"Cash Transfer Schemes in the Reproductive and Child Health Programme: A Study of Sultanpur District in Uttar Pradesh"

Thesis submitted to Jawaharlal Nehru University
in fulfilment of the requirements
for the award of the degree of

Doctor of Philosophy

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DECLARATION

This is to certify that the dissertation entitled "**Cash Transfer Schemes in the Reproductive and Child Health Programme: A Study of Sultanpur District in Uttar Pradesh**" is submitted for the award of the degree of **Doctor of Philosophy** of this University. This thesis has not been submitted for any other degree of this University or any other University and is my original work.

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CERTIFICATE

We certify that the thesis entitled "**Cash Transfer Schemes in the Reproductive and Child Health Programme: A Study of Sultanpur District in Uttar Pradesh**" is submitted to Jawaharlal Nehru University, New Delhiin partial fulfillment for the of the degree of **Doctor of Philosophy** in **Centre of Social Medicine and Community Health**, is a record of bonafide research work carried out by her under the supervision of **Prof. Rama. V. Baru.** This thesis has not been submitted for any other degree of this University or any other University and is my original work.

We recommend that the thesis be placed before the examiners for evaluation and consideration of the award of Degree of Doctor of Philosophy.

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Acronyms

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
APHC	Additional Primary Health Center
ASHA	Accredited Social Activist
AWW	Anganwadi Worker
AWCs	Anganwadi Centers
BFP	Bolsa Familia Program
BPL	Below poverty Line
BJP	Bhartiya Janta Party
BSP	Bahujan Samaj party
CAG	Controller and Auditor General
CDPO	Child Development Programme Officer
CHC	Community Health Centre
DH	District Hospital
DLHS	District Level Household Survey
EmOC	Emergency Obstetric Care
FRU	First Referral Unit
GDP	Gross Domestic Product
GNP	Gross National Product

GOI	Government of India
HDI	Human Development Index
HPI	Human Poverty Index
ICDS	Integrated Child Development Services
IFA	Iron Folic Acid
IGMSY	Indira Gandhi Matritva Sahyog Yojana
IPHS	India Public Health Standard
JSY	Janani Suraksha Yojana
JSSK	Janani Shishu Suraksha Yojana
KKSY	Kishori Shakti Yojana
MDG	Millennium Development Goal
MNREGA	Mahatma Gandhi National Rural Employment Guarantee ACT
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
MOWCD	Ministry of Women and Child Development
NRMBS	Muthulakshmi Reddy Maternity Benefit Scheme
MP	Madhya Pradesh

HV	Health Visitors
NMBS	National Maternity Benefit Scheme
NRHM	National Rural Health Mission
NSAP	National Social Assistance Programme
NSSO	National Sample Survey Organisation
OECD	Organisation of Economic Co-Operation and Developed
OOPs	Out of Pocket Spending
OT	Operation Theatre
PDS	Public Distribution Shop
PHC	Primary Health Centre
PNC	Postnatal Care
PPP	Public Private Partnership
RSBK	Rashtriya Baal Swasthya Karyakram
RCH	Reproductive and Child Health
RSBY	Rashtriya Swasthya Bima Yojana
SAP	Structural Adjustment Programme
SC	Schedule Caste
SCs	Sub-Centers
SP	Samajwadi Party

SRS	Sample Registration Scheme
SSMY	Saubhagyavati Surakshit Matritva Yojana
ST	Schedule Tribe
TBA	Traditional Birth Attendants
TT	Tetanus Toxoid
UNDP	United Nations Development Programme
UP	Uttar Pradesh
UPA	United Progressive Alliance
VHND	Village Health Nutrition Day
WHO	World Health Organisation

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Introduction

Over the last several decades due to under investment in the health sector, the Indian government is unable to provide basic facilities such as education, employment, food, health and related social security measures to the people, especially those who live below the poverty line (BPL). Due to the lack of financial resources, people living below the poverty line (BPL) cannot access basic amenities. To rectify the problems of access for the poor, government has introduced various cash incentives schemes from time to time. However, these programmes have failed to reach majority of the targeted population. These schemes have either faced financial constraints due to the low allocation of funds, poor functionality of the public health services through which they are implemented or poor monitoring and evaluation. Along with this, one of the main obstacles that also draw negative effects on the social schemes is difference in ideologies of political parties. The differences in ideology and commitment of the Centre and State political parties also effect the schemes in their functioning. Often, change in the leadership at the Centre and states hinder the implementation of schemes introduced by previous governments. This either leads to the reformulation or abandonment of the scheme. An apparent example of this is conditional cash transfer (CCT) scheme. Under any CCT scheme, government provides monetary incentives to the targeted population after completing its criteria. CCT has started in the form of welfare programmes in the social sector like in health, education, employment etc.

In the area of health, CCT was first introduced in the reproductive and child health programme inorder to reduce the maternal mortality and infant mortality. Maternal mortality is one of the key indicators of the women's health status in society. It has direct effect on their families, community and entire country. Maternal morality not only effects women's health but also their new born's. Asia and Africa have largest share (90%) of maternal death worldwide and India alone contributes one quarter to this global maternal deaths data. Therefore in India, one of the prime objectives of the Millennium Development Goals (MDG) was to reduce maternal mortality ratio (MMR) by achieving universal access to reproductive health care. The target of this

programme was to reduce maternal mortality from 301 in 2000 to 108 deaths per 100,000 lives born, by the end of 2015 (Gundbowdi et. al, 2015; Sanneving et. al, 2013). The evidence shows that in India, MMR has declined over a period of time but still is much higher compared to other countriesMost of the MMR and IMR occur due to medical causes including hemorrhage, sepsis, hypertensive, abortion, obstructed labours etc. As per the District Level Household Survey (DLHS-III, 2014), most maternal deaths occurred in India due to the postpartum hemorrhage. Postpartum hemorrhage can be prevented through timely diagnosis and regular visits to the Post natal care (PNC) centre. MMR due to the medical causes can be prevented if delivery is conducted by some skilled medical personnel at a health institution where all necessary equipments and drugs are available. But number of studies have identified that there are huge gaps between supply and demand sides that act as barrier in utilizing the health facilities in India. Supply side factors include availability and accessibility of health services e.g. absence of lady doctors, lack of drugs and diagnostic test etc. while the demand side factors include the economic status of women, their education etc. Also, it is individual households' ability to pay the cost of good health services that is the main obstacles in utilizing the health services (Mohanty and Srivastva, 2012).

In short, reduction in maternal and neo-natal mortality is associated with access and utilization of health institutions. There are some nonmedical causes that lead to maternal deaths. The other main causes for the decline of MMRs in India are due to the multiple axes of inequalities- regional, caste and class. Evidence shows the association between MMR and these socio-economic inequalities. Burden of high maternal deaths have been seen in under developed states, low caste as well as low income groups (Baru et. al, 2010). Therefore to reduce the burden of maternal mortality, the Government of India launched some nationwide programmes and schemes such as CCTs to improve access to health services for those below the poverty line. In case of Reproductive and Child Health (RCH) the cash transfer scheme, Janani Surksha Yojana (JSY) is designed to improve access for institutional births with the support of medical professionals and skilled birth attendants by giving them cash incentives. This scheme functions with the help of an

Accredited Social Health Activist (ASHA) a community health worker who will motivate the women for accessing health facilities for delivery of their child. Under this scheme, child births occur at free of cost to the women who opt for health institutions for their delivery. Lately, this scheme has modified as Janani Shishu Suraksha Karyakram (JSSK) and added some more facilities like transportation and medical treatment of the new born. However, these initiatives only cover some extent of indirect costs and do not cover the loss of wages of poor people during pregnancy and child birth. In my earlier study that was based on the direct and indirect expenditures of the institutional deliveries, I found that indirect cost of institutional deliveries was one of the main obstacles that prevent women, especially who belong to the below poverty line, to access the government health institutions. Findings of the study show the ratio of the direct and indirect expenditure of birth as 1:3 which is not a small ratio. And this situation exists in spite of the fact that some conditional cash transfer schemes have been supposedly implemented for the poor. To address the issue of daily wages of the poor women, Ministry of Women and Child Health, started Indira Gandhi Matritva Sahyog Yojana (IGMSY, a pilot based scheme), a centre government sponsored scheme that gives compensation for loss of wages to the pregnant and lactating mothers who do not get maternity benefits, entitled by the government.

Under this scheme, women of nineteen years and above will be given INR. 4000 for their first two child births on the provision of registration in Anganwadi Centres (AWCs). They will also receive the complete dose of tetanus toxoid (TT) injections and iron tablets, compulsory attend a specific number of counseling sessions, register for childbirth, get full immunisation of the child and take exclusive training and lectures on breast feeding the child for the first six months.

Now CCT has become an important tool for creating demand for utilizing health services. CCTs are used as a strategy to address those who are unable to access health services due to financial barriers. Under this targeted scheme, money is given to people only when they meet a certain criteria. In the last few years, it has been used in the area of health for accessing health care services

by the poor. It also has a long term goal of accumulating the human capital by supplying health and other social upliftment services. Although government provides these basic facilities free of cost, often it has been seen that these services are not utilized by the economically vulnerable groups. For the poor, cost of medicines, transport, and loss of wages are some of the obstacles towards accessing these services (Sekher, 2010).

One of the main reasons for low utilization of maternity health care and institutional delivery is the high rate of pocket health expenditure in India. Out of pocket expenditure (OOP) could be an important determinant for seeking skilled/institutional maternity care. Poor people are more vulnerable to this increasing-out of pocket, health expenditure as a proportion of household's expenditures. This becomes worse when it exceeds their capacity to pay. The major problem of increasing OOP expenditure is low monetary allocation and low investment of the Centre as well as the State in uplifting the health status in India. The revenue expenditure of the Centre has remained stagnant over a period of time and also in the case of States, it has been declining. The fluctuating share of government funding has raised the problem of high pocket expenditure and financial risk for poorer households (Garg and Karan, 2009). This out of pocket expenditure imposes considerable monetary burden on poor households.

The deterioration of government investment in health sector worsens the health care services in public hospitals which further forces people to utilize private health institutions, which most of the poor cannot afford. This inability of the government has attracted the private sector in investing in public health due to which private health institutions are widely expanding in India. As a consequence, the problem of out-of-pocket expenditure has arised in India. At present, the main source of financing in India is out of pocket expenditure which is around 80% of the total health expenditure. This out of pocket expenditure is the main barrier for the poor in seeking the institutional maternity care. By increasing the share of OOPs, poor families become more vulnerable when it exceeds their capacity to pay. Although, the investment of

private sector is growing but there is lack of proper rule regulation and norm implementation unlike public sector.

Apart from these problems, several researchers have raised a number of serious concerns. Treatment cost, quality of care, excessive use of technology, over prescription of drugs etc. are some major issues that have been raised by the health researchers. It is assumed that demand side financing schemes will improve institutional delivery and institutional visits by offering financial incentives and free of cost health services but evidences show that non-BPL (Below Poverty Line) households also prefer home delivery as it is not always a matter of monetary barriers but also convenience. In such cases, demand side schemes need to be re-examined.

Thus, this study aims to explore to effectiveness of these conditional cash transfer (state and central) schemes. The study examines the various issues, difficulties and problems faced by poor women in accessing public health services and availing governmental schemes that are especially meant for them.

Chapter Outlines

In the first chapter, "International Perspectives of Conditional Cash Transfer programmes: Experiences from the Latin American Countries" researcher has described firstly, what the conditional cash transfer programme is and in what kind and capacity is this programme available for the public. Apart from that, this chapter also explains how these CCTs have evolved and how much this programme has been successful in the Latin American countries where it first started. This chapter also discusses the conceptualization of the problem as well as methodological approach which is used in the study and includes the study area where this study has been conducted.

The second chapter is "Maternal Health Policy in India: From Maternity Benefit Act to Conditional Cash Transfer Scheme". This chapter illustrates the policies and programmes related to maternal health and various other kind of

conditional and unconditional cash transfer schemes initiated by the state as well as central Government of India.

The third chapter is "Janani Suraksha Yojana: Reviewing the Evidence". This chapter includes the analysis of DLHS data on health services as well as MMR and IMR of Uttar Pradesh and its district Sultanpur. This chapter deals with the issues of JSY scheme which demonstrates both supply and demand side barriers. Moreover, in this chapter researcher has also included her study which is based on JSY, conducted in Varanasi district of Uttar Pradesh state.

Fourth chapter is based on the data analysis of health services and IGMSY scheme in Dhanpatganj block of Sultanpur district, Uttar Pradesh state and hence is named "Structure and Functioning of the Health Services and IGMSY scheme in Dhanpatganj Block of Sultanpur District". This chapter looks at various loopholes and gaps in the availability of health services in public hospitals of Sultanpur district and also studies the bottleneck situation of the current functioning schemes in that area.

The fifth chapter is "Cash Transfer Schemes: Effectivity and Challenges". It is another analysis of the primary data on the experiences of women who had accessed health institutions for child birth during last one year. This chapter analyses the direct and indirect expenditure of/for institutional delivery in poor households. Also, this chapter highlights the beneficiaries' perception regarding schemes that have been financed for the institutional delivery of the poor public.

Sixth chapter, which is the last chapter of the study, is "Discussion and Conclusion". It is the conclusion of the findings of this study.This chapter summarizes the prime and principle themes which are emerge from this study.

Chapter 1

Evaluating the Conditional Cash Transfer Programmes: An Overview of International and National Experiences

CCT has become an important tool for creating demand for utilizing health services. CCTs are used as a strategy to address those who are unable to access health services due to financial barriers. Under this targeted scheme, money is given to the person only after meeting certain criteria. It also has a long-term goal of accumulating the human capital by supply of health and other services. This chapter would trace the history of CCT, various kinds of CCTs, its experiences globally as well as nationally. At the national level, this chapter specifically discusses the Janani Suraksha Yojana (JSY) scheme because it was launched by the Central Government of India in response to slow and varied progress in improvement of maternal and neonatal mortality. Since the launch of JSY, the numbers of institutional deliveries have started increasing. In fact it is a key driver for utilizing the health services. But from the available literatures, it has been found that the Scheme has its own implementation problems like supply and demand side problem which is also one of the major obstacles towards targeting the aims of the Scheme. Therefore, this chapter will give an insight into the earlier mentioned issues.

1.1 Concept of Cash Transfer Scheme and Its Various Forms

Cash transfer scheme is a policy instrument that can be defined as a scheme which provides money to needy households to meet their basic needs of food and non-food items, services (education and health) and other necessary goods. Some other types of cash transfer schemes are conditional cash transfer, unconditional cash transfer, voucher scheme etc. (Gupta et.al, 2010).

1.1.1. Conditional Cash Transfer (CCT) Scheme

In conditional cash transfer, cash is given to the beneficiaries only when they fulfill certain conditions. These conditions include, for example regular health institution visits for pregnant women, school attendance of school children etc.

Indira Gandhi Matritva Sahyog Yojana at central level and Mamata, Prasav Hetu Parivahan Evam Upchar Yojana etc. are some state led conditional cash transfer schemes (Hunter et.al, 2014) which are elaborated in detail in the next section. CCTs have direct effect on the poor in terms of health, education and other socio-economic wellbeing and hence improve the human capital development. In fact, CCTs are a kind of human capital investment aiming to break the vicious cycle of poverty and its consequences. It was first introduced in Latin American countries in the 1990s. In context to India, it gained attention with the introduction of JSY which provides some cash incentives to pregnant mothers for institutional deliveries although cash transfer programmes were launched prior to JSY (Fiszbein, 2009).

1.1.2. Unconditional Cash Transfer (UCT) Scheme

In contrast to Conditional Cash Transfer, unconditional cash transfer scheme has no requirement of specific activity or conditions. In other words, in unconditional cash transfer scheme, there is no restriction on use of money and therefore beneficiaries are free to spend that amount of money any way they want (Narayanan, S. 2011).

The National Maternity Benefit Scheme (NMBS) was one of the unconditional schemes which did not have any conditions. This scheme was launched in 1995 for pregnant women who were below poverty line and was meant to increase their nutritional levels. This scheme was initiated as a part of National Social Assistance Programmes (NSAP) and later was transferred to the Health Ministry in the year 2001. Under this scheme the below poverty line (BPL) pregnant women who were aged 19 ot above were entitled the cash assistance of INR 500 up to two live births, 8-12 weeks before delivery (Tripathi, S.P. et. al, 2013). However in year 2005 with the launch of Janani Suraksha Yojana (JSY), the scheme (NMBS) was merged into JSY (Hunter et. al, 2014).

1.1.3. Voucher

Voucher is a kind of a token that can be redeemed in exchange of specific goods or services. In other words, under the voucher scheme, individuals

receive cash to buy some specific goods or services from specific set of suppliers at a given point of time. In the area of health, some health care vouchers are used, for example in the case of Chiranjeevi in Gujarat and Sambhav scheme in U.P, to encourage the use of health services such as family planning, institutional delivery, immunization etc. (Gupta et. al, 2010, Cave, 2010).

The Chiranjeevi Scheme implemented by the Gujarat Government in 2005 proved to be the best example of the voucher scheme. The aim of this scheme was to encourage the BPL families to access institutional deliveries in private hospitals (Bhat et. al, 2009).

The second example of voucher scheme is Sambhav Swasthya Koopan Pariyojana. This Health voucher scheme was implemented in 2007 on a pilot basis in Uttar Pradesh. It covered 368 urban Slums of Kanpur, two blocks of Haridwar in Uttarakhand, and two blocks of Gumlain, Jharkhand. The Shambhav Scheme targeted the BPL population and its main objective was to improve accessibility of Reproductive and child health (RCH) services through private health facilities (futuregroup.com/files/publications/Sambhav_Voucher_Scheme_Report.pdf).

1.2 Evolution of Cash Transfer Programmes

Tarschys states that the conditional cash transfer schemes have originated in the favor of neo-liberal policies, which had two major concerns, i.e. efficiency on the one hand and targeting on the other. In the late seventies and beginning of eighties, The Organisation for Economic Co-operation and Development (OECD) countries started to experience the economic crisis. Terms like "scissor effect" explained that the widening gap between input and output which led to a growing demand for reducing the expenditure of government lead to the shrinking of government programs. In short, less public expenditure and efficiency had become the main themes. The idea of efficiency provided the basis for cost benefit analysis to become an important tool in social policy. It further provided legitimacy to a number of initiatives

like consumer led demand side financing, targeting, contractual basis recruitment and so on (Tarschys, 1983).

The concept of cash transfer programmes originated in Latin American countries (like Brazil and Mexico) as a reaction to the economic crisis of 1990s (Sachdeva and Malik, 2012). It has been used for development purposes, especially for social protection for number of decades. These types of scheme or programme are generally designed for those who are unable to access the basic needs such as health, food and education due to low or no income. Transfer can be conditional or unconditional. In the conditional cash transfer schemes, cash incentives are provided to the poor households for fulfilling some specific conditions. While in the unconditional cash programmes, there is no condition or requirement, money is given to people directly, without any conditions for unconditional use. (www.undp.org/content/dam/india/docs/cct_dp.pdf).

In 1997, Mexico introduced the Education, Health and Food Programme (Progressa) which provided cash to rural families, who were extremely poor, on the condition that they take education and health care services. Since then this conditional cash transfer scheme has been implemented all over Latin America and the Caribbean. Although reproductive health and family planning have not been a priority of many of these schemes in Latin America, this scheme at least offered a way for the poor to access information about reproductive health and family planning (Cecchini and Madariage, 2011). Details of some important CCT programmes in developing countries have been given in the table 1.

Table 1 CCT Programmes in Developing Countries

	Conditions	
Program size/Target	**Education and health**	**Education only**
Nationwide	Bolsa Família (Brazil)	Bolsa Escola (Brazil)
	Oportunidades (Mexico)	Jaring Pengamanan Sosial (Indonesia)
	Bono de Desarrollo Humano (Ecuador)	
	Familias en Acción (Colombia)	
	Program of Advancement through Health and Education (Jamaica)	
Niche (regional or narrow target population)	Chile Solidario	Female Secondary School Assistance Program (Bangladesh)
	Social Risk Mitigation Project (Turkey)	Japan Fund for Poverty Reduction (Cambodia)
		Education Sector Support Project (Cambodia)
		Basic Education Development Project (Yemen)
Small scale/pilot	Programa de Asignación Familiar (Honduras)	Subsidio Condicionado a la Asistencia Escolar–Bogotá (Colombia)
	Cash Transfer for Orphans and Vulnerable Children (Kenya)	Punjab Education Sector Reform Program (Pakistan)
	Atención a Crisis (Nicaragua)	
	Red de Protección Social (Nicaragua)	

Source: 'Fiszbein, A. et al. (2009), "Conditional Cash Transfers", A World Bank Policy Research Report, *The World Bank.* Washington DC. pp.5

However, some countries have criticized social safety net because it is seen as a means to get votes for the ruling party. Undoubtedly there is need to invent more effective and efficient programmes and keeping the motive of innovation in mind, Latin American countries have developed new programmes with new strategies which they call Conditional Cash transfer Scheme (Sugiyama, 2011).

1.3 The Social Assistance Context

In some other studies, the cash transfer scheme has been used in context to social assistance and can be categorized as social assistance programs that provide public safety net to needy households. The aim of this program is to transfer the income and resources to the poor to overcome their short term poverty during the period of financial crisis. The transfer is given in the form of cash or income e.g. child allowances, food or subsidies or sometimes jobs also through public work programs.

Social assistance programs have usually been different from social insurance programs which only focus on market failures or giving some kind of support in longer term to risk management (file:///C:/Users/home/Downloads/KE-02-14-922-EN-N.pdf).

1.4 What Has Ignited This Transformation in Social Assistance Policy?: Social assistance program has traditionally been associated with a focus on reducing current poverty with little attention to issues of long term structural poverty. The problem has been viewed as a trade-off between short term equity objectives achieved through efficient economic, and long term objectives of efficient economic growth. "*The short equity focus has often been associated with the use of perverse incentives developed as part of crisis driven approaches, which have often been criticized for reducing the current labor supply, crowding out private transfer and encouraging dependency"*. (Rawling, 2004, pp. 3)

The aim of current social safety net policies is going beyond short term poverty reduction goals and focuses on long term economic growth and human capital accumulation. With this objective, CCT program has a clear goal for long term role. The limitations that these social assistance programs have are explained in the section ahead. (file:///C:/Users/home/Downloads/KE-02-14-922-EN-N.pdf).

1.5 Rationale for Conditionality

The motive behind the Cash transfer programme is poverty eradication. Yanes (2011) has explained that Conditional cash transfer is the right way to overcome poverty in a sustained manner. CCT program is especially meant for the poor in order to maintain human capital and its ultimate purpose is poverty reduction. It is built on the assumption that poor people do not behave in rational manner and cannot take decisions on their own. Therefore by employing a targeting method, resources are transferred to the targeted group to protect the poor from adverse shocks or long run move out of poverty. Such steps or measures include sending the poor children to school, giving them food, employment and taking care of their health etc. (Yanes, 2011).

Another feature of conditionality mechanism as discussed by Bourguignon et. al (2002) shows that the amount provided unconditionally does not have a major impact on the purpose for which it is designed by planners. This is because the poor spend the given money on their basic needs and not on what the government wants them to spend it on. For instance in a programme of West Kenya, money was given to buy bed nets to reduce malaria incidences but people spent the cash on other items like food, clothes etc. on the basis of their priorities of needs and as bed nets remained a distant priority for them (Bourguignon et. al, 2002).

There has been much debate between conditional cash transfer scheme and unconditional, that whether poor people know the best utilization of limited resources and act according to conditional cash transfer scheme or not. However, these basic assumptions and arguments have become root cause of conditioning the cash transfer scheme.

Before proceeding towards various conditional cash transfer schemes, it is important to understand how effective these schemes are in meeting their objectives. The next section will discuss the experiences as well as the achievement of these schemes in Latin America where it was introduced first.

1.6 Performance and Achievement of CCTs in Latin America

In the context of cash transfer schemes, it becomes important to understand the experiences of Latin America as they were the first who introduced the conditional cash transfer schemes. In the 1960s, most countries focused on poverty alleviation programmes but after economic crisis in 1990s there was a shift from structural adjustment programme (SAP), delivery mechanism for reducing poverty to social protection by enhancing the human capital, this was called Social Risk Management Approach[1] (Silva, 2008).

CCTs was seen as a social protection tool which is linked to health and education but there have been lot of diversity in terms of coverage (varies from 40% to about 20% in Ecuador and Brazil and Mexico respectively), budget etc. within Latin American countries (Fiszbein, 2009).

Based on the literature, it has been found that CCTs have positively influenced in some cases, for instance preventive infant care, vaccinations, visit to health care centres, illness rate, and reduction in maternal and infant mortality. The study also suggests improvement in nutritional status as well as consumption level. But some other studies that analyzed the Opportunidades programme's impact on anemia, found that this CCTs have no positive impact on anemia. In fact anemia continues to be a serious problem in the country (Lomeli, 2008; Gertler, 2004; Freije et al, 2006). Though the impact of these CCTs programmes is positive but the impact evaluation studies often ignore the aspect of people's experience with the health system. The table 2 has given an overview of some CCTs programme.

[1]"According to the social risk management approach, individuals, households and communities are exposed to multiple risks. Poverty means greater vulnerability, since the poor have little access to suitable risk management instruments and are ill placed to cope with crises. The mechanisms most used by poor families to deal with economic shocks are informal strategies (i.e. taking their children out of school) whose inefficiency results in an irreversible loss of human capital and perpetuation of the intergenerational cycle of poverty. Social protection measures based on conditional cash transfers are human capital investments that enhance access to basic services and prevent the use of strategies with adverse long-term consequences, benefiting in this fashion people living in structural poverty, those just above the extreme poverty line1, and groups with special needs" (Silva:2008).

Table 2, Effect of CCT Programs on Health Outcomes in Latin America

Outcomes	Overall assessments	Cases with significant effects	Cases with minor or nonexistent effects
Having regular medical checkups	General increase	PROP-Mexico	
Receiving prenatal, natal, and postnatal care	General increase	PJ-Peru, PRAF-Honduras, ´ PROP-Mexico, RS-El Salvador	
Care of growth for children	General increase	FA-Colombia, PRAF-Honduras, PROP-Mexico, RPS-Nicaragua, ´PJ-Peru	
Vaccination	General increase	FA-Colombia, PRAF-Honduras, RPS-Nicaragua, PJ-Peru	
Mortality		PROP-Mexico: 11% reduction in maternal mortality, 2% in infant mortality	PRAF-Honduras: increase in diarrhea for children <5
Incidence of illness	General increase	PROP-Mexico: 12% for children <5, 20%–22% in rural areas; FA-Colombia: 5% reduction in diarrhea for rural children <5, 10% for urban children <5	PROP-Mexico: no effect on risky ´sexual practices among adolescents
Knowledge of health care		PROP-Mexico: increase among ´Women	

Cited in Lomeli, E.V, 2008, pp. 481.

Apart from less effectiveness, this scheme also seems problematic to incentivize behavior change. One study found that *while CCT programs work on the assumption of rational economic behaviour, in reality people act according to a "conditional rationality" shaped by multiple constraints,*

experiences, and preferences, and their "own reading of their sociocultural and sociohistorical context" (Leatherman, 1996 as cited in Adato 2010). There are multiple factors that determine people's health behaviour and it will be too simplistic to assume that 'conditions' as in CCTs can induce such behaviours (Leatherman, 1996 cit in Adato, 2010). From the above, we can say that there are several factors, which determine the human's health behavior, and it will be wrong to believe that due to the CCTs, people will act according to conditions or we can say that CCTs can promote such behaviors.

1.7 An International Perspective of the Conditional Cash Transfer Scheme

1.7.1The experience of the Brazil's Conditional Cash Transfer Program

Brazil has always been concerned about inequality of income distribution and poverty and the aim of innovation or intervention of the CCT programs were to reduce poverty, hunger and income distribution in the country.

In Brazil, the belief is that, poor are poor because it's the "fault of society" and therefore in 1988 a constitution of social assistance established for the needy, that obligated to the state provide health, education and other basic rights to the needy. (http://worldbank.org/.../Resources/BRBolsaFamiliaDiscussionPaper.pdf)

Brazil was the first country that implemented CCTs in Latin America. The idea of CCT was derived from two strands of an ongoing debate (1) the program should give minimum income to the poor and (2) poverty reduction strategies should be based on the current incomes problems and as well as focus on structural poverty in the country. With these aims, the Municipalities launched CCTs programs in some part of Brazil in 1995. In year 2001 to 2003, Brazil has launched 4 other cash transfer programs, these programs were merged in Bolsa Famila Program (BFP) in 1994. BFP is the one of the world's largest program that reaches 5,564 municipalities in the 27 states of Brazil that cover 12.9 million families. (http://worldbank.org/.../Resources/BRBolsaFamiliaDiscussionPaper.pdf; Stampini and Tornarolli, 2012)

If we talk about the effects of BPF on poverty, inequality, food, education, nutrition outcomes and access of health services than we will find that the Gini Coefficient, which is an indicator of income concentration or income inequality of Brazil was stabled from many years but fell due to the BPF program. The other study which was conducted in rural areas showed that enrolled families spent more on food.

The study on education also demonstrates that lower number of children who were engaged in BFP escaped school and engaged in labor market (Stampini and Tornarolli, 2012).

1.7.2 CCTs in Mexico: Progress or Oportunidades

Progress is a conditional cash transfer program that was introduced by the Mexico Government in 1997. This Progress was re-introduced in 2002 with new name Oportunidades. The main objectives of this program are to improve education, nutrition and health status of the poor families especially of the mothers and children.

This program has given cash incentives to the poor families so that they can send their children to school and also access health services.

Before Progresa, in Mexico, poverty was very severe especially in rural parts. In Brazil, every third person suffered from hunger. Majority of rural Mexico had agricultural laborers who were deprived from the mainstream, especially those who did not know the Spanish language. A large number of Mexicans lived in crowded areas and had no access of clean water, electricity or other basic facilities. Illiteracy rate was also very high and large number of population lived with no knowledge of modern health care or its benefits.

Overall, the program has been largely successful in terms of attendance of children, nutritional level improvement, and increase in income of poor households. Though critics have criticized this program at some levels, but overall the program has largely been successful

(http://www.preventionweb.net/english/hyogo/gar/2011/en/bgdocs/Arnold_&_de_la_Fuente_2010%20TS%20pdf.pdf).

1.7.3 Chile: The Solidario Program

In Chile, poverty rate was very low among the three (Brazil, Columbia and Chile) and also one of the lowest among countries in Latin America. Around 13.7% Chilean population was under the poverty line. In 2008 it was around in 25.8% in Brazil and in Columbia 46.8% in 2005 (www.ipc-undp.org/pub/IPCworkingPaper69.pdf).

Chile Solidario was not a typical type of CCT program whose objective was to eradicate poverty. This program was launched in 2002 as an instrument to resume poverty observed in during 1980s and 1990s. There was residual poverty in Chile and this poverty was isolated and disconnected by the social services, therefore to access these services the programme was introduced by the Ministry of Planning and Cooperation (Mideplan). This programme had strong connections and leakages with other social programmes such as Puente (for the family support), Vinculous (for the elderly), Calle (for the homeless), Caminos (for the Children, part of the jail) and Programa de Habitabilidad (housing) etc. Thus, Chile Solidario covered following dimensions: health, education, income and employment, family dynamics and identifications.

Chile Solidario showed success in reaching the poorest population although; it did not reach the set of target population. This programme didnot prove to be sufficient inovercoming poverty due to insufficient amount of cash transfer (www2.uah.es/iaes/publicacimes/DT_05_12.pdf).

Although CCT program was introduced as a tool to reduce short-term poverty it was not very successful. It could have been effective if it had managed to maintain the equilibrium between short term and long term goals to build human capital. This was also the main logic behind launching this programme, i.e. especially to prevent intergenerational transmission poverty.

From the Latin American' experience regarding CCTs, it is evident that it can work if it is implemented well, but the question is, in introduction of such programmes inplaces like India, where about 363 million people live below poverty line and around 260 million live in rural areas, are they really feasible to carry out and truly benefit the public? Number of hindrances for CCT in India are related to the identification and evaluation of poor households, access etc. Apart from that, one main problem is to know what condition should be imposed on the beneficiaries. These are the important points that need to address before proceeding towards CCT in India. CCT should be first understood from the example of its implementation in other South Asian nations so that we can learn from their experience while building our focus on maternal health policies and understand the various changes in it and analyze how CCT can come and benefit into maternal reproductive health of India. The next section deals with similar topics.

1.8 Demand Side Financing Scheme in South Asian Countries

As it has been already mentioned, conditional cash transfer scheme originated in Latin American Countries that had good supply side facilities and infrastructures. This scheme showed remarkable success in many ways in these countries but the question is, is it as successful in other developing countries like those in South Asia, as in Latin America, where the scenario is totally different? There have been lots of evidences that give insight on experiences of the CCTs in South Asian Countries.

Several studies on conditional cash transfer and voucher schemes in South Asian countries (Nepal, India, Bangladesh and Pakistan) mentioned that maternal mortality and morbidity rate in these countries is very high. The utilization of maternal health care services is low despite the initiatives taken by the government and international donors. To improve the health services in relation to availability, training, drugs and equipment, government of these four South Asian countries as well international funders invest in order to overcome these problems and difficulties experienced by poor women and their families. Usually, women face lot of difficulties like lack of information,

these includes where and when to seek care, distance barriers, direct and indirect costs, socio and cultural norms, perception regarding home deliveries etc. out of these barriers, financial barriers are superficial and stand out as one of the main causes for not utilizing health facilities for delivering child. Therefore to keep this in mind, special attention has to be given by the policy makers to address the monetary barriers faced by poor women.

Jahan et. al, 2012 overviewed the five major demand side financing schemes of four different South Asian countries namely Aama Programme of Nepal, Janani Suraksha Yojana and Chiranjeevi Yojana of India, Maternal Health Voucher's scheme of Bangladesh and Sehat Voucher scheme of Pakistan. This study analyzed the objectives, implementation and limitations by reviewing the available data on the schemes. The findings of the study show that though maternal health services have increased after the implementation of these schemes, enough evidence on improvement of maternal health outcomes could not be found due to lack of controlled studies. Lack of clarity in the design is also one of the issues that have been found in the study by reviewing the available data.which further impacts negatively on user's perception regarding scheme and thereby less utilization as well as low coverage of these schemes. Apart from clarity, corruption, funding and sustainability are some other issues that have been obstacles to meet the objectives of these schemes (Jehan et. al, 2012).

Jackson et. al, (2009) had examined the Safe delivery Incentive programmes, launched in in Nepal, 2005. This study showed that several severe constraints in regard to this scheme are delay in disbursement of funds, complexity of the programmes's design, confusing and lack of details of the guidelines as health officials and health workers are not cleared about the policy related to scheme and also lack of focus on how to implement the scheme and make it function properly (Jackson et. al, 2009).

In Bangladesh, Ministry of Health and Family Welfare implemented the Maternal Health Voucher scheme that was launched to analyze the earlier scheme related to maternal health. The main motive of this voucher scheme

was to motivate the private providers into health investment but it was found in on studying about the scheme that the scheme failed to attract new private providers in entering health sector. Public providers also remained same as before even after the Voucher's implementation. The finding of the study showed that although this voucher scheme increased the demand for the services but there was apparent lack of facilities on the supply side. The shortage of these facilities was not readily tackled to ensure flow of all types of maternal health care services. Therefore, it can be learnt thatto improve the performance, there needs to be a balance between supply and demand side facilities (Ahmed and Khan, 2010).

After explaining the experience and contribution of demand side financing schemes in South Asian regions, now it's time to discuss about how conditional cash transfer scheme has been included in maternal health policies in India and what are the reason for adoption of this conditional cash transfer scheme.

Chapter 2

Maternal Health Policy in India: From Maternity Benefit Act to Conditional Cash Transfer Scheme

This chapter discusses how conditional cash transfer scheme started and what were the milestones in the evaluation of the maternal health policy in India. This chapter also discusses the history of maternity benefit act in and how Janani Suraksha Yojana was an outcome of reform of the maternity benefit act in India. This chapter gives an overview of Janani Suraksha Yojana along with a brief introduction to several central and state led conditional cash transfer schemes in India. The present chapter also includes the conceptualization of the problems as well as the methodological framework used to meet the objectives of the study.

There have been various shifts and changes in maternal health policies of India and these policies can be separated on the basis of their concern areas. In the beginning of 1950s an integrated approach to maternal and child health care was adopted. Other initiatives taken duringthat period was introduction of midwives and reduction in the role of dais (B, S.S and Khanna, R. 2012). These policies and programmes changed drastically, when it gained attention at the international level which further resulted in the launch of safe motherhood programme with support of UN agencies in 1987. In 1992 policymakers also gave attention towards nutrition, immunization as well as maternal healthcare in the safe motherhood programme. In the year 2005, The National Rural Health Mission was launched for improving the quality as well as accessibility of health services in India under which Janani Suraksha Yojana (JSY) a conditional cash transfer scheme was also started. Prior to JSY, some other cash transfer schemes like The Muthulakshmi Reddy Memorial Maternity Assistant Scheme1986 in Tamil Nadu and The National Maternity Benefit Scheme 1995, which remained separate until 2005. Their merger with JSY was in 2005(Hunter et al, 2014). Apart from these, there were some other several cash transfer schemes, which functioned across states in India.

2.1 History of Maternity Cash Assistant Scheme in India

In India, maternity benefit act has been recognized as a part of labour rights for working women since 1961, when the first Maternity Benefit Act was enacted. Under this act, 12 weeks of paid leave is given to pregnant women. Apart from this, several other amendments, legal assurance is also given to the women so that they return back to their job without any discrimination or job related fear such as transfer, dismissal, problems in promotion etc. However, this act was not effectively implemented in the private sector and did not follow the rule and norms of the Act. As a result most of the eligible women did not get benefit from the Maternity benefit Act, which was meant for the protection of women and their new borns. In the meantime, a large number of female workers in the unorganized sector also did not have any maternity support (http://phrsindia.org/towards-universalisation-of-maternity-entitlements/). Therefore government of India launched several maternity related schemes for poor women. These schemes formulated by concerned ministries and departments were implemented either by the central government or state governments.

The first attempt at providing maternity related childbirth assistance for women in the unorganized sector was the Dr. Muthulakshmi Reddy Maternity (MRMBS) Benefit scheme in the1980s in Tamil Nadu. This scheme was launched in 1987 under the Ministry of Health and Family Welfare department. The scheme initially provided INR 300 for bearing the expenses of childbirth, but in 1995, the amount increased to INR. 500. However, given the importance of maternal nutrition, the financial assistance has been enhanced to INR 6000 from the year 2006-07. This amount was given to the BPL pregnant women to compensate for the loss of wages and providing nutritious food inorder to avoid the low birth weight baby. The amount of money was given into two equal installments, first in the seventh or later months of pregnancy and second installment was given after delivery within six months. But from year 2012, the government ordered the enhancement of the financial assistance from 6,000 to 12,000. An amount of INR 12,000 were given to pregnant women in three installments. The first installment wasgiven

after Antenatal Care (ANC) checkups, second one, after the delivery in government hospitals and third installment, after completion of third dose of pentavalent immunization (MoHFW, Government of Tamil Nadu; Balasubramanian and Ravindran, 2012; http://phrsindia.org/towards-universalisation-of-maternity-entitlements/). Influenced by the Dr. Muthulakshmi Reddy Maternity Benefit scheme in 1995; the central government also launched National Maternity Benefit Scheme (NMBS) under which INR 500 was provided until 2005, when it was not merged into the JSY scheme.

Janani Suraksha Yojana was another major intervention of the Indian government, which was launched in April 2005 under the National Rural Health Mission (NRHM). Under the scheme, there was provision of giving cash incentives to the BPL women for institutional delivery (Das et. al, 2011).

Thus the Muthulakshmi scheme paved way for various maternity entitlement and cash transfer schemes at the central as well as state level. Keeping in mind the difficulty faced by the pregnant women and health of new born baby, Ministry of Health and Family Welfare (MoHFW) took another step by renaming and re-launching the JSY scheme as Janani Shishu Suraksha Karyakaram (JSSK) on 1st June 2011. This scheme provide complete free of cost health services to pregnant women during delivery whether normal or caesarian, as well as for the new born baby, if sick up to 1 month after delivery (http://nhm.gov.in/janani-shishu-suraksha-karyakram.html).

Apart from this, States also adopted the JSY model to boost the gain of JSY or for those areas which were not covered by the scheme such as Saubhagyavati scheme in Uttar Pradesh, Janani SuvidhaYojana in Haryana, Janani Sahyogi Yojana in Madhya Pradesh, Ayushwati scheme in West Bengal etc.

2.2 Maternity Related Cash Transfer Schemes in India

Schemes are usually seen as monetary mechanisms. The aim of maternity related scheme is to improve maternal and neonatal health in India. There are number of functioning schemes which include central and state led initiatives,

all over the country. At the National level, Reproductive and Child related health programmes and schemes are implemented by Ministry of Health and Family Welfare and Department of Women and Child Development. State level schemes are also functioning, introduced by the Ministry of Health and Family Welfare. Centrally sponsored schemes launched are namely, Janani SurakshaYojana, in the year 2005, under the umbrella of National Rural Health Mission (NRHM) and Indira Gandhi Matritva Sahyog Yojana a centrally sponsored scheme, formulated in 2010. Some state led schemes are Janani SuvidhaYojana, Chiranjivi Yojana, Mamta etc. There is also a government scheme such as Rashtriya Swasthya BimaYojana (RSBY) which provides cashless health insurance for hospitalization to the poor (Gupta et. al, 2010).

It is very interesting to note that, most of the state governments took initiatives in implementing the schemes and counted them as their biggest achievement. Most of the state schemes are closely related to their respective Chief Ministers. For instance, the Ladli scheme was launched by Sheila Dikshit in Delhi. In Karnataka the Bhagyalakshmi scheme was formally launched by the Chief Minister, H D Kumarswamy and Deputy Chief Minister B S Yediyurappa. The Department of Women and Child Health schemes implemented them. Apart from them there are some other schemes which have were launched by Ministry of Health and Family Welfare department such as Balika SamridhiYojana in Himachal Pradesh and Balri RakshakYojana in Punjab. Although it has been observed that there are some schemes which were initiated by the Central Government of India, but after some point of time, they whereby the state government with some modification like renaming or addition of some extra financial assistance. Balika Samridhi Yojana was replaced in the year 2010 by the scheme Beti Hai Anmol with similar eligibility and benefits (Sekhar, 2012).

2.2.1 Central Sponsored Cash Transfer Scheme

There are currently several central as well state sponsored schemes that are functioning or have stopped functioning due to some reasons in India and its states. The list of these schemes is given in the next table that is centrally sponsored schemes of India.

The following table (3.) Lists of the Centrally Sponsored Cash Transfer Schemes.

Balika Samriddhi Yojana BalikaSamriddhiYojana was launched in 1997 and it has been recasted by the Government of India during 1999-2000. The motive of this scheme is to cover the girl children in poor families, in rural as well as urban area as for their schooling. Under this scheme an eligible girl child is entitled a grant of INR 500 and this scholarship is given until they are unmarried and their study is not complete till class 9 (http://wcd.nic.in/BSY.htm).
Kishori Shakti Yojana (KSSY) This scheme was implemented under the centrally sponsored Integrated Child Development Services (ICDS) scheme in the year 2000-01. KSSY is a redesign of the already functioning Adolescent (11-18 years) Girls scheme to expand the range of the latter scheme. Under this scheme, adolescent unmarried girls who belong to poor families and also who do not complete their study are selected and then provided required education. It also trains them to improve home as well as vocational skills along with awareness about health related information, hygienic, nutrition, family welfare, childcare etc (http://wcd.nic.in/KSY/ksyintro.htm).
Janani Suraksha Yojana JananiSurakshaYojana is a scheme which was launched under RCH II (Reproductive and Child Health) programme of NRHM (National Rural Health Mission) in April 2005. This is a safe motherhood intervention which has been especially launched to reduce the maternal as well as neo-natal mortality through increasing the institutional delivery (www.nrhm.in/UI/Reports/Documents/JSY_study_UNFPA.pdf).
Dhanalaksmi Yojana It was started in March 2008 by the Ministry of Women and Child Development. This scheme covers 11 blocks of seven states (Andhra Pradesh, Chhattisgarh, Jharkhand, Uttar Pradesh, Bihar, Orissa and Punjab). DhanalaksmiYojana providescash transfers and insurance coverage (in certain cases) to family of girl child (especially to the mother) on satisfying certain specific conditions for the girl child, including birth registration,

immunization, school enrolment, continued attendance in primary and secondary school, and marriage after the age of 18 (http://wcd.nic.in/Dhanalakshmi/dhanalakshmi301013.pdf).
Janani Shishu Suraksha Karyakram This scheme has been started in year 2011, June by the Ministry of Health and Family Welfare under the NRHM. The main motive behind launching this scheme is to provide free and cashless services to pregnant women for normal as well as caesarian section of the operation and care for the neo born Childs up to 30 days in all public health facilities across the country in both rural and urban areas (Subha Sri B. and Khanna, 2012).
Indira Gandhi Matritva Sahyog Yojana (IGMSY) The limitations of the JSY scheme in terms of out of pocket expenditure incurred as a result of wage loss etc. led to its revision and thus Indira Gandhi Matritva Sahyog Yojana was launched to cope up to these difficulties. This scheme is also a centrally sponsored maternity benefit scheme, under which cash incentives are given to the pregnant and lactating mother, formulated in 2010 by the Ministry of Women and Child Development (MWCD). INR 4000 are provided to the mothers who are19 years or above age, for the two live births in three installments. JSY has become a component of this scheme.Through these scheme women become encouragedabout availing JSY because this scheme compensates the loss of wage during delivery. IGMSY has been implemented in 52 districts across the country on the basis of pilot study. The list of districts is given in the appendix-1. However during the researcher's field visit, researcher found that in Sultanpur district, the scheme is functioning separately (http://wcd.nic.in/SchemeIgmsyImpGuidelinesApr11.pdf).

2.2.2 State Sponsored Cash Transfer Schemes

Apart from the centrally sponsored health cash transfer schemes, state has also taken initiatives to implement the health, education, and employment related schemes. In different states of India, there are numbers of maternity related cash transfer schemes which are functioning and given in table 4.

Table 4, List of State Led Cash Transfer (Conditional, Unconditional and Voucher) schemes

Dr. Muthuthlakshmi Reddy Maternity Benefit Scheme was launched in 1986 in Tamil Nadu as an unconditional cash transfer scheme that provided 200 INR. In 2006 the amount of money was increased to 6000 INR and then in 2012, the government again ordered enhancement of the financial assistance from 6,000 to 12,000. The money of INR 12,000 is being given to the pregnant women in three installments.
Prasav Hetu Parivahan Evam Upchar Yojana was implemented in 2004 by Madhya Pradesh Government. Under this scheme payment of INR. 3000 is given to the women, belonging to specific tribes and castes for institutional delivery.
Chiranjeevi Yojana is a voucher scheme, launched in 2005 in Gujarat. This scheme was started to motivate women to receive antenatal, intrapartum and postnatal care in private hospitals.
Devi RupakYojana was introduced in Haryana and the criterion of this scheme was sterilization. After the first or second child, if parents undergo this procedure (sterilization) then they get a monthly pension for 20 years.
Vijaya Raje Janani Kalyan Bima Yojana was started in 2006 and ended after one year (2007) due to the similar criteria of JSY in Madhya Pradesh for encouraging institutional delivery.
Janani Suvidha Yojana (2006-08) was a voucher scheme of Haryana state for the urban slum women to use private health facilities.
Janani Sahyogi Yojana is introduced in 2006 for Madhya Pradesh women to use of private facilities for intrapartum care.
Sambhav Swasthya Koopan Pariyojana- Health voucher scheme which was implemented in 2007 on the basis of pilot study in Uttar Pradesh (368 urban Slums of Kanpur), Uttarakhand (two blocks of Haridwar) and in Jharkhand (two blocks of Gumla). This scheme also targets the BPL population and its main objective is to improve accessibility of Reproductive and child health (RCH) services through private health facilities
MAMTA Scheme is a cashless scheme for Delhi urban slum women for antenatal, intrapartum, and postnatal care, implemented in year 2008.

Cont….

Prasuti Aaraike is a Karnataka state sponsored scheme, launched in 2008.INR 2000 are given on the conditions of antenatal care as well as institutional delivery.
Mamata is implemented in 2011 in Odisha. The amount of the money is paid through IGMSY scheme.
ThayiBhagya is a cashless scheme, introduced by the state government of Karnataka for accessing the private health services.

Health Department of Haryana; Hunter et. al, 2014, pp.67; Sukhija, 2010;

2.3 Uttar Pradesh State Sponsored Schemes

While the status of women in Uttar Pradesh has improved over a period of time, the rate of improvement is slow and therefore it is still an area of concern for the state government. The maternal mortality ratio in 1997 was estimated to be 707 per 100, 000 live births while according to SRS (sample registration scheme) 2010-12, the maternal mortality ratio of the state has been estimated 292, which has shown improvement in comparison to 1997.

It has been argued that institutional deliveries contribute to reduction in maternal mortality and improve maternal and child health. Institutional deliveries increased from 11.2% in 1992-93 to 15.2% in the 1998 and according to NFHS-III it is estimated 22%. The DLHS shows 24.5% deliveries have occurred in the institutions in Uttar Pradesh. Though figures show the improvement in percentage of institutional deliveries but still substantial efforts are required to improve the condition of women in the state (Department of Health and Family Welfare, GOI; upnrhm.gov.in/health-statistics.php).

2.3.1. Mahamaya Garib Balika Ashirwad Yojana

The state government of Uttar Pradesh has also launched some schemes which function along with centrally sponsored (JSY, JSSK, IGMS) schemes. Although, these state sponsored schemes change with every new elected government, for instance, during the reign of former Chief Minister Smt.

Mayawati, a scheme called Mahamaya Garib Balika Ashirwad Yojanalaunched in 15 January 2009 and was sponsored by Uttar Pradesh. Under MGBAY, there was the provision of giving the fixed deposit of INR 20,000 for the first girl child of the BPL or Antyodaya card holders. As per the rules of this scheme, this would be given only to the daughter at the age of 18 (eighteen) years when she is unmarried. This scheme was not implemented in the whole country as part of the Integrated Child Development Services (ICDS) but this scheme was implemented by the state government for the welfare of the girl children in BPL households to prevent the female feticide and child marriages and to give financial security to the family. In the scheme, parents' name must be in the current BPL list and date of birth (DOB) which was as from the health institutions at the time of baby's birth etc. are some of the key requirements to avail the scheme. These requirements also prove to be the difficulties for families that lack the collection of such information; people without sufficient proofs fail to avail the benefits of schemes like MGBA (nhrc.nic.in/Documents/Reports/misc_SKTiwari_Gorakhpur.pdf).

During the reign of the Samajwadi Party government in Uttar Pradesh, various schemes and programmes, which were launched by the former Chief Minister Mayawati, have been cancelled and one of them is this Mahamaya Garib Balika Ashirwad Yojana.

2.3.2. Saubhagyavati Surakshit Matritva Yojana (SSMY)

The government has launched a public-private partnership (PPP) scheme in 2008-09 along with Rastriya Swasthya Bima Yojana (RSBY) to reduce the burden of high demand of institutional delivery. This scheme provides the reimbursement of private facilities for normal or C-section delivery for BPL women. Under this scheme, facilities are entitled to a payment of upto1.85 lakh per hundred deliveries (www.intrahealth.org/files/media /strengthening-public-private-partnerships-for-institutional-deliveries-in-uttar-pradesh/PublicPrivatePartnership brief_final.pdf).

2.3.3. Vandemataram Scheme

This scheme is functioning under the public private partnership. The motive of the scheme is reducing maternal mortality and morbidity of the pregnant women by involving the private sector doctors and specialist. The base of the scheme is volunteer means, these private doctors and other private workforces take initiatives themselves for safe motherhood services. This scheme was started in 8 states (Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Haryana, Assam, Nagaland and Orissa) and has been extended in 1999-2000 in remaining 6 North Eastern States (http://mohfw.nic.in/WriteReadData/l892s/Chapter04final-85836829.pdf).

Next section will provide insights on the available literature review in the area of cash transfers schemes. It highlights the historical context of cash incentives programmes, transfer schemes in India with especial focus on Janani SurakshaYojana and related issues which include addressing both the supply side and demand side constraints as well as interaction between both.

2.4 Janani Suraksha Yojana (JSY) in India: An Overview

In India, there were several committees (Bhore, Sokhey, Mudaliar, Chaddha and Kartar Singh reports) that have been focused on the issues related to the three tier public health system in India. The issues raised by them include inadequate investment in the health sector, lack of human resources especially doctors and infrastructures, rural urban disparities in terms of health services and increasing the role of private sector in health. 1990s was the era of public-private partnership and liberalization. In this period of time liberal tax and incentives were given to the investors for setting up private clinics and health institution which further resulted in the rapid growth of private sector. But it was found that even this partnership was not effective in sorting out these various issues. In 2005, with the introduction of JSY under NRHM, focus was shifted from supply side to demand side financing, although attempt to strengthen the supply side services were also given attention (Sen, 2012). But due to some reasons, this scheme did not work properly. Findings of the

available literatures indicate the barriers of the scheme in relation to supply and demand side factors.

A number of studies have identified the supply side constraints but very few have focused on the demand side as well, which acts as an obstacle for availing the scheme. This supply side factors include availability of health services, drugs as well as availability of human resources available the health institutions, while demand side factors are financial status or income, cost of health services, out of pocket expenditure which include direct and indirect costs, both. There are even fewer studies that have examined the interaction between supply and demand side factors.

2.4.1 Supply Side Barriers

Reduction of maternal mortality has become a core area of concern for the government due to the high burden of maternal mortality. Although in India, several welfare programmes have been launched but JSY is the scheme in which cash incentives are directly given to the poor women who have given childbirth in health institutions. It was launched in 2005, aiming to reduce maternal and neonatal mortality, under the umbrella of National Rural Health Mission in India (Sharma et al. 2012).

Maternal health is one of the key indicators of any health system. It is said to indicate the functionality of the health system. Therefore Government of India has introduced JSY a maternity benefit scheme, but due to various reasons, for instance inadequate facilities in public health institutions, delay payment, untrained staff, multiple referral, lack of drugs and other necessary amenities etc. the scheme couldn't work properly (Paul et al. 2011). These all issues realted to the JSY has been given in further section.

a. Features of Cash Transfer Scheme- Janani Suraksha Yojana

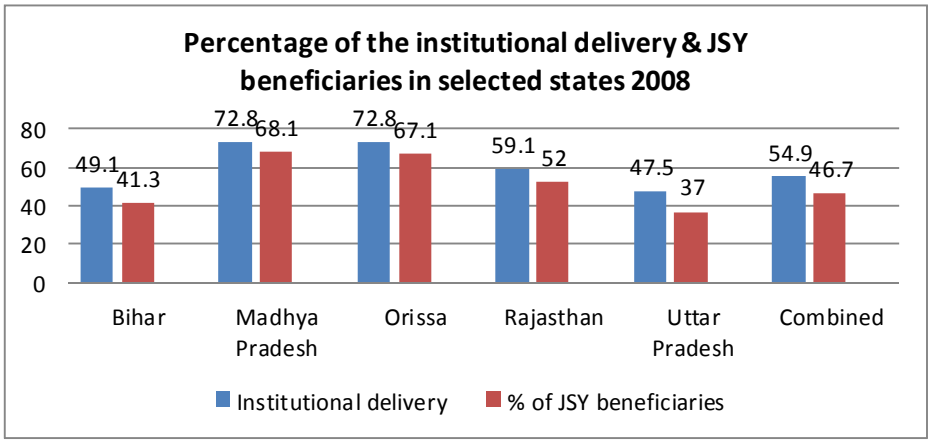
Janani Suraksha Yojana is a scheme which was launched under RCH II (Reproductive and Child Health) programme of NRHM (National Rural Health Mission) in April 2005. This is a safe motherhood intervention which has been especially launched to reduce the maternal as well as neo-natal

mortality through increasing access to the institutional delivery (www.nrhm.in/UI/Reports/Documents/JSY_study_UNFPA.pdf). It is a hundred (100%) percent centrally sponsored scheme. Under this scheme there is provision of giving cash incentives to the BPL (below poverty line) pregnant women when she delivers the baby in a government health (DHs, CHs, PHCs or SCs) institution (jknrhm.com/PDF/JSR.pdf). In the case of private institution births, the beneficiaries only get cash incentives when she or her family have genuine BPL card, approved by census or rather a SC/ST certificate. In this scheme the mother gets INR. 1400 in rural areas .whereas the mothers who resided in urban areas get INR. 1000. This cash assistance of INR.500 is also given to the BPL women who are pregnant (above age of 19) and up for home delivery. This scheme is restricted to only two live births (angul.nic.in/JSY.pdf).

India contributes more than twenty (20%) percent tothe global maternal deaths. To tackle this problem, the central government of India has launched the Janani Suraksha Yojana. Through this scheme, the government has targeted to promote the institutional deliveries, for starters, which include three antenatal checkups and a provision of cash incentives for the expecting, provided they deliver the baby at a government clinic. But due to various reasons (such as lack of awareness of the programme, cumbersome process, delay in getting the amount etc.) the mothers are not availing this scheme (Devadasan et al. 2008).

The success of the scheme is dependent upon the ratio of the institutional births either in the public or private. During the year 2008, Orissa and Madhya Pradesh were highest in the institutional delivery while Uttar Pradesh and Bihar, total number of institutional births were less among all five (Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh) states. The mothers who delivered the baby at home reported various reasons such as high cost of institutional delivery, inconvenience, distance to the institutions from home, and unavailability of the health personnel's like ASHA, ANM for home delivery etc., among all five states. (See figure 1.) (www.mohfw.nic.in/NRHM/Documents/JSY_study_UNFPA.pdf).

Figure1, Percentage of the Institutional Delivery and JSY Deneficiaries



Source: (www.mohfw.nic.in/NRHM/Documents/JSY_study_UNFPA.pdf).

Varma et al. (2010) studied the institutional births in rural Uttar Pradesh. This study was done in two phases. The first survey covered four thousand seven hundred and fifty four (4,754) respondents, which included married women, their husband, ANM, ASHA, AWW, staff of the government health centre and panchayat members. Out of four thousand seven hundred and fifty four, four thousand four hundred and seventy two (4,472) women were interviewed. The second phase conducted in-depth interview with the family, health care providers and panchayat members. From the above sample, the result revealed that only forty four (44%) percent had delivered in the hospital while rest had delivered at home. Though, from the data result shows an incremental increase in institutional births during the period of 1992-93 to 2007-08, but this incremental increase was slow. The marginal increase was because of JSY. The study highlighted the key reasons for the marginal increase. The study highlighted the reasons for the slow uptake of the scheme. The study showed that fifty six (56%) percent of women had delivered at home because they perceived pregnancy and delivery as a normal function if they did not experience any complications; husband and elders' decision, unavailability of money and transportation at the time of delivery, labor pain at night, lack of privacy on health institutions, trust on Dai, convenience at home, lack of drugs and other facilities, rude behavior of the staff in the institutions, distance from

the hospitals were some reasons why women chose to deliver at home. The women who had delivered in the hospitals mostly belonged to the upper and middle classes and were educated compared to the others (Varma et al. 2010).

b. Awareness and Utilization of the JSY Scheme

Regarding the awareness of JSY (Janani SurakshaYojana), Mandal et. al. (2010) study found that ninety (90%) percent mothers knew that some incentives are given to the pregnant women but only sixty four (64%) percent heard about the JSY scheme. The result also shows that there is positive association between husband's education, awareness of JSY and getting the amount of this scheme. The delay in the payment of JSY and insufficient funding of the scheme were the other reasons for low coverage of Janani Suraksha Yojana in the country (Mandal et al. 2012).

Gupta et al. (2011) studied the levels of awareness of JSY in Jabalpur of Madhya Pradesh and showed that only a small number of respondents heard the name of JSY scheme but majority of respondents knew that there is a scheme for institutional delivery. ANMs, Dai, ASHA informed majority of the respondents about the scheme. The doctors motivated very few. In the case of home and institutional births, most of the women were in favor of home births and said that home delivery is better than institutional delivery. In the utilization of amount of the JSY, it is found that one third (1/3) of the respondents wanted to use it for nutrition while one sixth (1/6) were interested to buy medicines for themselves and their babies. ASHA or ANM only motivated 52% for institutional delivery because the women were highly dependent on her husband or head of the family for health expenditure (Gupta et al. 2011).

c. Difficulties in Availing the JSY Scheme

Narayanan et al. (2008) has shown the same issues with JSY. In the scheme, BPL card is compulsorily required to avail JSY scheme. At places where BPL cards have not been updated or issued, various other criterias specified for such areas, which varies from state to state. In some states, there is no time

limit for getting the amount of JSY whereas in some, such as Maharashtra states have made some limits (like as within seven days after submitted the documents) to avail the scheme. Late reimbursement is another and most common reason, found in the scheme for not replenishment by the government (state/ district). The state or district governments argued that non-submission of documents and certificates on time by the ANMs and ASHA were the reason for delay in providing the benefits of the scheme. Along with all this corruption has always been the biggest issue observed by the beneficiaries. Due to corruption, most of the beneficiaries have got only half amount of scheme instead of full amount (Narayanan et al. 2008).

d. Reason for Not Availing the Scheme

Vishwanathan et al. explored the reasons for not getting the full amount from the JSY schemes. This study has been conducted in the slum areas of the Solapur, Western Maharashtra. In the study, three hundred and sixty women were eligible for the scheme, out of that only one hundred and eighteen have got the money of INR 1400. The general reasons for not availing the scheme amount was lack of informationas JSY documents were not available on time (Vishwanathan et al. 2011).

Similar findings have been also seen in Lahariya's study (2009). By increasing the institutional delivery, author has suggested that cash incentives which are given to the mother at the time of or after delivery should be given to the pregnant prior to the birth of the baby and so that the family need not to take loan from private money lender or some local loan provider at high interest. It is also suggested that government should improve facilities at the public hospitals, for instance equipment, beds, drugs and transportation services, inorder for a better uptake of cash incentive program (Lahariya, 2009).

e. Lack of Essential Obstetrics Equipments

A study of four states (Uttar Pradesh, Madhya Pradesh, Bihar and Rajasthan) has found that the scheme does not report any facility quickness to deal with emergency. In these four states, a huge number of maternal deaths occur.

Although, primary health centres in these states are open daily even for 24 hours, these primary health centres had very low quality of health services and are also very few in numbers. Some necessary services and equipments are required to prevent maternal mortality as well as newborn care and should be kept at primary centres as well as community centres Hardly any of these centres were providing amenities for caesarean section, or had blood storage facilities, as found during the study. (Das et.al, 2011).

Paul et al (2011) study's findings show that due to inadequate facilities in the public hospitals, most of the mothers get discharged within hours. Thus they do not get much awarenessabout important information regarding babies care and other details such as breastfeeding, postpartum care etc. It has been also found that deliveries were conducted by untrained staff rather than doctors or nurses. Corruption, delay in payments and lack of referral emergency system and also multiple referrals are other core problems in the JSY scheme (Paul et al. 2011).

Though, in this scheme, there is provision for giving the cash incentives to mothers for bearing the child birth expenses as well as other indirect costs such as transportation cost and food during delivery, a study in Rajasthan shows that families have to bear hospitalization charges, purchase of drugsand hire transportation at their own risk. This requires them to take loans at a high rate of interest. This is because of unavailability of drugs, late payment of JSY money to the beneficiaries. As it has been seen from the various studies that in most states there is a higher utilization of private institutions but in Rajasthan it is low. They use private hospitals for antenatal care or some other reproductive related problems and use the public hospital for birthing. The findings also show that there is shortage of basic amenities in the government (SCs, PHCs, CHCs and FRUs) institutions as well as insufficient number of staffs, blood banks and drugs which people compel to bear from their pocket (Iyenger et al., 2009).

Gujarat is not one of the high focus states of NRHM and a better performing state as well. More than 75% deliveries are institutional and maternal mortality

ratio is 122. Although, some remote area have been focused as state has taken initiatives to strengthen about 100 PHC to give 24*7 emergency obstetric care but in the study of Yasobant, Vora and Mavalankar (2014), findings show around 50% of the PHCs have toilet facilities and baby care unit and 70% have basic equipments. Overall all surveyed PHCs have basic amenities for the obstetric care but the major problem found in the study is lack of skilled and qualified health personnel'swhich is a mandatory condition for obstetric care. The lack of health care providers, made it difficult to function round clock for the obstetric care perople in the health institutions (Yasobant et. al 2014).

f. Effect of the JSY Scheme on Institutional Births

Though the scheme reported the raising of institutional births, De Costa et. al (2009)'s study in an economically deprived area of Madhya Pradesh, was found that cash incentives could not motivate women to seek institutional deliveries. This was because their poor socio-economic condition proved to be a barrier to accessing the scheme. The reasons for not seeking institutional deliveries was due to ,loss of wages of care giver during hospitalization, distance of hospitals, non- availability of transportation and poor quality of health services at the government hospital (De Costa et. al, 2009).

Khan et al. (2010) conducted a study on the impact of Janani SurakshaYojana in Uttar Pradesh showing that the ratio of women who received, at least three ANC checkups increased in the year 1992-93 (19.2%) to 2008-09 (34.4%). But despite of this fact there is also other side of the picture which is that, still huge number of women, about sixty six (66%) percent, have not received the last three ANC checkups (Khan et al. 2010).

Sidney's study in Ujjain showed that there was an incremental increase in institutional births. About seventy six (76%) percent of the deliveries took place within the JSY scheme. The reason reported was that most of the families, about 44%, had houses near to the health clinic. Though, only seventeen (17%) people reported about the availability of good facilities in the institutions. The analysis also showed that women, who belong to the general

caste and above poverty line, selected private hospitals or nursing homes for themselves. The reasons they stated for this were that they were familiar and comfortable with the medical staff of the private institution and also opined that private institutions are meant for ladies belonging to upper castes. The remaining twenty four (24%) percent had home births because there was lack of transportation. Unavailability of transportation was the biggest barrier for institutional births in the study and second was that mother felt that previous deliveries were easy and therefore there was no need to go to hospital. So it is found that there was an important program uptake with a large number of women had delivered baby in the hospitals. However there were some problems as complained by the women who had delivered the baby at home. If the difficulties they have (women) faced are included in the scheme, than it is beneficial for the scheme as it increases the efficiency of the scheme. (Sidney et al. 2012).

g. Factors Influencing the Utilization of the Health Facilities and JSY

ASHA is an important part of the JSY scheme who motivates the pregnant women for institutional delivery, three ANC checkups, immunization, post-partum checkup as well as counseling the mother regarding breast feeding etc. Though the selection of the ASHA is done by the recommendation of the Gram Pradhan, ANM and Anganwadi workers but still there is little transparency in the selection procedure of ASHA, because the socio-economic background of ASHA has effects on her works. It is found in some states especially in Madhya Pradesh, ASHA belonged to good family background of the village and keenness towards working for the poor doesnot matter for her. The availability of drugs kit which is provided to the ASHA is not adequate to do her work efficiently. Though data shows that ASHA has received around 69% of the kits in 2009-10, still the figure is low. Differences in the quality of training of ASHA among states have varied widely. Through the effort of ASHA, the positive impact in increasing the ratio of women, in taking at least three antenatal checkups, immunizations, institutional births is also found, (Bajpai et al. 2009). Therefore it is better to accept her as a social activist

rather than health worker to enhance her role in health care in the village (Husain, 2011).

Sharma's study in Uttarakhand showed the positive association between socio-economic background of respondents and number of ANC visits. The women who belonged to upper class had higher number (93.02%) of ANC visits than the lower middle class. The data also reflected that the women who lived in joint families had a greater percentage of ANC visits compare to nuclear families. According to the data of the present study, the consumption of iron folic acid (IFA) tablets reflect the absolutely opposites result as illiterate women consumed hundred IFA tablets of the rural counterpart compared to sate level's findings (Sharma et al. 2012).

In case of caesarean deliveries, post natal checkups are higher compared to normal births. Even in the case of cesarean, not all babies received all three checkups and this percentage is lower even in the normal delivery as well. Finding is based upon the third round of DLHS (DLHS-3) data. There has been research in 601 districts of 34 states and union territories that show babies born by caesarean are more likely to go checkup in the private institutions while the normal babies go to in public hospitals. Another observation is that the poor are more likely to access the government hospitals than the rich, who utilize the high proportion of private ones (Singh et al. 2012).

2.4.2 Demand Side Barriers

Vyas et al. (2011) cross sectional study, conducted in various health care setting in Ahmedabad city during September to October 2008 in which the authors have presented the differences in the total average of normal births and caesarian section in the government, private, corporate hospitals and also in the home delivery. In this study they found huge differences within types of hospitals. These significant differences were found mainly because of the medical expenses. It was found in the study that despite the fact, JSY and Chiranjeevi like centrally as well as state sponsored schemes are functioning in the Ahmedabad city of Gujarat state but still many child births are

conducting at home in urban slum of the city. While, sometimes home delivery become more expensive than the normal delivey in public hospitals due to the expenses of delivery comes to be in cash form or in kind taken by the personal that are higher than public hospitals. For caesarian sections, indirect cost and non-medical fee were found higher in the government hospitals because of the long stayduring hospitalization. The charges, which patients had to bear in the private and corporate hospitals was very high for normal and caesarian delivery which exceeds more than hundred percent (Vyas et al. 2011).

It is also observed that the pattern of health expenditure varies across different socio-economic backgrounds. The average per capita and per episode expenditure in the middle as well as upper middle classes is higher than the lower and lower middle classes. The reasons for lower expenditure by the latter could be due to greater reliance on government hospitals and unavailability and lack of money to spend on private health care. In government hospitals, there is lack of resources and hence they suffer from a variety of difficulties in terms of funding, facilities, essential drugs etc. On the other hand, the financial resources are flowing towards private health sector from the community (Ray et al. 2002).

In India, it is noticeable that the out of pocket (OOP) expenditure is much higher among all sources of private funding but inpatient expenditure is high either in public or private institutions. The amount of expenditure which patients bear is greater in private than the government hospitals. Based on an analysis of the NSSO data, it is found that average per episode out of pocket expenditure has increased from 528 (five hundred twenty eight) rupees in year 1986-87 to 4950 (four thousand nine hundred fifty) rupees in year 2004 in the private hospitals. Out of pocket expenditure for inpatient treatment is unreasonably higher for two higher quintile compared to the two lowest quintiles. The study also shows that treatment in private institutions is much costlier and proves to be a great burden for the poor than the rich (Dilip, 2010).

a. Rural-Urban Disparities Regarding OOP

Selvaraju (2003) measured the expenditure on health at state level (macro) and households (micro) level in the rural areas of India. This study revealed that money spent on health care by households in the year of 1993-94, was seventy to eighty (70-80%) percent of total household expenditure in India. This study shows that villagers spent about 5.40 percent of their income on health expenditure, whereas the government only spent 1.09 percent on health during 1993-94. It also shows that the structure and pattern of the government health spending went towards machinery, equipments, personnel salaries etc. while patients spent their money on medicines, doctors' fees, transportation etc (Selvaraju, 2003).

Mahal et al. (2001) also showed that the rural and the urban areas have still inequalities in health facilities' utilization. It has been estimated that the secondary services utilization of public services was quite low due to poor quality service as well as the presence of the private institutions in these areas. This study also revealed that government finance as well as healthcare services are biased towards the rich but there are some states such as Tamil Nadu, Maharashtra, and Gujarat where the health care services are not biased while it is equal to everyone. Thus, the author suggested that the state government should take major steps towards improving the quality of secondary care which will provide better health services to the poor in rural areas (Mahal et al., 2001).

George (1997) conducted a study in Maharashtra and Madhya Pradesh and estimated that private sectors were used more in rural Maharashtra as compared to urban areas. In Madhya Pradesh the utilization of the private sector was same for both rural and urban areas. The cost per episode was higher for both states in the rural as well as urban (George, 1997).

Using the NSSO data of 1999-2000, Garg & Karan (2008) showed that out of pocket expenditure is about 5% of total household expenditure. This is higher in the rural counterparts as well as prosperous states. It has been found that the major contribution of the out of pocket expenditure was the cost of drugs that

contributed to nearly 70% of the total out of pocket expenditures. This OOP expenditure has been estimated 80% in 1995-96 (Peter et al. 2002) and 70% in 2000-01 (Macroeconomic Commission, 2005). The major part of the expenditure of the OOP expenditure is on private health spending which is accounted 97% of the total private health expenditure (Garg and Karan, 2005). The percentage of the OOP spending on inpatient care, outpatient care and drugs in rural as well as urban area in 1999-2000 has been given in table 5.

Table 5 Percentage of the OOP expenditure on Inpatient, Outpatient and Drugs in Rural and Urban Area in 1999-2000

	Rural			Urban		
Consumption expenditure quintile	Inpatient	Outpatient	Drugs	Inpatient	outpatient	Drugs
Poorest 20%	3.0	10.3	86.7	5.0	10.9	84.7
2nd Poorest 20%	4.3	11.4	84.3	6.8	12.6	80.7
Middle	5.6	10.7	83.8	10.7	13.5	75.9
2nd Richest 20%	7.6	11.7	80.7	11.7	15.2	73.0
Richest	11.9	12.9	75.3	17.4	17.8	764.7
All households	7.4	11.8	80.9	10.9	14.4	74.7

Adapted from Garg and Karan, 2005, pp.24

From the above table 5 it is obvious that OOP expenditure is higher in rural areas than the rich quintiles, whereas it is high among all quintiles in urban area. This table also shows the cost of drugs accounted for higher OOPs in urban and rural areas (Garg and Karan, 2005).

b. Negative Consequences of the Out-Of-Pocket Expenditure and Catastrophic Payments

Out of pocket health expenditure is considered as catastrophic when the health expenditure exceeds some threshold of the household budget which effects

negatively on basic and necessary needs of the people such as food and non - food consumption (Ghosh, 2010).

> "*This catastrophic payment defined as higher level of out of pocket expenditure, spent by the households on the health care, which exceeds (fixed proportion of their incomes) from the threshold of their budget. It is suggested that those who have paid more than 5% of the total consumption expenditure on medical care have greater chances of trap in catastrophic web*" (Tyagi et al. 2009).

The Out-of-pocket expenditure has reversed and deepened its effects on those who are already living below the poverty line, for example around ten to fourteen (10-14%) percent households come under the poverty line as a result of high expenditures. The result has also shown that in urban areas, more than quarter of the households had taken money from the private money lenders to meet their medical expenses and in rural areas around nineteen (19%) percent people had borrowed money from private sources such as micro credit institutions, which are major sources of loans for the poor in UP and Rajasthan. Data indicates that the share of the borrowing money in rural and urban areas, majority (52%) of UP and Rajasthan's villagers comes under cash debt due to the health payments. While in the urban area it is more than the quarter of the total sample. It is no surprise that the catastrophic expenditure in India is very high and it can be interlinked with the socio-economic and public health deficits. The medical loans are prevalent in the most of UP and Rajasthan's' area (Alam& Tyagi, 2009). The table no 6 present the prevalent of medical loans in UP and Rajasthan.

Table 6 Utilization of Public-Private Hospitals by Catastrophic Households:-*Z*=5% and 25%

Catastrophic Level	Place of Residence									
	Rural		Urban*		Slum		Non Slum		Total Hospitaliz at-ion	
	Private	Public	Private	Public	Private	Public	Private	Public	Private	Public
Catastrophic1 : 5%	41.1	58.9	56.0	44.0	35.0	65.0	62.1	37.9	47.2	52.8
Chi2(1)	Pr.=0.0334		Pr.=0.005		Pr.=0.090		Pr.=0.031		Pr. =0.197	
Catastrophic2 :25%	41.8	58.2	64.3	35.7	75.0	25.0	57.1	42.9	48.9	51.1
Chi2(1)	Pr.=0.895		Pr.=0.032		Pr.=0.000		Pr.=0.731		Pr.=0.351	

*including households from slum and non-slum areas of Delhi.

Source: Adapted from Alam&Tyagi, 2009, pp.143.

This study also reveals that catastrophic expenditure is not only a result of utilizing private facilities but it also occurs in public facilities. It is mainly seen in outpatient cases, especially in the private sector. The person who has been treated in public institutions or has been hospitalized in a public hospital can also be driven (see the table no.3 a) into the category of catastrophic expenditure (Alam&Tyagi, 2009).

The high share of out of pocket spending affects badly on poor households and it is one of the major causes of impoverishment of the poor in India. Due to their medical expenses, they are compelled to take loan on a large interest. If the health payment is not necessary or in the absence of medical expenses, the households' non- medical expenses would be high and it would contribute positively to raise the welfare of the households' (Berman et al. 2010).

Whereas in a study, an intensity of catastrophic payment is also measured and thus it is found that rich households spend large part of amount on their given thresholds, as compared to the poorer. It could be expected that in low income states, the government has less money to invest in pharmacies and that is why

drugs are not available in public hospitals and people have to purchase medicines from their own pocket. This could be the main reason why drugs remain the cause for high out of pocket expenditure for the poor (Ghosh, 2011).

In the study by Xu et. Al (2003) catastrophic health expenditure is defined as; the portion of out of pocket expenditure compared to income that has been left after deducting subsistence expenditure is at least 40%. This can be explained in below manner also-

$$\frac{\text{Out of pocket health expenditures}}{\text{Total household expenditures} - \text{Subsistence expenditures}} >/ 40\%$$

This out of pocket expenditure is divided into direct and indirect expenditures. Though direct expenditure can be reimbursed from the third party payers but these indirect expenditures such as transportation cost, loss of wages etc. are not included in reimbursement process and these catastrophic expenditures may push some households into impoverishment (Xu et. al, 2003).

2.4.3 Interaction between the Supply and Demand Side Factors

There are few studies that have examined the interaction between demand as well as supply side barriers. Based on an analysis of two secondary data sets - Sample Registration System (SRS) and Annual Health Survey, conducted by Government of India, Randive et. al (2013) included nine major states- Uttar Pradesh, Bihar, Uttarakhand, Madhya Pradesh, Orissa, Rajasthan, Chhattisgarh, Jharkhand and Assam. Findings of the study show, that despite the various efforts, the scheme still needs to develop more effective mechanisms to reach the vulnerable people. Although all states have indicated the improvement in percentage of institutional deliveries but within each state, there have been wide variations. The districts that have higher literacy rate and urban population also have high institutional deliveries whereas; poor and high fertility rates have low institutional deliveries.

Although JSY has increased the uptake of institutional deliveries but in some districts, still half of the child births are conducted at home. This indicates that

cash incentives is not only able to attract poor women for utilizing the health services but also supply side non-financial issues (lack of trust on public hospitals, perception of child birth that is normal phenomenon and does not need any specialist etc.) are responsible for reducing institutional delivery. A weak supply side has created a situation in which even financial assistance is unable to increase institutional delivery and there by reduction in MMR (Randive et. al, 2013).

Though, JSY is a demand side financing scheme to reduce maternal mortality rate in India by enhancing institutional deliveries, the findings of the various studies show that the scheme is not functioning properly due to the supply side barriers. These include lack of infrastructure, poor quality of health services, unavailability of human resources, lack of drugs, late reimbursement, corruption etc. The demand side obstacles include direct and indirect expenses of child birth. Thus presence of even one of these obstacles cannot induce the poor to access the health institution. Therefore there is a need to strengthening the supply side quality of care along with demand side intervention.

To increase the utilization of institutional delivery under JSY scheme, the Government of Madhya Pradesh has started Janani Express Yojana in 2006 that covered all provinces in year 2009. From the study it has been found that around 75% maternal death happen due to the lack of access of obstetric care on time and it is due to the unavailability of transport on time. This is the main factor and significant element that has associated with maternal mortality. Sabde, De Costa and Diwan (2014), show that though utilization of Janani Express is high and also motivates more women to access institutional deliveries, ithas still failed to reach on time. Around 40% of women reported delay to reach Janani Express Vehicle from their residence on time and this is the major cause for the rise in riskof complications and maternal deaths (Sabde, De Costa and Diwan, 2014).

As it can be seen that, though several schemes have been launched under the National Rural Health Mission (NRHM) to prevent financial barriers to the poor and needy households like JSY, Chiranjeevi Yojana, Indira Gandhi

Matritva Sahyog Yojana, Conditional Maternity Benefit Act etc. but still evidences show that low proportion of the targeted population get advantage of these schemes. A study was conducted in two districts namely Surendranagar and Dahod of Gujarat from June to August 2013. The results of this study indicate that there are several indicators such as socio-economic status like caste, individual variables like mother's education and health system barriers like administrative issues or disinterest of the health care providers that are main factors of utilizing maternal health scheme. Therefore to reduce inequities in utilizing maternal healthcare, it is important to pay attention on all these different level of factors (Vora et. al, 2014).

2.5 Performance of Janani Suraksha Yojana in Uttar Pradesh

The main objectives of the JSY include reduction in maternal and child mortality. The target of the scheme was to achieve 70% institutional deliveries by the end of March 2012. The achievement of institutional deliveries, number of beneficiaries and number of pregnant women registered during the period of 2005-06 to 2010-11 is given in table 7.

Table 7 Target and Achievement of JSY

Year	No. of Pregnant women registered (in Lakh)	No. of beneficiaries in cash payment (in Lakh)	Expenditure (in Crore)	No. of Institutional deliveries		Percentage shortfall in institutional deliveries in comparison to the target of 70% registered pregnant women
				Target (in Lakh)	Achievement (in lakh)	
2005-06	53.28	0.12	1.49	NA	NA	NA
2006-07	53.56	1.68	19.22	NA	1.68	96
2007-08	53.63	7.63	113.06	7.33	9.64	74
2008-09	56.18	15.44	270.03	15.00	15.63	60
2009-10	58.49	20.82	378.85	18.00	20.82	49
2010-11	54.05	23.41	436.88	21.00	23.41	38
Total	329.19	69.10	1219.53	61.33	71.18	69

http://upnrhm.gov.in/site-files/cag_audit/10-11/english/10-Chap_8.pdf

From the table7 it is clear that achievement in number of beneficiaries, registered women, percentage in institutional deliveries has increased from 2005-06 to 2010. Though improvement is seen, but it has also been revealed in the report on Uttar Pradesh National Rural Health Mission (UPNRHM), that majority of registered women between 2005-06 to 2010-11, did not choose for treatment in health centres for institutional delivery. Not getting the payment for transportation charges, late payment have also been reported as the drawbacks. Under the scheme, it has been clearly mentioned that all states would maintain documents and reports in order to monitor the scheme. But, on actual finding in U.P., it was seen that documents and records of the various districts were insufficient as well as improperly recorded and lists of beneficiaries' payments were not maintained (http://upnrhm.gov.in/site-files/cag_audit/10-11/english/10-Chap_8.pdf).

2.6 Factors Influencing the Accelerator of the Economy and Social Development in the Uttar Pradesh

2.6.1 Demography and Socio-Economic Indicators of Uttar Pradesh

Despite having such rich natural resources and agro-climatic conditions, than the other Indian states, what are the causes behind less and low development of U.P. Why the state does still faces development challenges? Well the main reason for lagging behind of the state is its high poverty rate and huge population. Due to these, Millennium Development goals could not be achieved.

Uttar Pradesh is the one of the most populous states of India. The total population of U.P. was 166.20 million in the year 2001 whereas it is estimated to be 19.95 crore in the year 2011. There has been an increase in the sex-ratio of the state which is 908 female per one thousand (1000) male in the year 2011. However, there has been a decline in the child sex ratio from nine hundred and fourty two (942) to eight hundred and ninety eight (898) (GOI, 2011).

Map of Uttar Pradesh (Map No. 1)

Source: Source-http://www.censusindia.gov.in/maps

However, according to the some classical economists (Ricardo, Adam Smith etc.), natural resources like land, labour and capital are the key factors for the economic growth, but from the other economists (Hodler, Sachs and Warner) point of view though resources endowment vitalize the growth in the short terms but if these resources will not use in efficient and equitable manner, it also be a curse. Human resources are assets when they are skilled enough to take advantage from the existing opportunities through innovation. But in Uttar Pradesh where a large number of population lives, majority of people are unskilled and uneducated who do not contribute in the economy growth (Rasul and Sharma, 2014).

As in the study of Randive (2016) it has been found that the districts with higher fertility rates or higher proportion of poor population are significantly associated with high MMRs. Therefore at this point of time it is necessary to describe the poverty level of the Uttar Pradesh as it is strongly correlated to the health indicators.

2.6.2 Poverty Level

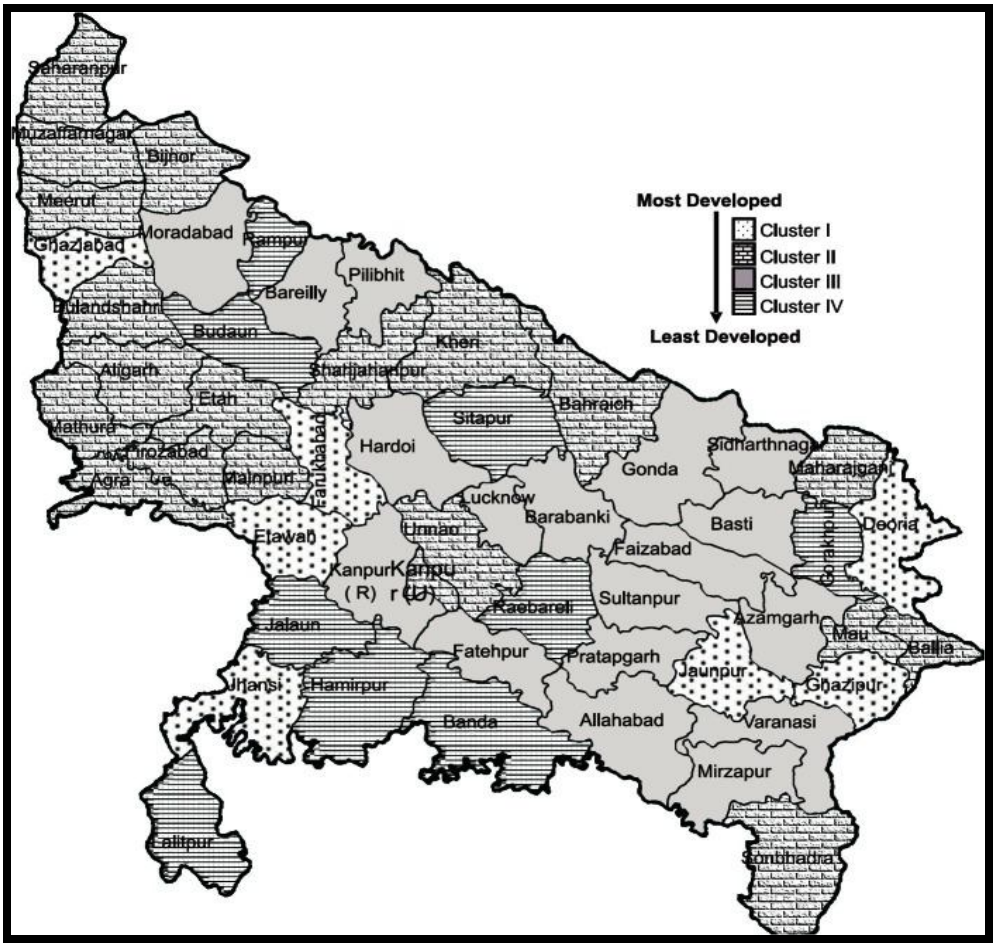
In Uttar Pradesh, the level of poverty is relatively high. However, this level of poverty has decreased over the period of time from 57.4 per cent in 1973-74 to 32.8 per cent in 2004–05 and around 30% in 2011-12 (http://planning.up.nic.in/apd/hdr-2006/chapter-1.pdf; http://planningcommission.nic.in/news/pre_pov2307.pdf).

Although, substantial decline in the poverty ratio has been noted but still, the absolute number of poor population has remained constantly high in the State.

2.6.3 Intra-Regional Disparities Within Uttar Pradesh State

Uttar Pradesh is one of the largest and backward states that have faced regional disparities and inequalities despite the government active role in taking many pro-public initiatives. Generally, Uttar Pradesh is divided into four economic regions, namely, Western U.P., Central U.P., Eastern U.P. and Bundelkhand. Eastern U.P. and Bundelkhand are the most backward regions in almost every area. Regional data shows that 39.98 percent of the total population of State lives in Eastern region followed by Western (37.17 percent), Central (18.00 percent) and Bundelkhand region (4.85 percent). This increasing population affects almost all economy sectors. These inter-regional disparities also exist in economic and social development activities like productivity, education, health infrastructures etc. Western region stands highest in industrial development followed by central and eastern region. Bundelkhand is lowest among them.

Map 2, Most Developed to Least Developed Regions of Uttar Pradesh



Source: adapted from Rao, Kumar and Brahmam, 2013, pp. 9.

As from the above map, it is clearly visible that most of the districts (Ghaziabad, Farukhabad, Etawah etc.) are relatively prosperous region as compared to cluster III and IV. In cluster II, majority of the districts like Bijnor, Saharanpur, Meerut, Aligarh, Mathura, Maharajaganj etc. are considered as second most developed parts of the Uttar Pradesh. In contrast, cluster III and IV represent developed and under developed regions of the Uttar Pradesh (Rao, Kumar and Brahmam, 2013). In other word, western region of the Uttar Pradesh is economically most developed area. On the other hand, most of the districts of the eastern as well as Bundelkhand come under the most backward or low medium developed areas (Diwakar, 2009).

Apart from the intra-regional disparities within state, uneven distribution of health facilities and health infrastructures is also a major cause of concern.

Under social services, health facilities are very important for social development of the State. In health infrastructure, the number of Allopathic hospitals/dispensaries (including PHC) per lakh of population is highest (3.18) in Bundelkhand region followed by Eastern region (2.27), Western region (1.99) and Central region (1.91) during the year 2012-13. Similarly when the number of beds in Allopathic hospitals/dispensaries (including PHC) per lakh of population is considered, the Bundelkhand region is at highest position (33.93) with a State figure of 27.63.The Western region (25.21) is at lowest position in this respect. (http://planning.up.nic.in/spc/annual%20plan%202014-2015/Vol-I (Part-II)/Chapter-III.doc); AHS, 2012-13 of UP).

The poor health infrastructure results in less effective functioningof existing health facilities which is major reason for the poor health indicators in the State. Infant Mortality Rate and Maternal Mortality Ratio are very important health indicators. As per Sample Registration Bulletin (September, 2013), the infant mortality rate of the State for the year 2012 is at the level of 53 against all India average of 42. The inter-district data of Annual Health Survey, 2010-11 reveals that in Uttar Pradesh, this rate is highest in Shrawasti (103), followed by Faizabad (98), Badaun (91), Pratapgarh (88) and Shahjahanpur (87). Infant mortality rate is lowest in Kanpur Nagar (36) followed by Jhansi (42) and Lucknow (45). http://planning.up.nic.in/spc/annual%20plan%202014-2015/Vol-I(Part-II)/Chapter-III.doc)

Similarly, as per the Annual Health Survey 2010-11, The Maternal Mortality Ratio (MMR) of the State is 345. This ratio is highest (451) in Faizabad division comprising of the districts of Barabanki, Faizabad, Ambedkar Nagar and Sultanpur. In Bareilly (437), Allahabad (442) and Devipatan (434) divisions its value is almost nearer to that of Faizabad division. MMR is

lowest in Kanpur (267), Meerut (255) and Jhansi (241) divisions (GoUP (2007).

As above data shows that IMR and MMR of UP are very high and the ratio of maternal mortality is highest in eastern region of UP. Therefore, safe motherhood and child survival have always a priority of the all policy makers. Due to this reason, the National Rural Health Mission (NRHM) launched in 2005 in India,for accessing and providing health services to the poorest households in the outskirtregions of the country. This mission has encouraged changes in the pattern of place of delivery. Under the NRHM Janani Surakhsha Yojana (Maternity Security Scheme), Accredited Social Health Activists (ASHA), Delivery Huts, 24×7 Primary Health Centres and Community Health Centres, and Medical Obstetric Care in First referral unit are some ways of means for increasing the utilization of health services for child births and thereby reducing IMR and MMR (Singh et. al, 2012).

2.7 Initiatives for Improving Maternal and Child Health Care Under National Rural Health Mission in Uttar Pradesh (UP)

National Rural Health Mission (NRHM) has been launched with the objective to improve access to health services and improve health status in economically backward districts and states in India. It is the first programme that recognized the need of quality of health care. As per the Indian constitution, health is a state subject but Centre will always give help to the states by providing funds, technical and institutional support. The NRHM was launched on 12th April 2005, by the then honorable Prime Minister, during the United Progressive Alliance (UPA) government of India. The main aim of this programme was to improve health status of Indian population by giving quality services to the rural population with special focus on 18 states; Uttar Pradesh being one of them.

In Uttar Pradesh, out of 1,051 surveyed PHCs as well as those functioning on 24×7 hours only 23.7 per cent have the facility of referral services especially for pregnancy/ deliveries. It has decreased from DLHS 3 where it was 39.7 per cent. Though the performance of the PHCs in regard to child deliveries have

improved from 44.5 (DLHS 3, 2010) to 47.6 percent in DLHS 4 but still child deliveries at PHCs is low. Health staffs in the CHCs in Uttar Pradesh are also area of concern. As per the DLHS 4, only 14 per cent of the CHCs have a gynecologist/obstetrician and Paediatrician available in about 18 percent of CHCs. Only 11 per cent of the CHCs have Anaesthetist and one-tenth of the CHCs have Public Health Manager in Position (DLHS 4, 2014). Only 6.2% ASHAs have received incentives for Village Health Nutrition Days (VHND), 13.2% ANMs stay at their office residence (DLHS 3, 2010).

For the above low health indicator reasons, UP was the highest recipient under the NRHM. According to CAG (Controller and Auditor General) report, a total INR. 8,657.35 crore were sent by March 31, 2011 but INR. 5,754 crore were not accounted in UP. Apart from that, INR. 1364.80 crore funds were not utilized by the end of March 2010. Various politicians, beaurocrates, officials were involved in this scam. The money of around 10,000 crore was involved in this case (http://archive.indianexpress.com/news/up-cag-report-alleges-gross-mismanagement-of-nrhm-funds/955730/).

2.8 Politics and Welfare Programmes in Uttar Pradesh

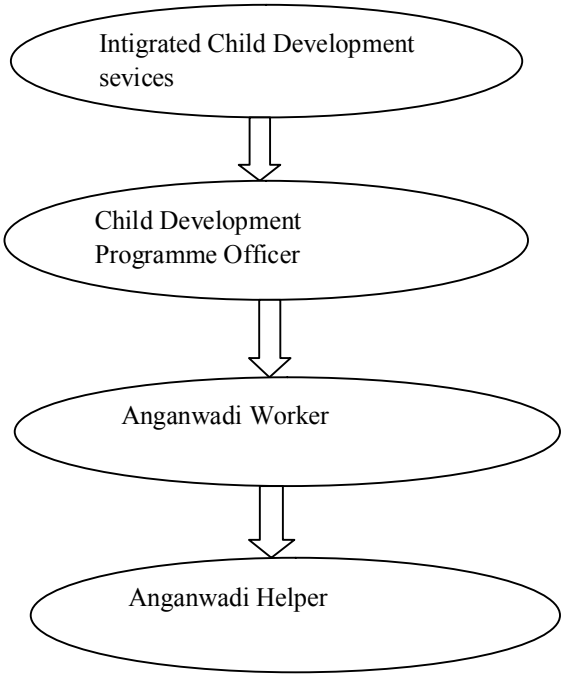
India is a federal democratic country, where there division of the power, distributed between Centre and States but is in favor of centre especially in the area of finance. Every state has different socio-economic, cultural and political conditions; hence, policies concerning health and wellbeing of citizens are mostly subject to the concerns of the state government.Policies play an important role in budget allocation to the health sector as well as public health expenditure of the state. Governments are different among centre and state, if there is rule of same government in both, state and centre then there are more chances of development in that particular state, as the centre would obviously favor the state in allocation of funds and policies, which has same government rule. It is the apathy of our political system that political parties of our country favor power more than public health. In other words, every states performance will depend upon its elected political party (Bhat, 2004).

Singh and Kumar (2012) observed that in Uttar Pradesh political parties shaped policies for human welfare and development. In other words these welfare and human development programmes have been linked with some political parties like for example, in the power of Congress party in the state during 1970s lot of schemes and programmes were launched for the low caste people in Uttar Pradesh. Bhartiya Janata Party (BJP) was also in power in Uttar Pradesh thrice. During the reign of BJP the attention was given on improvement of Hindu Rights like economic resources, cultural capital of upper caste Hindus through pro-Hindu policies and ideologies. BJP was in favour of Hindu caste and attempted to bring Mandal reservation policy in the state. The politics of welfare programmes in Uttar Pradesh became more prominent during 1990s and even after. Caste and politics are interlinked in Uttar Pradesh; in fact caste is one of the key factors for human development policies. The Samajwadi Party (SP) and Bahujan Samaj Party (BSP) are two important parties that have advocated caste politics and succeeded to mobilizing the people on caste basis in Uttar Pradesh. Main motto of these political policies was to mobilize the lower and other backward castes for their own political profits. In Uttar Pradesh, poverty does not treat all people equally because these development programmes are meant for the specific sections of society. BSP has launched various social policies for their health, education, employment, housing etc. SP was in favour of OBCs (especially Yadavs and Pals) and hence mobilized the OBCs by giving benefit on their social basis rather than through social welfare policies. So in the SP regime, human development and welfare policies hardly got any special treatment, as compared to the BSP regime. Therefore we can say that in Uttar Pradesh, the schemes, development programmes and related policies were very much influenced by the state politics by adopting different agendas. The nature of these public policies depended upon social bases of political parties (Singh and Kumar, 2012; Pai, 1997; Jeffery et.al, 2008).

2.9 Background of Indira Gandhi Matritva Sahyog Yojana: A Maternity Benefit Scheme

The IGMSY, a centrally sponsored scheme is functional under the Integrated Child Development Services (ICDS) that comes under the Ministry of Women and Child Development. The functions of the scheme can be described through figure no.2.

Figure 2, Fuctionality of the IGMSY



From the figure no. 2, it is quite clear that the main role of Anganwadi workers at community level in the scheme, is to conduct regular checkups of pregnant women, providing immunization services and health education with the assistance of the, Anganwadi helpe. They (AWW and AWH) both will get 200 and 100 INR respectively as per beneficiary. Child development protection officer is main health official who isresponsible for monitoring the scheme and AWW and AWH as well (http://wcd.nic.in/sites/default/files/IGMSYscheme.pdf).

2.9.1. Conditions of the IGMSY Scheme

This scheme has been made for women aged 19 and above, for their first two child's live birth. The government employees are excluded from this scheme as they are already entitled to paid maternity leaves. The beneficiaries get 4000 INR in three installments after completing some certain conditions of the scheme. These conditions have been given in below table 8.

Table 8 Conditions of the IGMSY Scheme

Period of the cash transfer	Conditions	Incentives in INR	Means of verification
First installment (at the end of second trimester) that is completion of 6 months of pregnancy	• Registration at any health institutions (Sub centres/ PHC/CH/ District hospitals or any private institutions comes under the JSY) within 4 months of pregnancy. • Receive IFA tablets • Receive at least one antenatal checkup out of three. • Receive at least TT vaccinations out of two. • Receive at least one counseling session at AWC/Village Health Nutrition Day (VHNS)/Home visits	1500	1. Verification by AWW A. Mother and Child Protection Card B. IGMSY register C. Growth monitoring register of ICDS 1. Verification by the ICDS supervisor A. through recheck the IGMSY register and MPC card given by AWW B. Supervisor also checks Monthly progress report (MPR) for the correctness.
Incentives under JSY	JSY incentives for the institutional delivery and after completion of the criteria of the scheme	As per the JSY norm	
Second Installment	After the end of three months of delivery and fulfilling these conditions of • Child birth	1500	

Cont….

	registrations. • Child receives polio and BCG vaccination • Child receives Polio and DPT-1 vaccination • Weight done at least two times after births, out of four • Mother who attended at least two IYCF counseling sessions at the AWC/VHND/Home visits out of three times.		
Third installment	• During first six months child is exclusively breastfeed • After completion of six months child to be introduced to complementary foods • Baby to receive vaccination of polio and DPT-3 • Weight done at least two times in between 3 to 6 months • Mother who attended at least two IYCF counseling sessions between 3 to 6 months of lactations at the AWC/VHND/Home visits out of three times.	1000	

2.9.2. Procedure of the Payments

The beneficiaries' cash incentives of the IGMSY are transferred through bank account or post office only. Modes of the cash transfer include Nationalized or cooperative bank and post office.

2.9.3. Need of IGMSY Scheme

National Family and Health Planning Survey conducted an important investigation in the year 2005-06 and came out with the result that there is a need of the scheme for Pregnant and Lactating (L and T) women. This programme aims to improve the health status of L and T women along with the new born's. This scheme is especially meant for those women who work till the last months of their pregnancy. To compensate their wages, this scheme gives 4000 INR at the rate of 40 INR for 100 days ((http://wcd.nic.in/sites/default/files/IGMSYscheme.pdf).

2.9.4. Selection Criteria

This scheme has been implemented in 52 districts (see in Appendix 1.) of Uttar Pradesh on pilot basis. These districts have been identified on weak, good and average performing basis. Out of 52 districts, 11 are selected from good and weak performing districts, 26 are average and 4 are Union Territories. These combinations of good, medium and bad performing districts have been chosen from across the country based on the six indicators which are available on DLHS 3. Every indicator has got equal weightage. These are (A) Percent literate Female Population (Age 7+), (B) Mothers registered in the first trimester when they were pregnant with last live birth/still birth (%), (C) Mothers who had at least 3 Ante-Natal care visits during the last pregnancy (%), (D) Institutional births (%), (E) Children (12-23 months) fully immunized (BCG, 3 doses each of DPT, and Polio and Measles) (%) and F) Children breastfed within one hour of birth (%). (http://wcd.nic.in/sites/default/files/IGMSYscheme.pdf).

Conclusion

Based on a review of relevant literature, it is apparent that the CCTs are not functioning properly due to the supply side constraints that includes lack of infrastructures, poor quality of health services, unavailability of human resources, lack of drugs, late reimbursement, corruption, etc., as well as barriers on the demand side which include direct and indirect expenses (out of

pocket expenditures) incurred for child birth. Thus, the presence of even one of these obstacles cannot induce the poor to access the health institutions. Several studies show that due to the high out of pocket expenditures and especially catastrophic payment for institutional delivery, poor households pushed into further poverty and trapped into indebtedness. Therefore, there is a need to strengthen the supply and quality of care along with demand intervention.

The negligence of the government and poor investment in health are the main reasons for the high out of pocket expenditure in India. Issues regarding health infrastructures need to be given special attention. Although, government of India has taken many steps for improving health status of people under NRHM and also introducing some other state government schemes, but still India is far away from the goal.

2.10 Methods

2.10.1Conceptualization

In countries like India, where a large number of people live below the poverty line and supply side resources are limited, Janani Suraksha Yojana has been implemented with the assumption that cash transfer schemes will increase demand and therefore utilization of services. This scheme will contribute to the decline of MMR by promoting institutional delivery (censusindia.gov.in/vital_statistics/SRS_Bulletins/MMR_release_070711.pd). Government of India (GOI) has launched JSY scheme under which lot of facilities are given to the poor for accessing free of cost health services (Devadasan, 2008). Despite providing various health facilities, the major concern is that, still enough number of deliveries occurs at home. Most studies found that inadequate quality of care, unhygienic health services; high out of pocket expenditures are some reasons for limited success of this cash transfer programme (Paul, 2011).

Although a large number of studies have examined the supply side constraints in the JSY scheme and its utilization, but there are few studies that have drawn

attention towards demand side financing problems. In order to gain a holistic understanding of the working of this scheme and its constraints, it is important to address the supply and demand side issues. Worrall et. al (2011) is among the few studies that was conducted in slum area of Mumbai, it showed that money is a major barrier for not accessing health services for the poor. Even among those who use health services do so by paying a huge proportion of their income on it. In order to pay for medical care, these households cutback on basic necessities like food, education and other basic necessities. This out of pocket health expenditure increases the chance of poor households getting trapped in a medical poverty net. In short this study shows that out of pocket health expenditures increase the risk of catastrophic expenditures. This problem does not rise only because of direct or formal payment but also because of indirect cost of health services. These informal payments may have raised the economic consequences in the poor households. These indirect payments usually cover loss of wages, care seeking cost, travelling charges and waiting times (Worrall et. al, 2011).

In a recent study of "direct and indirect cost of birth among poor households in Tilmapur village of Varanasi district", Gupta also found that indirect expenses (loss of wages, transportation charges, food cost etc.) are responsible for opting for home birth. This study demonstrates that the burden of indirect costs of institutional delivery has greater negative impact on the poor as compared to the rich. Another key finding of the study shows that accessibility is one of the other reasons for not using health services as well as government schemes which are meant for poor households (Gupta, 2012). When we talk about women wage workers of informal sectors then we find that they work until the last stage of pregnancy and even after delivery, come back on their work immediately due to the fear of wage loss. Currently functioning, maternity or cash transfer schemes do not address the issues of financial crisis which compels them to continue their work even in the hazardous period (*www.sahayog**india**.org/wp-content/.../08/The-Crisis-of-**Maternity**.pdf)*.
Therefore this study will attempt to provide insights on direct and indirect payments for childbirth with the help of primary as well as secondary data.

2.10.2 Rationale of the Study

CCTs have been designed as an instrument, which directly impacts the households' income and their consumption. These cash transfer schemes have been started by the government as policy mechanisms to benefit the poor. Although India has vast number of poor and marginalized people and government has seriously started considering CCTs as a tool for poverty reduction but these programmes hardly provide benefit to the needy, as has been studied in various studies.

In the area of reproductive health, JSY, a conditional cash transfer scheme has been implemented for the poor to improve their health, maternal and neonatal deaths, by giving cash to them, for utilizing health institutions. From available literatures, we came to know about various problems and issues regarding this scheme. One of them that appear to be clear is supply side barriers which include lack of health infrastructure, manpower, and other basic amenities. In fact there is substantial literature that provides insights on supply side constraints. Apart from supply side barriers, there are some other issues that have been rarely noticed by the policy planners and researchers, which are focusing on demand side factors. These demand side barriers include direct and indirect costs, while utilizing health services which are also accountable for not using the services. In fact it cannot be denied that these direct and indirect costs are also responsible at the household level that inhibits persons from using the health services. And that's why these aspects of CCT definitely need to be study.

Apart from these barriers, there are some other aspects that have been obstacle in the way of successful functioning of the scheme such as structural issues. These structural issues include requirement of paper work such as ration card, bank details, BPL card which creates problem for poor women. This aspect also needs to be studied.

To develop a more inclusive and widened understanding of the association between structural and institutional barriers of cash transfer schemes and utilization of the maternity services by the BPL women, more comprehensive

approach is needed. These structural as well as institutional issues greatly impact the poor people for not using the health facilities.

It must be accepted that the issues related to cash transfer schemes in reproductive health areas are not new and unique but through this study, attempts are made to forefront the experiences of BPL women and their families and showcasing the difficulties they have faced regarding accessing health services and availing schemes which are meant for them. The present study will try to show interesting insights of the various aspects (such as what kind of barriers they face for accessing the health services, direct and indirect expenditures during institutional delivery, structural issues etc.) of the cash transfer scheme and experiences of BPL women in the Sultanpur district of Uttar Pradesh.

2.10.3 Objectives

a. Broad Objective

To understand the experience of women accessing the IGMSY scheme in selected blocks of Sultanpur district of Uttar Pradesh.

b. Specific Objectives

- To provide an overview of all the Government schemes that finance institutional births.
- To study the structural and institutional features of the IGMSY scheme in the selected districts of Uttar Pradesh state.
- To study the supply and demand side barriers in the scheme
- To study the experience of women who accessed the scheme.
- To understand the quantum of direct and indirect expenditure incurred by women who have enrolled in the IGMSY scheme.

2.10.4 Operational Definition

a. Direct Cost

NSSO only includes direct cost in out of pocket expenditure and according to this organization, Out of pocket expenditure is the direct cost which is paid by the patient for medical treatment. This includes medicines or drugs, doctors and nurses fees, diagnostic and other miscellaneous services. The patient has to incur this expenditure from their pocket since it is not provided free of cost by public services or covered by insurance (NSSO, 2001).

b. Indirect Cost

Indirect expenditure can be seen as a direct cost which is paid by the patient for accessing the health services and that are not officially sanctioned by the facility. These indirect medical expenses are incurred due to transportation cost, loss of wages, tips and bribe, payment diet on sick as well as care givers and other informal payments for utilizing the health services (Simkhada et. al 2012; Misra et.al, 2013).

c. Access

Researchers use the term access in the study to measure the availability of health services, physical accessibility, affordability, acceptability of health services as well as accommodation.

Thus definition of access which has been used in the studyis taken from the study of Penchansky and Thomas (1981) as given below:

"Access is presented here as a general concept that summarizes a set of more specific dimensions describing the fit between the patient and the health care system. The specific dimen-sions are availability, accessibility, accommodation, affordability and acceptability". (Penchansky and Thomas, 1981, pp.2).

d. Quantum

In the study, quantum word is used in negative sense which means, how much amount or in what proportion of their income, poor people spend money on direct and indirect expenditures during child birth.

2.10.5 Pilot Study

Pilot study was necessary for the research. It was realized that to have a better understanding of the IGMSY scheme, about the criteria, implementation process and other information related to the scheme. Although some information was available but for more information about beneficiaries' criteria, the pilot study was required. As this scheme has been implemented in 2 districts (Sulatnpur and Mahoba) of Uttar Pradesh.Since Sulatnpur proved to be convenient for the researcher, so it was planned for field visit.

The pilot field visit was undertaken in October 2013. Based on the pilot study, a research design was prepared. The detailed description of the research design has been discussed in the next section.

2.10.6 Research Design

A solid research design is very important for any kind of research study. Without appropriate research design, we can't meet our research objectives. In this study, mixed method has been used to understand the research problem. Mixed method is a combination of qualitative and quantitative approaches. As Creswell et al observe: **"***Integrating quantitative and qualitative data collection and analysis in a single study or a programme of enquiry*" (Creswell et. al, 2003 as cited in Johnson et. al 2007, pp. 119).

The purpose of using this method in the study is, for better understanding of the research problems as well as collecting and analyzing both types of datas, qualitative and quantitative. For objective four, quantitative method will be used with the help of close-ended interview schedules and for the rest one, two and three qualitative data will be gathered through structured and unstructured interview schedules and guides (see Appendix 2.). The structured interview

schedule will be used for doctors, health staff and other key informants, to know more specific information. Unstructured interviews will be employed with BPL women, with the help of an unstructured interview guide.

The main motive behind the use of mixed method approach is to avoid weaknesses in the research study which are possible through the use of single method approach. Qualitative method only gives us the reason about any issue not quantifiable data of the problem. Quantifiable data can be identified through qualitative method. Therefore both the methods are useful for this study.

2.10.7 Area of Study

The research has been done in Sultanpur district of Uttar Pradesh. This particular area is chosen for research due to the implementation of IGMSY scheme for the past four years. In addition, the researcher belongs to the state and is familiar with the area and for reasons of feasibility, Uttar Pradesh has been chosen for the study.

This study is an attempt to understand the experience of women in accessing the JSY and also the effectiveness of demand side financing in addressing the needs of women below the poverty line for maternity services.

Sultanpur District

The study area is Sultanpur district which is located in the state of Uttar Pradesh (as mentioned in Chapter 4). Sultanpur district is one of the 52 pilot districts for IGMSY and therefore chosen for research study. According to the Census 2011, Sultanpur has a population of 3,797,117. Total area of this district is 4.436 sq. km. There are 14 blocks, 7 cities and towns and 2,531 villages in Sultanpur district (sultanpur.nic.in/tab.htm). During preliminary visit of researcher it was known from NRHM department of Sultanpur that the MMR of district in the year 2013-14 was 440 which is undoubtedly very high despite the fact that there are various conditional cash transfer schemes which are functioning in the district for the BPL women.

2.10.8 Sampling of the Study

This study has been conducted in Dhanpatganj block of Sultanpur district to understand the experiences of the beneficiaries of the scheme. The source of the data collections were primary as well secondary data both, as per the requirements to fulfill the research objectives.

a. Study Population

The study has been conducted on beneficiary (IGMSY, JSY) women of age 19 and above, who were pregnant during the last year, as from the time of conduction of this study.

b. Sampling Method

Though, this study has been conducted on those beneficiaries who have delivered babies in last one year in any health institution. Therefore the list of the beneficiaries of the schemes would be taken from the CHCs and additional PHCs and cross checked by ASHAs/ ANM and Medical officers for JSY scheme. The list of the users of the IGMSY would be taken from ICDS office and cross checked by the Child Development Programme Officer (CDPO) of the programme.

- **Number of Subjects:** This study has been undertaken in a block (Dhanpatganj) of Sultanpur district and this was block selected on the basis of accessibility in terms of road connectivity, number of pregnant women and eligible beneficiaries' criteria. The number of institutional deliveries in the block during 2014-15 (till march) came to be 2480 and home deliveries as 133. The numbers of beneficiaries of JSY were 2480 while IGMSY beneficiaries as only 53.

2.10.9 Sources of Data Collection

For the data collection, both primary and secondary methods have been used.

a. Primary Source: In the study, three different set of semi structure interview schedules have been used for the primary level of data collection. One for the beneficiaries to know their experiences regarding schemes and health services that they have accessed.Second for the health officials and third for the AWWs and ASHAs to capture their view on the schemes (JSY, IGMSY) and key issues regarding these schemes.

b. Secondary Source: Published government as well as private reports, documents, articles, Journals, published studies and micro level studies.

2.10.10 Tools for Data Collection

In-depth interviews have been used to interview the women who had delivered babies during last one year with the help of semi-structured interview guide to know their experiences and perceptions. A semi-structured interview guide has also been used for the PHC doctors, ANM and other health staffs and also for the ASHAs of the villages. A close-ended interview schedule was also used for the objective of quantum of direct and indirect expenses of institutional delivery.

2.10.11 Process of Data Analysis

For familiarizing the data, the raw transcribed data has been read and re read again. After thoroughly reading the transcriptions, there were found some categories and these categories were coded under some themes and sub themes. After coding, many key findings have been arrived.

Interviews and informal group discussions have been recorded with the help of recorder after taking the consent from the interviewee. Apart from that, researcher also maintained field notes and diary. The interviews were conducted in Hindi therefore these recoding and hand written interviews have been transcribed into English from the local language.

2.10.12 Ethical Consideration

Several ethical issues have been kept in mind during the research study therefore I (researcher) had also taken ethical clearance (see Appendix 4 for ethical clearance certificate) before going to field. One of them was informed consent from the participants. In the present study the researcher has described the aim of the research to all participants and their importance in the study. The researcher aims to ensure that all participants have a complete understanding of the study, purpose and the method which has been used in the research as well as in any case of risk involved in the study. However researcher‘s primary responsibility was protection of the participants from any harm. As much as possible, research has been conducted in such manner that gives no or minimum harm to the participants.

Participation of the respondents was voluntary by nature and they could withdraw at any level of the interview process. The participant’s convenience was the priority of the researcher in terms of that researcher would never create unnecessary stress or anxiety except minimal which further needed a desired effect for the research and before asking such types of questions, permission was be taken by the researcher.

As, this study has been conducted on poor households, therefore it has found that all participants were not literate. So interviews have been conducted in Hindi language and researcher has taken especial care that respondents understand the research questions. Also consent has been taken for recording their interviews as well as taking photographs whenever necessary.

The other important thing is confidentiality and anonymity. In the study, confidentiality and anonymity of information are assured. In order to maintain privacy, the identifications of the participants, have been not disclosed. This has been done due to the sensitive nature of the research questions related to the study as well as their answers. The researcher is well aware of ethical as well as social responsibility which she has never ignored. Last but not the least; information has only been processed for academic purposes.

2.10.13 Difficulties Faced During Field Visits

Researcher faced several problems and difficulties during field visits.

- The main problem that has been faced by the researcher was to build rapport. In the initial stage rural women hesitated to say anything. Apart from that, most of the family members were interrupting and giving answers in spite of the presence of the women of the households.

- The second difficulty that has been faced by the researcher was that respondents were not ready to sign on consent form. Hence researcher took interviews without signed consent form.

- The last but not the least problem that the researcher faced is related to transportation. Dhanpatganj is a small town with no great transportation connectivity. The last bus that left the town everyday used to be the 5pm one and hence, the researcher had to be careful and conscious of time constraint during the field study.

2.10.14Limitations

The study is carried out only in one block of Sultanpur district of Uttar Pradesh, therefore, findings of the study cannot be generalized for all districts of the state. A small sample size has been taken so that the researcher investigates the research problems in in-depth manner. However this small sample size brought an opportunity to draw useful recommendations on the basis of their findings.

Chapter 3

Janani SurakshaYojana:Reviewing the Evidence

Maternal and Infant Mortality are some indicators that present the status of healthcare delivery system of the country. High rates of these (MMR and IMR) indicators show that there is poor access to healthcare services and social determinants of health. One of the inputs for reducing MMR and IMR can be reduced by strengthening the access to services for safe delivery and follow up care with adequately skilled personnel and other supportive services. With this broad understanding, the Government of India launched Janani SurakshaYojana (JSY) a special focus scheme with the aim of reducing MMR and IMR by promoting institutional delivery under the National Rural Health Mission in April 2005 (Dongre and Kapur, 2013). Under this scheme, financial assistance is provided to the mother who goes for institutional delivery. Therefore, this chapter focuses on the utilization of elements of JSY by using two rounds of District level Households Survey (DLHS-2 and DLHS-3) data along with relevant researches in order to analyze the health seeking behavior of women for pregnancy and delivery in order to comment on the trends and effectiveness of the JSY scheme. DLHS data gives us information related to Maternal and Child healthcare for the births that have taken place during 2005 to 2008. This helps us to analyze the trends in institutional deliveries. Results indicate that compared to the initial stage (2006), the post (beginning of the 2007) of the implementation of the JSY, institutional deliveries grew more rapidly in the high performing states as compared to the low performing states. As a result, the gap between two set of states widened. But in 2007-08, the institutional deliveries grew at higher rate in the low performing states and the gap reduced. What about its effects on IMR and MMR? Available data shows that, there has been no significant effect on the improvement in these two health indicators. Data also shows that institutional deliveries have increased in the backward states, but this is not enough to say that JSY is the cause behind this. As we know that JSY is the component of National Rural Health Mission (NRHM) and the up-gradation of the medical facilities is the essential element of the NRHM. Therefore it is hard to say the changing scenario of the institutional deliveries is due to the

JSY or creation of the availability and accessibility of medical facilities have improved this. These are the important questions that need to be answered. Therefore, this chapter evaluates the JSY scheme by evaluating the DLHS data.

The main objective of this chapter is to study the trends of the components of the JSY. These components include the following:

- Coverage of full Antenatal Checkup and Immunization services
- No. of Registered pregnant women/institutional delivery/home delivery/safe delivery
- Reason for not choosing institutional delivery
- JSY beneficiaries
- Transport facility by JSY beneficiaries
- Duration of stay at the health institution
- Post natal care (PNC) services

Before analyzing the DLHS data with JSY's components, there is need to understand the trend of maternal mortality of India. As discussed in the prior section that MMR and Infant Mortality are important indicators which show the quality of health services of the country. The MMR of the India has changed over a period of time as it has sharply declined. It has been observed that MMR has reduced by16% from 2007-09 to 2010-12. It has started declining even before JSY was introduced. So here the question is: what are the attributions of JSY in reduction of the MMR, which was declining even before the launch of JSY? Is there any association of the JSY and reducing mortality, or some other factors (income increased, awareness, availability of medical care etc.) contribute in declining MMR that have been not noticed due to the JSY, a huge investment programme of National Rural Health Mission (NRHM) of India. In 2011, government of India expanded the JSY scheme with another scheme namely, Janani Shishu Suraksha Karyakram (JSSK) to keep in mind the limitations of the scheme. This scheme provides more facilities especially for women getting in hospitals sooner and keeps them in health institution at least 48 hours. Under the scheme, food and transportation

charges are free. But despite these initiatives, this scheme is not showing any direct impact on deliveries and mortality (Butrick et. al, 2014). It may be possible that there is some correlation but nothing can be said about the causality (Dongre, 2013). One of the other studies of Jackson, Mazumdar and Mills, 2015 (that has been used two rounds of DLHS data conducted in 2002-04 and 2007-08 respectively) has been pointed out that JSY did not create much effect on MMR and neonatal mortality. The correlation between JSY and mortality is modest. This study indicates that this is because of the possibility of poor quality of health care in the public health institutions and lack of equipped to manage the emergency complication at the time of delivery (Jackson, Mazumdar and Mills, 2015).

3.1 Coverage of Full Antenatal checkup

According to the Reproductive and Child Health Programme of India, pregnant women should be registered in the first 12-16 weeks and also every trimester, they should visit health facility centre for antenatal checkups including at least three antenatal visits, two dose of tetanus toxoid (TT) injection and hundred Iron Folic Acids (IFA) tablets (http://nrhm.gov.in/nrhm-components/rmnch-a/maternal-health/background.html).

According to the DLHS 3 (2010), Mothers who had full Antenatal checkup in UP are 3.3 % (in which 2.7 in rural and 6.6% in urban) whereas, the percentage of full ANC was 4.0% that shows the reduction from the earlier DLHS data. Full ANC was highest in the age group of 20-29 followed by 30-34 age groups and lowest in the age group of 15-19 and above 35 that are 1.8% and 1.9% respectively. Data on ANC was also highest (6.5%) in urban area as compared to rural (2.7% only) part. Apart from that, the women who had institutional ten or more years of education have high (14%) percentage of antenatal checkups. Coverage of the full ANC was highest in the Jain (9.1%) and in the Christian (7.7%) followed by the Hindu (3.4%). Coverage of the full ANC was low in Scheduled caste (1.7%) and Scheduled Tribes (1.7%) as compared to others and also it is high in highest income quintile, as it was 14.5% in the highest wealth index.

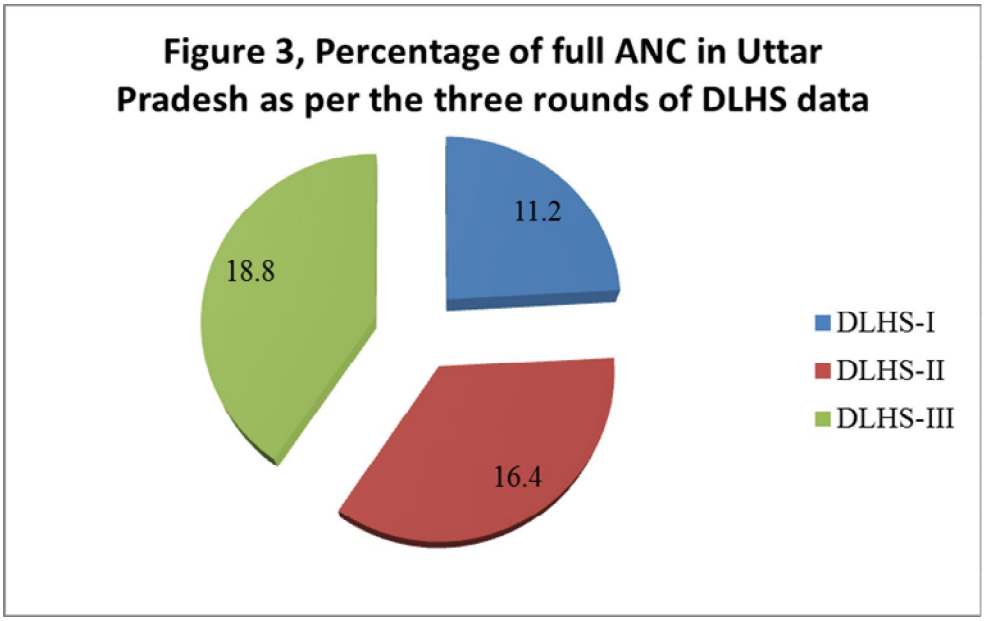
Table 9 Percentage of Women Who Received Full ANC by Some Selected Background Characteristics, Uttar Pradesh 2002-04										
Religion				Caste				Standard of living		
Hindu	Muslim	Sikh	Other	SC	SC	OBC	Other	Low	Medium	High
4.6	3.0	23.1	16.7	3.2	1.9	3.4	7.9	1.8	4.0	14.2

Percentage of women received full ANC according to selected background 2007-08		
Age groups	Full ANC	Number of women
15-19	1.8	2,702
20-24	3.8	11,987
25-29	3.8	11,519
30-34	3.0	7,000
35+	1.9	4,639
Residence		
Rural	2.7	32,120
Urban	6.5	5,727
Religion		
Hindu	3.4	30,408
Muslim	2.5	7,266
Christian	(7.7)	14
Sikh	5.2	128
Jain	9.1	19
Others	(0.0)	12
Caste/Tribes		
Scheduled Castes	1.7	8,093
Scheduled Tribes	1.7	590
Other Backward Classes	2.7	21,590
Others	6.8	7,574
Wealth Index		
Lowest	1.1	11,981
Second	1.5	10,186
Middle	2.6	6,855
Fourth	5.4	5,536
Highest	14.5	3,289
Uttar Pradesh (15-49)	3.3	37,847
Uttar Pradesh (15-44)	3.3	37,563

Source: DLHS-II (2002-04), 2006; DLHS-III (2007-08), 2010.

Though the government of India has taken several initiatives for the poor to improve their health status but the data shows that the poor are still the most deprived in receiving full Antenatal care services while those who are from the forward classes, belong to highest wealth index. They have greatest percentage in attending and receiving ANC in Uttar Pradesh. It is coming out from the data whether it is DLHS-2 or DLHS-3, though in the percentage of receiving full ANC, we can see slight differences but still these are upper socio-economic groups who have more percentage of getting full ANC.

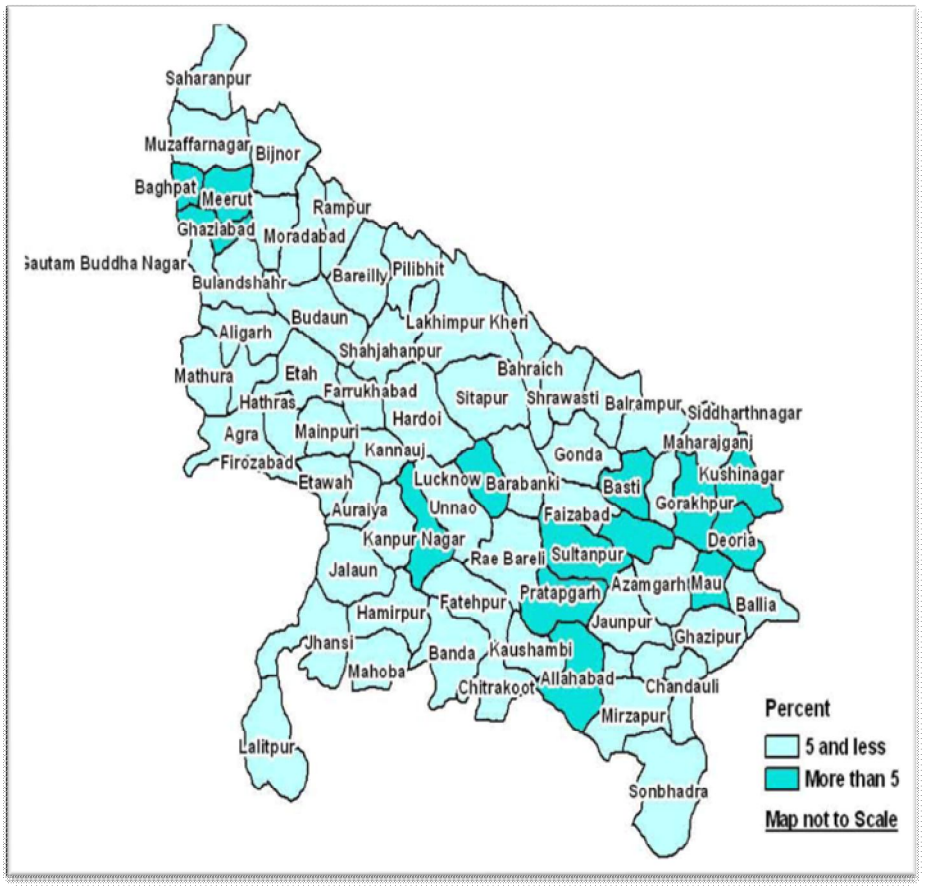
The full antenatal has been increased from DLHS-I (11.2) to DLHS-II (16.4%) to DLHS-III (18.8%).



Source: DLHS-I 1998-1999 (2001), DLHS-II, 2002-04 (2006) and DLHS-III, 2007-08 (2010)

At national level the percentage of full ANC checkup is very low as compared to universal. It varies from state to state and within state also. Uttar Pradesh has 3.3% full ANC while in Goa, Kerala and Lakshadweep it is 91%, 72% and 68% respectively.

Map 3. Full Antenatal Checkup by the districts of Uttar Pradesh



Source: Full Antenatal Checkup by the districts of Uttar Pradesh, adapted from DLHS-3, 2010

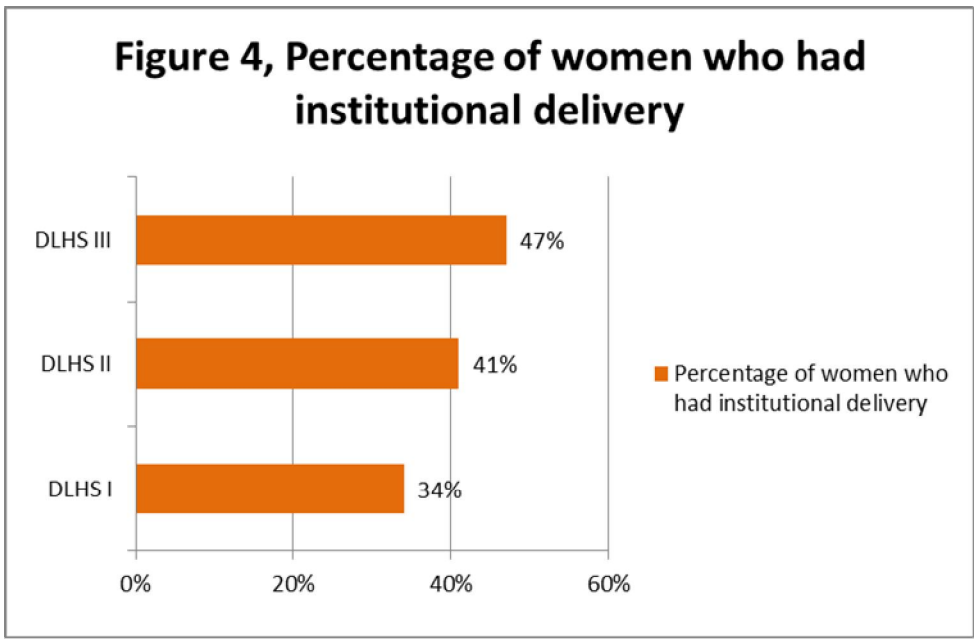
Within Uttar Pradesh, in the district Sultanpur the percentage of women in the age group of 15-49 who received full antenatal care is only 5.2 % which indicates very less number of pregnant women who had antenatal checkup, but it is slightly better as compared to pan-state (Uttar Pradesh) level.

3.2 Delivery Care

One of the important strategies that have been taken by the Reproductive and Child Health Programme in India is to reduce maternal and neo-natal mortality by giving proper hygienic and healthy environment to pregnant women. In this direction, the government of India has focused on institutional deliveries,

whether it is through government clinic (Sub-centres/PHC/CHC or DH) or private. The motive behind taking this step is to reduce the maternal, infant and neo-natal mortality by conducting safe deliveries under the supervision of skilled health personnel's.

The data shows the percentage of institutional delivers which increased at national level. According to the DLHS-3 (District Level Household Survey), 47% of women had institutional deliveries. This shows an increment in percentage of women who had institutional child births as compared to DLHS-2 (41%) and DHS-1 (34%).



Source: DLHS-I, 1998-99; DLHS-II, 2002-04; DLHS-III, 2007-08.

As per the DLHS-3, all over India, around 70% of the deliveries in urban areas and only 38% deliveriesin rural areas are conducted in health institutions. Whereas, in Uttar Pradesh the percentage of safe deliveries is even lower (30% only) than the national level while home delivery stats is 74.6%.

Table 10 Place of Delivery and Assistance

Percentage of Women (15-49) According to the Place of Delivery, Assisted Home Delivery, Safe Delivery According to the Background Characteristics of Uttar Pradesh 2007-08

Background Characteristics	Percentage of who had institutional delivery	Percentage of women who had delivery at home	Home delivery assisted by skilled persons	Percentage of safe delivery	Total Number of Women
Age group					
15-19	27.3	71.1	5.9	33.2	2,702
20-24	28.5	70.5	6.3	34.8	11,987
25-29	25.2	73.9	5.5	30.7	11,519
30-34	20.6	78.7	4.8	25.4	7,000
35+	16.4	82.5	4.4	20.8	4,639
Residence					
Rural	22.0	77.0	4.9	26.9	32,120
Urban	38.0	61.3	9.1	47.1	5,727
Religion					
Hindu	24.7	74.2	5.5	30.2	30,408
Muslim	22.7	76.5	5.8	28.5	7,266
Christian	(23.1)	(76.9)	(8.1)	(31.2)	14
Sikh	55.9	42.6	3.1	59.0	128
Jain	(78.9)	(21.1)	(21.1)	(100.0)	19
Others	(8.3)	(83.3)	(8.4)	(16.7)	12
Caste/Tribes					
Scheduled Caste	17.2	81.5	5.2	22.4	8,093
Scheduled Tribes	14.4	84.4	3.8	18.2	590
Other Backward Classes	22.8	76.2	5.2	28.0	21,590
Others	37.7	61.7	7.1	44.8	7,574
Wealth index					
Lowest	12.7	86.0	3.8	16.5	11,981
Second	18.3	80.6	5.0	23.3	10,186
Middle	25.5	73.6	6.1	31.6	6,855
Fourth	36.5	62.9	8.1	44.6	5,536
Highest	63.8	35.6	8.3	72.1	3,289
Uttar Pradesh (15-49)	24.5	74.6	5.5	30.0	37,847
Uttar Pradesh (15-44)	24.5	74.5	5.8	30.3	37,563

Source: DLHS-3, 2007-08

As above table clearly shows that safe delivery is high in urban (76%) areas as compared to rural (52%) and this institutional delivery is directly associated with the wealth index and school education.

Thus, from the above table, it has been found that although in Uttar Pradesh, institutional deliveries increased at rapid rate among those women who were from high wealth index. This has increased the gap between high wealth households and women from low income households. But this trend has turned after 2006, as institutional deliveries increased swiftly among those women who are from low and medium wealth index groups. But this is not same in the case of Rural and SC/ST group women. The evidence is slightly different with urban women as institutional deliveries increased in medium wealth indexes and in some extent to low wealth index households' also. There is no noticeable evidence in urban women who are SC/ST and non-SC/ST women. Due to these reasons the gap between these two groups remained more or less same.

Regarding place of delivery in Sultanpur, around 36.3% of women had institutional deliveries and 61.8% women had deliveries at home. About 11.4% of the home deliveries were assisted by a skilled person of the district and the percentage of safe delivery was 48% in Sultanpur.

3.3 Reason for Not Accessing Health Institutions for Delivery

The survey data also indicates various reasons due to which pregnant women do not choose the health facility for childbirth. Table 11 and 12 shows the DLHS data (I and II) on the several reasons regarding not going for health facility for child birth. The main reason for not choosing health facility for conducting child birth are given according to different socio-economic background barriers such as age group, education, residence, religion and caste wise. A large number of women have stated that institutional delivery is not necessary. Around 40% womenreported that there was no need of health institutions for child birth while 26% women did not go due to cost barrier and also claimed home care as best. About 16 % of the women felt that it was not contemporary. Other reason for not going health facility was family did not

allow for institutional delivery. About 8% women reported that their family had not permitted for institutional child birth. Apart from that, there was less number of women (about 3%) who had reported poor quality of health services that is why they did not choose health institutions for giving child birth. About 7% women had no knowledge of services related to health institutions, 12% women had no time to go for institutional delivery and also 5.5% women did not opt institutional child birth because of unavailability of transport to the health clinic.

Table 11. Reasons for not going to the health institution for delivery Percentage of the Women Who Had Last Birth at Home According to Residence (Urban/Rural) in 2002-04 in Uttar Pradesh

Reason	Residence		
	Total	Rural	Urban
Not Necessary	59.1	58.4	62.3
Not Customary	4.6	4.6	4.8
Cost too much	7.7	8.2	5.6
Health facility too far/No transport	1.4	1.5	1.0
Poor Quality Services	3.2	3.1	3.6
No time to go	3.8	3.7	4.0
Family did not allow	11.3	11.4	10.8
Better care at home	3.6	3.8	2.7
Lack of knowledge	4.9	5.0	4.4
Other	0.3	0.3	0.4
Total Percentage	100.0	100.0	100.0
Number of Women	24,029	19,459	4,571

Note: 1 includes sub-centre, primary health centre, community health centre or referral hospital, government hospital and government dispensary within the village.

Source: DLHS-II (2002-04), 2006

Table 12. Reason for Not Going Health Institutions for Delivery

Percentage of Women (15-49) According to Main Reasons for not Going Health Institution for Delivery, According to Selected Background of Uttar Pradesh, 2007-08

Background Characteristics	Cost too much	Poor quality of services	Too far/no transportation	Not time to go	Not necessary	Not customary	Better care at home	Family did not allow	Lack of knowledge	Other	No. of women
Age groups											
15-19	22.9	2.4	4.8	12.8	38.1	14.8	22.2	9.2	8.4	1.6	1,941
20-24	22.2	2.5	5.3	14	40.3	12.7	22.6	8.7	6.4	1.5	8,527
25-29	25.3	3	5.6	12.5	33.7	13.4	22.8	7.7	6.2	1.5	8,574
30-34	30	2.7	5.4	11.2	38.8	14.4	21.6	6.2	6.9	1.5	5,556
35+	31.3	2.8	5.8	10	41.1	13.5	19.3	6.1	7.7	1.5	3,892
Residence											
Rural	25.7	2.6	5.9	12.4	40.6	12.7	21.4	7.6	7.1	1.4	24,973
Urban	27.5	3.9	2.6	12.1	31.9	18.6	25.8	7.7	4.3	2.1	3,517
Education											
Non literate	29.2	2.8	5.2	11.2	39.9	13.5	20.9	7.2	7.8	1.4	19,946
Less than 5 years	27.2	2.3	5.4	12	37.6	14.1	21.7	8.3	6	1.8	1,207
5-9 years	18.6	2.6	6.5	14.6	38	13.9	24.6	8.9	4.6	1.9	5,583
10 or more years	11.2	2.4	4.9	18.9	40.2	11.1	25.9	7.7	1.9	1.7	1,754
Religions											
Hindu	25.1	2.7	5.8	13.2	39.7	12.6	21.6	7.3	6.8	1.4	22,799
Muslim	29	2.8	4	9.1	38.7	16.8	23.4	8.5	6.7	1.8	5,609
Christian	(31.7)	(16.8)	0	(13.1)	(9.6)	(19.7)	(28.6)	(9.8)	0	0	12
Sikh	36.3	1.8	17.9	9	17.8	16.4	29.7	10.6	1.8	3.6	56
Jain	*	*	*	*	*	*	*	*	*	*	4
Others	(60)	(10)	(10)	(0)	(10)	(10)	(40)	(10)	(10)	(0)	(10)
Castes/Tribes											

Cont…

Scheduled Castes	29.2	3	5.9	13.7	39	11.2	20.8	6.9	7.3	1.4	6,674
Schedued tribes	31.7	0.6	10.4	9.7	38.3	10.9	15.9	6.7	11.1	0.6	506
Other backward class	25.5	2.7	5	11.6	40.2	14.1	22.2	7.8	6.9	1.5	16,590
Others	22.2	2.8	6	13.3	37.7	15	23.3	7.7	4.9	1.8	4,720
Uttar Pradesh	25.9	2.7	5.5	12.4	39.5	13.5	22	7.6	6.8	1.5	28,490

Source: DLHS-3, 2007-08

3.4 Mode of Transportation and Janani Suraksha Yojana Beneficiaries (JSY)

The data indicates that around 34% women who had institutional deliveries used Ambulance/Jeep or car to reach the health institutions and about 54% used other mode of transportation. The data also shows the mean cost of transport is 337 INR that have been used by the women who had institutional delivery. The mean delivery cost for the government health facility for the child birth is 1,641 INR whereas, for the private it is 5,286 INR.

Although, Janani Suraksha Yojana has been stated as a protecting tool from financial threat by providing cash incentives, for the poor who had institutional delivery but the data clearly shows that only 4.6% women got JSY assistance. Those who have at least 10 or more years of education have highest (6.7%) percentage of recipient of monetary assistance as compared to the ones who are non-literate (3.8%). Apart from that, those who belong to fourth and highest wealth index have greatest percentage (5.2% for both) of beneficiary of JSY cash assistance. Scheduled Tribes have the highest (6.8%) percentage of beneficiaries who got the JSY financial cash followed by other Scheduled castes (5.3% for both). Percentage of mothers who availed financial incentives for institutional delivery under JSY in Uttar Pradesh is only 36.4% whereas in Sultanpur the evidence shows slightly better (45.9%) than the state (UP) level. In the next table, the proportion of women, who got monetary

assistance has been given as per the residence (rural/urban) as well institutional child birth basis under the scheme, JSY.

Table 13. Percentage of Mother Who Had Availed Financial Assistance Under JSY in Uttar Pradesh

Mother who availed financial assistance for delivery under JSY (%)			Mothers who availed financial assistance for institutional delivery under JSY (%)			Mothers who availed financial assistance for government hospital under JSY (%)		
Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
36.4	38.5	27.0	62.8	68.4	4.1	88.7	89.8	82.5
Percentage of Mother who had availed financial assistance under JSY in Sultanpur								
Mother who availed financial assistance for delivery under JSY (%)			Mothers who availed financial assistance for institutional delivery under JSY (%)			Mothers who availed financial assistance for government hospital under JSY (%)		
Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
45.9	45.9	-	70.4	70.6	-	84.6	84.2	-

Source:http://www.censusindia.gov.in/vital_statistics/AHSBulletins/AHS_Factsheets_2012-13/FACTSHEET-UTTAR_PRADESH.pdf

The table (13.) clearly shows that in UP as well as in Sultanpur, the percentage of women who got monetary incentives is low. Even in rural areas, the percentage of getting cash incentives in both UP as well as in Sultanpur district is also very less.

3.5 Duration of Stay at the Health Institution

As per the government guidelines, women should stay in the health institutions at least 48 hours after delivery. But on the contrary, enquiring on the number of days a woman stayed in health facility care after child birth, the study reveal that around 70% to 73% of the mothers got discharged within one day or less from the health institutions after delivery (Dongre and Kapur, 2013; Uttekar et.al, 2008).

Table14. Percentage Distribution of JSY Beneficiaries by their Duration at Health Institution after Delivery in 2008

Particulars	State
	Uttar Pradesh
Number	444
No. of the days stayed in the institution	
< 1 day	73%
2 days	16.2%
3days	6.5%
4 days	2.3%
5 days or more	2.0%

Source: UNFPA-India, 2009

In the study conducted by the UNFPA in 2009, the mothers were asked about their duration of stay in the hospital after child birth. They reported that 73% womenstayed one or less than one day in the hospital after delivery whereas only 27% women stayed two or more days in the health institution.

3.6 Mean Cost of the Institutional Delivery and Transportation

The District level household survey data-III also collected the data regarding average cost of the women (aged 15-49) who had institutional delivery. The women reported the mean cost of the institutional delivery in the public health facilities is INR 2,175/- and in private it is INR. 7,054/-. The average cost of the institutional delivery varies from rural to urban, also as in the government hospital the delivery cost in urban is low (INR. 2,406) as compared to rural (INR. 2,052) whereas in private hospital, the average cost of the delivery is much higher as it is INR. 8,035/- in urban compared to INR. 6,137/- in rural private hospitals.

The mean transportation cost to the health institution for institutional child birth has been estimated as INR. 359/- according to the DLHS-III and it varies as per the women's social background like place- whether rural area or urban, the average cost estimated for rural aewa is INR. 414/- as compared to INR 274/- in urban area. The average cost of transportation for institutional

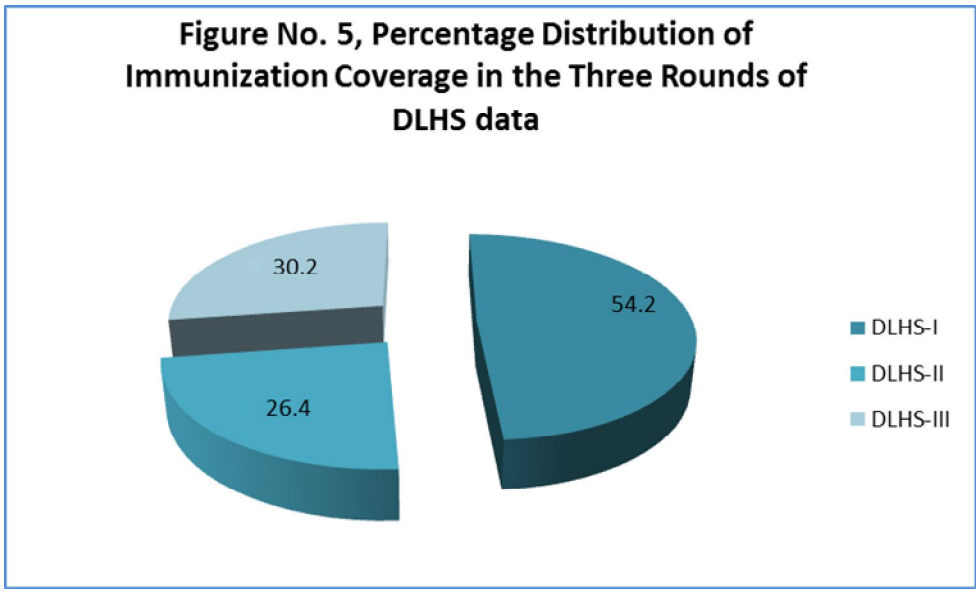
delivery is even higher in tribal women as it is INR. 494/- compared to INR.321/- for the other backward classes (rchiips.org/pdf/india_report_dlhs-3.pdf).

3.7 Post Natal Care (PNC) Services and Immunization of Children of 12-23 Months

The DLHS data also enquired that, women who had delivered childred either in government hospital or in private received post natal care services for their neo-natal. Postnatal care is the care given to the mother and new born baby immediately after delivery, within six weeks. It follows- first checkup within 48 hours, second checkup after 3-7 days and third within 42 days of delivery (Hazra et. al, 2010). Around 34% women received postnatal care services within two weeks of delivery in Uttar Pradesh as per DLHS-3. The data of DLHS-3 shows that 31% rural women reported postnatal checkups within two weeks of delivery while the percentage of postnatal checkups is far better in urban women. About 50% women reported receiving postnatal checkups in urban areas. In contrast, it is lower in SC (41.4%) and lowest amongst ST groups as only 29.4% women received postnatal checkup as compared to upper caste groups (50%). It is highest (around 52%) among those who have 10 or more years of education.

The immunization of the children includes Polio, BCG, DPT and Measles. As we compared the DLHS-2 and DLHS-3 data, we found that the full vaccination of children in between 12-23 months was 26.4% whereas in DLHS-3, it slightly increased and reported 30.2%. The table also indicates that, it is higher in urban (37.0% in DLHS-2 and 35.2% in DLHS-3) as compared to rural (22.8% in DLHS-2 and 29.3% in DLHS-3). As we can observe from the data residence wise, it is clear that it decreased about 1.2% from DLHS-2 to DLHS-3 in terms of full vaccination in the urban areas. The proportion of male child getting full vaccination is higher as compare to female child in both DLHS data. Those mothers who have 10 or more years of education, have high percentage of full vaccination which seems decreased around 6.0% from DLHS-2 to DLHS-3. It is high in high income groups and

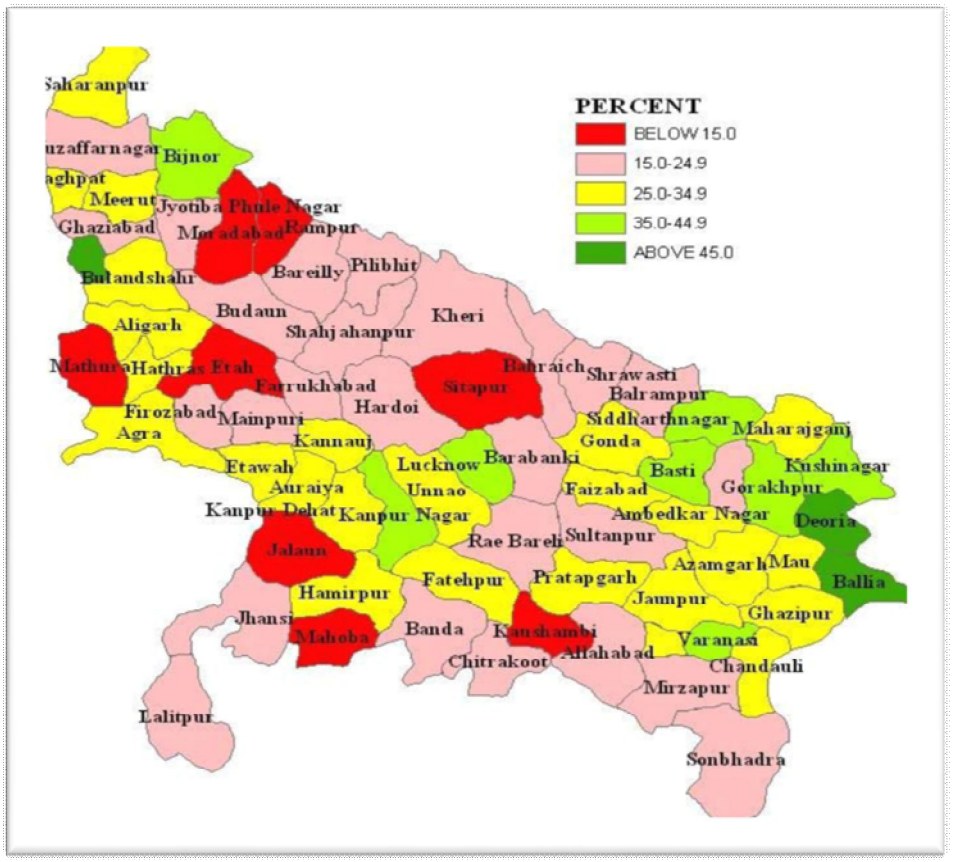
even in forward class people. Scheduled tribes have less percentage in taking the full vaccination of post natal care services.



Source: DLHS-I, 2001; DLHS-II, 2006; DLHS-III, 2010

In the year 1998-99 (DLHS-I), it has been observed that the coverage of full immunization was 54.2% which was much higher from the DLHS-II and even from the DLHS-III also. The data related to DLHS-I show that it was higher in males, other castes and also in urban areas. These evidences indicate gender discrimination within the health facilities of the state. The low coverage of immunization in terms of measles, BCG, DPT and Polio in the female childrens strongly proves this discrimination.

Map 4. Percentage of Children (Age 12-23 Months) of Full Coverage of Vaccination of All Vaccines in Uttar Pradesh in the Year 2002-04.



Source:http://www.iegindia.org/upload/publication/Workpap/wp283.pdf

The coverage of full immunization for the children in age group of 12-23 months in each district in Uttar Pradesh has been given in the map 4. The map 4 shows the inter district differential of the coverage of vaccination.

3.8 Out of Pocket Health (OOP) Expenditures and JSY Scheme

In India, one of the main deterrents in accessing the health facilities is high out of pocket expenditures. With increasing out of pocket health expenditures, poor people have become more vulnerable. In 2004-05, around 39 million people fell into poverty trap due to the OOPEs on health care (Modugu et. al, 2012).

A WHO, 2012 study reveals that India was the third country among all the South East Asian countries where OOP expenditures is very high. Around 60 percent of the total health expenditure in India was estimated to be out of pocket expenditure on health care (sifpsa.org/out-of-pocket.php). Sidney et. al, 2016, conducted in Madhya Pradesh (in which authorsused some statistical model) shows that out of pocket expenditure is prevalent among JSY beneficiaries. In JSY, OOPEs varies from income quintiles as it is higher in highest quintiles. Further, OOP expenditure was found progressive, whichwas less for both JSY beneficiaries as well as home deliveries compared to wealthier households. According to the authors of the study, after adjusting confounder properly, the results show that JSY beneficiaries actually had less OOPs s compared to home deliveries. Further the study finding also shows that the OOPE is largely due to the indirect payment. (Sidney et al. 2016).

Another study of Modugu and Srivastava, 2012 reveals that OOPE is high under JSY in public health facilities as compared to home deliveries. Also mean OOPE of the normal deliveries in public institutions was more than the JSY-compensation (1400 INR). However this study is based upon descriptive analysis and did not take possible confounders into consideration.

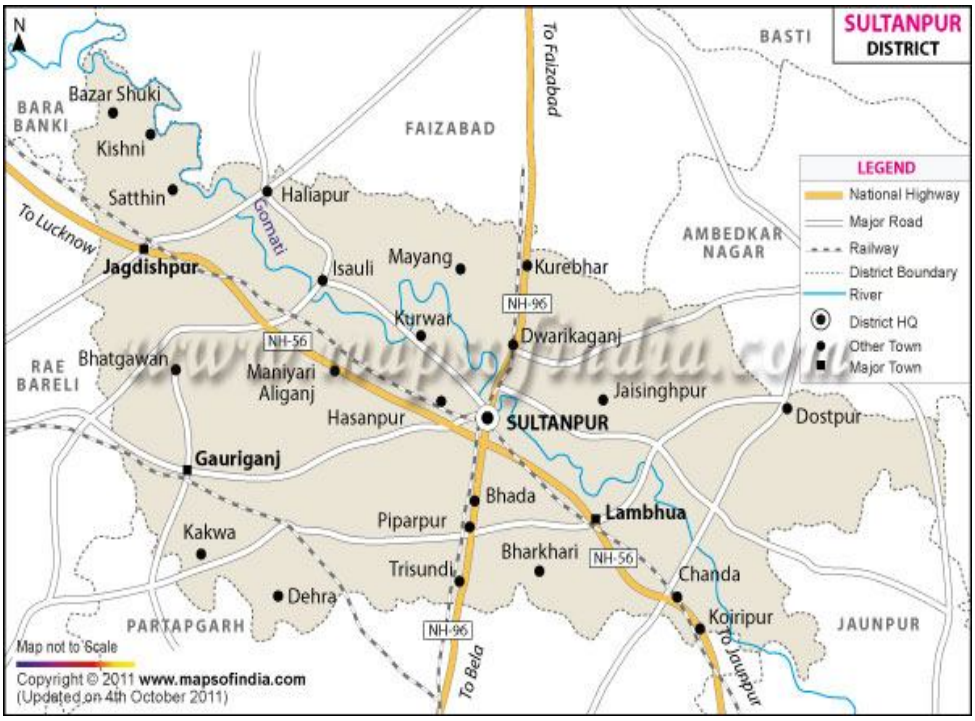
As above mentioned studies have showed that despite the function of the JSY scheme, people have to pay from their pocket for utilizing the health services. In order to reduce out of pocket expenditures and improve the maternal health services, government of India has launched JSY scheme for the vulnerable to easily access health facilities but in spite of this, out of pocket expenditure has become one of the main hindrances in accessing the health facilities. High out of pocket health expenditures push the considerable proportion of households, below poverty line.

3.9 District Profile and Maternal Health Care of Sultanpur

The Sultanpur district is situated in Uttar Pradesh. The total geographical area of the Sultanpur district is 2672.89 km. From the administrative point of view, the districts have been divided in to 04 Tehsils, 14 blocks, 01 Nagar

Palika and 04 Town areas. There is also 01 Lok Sabha seat and 05 Vidhan Sabha Seats (http://sultanpur.nic.in/dis11.htm).

Map (5) of Sultanpur



http://www.mapsofindia.com/maps/uttarpradesh/districts/sultanpur.htm

Sultanpur has large number of populations who lives below the poverty line. Around 49% people have BPL cards, issued by the government of India (DLHS 3). In the district, the percentage of women who had institutional deliveries was 36.6% and women who had delivered at home was 61.6% (DLHS 3). The data indicates that, still a large number of women are delivering children at home. Around 11.4% home deliveries had been assisted by skilled attendant and the percentage of safe delivery in the district was 48% according to DLHS 3. The percentage of full vaccination of the children at the 12-23 months is 43.4% which is better as compare to state level in Sultanpur. It has increased from the earlier survey (DLHS-2) as it was only 24.9% in 2002-04.

In the district, the utilization of maternal health services is very low. According to DLHS 3 data, only 38.5% have antenatal checkup in the first trimester of pregnancy whereas only 28.2% have three or more antenatal checkup. 82.4% and 26.4% have at least one tetanus toxoid injection and 100+IFA tablets/syrup respectively.

Table 15, Percentage of Antenatal Checkups

Antenatal checkup in the first trimester of pregnancy	Three or more antenatal checkup	At least one tetanus toxoid injection	100+IFA tablets/syrup	Full antenatal checkup
38.5%	28.2%	82.4	26.4	5.2%

Source: DLHS-3, 2010

The problem of maternal health in Sultanpur is more acute even in 2015-16. As per the summary sheet of Health Mission Bulletin of Sultanpur 2016-17, the total deliveries have been estimated as 12,573 but reports say only 5,019, out of which 4,871 were truly institutional deliveries. Number of women who have been discharged under 48 hours are 3855 which is also an area of concern. Despite the government rules for the mother to stay at least 48 hours at health institutions, this thing is still happening. The mothers, who got incentives of the JSY scheme for institutional delivery are only 1,874 out of 4,871 and for home delivery, only 50 were paid out of 238 (NHMB Sultanpur, 2016).

The percentage of JSY incentives paid to mothers in the district is around 38.5% out of total number 1,874 mothers who received incentives of the JSY in the year 2015-16.

3.10Deterrents of Supply Side Determinants of Demand Side Financing Scheme

The ultimate objective of the Indian healthcare delivery is to ensure that health facilities reach all people whether they are poor or rich. Monetary should not

be the barrier towards accessing the healthcare services. Therefore, in order to provide effective health care delivery to all, NRHM has emphasized on improvement of health infrastructures and human resources in those states and districts that are backward by setting the standards under Indian Public Health Standard (IPHS). IPHS has been set up for all levels of public health facilities to ensure the quality of health services in the country. Now, in the next paragraph, we are going to examine the availability of the existence of the health infrastructure and manpower as per the IPHS norms of Uttar Pradesh and one of its districts Sultanpur which is the study area of the researcher.

3.11Shortfalls of the Physical Infrastructure and Human Resources of the Uttar Pradesh and Sultanpur District

Regarding health infrastructure, Uttar Pradesh is very backward as compared to other states. It has been observed that there is huge scarcity of health institutions as well as health personnel's in this state. According to the RCH bulletin 2008 and report of the Government of India and Ministry of Health and Family Welfare (MOHFW), the current position of the sub centre, PHCs as well as CHCs are much less from the required number of institutions which are 26344, 4390, and 1097. But unfortunately the availability of these institutions are in the given numbers of 20521, 3690, 515 respectively. The data shows that CHCs are half in number of what the required number should be in the state. The conditions in terms of number of the doctors are very critical. The doctors and other health staffs in Government hospitals are very less. For instance, the number of doctors at PHCs was 2001 but the requirements of doctors are in the number 3690. Gynecologist and obstetricians at PHCs are 135 in number as against the required mark of 618, which is one fourth less of the required numbers in U.P. (http://www.rchiips.org/pdf/rch3/report/UP.pdf)

Like Uttar Pradesh, Sultanpur district is also inadequate in medical infrastructures, health facilities and manpower that do not fulfill the healthcare demand of the needy people.

There are 2 district hospitals, 0 sub-divisional hospitals, 11 CHCs, 54 PHCs and 232 Sub-centres are in Sultanpura as on 31st March 2014.

As per the DLHS-3, the average population covered by the Sub-centre, PHCs and CHCs are 8,345, 43,289 and 1,60,556 respectively and 8,032, 69,037 and 1,76,720 are at state standard.

The below table 16 giving insight regarding infrastructures, health personnel and equipments

Table 16. Average Population Covered by Health Hacilities in Sultanpur and Uttar Pradesh in 2007-08

	Sub-centre	PHC	CHC
Sultanpur	8,345	43,289	1,60,556
Uttar Pradesh	8,032	69,037	1,76,720

Source: DLHS-3, 2010

Table 16, clearly shows that in Uttar Pradesh as well as in Sultanpur, the average population covered by the health facilities like CHCs, PHCs and Sub-centres is more than standard level.

As per the Bhore Committee Report, Government of India has set three tier of health care delivery systems- Primary Health centre at village level, Secondary at sub district and district level and tertiary at regional level. Normally, population norms for the different health facilities in India are:

Table 17 Average Population to be Covered by Health Facilities

Health Facilities	Plain Area	Hilly/Tribal Area
Sub-Centre	5,000	3,000
Primary Health Centre	30,000	20,000
Community Health Centre	1,20,000	80,000

Source: DLHS-3, 2010

If we compare both of the tables than we will find that in Uttar Pradesh, an average population covered by the Sub-Centres is around 8,032 while in Sulatnpur the number is 8,345. The table provides information that Sub centres in Uttar Pradesh as well as in Sultanpur district have overloaded in regard to population covered by these health facilities. It is not limited to the sub-centres only but the situation is worst for PHCs and CHCs also which are respectively 69,037 and 1, 76,720 for the UP and for the Sultanpur it is 43,289 and 1, 60,556.

3.12 Availability of Human Resources, Drugs and Equipment in Health Facilities

3.12.1 Sub-Centres

The table 18, shows data on having equipment and essential drugs in Sub-centres in Uttar Pradesh and Sultanpur in Table 18 are related to villages having sub-centres and then sub-centres, having ANM in Sultanpur and Uttar Pradesh.

Table 18 No. of Sub-centres Having Adequately Equipped and Essential Drugs by District Sultanpur and Uttar Pradesh in 2007-08

	Adequately equipped (at least 60%)	Essential drugs (At least 60%)	Total number of Sub-centres
Sultanpur	20	0	42
Uttar Pradesh (%)	2,017 (83.9)	848 (35.3)	2,403 (100.0)

Source: DLHS-3, 2010

Table 19 Percentage of Villages Having Sub-centres Within Villages and ANM at Sub-centres and Staying in Sub-centrer Quarter by District and in Uttar Pradesh in 2007-08

	Village having sub-centres within village	No. of villages	ANM/FHW available at sub-centres	ANM residing in sub-centres quarter	Total number of sub-centres
Sultanpur	27.7	47	100.0	84.0	42
Uttar Pradesh	31.1	2,827	99.5	57.3	2,403

Source: DLHS-3, 2010

From the table 18 and 19, Out of 47 villages, Sultanpur has only 42 sub-centres and 2,403 in Uttar Pradesh out of which, the percentage of the villages having sub-centres in Sultanpur is only 27.7% this is less than entire Uttar Pradesh. However, the condition of the whole UP is also very worst as it is only 31.1% out of 2,827 villages. The total number of sub-centres is 42 and 2,403 in Sultanpur and Uttar Pradesh respectively. Apart from that, the data on equipment and essential drugs shows out of 2,403 sub-centres in Uttar Pradesh 2,017 are adequate equipped and only 848 have essential drugs. This scenario is even worst in Sultanpur district where 20 sub-centres are adequate equipped but none has essential drugs, even out of 42 sub-centres. These are the major factors that constrain the functioning of public health facilities. The huge shortfalls of necessary drugs, equipments as well as human resources have been key obstacles for the government health facilities to deal with the optimum capacity.

3.12.2 Primary Health Centres

Primary Health Centre (PHC) is a referral unit of 5-6 Sub-centres. It should have 4-6 beds for the patients and one medical officer, 14 paramedical and other health staffs. From the DLHS 3, it has been found that total numbers of 819 PHCs in Uttar Pradesh 79.6% have Medical Officers, 79% have pharmacists, 20.8% have AYUSH doctors and only 2.9% have lady doctors.

Table 20, Available Human Resources at Primary Health Centres by District Sultanpur and Uttar Pradesh in 2007-08

Uttar Pradesh	Medical Officers	Lady Medical Officers	AYUSH doctors	Pharmacist	Total number of PHCs
Sultanpur	13	0	6	15	16
Uttar Pradesh (%)	652 (79.6)	19 (2.3)	170 (20.8)	647 (79.0)	819

Source: DLHS-3, 2010

On the other hand, it has been noticed from the above table that out of 16, 13 Medical Officers, only 6 AYUSH doctors and 15 pharmacists are available in PHCs in Sultanpur. One important issue is also pointed out that out of 16 there

are no lady medical officers available at PHCs, this is a matter of great concern.

3.12.3 Community Health Centres

As per the government norms, Community Health Centre is basically a referral unit of 4 Primary Health Centres and should have one gynecologist, one physician, one paediatrician and one surgeon and also 21 parameds and heath staffs. In the infrastructure facilities, Community Health Centres should have at least 30 in-door beds, one labour room, OT, Laboratory and also X-Ray facility.

In Uttar Pradesh, around 693 Community Health Centres are functioning out of this, 19.5% have obstetric gynecologists, around 21% have pediatricians and only 16% have Anesthetists. Apart from that, 88.5% have functional OT and very few around 1.3% have blood storage facilities in state of community health centres.

In Sultanpur, out of 22, the number of CHCs having OT and labour room are 22 where as evidence shows that there were no CHCs where blood storage facilities are available in the district. Only 3 CHCs have general surgeon, 1 has obstetricians/gynecologist (https://www.scribd.com/document/59581980/49-Revised-Factsheet-Sultanpur-UP).

The conclusion is that infrastructure and manpower are substantially less from IPHS norms. Strengthening of these resources under NRHM did not reflect much improvement of the health status of the Uttar Pradesh and its district Sultanpur as they still need a lot of attention.

3.13 Overall Inequalities in Health Care Utilization and Health Infrastructures: A Conclusion

The DLHS data as well as a huge set of literatures (As per the Social Assessment Report (SAR), UPHSSP, Baru et. al, 2010, Balarajan et. al, 2012) highlight that there are widespread inequalities in accessing the health care facilities. These disparities especially show for those who have great need of

healthcare but unfortunately they don't get, as they fail to afford it. The survey data indicate that the status of reproductive and Child health, in Uttar Pradesh is too poor and below the national level. It is far below from southern states of India. Within the state, there is existence of vast gap among districts also. It is revealed from the data, although number of institutional deliveries increased from the year of DLHS-I (2002-04) to DLHS-III (2007-08). A large number of deliveries were conducted by skilled birth attendants; however the other health indicators have not increased well. Other health indicators like full ANC, proportion of pregnant women consuming IFA tablets/syrup, postnatal care etc. have changed little. The evidence also depicts the existence of huge gaps between rich and poor in accessing the delivery care. A higher proportion of women belonging to high income quintile received a proper delivery care than those who came from lower quintiles. Inequalities are also seen in preventive maternal health care and child health care services such as immunization and antenatal care on the basis of gender, as well as caste wise. The women of the ST and SC group have reported lower coverage of maternal and child health care services as compared to other groups. To be more specific, the vulnerable sections of the population are more deprived of availing the maternal and child health care services (www.academia.edu/566843/Economic_Inequality_in_Preventive_Maternal_and_Child_Health_care_A_Study_of_Rural_India).

Overall, the key intervention of NRHM, JSY has limited effect especially on the utilization of antenatal and postnatal care. One of the reasons is the incentive that is given under the JSY which excessively focuses on institutional delivery and not on quality of care and other components. Additionally, ASHA is the most important link between pregnant women and health centre and also integral to make JSY more successful. It is her responsibility to track down the beneficiaries during pregnancy and even after delivery also.

Apart from health indicators, it also clear from the evidence that a large number of deprived sections have been kept away from the basic amenities and health facilities at national level and in Uttar Pradesh also. The uneven

distribution of health care services has become a major concern. The evidence shows the huge shortfall of basic health facilities at sub-centres, Primary health centre and Community health centre. The existing data shows the high gap between required resources and actual number of available resources. It reveals that the objective of the Bhore Committee which was the milestone in the provisioning of health facilities in the country to give minimum level of health infrastructures which are not fulfilled even in the year 2007-08 and India is far more lagging behind to achieve its target.

Lack of these basic facilities pushes the poor to the private sector which increases their burden. Improvement of the basic infrastructures, healthcare delivery systems, human resources, equipment and drugs etc. can improve the health indicators in the country. However this all needs financing in a proper manner. Despite having 16% population of the world and 18% mortality burden, India spends only more or less than 1% on health. Based on the report of the global and national commission on Macroeconomics and Health (by World Health Organization in 2001), it has been estimated that the government health spending in India is much lower ascompared to the low income countries. Therefore, the government has been paying special attention to boost the health care expenditure. A lot of national programmes and schemes have been launched to improve percentage (%) share of health in GDP. For instance, a new national scheme was launched under the National Rural Health Mission (NRHM) in April 2005 to increase the health expenditure from its previous level (1% of GDP) to targeted (2-3% of GDP) level by the end of 11^{th} five year plan. (Berman& Ahuja, 2009)

In India, the share of the States in government health spending is ¾ (three fourth) and any kind of fluctuation in the state health spending influences the total spending much more than the centre's. The share of the government health spending is only 0.9% whereas private share in health is around 4.8% of the total health expenditure in the percentage of GDP. Health being a subject of state, investment in health services is primarily by the state governments and it is affected by resource allocation which is provided by the centre. The budgetary allocation to the health sector during 1990s to 2000 declined and the

share of state spending on health also declined over a period of time (Macroeconomic Commission Report, 2005).

During this period, the patterns of privatization in health sector have increased tremendously, due to the reformation in health sector. In this period, private sector in health care has played a dominant role in medical education and technologies, diagnostic, manufacture as well as pharmaceutical companies etc. The consequences of the interference of private sector in health care services, the cost of health services has gone up and which further causes not only high OOP expenditure but also rapid growth over a period of time (Macroeconomic Commission Report, 2005).

Out of pocket expenditure is the direct cost which is paid by the patient for medical treatment. This includes medicines or drugs, doctors and nurses fees, diagnostics and other miscellaneous services. The patient has to incur this expenditure from their pocket since it is not provided free of cost by public services (NSSO, 2001). To reduce this out of pocket expenditures, central government has started various programmes and insurance schemes to lessen the financial burden of the poor people like RSBY and JSY etc. Apart from the central government, various schemes have been launched by the state government for the betterment of their people.

Findings from my MPhil work corroborates the DLHS data and indicates that out of pocket expenditures on indirect cost are an important barrier that prevents the poor from utilizing health services and thereby from availing the scheme. Apart from this lack of supply side resources are also main responsible factors that have acted as an obstacle in accessing the health services and availing the CCT scheme which is meant for the poor. For the better understanding and evaluating the JSY, researcher has also shared the experiences of the poor women who had accessed the health institutions for child births and in availing the JSY scheme of her MPhil' work.

3.14 Experiences of Institutions Births among Households Below Poverty Line in the Village

The present section highlightsthe experiences of the women who had delivered in institutions. It examines the various targeted conditional cash transfer and insurance schemes that have been introduced by the State and the Central governments. In addition, it focuses on quality of service, reimbursement of funds, direct & indirect expenses for child birth and the behavior of providers in the health services.

Through in-depth interviews primary data was collected to meet the objectives. This information was used to assess advantages of conditional cash transfer schemes which have been implemented in Varanasi district.

The study showed that there are several schemes initiated by the state and the central government. These include the Janani Suraksha Yojana initiated by the central government and the Mahamaya Garib Balika Ashirwad Yojana by the erstwhile government. It is well known that the overall cost of institutional births in the public as well as private sector is very high (Ray et al. 2002). Therefore, some conditional cash transfer schemes, like JSY have been launched in the state for improving and enhancing the efficiency of delivery cases in government hospitals. In order to successfully implement these schemes, regular checkups of patients are carried out as it improves the health indicators and working conditions of the poor.

In this study, when the researcher asked patients about the schemes and their experiences with PHC at the time of delivery, most of them complained about the insufficiency of the amount given under JSY (INR1400). Reason quoted for this was the commission which is given to the health care attendants for using their services.

Study points out the fact that several schemes are not managed well and working inappropriately in government hospitals, under which BPL patients get free-of-cost treatment including drugs, ambulance, good quality of diet etc. Poor patients have to buy their own medicines as drugs are unavailable in

hospitals. Ambulance is inaccessible to the villagers because the village is located in very interior areas and this ambulance facility is accessible only for those villages, which come within the range of two kilometers, whereas it is easily available for Gram Pradhan of the village or politically strong people of the village. Thus patients are compelled to arrange a private vehicle. Patients get disheartened too, as many a time doctors do not examine them properly, due to the lack of appropriate facilities and long queues. Thus, people are unwilling to visit government hospitals as doctors are either not available on time or are non-co-operative.

In the following section we present case profiles of women who availed the benefits from the schemes for institutional births and the direct and indirect expenditures incurred despite the scheme being in place; the quality of interaction between the provider and beneficiary.

> "Chanda Devi, 25years old, who belongs to the Dhobi sub caste, was admitted to the PHC for her child birth. She went there along with her husband and ASHA. Her husband hired an auto rickshaw, which charged him Rs 200 to reach the PHC. This was because the ambulance could not reach the village and mostly it was used for doctor's field visit. She further told, the cost of the delivery was around INR 2000, and she got only Rs 1400 which was inadequate to bear all the expenses of delivery charges. At the time of her delivery, medicines were also not available and thus they had to pay for medicines from their own pocket. They also had to pay charges to other staff as well, such as to ANM, ASHA etc. Even after her successful delivery she had to stay with her husband for an extra day in the PHC. ASHA also stayed with her and her husband had to spend additional Rs 30-50 for ASHA's food. Because of staying for one day extra at the PHC, her husband's job got affected, as he was a daily wages worker. Overall, they faced lot of problems in terms of money expenditure. Due to her above mentioned experienced, she is convinced that home delivery is a better

option if there is no complication" (Chanda Devi, SC, 8 January 2012, Tilmapur Village).

Based on in-depth interviews with all the women who had delivered during the last one year in an institution or at home, I present my findings across selected themes.

a. Casteism

In Tilmapur village, BPL cards are given to those who belong to certain social groups. All BPL card holders are either Schedule castes (SCs) or Other Backward Class (OBCs), except one family belonging to the general category, who got a card by special request, since their economic condition was very weak. Usually, cards are not given to upper caste people even if they desperately need it on account of their poor economic conditions. Villagers have imbibed this fact that cards are meant for lower caste people only, no matter, whether upper caste people too, can come under BPL. Thus, it has been observed that only lower caste people hold the cards. Although this caste system is hereditary in Hindu religion, which restricts the occupation of their members and affects their daily lives. Lower caste people also suffer from discrimination by upper caste society. A recipient of BPL card belonging to the lower caste group shared his experience of discrimination by the Gram Pradhan, who is a Brahmin:

> *"When Gram Pradhan was making the list of BPL card holders, she asked me a number of times that are you from this village? From how long are you living here? Oh yeah You live in dalit basti, which is located at the outskirt of this village. That's why I (Gram Pradhan) didn't recognize or remember you. As, she knew everything about me like where and which place I live and for how long, then why she was asking me these questions repeatedly?*(Basant Kumar, 29, SC; 12 January2012, Tilmapur Village of Varanasi District).

Another woman also faced such discrimination and said that, the former Gram Pradhan had cut their name from BPL list.

Saroj has seven members in her family. Her husband Rakesh is the sole earner in family and works in a laundry in Surat. Earlier they were BPL card holders, as Rakesh's monthly income was INR 3000 which was insufficient for his family's monthly expenditure. Her father-in-law too used to work in a small factory as a weaver, but he got paralyzed due to sudden attack and he stopped working. Thus, they started facing financial and other problems.

> "*Without any prior intimation, former Gram Pradhan cut our names from the list. The reason behind this was that Saroj and her family were dhobi by sub-caste and former pradhan, was Jatav, who believed cards were meant for Jatavs only. As Saroj has no BPL card, she used to buy ration from market which has drawn her into more financial crisis*". (Saroj, 35, SC dhobi, 12 January 2012, Tilmapur Village of Varanasi)

Bimala who is SC by caste related her experience with a Thakur lady:

> "Once a Thakur woman came to her house to buy a woven rope for her a wooden bed. Bimala offered a glass of water to that Thakur lady, but she refused to take it. After a moment that Thakur lady went outside of her house to take water from the hand pump to satisfy her thirst" (Bimla Devi, SC, 25 November 2012, Tilmapur Village of Varanasi).

From above incidents one can see that lower caste people get discriminated by upper caste people, despite being of a better economic status.

Within the SC sub-caste, Mehatar sub-caste people suffer a lot of discrimination by the other castes as well as the same caste. People in their surroundings do not want to interact with them. People hate to eat in their houses and do not even like to be invited by them for any festival, party and

marriage etc. They live in isolation in their own village. Thus we can see here that there is also a hierarchy within the Schedule Caste group.

b. Income

Income plays a dominant role in villager's health seeking behavior. BPL card holders, who are slightly economically better, do not prefer government hospital for their treatment. According to them, the quality of service is poor and they have to pay additionally for the treatment, so they prefer to go to private. In the study, it was found that most of the people treat themselves with home remedies. For major illness except deliveries, they prefer private hospitals. Specifically, they opt for the government hospitals for delivery as they are aware of schemes (JSY, MAGBY etc.) which provide some financial security to them for their children's future.

In conclusion of the above, within BPL cardholders, who are in better condition usually, prefer to choose private hospitals.

In village, most of the BPL card holders are daily wages laborers. They earn in a range of fifty to three hundred rupees if they get job. Some time they become jobless and face lot of problems to feed their families.

MNREGA, is a unique policy introduced by the state government for providing employment to poor people of rural area. Under this act, the government is legally bound to provide jobs to unskilled local villagers. During field visit, researcher found, majority of poor's were unemployed despite being MGNREGA in place.

Nakhadu a 32 year old man, belonging to the Ravidas by subcaste, narrated his experiences with MNREGA. He said:

> *"I used to work under MNREGA some time back, but the administrative officers of the program were very corrupt. I was frequently either not paid or half paid for the work done. My brother in law was unemployed and willing to work under MNREGA but the officials use to force him to pay some money*

or give bribes for getting job. That's why he is jobless, since there is no money to give to the MNREGA officials". (Nakhadu, SC; 12 January 2012, Tilmapur Village, Varanasi)

c. Places of Birth

In-depth interviews revealed that people select the place for birth based on their previous experiences, knowledge or convenience. In Timalpur village, during the past one year, there have been twenty two live births. Out of 22, eighteen were institutional births. Five were in private and thirteen in government facilities. The remaining four were home births. These births were conducted with the help of ANM and ASHA, as there were no Dai in the village. They lived in the same village and hence could easily attend to delivery cases. The PHC was situated 5.2 km away from the village while private hospitals were located within the range of 2 km which led the villagers to opt for private institutional birth.

"When I was having labor pain, I went to the primary health centre with my mother. After my formal check up, the doctor said to me that I still have to wait for delivery as right time hasn't come yet. So, we went back to home. An hour after we reached home, I again started getting severe labor pain but this time my mother had decided not to go to the PHC, as it was located 5.2 km far from my home. So, she called ASHA and thus, the delivery was done at home."(Sharda. 21 year old; 15 January 2012, Tilmapur Village, Varanasi)

Experiences with institutional birth

a. Comparison of Doctor's Behavior in PHC, District & Private hospital

According to the villagers of Varanasi district, PHC's doctor's behavior in comparison to district hospital is good. At the PHC, doctors listen to their patient's problems politely and calmly. They provide them with proper advice and consultation as per their disease.

In district hospitals, doctor's behavior is completely unbearable. They never pay proper attention and provide care to their patients. They become silent and rude when patients ask questions related to their problems. Sometime they even scold them for their questions.

In private hospital, doctor's behavior varies according to the patient's standard of living. If patients belong to an economically well off family, then doctors take them as first priority and devote all their time and attention for their care and treatment. If patients, who cannot afford bill and hospital charges, approach doctors for concession in the bill, then doctors' become very rude.

Hari Prakash shared his experience with researcher about refusal to his wife's operation due to insufficient finance:

> "He took his pregnant wife Radhika to the private hospital with severe labor pain. After the doctor examined his wife, he told him, that his wife should undergo cesarean and instructed him to first complete all the formalities (including paying charges) only then she will start operating his wife. As he enquired to the concerned hospital staff about the formalities and charges of operation, he came to know that the operation charges cost INR. 8000, but he had only INR.6000 with him. So he requested to the staff to start the operation with INR. 6000 and rest of the money will pay after the delivery. Staff refused but advised him to consult the doctor. If she agrees, then only, they will admit his wife. As per staff's suggestion, he went to the doctor to request her for the same. But the doctor was completely against this, angrily scolded him in spite of his repeated requests; and later directed him to take his wife to another affordable hospital" (Hari Prakash, SC, 2 February 2012, Tilmapur Village, Varanasi).

b. Quality of Services in the Public Hospitals

In the public hospital, the quality of services is very poor with regard to water supply, equipment availability, cleanliness (in terms of hygiene and sanitation), nurse support etc. As per one woman who underwent delivery in a government hospital, doctors' unavailability and lack of punctuality was the big issue to deal with. Majority of people believed and experienced better facilities and services in terms of doctor's support inprivate hospitals as compared to a government hospitals. Though private hospitals cost more in comparison to the public hospitals but their quality of service is quite appreciable.

c. Corruption

In due course of the study, researcher found that bribe plays a vital role in availing benefits under the government schemes (JSY and MGBAY) as well as getting patients' admitted into hospital. Villagers are mostly deprived of the schemes whenever they fail to pay money.

People reported to have to pay bribes to ASHA, Angandwadi worker, Gram Pradhan, village secretary etc., for availing benefits guaranteed under above mentioned schemes. One poor respondent Meera Yadav, 26 years old, who failed to avail MGBAY scheme due to the lack of money narrated to the researcher about her experience:

> *"My husband is a daily wage worker who used to drink daily. When he failed to earn money due to unavailability of work, then he used to sell some home's articles for his drink. At the time of my baby's birth, my husband was not working. Somehow we managed to afford charges of ASHA and other attendants but we failed to arrange INR 500 for MGBAY scheme for my baby. We requested Anganwadi didi to pay later but she refused and said "We too have to give the commissions to the higher authority for further formalities, so until you give the money, we can't do anything for you regarding this*

> *scheme." My husband didn't't allow me to save money. Sometimes I managed to save, but somehow he got to know and snatched it from me for his drink. 5months have been over and still we are unable to arrange Rs 500 and get the benefit from the scheme*."(Meera yadav, OBC, 10 December 2012, Tilmapur Village, Varanasi)

Ram Prasad, 28 years old, Ravidas by subcaste had to pay bribe to get his wife admitted to the hospital for her delivery. Entire experience as shared by him is stated below:

> "Rita suffered from labor pain in a cold midnight of winter season. Her husband faced a lot of problems in order to admit his wife. First, he failed to get transportation facility immediately, but fortunately, after an hour of his continuous search, he found one rickshaw in which he took his wife to PHC. Second, doctor declined to admit his wife as he declared it a complicated case of twins after examining her. He advised him to take her to the district hospital which was very far from the PHC. Third, he doesn't have any transportation facility at that time as well as his wife's condition became more critical due to severe pain. So, he requested and begged to the doctor and then ANM for his wife's delivery. Fourth, at last he paid a bribe of Rs 200 to ANM who later insisted doctor. Upon ANM's request, his wife finally got admitted in the PHC for her delivery". (Ram Prasad, SC; 7 February2012, Tilmapur Village of Varanasi Distrct)

d. Reimbursement of Funds

As we all are aware that, government is running many reimbursement health insurance schemes for the welfare of the poor. One of the schemes called RSBY (Rashtriya Swasth Bima Yojna), in which unorganized workers can get health benefits. According to this scheme, BPL card holders should have smart cards and their names should also be registered with state as well as in central list of BPL card holders. But majority of people's names are not mentioned in the central list due to the lack of proper awareness, and as a result villagers are

not able to avail benefits under this scheme and instead take loan to bear their delivery charges. This happens because of non-co-operation from the Gram pradhan who do not disclose schemes for the poor to them especially, lower caste groups, as he is a Brahmin by caste. Only very few villagers who are Jatav by sub-caste are enrolled in this scheme.

e. Difficulties

In the study, villagers faced a number of difficulties during hospitalization for child births as well as for treatment. The primary health centre was located at some distance from their homes. So, firstly they faced the problem of distance. Secondly, they faced long queues at PHCs. Thirdly, there was no pathology centre which led patients to go to other private pathology centre. Fourthly, cleanliness was the major problem. There was no proper facility for accommodations and toilets. Therefore, patients' relatives used to sleep on the floor or in lobby of the hospitals and go outside for toilets. Non-availability of medicines and inadequate staff in government hospitals, were the other fatal problems they faced.

For availing the amount of schemes by the patients, the administration used to take lot of time to decide and most of the time patients were not able to get the amount of the scheme. Doctors' unavailability was another serious issue including the non-cooperative behavior of the other staffs towards patients. Doctor's were unavailable at the timings fixed. Villagers also faced scolding of other staff members for their doubts and queries which they had in relation to their person admitted in the hospital.

> "Munni was a diabetic patient who took her pregnant daughter Kalavati to the district hospital for child birth. She stayed with her for a week there, as she had a caesarian section. She told that the sanitation was the major problem of that hospital. Because of diabetes, she used to go for toilet in every short span of time which later led her to a urine infection. In this way, she came back home with another health complication" (4 February 2012, Tilmapur Village of Varanasi District).

f. Direct and Indirect Expenses

During hospitalization for institutional birth, people used to pay from their own pocket for a number of expenses which included direct and indirect costs both. People paid not only for the direct costs like doctor's fees, drugs cost, user charges, pathological charges, bed charges, operation charges but also to paid for transportation cost, loss of income, premium of insurance, lodging and boarding etc. These costs further caused weaker financial situations for poor households. Expenditure on medicines as a direct cost along with indirect cost really scaled up the entire cost of the delivery. In the field, researcher came to know that the ratio of the direct and indirect expenditure of birth is 1:3 whichnot a small ratio is. And this situation exists in spite of the fact that some conditional cash transfer schemes have been supposedly implemented for the poor.

A 45 years old lady Sheela, a Nai by subcaste, narrated her experience to the researcher that what amount she has paid for the birth of her daughter:

> "*When I took my daughter to PHC of Chiraigaon block for her delivery, the doctor told me that it is not a normal birth, and he advised me to take her to the Kabeer Chaura or Deendayal Hospital (district hospital). Despite her eligibility to be admitted in the district hospital; I took her to the nearby private Umang Nursing home, as the district hospital is far away from that PHC as well as from my house. I had heard that there were lots of formalities to be done before admitting patients and my daughter was in severe labor pain. So I didn't feel like to take this risk. The total cost, I paid for her delivery, was INR 14,300 excluding other expenses. The other expenses which I bore were transportation cost, food, loss of money, interest on loan, etc., which overall came out to be an additional INR 4500 which was a huge amount for us*." (Sheela; SC, 23 January2012, Tilmapur Village of Varanasi District)

Choice of Institutions

In the village, the researcher found that, most of the villagers prefer to go to private hospital for major and minor ailments. They have conditioned their minds that the government hospital doesn't provide better health services and treatment. They preferred government hospitals only for their normal birth but for rest other ailments they chose private institutions. One of the patient's husband Pancham who belongs to OBC, shared his experience of opting private in place of government hospital for his wife's delivery, is described ahead:

> "He admitted his wife into the private hospital, as he lost trust in the government institution. His first child was not safely delivered at PHC. The death of his child occurred during the birth and this is the main reason for his loss of faith. Thus, he took his wife into a private institution where his second child was born. His second girl child was totally fit and fine which further strengthened his belief in private hospitals. He then stated that he is an illiterate who can't read and understand and if government hospitals give wrong or expiry medicines then he can't do anything. Therefore, he believed private hospital treated well and properly as they charge for the whole treatment" (Pancham, OBC, 18 November 2012, Tilmapur Village of Varanasi District).

Researcher also encountered that casteism too plays a vital role in the choice of an institution. The majority of upper caste people preferred to choose private hospitals for their treatment as well as for delivery, as it was a matter of reputation and ego for them. Upper caste people have a belief that government hospitals are meant for lower caste people only.

This study also reveals that even the lower caste people from BPL households also want to opt for private in place of government hospitals, if they have money. Villagers were aware of some schemes which state finances in the form of cash transfers to patients who give birth in the government

institutions. Therefore, only for delivery cases villagers preferred government institutions.

Loans

It is well known fact that the costs of the birth in the institutions for poor people are not affordable. It adversely affects the BPL households. To bear these expenses, they borrow money from their relatives, friends, local money lender in the village etc. and get huge amounts of debt on their heads. Situations are worsened to an extent of selling their assets like lands and other sources of capital for instance auto rickshaw, animals, jewelries etc. For repayment of loans, poor used to forsake their essential needs such as food, clothing's and schooling of their children. Thus, this is one of the main reasons in the village, why poor people are trapped deeper into indebtedness.

Ashok, who is a daily wages laborer, explains about his critical condition.

"In order to bear the cost of delivery of his wife in the private institution he had to sell his auto rickshaw-the only source of income to house. Because of the complication in his wife's delivery, she was hospitalized in a private hospital. To bear all the expenses, he had to ultimately sell his auto-rickshaw. Now he is doing labor job, but through this work he does not get enough to feed his family. Some time, he has to borrow some ration from his neighbors or relatives to feed his children". (Ashok, SC, 20 November 2012, Tilmapur Village)

The given case study clearly depicts how poor people are trapped into the poverty line in order to meet the expenses incurred at the time of delivery. Many a times they had to forsake their basic needs for the same.

> "Chinta Devi, a 45 year old lady from Patel (OBC) by sub-caste had taken loan from the Micro pore credit agency for the payment of her daughter-in-law's delivery. For repaying this loan, she used to pay loan interest amount on every Thursday at 7:30 am. One day on Wednesday, her son got injured and she

> immediately took him to the hospital, where she stayed the whole night with her son. Only her daughter-in-law with her baby was at home. Due to her stay at hospital, she failed to repay loan interest on next day. On that same day, the money lender went to her home and asked her daughter-in-law for the loan installment. She pleaded to him for some time till her mother-in-law returns with her husband. But the money lender refused and said according to the terms and conditions of this finance group, ones need to pay all the installments on time otherwise they sell their land on the very same day. Fortunately, all villagers contributed and pooled money on her behalf for the installment and gave it to the money lender. Thus, with the help of villagers her land got saved. (Chinta Devi; OBC, 8 February 2012, Tilmapur Village of Varanasi District).

because of Jaundice, she and her daughter started to sustain their family financially by working as Maidservants. She also took a loan of INR 10,000 from Micro pore credit Agency to cover Ajay's medical expenses. She and her daughter used to work in 2 and 5 homes respectively to earn INR 1050 as a whole for a month with an average of INR 150 per month per house.

> "Out of sever Labor pain, her pregnant daughter-in-law Rani was taken to the nearest Primary health Care (PHC) which is 5.2 km away from her home. Doctors of PHC referred her to the nearest district hospital, which was unfortunately 18-20km away from her home for successful delivery by Caesarian section. Syama Devi could not take Rani to the district hospital taking into account Rani's poor health condition and inefficiency of District hospital doctors (Source: Neighbors). This situation forced Syama Devi to borrow an additional INR 15000 from Micro pore Credit Agency, out of which INR 13,000 was utilized for Rani's Caesarian section at private hospital. She is now suddenly trapped into an un-expected

> economic crisis due to her son's illness and Rani's caesarean delivery which has led her into a great debt of loans. She promised to pay an equated weekly installment of INR200 and INR 300 for INR 10000 and INR 15000 loan respectively for 52 Weeks. To meet the entire repayment amount, she and her family members cut their diets and started feeding starch water in place of milk to her granddaughter" (Syama Devi, 50 years old, Dhobi by Sub caste, 8 February 2012, Tilmapur Village of Varanasi District).

In the village there was no bank for providing loans for delivery cases as well as for personal needs. Most of the people (BPL households) have taken loan from this above mentioned finance group. This group only gives loan for generating income and employment. The villager also don't want to take loan from the bank, as according to them, there were lots of formalities that need to be fulfilled which takes not only takes time but it is also very cumbersome. Therefore, they take loan from these types of finance agencies.

This chapter has drawn attention towards various health care and insurance schemes launched by government for the betterment of underprivileged's health. These schemes have proved to be of benefit to few, as most of the time, they are not fully aware of such schemes. Sometimes, in spite of being aware of particular scheme they do not get the benefits because of innumerable paper formalities and lack of money to be given as bribe to service providers. OOPs of households of rural areas, has grown up day by day. Indoor and outdoor treatment cost also gets increased due to the continuous rise in privatization in health services like doctor fees, medicines, diagnostic and other miscellaneous (Duggal, 2005).

The further chapter is an analysis chapter that will describe the conditional cash transfer scheme run by the government in Dhanpatganj block of Sultanpur district of Uttar Pradesh. That chapter discusses how lack of infrastructures and unavailability of basic amenities at the health centres impact the schemes. It contains the structural as well as operational problems

pertaining to the scheme. Administrative obstacles and complex conditionalities could make the programme weaker and reduce the enrollment of the needy; further, even if they do enroll, corruption and other administrative problems turn against their receiving the transfer(s) to which they are entitled.

Chapter 4

Structure and Functioning of the Health Services and IGMSY Scheme in Dhanpatganj Block of Sultanpur District

The aim of this chapter is to identify the determining factors that affect the low enrollment of the schemes and underutilization of the health services in the Dhanpatganj block. In this chapter, researcher examines the various factors influencing this scheme. As it has been mentioned in earlier chapter, in Sultanpur two conditional cash transfer schemes (JSY and IGMSY) are functioning in parallel for the pregnant and lactating women who cannot afford the cost of institutional delivery and also to change the nutritional behavior and partially cover of their loss of wages.

The main objectives of this chapter is to conduct an analysis of the public health services maintained by the Ministry of Health and Family Welfare Department and Integrated Child Development Services (ICDS) of the Department of Women and Child that are linked with two (JSY and IGMSY) schemes at the Dhanpatganj block. Since there are very few studies and reports that have looked at this (IGMSY) scheme in details. Therefore, there is a need to intensive and broad understanding of this scheme. This analysis chapter is based upon the in-depth interviews of the facility staff at the CHC/APHC/Sub-Centres, Community health workers (ASHAs, Anganwadi Worker and Anganwadi Helpers) and Programme Officers etc.

ICDS was launched in the year 1975 and the main objective of this programme is to improve the health conditions of the children, pregnant and lactating mothers by providing nutritious food, education related to the hygiene as well as the non-formal education to the 3-6 years of children. Along with these services provided by the ICDS programme, it includes monitoring of the growth of the pregnant women and children, checking of the availability of healthcare facility, routine health checkups etc. All these services are conducted by the Anganwadi Workers who are accompanied by

an Anganwadi Helper. (ww.cbgaindia.org/wp-content/upwads/2011/04.ICDS.pfd).

Health services like health checkups of the pregnant women and newly mothers as well as children are undertaken through the public health infrastructure such as Community Health Centres (CHC)/Primary Health Centres (PHC)/Sub-Centres (SC) managed by the Anganwadi workers.

Hence, in the first section by using both the secondary as well as primary data, researcher critically analyzes the institutional constraints like condition of the health infrastructure, existence of the Anganwadi Centres and short fall of the human resources in Uttar Pradesh and also in Dhanpatganj block which is the focus of this study. The poorly maintained infrastructure and understaffed health centres also act as a barrier for the scheme.

The second part of this chapter discusses the administrative constraints impeding the proper functioning of this scheme. The researcher draws from the findings during the field work where various issued faced by the health officials and community health workers (ASHA, AWW and AWH) under those schemes were observed and analyzed.

Data from (Community Health Centre) CHC revealed that in the year 2014-15 institutional deliveries were 2480 and out of this 1785 were the beneficiaries of JSY scheme. However home deliveries were 133. This has been raised question that despite the functioning two conditional cash transfer schemes in Dhanpatganj block of Sultanpur district, still home deliveries are conducting. What are the reasons behind opting home deliveries?

Apart from the beneficiaries of the JSY, researcher also visited the ICDS (Integrated Child Development Services) office to document the number of beneficiaries of IGMSY scheme. There researcher found that there were 2300 women who were registered under the scheme but only 53 got IGMSY scheme's incentives.

Table No. 21, Pecentage of Registered Women who Benefitted from JSY and IGMSY

JSY (NRHM)	Women registered for Insitutional Delivery	2480	71%
	Registered Women benefitted from JSY	1785	
IGMSY (ICDS)	Women registered for Insitutional Delivery Under IGMSY	2300	2.3%
	Regsitered Women benefitted from IGSMY	53	

Source: Based on Primary Data, 2014-15

From the above data it is clearly visible that the percentage of the IGMSY's beneficiaries (2.3%) is very low as compared to JSY's beneficiaries (71%).

Therefore this chapter will draw attention towards the several reasons for the low coverage of the IGMSY scheme as compared to JSY in the block. In the following section institutional barriers will be discussed along with the provider's perspectives about the schemes and their roles, and difficulties faced by them in implementing it.

4.1 Dhanpatganj Block

As per the BDO (Block Development Officer) record of Dhanpatganj block it is based in Sultanpur district of Uttar Pradesh. It is among 14 blocks of Sultanpur district. As per the government register, this block has 118 villages and there are a total of 27,774 houses. The total population of Dhanpatganj is 1,75,167.

As per the UP Health Mission (HMIS, 2016-17), the proportionate estimate of pregnant women was 4,367 and deliveries reported were 4,010 during Jan 2016-17. Out of the reported deliveries (4,010), 71 numbers of deliveries were home while 1,578 were institutional deliveries this is around 42 percent

of the reported deliveries only. Rest deliveries were missed in reporting. Out of reported deliveries, 2,182 were registered in ANC. This was only 50% of estimated pregnant women. The percentage of full 3 ANC was even low (35.5%) compared to the percentage of women who had registered (49.5%) under ANC checkups. Out of registered women in ANC, around 36 percent reported having low level of hemoglobin that was below from 11 and this severe anemia problem treated only 0.5 percent at institutions in Dhanpatganj block (http://upnrhm.gov.in/site-files/mis/hmis/districts/Sultanpur_HMIS_Bulletin_for_Apr_to_Jan_2017.pdf).

Despite the government running two crucial conditional cash transfer schemes at the block level, the results show that these schemes have failed to address the issues related to the expectant mothers, new mothers and children. This failure could be because of the gap in the supply and demand. They both are complementary. Without proper supply of the health services, demand cannot be generated. Therefore for the successful running of the schemes it is necessary to make a strong backup of these health services in line with the demand for these services. In the next section, health infrastructure availability will be discussed in detail.

4.2 Infrastructural Facilities: Dhanpatganj Block

It has been reported that in the block there is one community health centre, four additional PHC under which only two are functioning and 18 sub centres. These sub-centres are located in their respective villages. Out of 18 sub-centres two are not functioning. Where there are no medical health facilities, rural people have to travel more than 10 km for accessing the health services. The road connectivity is generally very poor and people face a lot of problems in accessing the health facilities. Apart from the government hospitals, there are four private medical practitioners in the Dhanpatganj block.

Table no. 22, Health Facilities in the Dhanpatganj Block

Sl. No.	Types of Health facilities	No. of Health facilities within block
1.	CHC	1
2.	APHC	4
3.	Sub- centre	18
4.	Family Welfare Centre	1
5.	Private Health Facility	4
6.	Private doctors with no degree	5

Based on primary data, 2016

4.3 Staff Position in the Community Health Centre of the Block

Community health centre play a very crucial role in providing health services. As per the norms, CHC should have at least 30 beds for indoor patients with OT, Labour room, X-Ray and laboratory.

Shortage of the health staff has a significantly negative impact on the patients in the rural area. It has been found after the field visit that the community health centre of the Dhanpatganj has huge shortage of various staff. As per the ideal scenario, All CHCs should have four doctors (Surgeon, physicians, gynecologist and pediatrician) but in the Dhanpatganj CHC, there are various vacant posts including that of a surgeon, gynaecologist, child specialist and a physician. The below table will give an insight on the shortage of the medical staff in the CHC.

Table no. 23, Staff Position in the Community Health Centre of Dhanpatganj Block, Sultanpur

Sl. No.	Category/Cadre	Required No. of Post	Available No. of Post	Vacant No. of Post
1.	Medical officer	06	04	02
2.	Physician	01	0	01
3.	Child Specialist	01	0	01
4.	Surgeon	01	0	01
5.	Gynecologist	01	0	01
6.	Radiologist	01	0	01
7.	Dental Surgeon	01	0	01
8.	Pharmacist	06	05	01
9.	Chief Pharmacist	01	0	01
10.	Lab Technician	01	0	01
11.	Dai	04	01	03

Source: Based on Primary Data, 2016

The table shows that more than half of the posts of various staff are vacant. To meet the requirements of the centre the, CHC has also appointed some health personnel on contractual basis.

It is proposed to fill gaps of shortage of human resources and to hire contractual staffs to meet these issues. Two medical officers of Rashtriya Baal Swashtya Karyakram (RBSK) have been appointed as against four positions available, one pharmacist as against two posts, two ANM RBSK. Even after

these contractual appointments there is still a gap between sanctioned post and available heath personnel.

Kaushlendra Singh, 32 Years Old, Medical Officer, CHC stated that*"If a single man works for four people, then how efficiently he will be able to do his job?"* (Kaushlendra Singh, MO, CHC, 28January 2017, Dhanpatganj Block)

In the above text, MO of the CHC of the Dhanpatganj block expressed his concern about the efficiency of the work due to the shortage of the health staffs at the CHC. He further said that though government has introduced various scheme and programmes to reduce the MMR and IMR but government not showing much interest and effort for increasing the health facilities of public hospitals rural area due to which doctors does not want to work in rural hospitals. It not only affected the efficiency of the doctors and other health staffs but also poor women do not want to visit public hospitals.

Kaushlendra Singh (MO, CHC) 32 Years old further stated:

> **"***Due to the newly appointment of contractual gynecologist, situation is better now as compared to earlier when there was no gynecologist at the CHC and delivery cases were handled by the ANM only. However, the Gynecologist here has BAMS degree only and does not have any specialization. She attends the delivery cases only during the day time while at the night it is the health staffs who attend the delivery cases.This is just how we are managing the work here some what".*(MO, CHC, 29 January 2017, Dhanpatganj Block)

According to the doctor of the CHC of the Dhanpatganj block*, "there are also see the difference between on paper medical staffs and in reality. On paper there are 4 MO who appointed at the CHC but currently I am the only one who is on duty".*

About asking the various posts of the CHC, MO said that:

> *"One will find a lot of such posts in paper while it does not actually exist in reality. At the CHC level, there should have been one physician, a gynecologist, one pediatrician and one surgeon ideally. However, in this CHC there is no one else a part from me to handle things here. It is me who looks after both OPD and emergency cases. In a day I attend to 60-65 cases on an average. Due to the severe shortage of the doctors and health staff there is a huge burden on me".* (Doctor, CHC, 4 February 2016, Dhanpatganj Block)

As per the doctor of the CHC,

> *"According to the norm, there ought to be one CHC on One lakh population however here the number of inhabitants in the Dhanpatganj is around 1 lakh 75 thousands and has one CHC. It is clear that CHC has over burden in terms of population that has covered by the CHC. Most of the time, it increase the burden of doctor and other health staffs. To reduce our burden there should be PHCs as there were no PHCs and have only Additional primary health centre and most of the time it not function due to the lack of doctors*" (Doctor, CHC, 26 June 2016).

From the interviews it is apparent that the CHC as well as PHC and sub-centres are under staff which further results in increased burden on doctors and other medical staffs who are posted there. However to bridge this gaps, government has started to appoint some contractual basis doctors and other health personnel but It was found that less paid as compared to regular staffs discourage them to do their work efficiently. Apart from the less paid; it was also found that contractual staffs have overloaded of work as they have to come on time at institutions and have to go very late. While there were no restrictions on regular staffs. In the following paragraph, as shared by the ANM explains in itself, that*"Samvidha (contractual) medical staffs are*

supposed to work for eight-nine hours a day, but due to frequent absence of the regular health staff, we have to work of the permanent staff's also. They never come on time due to this we work during non-duty hours" (ANM, 18 August 2015, CHC of Dhanpatganj Block)

It is clear from the above statements that despite the several initiatives to address and overcome the severe shortage of human resources, the problem persists. However to bridge the gap of shortage of health personnel, various posts have been filled with contractual staffs but due to various problems like exploitation, over work, less salaries the contractual staff tend to be demotivated that has a negative effect on their work.

4.4 Sub-Centres

The field investigation shows that in the Dhanpatganj, almost 20% sub-centres are located in the government building and nearly 80% are located in either rented buildings or in Anganwadi/ANM's house.

Data on health workers show that there is large gap between required numbers of health personnel in the sub-centres also. On paper, there are 18 sub-centres but only 12 are functioning. As per the norm, each sub-centre should have one ANM (Auxiliary Nurse Midwives) and one male multipurpose worker (MPW). But during the field visits it has been found that out of the 12 sub-centres, 8 sub-centres are functioning without ANM.

Out of 18 sub-centres, 10 posts of ANM were vacant. This has increased the work load of the other ANM's in functioning sub-centres. Due to these reasons most of the sub-centres are not being used for any purpose, neither for conducting delivery procedures nor for the residential purpose of the ANM, who is supposed to stay there to provide healthcare services.

As we know these sub-centres are supposed to give RCH services like ANC, PNC, child care services etc. However from the field observation and from the interviews of the respondents, it has been revealed that most of the time sub-centres remain closed. The sub-centres that are functioning do not have

adequate medicines and most of the time ANMs are not available at the sub-centres. Apart from this there isn't a separate labour room at these centres.

Picture 1.Sub-Centre of the Majhwara Village

Sub-Centre of the Majhwara Village, Sultanpur

4.5 Additional Primary Health Centre

As per the clerk of the one of the additional primary health centre, all APHCs are functioning properly but reality is far different. This looks fine on paper but not in reality. Out of four APHCs two are not functioning and other two are severely under staffed and under supplied.

As per the norm, at the Additional Primary health centre, there should be one MO, one ANM, one HV, one pharmacist, one lab assistant, one ward boy and one sweeper. But it has been observed that, there was no health staff available at the additional PHC except one pharmacist and a sweeper. In the absence of these medical staffs, pharmacist has recommended medicines.

The condition of all additional PHCs is equally bad. There were no doctors in the health centre. In the absence of the doctors, pharmacists prescribe medicines. ANMs are not available in the health centres. Even basic aid is not available at the health centre that treats minor ailments.

Picture 2. Additional PHC of Pipar Gaon

Additional PHC of Pipar Gaon, Sultanpur

It has been revealed from the pictures, that the conditions of the APHC/Sub-centres are worse. Most of the facilities were available at the community health centre as majority of the health facilities were lack of basic facilities and mostly were closed due to the shortage of medical doctors and other health personnel.

Table no. 24, Facilities at the Sub-centre/ APHC

Sl. No.	Facilities	Sub-Centres	APHC
1.	Doctors	0	0
2.	ANM	9	2
3.	Pathological Test	0	0
4.	X-Ray	0	0
5.	Beds	0	2
6.	Medicines	10	2

Source: Based on primary data, 2016

Apart from the medical facilities there were no basic amenities in the health centres of the Dhanpatganj block of Sultanpur. Majority of the health centres (sub-centres/additional primary health centres) were without electricity and

drinking water as well as toilet facilities. Where ever have toilet facilities they have either been locked or only used by the medical staff.

Due to the lack of proper facilities, poor people avoid to visit government health centre even though they don't have money to spend in private hospitals.

In the following section, researcher presents the case profiles of the respondents who were to avail the benefits of the scheme regarding the obstaclesfaced by them. Questions were raised that despite 2300 pregnant women registered under IGMSY only 53 (around 2 percentage only) percent availed the benefits. What are the factors responsible for low coverage (only 1.9 %) of the IGMSY scheme?

Radhika (an ASHA worker from Kutta-II village) stated that,

> *"Everyone knows that to what extent one duty is bound in a government hospital. Most of the time the doctors here, refer the medical test to other centres. Under such circumstances why a pregnant woman from an interior or far flung area would wish to come here? Since she has to spent money anyways, she would obviously prefer to visit a place that would be of her convenience. I do not wish to ask anyone to come get treated here in a government hospital, especially when I am aware of the state of affairs here. People should visits wherever they want themselves to be treated. Also there is only one diagnostic centre in this block which is 5-6 km away"* (An ASHA worker of Kutta-II village, 8 November 2016).

Another respondent (Anita) told that,

> "*She is a 23 year old pregnant mother of one child and a housewife. Her husband, Ramdhani is educated till 6th standard and works as a driver in Punjab. She lives with her in laws in Dharamdaspur village in Dhanpatganj block. Her child was born when she was 25 years old and had miscarriage earlier. There were no complications with the delivery. She is 5 months*

pregnant. She has visited CHC for vaccinations and medicine during her 3 months pregnancy. But due to the load of patients, doctor told her to come to the next day. Before going to the CHC, she was also visit sub centre but because of the unavailability of ANM, she went to the CHC but she did not go to the CHC next day and had done all her Antenatal check-ups as well as all lab investigations from the private hospitals. She further said that, in private hospital although we have to pay more money as compared to public hospitals but in the private clinic at least all facilities are available at the same place and you do not need to run one place to another place to seeking services." (Anita kumari, SC, 12 January 2016, Dharamdaspur village)

These are a number of obstacles that people face and are the reasons why they do not go for utilizing the government health services. Though government has implemented several schemes but without the basic amenities at the health centres these scheme cannot functioning properly.

4.6 ICDS/Anganwadi Centres: An Evaluation

ICDS is considered a well-designed and the larger pogramme in India aiming to address the issues related to the child health care. More than four decades since its launch, still every third child suffers from the malnutrition. The situation of the neo-natal and infant as well as maternal mortality is still poor.

Although there is no doubt that the programme is aimed to decrease these rates but there are significant gaps in its implementation that weaken the purpose of this programme. Due to the lack of proper implementation it does not fulfill the desired purpose. Major issue that has been found in this programme is operational problems such as lack of evaluation and monitoring, lack of transparency as well as absence of supervision. All this results in the poor performance of the programme. (Bajpai and Dholakia, 2011).

Successful implementation of the scheme mainly depends on the proper planning and timely evaluation. The Anganwadi Centres and its workers could resolve theproblems relating to the ICDS programme.

In Uttar Pradesh, 187,517.0 centres had been sanctioned in the year 2010 out of this only 170,230.0 were operational). As per the Minister of Women and Child Development, Meneka Gandhi, 187,659 Anganwadi Centres were operating at the end of 30 September 2013 in Uttar Pradesh. Despite more than one lakh centres in Uttar Pradesh, there have been no satisfactory changes found in nutritional outcomes of the children. Nearly 46% children were malnourished in the year 2009 in India. This shows that despite there has been increased in Anganwadi centres but there have been no changes in nutritional status of the children in India (http://www.cbgaindia.org/wp-content/uploads/2011/04/ICDS.pdf).

Now the question is what are the major barriers that make poor outcomes? Report on Integrated child development services, budget for change series, 2011 found two major hurdles that are inadequate proper funding and poor utilization of the fund are the main issue making this programme weak. However the data reveals that significant number of increase in the allocation of budget under the ICDS (from INR. 48.6 billion in 2007-08 to INR. 87 billion in 2010-11) but still this is not adequate to meet the needs of targeted population. Apart from the low budget allocation, poor quality of the fund utilization is another bottleneck under the ICDS programme. Though the evidence shows that under the ICDS, level of fund utilization is high (around 90%) as compared to other government programme but quality of utilization of the fund is very poor. Avoiding the non-wages components like as drugs, kits, equipment and other essential components are the major factors that constrain the effective and smoothly functioning of the programmes. In order to cop up the fiscal deficits, there has been cut back these non-wages spendings. Along with that, the analysis has been done Comptroller and Auditor General in India shows that in the year 1999-2000 to 2004-05, in UP, allocation fund was only 16% as against to establishment expenditures

constituted 56%. Due to this reason, provision of nutrition, health services and pre-school education suffered a lot.

The same situation has been found in the Dhanpatganj block. Although in the block, there are 192 Anganwadi Centres and one ICDS centre as well, but out of 192 Anganwadi Centres only 3 are located in their own buildingand the remaining are running in the primary schools, private buildings, Anganwadi worker's home, panchayati buildings and other community buildings etc. Even the ICDS centre/office is also situated in a privatebuilding.

Table 25, Required and Available Post of the Community Health Workers in Dhanpatganj Block

Required and Available Post of the Community Health Workers in Dhanpatganj Block				
Serial No.	Name of Post	Required No.	Available No.	Gap
1.	Supervisors	6	2	4
2.	Anganwadi Workers	192	188	4
3.	Anganwadi Helpers	149	144	5

Source: Based on Primary Data, 12 April, 2016, ICDS office, Dhanpatganj Block

The Anganwadi centres are not running at the allotted government building because of the lack of funds. As per the CDPO, "*funds have not been given since two years despite complaining several times. Due to this reason, we built Anganwadi Centres in the private buildings".* (CDPO, Dhanpatganj block, 29 January, 2017)

Apart from the fund issue, the findings show that the lack of basic facilities in the functioning of the Anganwadi centres also act as a barriers for the Anganwadi workers to undertake their duties responsibly.

An Anganwadi Worker stated that

> *"However 192 Anganwadi centres are running in the block, but only few are functioning in good position. Most of the Anganwadi centres lack basic amenities like electricity, drinking water, toilet facilities and food storage facilities. Some of them are functioning in open area also. Apart from that, we are not getting medical kits on time; we do not have weighing machine at the Anganwadi Centres. To monitor child and pregnant lady's growth, we have to go to the CHC for weighing them. I am from Chandaur Village and it is situated around 12 km. away from CHC. In this situation, we have to face a lot of difficulties to accompany the pregnant lady or child with mother for weighing"* (ANM, 12 March 2017, Mayang Village).

Additionally, the limited number of supervisors is another concern. Although, in the Dhanpatganj, there are enough numbers of Anganwadi workers and Anganwadi helpers, but shortage of supervisors is also a matter of concern. As shown in the table, the sanctioned post of supervisors is 6 out of which only two supervisors are operational. The lack of adequate number of supervisors (also called Mukhyasevika) results in increasing the workload of other supervisors. Shortage of Supervisors in the block is also responsible for the lack of better quality of supervision and monitoring of the Anganwadi workers.

A Mukhya Sevika stated about her duty that:

> "*Normally a supervisor supervises about 20-25 Anganwadi workers under her but here at Dhanpatganj block only two supervisors are employed due to which we have to supervise about 96 Anganwadi Workers. Providing guidance to them, monitoring their work and checking the lists of the beneficiaries given by Anganwadis is really a tough job. We are doing this hectic job without any extra money. Government*

should give extra incentives for making us work extra." (21 March 2017, Dhanpatganj Block)

Anganwadi worker of SC caste stated-

"*Dalit basti is situated separately especially outskirts of the village. This scenario is almost same in the other dalit basti of other villages too. Due to this we face lot of inconvenience in accessing the various services. The road as you see is kachha and even broken. In this situation we face wide range of problems in reaching one house to another house and also to the health centre and ICDS office to submit the form*." (Dikhoura Village, March 2017)

Shortage of the health personnel and community health workers is a major reason for underutilization of the health services and thereby of the low coverage of the schemes.

4.7 Shortage of Equipment

Under the nutrition programme of ICDS focus is given on growth monitoring and nutrition surveillance for children up to the age of six and also for expectant mothers. It was found that baby weighing machines were absent in 26% of AWCs audited and adult weighing machines were not available in nearly 58% Anganwadi Centres. The findings also show similar result of our study. Most of the AWW centres are functioning without proper equipment like as weighing machine, lack of growth cards, books etc. for children. Due to shortage of equipment, monitoring of the growth of children as well as pregnant women are effective and hampered due to the poor and inappropriate access of the equipment in the block.

4.8 Medicines

Availability of medicines is also an important factor that decide the utilization of the health services on part of the people. Unavailability of the medicines is one of the major reasons that increase the cost of health services of the poor.

Majority of the patients say and also on the basis of the observations it is clear that around 60% prescribed medicines are from outside of health centres.

Researcher found that Sub-Centres and Additional PHCs do not have adequate stock of medicines. Although pharmacists said that they had sufficient availability of the drugs, but after requesting to show stock of the medicines it was found that there was limited quantity of the stocks. Apart from the user fee of INR 2 charges for prescription, government health centres are supposed to provide medicine for free.

As per one of the pharmacists at one of the sub-centres, *"Did you see the sub-centres first time? Health centres are very much like this in village. Government cannot open a multi-specialty private hospital for the poor"* (Manmohan Prasad, 48 Years old Pharmacist of Sub-Centre of Anjer Village, 2 May 2015).

Asking about the availability of the medicines at sub-centres, a respondent said:

"*Yes, in the sub centres here you get medicine for cold, cough, fever, diarrhea and other such illnesses. But the medicine is free just for the sake of saying. The pharmacists who give these medicines ask for money from us. They often say if you buy medicine from the pharmacy you will have to pay. Add to it the bus fare because we have to go from one block to another which is at least 6-7 kms from here. We are helpless, so we pay*". (12 January, 2017, Pipargaon Village)

Another respondent Raziya, 29 Years Old Muslim women stated that-

> "*At the CHC, there is always a long queue of the patients. We have to wait long time for our turn. Due to the long list of the patients, doctor give you hardly 2 minutes and prescribed medicines that we have to buy from the chemist shop outside of the CHC. This* long queues *in the* hospitals *resulted in losing the day's wages of ours. If we have to give charges in the*

government hospitals and also due to long wait then there is no need to we visit the government hospital". (Raziya Begum, 17 February 2015)

From the in-depth interview with the CDPO of the programme as well as community health workers and from the beneficiaries, it has been found that there have been a number of structural problems that are responsible for low coverage of the schemes. All these factors responsible are discussed under the theme and sub-theme given in the next chapter.

Conclusion

The above discusses elucidates that there are several factors that are responsible for the low coverage of the IGMSY scheme and corruption is one of the leading causes that makes this scheme weak. IGMSY scheme is functioning under ICDS programme implemented through Anganwadi Centres to address the issues related to the pregnant and lactating women. But this study highlights the gaps between policy formulation and implementations. From the findings of the field study, several problems have been found to hamper the objectives of the scheme. Issues related to administrative and structural problems, block level corruption, inappropriate information, delay in payment etc. are the responsible factors that impact the quality implementation of the scheme. Without addressing these issues, success cannot be achieved.

Lack of required number of infrastructures and basic health facilities, shortage of man power are some other major obstacles that prevent poor and needy people for accessing the health services.

Overworked due to the shortage of the staff results in administer doing the multiple tasks. The lack of staff acts as a hurdle in smooth functioning of the scheme. In addition to this, the multiple formalities of the scheme lead to exclusion of the beneficiaries. In order to get a deeper understanding of the functioning scheme there is a need to understand the beneficiaries' views regarding obstacles in availing the scheme.

Chapter 5

Cash Transfer Schemes: Effectivity and Challenges

This chapter aims to underline the experiences of women who are beneficiaries of the IGMSY schemes that have given birth in institutions. In this chapter, the researcher examines the cash incentive programmes that have been introduced by the Central government. Apart from that, it also focuses on the quality of service, direct & indirect expenses incurred on institutional child birth and the perspectives of the beneficiaries regarding the said schemes.

Through in-depth interviews, primary data was collected to meet the objectives of the study. This information was used to assess the advantages of conditional cash transfer schemes which have been implemented in the Dhanpatganj block of Sultanpur districtof Uttar Pradesh.

Research reveals that there have been several conditional cash transfer schemes initiated by the government like JSY and IGMSY for those who cannot afford institutional delivery but from the available literature as well as the data from my study we find that these schemes are neither well managed nor do they function properly. People face lots of difficulties in public hospitals due to their unwillingness to visit government hospitals, because of which they cannot avail these schemes.

In this analysis chapter, the problems have been categorized into four themes and further sub themes for a better understanding. These themes emerged from the interviews and have been presented in the following table. These include the conditional cash transfer schemes that have financed to the institutional deliveries, reasons for low coverage of the scheme, administrative constraints of the scheme and financial constraints of the IGMSY. This further categorized into sub-themes that include reason for low utilization of the health services, health services accessed by the beneficiaries and the experience in accessing the scheme etc.

Theme 5.1. Scheme that have Financed the Institutional Delivery

As per a discussion with the MO (Medical Officer) and CDPO (Child Development Programmes Officer) there are two schemes 1. Janani Suraksha Yojana and 2.Indira Gandhi Matritva Sahyog Yojana currently are functioning in the block Dhanpatganj that finance institutional deliveries for poor women. The scheme JSY was implemented in the year 2005 and the IGMSY scheme was introduced in the year 2012. Both the conditional cash transfer schemes provide cash incentives after their conditions are met. Apart from those schemes, there was a scheme MGBAY (Mahamaya Garib Balika Ashirwad Yojana) that also provided money for those who had delivered a baby girl at health institutions. The scheme was launched in the reign of the former chief minister of UP, Mayawati but was stopped off after she left office.

As per the CDPO of the Block,

> *"This MGBAY was functioning better as compared to IGMSY scheme. Under MGBAY, there was the provision of giving the fixed deposit of INR 20,000 for the first girl child of the BPL or Antodaya card holder families. As per the rule of this scheme, this would get only to the daughter at the age of 18 (eighteen) years when she would not get married. But after the tenure of Mayawati, the scheme has stopped functioning now. I believe, if any scheme is functioning better and provide advantage to the most of the target population; it should not be banned even after government has changed"* (CDPO of ICDS of Dhanpatganj block, 10 December, 2015).

5.1.1 Coverage of JSY and IGMSY scheme

The researcher found that the coverage of IGMSY scheme was very low as compared to JSY scheme. As it was earlier explained also, that in the block during the period of 2014-15, total number of institutional deliveries was 2,480 while out of this number 1,785 were the beneficiaries of JSY who got the incentives. But during this period of time out of 2,480 institutional

deliveries, only 53 got IGMSY' incentives. It is clear that in the block JSY is a better functioning scheme as compared to IGMSY. These conditional cash transfer schemes are meant for the poor who cannot afford to miss their wages due to the pregnancy and work till the last stage of their pregnancy and give low birth baby due to the low nutritional level. But from the field it has been found that a large number of eligible pregnant women and mothers were not enrolled in the IGMSY scheme. Even those who were enrolled in the IGMSY scheme, majority got half or one instalment only.

Table 26, Percentage of Respondents Who Got Amount of the Scheme

No. of Respondents (53)	Amount of scheme	Percentage (%)
7	4000	11.32
1 3	3000	24.52
33	1500	62.25

Source: Based on Primary Data, 2015 July, Dhanpatganj Block

In the fifty three beneficiaries, only seven (7) got the full amount (INR 4000) of the scheme while thirteen (13) got three thousand (INR 3000) and rest (33) were got INR. 1500 only. Data shows the very low reach of IGMSY scheme while from the interview, it was found that all of the beneficiaries got the JSY amount except four (4).

Though, the government of India has launched these two conditional cash transfer schemes for increasing institutional child birth by giving monetary assistance, it has been found in the study that the amount of money is less to cover the all expenses of hospitalization. Moreover, as shown in the above table, the full amount of the IGMSY scheme was not given to beneficiaries except a few.

One of the reason for not getting the full amount of INR 4000 promised by the scheme, the researcher found after interviewing the mothers was that they were not receiving full antenatal and post natal check-ups (that would be three

visits of antenatal care + one tetanus toxoid injection and 100 iron folic acid tablets/ syrups).

This is the one of the criterea of the scheme and after completing these criteria, beneficiaries will be entitled to the second and third installments of the IGMSY scheme. But due the irregular supply of the drugs as well as lack of information given by the Anganwadi worker and ASHAs, people are not getting the whole money of the scheme.

In this study, when the researcher asked the mothers who had delivered a baby in the health institutions about their view of the schemes, most of them complained about the inadequate amount of money of the scheme and to afford all the expenses they paid from their own pocket that has negative impact on them. The findings also demonstrate that, in the rural areas, those who suffered a lot are lower castes, i.e. scheduled castes or other backward castes. They face discrimination in availing various services which is actually meant for them. They are still discriminated by the upper caste of the village, despite the government talking about equality. Contrary to the claims of equality, these castes face discrimination and have hardly got any services without being targeted by the upper castes. Therefore, it is necessary to discuss the women's (beneficiaries) socio-economic profile to know the better understanding of the issues that have been faced by them.

5.2 Socio-Economic Background of the Beneficiaries

a. Social Groups

This section provides the socio-economic background of the 53 beneficiaries of IGMSY those are from the age group of above 19 and 49 and have only one or two children. Out of 53 beneficiaries, 45 women were Hindu and rest eighteen (18) were Muslim. Out 45 beneficiaries, majority (28) of them from SC, followed by OBC (19) and 6 were from general category. Majority (47%) of the beneficiaries had no formal education but knew how to write their name, followed by 34% having primary level education and only13% beneficiaries had middle level education.

b. Social Hierarchies and Discrimination

During the field visits, researcher found that most of the villages are deeply divided on caste lines. The backward castes and dalits are marginalized in access to basic facilities. In the Dhanpatganj block of Sultanpur, Kutta-I, Majhwara, and Lohangi are the Ambedkar villages where there were no facilities of drinking water, no toilets in the houses. People use the sarkari nal (hand-pump) for their daily work and used to open defecation.

Chamar and Mehtar belong to SC caste and found lowest in hierarchy. People from other caste do not eat in these sub-castes' house. Even Nai by sub-caste of SC group does not like to go to the Mehtar and Chamar' house. They are the most discriminated sub-caste in the Block.

A woman (Meera Devi, SC) stated that, "*I am from Mehtar sub-caste and work in the house of upper caste. I use to work cleaning their house but I am not allowed to enter their pooja ghar and kitchen area"*. (Meera Devi, SC, 13 February, 2016)

From above incidents one can see that lower caste people get discriminated by upper caste people, despite being of a better economic status.

Within the SC caste, Mehatar and Chamar sub-caste people suffer a lot of discrimination by the other castes as well as the same caste. People from the other caste do not want to eat in their houses and do not even enter their house and live in segregated area in their own village. Thus we can see here that there is also a hierarchy within the Schedule Caste group.

In comparison to the SC, OBC caste, Yadav and Patel found are in better conditions. They lived in pucca house and had regular income in Dhanpatganj block.

c. Income of the Beneficiaries

It has found that income as an important determination of health seeking behaviour and also found that within the low income group those are most

vulnerable has most negative impact in utilizing the health services. There is an association between health and income.

Table 27, Average Income of the Respondents

Monthly Income in INR	No. of Respondents
1000-3000	32
3000-6000	14
6000 and above	7
Total	53

Source: Based on Primary Data, 2015

The table 5.2.2 on the monthly income of respondents reveals that, out of 53, only 32 had earned in the range of 1000-3000 in a month. 14 had earned in the ranging in between INR 3000-6000 and only 7 had earned around 6000 and above.

The first group of beneficiaries are self-employed and work as preparing baskets and mats, street vendors who sell fruits and vegetables etc. The second group included mostly daily wage labours whose monthly income on an average was in the range of 3000-6000. In the third group those beneficiaries have been included who work of the cultivation on other's land and earned between 6000 and above in a month.

> *One of the beneficiaries stated that, "When I was pregnant and during delivery, my husband was not having any regular income and he is the sole earner of my family. We have struggled to get even one time meal as there was no regular source of income. Our family income was not even INR 1500/-. In such condition, how we have managed and bore the expenses that only we know."* (Madhu, 27 Years old, OBC, Kutta II Village of Dhanpatganj Block of Sultanpur, 8 August 2016)

5.3 Reason for Low Utilization of the Health Services in Dhanpatganj Block

Researcher found during field visits that in Dhanpatganj block, the number of pregnant women had registered in IGMSY scheme in the year 2014-15 were 2300 while only 53 women got incentives of the scheme and out of 53 beneficiaries majority were got only one installment of the scheme. Despite the incentive that has been given under IGMSY is large as compared to JSY scheme but the coverage of the IGMSY scheme is very low as compared to JSY scheme. Researcher found several factors that are responsible for the low coverage of the scheme. One of the determinant factors are low utilization of health services by the pregnant women. The reason for less utilization of government health institutions are many such as poor quality of health services, lack of drugs and laboratory, shortfall of the health staffs and direct and indirect expenditures of institutional delivery, bribe.

5.3.1. Quality of Services

Around 20 individuals expressed the same opinion about the quality of health services in the CHCs. Out of 20, 9 respondents complained that in a government hospital, the quality of health services is very poor. This is due to unavailability of doctors and health staff support, long queues, lack of cleanliness (in terms of hygiene and sanitation). Most of the women complained that the beds of hospitals were very unclean and that the bed sheets were never changed. As per one woman who had delivered her child in a government hospital:

> *"Doctors' unavailability and lack of punctuality was the big issue to deal with. They do not come timely or regularly to see their patients. Even other health staffs do not come when they are called until and unless you have requested them again and again to do so. These are some of the reasons which people turn towards private hospitals even though, they don't have the money. Most of the people believed and experienced better facilities and services in terms of doctor's support in a private*

hospital as compared to a government hospital. Though private hospital costs more in comparison to the public hospital but their quality of service is quite appreciable." (Angoori Devi, 32 Year Old, SC, Anjer Village of Dhanpatganj Block of Sultanpur, 18 November 2015).

11 respondents complained of the lack of drugs and equipment in public hospitals. According to them, doctors would always prescribe costly medicines which were never available at the government hospitals and could be purchased only from the chemist shop outside the hospital. Staffs also identified that irregular and insufficient drug supply forces the doctors to prescribe medicines that can be procured from private medical shops outside the hospital. Apart from that, malfunctioning of the laboratory is another barrier that prevents the patients from going to public hospitals.

ASHA told that,

"Generally, CHC is overcrowded. People are used to avoid going to the government hospitals. I remember I took a 6 months pregnant woman to the CHC for examination after a sudden pain started in her stomach. There we had to wait for two and half hours. After two and half hours, doctors examined her and told her that she needed an ultrasound test. They asked her to return next day with the ultrasound report. Since there was no ultrasound machine in the hospital therefore she had to get it done from a private laboratory. But the woman did not go to the hospital the following day due to the long distance (15-16 km) of the government hospital from her house. When I asked her why she did not come to hospital next day, the pregnant woman said that if she has to bear the ultrasound expenses from her own pocket by going to a private hospital then there is no advantage of going to a public institution. She (pregnant women) asked me "You tell me I only go to the CHC just for showing my report by covering that much distance? I

have done the ultrasound from a private pathology and diagnostic centre and show to private doctor that was situated near my home." (ASHA, Majhwara village, 29 January 2016)

5.3.2 Lack of Receiving Full Antenatal Check-Ups on Time

Antenatal care services helps to identify the serious problems and complications during pregnancy. Therefore to reduce complications related to pregnancy, pregnant women should have at-least 3 ANC check-ups during their trimesters. Under the 3 ANCs check-ups, the weight of the pregnant women should be measured, the blood pressure (BP) should be monitored, measurement of the haemoglobin level etc. But field findings of the study show that, most of the pregnant women had not received full ANCs check-ups. Some causes were found for not receiving full ANCs check-ups that have been given in the next section.

a. Distance

Data shows that the percentage is high in those pregnant women who stay less than five (< 5) km away from the public hospitals. On the other hand those who lived more than (< 5- 10) km had a lower percentage of them getting full ANCs services.

This complaint was reported about the JSY scheme also. Under the scheme, ambulance services 108 as well as 102 are provided to pick the pregnant women from her home and there is also provision to drop her back from the hospital. However it was found that the women were picked from their home only if their houses were not located in the interior and the facility of being dropped back home was not given to poor women by the ambulance services.

A respondent, Kiran Kumari from SC caste stated that, "*You can see the condition of this village; the roads are in a very bad state. It is difficult to travel on foot here then how do we expect a vehicle to ply on such roads. The Anganwadi worker who is from a different village hardly comes here.*

Whoever has a problem has to travel to her somehow, as it is them who is in dire need of her (Kiran Kumari, 29 Years old, SC, 18 August, 2016)

b. Road Connectivity

Absence of proper road connectivity was found to be another cause for low level of ANCs check-ups. In those villages where continuity of transport was available, pregnant women were more likely to get ante-natal care services as compared to outskirt villages where no transport facilities were available.

Saroj from Anjer village of Dhanpatganj block stated to the researcher the condition of her village that have been given in following lines:

> "*I reside in the Anjer village which is situated around 10-15 Km far from the CHC and in this village there is no sub-centre. There is no private clinic and to access the private hospital we have to travel at least 5-7 km from our village. The road is kuccha and balua because of this; vehicle cannot reach in this village due to the poor condition of the road. My husband goes to their work by cycle. There is no one except my husband who accompany me to visit the health services. In this circumstances, how we manage to visit health centre for antenatal care and taking medicines*". (Saroj Kanaujia, SC, 35 Years Old, 5 March, 2016)
>
> She further said that, "*We pray/wish that Mayawati becomes the Chief Minister. On her becoming the Chief Minister, it will lead to our betterment. As no one else can understand our problems otherwise*" (Kiran Kumari, 29 Years old, SC, 18 August, 2016).

c. Work vs Health Care: The Difficult Choice for Women

In the study, it was found that majority of the women were either wage labours or working on the field. Some of the women were maids who worked in the

houses of other people. In such a situation women could not miss afford to miss work.

Table 28Distribution of Respondents' Occupation		
Occupation	Frequency	Percentage
Agricultural labour/maid	15	28.3 (28)
Daily wage Labour	24	45.23 (45)
Housewife	10	18.86 (19)
Other (Street Vendors)	4	7.5 (8)

Source: Based on primary data, 2015

The table28, shows that around nineteen percent women are housewives while eighty one percent women were working to support their families. Data shows that majority of the women are daily wage labourers. In such situations, women did not go for antenatal check-ups due to the fear of losing a day's wage. Threat of unemployment or job insecurity was found in most of the respondents.

5.3.3 Lack of Trust

Apart from quality of health services, researcher also has taken interview of those respondents who accessed the private health institutions because of the perception of better health care.

One of the respondent's husband Nandu who belongs to the OBC category, shared his experience of opting for a private instead of a government hospital for his wife's delivery:

> *"I admitted my wife into a private hospital, as we (I and my wife) lost trust in the government hospitals. During the birth of our first child, what doctors and nurses did with my child that my son has become paralyzed now? I don't know, it was the reaction of expiry medicines or injections they have injected into my son. This is the main reason for losing faith in the*

> *public hospitals. Thus, I took my wife into a private institution where my second child was born and he is totally fit and fine which further strengthened my belief in private hospitals.We poor people are uneducated and can't read and understand and if government hospitals give wrong or expiry medicines then we can't do anything. Therefore, I believe that private hospital treat you well and properly as they charge for the whole treatment"*(Nandu, 38 Years Old, OBC, 28 January, 2017).

Apart from the hospitalization, some women did not want to take the services of ANC also because they believed that pregnancy is not a disease which needs check-ups by a doctor. A woman stated that, *"In earlier days who'd go to these hospitals? This is not a disease that you have to cure it. If there is some problem then one can go to Health Centre or Anganwadi Centre otherwise what's the use? Children were born without all this before as well. Now there are these doctors, earlier all of this would be done by the Dai"* (Laxmi, 23 Years old, OBC, Lohangi Village of Dhanpatganj Block of Sultanpur, 29 August, 2016).

The researcher found after cross checking the data that in one village (Pipar Gaon) of Chanpatganj block, most of the pregnant women were not getting ANC services. After speaking with several women it was revealed that an incident had happened.

A woman stated that:

> *"In our village a baby boy was dead due to the carelessness of the ANM. One day, the mother of the boy went to the ANM for baby tika (immunization), after that, the baby had a sever fever and after two days he was dead. It was a fault of the ANM that the baby developed a fever and died. There was a lot of tension during that time because of which the ANM had to leave. Another ANM comes sometimes now but after that no one*

wants to visit her". (Jugani Devi, 38 Years Old, SC, 21 July, 2016)

5.3.4 Doctor's Behaviour in CHC, & Other Public Hospitals

According to the villagers of Dhanpatganj block, the behaviour of the doctors as well as health staffs of the CHC's is very rude. Doctors often scolded the poor patients rather than explaining things politely to them. The villagers were verbally and physically abused.

> *"I remember my delivery, as I was pregnant for the first time I was very scared. At the time of delivery the staff nurse was shouting abusively at me. Further she commented at me, "Now you've become so shy in front of me, why did you not show this when you got pregnant?"* (Reema, 23 Year old, OBC, 19 June, 2016, Lohangi Village)

The mother-in-law of the lactating mother said that *"We poor people depend on government hospitals, so that is where we go. We'll have to bear however they treat us"*. (Ranno, 30 Year Old, SC, 20 November, 2016, Dehli Bazar Village)

She further stated that:

> *"In district hospitals, doctor's behaviour is completely unbearable. They never pay proper attention and care to their patients. They become silent and rude when patients ask questions related to their problems. Sometimes they even scolded them for asking questions. But poor people bear all this as they have no other choice*" (Ranno, 34 Year Old SC, Majhwara Village of Dhanpatganj Block, 18 February 2016).

Another respondent narrated that:

> "*In a private hospital, the scenario is totally different. Doctor's behaviour varies according to the patient's standard of living.*

If the patient belongs to an economically well off family, then doctors take them as first priority and devote all their time and attention for their care and treatment. If patients, who cannot afford bill and hospital charges approach doctors for a concession in the bill, they becomes very rude". (Ram Prasad, Nai by Sub-Caste, 31 Year Old, 4 February, 2017, Dehli Bazar)

5.3.5 Environment of the Delivery Room

The researcher found most of the time the sub-centres of the block to be closed. Only two sub-centres were open and those too were poorly maintained in regards of infrastructure, equipment and cleanliness. The condition of one sub-centre's delivery room was pathetic the floor was filthy with blood spots, dirty clothes, used blades and syringes were openly thrown, there was no sheet on the bed, a torn and dirty curtain hanged in the room. The conditions of the additional PHCs were more or less same.

The condition of the CHC' delivery room was better as compared to sub-centres and APHCs but the environment of the delivery room was very chaotic. The researcher observed that people were talking loudly and continuously moving in and out. During interviews with staffs, it was found that irregular power supply and unavailability of power backup was a major problem of the CHC.

5.4 Cost of the child births (including Direct and Indirect out of pocket expenditures) in public

5.4.1. Direct and Indirect Expenditures

From the various interviews it was found that at the time of hospitalization for child birth, people pay from their own pocket and that some of these expenses are direct while others are indirect expenditures. Direct expenses include the cost of medicines, user charges, charges for diagnostic tests and miscellaneous charges of such nature. Along with these they have to pay for transport, loss of income, food and lodging charges, tips given to the health staff during

delivery, interest of loan that have taken from the money lender or relative and neighbour. Poor have to bear all these expenses from their own pocket as they have no other options. Even in my earlier study shows the same findings. These costs further caused weaker financial situation for poor households. Expenditure on medicines as a direct cost along with indirect cost really scaled up the entire cost of the delivery. In the field, researcher came to know that the ratio of the direct and indirect expenditure of birth is 1.6 for the Normal delivery which not a small ratio and while the ratio of direct and indirect expenditures is huge in caesarean section found 2.3. This situation exists in spite of the fact that some conditional cash transfer scheme has been supposedly implemented for the poor.

> *"One of the respondents Shyama Devi said that though these government hospitals are meant for us (poor) and provides free of cost treatment but that happens only on paper. These public hospitals also collect money from us for providing their services".* (Shyama Devi, Pipargaon Village of Dhanpatganj Block, 27 February 2016)

Table 29 Direct and Indirect Expenditures in Government Hospitals for a Normal Delivery (n=48)

Direct and Indirect Expenditures in Government Hospitals for Normal Delivery in Dhanpatganj block			
Direct Items	Average cost in INR	Indirect Items	Average cost in INR
User Fee	5	Loss of wages	262
Drugs	1020	Transportation cost	350
Pathological and diagnostic charges	1580	Cost of food for patient and care giver	250
		Tips	450
		Interest of loan	6%

Source: Based on Primary Data, 2016

Table 30 Direct and Indirect Expenditures in Government Hospitals for Caesarean Section (n=5)

Direct and Indirect Expenditures in Government Hospitals for Caesarean Section in Dhanpatganj Block			
Direct Items	Average cost in INR	Indirect Items	Average cost in INR
User Fee	5	Loss of wages	840
Drugs	2830	Transportation cost	689
Pathological and diagnostic charges	3332	Cost of food for patient and care giver	546
		Tips	450
		Interest of loan	6%

Source: Based on Primary Data, 2016

It has found from the data table 29 and 30 that all beneficiaries of the IGMSY scheme were related to the public hospitals therefore in-depth interviews were taken of those who have delivered child at government hospitals. As in the given tables of direct and indirect health expenditures in government hospitals for institutional delivery, it is clearly visible that the cost of drugs and pathological tests are more or less the same. There were huge differences between the money that was spent on drugs in normal delivery and caesarean section in the government health institutions. However it was found that drugs and the facility of diagnostic tests were not available at government hospitals, people had to purchase medicines from outside the public hospital from their own pocket and also have get done diagnostic test from the private laboratory which is around 4-5 Km far away from the CHC.

If we talk about the direct and the indirect expenditures especially in loss of wages of the patient as well as care givers, it is more in caesarean section in the cases of public institutions. It is because of the longer stay in the hospitals and also complicated case has been referred to the district hospital. District hospital is in main Sultanpur city which is situated around 30-35 km from the Dhanpatganj block but it seems more than double distance due to poor road condition and road pit. Patient as well as the person who accompanies the

patient has to stay in the hospital which affect their income. The other indirect cost that has to be borneby the patient is transportation cost despite the fact that there is a provision of INR. 250 to the ASHA for bearing the transportation cost of the patient. But in the field it was found that almost every patient has paid money for transportation from their own pocket and on top of that for ASHA also. Bribes and commissions (tips) are very much prevalent in government hospitals Bribe for admission in a government hospital by the ASHA, ANM, AWW and other health officials, tips for conducting child birth which becomes even more if the child born happens to be a boy.

One of the respondents Sharla stated,

> *"I delivered a baby boy at the CHC. ANM wanted to charge 500/- as she said "It's a boy, I won't accept less than 500" but at that time I had only 1000/-. In INR 1000 I had given INR 250 to the ANM with this assurance that rest will give very soon. Cost of the medicines was around INR. 700 as all medicines were prescribed from the outside. Dai had also asked me to give at least INR. 200 but I had only given her INR 150 as only this much amount was left. I had no money left to reach home therefore I had to borrow money from my neighbour who had come with me"* (Sharla, 27 Years old, SC, 14 September, 2016).

Above mentioned expenditures are related to the institutional delivery. Apart from that, there were also several indirect costs that have to be bear to the beneficiaries in availing the scheme that has meant for them. It has found from the field study that people has to pay to avail the benefit of the scheme. They have to pay from starting that is in enrolling in the scheme to getting the incentives of the scheme. This has discussed in further section in detail. Along with that, to get a better understanding of the scheme's functionality, perspectives of the beneficiaries have been given who described their own experiences regarding the scheme.

5.4.2 Coping Mechanism

From the interviews the researcher found some coping strategies used to bear the cost of child birth that could not be managed through the income of poor people. The dominant key strategy for bearing these expenses was found to be taking a loan. Around 66% of the study participants had financed their hospital bills by borrowing money. Table 31 depicts the number of respondents who took a loan for institutional child birth.

Table 31, Borrowing of Money among Villagers Opting for Institutional Child Birth

Source of money (Coping mechanism)	No. of respondents	In percentage (%)
Borrowing money from local money lender+ Gram Pradhan(loan)	35	66%
From friends, relatives and neighbours	11	21 %
Sell the assets	7	13%

Source: Based on Primary Data, 2016

In the study, the researcher found around 66% of the women's family had borrowed money from a private money lender. The interest on the loan was around 4-8%. This was because of the lack of knowledge of bank and various formalities of the government banks which force the poor family to turn towards local money lenders. 21% of the families borrowed money from their friends and relatives while around 13 % of the households sold their assets like lands, jewelleries, animals or compromised with their basic needs like cut down their food consumption, dropping their kids out of school and so on.

*"*After asking about how she managed the expenses of institutional delivery, Mamata, 29 year old woman, said that, *"We have to forego our food. Often, we would remain without food and giving our child starch water of the rice instead of milk. To bear the expenses of institutional delivery, sometimes we have to stop sending our children to school."* (Mamata, 29 Years Old, General, 20 November, 2016)

Apart from that, in the study one of the respondents had sold their animal to repay the cost of institutional delivery institutional delivery.

> *"My mother-in-law and I make baskets, mats and some handmade utensils but it was not always like this. Earlier we had our own cow and we used to sell the cow milk to feed our family. But at the time of child birth, we failed to arrange the cash. Therefore we had to sell our cow, the only source of income for our house. In a hurry, the cow was sold at half its price at INR. 15,000 while the actual price of the cow was around INR. 40,000. Though I got IGMSY scheme's amount but it was not enough to afford all the expenses of the hospitalization. These hospitalization costs have taken our only means of earning (ek matra rozi roti ka sadhan). In the future we will not go to the hospital until and unless there isan emergency"* (Suku Devi, 41 Years Old, Malin by caste, 23 August, 2015).

Champa Devi's son Ajay, whose net daily income of INR. 250-300 with a rented auto-rickshaw was the only source of income for her family of four, including her daughter and daughter-in-law. Once her son got unemployed because of Jaundice, she and her daughter started to sustain their family by working as maidservants. She also took a loan of INR. 10,000 from Micro credit Agency to cover Ajay's medical expenses. She and her daughter used to work in 2 and 5 homes respectively to earn INR. 1050 per month with an average of INR 150 per month per house..

> *"Out of severe labour pain, her pregnant daughter-in-law Rani was taken to the nearest Community health Care (CHC) which is 5.2 km away from her home. Doctors of CHC referred her to the nearest district hospital (which was unfortunately 18-20 kms away from her home) for successful delivery by Caesarean section. Champa Devi could not take Rani to the district hospital taking into account Rani's poor health condition and*

inefficiency of District hospital doctors (Source: Neighbours). This situation has forced Champa Devi to borrow an additional INR 15000 from local money lender, out of which INR. 13,000 was utilized for Rani's Caesarean section at a private hospital. She is now suddenly trapped in an unexpected economic crisis due to her son's illness and Rani's caesarean delivery has led her into huge loans. She has promised to pay an equated weekly instalment of INR. 200 and INR 300 for INR 10000 and INR. 15000 loan respectively for 52 Weeks. To repay the entire amount, she and her family members have cut down their diets and started searching for more jobs of maid servants to repay the loan as early as possible" (Champa Devi, 50 years old, Dhobi by Sub caste, 8 February 2015, Anjer Village of Dhanpatganj Block).

In the village there is no bank that could provide loans for child delivery or for personal needs. Most of the people (BPL households) have taken loans from this above mentioned finance group. This group only gives loan for generating income and employment. The villager also do not want to take loan from a bank, as according to them there are lots of formalities that need to be fulfilled which takes not only takes time but are also very cumbersome. Therefore, they borrow from these finance agencies.

It is quite clear from the interviews with the respondents, that the expenses of child birth in health institutions are not affordable for poor people. It adversely affects the BPL households. Due to lack of liquidity to bear these expenses, they borrow money from their relatives, friends and local money lenders in the village and end up amassing huge amounts of debt. Situations worsen to the extent of forcing them to sell their assets like land and other sources of capital for instance auto rickshaw, animals, jewelleries and so on for the repayment of loans.They forsake their essential needs such as food, clothing and education of their children to clear their debts.

"Amar Nath, who is a daily wages labourer, narrated his critical condition. In order to bear the cost of delivery of his

child in a private institution, he had borrowed money from the Gram Pradhan. Due to a complication however, his wife was hospitalized. To bear all the expenses, he had to ultimately take a loan from the Pradhan of the village at an interest rate of 8% which was normally higher from the local money lender. But that day the local money lender was not there in the village, I had taken a loan from the Gram Pradhan. It has become a great burden on him". (Amar, 28 Years Old, SC, 19 July, 2016).

One of the respondent's husband said,

"*I am a wage labour; sometimes I get work, sometimes not. Chances of getting job is slightly higher in the peak time of Diwali or the wedding season as I am a painter but rest of the time, half of my time is spent lookingfor work. In this case, it is difficult to pay all instalments of the bank on time if I had taken loan from a bank as I've heard that all instalments of the bank should be paid on their given time"* (Deena Nath Mishra, 34 Year Old, 9 of February 2016, Anjer Village of Dhanpatganj Block).

The villagers do not want to take a loan from the bank, as according to them, there are lots of formalities that need to be fulfilled which not only take time but are also very burdensome. Therefore, they take loans from a private money lender.

5.4.3 Informal Payment (Bribe and Tips)

Bribe is one of the most important problems that are prevalent in the public institutions when it comes to accessing the health services. Available data suggests that large number of respondents reported that they had to pay bribe to avail services of health institutions that are ironically meant for the poor to be had at no cost.

In the period of the field visits, the researcher found that bribes play a vital role in availing benefits under the government schemes (JSY and IGMSY) as well as getting patients admitted into a hospital. Villagers were mostly deprived of the schemes whenever they failed to pay the money.

People reported that they have to pay bribes to ASHA, Anganwadi worker, Gram Pradhan, village secretary etc., for availing benefits guaranteed under above mentioned schemes. The following case study shows how they have to pay money to access public institutions.

A woman narrated her experience:

"In the hospitals you have to give money from the beginning till the very end and if you will fail to arrange the money then they (health staff especially nurses) treat you very badly. She even asked a nurse if a government hospital is meant for providing free of cost health facility for them. The nurse told her very rudely that "the cash incentives programs are also meant for you people. You take benefit from this hospital as free of cost health services and also get incentives from those schemes; do you think that we (nurse) are sitting here to serve you for free?" (Gudiya, 24 Years Old, OBC, 26 December 2016, Mayang Village of Dhanpatganj block).

5.5 Caste as Constrained

The evidence from this study shows that caste is another reason for low coverage of the scheme. In some of the villages of the Dhanpatganj block such as Kutta, Mayang, the health provider especially the ANMs were from an upper caste and did not visit the villages regularily especially the Ambedkar villages. They do not provide regular health services to the women who belong to the lower caste and this becomes worse when the women happen to belong to the Mehtar subcaste of the Scheduled caste.

Munni, one of the respondents told that health providers never visited their houses (as Mehatar houses are situated on the outskirts of the village) *"When ASHA didi or ANM ji pass near our village they only inform us to come to the health centre but they hardly come close to us or do complete check-up of our*

body or of our children. They only come along with the government doctors and other government officers when they are on field visits" (Munni, SC, 25 January 2016, Pipargaon Village of Dhanpatganj Block).

She further stated that,

> *"Once I went to the health centre for my routine check-up. Sheela Singh didi (ANM who was from upper caste) was present in the health centre. She was continuously talking over the phone for the last one hour during the duty hours and when I asked her to please do my check-up, she said in a very rude manner "Don't you see, I am busy?..so just wait" and she started to chat with the others. I waited for one and half hours till the other nurse came."*(Munni, SC, 25 January 2016, Saraigokul Village of Dhanpatganj Block).

While on the field, when the researcher was trying to find out another household of the beneficiaries, a woman (Rajkumari Devi, 28 Yrs old) narrated her story about why she did not get the JSY scheme.

She said that:

> *"She is the only Yadav, living in Majhwara village of Dhanpatganj block due to which she faced a lot of problems. Other households in the village are from SC (Scheduled Caste) especially Mallah by sub-caste except two (Gram Pradhan and Sansad) who are Rajput by caste. Most of the SC families work on the land of the Pradhan and are also used for personal work (like bringing alcohol for the Pradhan as well as Mantri ji). This is neither our work nor will we do it. Due to this, my family and I are an enemy to others. Even ASHA (who also belongs to SC caste) does not visit our home. We don't even know anyone at the CHC. This was the main reason for choosing a private clinic in spite of the government health*

centre" (Rajkumari Devi, 28 Yrs old OBC, Mayang Village of Dhanpatganj block).

It is clear from the above mentioned incidents that lower caste people suffer a lot due to their caste. They get discriminated by upper caste and does not want to help even for the help related purpose.

5.6 Administrative Constraints of the Scheme

Above mentioned expenditures are related to the institutional delivery. Apart from that, there have been noticed some administrative constraints related to the scheme. From the in-depth interview with the CDPO of the programme as well as community health workers, it has been found that there have been a number of structural problems that are responsible for low coverage of the schemes. All these factors responsible are discussed under the sub-theme given in the next section.

There are multiple challenges in the provision of the better quality of the maternal health services some of the practical issues regarding IGMSY were discussed from the CDPO and with other health officials.

As per the CDPO:

> *"The real issue is that even if this scheme is designed to give compensation for wage loss to those pregnant women who work till the last stage of their pregnancy, it does not function well due to multiple reasons. The women who work in the field or as wage labour cannot fulfill all the conditions of this scheme because they cannot come in between of their work only for completing the formalities of the scheme. IGMSY only works on those women who stay at home and not working outside"* (Chandaur Village, 24 June, 2016).

5.6.1 Participation of the Anganwadi worker/ ASHA

Community health worker is an important motivating factor that encourages the women to utilizie the health services as well as availing the schemes.

Active participation of the community health worker can bring more beneficiaries to the schemes.

Indira Gandhi Matritva Sahyog Yojana is being implemented in the Anganwadi Centres and Anganwadi worker is the main source for creating awareness of the scheme. Therefore the success of the scheme depends upon Anganwadi workers. But from the in-depth interviews with the Anganwadi workers, it has revealed that as compared to the JSY that comes under NRHM programmes, this (IGMSY) scheme has lot more facilities as compared to JSY. The main facility that has been given under the JSY is emergency ambulance (108) services. This helps a lot in reaching the health centres. The function of ambulance services in Dhanpatgaj block is relatively better.

One of the respondents said,

> "*In rural areas, the hospitals are located far away and if you don't have your own vehicle you cannot reach the hospitals. But after introducing ambulance services in the block, it has become easier to access health services. Otherwise people had to face lot of difficulties."In some situations, delivery is conducted inside the ambulance. The ambulance services are well managed and delivery kit is always available in the ambulance with all necessary instruments*," (Shobha, SC, 9 June 2016, Anjer Village of Dhanpatganj Block).

5.6.2 Lack of Coordination between AWWs, ASHA and ANM

Apart from the lack of human resources, lack of co-ordination between the voluntary worker ASHA and AWW of Ministry of Health Department and Ministry of women and child health respectively was an important issue that has found during field study. Under the (IGMSY) scheme's guidelines, it is clearly written that Anganwadi worker will motivate the pregnant women in availing the JSY scheme also. But both AWWs as well as ASHA both are not very much interested to share the job responsibility.

One Supervisor said:

> *"Those who want to avail the JSY scheme, they definitely can. But it is not our responsibility to do all these things. The scheme comes under the Ministry of Health Department so one who wants to avail the scheme, has to contact health officials. We can only suggest them and not more than that'. It is the duty of ASHA to aware the pregnant lady about JSY scheme or she (ASHA) has to accompany the visits of the pregnant women to give her necessary information about both scheme. But she never visits houses of the pregnant lady with me by giving excuses that she has some other work to do"* (Supaervisor of ICDS, 23 September 2016, Dhanpatganj block).

5.6.3 Excess Workload

Excess workload is another obstacle that has been a complaint of around 85% Anganwadi workers in the Dhanpatganj block. The problem of severe heavy workload is an important factor hampering the service of providing proper health care in the block.

The IGMSY guidelinesclearly mentions that for the verification of the beneficiaries, Mother and Child Protection (MCP) card will be given through AWWs or ANMs. Field study shows that AWWs and ANMs do not share their data. Even ANMs are not very much interested in taking part in the scheme (IGMSY). Thus AWWs are the only people who bear the all responsibility of identifying the pregnant women and submitting the form of eligible beneficiaries of the IGMSY. Hence accessibility of the AWWs in every village has become very difficult.

AWW is headed by Supervisors and each supervisor is responsible for 20–25 AWCs. As per the data, due to unavailability of staff, supervisors are managing up to 50–60 AWCs. As a result of the increased workload, the supervisors are unable to perform well. They are heavily burdened by paper

work, and are unable to do more than 2–3 visits per day. As a result of this many of their centres get neglected.

5.6.4 Incomplete Knowledge of Scheme

Lack of complete information about the scheme is also one of the reasons for low coverage of the scheme. It was found that most of the beneficiaries were not fully aware of the scheme and knew only that there is a scheme that gives incentives to the pregnant women. Anganwadi workers played an important role in giving information related to the scheme but researcher found that even AWWs did not had complete knowledge related to the scheme. She did not know if women will be entitled under scheme who had miscarriage or women who give birth twin or even if child die during delivery or not. She only knew that the scheme is only for two live births of women aged 19 and above.

An AWW stated that, *"nobody listens to us. What is the use of telling them? They will do what they want to do; they never pay attention to our advice*". (Benipur Village, 19 August, 2016)

Another AWW said while asking the criteria of the IGMSY scheme, she said that:

> "*Women who had child birth in the private hospitals can also get registered under the IGMSY scheme. But i did not know about the private empanelled hospitals that come under the JSY and IGMSY along with that at least five years of gap between first two children of the mother is essential for taking the benefit of the IGMSY scheme".*(AWW, Kutta-I, 4 October, 2016)

They did not know whether incentives were given to the women who had miscarriage. Norms for twins were also not known to the AWW.

One of the respondents said that, "*Earlier I was informed by the AWW that women who are pregnant for the second time are also eligible for IGMSY. Later on, after I delivered a twin then only I found out that mothers who*

delivered twins are not covered under the scheme. Both the AWW and I had to take a lot of pain just to open the account through which the money for the scheme was to be deposited directly. Since the village I reside didn't have a bank we have to go to the neighboring village multiple times, which also involves money. I had to spend 220 INR on commuting and another 500 INR for opening the account for the first time. After taking all these trouble, I was told that I am not eligible. Had I knew from before that I would not be eligible, I would not have registered myself in the scheme" (Phoolwati, OBC, Kutta II village of Dhanpatganj Block, 16 May 2016).

Apart from that, Anganwadi Workers were inquired about what advices have been given to the pregnant and lactating women during pregnancy. Analysis has been presented in the table32.

Table No. 32 Advice Given by the Anganwadi Workers to the Pregnant Women During Pregnancy (No=10)

Early registration (within 3 months)	8
Registration can be done within 5 months also	2
At least 3 ANCs	8
2 Tetanus Toxoid	5
To consume 100 IFA Tablets	6
To take supplement food from AWCs	10
Motivating for to take advantage of JSY	0
Motive of the scheme To reduce MMR by increasing the institutional delivery	8
To give compensate of wage loss during pregnancy	2
Advice for taking rest after delivery	0
Advice for the post-natal checkups after delivery	3

Source: Based on Primary Data, 21 February, 2017

From the table no. 32, it is clear that majority of the AWWs gave advice of the early registration while two knew that registration can be done within 5 months of pregnancy also. 8 AWWs knew about 3 ANC check-ups of the pregnant women whereas half of the AWWs knew about 2 TT injections. More than half AWWs knew about iron tablets but they did not give answer about how much IFA tablet should be consumed by the pregnant women. Most of the AWWs knew that the scheme is for reducing MMR by increasing institutional delivery but they did not know the difference between JSY and IGMSY scheme. Only two stated that the scheme is meant especially for the wage loss during pregnancy and delivery. None of the AWWs suggested taking rest after delivery.

Second AWW said that,

> "*If it is a normal delivery, there is no need for prolonged rest. You can rest for two to three days and after that everyone has to work. Women have to pay attention to their household work. When I delivered a baby, I rested for two days and that is it. If I didn't take prolonged rest how can I suggest others to take rest?"*(AWW, Anjer Village, 21 April, 2016)

Such type of inappropriate and misinformation is a result of inadequate and improper counselling of the women trainers and Anganwadi workers. These further results the low coverage of the scheme. Therefore without paying proper attention towards awareness building, government fails to fulfil the demand of women entitlements.

5.6.5 Coverage Criterea

It was also found that many women were not covered due to the restriction imposed on the number of children. Under this scheme, benefits are limited up to first two live births as I have also mentioned earlier. It is one of the major factors for low coverage of the scheme. It was found out that the most marginalized and vulnerable population who needed it the most was getting excluded because of this criterion. The scheme did not take into account the

socio-cultural determinants why many women get pregnant for more than twice such as education, for the sake of male child, lack of family planning information and so on.

A 33 years old Prema, a dalit agricultural labour shared that,

> *"We did not go for sterilization as both me and my husband desire to have a son as the first two children are daughters. One day the daughters will get married and leave the house. It will be the son who will take care of us during our old age. The teacher in the primary school of our village never visits the school. Now tell me under such condition, who will send their children so far for studies? And we don't have so much money to education our girls so that they get into some job like you. We are not worried for the boys as they can move anywhere looking for a job and settle down. Do you think our desire for a third child is not justified? And since it is my third pregnancy, the AWW did not register my name as a beneficiary of the scheme?"*(Prema, 33 Year old Dalit woman, 8 June 2016, Majhwara Village of Dhanpatganj Block).

- **Migration**

Migration remains as one of the reasons for exclusion from the scheme. It was found that those women who were migrants from another place could not be entitled to the scheme as per the supervisors. The programme officer said,

> "*We have no idea about the migrated women. There is no clear cut information and there always remains confusion about the woman who has migrated from one place to another regarding whether she is entitled to the scheme or not therefore we force them to leave the scheme*." (Programme Officer, ICDS department, Sulatnpur City, 18 January, 2017)

The coverage critera of the scheme especially exclusion criteria has resulted in a significant negative impact on the scheme that was implemented for the poor

and lactating women. There should have been clear and defined guidelines of the functionality so that the scheme can function in a proper manner. If executed properly the effect could have been measured appropriately.

5.6.6 Lack of Transparency

At the level of selection, the respondents also complained that there was a lack of transparency regarding the scheme. They enrolled in the scheme but never got to know the reason for not being selected for the incentives. According to them, influence of powerful people, multiple registration, overemphasis on the eligibility criteria are some of the factors that are the main obstacles from availing the scheme.

5.6.7 Difficulty in Opening a Bank Account

In order to receive cash assistance of the scheme, women should have a bank account where incentives can be transferred. Findings from the interviews of the women show that, to open a bank account especially for the scheme was a big problem for the people. Majority (89%) of the respondents (beneficiaries) were illiterate. Being uneducated, it was hard for them to understand the process of opening a bank account which takes time therefore people suffer a lot. Along with that, banks are not available in every village. Therefore, people have to travel long distances to get to a bank. Some respondents reported bribe demands while trying to open a bank account.

Researcher observed that the Bank staff behaved very rude with poor people. They are not interested in giving any information related to opening a bank account. Anganwadi as well as CDPO also complained about bad behaviour of bank employees.

In Chandrakala's words,

> *"Even the thought of visiting the bank is scary. There we have to look for help from someone who'd fill up our form. If they paid in cash, we wouldn't have to go to the bank all the time"*

(Chandrakala Singh, SC, Chandaur Village of Dhanpatganj Block, 29 April 2015).

Several reasons were found for not accessing a bank account or hesitating to open one. It has been found that the poor are vulnerable and they don't have a regular income. Several uncertainties plague their cash flow. In such circumstances, it is difficult for them to take a loan from a bank.

5.6.8 Illiteracy as a Barrier

To understand the complex procedure and multiple formalities of the bank one should be educated due to which poor people suffer various difficulties as it has been explained in the earlier section also. Generally poor people are uneducated and this is an important factor in not having/using a bank account. In the study it was found that majority of the respondents are illiterate and to fill all mandatory information, they need people who can help them. *"It's not so easy to find someone who'd help you in a bank since everyone is busy in their own work"* stated Ramesh, a farmer, 29 August, 2016.

5.6.9 Transportation Cost for Accessing Bank Account

Those who live on the outskirts of the villages or where no bank is available face difficulties in reaching the nearest bank due to the high transportation cost along with losing their entire day's wage. Transportation cost is one of the major barriers faced by the poor in travelling several times to the bank.

One of the respondents Hasiya Begum (Name changed) said that,

> *"There is no bank in my village and to access the bank we have to travel around 5-6 km. to reach the bank, we had paid the transport cost of INR 50/- each time and because we are uneducated and no knowledge about the how to open bank account, Anganwadi worker also accompany to me and that's why the transportation charges had double. The account did*

not open in one time; we had to go three times for opening bank account." (Hasiya Begum, 43 Years old, 3 March, 2016)

5.6.10 Corruption

From the field findings, it is revealed that one of the main reasons along with others for the low coverage of the scheme as well as lack of proper funds is the corruption that was done by the former CDPO of the block in the year 2012-13.

As per Sumitra, an Anganwadi worker,

> "*Two years back, there was a female in charge officer of the scheme who had done a huge scam. That in charge officer had changed the name and account no. of the beneficiaries with their relatives and thus the cash had been transferred directly into their relative's accounts rather than beneficiaries. Due to this, since last one year, the forms of IGMSY scheme that we sent to the ICDS department in Sultanpur got rejected. They even don't give us the reason why the forms of the eligible beneficiaries are rejected*". (Sumitra, SC, 33 Years old, 3 March, 2016)

"Due to this scam, no one got the assistance of the scheme in the next year and after two years, only 53 beneficiaries entitled cash incentives of the scheme." - Stated by the Supervisors

Lack of transport facilities is one of the other reasons for low coverage of the scheme. Unlike ASHA under JSY, AWW does not have facility of transport. Anganwadi as well as registered pregnant women bear the all the expenses of the transportation cost to reach health centres as well as to opening the bank account. AWWs belong to the outskirts of the village unable to frequently visit those villages that are assigned to them.

5.6.11 Time Taking and Multiple Procedure of the Scheme

Under the scheme, the financial assistance that is provided by the Ministry of Women and Child Development comes into the consolidated account managed by state government. State government transfers this assistance into the District cell of IGMSY that are operated by the district magistrate or ICDS programme officers at district level. Then it comes to the block level where CDPO is the in-charge of the ICDS project/IGMSY scheme. Discussing with the district programme officer of the ICDS cell, main reason for the delay in payment as he pointed out is long and complicated procedure of the scheme. Earlier payments were made through cheque but nowadays it has become online under which incentives are transferred online to the beneficiaries' account. It takes lot of time. Supervisors make all the lists of the beneficiaries and also segregate it according to which bank beneficiaries have accounts. The list is given to the CDPO and it is forwarded to the district cell where all forms are rechecked and then money comes to the CDPO' account and he transfers the money to the beneficiaries' account.

The multiple procedure of the scheme has also act hurdle for the scheme. As per the CDPO,

> *"The real issue is that even if this scheme is designed to give compensation for wage loss to those pregnant women who work till the last stage of their pregnancy, it does not function well due to multiple reasons. The women who work in the field or as wage labour cannot fulfill all the conditions of this scheme because they cannot come in between of their work only for completing the formalities of the scheme. IGMSY only works on those women who stay at home and not working outside"* (Chandaur Village, 24 June, 2016).

According to the Anganwadi worker of the Kutta 1 village,

> "*This scheme has lot of formalities that need to be done by the woman for incentives. I try my level best to give all information related to the scheme but the villagers do not show any interest*

regarding information of the scheme due to its numerous formalities. They only want money that could be found without any effort." (AWW, 18 January, 2017, Saraigokul Village)

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5.6.12 Lack of Complete Documents (Birth Certificates of the Beneficiaries)

Absence of complete documents is also a major reason for not getting entitled to the scheme. Without having proper documents like MCP card, proper valid certificate of age, and other necessary documents for opening up a bank account like address proof and so on, one can't avail this scheme. Due to this, women could not avail the scheme. In the village, most of the women did not have a valid age proof certificate, without which one cannot take benefit of this scheme. One of the criteria of the scheme is that the woman should be 19 years of age or above. Therefore a valid document certifying age is required. But in the village, women are generally uneducated, so they neither have an academic document nor do they even know their real age. This is one of the hurdles in the way of getting enrolled under the scheme.

5.7 Financial Constraints of the IGMSY Scheme

Along with the administrative and structural barriers, financial constraint related to the IGMSY has also found. This includes the late payment of honoraria and incentive given to the community health workers and beneficiaries respectively, delay allocation of the fund for the IGMSY scheme and low wages. These all are discussed in detailed in the further section.

5.7.1 Late Payment to the Beneficiaries and AWWs and AWH

Payment of the incentives to the beneficiaries and Anganwadi workers and helpers are central points for effective functioning of the scheme.

AWWs and AWHs also complained about not getting their salary on time. Mostly AWWs as well AWHs complained that for the last six months they had not been paid honoraria. Along with that, majority of the AWWs and AWHs were dissatisfied with their honoraria which is 3000/- and 1500/- respectively. It was found that almost all AWWs and AWHs were dissatisfied with the nature of their contractual employment this also adversely effect on the scheme.

An Anganwadi worker (Seema Yadav, 32 Years) stated:

> "*I joined All India Federation of Anganwadi Workers and Helpers and protested in the month of November for increasing our salary and dealt with the issue of our late payment, but I did not find any positive result. Even after this, still we did not get our honoraria*" (AWW, 32 Year old of Kutta Village of Dhanpatganj block, 16 April 2015).

5.7.2 Delay in Budgetary Allocation

IGMSY is a centrally sponsored scheme and under this scheme centre give the amount as grant in aid to the states and Union territories. During 2010 to 2013, budgetary allocation, revised estimates and utilization of the funds is as follows in Table No. 33

Table 33Budgetary Allocation, Revised Estimates and Utilization of the Fund

Year	Budget estimates (INR. in Crore)	Revised estimates (INR. In Crore)	Actual expenditure released to the states (INR. In Crore)	Fund utilized (as reported by states)	Percentage of Utilization	
					Vis a Vis BE (%)	Vis a Vis RE (%)
2010-11	390	150	1179.5	23	30.24	78.63
2011-12	390	403	293.83	121.18	56.50	72.91
2012-13	520	84	75.21	143.04	15.83	98.01

Source: 164.100.47.134/lsscommittee/Estimates/15_Estimates_26.pdf

It is clear from the above table that fund constraints is also one of the major factors that impact the effective implementation of the scheme. (164.100.47.134/lsscommittee/Estimates/15_Estimates_26.pdf).

5.7.3 Low Wages and Late Payment of IGMSY

There is a difference in monetary incentives given under the JSY and IGMSY to the ASHA and Anganwadi worker and this is one of the reasons for it lagging behind. Under JSY, ASHA will not get less than INR 250 per beneficiary. Along with that an ASHA worker also gets incentives of INR 300 for facilitating institutional delivery. Ambulance facilities also provided to the ASHA worker for taking the pregnant women to the hospitals. In contrast under IGMSY scheme, Anganwadi workers get only INR. 200 per beneficiary and this incentive is also not given on time. Almost all interviewed Anganwadi workers (96%) raised the issue of low wages under the IGMSY scheme.

Table 34, Problems Faced by the Anganwadi Workers (AWWs) Under the IGMSY (No=10)

Difficulties faced by the AWWs	Percentage (%)
Low wages	96
Excess workload	85
Lack of infrastructures/poor infrastructures	79
Any other problems	16

Source: Based on primary data, November 2015.

In the interviews with Anganwadi Workers, it is revealed that most of the AWWs had not received the incentives of the IGMSY scheme and those who were given it got it very late.

An AWW stated that,

> *"I have registered around 10 pregnant women under IGMSY who got the incentives also but still I did not get my honorarium (incentives). Though the incentives come into account through onlinemode I regularly visit bank to enquire about my money. It has been around one year and I hve still not received the money".* (AWW of Mayang Villages, 13 November, 2015)

5.7.4 Better Functioning of JSY Scheme

Good functioning of the JSY scheme at the block level is also responsible for the low enrolment of the IGMSY scheme. Timely payment of the JSY incentives to the beneficiaries is one of the causes of the poor functioning of the scheme. Now JSY has covered some extent of indirect expenditures in the form of transportation cost, food for the pregnant women during hospitalization.

Apart from that, awareness level of the JSY is more than the IGMSY scheme. The reason behind the comparative success of the JSY is stated by the Anganwadi worker as, *"Now days, no one wants to deliver a baby at home. People are more aware of the importance of institutional delivery especially after JSY was started. Women know that if the delivery occurs at institutions they get incentives of JSY. There are no other formalities needed to be done under this scheme. Whereas, in IGMSY, from starting to end pregnant women have to do several time formalities from going here to there (At times go to the health centre, other times run to the bank) and even after that, there is no assurance that women get incentives"* (AWW, ICDS office of Dhanpatganj block, 25 February 2016).

5.8Indirect Expenditures in Availing the Scheme

Researcher found that, in availing the scheme, beneficiaries have to pay from their pocket. Large number of respondents reported that they had to pay bribe to avail the scheme to the AWWs. Apart from that, beneficiaries also paid for form of IGMSY scheme that is free for the women. But respondent reported that AWWs also had taken around 50 Rs for the form. Despite that, beneficiaries also paid transportation cost of their as well AWWs for opening bank account.

Most of the beneficiaries were told that they had started their account of INR 1000/- and does not knew about zero balance account.

These indirect expenditures of the poor also throw the negative impact and major reason for poor coverage of the scheme.

5.9Experiences of the Home Delivery

Though there are two cash transfer schemes functioning in the district for institutional child birth but still home deliveries are being conducted. During field visits, the researcher found that there have been 133 home deliveries conducted in the block. Respondents have given various reason to for opt home deliveries. Some case studies show the reason why they did not go to the government hospital for the delivery where several facilities and schemes were available for them.

Shobha (name changed) 23 years old SC, has delivered her child at home as her family weren't in favour of a hospital. As per discussion with one of her family member, she stated "I lost my trust on government institutions as I have already experienced the public hospitals during my child birth. There is no privacy in the government hospitals, people come and go continuously. Apart from that, we need to carry or arrange all the required materials (like blade, soap and clothes etc.) for delivery. Thus, I completely believe in home delivery and the child who was delivered at home is fit and fine now.Moreover it saves our money and time (Shobha, 32 Year old SC, Saraigokul village of Dhanpatganj block, 3 April 2015).

Another one of the respondent replied:

"All my three children were born at my house with the help of a Dai. All of them were fit and healthy. The dai who helped to deliver the babies was an expert, familiar and trained. She had been doing this for a long time. Dais were doing their job when these hospitals were not made. I completely trust on them (Dais). The other good thing was that, whatever we gave to her, she happily accepted it. According to her, home delivery was very convenient. My delivery and stay at home helped me in looking after the rest of my children. My husband's job also did not suffer and he earned money on daily wages. I believed that the schemes which have been implemented in the government hospitals are meant for convenience but they are on paper only. The fact is that, one has to pay for their services no matter whether it's in private or government hospital" (Sarita, 29 years old SC, Pipargaon village of Dhanpatganj block, 2 December 2016).

Another respondent stated that:

> *"I have two children. First was delivered at CHC as my husband always wanted to deliver a baby in a health institution for claiming the amount from cash incentives schemes. But the second time, my husband also did not want institutional delivery because in the hospitals one of the family member has to stay with the patient due to which their job gets affected. We are daily wage labours and we know only the importance of one day. In my house there was no one except my husband and my two year old son. If I choose institutional delivery, then my husband's job suffers. Apart from that, there is no one who can take care of my son in my house. Therefore home delivery was the right decision for us and I am more than happy with that as both of my sons are fit and fine and my husband's job also did not get affected"* (Sarita, 29 Years old, SC, Majhwara Village of Dhanpatganj block, 4 April 2016).

Thus we can find from above mentioned case studies, there are some reasons like earlier experiences, inadequate supply of drugs and necessary equipment and convenience are the main causes for choosing home delivery.

Conclusion

There are several factors that are responsible for the low coverage of the IGMSY scheme and direct, indirect costs and difficulties in accessing the health services are among the major reasons for not opting for institutional births and thereby not availing the schemes. IGMSY scheme is functioning under ICDS programme implemented through Anganwadi Centres to address the issues related to the pregnant and lactating women. But this chapter highlights various issue related to the scheme. From the findings of the field study, several problems have been found to hamper the objectives of the scheme. Issues related to administrative and structural problems, block level corruption, inappropriate information, delay in payment etc. are the

responsible factors that impact the quality implementation of the scheme. Without addressing these issues, success cannot be achieved.

Lack of required number of infrastructures and basic health facilities, shortage of human power are some other major obstacles that prevent poor and needy people for accessing the health services.

Overworked due to the shortage of the staff results in administer doing the multiple tasks. The lack of staff acts as a hurdle in smooth functioning of the scheme. Additionally the multiple formalities of the scheme lead to exclusion of the beneficiaries.

Chapter 6

Discussion and Conclusion

A number of studies have been conducted on conditional cash transfer schemes under which they are given numerous suggestions about how to improve the performance of this conditional cash transfer scheme. However, majority of the studies are based on direct expenditures of institutional delivery but apart from the direct cost, indirect costs are also one of the major barriers due to which poor people do not want to opt government hospitals.

In my earlier study that was based on direct and indirect expenditures of the institutional deliveries, it was found that though government of India has started JSY scheme and also state leading some self-led programmes (earlier started by Mayawati, Mahamaya Garib Balika Ashirwad Yojana) that provide cash assistance to bear the direct expenses of institutional deliveries but it was also found that indirect expenditures for the delivery were one of the main hindrances that prevent poor people to access the public health services and thereby the scheme (Gupta, 2012). Therefore to reduce the burden of indirect expenditures of the institutional deliveries, government has taken some initiatives by modifying JSY to include some indirect expenditure such as transportation cost and food cost. However, these initiatives cover only to some extent the indirect expenditures but it (JSY) does not address the loss of wage during pregnancy and after delivery. Severe negative impact can be seen on those whose earning is dependent on daily wages. To cover the loss of wages and improve the nutrition status, the Ministry of Women and Child Development introduced a new scheme called IGMSY in 2010. This was launched on a pilot basis in the 52 districts of India. In Uttar Pradesh, it has launched in two districts Sultanpur and Mahoba namely. The incentive that has been given to the pregnant and lactating women is large as compared to JSY scheme. But from the findings it was revealed that coverage of the IGMSY scheme is very low as compared to JSY that is one time incentive scheme. Evidence shows that, during the period of 2014-15, only 2.1 percent (2.1 %) women got IGMSY monetary incentives while percentage of getting

JSY's cash incentives were high (around 72%) as compared to IGMSY. This IGMSY scheme is especially introduced to compensate the loss of wages of the pregnant women who work till the last stage of their pregnancy and women who have recently delivered a child who need enough rest. But findings show that due to the loss of wages, poor women work until the last months of their pregnancy and during the lactating periods.

It has been found that, more than 90% workforce of India work in unorganized sectors and are still deprived of the advantage of welfare schemes. This has attracted some serious attention of the government and its policy makers and thus, some schemes have started to include them also. One of them is IGMSY scheme that provides incentives to those pregnant women who do not work in the organized sector. The reason for introducing this scheme was to compensate the loss of wages during pregnancy and delivery. It has been found that the women, who work in the unorganized sector such as daily wage labours, continue their work till the last stage of their pregnancy in order to provide financial support to their families. However, this scheme cover only 28% targeted population in between 2010 and 2013 (http://crsgpp.nujs.edu/wp-content/uploads/2017/02/Article-8-Seemant-Himanshi.pdf. My study also shows that under the IGMSY scheme, only 2.3% of the targeted population benefitted under this scheme out of the total enrolled women. The reason why women did not visit health facilities was due to the burden of direct and indirect expenditures. Most of the beneficiaries were misinformed and lacked the complete knowledge of the scheme. Apart from that, administrative as well as financial constraints were other major issues that have been bottlenecks in the way of successful functioning of the scheme.

A large number of the studies have been conducted on conditional cash transfer schemes, especially on JSY scheme has focused on institutional delivery for child birth and given number of suggestion in regard of the constraints of the scheme. But in this study, the researcher has tried to attempt to address the issues related to IGMSY which is another centrally sponsored

scheme, implemented by the Ministry of Women and Child Health. According to this study, however the amount (incentives) that have been given under IGMSY scheme is large as compared to JSY but despite the larger amount, the problems remain the same and have been faced by the poor. In the earlier study of the researcher (Gupta, 2012) which was also related to the direct and indirect expenditures of the child birth, it was shown that in spite of the government initiatives and several efforts, the lack of basic amenities, bribing, corruption and other several issues continue to be widely prevalent in government hospitals leading to increasing dependence on private facilities.

It is clear that both JSY and IGMSY cash incentive schemes have similarity in terms of their goals. Objectives of these two schemes are to provide mother-child care by giving cash without any discrimination. But problems were faced due to the lack of clear line between the two departments and thus, the schemes did not function properly. Also, there should be a clear division of work responsibilities between community health workers of the programmes (JSY and IGMSY) which would further extend their reach. The issue related to the lack of sharing responsibilities that lead the low coverage of the scheme and thereby less benefit to the targeted population is also pointed out in the report of study on IGMSY scheme Falcao et. al (2015) that was conducted in Bihar, Chhattisgarh, Jharkhand and Madhya Pradesh.

Our findings of the functioning of IGMSY as well as JSY in Sultanpur corroborates Donnell' study which highlights that the obstacles of accessing health services. These have emerged from supply-side factors, like the scarcity of human resources such as doctors and other health staff in the public hospitals and demand-side factors, that are social and financial constraints such as literacy level of the women, lack of awareness, lack of money, etc. Thus, for better access to the public health services and thereby conditional cash transfer schemes, it requires tackling both demand-side and supply-side issues (O'Donnell, 2007).

Findings of this study reveals that the women, who have delivered babies in the government hospitals, have not taken the full coverage of immunization and the complete doses of iron and folic acid tablets. The ASHA also complained that these necessary drugs and injections are never available in the PHC. Even AWWs also complained about not having medical kits at the Anganwadi centres. Therefore, she is unable to give the full doses to the pregnant women. Husain, 2011 also stated in his reviewed paper that the amount of drug kits which were provided to the ASHA was not adequate for her to work smoothly. Though the data shows that ASHA has received around 69% kits in 2009-10 year but still it is low in figure.

In the present study, respondents (ASHA and Anganwadi workers) also raised concerns that, due to the lack of amenities in hospitals and Anganwadi Centres, the beneficiaries do not prefer to visit health centres and they only go there for the money, without any awareness of safe delivery. Majority of the women also reported that they and their babies were discharged within three to four hours of delivery and this has further resulted to missing the opportunities of providing essential post-partum care and detecting danger signs in mothers and children. This is because of the heavy load of patients, due to the rapid increase in institutional deliveries, as a result of the conditional cash transfer scheme. Even though, government had launched this cash incentive programme to improve the maternal mortality by increasing institutional deliveries but it did not give proper attention to supply- side demand and without significant investment in strengthening the health system, the maternal mortality as well as status of women could not be improved. However positive steps have been taken by the NRHM but still serious implementation issues exist. These similar issues have been reported in the study of Bhattacharyya et. al, 2012 that reports that shortage of health staff, poor quality of health services, lack of proper infrastructures, lack of drugs and other facilities are some of the reasons of women's dissatisfaction and limited or no utilization of the public hospitals.

Medical expenditure is another key issue of the health services in the government hospitals. It has been found that poor people have to pay in the

government hospitals despite the fact that the government has been running a lot of schemes for the poor, for instance JSY, IGMSY etc. schemes, under which there is a provision that the poor people will get treatment without any charges. But it is found in most of the cases that the patients had to spend money from their own pocket for the treatments. It indicates that these schemes and programmes are not working properly and due to this, patients have to bear the expenses, for which they borrow money through loans, selling their assets and securities.

The present study indicates that in the government hospitals, problems related to the lack of drugs and absence of pathological services is a major expense that the poor have to bear. This cost has to be borne by the patients because around 60% of prescribed medicines are not available in the government hospitals. Due to this, poor have to pay from their own pocket. Apart from the medicines, due to the lack of ultrasound and X-Ray facilities in the public hospitals, poor people bear this cost too. The researcher found that medical cost constitutes the major part of the expenses for normal births as well as caesarean section. In a few cases these expenses are less than the home birth cost. The indirect cost such as a loss of wages of the patients as well as care givers, transportation cost, commission to the staff, expenses on the food, on the mother and other people who stay with her to look after during hospitalization, are almost same in the normal delivery whether in the public or private. But in the case of caesarian, it has been found that, indirect costs are also high. As it is known that in the Caesarian Section, the mother has to stay for a longer period of time. The other family members also stay with the mother to look after her. Therefore indirect costs, especially loss of income increases. The study of Issac (2016) and Mondal (2015) also reported similar findings that highlighted the direct cost for the institutional delivery in government hospitals were mostly contributed by cost of drugs followed by diagnostic test. Other major components for indirect costs were found tips for the health staff, loss of wages etc.

The result of my study corresponds to the study of Worrall et al which shows that indirect cost is regressive in nature and therefore, is a greater burden for

the poor as compared to the rich. It means that the burden of indirect costs of delivery have a greater negative impact on the poor as compared to the rich. While the direct cost is dependent on patient's socio-economic conditions, it has been observed that people from higher economic groups generally opt for private hospitals while on the other hand poor people prefer the government hospitals and thus the direct cost of the medical care is progressive in nature. This study also found that the vast majority of births have occurred in public institutions because the PHC was located within the range of six km and majority of the villagers were aware about the schemes sponsored by the government. But majority of them were not satisfied with the schemes and facilities which were provided in the government hospitals, due to the lack of hygiene in terms of toilets and cleanliness of the ward, drinking water facilities, availability of drugs etc. (Worrall et al. 2011).

My study corroborates the same findings as the study of Bonu et al. (2005) which is based on the analysis of NSSO data; it notes that poor households are more likely to face the catastrophe compared to others. Rural agricultural and daily wage labors have higher probability of being trapped in catastrophe net and it is also high among SC and OBC as compared to upper caste people. In the case of inpatient care people have greater chances of catastrophe. Those who are poorer, have low possibility of catastrophe because of their low ability to pay for medical care (Bonu et al. 2005).

It is well acknowledged in the study of Bajpai, 2014 that, catastrophic health expenditure is a major cause to poor pushed into poverty trap. Even this study also shows that to bear the hospitalization cost, people borrow money, mortgage their land and animals and other assets when it crosses their ability to pay even when government has launched two major centrally sponsored cash incentive schemes that state to cover all the cost of institutional delivery. Apart from the loan, findings also demonstrate that poor people cut their basic needs to afford their expenses.

My study corroborates with Narayana (2008) whose study highlights the role of informal payment (bribes) to personnel in public institutions for the

utilization of health care is very prevalent. These informal additional payments make the health services unaffordable, especially for the poorer households. In public hospitals it is compounded by the high expenditure on drugs/medicines as well as tips which are given to various health staff and members of the hospitals for their services. It is then quite apparent that the provision of free health services is not completely free as the vulnerable groups have to pay for seeking the treatment from their pocket. This has negative impact on the vulnerable groups of people. These difficulties (direct and indirect cost) are the major reason, why people turn towards home delivery.

Low utilization of the government health services was also found in the study and area is one of the important factors along with others. Poor infrastructures in terms of road and transportation are the other factors that prevent women from seeking medical assistance in delivery. The study of Prusty, Gauda and Pradhan (2015) also show that lack of proper transportation facility, road connectivity, long distance are some barriers that prevent women from utilizing the health services.

Findings of my study area similar to Balarajan et. al, 2011, who shows that physical access is a major barrier in accessing the health services. As large distance from facilities to their home is a key determinant for not utilizing the health institutions as well as Anganwadi Centres. To improve utilizing health services of the targeted population it is necessary to provide better transport facilities and road conditions especially to those who are disadvantaged and physically isolated groups, such as lower sub-castes within Scheduled Castes. Apart from distance, cost remains a greater barrier for women, because physical access of services does not necessarily assure utilization since the costs associated with seeking care also preclude uptake, even when services are physically available.

Experiences with the targeted schemes for institutional births

GOI has introduced various cash incentives schemes for the poor so that they can access health services without any problem, conduction of child birth at

health institutions, increases their nutritional uptake and also compensates for their loss of wages that affect the economic conditions during pregnancy and after delivery. The study shows that delivering a child in the institution or availing the scheme, is not an easy task for anyone and in fact more difficult for the poor. Though, JSY and IGMSY schemes have been launched to reduce the burden of birth cost but these schemes still pose many challenges. For instance low utilization of health services due to several reasons that include unavailability of drugs, inadequate accessibility of doctors, lack of transportation, poor quality of the health services, rude behavior of the doctors etc. factors make it problematic to access these services and hence, due to these various reasons women still prefer home birth and private hospitals in spite of government financial schemes. My Findings corroborates with Gopalan and Varatharajan, 2012 who shows that, majority of women had taken loan at a high rate (6%) of interest from the private money lender to finance their cost of institutional delivery which truly exceeds their ability to pay. Apart from the loan, to cope with these expenses, women also sold their assets, borrowed money from their relatives and neighbors etc. Incentives of the IGMSY as well as JSY scheme were received very late; therefore it could not prevent the needy from taking loans from these external sources.

The findings also demonstrate that, in the rural areas, those who suffer the most are lower castes, i.e. scheduled castes or other backward castes. They face discrimination in availing various services which are actually meant for them. They are still discriminated by the upper caste of the village, despite the government talking about equality. Contrary to the claims of equality, these castes face discrimination and have hardly got any services without being targeted by the upper castes. A study conducted in Kerala also found that the lower caste people are not only backward in accessing health care but also poorest in terms of economy, as it is found that majority of landless households are from lower caste (Paniya in Kerala). To meet their health expenditures the result shows that, Paniya and OBC group people are more dependent on the loans and donations from the Forward Caste (Mukharjee et. al, 2011).

Findings also corroborate of the study of Sydney (2016) which points out that income and caste are very important components which determine the choices of institutional delivery. The higher income as well as higher caste group people prefer institutional delivery and often have a choice of private institutions they prefer to approach whereas the low income and low caste people generally opt for public institutions. It is found these lower caste people are bound with their little incomes and therefore they have to opt for public hospitals. Otherwise most of them are in favor of private institutions. Provided they have money to avail its facilities. Lack of trust on public hospitals is also found as one of the other reasons why people turn towards private health institutions.

The findings related to the women who have delivered babies in government hospitals, have not taken any full coverage of immunization or complete doses of iron folic acid tablets also reported in the study of Vora et. al. (2009) and Balarajan et. al (2011). The Anganwadi workers as well as ASHA also complained that these necessary drugs and injections are never available in the PHC. Therefore she does not give these complete doses to the pregnant lady. Basically, every set of people have their trunks of problems to blabber. Government has papers to show as excuses for ensuring that it has done its duty, doctors and medical personnel have excuses, denying their duty from working or conducting proper services. In the chain of supply services each person blames the other. These excuses ultimately take toll on the health and wealth of poor people, who are the ultimate bearers and sufferers of all problems.

This IGMSY scheme is especially meant to give rest to those women who worked in last stage of their pregnancy by compensating their loss of wages. But from the findings of the study it was found that, minimal (only 4) number of beneficiaries got full incentives of the scheme that covered their loss of wages. In the study, it is found that poor women, who had delivered a baby, returned to their work after a week from their delivery due to the threat of loss of daily wages. This IGMSY did not help in reducing the burden of loss of wages because of late transfer of the incentives in the beneficiaries' account as

well as not getting complete incentives that are originally meant to cover all expenses of institutional delivery.

Findings from the study revealed that lack of awareness about the IGMSY must have led to lower enrolment and hence lower utilization of the scheme. The level of awareness was poor even among those households that were enrolled in the scheme. This insufficient information was due to the lack of communication between the giver (AWWs) and the recipient (enrolled women). Absence of exchangeable information is the principal reason for the low awareness, enrolment, and utilization of the scheme. Along with this, the qualitative data, quantitative data shows that despite two major centrally sponsored schemes (which provide not only cash incentives to the poor for bearing all hospitalization cost during child birth but also a compensation for the loss of wages) functioning in the block, under which institutional delivery is completely free (that covers all the expenses from medicines to the cost of conveyance), finding show that truly, these provisions are far from easy. Poor people incur all these costs from their own pockets as they have no other option.

Findings also show that mostly women did not take rest from their work mainly due to the loss of wages. It corroborates to the report on the study on IGMSY conducted by the Centre of Equity Studies (Falcao et. al, 2015) which found that majority of women are daily wage laborers and agricultural laborers because of this, they cannot afford to miss their wages even a single day due to economic constraints. Although IGMSY is meant to cover the loss of wages of the pregnant and lactating women but in Dhanpatganj block, the condition of the scheme was found very poor. It has been found that majority of the beneficiaries did not get full amount of the scheme. The incentives transferred in the beneficiaries' account also failed to give any support to the women who needed it most.

CHC supposedly is meant for providing the services of obstetrics and caesarean section but from the interview of the health staff as well as beneficiaries it was found that in the Dhanpatganj block, CHC has not

conducted a single C-section because of unavailability of the gynecologist. People have to go to the district hospital or private hospitals if there are any complication in delivery. In the study of Gaidhani and Quazi, edited by Hagopian, House and Das, 2009 also demonstrates that non availability of skilled attendants as well as specialist doctors at the CHC level was the main barrier in providing Emergency Obstetric Care (EmOC).

The issue of corruption has been found at every level, whether it is about Anganwadi Centre or about the scheme. It is revealed that one of the main reasons along with others, for the low coverage of the scheme as well as lack of proper funds is corruption, done by the former CDPO of the block in the year 2012-13.

Awareness levels among women group of IGMSY scheme are also found to be very low. Most of the women did not have complete knowledge of the scheme and majority of them knew only about the incentives that are given for institutional delivery, as mentioned in the study. Uttekar et. al, 2008 have also reported similar findings that have been conducted on JSY scheme.

Undoubtedly, conditional cash transfer scheme should be simple and transparent. This will prevent corruption in the scheme. In the study, most of the women complained about lack of transparency. Women wanted to know the reasons for not getting incentives despite full filling the all criteria's of the scheme. Malin et. Al's (2008) study in Orissa also pointed out similar issues; as most of the users complained that there were lack of transparency in money distribution and felt that there were lot of complications in the procedure in this scheme and that's why cash assistance of JSY was received late (Malin et. al 2008).

Anganwadi worker is a key resource person for the delivery of several services of ICDS. She has to conduct various kinds of jobs and in these jobs, Anganwadi helper and ASHA also assist her but in the present study, it is found that ASHA did not show any interest to work with Anganwadi workers. Lack of co-ordination between ASHA and Anganwadi workers ultimately affected the performance of these schemes, implemented by the government.

From the findings it is also revealed that there was no, or poor coordination between these different set of health assistants, especially in their share of job responsibility. As per the NRHM, Anganwadi workers and ASHA should meet regularly to keep the pregnant women informed about, medicines distributions, immunization, nutritional supplements but no such coordination was seen existing between them, during the actual on field study. According to the Anganwadi workers, ASHA only took pregnant women to the hospitals for their incentives (honorarium). Majority of the Anganwadi feels that they do almost all work from registration of pregnant women to giving postnatal services but the benefit (JSY money) is going to the ASHA.

Apart from this lack of co-ordination, late payment of incentives to the beneficiaries account as well as delay in getting honoraria to the AWWs are also some of the determinant factors for low coverage of the scheme. In the study, it was found that beneficiaries were getting incentive very late, while this scheme was meant to cover all the expenses of the institutional delivery as well as to increase the nutritional uptake for the pregnant women by give incentives. But due to late payment of these incentives, beneficiaries could not utilize the incentive, either for nutritional uptake or for institutional delivery usage due to which majority of women had taken loan from the unorganized sectors and even sold their assets to bear the hospitalization expenses. Along with late payment of incentives, findings also show that, this is not only beneficiaries' who received late incentives but also Anganwadi workers as well as ASHA, who got their honoraria very late, or even sometimes not received their money at all due to which, these community health workers do not show their active interest in the schemes. Salary is the one of the motivating factors for the effective delivery of the services to the targeted population. But in the present study, Anganwadi workers were not satisfied with their honoraria as they have a lot of responsibility and work to do but as compared to their work they get very little amount as salary. In the study of Sandhyarani and Rao, 2013; Sharma et. al, 2014 raised the same issue that, mostly Anganwadi workers have problems with their incentives and thus it hinders the public in getting full benefits of any scheme.

This study also reflects same findings of the study of Padhy et. Al, 2013 as inadequate health infrastructures and lack of human resources in the health facilities fail to meet the demand of the IGMSY scheme. In this study the medical staffs also expressed their view regarding need for improvement of infrastructure like creation of more functioning sub-centres and PHCs and placing more health staff to tackle the high load of institutional delivery after implementation of JSY and IGMSY schemes.

Findings of this study shows that most of the beneficiaries were dissatisfied with the way the process of enrollment of the scheme functions. Majority of them were unhappy about the number of complex procedures of the scheme and documents required to admit a patient or even before doing a regular checkup. The causes of dissatisfaction of the beneficiaries cited for this are- they have to make multiple visits, lack of cooperation from the officials and other stakeholders, and difficulty in obtaining the necessary documents, especially the age certificate and opening bank account for receiving cash incentives of the IGMSY. A study of Sekher and Ram, 2015 also depicts the similar findings as multiple and lengthy procedures also draw negative impacts on the scheme, which ultimately create hindrance in the way of success of the scheme.

In India, where around one fourth population is illiterate and live below the poverty line, government's welfare schemes work in a pathetic way as incentives are claimed to be directly transferred into beneficiaries account, which turns out to be a delayed and long process, ultimately harming and hindering the services made for the benefit of the sections of society who are economically challenged. If the government planned of transferring money directly to the beneficiaries' account while making such schemes, then it should also think of women empowerment, and how can women, who are the ultimate stakeholders of the scheme get the money directly. Availing bank accounts, to these women, is the duty of government. This insensitivity and thoughtlessness on the end of policy makers shows their ignorance towards solving actual problems of the citizens of the nation, who are culturally, socially, politically and economically diverse. Finding of this study shows

that, beneficiaries have faced lot of problems even for opening bank account. Being illiterate, it was hard for them to understand the process of opening a bank account which takes time therefore people suffered and still suffer a lot. Along with all this, banks are not available in every village. Therefore, people have to travel long distances to get to a bank. This has given opportunity to private money lenders to establish their financial market in rural areas despite of high rates of interest. This has raised interesting questions that, do only rate of interest matters? Or are there some other determined factors also, because of which poor people prefer to go to the private money lender? My Phil' study (Gupta, 2012) also shows that majority of the women had taken loan from micro finance companies and local money lender because they thought more reliable and affordable. The reason people trusted these companies were that a big amount was easily available without too many formalities. Apart from that, villagers have to face a lot of difficulties in accessing the organized bank since they have no savings and also face difficulties in understanding the formalities of bank

The finding of this study highlights the similar findings as of Sahyog report. This study also found delays in release of funds at the block level, which affects the better functioning of the scheme. Some of the beneficiaries identified in the list, have already delivered child, by the time the money was released and hence, as a result, they were no longer eligible for the scheme. Beyond this, beneficiaries have also been excluded due to unawareness of the scheme in Anganwadi workers as well as other community health workers, linked to the scheme. Moreover, to add to the apathy, local functionaries also impose limitations and reform the original guidelines, as per their benefit and comfort. Ignorance, insensitivity, irregularity and irresponsibility of both, the government and the health workers, lead to humongous problems in the houses of the poor, who live alone with the hope of being alive, only.

My study complimented the work of Husain (2011) that highlights the importance of ASHA and other community health workers in encouraging the women to utilize health services, motivating women for institutional delivery and thereby availing the scheme. In these conditional cash transfer schemes

Anganwadi workers, ASHA and other community health workers are the support system who work as a bridge between expectant mothers and institutional delivery care facility stakeholders. But in this study, results show that, there were very negligible number of women who were encouraged by the Anganwadi workers in order to fulfill all the formalities of the schemes to utilize government provided health services.

Another essential finding of my study that also supports the study of Vellakkal et al, 2017 which is that some women believe that, pregnancy is not any disease that needs any specialist or hospitals. Doctors or other medical help is needed in the case of complications. Reasons of this were that women were not comfortable with the male doctors and other health staffs, or lack of availability of anyone for care of children at home etc. This also shows that building better infrastructure alone, like as roads, transports and institutional delivery care facilities, would be inadequate to encourage the utilization of an institutional delivery care facility. There is also a need to generate awareness among all pregnant women and their families' regarding the importance of delivery care and also timely decision-making instead of waiting until the last moment.

One crucial gap in the scheme that pertains to the selection of eligible woman under the IGMSY scheme is the inclusion criteria for covering only those women with first two live births as a beneficiary of the scheme. The conditionality applied in the scheme is responsible for excluding many marginalized and vulnerable population who needed it the most. Even in the study carried out by Dasgupta et. al, 2017 also shows that Indira Gandhi Matritva Sahyog Yojana, disqualifying most vulnerable those who have more than two children and this negatively effects on marginalized groups such as SC and ST (Dasgupta et. al, 2017).

Conclusion

It is clear from the discussion that IGMSY has various gaps in the implementation and evaluations. This has further lead to several interlinked factors like lack of awareness, inadequate health and community workers,

overburden of the workers, corruption, delay in allocation of the funds etc. The government had introduced this scheme to compensate the loss of wages of the poor women during last stage of pregnancy and after delivery but the study highlights that this scheme has completely failed in achieving its goal. Besides proper implementation of this scheme, issues related to structure cannot be fulfilled.

Although it has been almost six years since its launch but still this scheme is struggling to meet its requirements. It was found that this scheme did not contribute positively to cover the direct health expenditures as well as the indirect cost during institutional delivery. This quantum of direct and indirect expenditures is the major reason for not utilizing the health services. , loss of wages, transportation cost and bribes are three main indirect expenditures that are bore by the poor as indirect expenditure. Loss of wages during hospitalization had a high rate because the majority of the women were daily wage labours and depended upon daily wages unlike the rich who had their savings. Finally, we could say that out of pocket expenditures are still prevalent while accessing the health services under the IGSY scheme. However, the incentive of the scheme was largely to cover the expenses of hospitalization but till now the poor have to pay from their pocket.

The percentage of institutional deliveries was found high because of the JSY scheme. Awareness level as well as coverage level of JSY scheme is far more better as compared to the IGMSY scheme in the block. It shows the poor performing functioning of the IGMSY scheme.

At the end, this study shows that IGMSY scheme does not lead to any significant increase in the institutional delivery and not even in reduction of the burden of additional expenditures. Supply-side constraint has also limited the demand for the health services and schemes. Therefore, in order to achieve better outcomes of the IGMSY scheme, there is a need to address both side issues, which are supply- side as well as demand- side constraints.

Recommendation

To address the several issues that have been found in this study, there is need to change the conditionalities of the scheme. This scheme is undoubtedly, complex and tedious, and that is what makes this scheme difficult to avail for poor women. There should be easier processes that will increase inclusion in the scheme. Also, inadequate amount of funds of the scheme, contribute to economic constraints on the health workers and the beneficiaries. Monetary incentives should be increased so that it can achieve its objectives, on whose basis it was formed. Though, this IGMSY scheme is functioning under ICDS programme, therefore performance of the scheme depends upon the ICDS. Lack of infrastructures, lack of human resources and other deficiencies have adverse effects upon the scheme. Therefore without addressing these issues, IGMSY could not extend its coverage and thereby cannot reach its goals.

Based on the findings of this study, I wish to highlight the importance of factoring in the quantum of indirect expenditure incurred by households while seeking medical care. I believe, it is important that indirect cost should be included in health related economic evaluation. This would be important to estimate the economic burden of medical expenditure for poor families. In general it is identified that direct cost of the delivery is high but indirect cost is not either negligible as it constitutes a considerable amount of total expenditure incurred for institutional delivery by the family availing the service or the scheme. Therefore, it is important that policy makers take steps regarding indirect expenses of poor households. I suggest that the government should generate resources for the poor to protect them from incurring debt and reduce their financial difficulties as well as the medical expenditures. It is inferred from the study that the poor have trouble in accessing loans from the government. As a result they have to depend on the private or unorganized sector loan which impose high interest rates, and thus, as a result, the poor people are further impoverished. Consequently, the government should take initiatives to make loans from the formal sector, more accessible and also simplify its procedure.

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Appendix 1

List of the states and districts where IGMSY scheme has been implemented

Serial No.	State	District
1	Andaman and Nicobar Island	South Andaman
2	Andhra Pradesh	West Godavari, Nalgonda
3	Arunachal Pradesh	Papum pare
4	Assam	Kamrup, Goalpara
5	Bihar	Vaishali, Saharsaz
6	Chandigarh	Chandigarh
7	Chattisgarh	Dhamtari, Bastar
8	Dadra & Nagar Haveli	Dadra & Nagar Haveli
9	Daman and Diu	Diu
10	Delhi	West, North West
11	Goa	North Goa
12	Gujarat	Bharuch, Patan
13	Haryana	Panchkula
14	Himachal Pradesh	Hamirpur
15	J & K	Kathua, Anantnag
16	Jharkhand	East Singh Bhumi, Simdega
17	Karnataka	Kolar, Dharwad
18	Kerala	Palakkad
19	Lakshadweep	Lakshadweep
20	Madhya Pradesh	Chindwara, Sagar
21	Maharashtra	Bhandara, Amravati
22	Manipur	Tamenglong
23	Meghalaya	E.Garo Hills
24	Mizoram	Lawngtlai
25	Nagaland	Kohima
26	Orissa	Bargah, Sundargarh
27	Pondicherry	Yanam

28	Punjab	Amritsar, Kapurthala
29	Rajasthan	Bhilwara, Udaipur
30	Sikkim	West Sikkim
31	Tamil Nadu	Cuddalore, Erode
32	Tripura	Dhalai
33	Uttar Pradesh	Mahoba, Sultanpur*
34	Uttarakhand	Dehradun
35	West Bengal	Jalpaiguri, Bankura

*includes Musafirkhana, Amethi, Gauriganj tehsil of ChhatrapatiSahujiMaharaj Nagar

http://wcd.nic.in/SchemeIgmsy/IGMSYImpGuidelinesApr11.pdf

Appendix 2

Interview schedule for woman who availed the scheme

(1) General information of the respondent

a. Name of block

b. Village name

No.	Name of respondent	Age	Religion		Caste	Educational Background	Occupation of the respondent/ main earning member*	Average income of the family
			Hindu					
			Muslims					
			Christians					
			Sikhs					
			Buddhists					
			Jains					
			Other religion					

*Categorisation of occupations of rural households according to 68th round of NSSO data

- Self employed in agriculture
- Self employed in non-agriculture
- Regular wage/salary earning
- Casual labour in agriculture
- Casual labour in non-agriculture others

c. BPL card Red [ ] White [ ]

(2) Experiences of women in accessing the health services

(A) Has there been any delivery in your household during the last one year?

(B) Where did the delivery take place?

(a) Sub Centre [ ]

(b) PHC [ ]

(c) CHC [ ]

(d) District Hospital [ ]

(e) Private [ ]

(f) Home [ ]

(C) Describe your experiences along the following domains-

Probe in terms of *(What was the main reason for choosing this health institution)*

(A) Availability (Existing health services and resources, location of the services in terms of geographical and physical accessibility).

(a) Timing of the health institutions

(b) Availability of doctors, lady doctors and other health personnel

(B) Acceptability

(a)Quality of health services

(b)Earlier experiences with birthing services

(C)*Affordability probe like*

(a)How far was the health institution from your village where you gave birth?

(b)What was the mean of transport for accessing the health institution?

(c)What were the transportation costs to reach hospital from your home?

(d)Did the hospital provide the treatment free of cost?

(e)How many care givers had gone along with the mother during hospitalization?

(D) Did anybody help you in availing the scheme?

Probe for *the persons who may have played a role in facilitation like as:*

(a) Political activist

(b) Member of Panchayat

(c) Any other

(E) Did you give any commission for availing the scheme? Yes/ No

(F) If yes to whom and how?

(G) Were there any complications during and after pregnancy?

(3) Awareness of the scheme

(A) Were you aware about schemes that give incentives for institutional delivery?
(B) How did you come to know about these schemes?
(C) What information did you receive about the scheme and from which sources?
(D) What documents did you submit for availing the scheme?
(E) Did you face any difficulty to get enrolled in this scheme?
(F) Did you receive cash incentives under this scheme?
(G) If yes, how many days after the delivery, did you receive financial assistance?
(H) What was the amount that you received during the three trimester of pregnancy?

a. What percentage of the cash covered the scheme for hospitalization?

b. How did you manage to cover the remaining cost

1. Borrowing money and rate of interest
2. Sale of assets
3. Mortgage of lands and live stocks
4. Cut expenditure on education or food expenditure
5. Other sources

c. The money was received through

(a) Post Office [ ]
(b) Bank [ ]

(4) Money transfer into bank account

1. How far is the bank from your house?
2. What are the travel charges to access bank?

3. How did you open account in the bank?
4. What is your experience of opening a bank account?
5. Were the bank staffs supportive?
6. Did they charge you for opening bank account?

(5) Direct and Indirect Expenses of the Institutional Delivery

How much have you paid Out of pocket expenses for institutional delivery on the following items-?

Direct Cost (INR)	**Indirect Cost (INR)**
Items	
Consultant charges	**Transport**
User Fees	**Food**
Medicines	**Income loss**
Diagnostic test	**Tips**

For the home delivery-

A. Where did your delivery take place?

B. What was the main reason for not going health institutions for childbirth?

C. Who conducted your delivery at home?

D. Did you suffer any problems during pregnancy or after child birth?

Interview schedule for Health Officials

1. General information of the respondent

d. Name of block

e. Village name

f. Name of respondent

g. Age of respondent

h. Occupation

2. Information about the scheme

a) What are the present government (Central and state) schemes that are presently implemented for financing institutional births in the district?

b) What are the objectives of the scheme?

c) What are the eligibility criteria for a person to be included as a beneficiary of the scheme?

d) What are the documents that a pregnant woman or her family needs to be submit to get the scheme amount?

e) What are the schemes, if any that were withdrawn from UP for financing institutional delivery

f) What are the reasons for withdrawing?

3. Implementation Process of the scheme (IGMSY)

a. How long has this scheme been functioning in the district?

b. How many blocks are being covered under the scheme?

c. Is this scheme being implemented effectively?

d. Do you think allocation of fund is on time and sufficient?

e. If no, what are the factors responsible for that?

f. Do you think, this scheme benefited those people who need it most?

g. Do you feel after introduction of these schemes (JSY, IGMSY) is there improvement in the percentage of institutional delivery?

h. What kind of changes do you find after the introduction of these schemes?

Probe like-

(a) Increased the utilization of services by pregnant women

(b) Increased the institutional delivery

(c) Decreased the maternal mortality

(d) Decreased the neo-natal

i. What kind of the difficulties/ complaint people generally face in order to avail this scheme?

j. What kind of strategies do you feel to minimize these difficulties?

k. What kind of mechanism use for feedback of the scheme from the beneficiaries as well as health personnel?

l. What do you think, that what are the main reasons why people don't prefer institutional delivery?

Probe like-

(a) For convenient reason

(b) Cost of institutional delivery

(c) Health institutional is far away

(d) Untimely delivery

(e) Transportation problem

(f) Family objection

(g) Or any other reason

Questionnaire for ASHA

(A)General information of the respondent

a. Name of block
b. Village name
c. Name of respondent
d. Age of respondent
e. Education
f. Occupation

(B)Do you know about any scheme which gives cash incentive for institutional birth?

(C)If yes, please explain about the scheme in detail.

(D) Do you give necessary information related to pregnancy to the pregnant women?

(i)Do pregnant women or their family listen to you and take you seriously?

(ii)Do you face any difficulty regarding scheme?

(iii)Are you satisfied with the scheme?

(iv) If no, what is the reason?

Appendix 3

Informed Consent

Title of the study: Cash Transfer Schemes in the Reproductive and Child Health Programme in India: A study of Sultanpur District in Uttar Pradesh

Researcher: Anjali Gupta

Brief Description of the study: First of all, I would like to thanks for giving your precious time to me. I am Anjali Gupta, a research scholar of JNU, New Delhi. Study is based upon the conditional cash transfer schemes such as JSY, IGMSY that have an ultimate motive is to reduce the risk of delivery by giving incentives. Through this study, we will evaluate that whether the mother as well as their family are benefiting from the schemes or not. It is also a kind of attempt to see what are the areas, where improvement can be done. In the part of interview, participants have to answer some questions of the researcher, related to the schemes. Researcher would not take much time of the participants. The participants' identify will be kept confidential. In the process of interview, researcher may be use recorder for recording the interview. It will use only after taking permission from them. Participant's participation is voluntary and their name will not be disclosed. Participants are free to leave during any stage of the interview. Their information will not be shared with any one and used for only academic purpose.

We hope you (Participant) will support us by participating in this interview.

Consent Form (for women who had delivered baby in institution during last one year)

Researcher has described the intention and motive of research in which I (participant) am expected to participates for which I have to answer some of the questions of the researcher-

I willingly, under no pressure from the researcher-

i. Agree to take part in this research and agree to participate in all investigations.

ii. Agree to share my experiences and problems regarding this scheme.

I have been informed that JNU and the researcher (**Anjali Gupta**) will use my information only for academic purpose.

Signatures

Subject/Participants **Witness**