL beneficiaries due to no motivation charges and there was also no delay in getting the

reimbursement. In their opinion there is no question of giving bank guarantee for advance money for the few cases they are getting in their hospitals. It can be said that there is no administrative drawback behind not opting for advance money, it is either very few number of cases with PSPs or prompt release of reimbursement.

“We don’t have enough number of BPL patients, so we don’t think that taking advance money is required. It is easier for us to claim reimbursement ,” said a PSPs in Jabalpur.

‘It takes very little time to get reimbursement from the CMHO office, therefore, we don’t feel the need of advance money ,” said PSPs in Betul and Chhindwada.



## Motivation Charges

Under the scheme, there is a provision for motivation charges as well monetary compensation to the beneficiaries. Because of these provisions, health workers prefer to bring beneficiaries to the government hospitals. In the beginning, it was a big obstacle to get BPL beneficiaries into private hospitals. It was suggested that the benefits of the JSY be given to the patients admitted in private hospitals and also provide motivation charges to the health workers accompanying them. This led to a significant increase in the number of beneficiaries going to private hospitals in Bhopal and Indore districts.

The PSPs in Jabalpur district are giving motivation benefit to ASHAs/AWWs, which have resulted in the increased number of BPL beneficiaries within a month, whereas other PSPs are finding it difficult to get BPL beneficiaries.

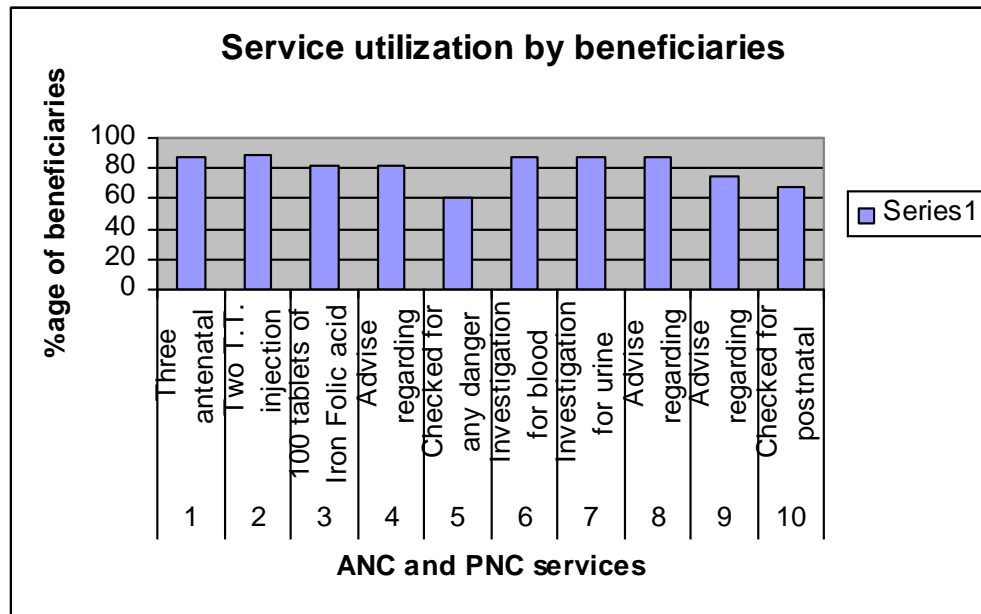
“After the implementation of the JSY, we are finding it easier to bring patients into private hospital in comparison to government hospitals. In government hospital, behaviour of the staff is not proper, paper work is more. On top of it we are now getting very good response from private hospitals. Private hospitals are less time consuming , and also we are getting monetary compensation immediately ,” stated by some ASHAs and AWWs in a Bhopal PSP.

“As in each village there is one ASHA and one AWW. We both look after pregnant women and we can motivate them for institutional deliveries. Many times the situation arises where we find it difficult to decide as to who will take the beneficiaries to the hospital. It leads to confrontation between us because of monetary benefits ,” admitted some ASHAs and AWWs, in a Bhopal PSP.

#### Coverage of ANC and PNC care under JSY

**Table 22: ANC and PNC Service uptake Amongst Beneficiaries**

S.No.	ANC and PNC services used by BPL Beneficiaries	No. of Beneficiaries	%age of Beneficiaries
1.	Three antenatal visits	88	88%
2.	Two T.T. injection	89	89%
3.	100 tablets of Iron Folic acid	82	82%
4.	Advise regarding nutrition	81	81%
5.	Checked for any danger sign for pregnancy	61	61%
6.	Investigation for blood	87	87%
7.	Investigation for urine	88	88%
	<b>3PNC visits</b>		
8.	Advise regarding breast feeding	88	88%
9.	Advise regarding Family Planning	74	74%
10.	Checked for postnatal complication	68	68%



**During antenatal period beneficiaries availed following services :**

Three antenatal check-ups (88%), two doses of TT (89%), and IFA tablets (82%). As many as 61% of beneficiaries were checked for danger signs of pregnancies. While 74% of women availed of the family planning counselling services, 68% women had postnatal check-ups.

As per the NFHS II, (PIP-NRHM) in M.P. women receiving three antenatal visits was 28.1%, those getting two T.T. doses were 55% and 76.4% got 100 tablets of iron and folic acids.

The study indicates a clear picture of the improved ANC/PNC services uptake by beneficiaries after involvement of private service providers.

The NFHS II report indicates that less than one-tenth of the children are breastfed within an hour of birth and less than one-third get thin in the first day. Further, 71% of mother squeezed out the first milk from the breast before feeding the baby, contrary to recommended feeding practices. Only one-third of the children of less than four months of age are exclusively breastfed.

The total demand for family planning services is 60.5% in the state, while women with anaemia is 54% of which 16.6% are found with moderate to severe anaemia. This is much higher among the rural women. Under this scheme, 74-88% women get advice on nutrition, family planning and breastfeeding.

It is anticipated that education and counselling on the above issues will definitely improve the health status of women and children in the state.

## Extent of satisfaction among BPL families who availed of JSY services

**Table 23: Positive aspects of Getting services from PSPs under JSY (multiple answer accepted)**

Services	Beneficiary (n=100)	
	No.	Percentage
Cleanliness	52	52%
Immediate treatment	35	35%
Good services	27	27%
Less paper work	29	29%
Relatives were allowed to stay	23	23%
Good staff behaviour	12	12%
Got money	10	10%
Free of cost	3	3%

The main positive aspect observed in private hospitals are cleanliness (52%) followed by immediate treatment (35%), less paper work (29%), good services (27%) and good staff behaviour (12%). However, the important observation is that just 10% of the patients are impressed by the compensation money, and just 3% by the free service which are being offered under this scheme. Since free service by PSPs is the essential element in this scheme, its low percentage as an element which the patients see as a major positive aspect indicates towards two major issues. Firstly, quality and ready availability of services are the features which attract the patients more, therefore they should be further strengthened both in public and private sectors; and secondly, there were and still are hidden out-of-pocket expenses which the patients used to incur both earlier and in the current scheme, which is making this critical element of free services unattractive.

Overall, most of the beneficiaries are satisfied with services offered by PSPs under the scheme. Most of the CMHOs and over half of the PSP in-charges consider that the scheme is really beneficial to the poor. Over half of the CMHOs opine that the poorest of the poor are getting quality services free of cost as well as monetary compensation.

“We are covering maximum neighbouring villages. Villagers come with very unhygienic conditions. Firstly, we take them to the room and give them clean gown to wear. We are providing quality services in very hygienic condition. That itself reduces the risk of infections. By providing ANC and PNC services properly we are going to see reduced IMR and MMR,” sated the PSPs in Bhopal.

### Negative aspect of the scheme as felt by CMHOs and PSPs

Approximately half of the CMHOs and PSPs strongly feel that under the present scheme, the selection criteria of BPL is not clear and hence the high risk cases are not included in the package. Some of the CMHOs and approximately half of the PSPs also feel that charges are

very less and some of the PSPs complain that there is no allocation of money for PNC services.

“ Mareez mobile phone lekar aur sone ke Gahne pahankar, motorcycle ya car me ate hai aur sath me BPL card bhi dikhate hain. Yeh scheme to bakwas hai. Ham to sirf CMHO sahib ke kahne par participate kar rahe hain.”

[“Patients come with mobile phones, motorcycle, wearing gold and bring BPL card. This scheme is hopeless. We are participating in this scheme just because of the CMHO,” averred a Bhopal PSP.

‘Kutch mariz ese bhi aate hain jinke pas B PL card to hota hai lekin usme unki bahoo ka naam nahi chadhaya hota hai, kyonki wo shadi se pahle kisi aur pariwar ki beti thi. Is karan BPL parivar ki Bahoo hone ke baad bhi usko is yojana ka labh nahi de paate hain. ’

[“Some patients come with BPL card without the name of their daughter-in-law in the BPL card, because earlier they were daughters of some other families. Due to this reason we can’t give benefit to these women even though they belonged to as a daughter-in-law of a BPL family,” says a PSP from Jabalpur.

### **PSPs Charging Money from Beneficiaries**

It has been observed that around 45% of the PSPs are also charging money in lieu of various services offered to the beneficiaries. This practice is highest in the districts of Indore, Jabalpur, Chhindwada where more than half (5 out of 8) PSPs are taking money from beneficiaries who are eligible for free treatment. This is less seen in Bhopal where only three out of eight PSPs are charging money from the patients.

However, this important observation is suggestive of the required enhancement in the quality of monitoring especially in the patients’ follow -up. This will not only be able to stop such practices which are against core objectives of the scheme but also to establish continuous two-way communication channel with the service providers and the scheme beneficiaries to understand the reasons for the additional billings which may be due to less amount of money being offered to PSPs for services which cost more under the scheme.

**Table 24: District-wise Distribution of PSPs Charging Money from Patients**

Districts	PSP Charging Money		PSP not Charging Money		Beneficiaries Response			
	No.	%	No.	%	PSP Charging Money		PSP not Charging Money	
	No.	%	No.	%	No.	%	No.	%
<b>Bhopal</b>	3	37.5%	5	62.5%	8	32%	17	68%
<b>Indore</b>	5	62.5%	3	37.5%	11	44%	14	56%
<b>Jabalpur</b>	5	62.5%	3	37.5%	8	32%	17	68%
<b>Chhindwada</b>	5	62.5%	3	37.5%	19	76%	6	24%
<b>Total</b>	<b>18</b>	<b>56.25%</b>	<b>14</b>	<b>43.75%</b>	<b>46</b>	<b>46%</b>	<b>54</b>	<b>54%</b>

**Service providers' perspective towards service charges**

**Table 25: Satisfaction level of PSP in -charges with present charges**

S.no.	Services	Satisfied		Not satisfied	
		No.	%age	No.	%age
1	Normal delivery	4	12.5%	28	87.5%
2	Spontaneous abortion	7	21.9%	25	78.1%
3	Caesarean section	4	12.5%	28	87.5%
4	Blood charges	14	43.8%	18	56.3%
5	Baby warmer	9	28.1%	23	71.9%
6	Phototherapy	11	34.4%	21	65.6%
7	Visit by paediatrician	3	9.4%	29	90.6%
8	Care for immature baby	13	40.6%	19	59.45

Table shows that approximately half of PSPs are satisfied with the charges being offered for blood charges, baby warmer, phototherapy and care for immature babies, followed by some other services for which also they are dissatisfied. According to almost all PSPs, service charge for paediatricians is not sufficient followed by other charges for other services being offered. It indicates that there is a need for reasonable increase in the present charges.

Majority of the PSPs recommend Rs. 2,000 for normal delivery in place of Rs. 1200, Rs. 750 for spontaneous abortion, Rs. 8,000 for Caesarean Section in place of Rs. 5,500, Rs. 1,000 for blood charges in place of Rs. 750, Rs. 100 for baby warmer in place of Rs. 50, Rs. 50 for phototherapy, Rs. 150 for visit by paediatrician in place of Rs. 50 and Rs. 250 for care of the immature baby.

In Indore there are 250 private hospitals and they are providing better services. Almost 50% of public is availing of services from these hospitals, so, we can't ignore this sector. Through this scheme institutional deliveries has increased. BPL people are getting quality service benefit as well monetary benefit, admits the Indore CMHO.

**Table 26: Satisfaction Level of Beneficiaries**

<b>Beneficiaries Satisfied with the Service Quality</b>		<b>Beneficiaries Dissatisfied with Service Quality</b>	
No.	%	No.	%
97	97%	3	3%

Maximum beneficiaries are satisfied with quality of services offered by PSPs with only 3% being not satisfied with the services.

Beneficiaries who are not satisfied cite the following reasons:

1. Money is charged during the critical baby care.
2. Full delivery charge is taken by PSP yet care is not properly given
3. Adequate care not given to a newborn later

“My daughter was admitted in the NICU because she was premature. Money was charged from us to provide newborn care services. That's why I am not satisfied,” says a beneficiary from Bhopal.

Most of the CMHOs and over half of the PSPs agree that this scheme is really beneficial to the poor, and over half of the CMHOs point out that the poorest of the poor are getting quality service free of cost as well monetary compensation. Significantly, nearly all, 97% beneficiaries are also satisfied with the service quality being provided by PSPs. But only 34% of the beneficiaries say that they got these services free of cost.

Approximately half of the CMHOs and PSPs feel that selection criteria of BPL is not clearly defined; high-risk cases are not included in the package and charges are less. One-third (33%) of CMHOs and 12.5% PSPs say that the scheme is applicable to all irrespective of the birth order and there is no emphasis on family planning.

## **VII. Monitoring and Supervision**

Activities of the JSY are monitored at two levels i.e. at the level of PSPs and at the level of the CMHO.

In many private hospitals, the PSP in-charges are closely monitoring the functioning of this scheme in following ways:

- Taking feedbacks from ASHAs/AWWs
- Identifying problems in client mobilisation
- Verifying BPL status of beneficiaries

- Interaction with CMHOs frequently and seeking solutions
- Monitoring reimbursement of claims, and
- Record keeping.

Overall monitoring is done at the CMHO level. But there are wide variations in the monitoring methodology adopted by the various CMHOs.

- The Bhopal CMHO is cross-checking with the beneficiaries by visiting himself the hospitals as well as villages for monitoring of the programme
- The Katni CMHO has appointed a person who visits the PSPs to collect the reports and claim for the services.

At one end there are CMHOs who are least concerned with the programme's performance and at the other end there are CMHOs who are totally committed to see that the programme is adopted by more and more PSPs. They are always ready to solve the obstacles in the implementation of the programmes. This observation indicates towards the need for development of a comprehensive monitoring and evaluation system exclusively for this scheme, may be on the lines of the system developed for the voucher scheme of SIFSA in U.P. and training the staff on these M&E tools to have a clear picture of time status of this scheme.

### **Innovation in Programme**

A unique innovation in the programme is seen in Bhopal, where one NGO has started a Centre For Maternal Emergency Services (CMES). An important unit of the CMES is a 'call centre', which is running 24 hours throughout the year. Through a software a record of all pregnancies in all the villages is maintained. Every ASHA/AWW in the village is also given a code no. and through her, record of all the pregnancies and child births is maintained at the call centre. These AWWs and ASHAs have also been given training through the NGO regarding ANC and PNC care. All ASHAs and AWWs have been provided with a mobile phone. In case of maternal emergency, ASHAs/AWWs call and the call centre in turn sends its special ambulance to the village, which are specially meant to bring the pregnant women and it has the facility to deal with normal delivery etc. Driver of the van is also given training about some aspects of the programme. He is given forms for the pregnant women. The van brings the pregnant women to the pre-identified PSP along with the local ASHA/AWW. After delivery, the driver collects the filled-up forms from the hospital and hands it over to the call centre, where this information is entered in the records.

Through the call centre almost all the pregnancies are registered and outcome of each pregnancy can be tracked.

The role of the call centre in this programme is quite appreciable. It has resulted in sharing the load of deliveries between government and private hospitals. It has also made possible the private sector to contribute appreciably in the field of maternal care. It has further helped in reducing maternal and infant mortality by increasing institutional deliveries.

## CHAPTER IV

### RECOMMENDATIONS

Areas of Concern	Actions Recommended
<p><b>Policy Issues</b></p> <ul style="list-style-type: none"> <li>● No guideline laid down in the scheme for financial benefit to the motivator which is a hindrance for effective implementation of the programme</li> <li>● As maximum PSPs are in urban areas, a proper transportation system for emergency service is required</li> <li>● Lack of participation by the rural PSPs</li> <li>● Lack of comprehensive behavioural change communication strategies</li> </ul>	<ul style="list-style-type: none"> <li>● There should be a provision for motivational benefit to the motivators (ASHAs/AWWs)</li> <li>● Establishment of more call centres for maternity emergency services</li> <li>● There should be relaxation in the criteria to select rural PSPs to give benefit to the rural people.</li> <li>● If rural PSPs don't have Caesarean delivery services in such case they should be recognised for normal deliveries and MTP services</li> <li>● As this scheme is aimed to change behavioural pattern of beneficiaries, there is a definite need and scope to develop cross cutting and programme specific behavioural change communication strategies in order to bring positive and sustainable change among BPL beneficiaries</li> </ul>
<p><b>Programme Level Issues</b></p> <ul style="list-style-type: none"> <li>● Lack of effective communication between CMHO and PSPs</li> <li>● PSPs charging money from beneficiaries and claiming reimbursement too</li> </ul>	<ul style="list-style-type: none"> <li>● There should be a laid down plans for constant dialogue between CMHO and PSPs to strengthen the partnership as well as to identify and rectify the problems faced by PSPs</li> <li>● There is a need to develop a monitoring and feed back mechanism to understand the reasons, find its solutions and also to check such malpractices</li> </ul>

<ul style="list-style-type: none"> <li>• PSPs are not satisfied with present charges</li> <li>• High percentage of Caesarean sections in study area in both BPL and non BPL groups</li> <li>• Lack of a monitoring and evaluation system for the scheme</li> <li>• Poor follow-up of the patients</li> </ul>	<ul style="list-style-type: none"> <li>• It is recommended that the present charges fixed for various services should be reasonably increased as suggested by PSP in-charges and these charges should be annually reviewed keeping in mind the market prices</li> <li>• There is need to develop a mechanism like the Chiranjeevi Scheme in Gujarat in which the payment is given to the PSP for 100 deliveries which includes proportionate normal and Caesarean section deliveries as per norms in discourage the unnecessary Caesarean section on patients</li> <li>• An incentive can be given to the PSPs which will perform the deliveries according to the acceptable national standards</li> <li>• Medical audit should be done to all PSPs periodically</li> <li>• Standard monitoring and evaluation tools should be developed on the lines of voucher scheme in U.P.</li> <li>• Monitoring and evaluation of JSY should be the part of HMIS (Health Management Information System).</li> <li>• For effective monitoring and follow up of patients a set-up like CMES of Bhopal may be established at district level</li> </ul>
<p><b>IEC</b></p> <ul style="list-style-type: none"> <li>• Lack of concerted promotional strategy</li> </ul>	<ul style="list-style-type: none"> <li>• Efforts should be made to increase awareness among beneficiaries at government as well as PSPs level through appropriate media especial emphasis for institutional delivery</li> <li>• Intensification of IEC activities in the community especially focusing at PNC component of the scheme is required to ensure uptake of the continuum of services offered by the scheme</li> <li>• Awareness campaign focused to dispel misconceptions and myths and clarifying various components of the scheme should become an integral part of the IEC campaign</li> </ul>
<p><b>PRI/community level issues</b></p> <ul style="list-style-type: none"> <li>• Identity issues on a BPL card needs clarification</li> </ul>	<ul style="list-style-type: none"> <li>• There should be some key persons like PSP in -charge or CMHOs or local village authorities to make temporary BPL card for the consideration of</li> </ul>

<ul style="list-style-type: none"> <li>• Lack of training for ASHAs/AWW/ PRI members on the JSY</li> </ul>	<p>women as Janani Sahyogi beneficiary like in SIFPSA U.P. model.</p> <ul style="list-style-type: none"> <li>• Guidelines for ASHAs/AWWs training on this scheme to be developed and implemented</li> </ul>
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### **Limitations of the Study**

- As this scheme is new and only a few districts are participating at this time, it was difficult for us to have a true picture about the functioning of the scheme
- The study duration was quite less therefore a large sample could not be attempted.

### **Future Directions of Research**

1. As in this stage only a few districts are participating in the JSY. So, it is recommended that after desired modifications, evaluation will be required at least after three years.
2. Another research could be done to explore the ways to find out whether only cash incentive is the means to increase more participation of beneficiaries as well PSPs or other kind of incentive can also make a positive impact.
3. As the percentage of Caesarean sections in the most of the study districts is higher than the accepted average of 8%. It is therefore required that a separate study on this high percentage of Caesarean sections should be conducted.

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