

**AN ASSESSMENT OF FUNCTIONING AND IMPACT
OF JANANI SURAKSHA YOJANA IN ORISSA**

Chief Investigator

Prof. Deoki Nandan

Director

National Institute of Health & Family Welfare

Study Team

S.C.B. Medical College, Cuttack, Orissa

Dr. B. Mohapatra

National Institute of Health & Family Welfare, New Delhi

Dr. U. Datta

Dr. Sanjay Gupta

Dr. V.K. Tiwari

Dr. K.S. Nair

Dr. Vivek Adhish



2007-2008

CONTENTS

Preface	i
Acknowledgements	iii
Abbreviations	iv
List of Tables	v
Executive Summary	vi
1. Introduction	1
2. Methodology	3
3. Findings and Discussion	7
4. Recommendations	30

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 NIHFV. The faculty of the NIHFV 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 Functioning and Impact of Janani Suraksha Yojana in Orissa**” by the Department of Community Medicine, S.C.B. Medical College, Cuttack, Orissa, was finalised by the institute in consultation with the UNFPA.

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

Dr. Dinesh Agarwal
National Programme Officer, UNFPA

Prof. Deoki Nandan
Director, NIHFV

ACKNOWLEDGEMENT

I extend my sincere thanks to Prof. Deoki Nandan, Director, National Institute of Health and Family Welfare, for assigning the study on “The functioning and Impact of the Janani Suraksha Yojana in Orissa” on behalf of the Department of Community Medicine, Orissa.

We appreciate the efforts of the Principal, S.C.B. Medical College, Cuttack. He was always supportive and cooperative in the pursuit of research and studies undertaken by this Department. I convey my thanks and regards for his relentless work and constant guidance for the study.

Dr. V. K Tiwari, Dr. U. Datta and Mr. Parimal Parya from NIHFWD deserve special thanks for their technical guidance, support and cooperation at every stage of the study. Their inputs have enriched the quality and overall content of the analysis.

My heartfelt thanks to Dr. Kaushik Mishra, (Asst. Professor & Co-Principal Investigator) for his support, enthusiasm and active involvement right from the initiation of the study to report-writing and dissemination. I extend my heartfelt thanks to Dr. B. B. Nanda, (Bio-statistician) for his excellent skills in analysis, management and interpretations of the data. His support during report writing also needs commendation.

I am thankful to the field supervisors Dr. S. K. Das, Dr. M. Biswas and Dr. S. Nivedita for their keen interest, hard work and team spirit during field data collection.

Special thanks to the Postgraduate students, Dr. R. N. Panigrahi, Dr. J. P. Samal and Dr. P. P. Giri, who were actively involved in the planning of the study, report writing and have benefitted for their academic activities.

I am also thankful to Mr. Nanda Kishore Naik, (Social Scientist), Dr. A. B. Dash and Mr. Pravas Mohanty for their support during the field work. I also extend my thanks to Mr. Priyaranjan Ray for his constant support in data entry and report writing.

The CDMOs, ADMOs (FWs), DPMs of study districts, block MOs, BPOs, HW (F), ASHAs of the studied PHCs/CHCs and Sub-centres have provided excellent support and co-operation in providing information and their opinions during the field study. I also sincerely extend my thanks to the community leaders, PRI members, SHG members, school teachers, and village heads for their generous participation in FGDs and the respondents for providing valuable information for the study during the course of in-depth interviews.

Prof. (Dr.) B. Mohapatra

ABBREVIATIONS

ADMO	Additional District Medical Officer
ANC	Antenatal care
ANM	Auxiliary nurse midwife
ASHA	Accredited social health activist
AWW	Anganwadi worker
CDMO	Chief District Medical Officer
CHC	Community health centre
DAM	District Accounts Manager
DHH	District Headquarter Hospital
DHIO	District Health Information Officer
DPM	District Programme Manager
FGD	Focus group discussion
FRU	First referral unit
HW(F)	Health worker-female
IFA	Iron folic acid tablets
JSY	Janani Suraksha Yojana
MO	Medical Officer
NRHM	National Rural Health Mission
ORS	Oral rehydration salt
PHC	Primary health centre
PNC	Postnatal care
PPP	Public private partnership
PRI	Panchayati Raj Institution
RKS	Rogi Kalyan Samiti
SBA	Skilled birth attendant
SDH	Sub-divisional hospital
SES	Socio-economic status
SHG	Self-help group
TBA	Traditional birth attendant
TT	Tetanus Toxoid

LIST OF TABLES

Sl.No	Content	Page No.
1	List of selected District, Blocks, PHC/CHC, SCs and Villages	4
2	Summary of the study subjects, sample size, data collection technique and tools	6
3	Adjectives used in the study for qualitative data	6
4	Knowledge of service providers : ADMOs and DPMs	9
5	Knowledge of service providers : MOs	9
6	Knowledge of service providers: HW(F)	10
7	Knowledge of service providers: ASHAs	10
8	Knowledge level of all service providers on JSY	11
9	Status of training of ASHAs and HW (F)	13
10	District-wise source of information for beneficiaries for availing JSY service	14
11	Mode of payment and time lag in payment of compensation to the beneficiaries	19
12	Period of delivery for cases who have not received the compensation as yet (N = 10)	20
13	Distribution of compensation received by the beneficiaries	20
14	District-wise delivery characteristics of beneficiaries	21
15	Delivery characteristics among non-beneficiaries	23
16	Birth order according to category of clients	24
17	Place of delivery according to category	24
18	Delivery out come according to the category of mothers	25
19	Delivery conducted by different personnel according to the category of clients	25
20	District-wise transportation of the beneficiaries to the Institution	26
21	Utilization of JSY money by the beneficiaries	27
22	Reasons for not availing the services by the non-beneficiaries	27
23	Year-wise institutional delivery: PHC/CHC level : 2004 -07	29

EXECUTIVE SUMMARY

Introduction

Since the inception of the National Rural Health Mission (NRHM), a large number of health programmes have been implemented to address various health related concerns and needs with the overall objective of improving the efficiency and effectiveness of the health system. The NRHM was launched in Orissa on July 17, 2005, with an aim of providing accessible, affordable, and quality health services to the rural and underserved populations of the state.

The National Institute of Health and Family Welfare (NIHFW), with financial assistance from UNFPA, initiated capacity building workshops on rapid appraisal methodologies and concurrently undertook appraisals of health interventions under NRHM in collaboration with its academic partners in low performing states of India.

This report is based on the rapid appraisal of the JSY in the three districts of Balasore, Jagatsinghpura and Nayagarh, selected on the basis of high, middle and low percentage of institutional deliveries respectively within the central revenue division of Orissa.

General Objective

To review the implementation process of JSY in the state of Orissa and to provide inputs for any corrective actions.

Specific Objectives

- To review the mechanism in place for implementation of JSY;
- To study the processes and procedures of ensuring financial benefit or cash assistance to the beneficiaries;
- To probe the acceptance of the JSY programme in the community; and
- To identify the problems/barriers (if any) faced during the implementation of JSY.

Methodology

Under the methodology, two blocks (one nearest and the other farthest) were identified from each sample district, amounting to a total of six blocks the three districts. From each block, one sub-centre was randomly selected. Further, from each sub-centre, two villages were selected randomly.

The study was held in a typically cross-sectional design, involving both qualitative (FGDs) and quantitative techniques. (In-depth interview and record analysis)

The Study Respondents:

- District level: ADMO (FW) & DPM;
- Block level: MO I/C of PHC/UGPHC/CHC;
- Sub-centre level: HW(F); and
- Village level – ASHAs, beneficiaries & non-beneficiaries.

A total of 210 respondents were contacted during the entire the study.

Salient Findings

1. It was revealed from the study that at the district, block and sub -centre levels, there was a shortage of medical and paramedical staff posing a major hindrance to the programme. Inadequate facilities for institutional delivery of healthcare were found at all levels. Delivery tables, instruments, and equipments were not sufficient to meet the increased delivery load. 50 per cent SCs had no building of their own.
2. It is encouraging to note that 92 per cent of the ASHAs in the study district had received modular training on JSY. About 84 per cent of HW (F)s got training on maintenance of account related to JSY and imprest money.
3. At some places, sensitization of MOs has been undertaken. The district and block health authorities have indicated some gaps in the sensitization programme.
4. So far as sensitization of the community members is concerned, tools like wall painting, leaflets, local dailies, local TV, and Radio were utilized as the means of IEC. Janamancha in the DHH Nayagarh was organized to generate awareness among the community members. Beneficiaries revealed that HW (F) and the ASHAs were playing the key roles in generating awareness regarding JSY. Still many non-beneficiaries were not aware of the JSY.
5. With regard to monitoring and supervision of the JSY, inadequate staff strength was a major impediment. Mostly during monthly review meetings, the JS Y activities were assessed. The HW (F)s were mostly supervising the JSY activities in the field. MOs were not able to go for field level supervision and monitoring due to extra workload.
6. Study in the six PHC/CHCs revealed that there was significant and sudden spurt in the percentage of institutional deliveries during 2005 - 06 to 2006 – 07, thanks to the introduction of JSY.

Recommendations

Based on the study findings, a set of suggestions have been formulated for better and more efficient delivery of services under the JSY:

- Ongoing and regular updates and orientation programmes are needed for the service providers about the JSY and their roles and responsibilities under the same;
- The GRAMSAT network should be utilized for cost-effective and timely orientation to the service providers;
- The fund flow mechanism should be streamlined at two levels -- immediate compensation to the beneficiary after the delivery and regular payments/salaries to the ASHAs;
- IEC activities must be strengthened for developing effective messages by using the Janmancha, banners and slogans, and putting up an effective communication strategy in place for better monitoring of JSY; and
- Infrastructure, supplies and human resources should be strengthened at all levels under the JSY.

CHAPTER I

INTRODUCTION

1. Genesis of Study

Newer, innovative, client-centered, and community-centred interventions were designed to address the major public health problems in India where maternal and child morbidity and mortality stand out as huge challenges. In order to address this challenge, the Government of India launched the National Rural Health Mission (NRHM) in 2005 with the sole aim of protecting and promoting the health and well-being of its citizens in general, and mothers and children in particular. It aims at reducing maternal and childhood morbidity and mortality through timely interventions like engagement of the ASHAs at village levels, the RKS, and the JSY to name a few.

The figures state that in every five minutes one woman somewhere in India dies due to pregnancy-related complications, amounting to one lakh maternal deaths and 10 lakh new-born deaths each year. The NRHM launched its JSY scheme as one of its most important key interventions to reduce maternal mortality.

The Janani Suraksha Yojana (JSY) is an incentive-based programme for the promotion of institutional deliveries. The main objective of this programme is to ensure that each delivery is conducted in an institution and is attended to by a skilled birth attendant (SBA) to minimize/prevent maternal deaths and pregnancy-related complications in women and at the same time ensure the well-being of the mother and the new-born. Under JSY, cash assistance to mothers and the ASHAs is provided for institutional deliveries. Recruitment and training of the ASHAs in each village has given further impetus to the efforts of preventing maternal deaths.

With a view to assess the functioning and impact of this scheme, NIHFWS, New Delhi under financial assistance from UNFPA took an initiative to conduct rapid appraisals at the district and State levels to provide information/feedback/recommendations to programme planners on the processes and mechanisms of JSY, with the ultimate purpose of improving the overall quality of the intervention.

JSY in Orissa

JSY was implemented in Orissa in June 2006. Under this scheme, a selected number of ASHAs have been identified at the village levels to facilitate early registration of antenatal women, provide ante-natal care, and ensure timely transportation of women for institutional delivery. Both the women and the ASHAs are given cash assistance for ensuring a safe institutional delivery.

2. OBJECTIVES

2.1 General Objective

To review the implementation process of JSY in the State of Orissa and provide inputs for any corrective actions.

2.2 Specific Objectives

- To review the mechanism in place for implementation of JSY;
- To study the processes and procedures of ensuring financial benefit or cash assistance to the beneficiaries;
- To probe the acceptance of the JSY programme in the community; and
- To identify the problems/barriers (if any) faced during the implementation of JSY.

CHAPTER II

METHODOLOGY

Study Area: Balasore, Jagatsinghpur and Nayagarh districts of Orissa.

Study Design

Study Type: A cross-sectional descriptive study

Study Subjects

A. Programme Managers at the District and Block levels

- CDMO/ADMO(FW),
- DPM, and
- MO I/C- Block level CHC/PHC.

B. Programme Implementers at Community levels

- HW (F)s, and
- ASHAs.

C. Programme Beneficiaries at village levels

- Beneficiaries (mothers), and
- Non-Beneficiaries

D. Programme Supplementers at village levels

- PRI Members,
- School Teachers, and
- SHG Group Members.

Sampling Design: Multi-stage Random Sampling.

a) Selection of Districts

The selection of districts was based on the performance (high, medium and low) according to the maternal health indicators (e.g. institutional delivery in 2006 -07-43% in Balasore, 18% in Nayagarh and 10% in Jagatsinghpur).

b) Selection of Blocks

From each selected district, two blocks were identified -- one closest to the district headquarters and other located remotely. With this selection criterion, six PHC/CHCs in the six selected blocks of three districts were selected.

c) Selection of Sub-centres and the Villages

From each of the selected block level CHC/PHC, one sub -centre was randomly selected. Under each sub-centre, two villages were identified -- one nearest to the sub-centre and another distant. In the three districts, six PHCs/CHCs, six SCs and 12 villages were thus selected.

Table 1: List of selected Districts, Blocks, PHC/CHC, SCs and Villages

District	Block (Distance from District HQ in km)	PHC/CHC ¹	Sub-centres ²	Villages
Balasore	Remuna (12)	Remuna	Somnathpur	Jugalapatna, Bartana
	Simulia (49)	Simulia	Jamajhodi	Gudapada, Janjhari
Jagatsinghpur	Jagatsinghpur Sadar (14)	Mandasahi	Singarpur	Sekhpata, Thakursahi
	Kujanga (46)	Kujanga	Patapur	Tentulia Karatutha
Nayagarh	Bhapur (45)	Bhapur	Bada Sahara	Gopalprasad, Badasahara
	Nayagarh Sadar (10)	Badapandusar	Rajpatna	Rajpatna, Kaithagadia

d) Selection of Service Providers

The Chief District Medical Officers / ADMO (FW) (3), DPM (3) of the selected Districts, six MO I/C of selected Block CHC/PHC, six HW(F) of selected sub-centres and 12 ASHAs of the selected villages were considered as respondents for the study.

e) Selection of Beneficiaries¹ and Non Beneficiaries²

It was decided to include 30 beneficiaries and 30 non-beneficiaries of the JSY scheme from each district, equally distributed in two blocks. All women who had had institutional and home deliveries, and received incentives during last 12 months were taken as beneficiaries while all other mothers as non-beneficiaries. Beneficiaries and non-beneficiaries were randomly selected, but equal in numbers (7-8) from each selected village. If adequate numbers were not available from the same village, they were then

¹ Beneficiaries: All institutional deliveries and home deliveries have received the JSY money during in last one year.

² Non Beneficiaries: Home deliveries for which the JSY money was not given.

Selection of the best, worst, and middle level performer districts on maternal health indicators was done on the basis of percentage of institutional deliveries during 2006 -07 i.e. 43% in Balasore, 18% in Nayagarh & 10% in Jagatsinghpur

chosen from the adjacent village. Hence, from each Block 15 beneficiaries and 15 non-beneficiaries were selected.

f) Selection of Programme Supplementers

Available PRI members, school teachers, and SHG leaders of the selected villages were chosen as respondents for the FGDs.

Study Duration: 12 weeks, including four weeks for data collection (Oct - Nov 2007).

Data Collection Methods

Data was collected using semi-structured schedules, in-depth interviews (IDI) and focus group discussion (FGD). Primary and secondary data sources were used for data collection. Primary data was collected from all the respondents. In addition, primary data was also collected from the beneficiaries and non-beneficiaries in each village by using semi-structured interview schedules.

Secondary data was collected from the available reports and the records at the district, block, and sub-centre levels regarding the operational mechanism and utilization of the services under the JSY. All the data collected were triangulated to have more clarity on the findings at the time of analysis.

The study maintained all research ethics throughout. All in-depth interviews and FGDs were recorded after taking prior consent from the respondents and were transcribed. One FGD was conducted in each block with the available PRI members, SHG groups, and school teachers to know about their perception and bottlenecks in the implementation of the programme at the community level. Data collected was from each block through one FGD, four in-depth interviews (IDI), and interviews with 30 beneficiaries and non-beneficiaries.

Quality Assurance

In order to ensure the quality of the data, the Principal Investigator (PI) / Co-PI conducted the FGDs at the village levels and in-depth interviews at district level, while the supervisors conducted the remaining IDIs and interviewed the beneficiaries and non-beneficiaries along with the investigators. The investigators facilitated in ensuring the availability of respondents for the interviews and the FGDs. Exactly 10 per cent of the field work was supervised by the PIs in each district.

A team of two investigators and one supervisor worked in one district for 20 days. Separate teams worked simultaneously to cover the three districts. Consultants from NIHFV monitored the training, field activities, data analysis, and report writing. All the staff involved in the rapid appraisal research were provided two days of training on research guidelines, tools, and research issues before the commencement of the actual fieldwork.

Table 2: Summary of the study subjects, sample size, data collection technique and tools

Stakeholders	Number	Data collection method and tool
CDMO/ADMO(FW) DPM MO I/C HW(F) ASHA	3(1 per district) 3(1 per district) 6(1 per block) 6(1per block) 12(2 per block)	In-depth Interview – Interview checklist
Beneficiary mothers Non-beneficiary mothers	90(15 per block) 90(15 per block)	Interview- semi- structured interview schedule
PRI, SHG, School teachers	6 FGDs(1 FGD per block)	FGD- FGD Checklists

Data Analysis

Quantitative data was analysed by using *SPSS 11* software. For qualitative data, semi-quantification was done by coding the responses for different stakeholders and merging them into different headings by using adjectives (Table 3) as per the guidelines provided by NIHFWS.

Table 3: Adjectives used in the study for Qualitative data

<10	Very few
10-20	Some
20-30	Approximately a quarter
30-40	Approximately one third
40-60	Approximately half
60-80	Majority over half
>80	Most

Ethical Clearance

The project structure was examined and cleared by ethical committee of the institution review board of NIHFWS for ethical considerations .

CHAPTER III

FINDINGS AND DISCUSSION

Existing Mechanisms for Implementation

3.1 Human Resources

In order to ensure increasing numbers of safe institutional deliveries, the health system needs to have trained medical personnel like doctors, ob-gyns, and paramedical personnel like staff nurses, the LHVs, the HW (F)s, and pharmacists along with expert managerial staff like the DPM, the BPO and the BEE. Even the community-based ASHAs play an equally important role for successful implementation of the JSY.

In all the three selected districts, the key stakeholders such as the CDMOs, the ADMOs(FW) and the DPM(NRHM Cell) were available during the visits by the investigating team. They were keen to participate in the study and share their observations and experiences about implementation of the JSY in their districts.

All the ADMOs(FW) who were interviewed had the apprehension that the shortage of medical and paramedical workforce may pose a great hindrance to the ultimate success of the programme.

“Not a single medical officer was available in half of the PHC(N)s of the district. As the BEEs are over-burdened with multitude of activities and assignments, the awareness generation efforts under the JSY are not at all satisfactory”, said DPM, Balasore

“Lack of adequate number of female attendants, sweepers, and ANMs is a major bottleneck in ensuring good quality delivery services in the institutions”, noted ADMO(FW) of Jagatsinghpur

The views and observations made by the two district level functionaries in short reflected the sentiments of most of the senior and junior functionaries in all the six blocks.

- It was revealed that in some places, a single medical officer was posted as against the sanctioned strength of three, thus leading to the overburden of work and job responsibilities.
- The non-availability of staff nurses and the LHVs further aggravated the problem of regular and quality service delivery.
- It was observed that the shortage/non-availability of the ASHAs has become the weakest link and posed a challenge in all the three districts.

3.2 Logistics

Provision and availability of required logistics is an important issue for success of any programme. Timely supply, prompt procurement, and judicious utilization are some of the key areas of significance.

With regard to the JSY programme, adequate logistic support in terms of forms and registers, labour room facility, instruments and equipments in the labour room, essential medicines, emergency delivery kits, and IEC materials are of primary importance.

At the district level, all the necessary registers namely, admission register, delivery register, verification register, payment register, and cash book, were available and were found to be continually updated in all the three selected districts.

As part of the JSY policy, it is a requirement to display the list of the JSY beneficiaries on a board at the health centre in order to ensure transparency in the process and to impart updated information to those in the area, but it did not exist in all the sample districts.

At the district level, the key stakeholders commented on the availability of the labour room facilities which were inadequate in terms of numbers (delivery tables, instruments and equipments) to meet the increased delivery load following the implementation of the JSY programme. Thus the service delivery was suffering a setback both in terms of quantity and quality.

“The labour rooms were not well equipped, not well-ventilated, and cleanliness was not at all maintained. This problem further is aggravated by inadequate supply and under-stocking of medicines such as antibiotics, IFA tablets, multivitamin tablets etc.”, noted ADMO (FW), Nayagarh

Concern was expressed at the Nayagrah PHC on the inadequate health facilities for institutional delivery and similar inadequacies were also observed in other PHCs/CHCs. At PHC Badapandusara, the labour room was ill-equipped and ob-gyns or medical officers were not available conducting normal deliveries. Cases with complications were referred to the higher facilities.

At Balasore, non-availability of vehicles at PHC/CHC level was posing a challenge for effective supervision and monitoring of the programme.

“The major bottlenecks in the smooth implementation of the JSY programme were poor quality of IFA tablets, short supply of IFA tablets and other quality medicines and non-availability of duty room and staff quarters”, MO I/C Kujanga said.

The MO I/Cs at Remuna and Simulia revealed that there was short supply of antibiotics, misoprostol, methergine and syntocinon and it was severely affecting the quality of services. Though the SCs are also considered as institutions for facilitating delivery, actual facility for the same was available only in one out of the six sampled SCs. The SC building was available only in three SCs and it clearly points at infrastructure inadequacy which is posing a major hindrance for institutional deliveries.

‘Patapur Swasthya Upakendrara Mahila Swasthya karmi kahile “Aneka dina hela delivery kit supply hoinahin.’ (There is no supply of delivery kit to the sub-centre since long.), according to the HW(F), SC Patapur, CHC Kujanga.

Absence of a sub-centre building, non-supply of required medicines, and ill-equipped labour rooms are some of the major obstacles in providing quality delivery services at

these institutions. Provision of cash assistance alone, without inadequate logistics, will not be of use to improve the efficacy of institutional deliveries.

3.3 Knowledge of Service Providers

The level of knowledge of the service providers is of paramount importance in the successful implementation of the JSY in the community.

The levels of knowledge of the ADMOs(FW) and DPMs (Ref: Table 3.1) at the district levels, the MOI/C of CHCs/PHCs at the block level, and the HW (F)s and the ASHAs at the village levels were assessed with the help of structured schedule for in -depth interviews incorporating key components of the JSY programme. The overall score of > 0.5 was considered to indicate poor knowledge, 0.5 to 0.7 as an indicator of average knowledge, and 0.7 < as good knowledge.

Table 4: Knowledge of Service Providers: the ADMOs and the DPMs

Component of Scheme	Balasore		Jagatsinghpur		Nayagarh	
	ADMO	DPM	ADMO	DPM	ADMO	DPM
Eligibility	2	3	1	2	1	2
Incentives	1	2	1	2	1	2
Accredited institutes	1	2	1	0	1	2
Roles and Responsibilities of Service providers	2	2	2	2	2	3
Average Score	0.5	0.75	0.4	0.5	0.4	0.75

It is evident from the above table that out of the three ADMOs (FW) interviewed, two had poor and one had average knowledge regarding the key components of the JSY whereas two out of the three DPMs had good and one had average level of knowledge. The ADMO (FW), being the nodal functionary for family welfare activities in the district, needs to have better understanding of the programme to ensure effective implementation along with regular monitoring and supervision.

The table also depicts that out of the three DPMs, only two had good knowledge on the JSY .

Table 5: Knowledge of Service Providers: Medical Officer

Component of Scheme	Balasore		Jagatsinghpur		Nayagarh	
	Remuna	Simulia	Jasipur Sadar	Kujanga	Bhapur	Nayagarh Sadar
Eligibility	3	3	2	1	2	2
Incentives	3	2	2	1	2	3
Roles and Responsibilities of Service providers	2	2	2	1	2	3
Average Score	0.9	0.8	0.66	0.33	0.66	0.89

At the block levels, the MO I/C was identified as the key stakeholder of the programme. Three out of the six MOs interviewed had good, two had average, and one had poor level of knowledge. As effective functioning of the programme depends to a large extent on the expertise and exposure of the MOs, there is an urgent need to address these issues in an appropriate manner.

Table 6: Knowledge of Service Providers: HW (F)s

Component of Scheme	Balasore		Jagatsinghpur		Nayagarh	
	Somnathpur SC	Jamjhari SC	Sigup SC	Patpur SC	Badasahar SC	Rajpatna SC
Eligibility	2	3	3	2	2	2
Incentives	2	2	2	2	2	3
Roles and Responsibilities of Service providers	2	2	2	1	2	3
Average Score	0.66	0.78	0.78	0.56	0.66	0.89

At the sub-centre level, the HW (F) is most often the first contact for the community member. In order to ensure proper implementation and optimum utilization of services or benefits, the HW (F) needs to have adequate knowledge about different key components of the JSY programme. The findings reveal that out of the six HW (F)s, three had good and the other three had average level of knowledge. Hence it is of prime relevance that the HW (F)s need regular orientation and training on key areas to ensure the desired performance. Supportive supervision and on-the-job training by the supervising officers will also help in the improvement of the overall programme.

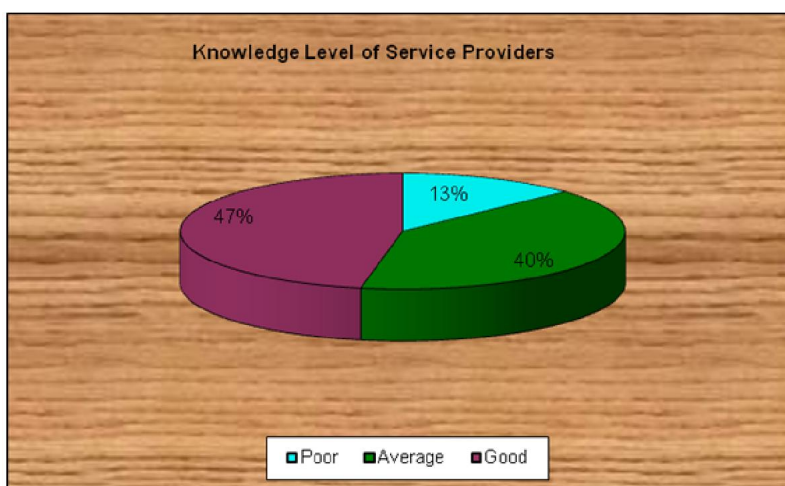
Table 7: Knowledge of Service Providers: ASHAS

Component of Scheme	Nayagarh				Jagatsinghpur				Balasore			
	Gopalprasad	Badasahar	Kaithagada	Patra	Sekpatna	Thakur Sahi	Patapur SC	Patapur SC	Jugalpatna	Bartana	Gandapada	Jamjhari
General Awareness	2	2	1	2	1	1	2	2	2	1	2	1
Roles & Responsibilities of ASHA	3	3	2	2	1	2	2	3	2	2	2	3
Average Score	0.83	0.85	0.55	0.67	0.33	0.5	0.67	0.83	0.83	0.5	0.67	0.67

Out of the 12 ASHAs interviewed, five had good, six had average, and one had poor level of knowledge regarding the JSY. The ASHAs are the key facilitators under the JSY programme at the village level. Right from the identification of a pregnant woman, early registration at the SC, ensuring minimum 3 antenatal checkups, 2 doses of TT immunization, 100 IFA tablets, institutional delivery and postnatal care with BCG to the baby of 6 weeks. They also act as first links of many prospective beneficiaries. It is therefore important that their knowledge levels should be kept at the optimum levels through frequent and repeated training inputs.

Table 8: Knowledge level of all Service Providers on JSY

Service Providers	Knowledge Level			Total (No)
	Poor (No)	Average (No)	Good (No)	
ADMO	2	1	--	3
DPM	--	1	2	3
MO	1	2	3	6
ANM	--	2	4	6
ASHA	1	6	5	12
Total	4 (13%)	12 (40%)	14 (47%)	30 (100%)



The above table reveals the overall knowledge of the service providers at each level of healthcare delivery system.

Out of 30 service providers interviewed, nearly half (47%) had good, 40% average, and 13% had poor level of knowledge.

As knowledge is a critical area of concern, there is an urgent need for repeated sensitization, periodic capacity building, and continued motivation for the service providers so that the programme can perform optimal in ensuring more and more safe institutional deliveries.

3.4 Training, Capacity Building and Sensitization

An urgent requirement is the availability of motivated and trained individuals to take the programme in the desired direction. Regular sensitization and capacity building are the two main components which will ensure effective implementation of the programme.

At the same time, the community can reap the benefits of a programme only if there are extensive awareness generation activities and a communication strategy in place for the community. Due to awareness generation campaigns, demand for institutional deliveries services/ANC/PNC check-ups has also increased.

Regular IEC/BCC activities at the community level will not only make the community aware but also increase patient inflow, and above all improve the efficiency and its overall functioning.

With regard to the sensitization programmes conducted and from their details, it was gathered that the orientation training for the ASHAs had been conducted twice in Balasore district. At the PHC level, training on accounting system was delivered to the HW (F)s, the LHVs, the BEEs, the MOs. In the district of Jagatsinghpur, the ASHAs have been trained while the HW (F)s have received training on maintenance of accounts. There has been a sensitization programme for all MO I/C, BDOs, ZP members under the aegis of Rogi Kalyan Samiti.

Scope of improvement is seen in these capacity building sessions.

“Sensitization programme was not at all satisfactory”, MO I/C Simulia, Balasore
“No special sensitization meeting has been undertaken for JSY exclusively”, MO I/C, Remuna CHC, Balasore.

“There was no sensitization programme for the MOs in the district”, MO I/C, CHC Kujanga.

However, the monthly meetings at the block PHCs and the weekly sector meetings have been the platforms for discussion on the JSY and tool for sensitizing the staff. At the PHC at Badapandusara, Nayagarh, a sensitization meeting of PRI members has been organized. Both the MO I/Cs of sample block PHCs of Nayagarh district indicated that they were utilizing the platform of weekly, monthly, and quarterly meetings to sensitize the ASHAs, the AWWs, the HW (F)s, the LHVs, the PRI members, the SHG members, teachers, and community leaders on different issues related to the JSY.

A training of three days duration was also organized for the MOs, the CDPOs, AYUSH doctors, the BEEs and NGO functionaries on the JSY. A one-day orientation was provided to the HW (F)s and the LHVs. In the district of Nayagarh, a one-day sensitization workshop was conducted in collaboration with White Ribbon Alliance for the SHG women, the ASHAs and the HW (F)s. The district has also organized eight one-day sensitization workshops involving the MOs, the BEEs, the LHVs and pharmacists.

Table 9: Status of Training of ASHAs and HW(F)

Name of the District	HW(F)			ASHA		
	Total	Trained	Not Trained	Total	Trained	Not Trained
Balasore	2	2	0	4	4	0
Jagatsinghpur	2	1	1	4	4	0
Nayagarh	2	2	0	4	3	1
Total	6 (100%)	5 (84%)	6 (16%)	12 (100%)	11 (92%)	1 (8%)

Table No. 3.6 reveals the training status of the HW (F) and the ASHAs. Besides one HW (F) in Jagatsinghpur and one ASHA in Nayagarh, rest of the interviewed the HW (F)s and the ASHAs have received training on the JSY. In Balasore, the ASHAs have undergone seven-day induction training during the first phase, followed by 16 -day modular training. They were provided information on mandate of the NRHM, namely the ANCs, the PNCs, safe delivery, water sanitation, safe motherhood, and safe child etc. The training also covered the components of the JSY. Though the first phase induction trainings for the ASHAs were held in all the three study districts, the 16-day modular training is yet to take place in Jagatsinghpur and Nayagarh district.

As an integral part of RCH – II programme, the JSY has been discussed in detail in many training sessions for the HW(F) and the ASHAs. But an exclusive JSY training is yet to be organized, aiming at strengthening the performance of the service providers (the HW (F)s and the ASHAs) under the JSY and brief them further on the aims and objectives of the scheme.

3.5 Sensitization of Community Members:

For the JSY to succeed in scaling down maternal and child morbidity and mortality, the community has an important role to play. The key stakeholders in the community are the PRI members, women SHG members, community opinion leaders, school teachers, the AWWs and the community itself.

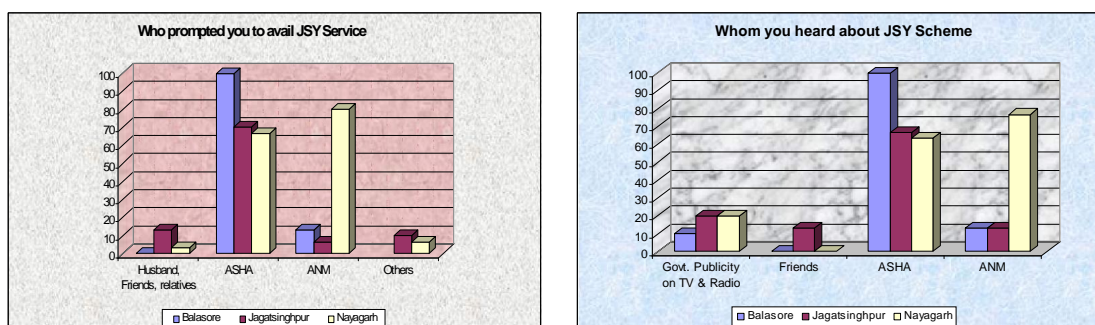
Efforts are being made in this direction. The district level authorities have taken the initiative of wall paintings and distributing leaflets at the district, block and village levels. Advertisements in local Oriya dailies and small video and audio clippings in local TV channels and radios are aired respectively. The PRI members and SHG women attend IEC meetings conducted at the sub-centre level. An innovative approach called the Janamancha was organized at the DHH in Nayagarh for a convergence meeting on JSY involving the ICDS, health officials, and PRI members.

“The cash-assistance to beneficiaries and the ASHAs is a great encouraging factor which facilitates the rapid spread of the JSY message through the community”, ADMO (FW) and DPM, Balasore.

Table 10: District-wise source of information for beneficiaries under the JSY

Who prompted you to avail JSY service	Name of the district						Total	
	Balasore		Jagatsinghpur		Nayagarh			
	No.	%	No.	%	No.	%	No.	%
Husband, Friends, relatives	0	0	4	13.3	1	3.3	5	5.6
ASHAs	30	100.0	21	70.0	20	66.7	71	78.9
ANMs	4	13.3	2	6.7	24	80.0	30	33.3
Others	0	0	3	10.0	2	6.7	5	5.6
From whom you heard about JSY scheme								
Government publicity on TV, Radio	3	10.0	6	20.0	6	20.0	15	16.7
Friends	0	0	4	13.3	0	0	4	4.4
ASHAs	30	100.0	20	66.7	19	63.3	71	78.9
ANMs	4	13.3	4	13.3	23	76.7	33	36.7

- Multiple sources possible



Graph 1: Various sources of information regarding JSY for the beneficiaries.

Out of the 90 beneficiaries interviewed, 79% were informed about the JSY by the ASHAs and 38% by the HW (F)s. With regard to availing the JSY benefits, 79% of the beneficiaries were motivated by the ASHAs and 33% by the HW (F)s. In Balasore district, the ASHAs have played an excellent role in providing information and motivating the mothers to avail the JSY benefits. Six FGDs were conducted involving 60 community leaders in the villages under study. In Balasore and Nayagarh districts all the participants were aware of the JSY, incentives given and its objectives. However, in Jagatsinghpur district, only 50% of the FGD participants were aware of the JSY.

Impact of IEC activities regarding the JSY at the community level was assessed in the FGD organized among PRI members, school teachers, village heads, women SHG members etc. It was revealed from the interviews with the non-beneficiaries that 27% of them did not know about the JSY programme. Though a good deal of effort was made at different levels, there still exists certain gaps in the level of awareness which needs to be addressed appropriately.

3.6 Monitoring and Supervision

With a view to assessing the mechanism of monitoring and supervision of the JSY programme, the ADMOs (FW), DPMs, MOs I/C, block PHC/CHC/UGPHCs and HW(F)s were interviewed in the sample districts.

It was revealed that at the district level during monthly meeting of all the block health functionaries, the JSY was reviewed along with other health programmes. Apart from regular monthly meetings, the DPM makes field visits to review the functioning of health programmes including the JSY. However, there was no fixed or prescheduled frequency of the DPM's field visits. There was also no supportive documentation of these field visits.

At the block level, the MO I/C reviews the different activities under the JSY programme, during the monthly review meeting. At times either the MO or the second MO or the BEE makes field visits for extending supportive supervision. But there was a visible absence of fixed or prescheduled programme of field visits. Even there was a little or no documentation of these supervisory visits.

At the weekly sector meetings, the sector MO along with the LHV of the concerned sector reviews the reports of the JSY. At times, the sector MO and LHV under take field visits to supervise the work of the HW(F)s.

At the sub-centre level the HW(F)s makes overall supervision of the functions of ASHA.

“A grievance cell has been formed consisting of members like the ADMO (FW), the DPM, the DAM, and the DHIO. One or two members of this cell will make surprise visits to each block at least once a month to supervise the JSY related activities like disbursement of funds to beneficiaries and the ASHAs, maintenance of JSY cashbook and payment registers and timely submission of SOE”, DPM , Nayagarh.

“I have not made any visit for supervision of JSY activities as I'm the only medical officer at the block PHC”,’ MO I/C, PHC Bhapur.

“Due to lack of time there was no supervision to review the activities of the ASHAs at the village level”,’ MO I/C, CHC Remuna

“There is no field level supervision. But the health-related programmes and activities are reviewed monthly at the block PHC meeting”,’ MO I/C, PHC Badapandusara.

These observations show that in all the sample districts there was no schedule for monitoring and supervision of field activities by the sectoral medical officers and the DPM and conducted either as a desk review during the weekly or monthly meetings at PHCs or as an additional activity whenever convenient. However all the HW(F)s expressed that they supervise the performance of the ASHAs in relation to the JSY programme at the village levels.

3.7 Coordination

The JSY aims at ensuring more and more institutional deliveries by skilled birth attendants in order to reduce maternal and neo-natal morbidity and mortality, through an incentives-based approach. At the same time it focuses on immunization of mothers and children. For appropriate and timely delivery of quality ante -natal, intra-natal and post-natal services, there is a need for well coordinated and synergistic effort of the key field level functionaries like the HW(F), the AWWs, the ASHAs as well as district and block level stakeholders. Thus intra and inter-sectoral coordination facilitates smooth functioning and efficient operationalisation of the JSY programme.

All the six HW(F)s indicated that they work in close co-ordination with the AWWs and the ASHAs. They accompany the HW(F)s during their home visits and facilitate provision of ante-natal and post-natal care at the doorsteps as well as at the sub-centres. The HW(F)s along with the AWW and the ASHAs motivate the clients to accept family planning methods (temporary and permanent).

“I always try to maintain good interpersonal relationship with the ASHAs and the AWWs. As per the JSY guidelines, I try to enhance their capability for identifying high risk pregnancies”, HW (F) SC Jamujhari

3.8 Best Practices

In any programme, some of the dedicated and highly motivated staff try to develop innovative and good practices to move the programme successfully.

This assessment highlights some of the best practices that were followed or adopted under the JSY.

- At DHH, Nayagarh, at times payments to the beneficiaries were delayed. The officials adopted a system of sending out intimation letters to the beneficiaries for collection of payment.
- At DHH, Balasore, there was provision for a separate counter to disburse the JSY money to the beneficiaries on every working day between 10 AM to 1 PM which ensured hassle free, prompt and timely disbursement.
- In district Jagatsinghpur, cash prize of Rs. 300 is given to the best performing ASHA in the respective sector.
- In district Nayagarh, local TV channels were utilized to air information/ advertisements on the JSY.

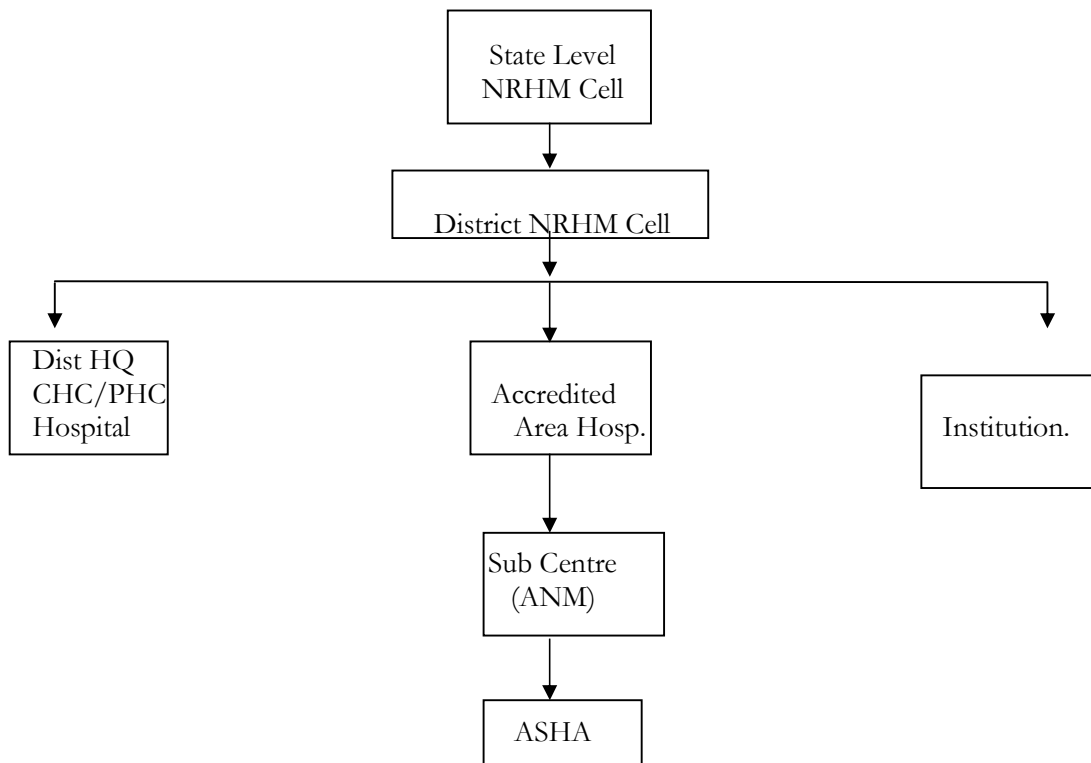
3.9 Process and Procedure of Financial Benefit

3.9.1 Funds Flow Mechanism under the JSY

Provision of financial incentives to the beneficiaries and the ASHA under the JSY is the key driving force to boost the institutional delivery set up. Therefore it is essential to ensure smooth and timely fund flow from state level till the sub -centre.

Schematic Diagram 1: Funds Flow Mechanism

Fig. 1 Mechanism of Fund Flow under JSY



Note: Funds flow is based upon SOEs and expected delivery load from the respective institutions. Beneficiary receives funds from each level of institution where delivery takes place.

The State NRHM Cell allocates funds to the district NRHM Cells basing upon expected delivery load and utilization certificate of previous allocation. The District NRHM Cell allocates funds to the District Headquarter hospital, block CHC/PHC/Area hospital and accredited hospitals. The CHC/PHC allocates funds to the sub -centre. The criterion for fund allocation is the expected delivery load statement and utilization certificate from the respective institutions.

In all the three districts, the process of fund allocation from state to the district is being done through electronic transfer. The improved funds flow now at Nay agarh district, against no-fixed frequency manner in the past is a good example of smooth fund transactions. The fund is allocated to the CHCs, PHCs, and the area hospitals on the basis of expected delivery load and submission of statement of expenditure. The fund is then allocated on monthly basis to all other districts from time to time on the basis of requirement. This allocation is made through a cheque or demand draft (DD).

3.9.2 Disbursement of Cash Assistance to ASHA

The district functionaries revealed that the ASHAs were receiving the incentives from HW(F)s in the form of cash for facilitating institutional deliveries in her area.

It was observed that the ASHAs were getting Rs 600 as down payment as against the prescribed guideline of payment (Rs. 250 for transportation, Rs. 150 for stay at the institution and Rs 200 after the child is immunized with BCG).

With regard to receipt of incentives, out of the 12 ASHAs interviewed, nine were in receipt of Rs. 600 each for promoting early registration, ante-natal care and institutional deliveries. Among the rest of three ASHAs, one had not received her incentives yet and the remaining two had received only Rs 350 and Rs. 150 respectively.

“Mu prati delivery pain 400 tanka paye. Matra gotiethara mote 150 tanka dei 400 tankara rasidare dastakhata karibaku kuhagala. Pacharibarukahile 250 tanka prsutiku diajiba” (I received only Rs 400 for facilitating each delivery. On one instance I had received only Rs 150 though she was made to sign for Rs 400. When enquired I was told that Rs 250 will be given to the beneficiary): ASHA in the Village Jamjhari of SC Jamujhari, CHC Simulia, Balasore

3.9.3 Incentives to Beneficiaries

As per the norms under the JSY, each beneficiary is given Rs 1400 for availing the institutional delivery facilities in rural area and Rs 1000 in urban areas. For this purpose, the woman must have a JSY card and the immunization card, and must have availed three ANCs, 100 IFA tablets and two doses of TT. If the beneficiary has arranged transportation at her own cost, then a sum of Rs 250 would also be paid to the beneficiary towards the cost of transportation and the incentive should be paid vide cheque on the same day in case of institutional delivery at the respective institution.

In case of home delivery, the guidelines states that the mother should be aged 19 yrs and above, from BPL family, have had up to two live births, and the delivery should be attended by a SBA or a trained TBA. The incentive amount is Rs. 500 which will be disbursed by the HW(F) in form of cash.

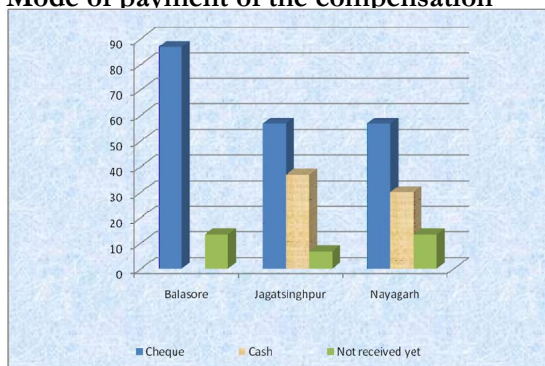
The health authorities at district level and block levels have pointed out that there is always an attempt that the beneficiaries should be given Rs. 1400 through cheque and Rs 500 by cash on the same day subject to verification of eligibility and availability of funds. In reality, the disbursement of money to the beneficiaries in both the cases of home and institutional deliveries is delayed due to non-availability of funds.

Three out of the six HWs expressed that the funds flow is irregular and delayed. According to 10 out of the 12 ASHAs, there is a usual delay of 15 days to two months in the disbursement of incentives to the beneficiaries. However, two ASHAs in the district of Balasore had stated that the payment to beneficiaries was immediate after delivery. (Ref: Table 3.8)

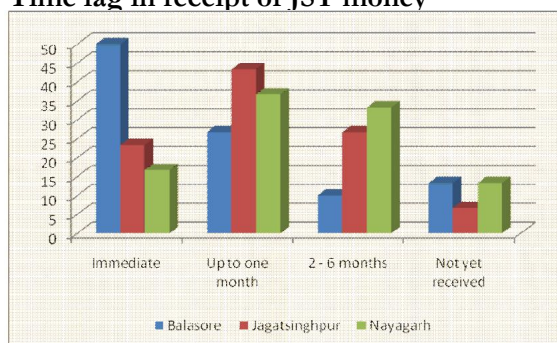
Table 11: Mode of payment and time lag in payment of Compensation to the beneficiary

Compensation payment	Name of the district						Total	
	Balasore		Jagatsinghpur		Nayagarh			
Mode of payment of the Compensation	No.	%	No.	%	No.	%	No.	%
Cheque	26	86.7	17	56.7	17	56.7	60	66.7
Cash	0	0	11	36.7	9	30.0	20	22.2
Not received yet	4	13.3	2	6.7	4	13.3	10	11.1
Time lag in receipt of JSY money								
Immediate	15	50.0	7	23.3	5	16.7	27	30.0
Up to one month	8	26.7	13	43.3	11	36.7	32	35.6
2 - 6 months	3	10.0	8	26.7	10	33.3	21	23.3
Never (Not yet received)	4	13.3	2	6.7	4	13.3	10	11.1
Total	30	100.0	30	100.0	30	100.0	90	100.0

Mode of payment of the compensation



Time lag in receipt of JSY money

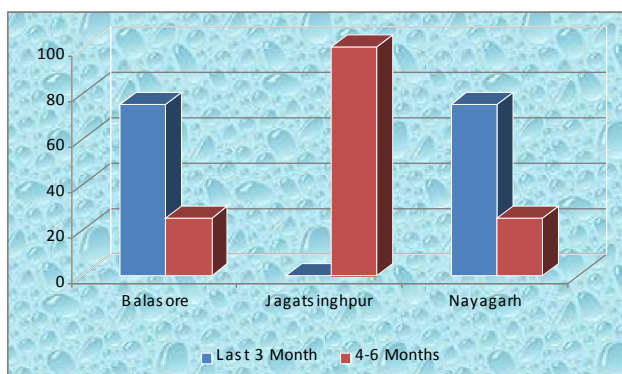


It was revealed that out of the 90 beneficiaries interviewed, 60 (67%) had received the money through cheques, 20 (22%) by cash, and 10 (11%) had not received money as yet. Out of the total beneficiaries, 32 (36%) received it after a time lag of one month, 21 (23%) from 2 – 6 months, 10 (11%) had never received the money. Out of these 10 cases, who had not received compensation as yet, six delivered in the last three months and four in last 4 -6 months.

Table 12: Period of delivery for cases who have not received the compensation as yet (N=10)

Period of delivery	Name of the district						Total	
	Balasore		Jagatsinghpur		Nayagarh			
	No.	%	No.	%	No.	%	No.	%
Last 3 Month	3	75	0	0	3	75	6	60
4-6 Months	1	25	2	100	1	25	4	40
Total	4	100	2	100	4	100	10	100

Period of delivery for cases who have not received the compensation as yet



This clearly revealed inordinate time lag in the disbursement of incentives to the beneficiaries. The district-wise frequency distribution of different quantum of incentives received by beneficiaries is presented in the table.

Table 13: Distribution of Compensation received by the beneficiaries

Compensation received under the JSY	Name of the district						Total	
	Balasore		Jagatsinghpur		Nayagarh			
	No.	%	No.	%	No.	%	No.	%
400	0	0	1	3.3	0	0	1	1.1
430	0	0	1	3.3	0	0	1	1.1
450	0	0	0	0	1	3.3	1	1.1
500	0	0	0	0	4	13.3	4	4.4
700	0	0	4	13.3	3	10.0	7	7.8
1050	0	0	0	0	1	3.3	1	1.1
1300	0	0	0	0	1	3.3	1	1.1
1350	0	0	1	3.3	0	0	1	1.1
1400	23	76.7	21	70.0	15	50.0	59	65.6
1450	1	3.3	0	0	0	0	1	1.1
1600	1	3.3	0	0	1	3.3	2	2.2
1650	1	3.3	0	0	0	0	1	1.1
Not Yet Received	4	13.3	2	6.7	4	13.3	10	11.1
Total	30	100.0	30	100.0	30	100.0	90	100.0

About 70% of the beneficiaries had received compensation amount of Rs 1400 or more and 3.3% had received compensation between Rs. 1000 to Rs. 1400, and 7.8% had received compensation amount Rs 700, according to the previous norm. Out of the seven beneficiaries of home delivery, three had received amount less than Rs 500. With the beneficiaries getting money less than the stipulated norm, there seems to be some pilferage in the disbursement processes.

As per the guidelines, the imprest money of Rs 10,000 should be given to the sub-centre and must be kept in the joint bank account of the HW(F) and the Sarpanch. This is to meet the fund requirement for home delivery and advance payment to the ASHA for meeting the cost of transportation for institutional delivery. However, the health authorities of three studied districts had stated that they were disbursing the imprest amount of Rs 5000 to the sub-centre. The HW(F)s have also confirmed the receipt of the same amount. This is an area of concern, as most of the delays of benefits to the mothers as well as to the ASHAs were mainly stated to be due to lack of availability of money at the sub-centres and if the fund release of Rs 10,000 can be ensured, then this situation can be avoided

3.9.4 Community Acceptance and Impact

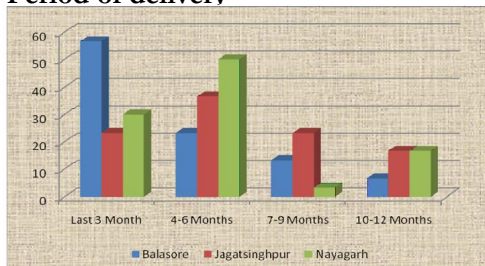
Clients Perspective

The beneficiaries and non-beneficiaries were interviewed to know their perspective on different aspects of JSY.

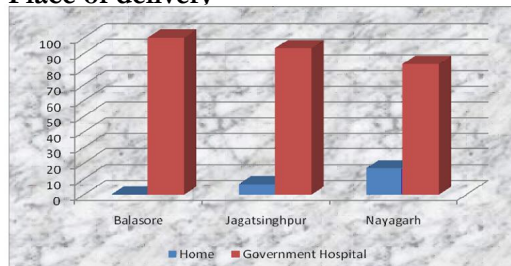
Table 14: District-wise delivery characteristics of Beneficiaries

Beneficiary Characteristics	Name of the district							
	Balasore		Jagatsinghpur		Nayagarh		Total	
Period of delivery	No.	%	No.	%	No.	%	No.	%
Last 3 Month	17	56.7	7	23.3	9	30.0	33	36.7
4-6 Months	7	23.3	11	36.7	15	50.0	33	36.7
7-9 Months	4	13.3	7	23.3	1	3.3	12	13.3
10-12 Months	2	6.7	5	16.7	5	16.7	12	13.3
Place of delivery								
Home			2	6.7	5	16.7	7	7.8
Government Hospital	30	100.0	28	93.3	25	83.3	83	92.2
Birth Order								
1	18	60.0	14	46.7	17	56.7	49	54.4
2	9	30.0	11	36.7	9	30.0	29	32.2
3 – 6	3	10.0	5	16.7	4	13.3	12	13.3
Delivery Conducted by								
Relative			2	6.7	3	10.0	5	5.6
HW(F)					2	6.7	2	2.2
Nurse	10	33.3	1	3.3	12	40.0	23	25.6
Doctor	20	66.7	27	90.0	13	43.3	60	66.7
Delivery Out Come								
Live Birth	30	100.0	30	100.0	30	100.0	90	100.0
Still Birth	0	0.0	0	0.0	0	0.0	0	0.0
Total	30	100.0	30	100.0	30	100.0	30	100.0

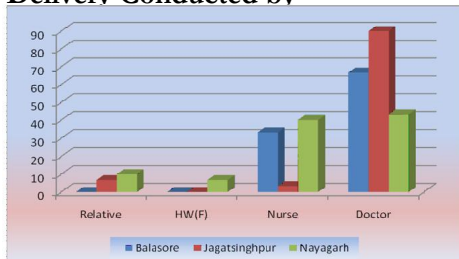
Period of delivery



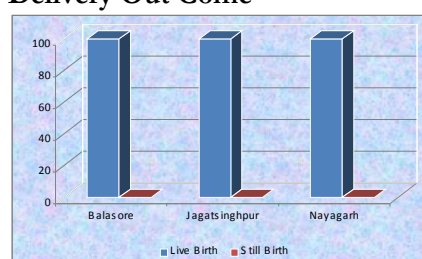
Place of delivery



Delivery Conducted by



Delivery Out Come



Beneficiaries

Among the beneficiaries, 13% had delivery within 10-12 months, 13% in 7-9 months, 37% within 4-6 months, and 37% during the last three months. As much as 92% of deliveries were in the Government hospitals. It was 100% in Balasore, 93% in Jagatsinghpur, and 83% in Nayagarh. Among the beneficiaries, only seven had home delivery, of which five were in Nayagarh, and two in Jagatsinghpur. Even though in five cases (Nayagarh three and Jagatsinghpurs two) the delivery was attended by relatives, still they were considered as beneficiaries and had received the JSY money.

Majority (2/3rd) of deliveries were conducted by doctors (67%), nurses (26%), and the HW(F)s (2%). The deliveries conducted by doctors were highest in Jagatsinghpur (90%), followed by Balasore (67%), and lowest in Nayagarh (43%). As much as 54% of the deliveries were of the first order, 32% second order, and 13% were having birth order 3-6.

The parameters discussed above for non-beneficiaries and beneficiaries were cross tabulated, to know the difference if any.

Non-Beneficiaries

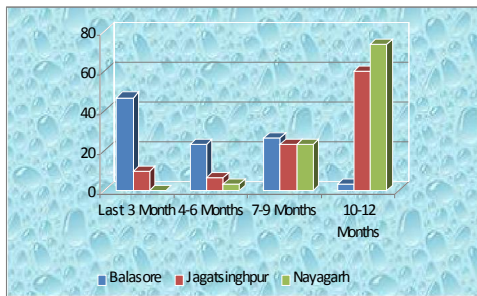
Out of the 90 non-beneficiaries under study, 46% had delivery during last 10-12 months, 24% last 7-9 months, 11% last 4-6 months, and 19% with in last three months.

As regards place of delivery, nearly 2/3rd had delivered at homes (63%), while the remaining 1/3rd delivered in the private hospitals (37%). Relatives had conducted 31% while traditional dai (22%), and the doctors (37%) took care of the rest. Doctors conducting deliveries was highest in Jagatsinghpur (63%) while in other two districts it was of the order of 23%. Only one delivery has resulted in still birth. As regards to birth order, 38% were of the first order, 27% of the second order, and 36% were having birth order 3-6.

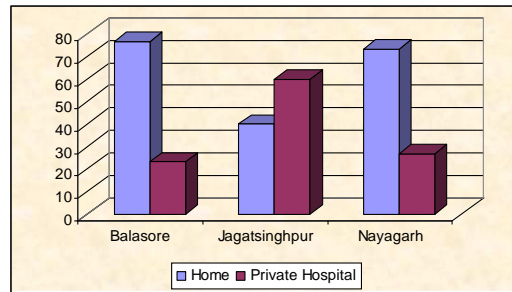
Table 15: Delivery characteristics among non-beneficiaries

Delivery Characteristics	Name of the district						Total	
	Balasore		Jagatsinghpur		Nayagarh			
Period of delivery	No.	%	No.	%	No.	%	No.	%
Last 3 Month	14	46.7	3	10.0	0	0	17	18.9
4-6 Months	7	23.3	2	6.7	1	3.3	10	11.1
7-9 Months	8	26.7	7	23.3	7	23.3	22	24.4
10-12 Months	1	3.3	18	60.0	22	73.3	41	45.6
Place of delivery								
Home	23	76.7	12	40.0	22	73.3	57	63.3
Private Hospital	7	23.3	18	60.0	8	26.7	33	36.7
Delivery Conducted by								
Relative	5	16.7	6	20.0	17	56.7	28	31.1
Traditional Dai	16	53.3	2	6.7	2	6.7	20	22.2
Trained Dai	2	6.7	1	3.3	0	0	3	3.3
ANM	0	0	2	6.7	3	10.0	5	5.6
Nurse	0	0			1	3.3	1	1.1
Doctor	7	23.3	19	63.3	7	23.3	33	36.7
Delivery out come								
Live	30	100.0	29	96.7	30	100.0	89	98.9
Dead	0	0	1	3.3	0	0	1	1.1
Number of deliveries								
First birth	9	30.0	14	46.7	11	36.7	34	37.8
Upto2	15	50.0	7	23.3	2	6.7	24	26.7
3 to 5	6	20.0	9	30.0	17	56.7	32	35.6
Total	30	100	30	100	30	100	90	100

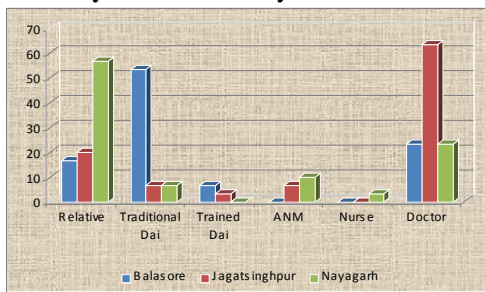
Period of delivery



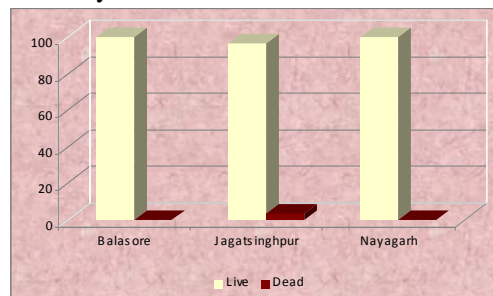
Place of delivery



Delivery Conducted by



Delivery Out Come



It was seen that proportions of deliveries of the first and second order were significantly higher among beneficiaries than the non-beneficiaries. The proportion of higher birth order (three or more) was significantly higher for non-beneficiaries than the beneficiaries. This indicated that non-beneficiaries have higher proportion of birth order and they need to be advised for family welfare measures

Table 16: Birth order according to category of clients

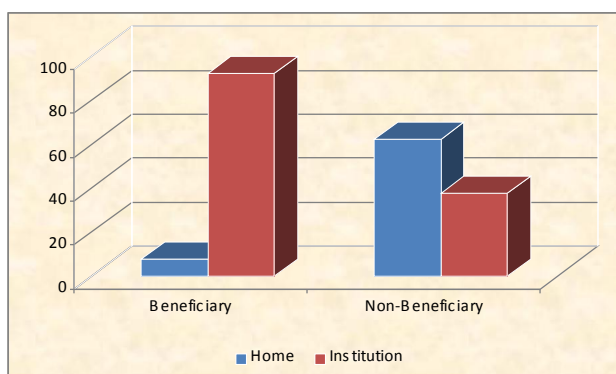
Order of birth	Frequency / %	Category		Total
		Beneficiary	Non-Beneficiary	
First	No.	49.0	34.0	83.0
	%	54.4	37.8	46.1
2nd	No.	29.0	24.0	53.0
	%	32.2	26.7	29.4
3-5	No.	12.0	32.0	44.0
	%	13.3	35.6	24.4
Total	No.	90.0	90.0	180.0
	%	100.0	100.0	100.0

Similarly place of delivery was cross-tabulated with category of beneficiaries. It was revealed that majority of non-beneficiaries had home deliveries while the majority of beneficiaries had institutional deliveries. The proportion of institutional delivery was significantly higher for beneficiaries

Table 17: Place of delivery according to category

Place of Delivery	DEL_PL1 No./%	Category		Total
		Beneficiary	Non-Beneficiary	
Home	No.	7.0	56.0	63.0
	%	7.8	62.2	35.0
Institution	No.	83.0	34.0	117.0
	%	92.2	37.8	65.0
Total	No.	90.0	90.0	180.0
	%	100.0	100.0	100.0

Place of delivery according to category



The outcome of the delivery was compared among the category of mothers. One delivery had resulted in still birth in case of non-beneficiaries which is of importance.

Table 18: Delivery out come according to the category of mothers

		Category		Total
Delivery out come		Beneficiary	Non-Beneficiary	
Live	No.	90.0	89.0	179.0
	%	100.0	98.9	99.4
Dead	No.	0	1.0	1.0
	%	0	1.1	0.6
Total	No.	90.0	90.0	180.0
	%	100.0	100.0	100.0

The categories of mothers were compared according to the medical personnel conducting the deliveries (Table 3.18). It clearly emerged that higher percentage of beneficiaries got delivered by doctors or nurses (SBA). Thus it is implied that they had more access to expert and quality delivery services.

Table 19: Delivery conducted by different personnel according to the category of clients

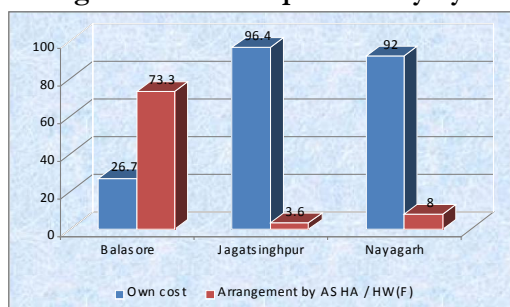
		Category		Total
Delivery Conducted by		Beneficiary	Non-Beneficiary	
Relative	No.	5.0	28.0	33.0
	%	5.6	31.1	18.3
Traditional Dai	No.	0	20.0	20.0
	%	0	22.2	11.1
Trained Dai	No.	0	3.0	3.0
	%	0	3.3	1.7
HW(F)	No.	2.0	5.0	7.0
	%	2.2	5.6	3.9
Nurse	No.	23.0	1.0	24.0
	%	25.6	1.1	13.3
Doctor	No.	60.0	33.0	93.0
	%	66.7	36.7	51.7
Total	No.	90.0	90.0	180.0
	%	100.0	100.0	100.0

In order to facilitate the institutional deliveries, the JSY envisages arrangement of transportation facility. About 70% of the beneficiaries had arranged the transportation on their own cost, while in 30% transportation was arranged either by the ASHAs or HW(F)s. In case of majority of the beneficiaries (78%), the ASHAs had accompanied them to the institution for delivery. The arrangement of transportation is one area, where the ASHA could play a more pro-active role. In the district of Balasore, the ASHAs had accompanied in 97% of cases, whereas it was significantly lower in Jagatsinghpur (71%) and Nayagarh (64%). Similarly in Balasore, the ASHAs had arranged transportation in 73% cases whereas it was significantly lower in Jagatsinghpur (4%) and Nayagarh (8%).

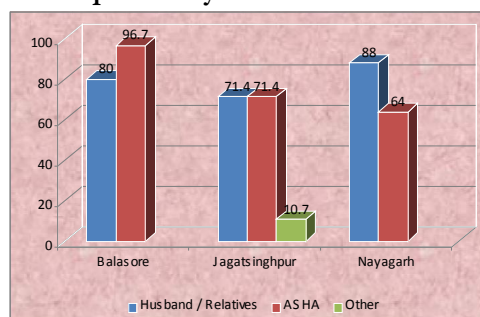
Table 20: District-wise transportation of the beneficiaries to the Institution

Beneficiaries movement to the hospital	Name of the district						Total	
	Balasore		Jagatsinghpur		Nayagarh			
Arrangement of Transport facility by	No.	%	No.	%	No.	%	No.	%
	Own cost	8	26.7	27	96.4	23	92.0	58
Arrangement by ASHA / HW(F)	22	73.3	1	3.6	2	8.0	25	30.1
Total	30	100.0	28	100.0	25	100.0	83	100.0
Accompanied by								
Husband / Relatives	24	80.0	20	71.4	22	88.0	66	79.5
ASHA	29	96.7	20	71.4	16	64.0	65	78.3
Other			3	10.7			3	3.6
Total	30	100.0	28	100.0	25	100.0	83	100.0

Arrangement of Transport facility by



Accompanied by



3.9.5 Utilization of compensation money by Beneficiaries

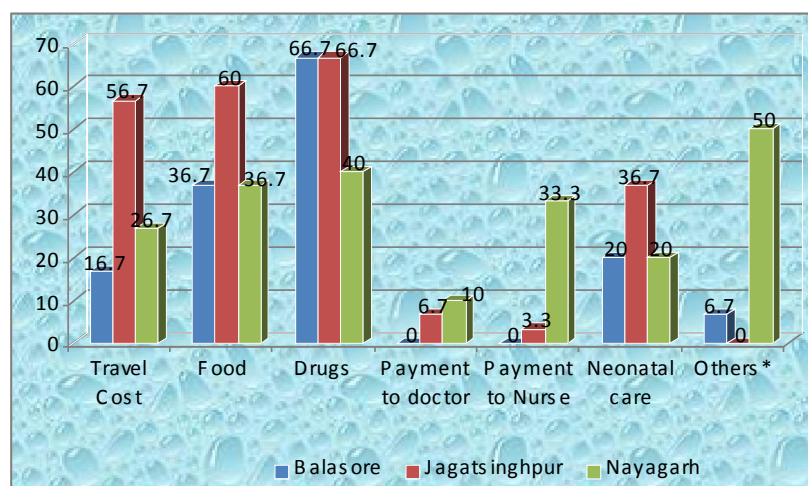
On enquiring about the utilization of the JSY money to the beneficiaries, 58% were utilizing the money for purchase of drugs, 44% for food, and 33% for travel. As much as 12 % beneficiaries had asserted that they had to make payment to nurses, while 6% to the doctors. During the course of interviews, they had indicated that in certain instances the hospital staff like doctors, nurses, and sweepers were demanding money for the services. However, 19% had deposited the money for the child in the bank.

Table 21: Utilization of JSY money by the Beneficiaries

Utilization of JSY Money for	Name of the district						Total	
	Balasore		Jagatsinghpur		Nayagarh			
	No.	%	No.	%	No.	%	No.	%
Travel Cost	5	16.7	17	56.7	8	26.7	30	33.3
Food	11	36.7	18	60.0	11	36.7	40	44.4
Drugs	20	66.7	20	66.7	12	40.0	52	57.8
Payment to doctor	0	0	2	6.7	3	10.0	5	5.6
Payment to Nurse	0	0	1	3.3	10	33.3	11	12.2
Neonatal care	6	20.0	11	36.7	6	20.0	23	25.6
Others*	2	6.7	0	0.0	15	50.0	17	18.9

* Deposited in the name of the child in Bank

Utilisation of JSY money by the beneficiaries



3.9.6 Reason for non-utilization of service by Non-beneficiaries

The non-beneficiaries were asked about the reasons for not availing the services under the JSY scheme. The most important reasons were that they were not aware of the JSY (27%) and the non-availability of transportation facility (19%). Another key observation was that 17% did not have faith in the Government health system and 8% stated non-availability of Government hospital service. This indicated that there was a considerable gap in awareness generation and a need to motivate the mothers and instil in them faith in the Government. Health facilities, along with improving the quality of service, is advised so that the non-beneficiaries can be included under the JSY programme.

Table 22: Reasons for not availing the services by the non-beneficiaries

Reasons for not availing the service	No.	%
Did not know about the JSY	24	26.7
Had incomplete information	9	10.0
Not allowed by husband and in-laws	1	1.1
No one from health department approached me	6	6.7

Reasons for not availing the service	No.	%
Transport facility not available	17	18.9
Hospital service not available	7	7.8
No belief in Govt. health system	15	16.7
Follow the traditional system	5	5.6
Referred to Private Hospital/Nursing home for CS	4	4.4
Delivered on the way	2	2.2
Others	1	1.1
Total	90	100.0

3.9.7 Study Outcomes

The objective of the programme is to increase institutional deliveries in order to safeguard the health of the mother and the child, and reduce or prevent maternal and infant mortality and morbidity. To see the impact on the MMR/IMR, a greater in-depth study needs to be launched over a period of time and hence this study did not have the scope to look at this aspect. However, the impact can be assessed from three -angles: the awareness, the generation of demand for institutional deliveries, and increase in number of institutional deliveries.

The study analysis points out that the awareness in the community has increased. This is also corroborated by focus group discussion with anganwadi workers, PRI members and community leaders.

“Pilamane Deshara Bhabishyata, tenu maa mane surakhita prasaba subidha paiba uchit” (“Child is the future of the nation. So mother should be safe and should avail safe delivery services): FGD - Badasahara SC, District of Nayagarh

“The objective of the JSY is to reduce infant and maternal mortality, to keep the baby healthy and keep birth spacing.” FGD – Patapur SC, Jagatsinghpur

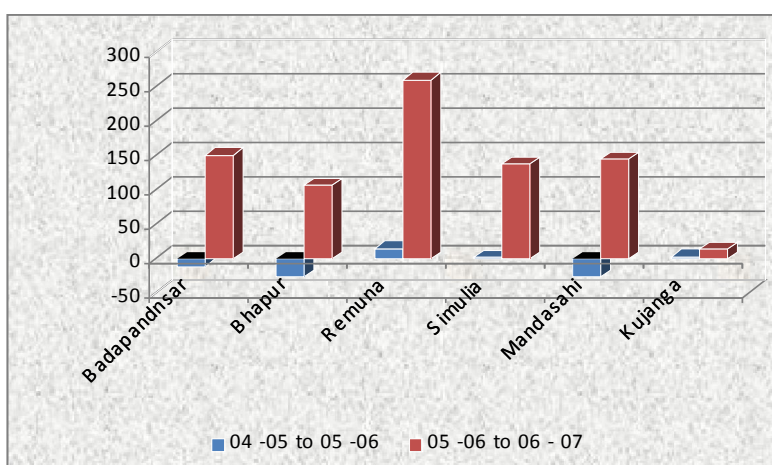
The community members demanded that the ANC and the PNC services should be available at the doorsteps through mobile medical units and the doctors should be recruited and be made available for services as and when required. The health authorities also mentioned that, because of increase in delivery load at the institutions the present service capability is becoming inadequate with regard to infrastructure, equipments, supplies and manpower.

It was revealed that, during the period from 2004–05 to 2005 – 06, the total number of institutional deliveries were more or less equal in the six PHCs/CHCs under the study. But from 2005–06 to 2006 – 07, the number of institutional deliveries had gone up by 76%. In four of the PHCs/CHCs, the increase was more than 100%, while in one of them, the hike was more than 250%. This increase in the institutional deliveries reveals the positive impact of the JSY programme.

Table 23: Year-wise Institutional Delivery: PHC/CHC level : 2004 - 07

Name of the district	Name of the CHC/PHC	06 - 07	05 - 06	04 - 05	% of increase	
					04 - 05 to 05-06	05-06 to 06 - 07
Nayagarh	Badapandnsar	40	16	18	-11.1	150.0
Nayagarh	Bhapur	309	150	205	-26.8	106.0
Balasore	Remuna	273	76	66	15.2	259.2
Balasore	Simulia	992	419	411	1.9	136.8
Jagatsinghpur	Mandasahi	66	27	37	-27.0	144.4
Jagatsinghpur	Kujanga	859	753	728	3.4	14.1
	Total	2539	1441	1465	-1.6	76.2

Year-wise increase in Institutional Delivery: PHC/CHC level: 2004 – 07



CHAPTER IV

RECOMMENDATIONS

Areas of Concern	Actions Recommended
<p>Policy Issues</p> <ul style="list-style-type: none"> • Lack/shortage of medical and paramedical staff for the implementation of the programme, leading to increased work load.. • Increased workload for the ASHAs (looking after a population of 2000 as per the norm of catering to 1000). As a result poor performance is indicated. • Absence of display board with list of the JSY beneficiaries along with date of disbursement of incentives at all levels of institutions, hence reducing transparency. 	<ul style="list-style-type: none"> • The vacancies at all levels need to be filled up immediately. • More number of ASHAs need to be engaged to share the increased burden. • Display of list of beneficiaries must be made mandatory at district and block levels.
<ul style="list-style-type: none"> • Absence of institutional logistics support, e.g. ill-equipped labour rooms. • Shortage of antibiotics, other medicines, poor quality of IFA tablets. • Lack of adequate facility within the sub-centre to conduct deliveries. • Lack of sub-centre building/infrastructure 	<ul style="list-style-type: none"> • The inadequacy of equipments, drugs, and the infrastructure should be assessed through facility surveys and the deficits are to be filled up urgently to meet increased demand for labour rooms. • The quality of IFA tablets should be enhanced. • Sub-centres without their own building need to be provided with adequate infrastructure • Delivery facility at the sub-centre has to be ensured both qualitatively and quantitatively.
<ul style="list-style-type: none"> • Ineffective monitoring and supervision by the medical personnel. 	<ul style="list-style-type: none"> • There is a need for clear policy on monitoring and supervision. The monitoring and supervision diary at district and block level must be made mandatory.
<p>Programme Issues</p> <ul style="list-style-type: none"> • Lack of incentives to the ASHA as per the norms. Less incentives or delayed payments. • Lack of clarity/system in receiving incentives. • Among the non-beneficiaries 	<ul style="list-style-type: none"> • Delay in disbursement of fund at district and block levels needs to be addressed appropriately. • Discrepancies in the amount of compensation received by beneficiaries and the ASHAs need

<p>significant proportion delivery (about half) are conducted by relatives or traditional dais. About 2/3rd had their delivery at home.</p> <ul style="list-style-type: none"> • Non-utilization of services under the JSY 	<p>to be seriously viewed.</p> <ul style="list-style-type: none"> • Time lag of one month duration needs to be identified early for timely corrective action. • There is a need for accreditation of private institutions for institutional delivery. • Transport facilities must be made available at the sub-centres and block levels.
<p>IEC</p> <ul style="list-style-type: none"> • Poor knowledge about the programme among the higher authorities • Inadequate knowledge about the components of the programme and their role and responsibilities. • A gap in the knowledge level of the ASHAs and health functionaries. • A gap in the awareness of other stakeholders and community results in large number of non-beneficiaries. 	<ul style="list-style-type: none"> • Sensitization of district and block level programme managers needs to be stepped up. • The HW(F)s and the ASHAs must be kept informed about the different aspects of the JSY from time to time on regular basis. • Any modification in the programme needs to percolate down the hierarchy in time. • Feedbacks from top to bottom need to be streamlined. • Awareness generation activities in the community need to be strengthened. • There is a need for repeated training and sensitization of the MOs, the HW(F), and the ASHAs.

Limitations of the study

- As the study duration was less, a large sample size could not be attempted;
- Number of study districts could have been increased in order to ensure more representation and generalization of the findings;
- Future directions of research;
- Facility assessment study may be undertaken to map out the areas of deficits and initiate timely corrective measures; and
- Impact analysis of PPP in the JSY could not be conducted.

REFERENCES

1. Government of India, NRHM implementation guidelines, Ministry of Health & Family Welfare. New Delhi 2005
2. Government of India, Implementation of Janani Suraksha Yojana, programme document by Ministry of Health and Family Welfare, New Delhi 2005.
3. Kishore J, National Health Programmes of India, Century Publications, 6th Edition, New Delhi, 2006.
4. Government of Orissa, Janani Suraksha Yojana, Director of Family Welfare, Bhubaneswar, 2006.
5. World Health Organisation, South East – Asia Region Document for improving maternal, Newborn & Child Health.
6. Govt. of India, National Maternity Benefit Scheme (NMBS) - draft document,
7. UNICEF/India/Patralkha 2007, Orissa, Koraput district.
8. Parliament of India, Rajya Sabha Department – Related Parliamentary Standing Committee on Health & Family Welfare Thirteen Report on action taken by Government on the recommendation observations contained in the eighth report on demands for grants 05-06 UNICEF/INIDA/2006.
9. PRESS Releases, Cabinet Committee on Economic Affairs (CCEA). Wednesday March, 30, 2005.
10. UNICEF, Assessment of Referral transport scheme for Emergency obstetric care under RCH-II, Phase – I, Rajasthan (undated)