Note on Janani Suraksha Yojana

1. Objective of the Note:
   1. To get a brief overview of the problems faced by the JSY scheme during its implementation. Also to re-visit some of the conceptual or foundational issues as regards this programme.
   2. To understand the possibilities and limitations that the scheme would have in terms of its contribution to the goal of maternal and infant mortality reduction.
   3. To consider some suggestions for strengthening proposed and to form an assessment of them.

This note is not a progress report, nor a programme appraisal. The JSY has undoubtedly contributed to a tremendous improvement in institutional delivery and brought pressure on the public health system to improve its performance and deliver services. These have spilled over, beyond care in pregnancy to other services also.

This note should help to focus on the areas of the programme that need strengthening or revision, to identify alternatives or supplementary programmes that are needed to achieve our health outcomes as also plan for a more detailed evaluation later.

The Janini Suraksha Yojana is a centrally sponsored intervention under NRHM for the objective of maternal and neo-natal mortality reduction through the strategy of promoting institutional delivery. As of today, there are 83.78 lakh beneficiaries, and the expenditure is now over Rs 1241 crores. Both number of beneficiaries and expenditure on this scheme is now increasing steeply and there is no clarity on where it would plateau. The scheme is now three and half years to four years old and it is a good opportunity for a review.

One key concern has been whether JSY is having commensurate impact on maternal and neonatal mortality, and even on care in pregnancy, taken in its entirety. External figures of DLHS-III relate to 2007-08 show a 47% institutional delivery and a 19.1% full antenatal care. These do represent a significant increase, but are less than what could be expected. The other dimension is how JSY impacts on the whole of public health system development. And the third is the sustainability of the model, its potential for both its expansion to cover more areas of care and its replicability for other wellness areas.

II. Issues With Janini Suraksha Yojana: Conceptual and Operational
1. This programme started out as an amalgamation of the earlier maternity nutrition benefit scheme and the referral transport scheme. Both of these had been very poorly functional. By bringing them together into a single package and by focusing this package on institutional delivery, the JSY was born. But soon after the Rs500
benefit for home delivery in a BPL family was reintroduced, due to a supreme court ruling on retaining the maternity benefit component. However the scheme in practice is almost completely focused on promotion of institutional delivery- to the exclusion of other related objectives. The payments on account of home delivery are low and not encouraged. Informally they could be actively discouraged. If the packages are unpacked there is only Rs 250 earmarked for referral transport though potentially the entire mothers package of Rs 1400 can be used for transport.

2. Thus there is a tension between two concepts: Is the JSY a conditional cash transfer scheme, defined as incentivizing a behavior change? Or is it an enabling and empowering programme by which a woman who makes a rational and informed choice to seek institutional delivery enabled to do so. The language of “conditional cash transfers” entered the discourse much after the JSY was born, but in many places could have taken over the whole dialogue- not only by those implementing and promoting it, but even those questioning the scheme and its benefits.

3. Operationally, seen through the lens of the CCT programme theory- we promote institutional delivery irrespective of objective conditions- whether the facility is ready or not, whether the woman wants to go or not, whether the available compensation is adequate or not. Those questioning it also assume that the reason why the woman and family comes to the facility for delivery is “paise ke lalach mein” and that is why as soon as the delivery is done they scoot. They are not bothered to stay at least through 24 hours, the period of highest risk for mother and child. (“they come by a tractor, keep it waiting, deliver, collect the money and then leave by the same tractor, so that they save on the transport charges” –a common quote from field visits). In such a programme theory, having attracted with money the woman to the hospital, the programme must now somehow persuade her to stay on for longer periods, and if possible get a post partum sterilization done . As such an understanding is propagated down the administrative pyramid the target of institutional delivery achieves such a power, that even the processes and protocols needed for ensuring that institutional delivery is safer than home delivery becomes a secondary target. This also acts as a rationalization or self-justification for local leakages, cut-backs, delays in payment etc.

4. Operationally, seen through the lens of JSY as enabling mechanism- we promote institutional deliveries where facilities are ready to take the load and we incentivize ASHA to inform her adequately, so that she knows the risks and can take an informed decision and opt for the safest possible delivery under her circumstances. The phenomenon of their coming by the same tractor, delivering and returning by the same is cost cutting certainly- but it is also because the family knows that delivery is dangerous, and there is no one to turn to in their village if there is a problem. And after delivery, it is really cold and uncomfortable. The woman would like a bath perhaps, a clean place for toilet, a warm place for the child, some privacy for breastfeeding- not something she has been used to doing, and some support
from her mother and perhaps other relatives. None of which is available here. And therefore she runs home, as you and I would have done also – and as in practice we even now do. (did anyone of our families stay for 48 hours??). The information and escort provided by the ASHA and the money available to pay for the transport, enabled her to exercise her choice. In such a programme theory, we need no further incentives- we need to improve quality of care and ensure referral transport arrangements. And inform her of why 24 hours stay is needed, and if she wants sterilization, keep her comfortable till this is done.

5. Programme theories are not conscious stuff nor rigid compartments. By programme theory in this context we mean the way various players/stakeholders/participants perceive the objectives of a programme the mechanisms set in motion by the programme components, and the outcomes they believe are gained. There is an implicit reasoning and perspective that is applied to all the evidence that is gathered. One can seldom changes the programme theories of stakeholders, but if they are conscious of it, they could communicate better to each other. Many professionals will tend to believe that people are foolish creatures, who need to be incentivized and persuaded to keep themselves healthy and alive. On the other hand many NGOs will tend to romanticize ‘the people’ and hold that ‘the people’ do no wrong. Also one cannot say all professionals or administrators share the same programme theory and most certainly NGOs would differ from each other. However constructing programme theories is useful as a broad structure for analysis, for interpretation of evidence, all of which is essential for both evaluation and for planning ahead. Being conscious of our own programme theories and of other programme theories around the table is useful for communication amongst decision makers and of and for decision makers to understand how their orders and schemes would be understood and implemented by different stakeholders. This analysis of all JSY issues in terms of a CCT theory or a enabling theory should therefore not be taken too literally. It is merely a tool for analysis. In practice we recognize that it is a combination of both.

6. The exclusion of women below age of 19 and the of women with more than two children is another issue. There is no doubt that this would not help in terms of mortality reduction. Most women who die would be in these two categories. The risk of mortality increases over nine times in the age below 19 and increases three to four times above three children. In a CCT theory, by paying them such incentives we are encouraging the wrong and even illegal behaviours and it would lead to impact adversely on the fertility rates. And since more children or early maternal age would also lead to increased maternal mortality, denial of incentives would be justified. In an enabling framework of analysis the JSY is not an incentive. No woman or even family if going to have more children just because of this paltry sum, which is not even enough to cover the costs of delivery let alone raise the child. And the punishment for breaching the age of marriage law is being handed out to a 19 year old girl who had no control over whether she became pregnant or not, and possibly
even did not want to get married so young. And how are we going to encourage post partum sterilization if women with three or more children are excluded. Fortunately this latter consideration has helped to remove these clauses in the low performing states- but they are equally relevant in the so called high performing states as well.

7. Quality of care needs to improve and this is universally accepted. In Tamilnadu we see them paying great attention to this. They have made the wards warm and comfortable. Clean sheets and clean toilets. They have allowed and even insisted on a birth companion and provided food and stay for the companion. They have installed a television in the ward, with the slogan- you do not even need to miss your favourite TV serial. And for good measure all pregnant women are brought to a party at the PHC using an idiom drawn from tradition( the bangle ceremony) and shown how comfortable it is and how culturally accepted. No wonder deliveries shifted from both private sector and from deliveries to PHCs. Would paying another Rs 500 per day as incentive achieved as much. Doubtful. Also if the ward is made good for mothers, all in patients benefit. But a monetary benefit under such circumstances and no one benefits- not even the mother. Only those illegally taking the incentive would benefit.

8. The Tamilnadu example has few parallels, but many states have made serious efforts in this direction. And to that extent they are also reporting a greater success in getting women to stay. But this is still not the general trend. One problem coming up is that if women actually stay 48 hours instead of 6, the number of beds needed to manage let us say a modest number of 60 deliveries per month goes up geometrically. And this is well beyond the capacity of PHCs.

9. Quality of clinical care also needs to improve. After all this is the single biggest reason for institutional delivery. The single main reason for institutional delivery is that in the Indian context, this is the only way the majority of the population can have access to skilled birth assistance. It is simply not possible for ANMs to visit and conduct home delivery as the habitations are far away and she has many other functions to attend to. Even at the sub-center she is seldom available- and hence the shift to primary care facilities for delivery. Skilled birth assistance involves making and using a partogram, injectables, anti-hypertensives and a certain level of neonatal management especially of asphyxia- all of which are well beyond the traditional trained dai levels of care. However the reports show that these concomitants of institutional delivery are not yet happening.

10. Whether sub-centers are sites of institutional delivery is a question. As per current guidelines, those accredited actively to be a site would qualify. Sub-centers of course would at best manage only one bed in them and that would mean stay for 48 hours would not be possible.

11. The skilled birth assistance training has faced two problems. One is that the entire scale and scope of the exercise has been far too limited. And secondly there is very little field support. Whatever monitoring is there is in the nature of administrative
monitoring, with little clinical care support elements. A mobile team of trainers who assist them and guide them on the job has been conceived only in Tamilnadu and two or three other states. Even quick refreshers on skills like the use of “skill halls” or availability of printed protocols and partogram charts have just not been factored in.

12. Another problem with JSY is that in practice it has got more or less limited to the moment of childbirth. Both antenatal care and postnatal care, though stated, are not inherent in its roll out. Efforts to address this have been ongoing and especially in antenatal care have been successful. But the postnatal care has not been thought through. The ASHA training does not currently have enough elements of either postnatal or newborn care in it. In antenatal care, there is not enough evidence that treatment of severe anaemia or of hypertension in pregnancy, the two most remediable contributors of maternal mortality are being addressed at anywhere near the expected frequency. This is both a quality of ANC and a referral chain issue.

13. The JSY referral transport benefit does not extend to such referrals nor to abortions or to postnatal sepsis- all of which are contributors of maternal mortality.

14. Institutional delivery needs to be backed by good quality of both basic emergency obstetric care and comprehensive emergency obstetric care. This is weak in most states. Though there are major skilled human resource constraints for making C-section available, by just training and support inputs, basic emergency obstetric care and blood transfusion services can be made available much more widely which would save numerous lives. But this is yet to be realized.

15. Given all these limitations the impact of JSY on both maternal mortality and neonatal mortality would be less than expected. Deaths due to complications strictly limited to the time of birth would be only about 20% of all deaths and much of this would be difficult to save if they present in the last minute. Indeed paradoxically a higher number of institutional maternal deaths would in some circumstances be an indicator, initially, of the programme taking off. (typically where only the district hospital is competent to manage complications they come into it too late). Given the quality of care issues, even if the woman were to stay for 48 hours, the actual lives saved would be less.

16. One strategy of the JSY programme to cope with provider related issues is to recruit private sector providers to actively engage in this process. In almost all states private nursing homes have been accredited for JSY deliveries. However these manage only a small part of the entire load. For one, BPL patients are excluded from JSY benefits in these facilities and secondly ASHA incentives are not available for private sector referrals. And given the fact, that as a rule, private sector facilities are only available where public sector facilities are also available, the load remains with the public sector. Given this distribution of the private sector vis a vis the public sector, this bar on incentivizing a movement to private facilities is welcome as it prevents conflict of interests( government employees providers in private practice) and kick back
approaches to private sector maximization. But there is a case for making exceptions to this rule where the public sector facility does not exist. It is largely mission based hospitals, and public sector undertaking run facilities that would then benefit.

17. Even if access to private care facilities is provided by JSY accreditation, quality of care is not assured. Qualities of care protocols for accreditation are not in use, and systems of verification are weak.

18. One alternative discussed in this context is the Chiranjeevi Approach. Some of the issues as regards maternal mortality are the same as discussed for JSY. Firstly only registered BPL can access it and in practice only half of the expected number of deliveries in the official BPL category have actually done so. Secondly, it also covers only the moment of delivery and 48 hours after, but misses out on antenatal and postnatal complications and abortion related deaths. Thirdly Chiranjeevi too misses out on neonatal care. Fourthly there is considerable evidence of cherry-picking or skimming whereby the more complicated cases are sent off back to the public sector- the percentage of complications and C-sections handled are less than expectations. Finally in the Chiranjeevi hospital, it is nurses, often untrained, who are handling much of the load with the doctor available on call. There is no system of objective verification of quality of care in place and even monitoring mechanisms to prevent double charging are weak. The experience with replication of Chiranjeevi is also awaited. In many states where replication started almost two years ago, the numbers handled are far less than expectations. What Chiranjeevi does teach us, is that it is possible to construct supply side subsidies and engage the private sector, though with stricter monitoring, the number of participants may be somewhat less. Chiranjeevi has been published in peer reviewed journals as a success story showing measurable reductions in maternal mortality. But that would be surprising given these limitations and out of line with theoretical expectations for changes at the demographic level. Peer reviewed publications authored by its main implementers in partnership with IIM, Ahmedabad, articulates a strong “developing health markets” programme theory. It would be worth analyzing the evidence with other perspectives as well to get a better grasp of its possibilities.

19. Another operational area of confusion is the contestation for the incentives between different peripheral workers. Some states have clearly divided the ASHA package into three components- Rs 250 for transport which is given to whosoever pays for the transport, Rs 200 for incentive to the ASHA – and to no one else- non transferable- and Rs 150 for the ASHA if she stays overnight/escorts the patient to the hospital- again non transferable. If the money is not used by ASHA then it cannot be claimed by anyone else either. The Rs 200 incentive is available if the ASHA can show that the pregnant woman was registered for JSY with her name alongside and that she has helped in ANC. She need not escort the woman to claim this rs 200. ( see accompanying photograph taken in Khatgora, Korba district, Chhattisgarh). Some states have added a separate Rs 50 or Rs 100 for the dai to
accompany the woman. On the ground in many states we see different patterns of conflict and resulting breakdowns. Thus a pregnant woman may refuse to take the ASHA along or deny her role since then she would get the entire Rs 600. Or the ASHA may claim Rs 600 for every institutional delivery from her area, irrespective of who paid for transport or whether she escorted. Or ANMs and AWWs or less frequently dais may contest the claims for the Rs 600 being given to the ASHA or even take the 600 on the grounds that there was no ASHA present. There many “programme micro-theories” behind why these confusions are allowed. For example many local programme managers may hold that if it very clear that ASHAs would get Rs 200 without escorting the woman, then all of them would stop escorting them. Or it is believed that it is “unfair for only ASHA to profit, what about ANMs and AWWs. For after all ASHAs would not sustain while ANMs would.” The point is not only to have instructions which are clear, but also to use evaluations to understand these confusions and thereby address them better through better monitoring, and better advocacy to explain to our own functionaries why certain rules are framed thus.

20. One approach that JSY has tried to make the programme reach to the three concerns of complete antenatal care coverage, better post natal care coverage and stay for 48 hours at the facility for 48 hours to the incentive payment for the ASHA. This has not been possible to monitor or enforce. Where local discretion is allowed, this could work against the ASHA as a way of excusing delays in payments or denying it altogether.

21. Another huge area of problems in JSY is the payment mechanisms. Long delays in payment are the rule. If the money is not available at the time of delivery than the whole rationale of JSY as support for transport and for expenses at time of delivery breaks down. Often money is received months later- and one can be sure that whatever debt burden had to happen has taken place, and the money is now more likely than ever to be used for non maternal care purposes. The minimum enabling aim of paying for transport- at least- for the return journey is lost.

22. It seems that in many situations payment by bearer cheque to the mother and to the ASHA is working. But whether there are situations within states where it does not work, and whether states are flexible and sensitive to these contexts needs to be tested. This is also true for who makes the payment, how much advance is kept with whom, who does the accounting and how it is monitored. Again the trend to use national guidelines to solve issues in this seems to be reflected upon. On one hand there is merit in having clear guidelines from the center so that all manners of errors and inconsistencies are avoided below. On the other hand states tend to copy it mechanically and no set of such guidelines on an administrative matter can suit all states equally. States should feel free to change guidelines with a clear mechanism for consultation if needed or at least for information. What we find that there are both errors- of copying and using guidelines where inappropriate and of innovating
inadequately and impulsively. Adequate mechanisms of therefore adapting guidelines are needed.

23. Monitoring is another area of weakness. There is large discrepancy between number of deliveries reported under financial payments in JSY as compared to children born or deliveries conducted. These mismatches are seen as data errors whereas they may be in reality useful information to track down and fix programme lacunae. Community monitoring has been used inadequately to address monitoring problems. Physical supervision and sample checks are also very weak, largely because of lack of clear job description and work allocation for supervisory staff.

24. The role of nutrition for the mother seems to be completely lost. Even the Rs 500 paid for home delivery is paid well after the event, and its maternity benefit function is lost. States tried to pay the JSY benefits in multiple installments- but the more number of transactions, the more the problems of accounting and payment- and it just did not happen. The proposed conditional maternity benefit scheme also does not have its clear focus on nutrition and there are problems with making it conditional. This has been discussed in a separate note on this scheme. Nutrition delivery services may be the way forward and for this one would have to expand on the anganwadi center’s functions and/or link it up with the midday school meal.

25. Provision for transport needs to be built up. JSY is not a substitute for this as in most vulnerable areas. JSY is not adequate financially or physically overcome the transport constraint. The EMRI approach helps – but again it outreach in vulnerable areas for pregnant women needs independent evaluation. Its cost is also prohibitive. Cheaper, more evolved models of Janini express or the Bihar approach with supply side feeds substituting for the user fees being charged currently would be essential. Most states are moving towards such a solution but rather too slowly and unsteadily.

26. If there are so many limitations- why do women come at all to the JSY scheme? Does this not point to a behavior change contribution at work? Even in a framework of enabling, the fact that JSY sends out a clear message that the public health facilities are now functional and that pregnant women are now welcome to attend it – is a big change which enables a safer health behavior. The JSY targets have influenced provider behavior also considerably. Therefore the behavior change action of CCT is not denied in an enabling framework of explanation. It is simply situated differently. Similarly CCT understanding does not exclude enabling mechanisms to ensure that women come to the facility and facilities provide quality service. It is just that the priority of this is different, and the cash is seen as overcoming an essentially irrational behavior- staying at home for delivery. In practical terms, neither schema of analysis excludes the action points of the other.

27. Having said all this, this note is not neutral on its own position between these two analytic frameworks. It is decidedly in favour of the enablement approach and would prefer to eschew the CCT approach. The recommendations that follow are based on this:
Recommendations:
1. **Emphasis on quality of care at the facility:** This is the most urgent area of reform.
   a. **Clinical care**
      i. **SBA acceleration:** All nurses and ANMs managing delivery require this. A road map of when this training would be completed for each district. Training institutions also need to be strengthened rapidly and accredited. Trainers- much larger than available now need to be accredited for the purpose.
      ii. **Visible Introduction of protocols:** Printed protocols of safe management of labour and its complications need to be pasted onto every labour room. Printed Partograms should also be available in every labour room and part of the labour record.
      iii. **Quick skills development with skill halls and mobile trainers:** In every ANMTCs and GNMTCs and RHFWTCs there could be attached a skill hall- which over a six hour period provides skill refreshers to all midwives. This could be used for quick refreshers for all midwives- so that within a year the basic information on key dimensions if provided. This is then backed by a group of 8 or nine mobile trainers for every cluster of 400 ANMs, who would travel to the facilities and provide on the job training for all facilities. These would be drawn from the nursing supervisors= and enough posts of which anyway needs to be created, Such supportive supervision for nursing and midwifery is missing and one of the major gaps in this area. These trainers also act as post training follow up to ensure retention and use of skills in those given SBA training.
      iv. **Newborn corners-** to be made mandatory wherever institutional delivery occurs. In addition stabilization units wherever complications are referred.
      v. **Clinical supervision and audit:** Death audit at the facility is part of it- but that should be positioned as a supplement to clinical audit at every level. This is a monthly review done by the supervisor who has also acted as trainer or at least has a higher level of clinical skills. The review addresses- what cases were treated, what complications were seen, what was the treatment given and records maintained etc. Even for ASHAs such a monthly meeting held in a participatory way would be useful. The concept of mobile trainers for ANMs/nurses and supervisors for medical staff would thus be able to improve clinical quality of care.( such mechanisms are in place in Tamilnadu – for example).
b. **Women and Baby friendly hospitals**

The key elements of making the hospital woman friendly and baby friendly are the following.

i. **Birth companion:** allowing and encouraging a birth companion to stay with the mother and help.

ii. **Cleanliness:** Needs an ISO type protocol to be put in place, so that responsibility for not doing it can be affixed. Also check on whether maintenance grants are being received and used at facility level.

iii. **Arrangements for stay:** For mother and child for 48 hours, for the birth companion or accompanying ASHA- all need to be thought through. There must be privacy for the mother to breastfeed the newborn. There must be clean sheets on a daily basis or even more often. The room must be warm and free of harmful drafts of wind and of dust.

iv. **Adequacy of beds:** Estimate beds requirement and allow for a flexible mechanism whereby wards are expanded and human resource increased in response to increasing demand. Upto 50% of beds should be available and in use for non maternity admissions also. The IPHS would be the aim for human resource deployment and three nurses or midwives would be the minimum for any place conducting institutional delivery.

v. **Newborn corners:** All sites of institutional delivery would have to open a newborn corner with staff trained to manage it within a year. Further first referral units should have a unit capable of managing many complications and the district hospital should have a full fledged SNCU.

vi. **Arrangements to drop the families back in their homes at public expense by government paid transport would also be a major inducement for the families to stay for 48 hours.**

c. **Accreditation for private hospitals and certification for public hospitals:** All private hospitals providing care may be accredited for quality and cost protocols by an independent agency. All public hospitals and PSU undertakings and recognized not for profit hospitals or chains could be certified for level of quality, with a road map to reach an adequate level with external certification down the line. This would give more seriousness to achieving and maintaining quality of care.

2. **Micro-planning as informed choice:** Micro-planning has been poorly understood and poorly implemented. It should mean that the care providers- ASHA, AWW and ANM are able to counsel the family and plan together for the best option in the family's context to manage delivery. The options could range from institutional delivery in a setting with emergency obstetric care available, to institutional delivery in a place...
with referral transport available, to a skilled delivery in a sub-center, to a skilled delivery at home, to a delivery assisted by a trained TBA. Thus a woman with hypertension or severe anemia, or past history of C-sections, or twins must be somehow reached to the first two options, preferably the first. A healthy normal woman with past normal obstetric history may be allowed to choose skilled home delivery if the alternative is delivery at the sub-center or a PHC which is termed as institutional though no skilled birth assistance is available and which perhaps is overcrowded.

3. **High Risk Pregnancies- revisiting the issue**: The issue of identifying cases at high risk for mortality and prioritizing their transport to institutions needs to be revisited. At the time of RCH-II design the understanding was that the signs of high risk are poor predictors for maternal mortality risk. Every child birth is a risk and quite often there are often no antecedent signs. However, there are many situations in the Indian context when the risk is much more. Any complication detected in the antenatal period, or bad obstetric history or pregnancies below a maternal age of 19 and beyond a parity of 4 must be seen as Pregnancies with complications and therefore particularly dangerous and given preference, even to the extent of sending transport to the house of shifting the mother to hospital or maternity waiting area in anticipation of the onset of labour. This becomes important to emphasize now when so many women are coming to hospital that the neediest may not get the care required. We should therefore operationally insist on the category of complicated pregnancies as an element of microplanning for delivery services.

4. **Expanding basic and comprehensive emergency care linkage**: The states are seized of this goal, and this would need to be further expedited. One important component of this- the availability of blood transfusions could be expanded along with basic emergency obstetric care and not only with the more demanding comprehensive care- since it is also useful to treat severe anemia in pregnancy. In addition the use of injectable iron to treat moderate and severe anemia of pregnancy in the antenatal period must be re-visited.

5. **Transport Arrangements**: Greater emphasis is needed on provision of transport. The transport sum provided is fixed for everyone, which is easy to administer but would mean that more vulnerable groups living further away would find the payment inadequate. Often the problem is the sheer lack of any vehicle for transport in that area. Many states have started local tie ups with vehicle owners, including taxi services or are trying to make their own ambulances more readily available by stationing them near police thana and enabling mobile telephone connectivity etc. The EMRI option is being used in many states. This is costly and effective especially in urban and peri-urban areas. Its effectiveness in rural areas depends on how pick up points and drop-off facilities have been designated. There is a case for regular provider- payments to transport facilities. In case of decentralized arrangements and supplementary arrangements even where EMRI is functional the payments to the
transporter could be made via self help groups or VHSCs which are provided a fund that they operate for this purpose. Not everywhere- but where it is mapped and found to be needed. Transport arrangements for the return trip home would be easier to organize and would also save the family considerable out of pocket payments and be an incentive for the families to stay for 48 hours.

6. The ASHA package may be trifurcated into incentive, transport and escort or birth companion costs. These are all non transferable. The Rs 200 incentive is paid only to the ASHA or it lapses. The Rs 150 escort cost is to be paid to the ASHA if she escorts her- or else it goes to the RKS for defraying birth companion costs. This is to defray her travel cost and wage compensation. ASHAs or birth companions who accompany the mother would need to be provided a hot meal by the RKS and this would be in addition to the escort cost payment. The Rs 250 transport cost is to be paid to the transporter if there is a prior tie-up and the transport has been provided to the mother free. On the other hand if for whatever reason the tie up did not work, then the Rs 250 is the amount available for transport to the family.

7. Payment/Financing mechanisms: In the immediate period the amounts paid now may be sustained. Any movement to decrease this should be gradual shift from demand side incentives and its high leakages and delays to supply side provider payments with adequate monitoring and contract management strategies in place. Currently the Rs 1400 mothers package is left to the discretion of the family and it usually goes towards transport and incidental expenses. But the direction of movement is that since other elements are paid for- it should accrue only towards her improved nutrition and wage loss due to maternity- the rest being taken care of by cashless, user fee free public provisioning or public purchase of services. The next question is then why the link to institutional delivery at all. This should be paid irrespective of site of delivery. At any rate Rs 500 is already maternity benefit linked for it is available to all. As free transport and free quality treatment becomes the norm, the need for this difference in payment between home and institutional delivery would become less. Without quality care, anyway institutional delivery is purposeless. The behavior change of the system has been achieved by JSY and with a good supervisory structure in place, and a commitment to public health systems, incentives for health seeking behavior would be redundant and gradually withdrawn.

8. Exit Policy: As awareness about the rationale for institutional delivery increases then the provision of free and reliable transport along with free good quality care at the facility would become adequate enablement for the mother to be avail of quality care to ensure a safe delivery. And with a birth companion allowed, the need for escort services of the ASHA would diminish. Thus the JSY package would become once again a maternity benefit to support the family for better nutrition, for child care and for wage loss compensation and not be needed to pay a behavior change role. And ASHA incentives can move to other areas. Such a change is not immediate- for both these pre-conditions are far from achieved. But it could be the form of an
exit policy for the JSY scheme. The expense made on transport and improved quality of care at the public health facility would have collateral benefits for all of health care- and not only the moment of child birth. In the long term an exit policy is much needed for JSY. One cannot indefinitely go on adding incentives for health seeking behavior changes- for neonatal care, for antenatal and post natal complications, for tuberculosis, for HIV etc. One could have enabling mechanisms – but not conditional cash transfers.

9. **Free transport and free care: Bringing ANC and PNC and neonatal care into the package:** Free transport and free care should be immediately extended for referral of all potentially life threatening complications of antenatal period, post natal period and spontaneous or medical abortions- all major causes of maternal mortality- which requires as much urgent intervention as does care at delivery. Since the free transport arrangements are not in place this would have to be established first. In the CCT approach, the suggestion is to add more behavior change incentive packages which would mean another huge jump in expenses without a corresponding increase in outcomes and more leakages. On the other hand we could begin the exit policy from CCT approaches, by including this in free transport and free quality care arrangements and if needed wage loss compensation for specific sub-groups. If this works well, it would signal our ability to move away from CCT even for institutional delivery.

10. **Addressing Nutrition:** There must be a serious effort made to address both malnutrition and anemia in adolescence and in pregnancy. This is discussed in detail on the note on nutrition- but the main suggestion is that nutrition delivery services is the preferred route, with unconditional cash transfers- unconditional like in Muthulakshmi Reddy scheme of TN being a second best option and conditional as proposed by WCD, being a distant third choice.

11. **Re-visiting exclusion criteria:** The exclusion criteria of age and parity needs to be re-visited. These two groups have a nine times and four times higher mortality. There is no evidence to believe that such a disincentive actually lowers fertility. Many women are getting pregnant due to lack of access to contraception.

12. **Private sector tie ups- how to maximize opportunities and minimize problems.** The system would need to actively engage with and maximise the use of private facilities for JSY and other related referral care. One key step in this is the process of accreditation. The difference between accreditation and just recruiting them is that accreditation would be external based on quality standard. Accredited facilities could be allowed to manage the advance amounts and also consider package reimbursement of costs. But for that an adequate monitoring system like what Janini had should be put in place. This could be costly but the out of pocket expenses that it would save would be tremendous- for the experience of most such schemes is a high amount of double charging.
13. **Area Approach and Vulnerability Mapping**: For every village there should be one or more designated sites of institutional delivery and emergency obstetric care. Preferably one which can be reached by motorized vehicle within 2 hours. In case there is no facility immediately available, a public health facility must be sanctioned and these could be done by building a facility or by contracting an existing agency to set up such a facility. Similarly village and block plans should ensure that there is access to a publicly paid transport facility for every habitation and gaps in this area should be consolidated and reflected in the district health action plan. Village plans should also inform us of which sections are still getting excluded, and would need more affirmative action for JSY to be more inclusive. Such mapping would ensure that areas and sections which are left out and more vulnerable would get included.

14. **Monitoring mechanisms**: The most important mechanism suggested is the generation of monthly feedback reports at block, district, state and national level- wherein the higher level HMIS officer writes to the next lower level a note on the comparative achievement across facilities and time and highlights areas of improvement. In addition periodic visits to a sample of facilities to cross –check data and provide support to improve performance would need to be institutionalized. Efforts at making each transaction visible through such mechanisms as tracking every pregnancy and payment by name, recording their mobile phone numbers, giving them UID numbers etc would help- but we should have modest expectations from these high cost and effort ventures. There are three reasons for modest expectations: Firstly- Most data is not falsified at the ANM or immediate supervisor level. It is only after they become numbers and start getting aggregated at block and above levels do the data mark-ups begin to happen. So greater and greater visibility of the ANM and facility level transaction has not much as far as data fidelity goes. Secondly the huge mass of data in the form of text and unique numbers would place a technical load on the HMIS system- if it has to be sent up to Delhi or even state capitals- which the current systems may be unable to bear. It would be enough if lists are pruned off at the block level and only aggregate numbers sent up- with a request to drill down to facilities/blocks to see the lists held off line at the block level. Thirdly the central eye which would observe all these transactions- by a call center perhaps- is very notional and even if it does observe there is very little in practice that can be done about it from such a distance. UID numbers and pregnancy and child tracking can however be used to facilitate facilities and service providers to provide full services to all their clientele, and for a more sophisticated level of analysis- especially disaggregations- that would be useful for local management . Another important gain of UID is that service entitlements would now become location independent, and even if they migrate, or attend different facilities for different parts of the service it could be provided without any difficulty. It could also be an effective tool of local monitoring to prevent double entries and double claims.
(often ANM reports a delivery as an area event, and the same is reported from the CHC as a facility event).

15. **Evaluation (formative, realist approach)** in all states to improve on mechanisms of JSY implementation leading to greater assurance of outcomes. This would be coordinated but flexible effort. Such an evaluation would help tune the programme design to their contexts. Specific elements that would be addressed are contribution to health outcomes, payment modalities transport gaps, package design for ASHA, private sector partnerships, nutrition delivery, options in micro-planning etc. It would also help add other elements like nutrition where needed and possible.
IV. Janini Suraksha Yojana - Extracts from the guidelines:

“Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National
Rural Health Mission (NRHM) being implemented with the objective of reducing maternal
and neo-natal mortality by promoting institutional delivery among the poor pregnant
women. The Yojana, launched on 12th April 2005, by the Hon’ble Prime Minister, is being
implemented in all states and UTs with special focus on low performing states.

2. JSY is a 100% centrally sponsored scheme and it integrates JSY benefits with delivery
and post-delivery care. The success of the scheme would be determined by the increase in
institutional delivery among the poor families.

3. The Yojana has identified ASHA, the accredited social health activist as an effective
link between the Government and the poor pregnant women in 10 low performing states,
namely the 8 EAG states and Assam and J&K and the remaining NE States. In other eligible
states and UTs, wherever, AWW and TBAs or ASHA like activist has been engaged in this
purpose, she can be associated with this Yojana for providing the services.”

The ASHAs role in JSY has also been defined as follows:

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**Eligibility for JSY benefits for Institutional Delivery:**

<table>
<thead>
<tr>
<th>LPS States</th>
<th>All pregnant women delivering in Government health centres like Sub-centre (specifically approved for institutional delivery by State), PHC/CHC/ FRU / general wards of District and State Hospitals.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BPL &amp; SC/ST women delivering in accredited private institutions.</td>
</tr>
<tr>
<td></td>
<td>Restriction of JSY benefit up to 2 live births removed (No restriction of no. of births).</td>
</tr>
<tr>
<td></td>
<td>Restriction of age of 19 years and above removed (No restriction of age).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HPS States &amp; North-Eastern States (Except Assam)</th>
<th>BPL pregnant women, aged 19 years and above delivering in Government health centres like Sub-centre (specifically approved for institutional delivery by State), PHC/CHC/ FRU / general wards of District and State Hospitals or accredited private institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All SC and ST women delivering in a government health</td>
</tr>
</tbody>
</table>

---
centre like Sub-centre (approved for institutional delivery by State), PHC/CHC/FRU/general ward of District and state Hospitals or accredited private institutions

- For SC/ST women, age restriction of 19 years is not applicable.
- Cash Assistance for institutional delivery would be limited to 2 live births for all the women.

4.4 Scale of JSY benefits for Institutional Delivery:

<table>
<thead>
<tr>
<th>Category</th>
<th>Rural Area</th>
<th>Total</th>
<th>Urban Area</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mother’s Package</td>
<td>ASHA’s Package</td>
<td>Rs.</td>
<td>Mother’s Package</td>
</tr>
<tr>
<td>LPS</td>
<td>1400</td>
<td>600¹</td>
<td>2000</td>
<td>1000</td>
</tr>
<tr>
<td>NE* (Except Assam) &amp; Rural areas of tribal districts of HPS States**</td>
<td>700</td>
<td>600¹</td>
<td>1300</td>
<td>600</td>
</tr>
<tr>
<td>HPS</td>
<td>700</td>
<td>NIL</td>
<td>700</td>
<td>600</td>
</tr>
</tbody>
</table>

*(Secretary(H&FW) do letter no. Z. 140171112005-NMBS/JSY dated the 31st Oct, 2006).
***(Addl. Secretary, MoHFW do letter no.Z. 14017/1/2005-NMBS/JSY dated the 27th November, 2006).

¹(For detailed break-up of ASHA Package, please see Para-4.5.2 below).

Note: In Andaman & Nicobar Islands (covered under HPS category) an additional assistance of Rs.700/- per delivery up to two live births is allowed under JSY to all eligible BPL pregnant women who are referred from Car Nicobar District and Middle and North Andaman to the Government Hospital at Port Blair. *(D.O. No.Z.14017/1/2005-NMBS dated 5th April, 2006).*

4.4.1 Compensation Money: If the mother or her husband, of their own will, undergoes sterilization, immediately after the delivery of the child, compensation money
available under the existing Family welfare scheme should also be disbursed to the mother at the hospital itself.

4.4.2 Assistance for Home Delivery: In LPS and HPS States, BPL pregnant women, aged 19 years and above, preferring to deliver at home is entitled to JSY benefits of Rs. 500/- per delivery. Such JSY benefits would be available only upto 2 live births and the disbursement would be done at the time of delivery or around 7 days before the delivery by ANM/ASHA/ any other link worker. The rationale is that beneficiary would be able to use the JSY benefits for her care during delivery or to meet incidental expenses of delivery. It should be the responsibility of ANM/ASHA, MO PHC to ensure disbursement. It is very important that the cash is disbursed in time. Importantly, such woman choosing to deliver at home should have a BPL certificate to access JSY benefits.

4.5.2 Disbursement towards ASHA Package (break-up of Rs.600):

This package, as of now, is available in all LPS, NE States and in the tribal districts of all states and UTs (table in Para 4.4 above). In rural areas the package is of Rs.600, which includes the following three components:

A. JSY entitlement for Referral transport to go to the nearest health centre for delivery. The state will determine the amount of assistance depending on the topography and the infrastructure available in their state. However, under any circumstances it cannot be less than Rs.250 per delivery case.

i. If ASHA has arranged and paid for the transport the JSY entitlement for Referral Transport should be paid to ASHA (which cannot be less than Rs.250/- under any circumstances).

ii. This payment will be due to ASHA (if she has arranged and paid for the referral transport) even if the cost has been met from the permanent cash imprest made available to her by ANM [Para- 4.7(iv)] so that the permanent cash imprest with ANM/ASHA/AWW remains intact.

B. Cash incentive to ASHA: Rs.200/- per delivery in lieu of her work relating to facilitating institutional delivery.

IMPORTANT: Payment of this component to ASHA after her postnatal visit to the beneficiary and immunization of child for BCG has been dispensed with. However, such visits and immunization should be separately monitored.
C. **Transactional cost**: Balance out of Rs.600/- (after paying Referral Transport charges and adjusting Rs.200 against Cash incentive to ASHA) is to be paid to ASHA in lieu of her accompanying the pregnant woman to the health centre for delivery, to meet her cost of boarding and lodging etc.

**IMPORTANT**: Payment of this component “in lieu of her stay with the pregnant woman in the health centre for delivery” in the old guidelines has been replaced with “in lieu of her accompanying the pregnant woman to the health centre for delivery”.

**Note 1**: In Urban areas, ASHA package consists of only the incentive for ASHA, for providing the services, as at para 3.1

**Note 2**: In case ASHA fails to organize transport for the pregnant woman to go to the health institution, transport assistance money available within the ASHA’s package should be paid to the pregnant woman at the institution, immediately on arrival and registration for delivery. To determine who has paid for the Referral Transport (ASHA or the beneficiary), an undertaking from the JSY beneficiary could be taken.

This assistance to beneficiary, if required to be paid, would be over and above the Mother’s package.

**Note 3**: In case ASHA is yet to join, transport assistance money may be kept with the institution and a voucher scheme may be introduced for disbursement.

**Note 4**: All payments to ASHA, viz. (a) **Referral Transport charges** (if due to ASHA as per Note-2 above), (b) **Cash incentive to ASHA** and (c) **Transactional Cost** should be paid at the hospital/institution itself in one go at the time of registration of the beneficiary.
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