

**ACCESS AND BARRIERS TO INSTITUTIONAL  
BIRTH SCHEMES: A STUDY OF JANANI  
SURAKSHA YOJANA (JSY) IN SULTANPUR  
DISTRICT,  
UTTAR PRADESH**

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

**MASTER OF PHILOSOPHY**

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**2015**

*This dissertation is dedicated to my dearest mother*

**Mrs. SHAKUNTALA DEVI**

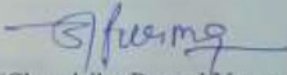
**Thank you for bringing me on this earth and  
supporting me in all endeavours of my life.**

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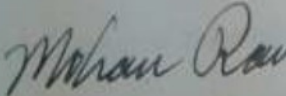
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CERTIFICATE


This dissertation entitled "ACCESS AND BARRIERS TO INSTITUTIONAL BIRTH SCHEMES: A STUDY OF JANANI SURAKSHA YOJANA (JSY) IN SULTANPUR DISTRICT, UTTAR PRADESH" is submitted in the partial fulfillment of six credits for the award of the degree of MASTER OF PHILOSOPHY of Jawaharlal Nehru University, New Delhi. This dissertation has not been submitted to the award of any degree of this university or any other university and is my original work.

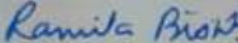
  
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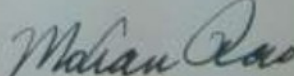
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## ABBREVIATIONS

UPA-	United Progressive Alliance
UT-	Union Territory
DSF-	Demand Side Financing
PHC-	Primary Health Centre
UNFPA-	United Nation Population Fund
ASHA-	Accredited Social Health Activist
RCH-	Reproductive Child Health
DLHS-	District Level Household and Facility Survey
SRS-	Simple Registration System
JSY-	Janani Suraksha Yojana
FWP-	Family welfare Programme
NRHM-	National Rural Health Mission
MCH-	Maternal Child Health
ICPD-	International Conference on Population and Development
IMR-	Infant Mortality Rate
MMR-	Maternal Mortality Rate
UNICEF-	The United Nations Children's Fund
TFR-	Total Fertility Rate
TBA-	Trained Birth Attendants

EOC-	Emergency Obstetric Care
MDG-	Millennium Development Goal
EOMC-	Emergency Obstetric and Medical Care
CSSM-	Child Survival Safe Motherhood Programme
WHO-	World Health Organisation
EAG-	Empowered Action Group
HIV-	Human Immunodeficiency Virus
AIDS-	Acquired Immunodeficiency Syndrome
CCT-	Conditional Case Transfer
USAID-	United State Agency for International Development
NMBS-	National Maternal Benefit Scheme
APH-	Antepartum Haemorrhage
PPH-	Postpartum Haemorrhage
ANM-	Auxiliary Nurse Midwife
LHV-	Lady Health Visitor
MOIC-	Medical Officer in Charge
HEO-	Health Education Officer
IGMSY-	India Gandhi Matritwa Sahyog Yojana
EMT-	Emergency Medical Technician
RGGVV-	Rajiv Gandhi Gramin Vidduat Yojna

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## ABSTRACT

India is one of the economically growing developing countries. But this economic growth has not improved the quality of life of people particularly poor and marginalised population. High maternal mortality rate (MMR) is still a major concern area for government of India. According to World Health Organisation 2012, India accounted for 19 per cent of global maternal death in 2010. India has recorded decline in maternal mortality over decades but the progress is too slow to achieve a steep decline in maternal mortality rate and achieve national health targets. Government of India 2011 data shows that mortality rate currently in the country is 212 which is very high compared to developed countries and other developing countries.

But data on national MMR only shows an average which does not show wide regional disparity in MMR indicator. Three states in India - Kerala, Tamil Nadu, and Maharashtra with MMR of 81, 97 and 104 per 100 000 births respectively have already achieved Millennium Development Goal 5 (MDG 5). However, nine large Empowered Action Group (EAG) states, MMR estimates still range between 258 and 390 (RGI 2011). These nine states account for 62 per cent of maternal deaths in India and 12 per cent of the global burden of maternal mortality.

To improve maternal and child health and achieve decline in maternal mortality and child mortality indicators government of India in 1996 launched Reproductive and Child Health Program (Phase I). Later on this program was launched in second phase under umbrella of the National Rural Health Mission (NRHM) programmes in 2005.

Janani Suraksha Yojana (JSY) is one of the significant initiatives under RCH launched in 2005. Janani Suraksha Yojana is a conditional cash transfer with objective to reduce high maternal mortality through promotion of institutional delivery.

After the implementation of the JSY increase in institutional deliveries has been recorded within four years of its implementation. The number of beneficiaries under JSY has increased from 7.30 lakhs per year in 2005-2006 to 1.33 crore in 2010-11 (GoI 2001).

But despite implementation of the JSY maternal mortality rate has not decreased and is still very high in the country. The success of JSY programme is measured based on increase in institutional births particularly among poor vulnerable household women. The proportion of deliveries increased rapidly with JSY implementation but reduction in MMR is not been achieved at the same pace.

The Government of India data shows that among EAG states Uttar Pradesh has second highest MMR with 350 per 100 000 live births after Assam. Uttar Pradesh consist 72 districts and divided in 18 Mandals/Zone. Janani Suraksha Yojana is performing well in states such as Kerala, Karnataka but doubts are being raised on overall rational of JSY program in reducing the maternal deaths and improving maternal and child health in states such as Uttar Pradesh where high MMR is still a major cause of concern.

Faizabad mandal (consisting of four districts Ambedkar Nagar, Faizabad, Barankai and Sultanpur districts) is one of the mandal in Uttar Pradesh with highest MMR of 437 per 100 000 live births (AHS 2011-12). High MMR recorded in Faizabad mandal show poor performance of JSY and low utilization of its services particularly among poor and marginalized household women. There are several barriers in accessing maternal and child health care services which pregnant women experience such as lack of awareness regarding programme, lack of transportation facilities, bad condition of roads and others. Such barriers in accessing health care services result in low utilization of maternal and child health care services and institutional deliveries.

The present study is focused in randomly selected Kurebhar block of Sultanpur District in Faizabad Mandal, Uttar Pradesh. The block is attributed to high socioeconomic development and good infrastructure facilities. The objective of research study is to understand perspectives of both the women beneficiaries

under JSY and healthcare providers on barriers in accessing JSY services and perception of health care providers on JSY and its relationship with increase in institutional deliveries. The study respondents were selected through purposive sampling and data was collected through a field survey. The key findings of the study were that there is low utilization of the JSY services among poor and marginalized household women. Women experience several barriers such as lack of awareness regarding programme, lack of transportation, bad condition of roads and others which result in low utilization of institutional deliveries under JSY program as a result maternal mortality is still high in the block. The conditional cash transfer scheme JSY has not been able to improve institutional deliveries and maternal and child health in the block.

## INTRODUCTION

Childbirth is a universally celebrated event, an occasion for dancing, fireworks, flowers or gifts. For many thousands of women each day, childbirth is experienced not as a joyful event it should be, but as a private hell that may end in death (Royston & Armstrong, 1989 p.9). In the National Population Policy of India, one of the socio-demographic goals mentioned is to achieve 80 per cent institutional deliveries and 100 per cent to be assisted by skilled health personnel by 2015 (National Population Policy 2002). In India, at present, most of the maternal deaths take place in institutions. Safe motherhood and safe child health are necessary for the development of the country. The current Maternal Mortality Rate (MMR) (212 ) of India shows that for safe motherhood target India still need proper guidance of health care and implementation for mother and child in rural as well as in urban areas(SRS, 2011).

*Over the years, there have been increasing commitments and efforts by the central government to improve the health of mothers and children. In the first two decades of India's independence, maternal health care was limited to the promotion of family planning (Mohanty & Srivastava, 2013 p.174).*

There are several health policies and programmes launched in India since independence such as Maternal and Child Health (MCH), Family Welfare Programme (FWP). After that Reproductive Child Health emerged with holistic approach, which implemented in 1996 throughout the country. After implementation of RCH, Government of India expected to provide quality services and achieve multiple objectives. The Government of India desired to reorient the programme and strengthen the services at outreach level. The second phase of RCH came in 2005 under the umbrella of NRHM, under this umbrella Janani Suraksha Yojana was the major programme for maternal and child health with the objective of reducing maternal mortality through promotion of institutional delivery. Though one decade has passed but

maternal mortality could not decline in expected proportion. The proportions of deliveries have increased sharply since the implementation of the programme. Yet within EAG states maternal mortality is remains high, which contributes three quarter of maternal death in India. The intervention of JSY scheme gave a new path to the poor marginalized section of the society to access health facility for birthing. It is approximately one decade of completion of JSY scheme, yet studies shows that the schemes objectives could not satisfactorily fulfilled. Maternal mortality is still a major issue for the government, and the Empowered Action Group States (EAG) states are still facing the major problem. A quarter of the maternal death in India continues to take place in the EAG states. There are four major reasons for high MMR and Infant Mortality Rate (IMR) in India: firstly, poor maternal and child health is a result of poverty and underemployment; secondly, lack of awareness; thirdly, lack of proper evaluation and finally, the public-private partnership in the health care delivery system. Therefore, there is need to strengthen and revisit maternal and child health programme and policies again at ground level. Comprehensive, universal access to health care was the main aim of Alma-Ata declaration in 1978, especially for developing countries like India. There is a lack of accessibility, accountability and affordability in health care system, which is directly affecting the poor and marginalised people. Less utilization of the health care system can be seen in the urban villages, slums and rural areas.

*“Health for ALL” stated in Alma Ata declaration on primary health care but still, due lack of universal access, equality in health status cannot be assured. Moreover, because there are other important social determinants of population health and its distribution, even with the increasing catchment of tertiary health care facilities, utilization of primary health care is low due to costs, attitude of health provider as well as location of facilities, etc. (Pandey, 2006 p.1).*

One more reason for less utilization of health care services in the rural areas is due to less awareness and lack of trust regarding health care services, and more trust on their traditional healers. The perception and kind of utilization



seem misguided and is impacted by their surroundings and belief on traditional healers. Recent studies shows that JSY could not give much impact on maternal mortality, there is no association between maternal mortality and institutional delivery(Randive et al. 2013).

The present study is conceptualised in Uttar Pradesh region focusing on high maternal mortality in the state and barriers in accessing JSY services among women. Faizabad Mandal (consisting of four districts Ambedkar Nagar, Faizabad, Barankai and Sultanpur districts) is one of the Mandal in Uttar Pradesh with highest MMR of 437 per 100 000 live births (AHS 2011-12). High MMR recorded in Faizabad Mandal show poor performance of JSY and low utilization of its services particularly among poor and marginalized household women. There are several barriers in accessing maternal and child health care services which pregnant women experience such as lack of awareness regarding programme, lack of transportation facilities, bad condition of roads and others. Such barriers in accessing health care services result in low utilization of maternal and child health care services and institutional deliveries.

The present study is focused in randomly selected Kurebhar block of Sultanpur district in Faizabad Mandal, Uttar Pradesh. The block is attributed to high socioeconomic development and good infrastructure facilities. The broad objective of the study is to study Janani Suraksha Yojana (JSY) scheme from both the health care providers and beneficiaries perspective for identifying the barriers to the utilization of the scheme and its role in institutional birth in Kurebhar Block in Sultanpur district Uttar Pradesh.

The study respondents were selected through purposive sampling and data was collected through a field survey. The key findings of the study were that there is low utilization of the JSY services among poor and marginalized household women. Women experience several barriers such as lack of awareness regarding programme, lack of transportation, bad condition of roads and others which result in low utilization of institutional deliveries under JSY program as a result maternal mortality is still high in the block. The conditional cash

transfer scheme JSY has not been able to improve institutional deliveries and maternal and child health in the block.

## **Organisation of Research**

**Chapter I** deals with maternal mortality in the world and India. Chapter begins with the problem of maternal death in the world and various programmes and initiatives from different countries. It then moves to the issues related to maternal mortality in the India wherein it discuss about the high load of maternal death, causes of maternal mortality and its social determinants.

**Chapter II** brings the existing literature related to Maternal and Child Health programme in India. Further it it specifically focuses on safe motherhood programme- the Janani Suraksha Yojana under the National Rural Health Mission. It deals with the emergence of JSY as conditional cash transfer programme in country with the objective of reducing maternal mortality through the promotion of institutional delivery. it provides a review of the JSY scheme, its utilization by the beneficiaries and its achievements in fulfilling the objective of JSY. The last section of the chapter focuses on, the increasing proportion of institutional deliveries and it impact on maternal mortality.

**Chapter III** contains the brief methodology of the present study. Chapter begins with conceptualisation of the research problem and statement of the objectives. It goes on to outline the research design used, sampling method and tools of data collection. It also contains the brief history of the study area.

**Chapter IV** deals with the findings of the presents study. Chapter commences with the utilization of the JSY services by the women which covers antenatal, intranatal and postnatal care. Further it also includes barriers that exist to access the JSY scheme and perception of health care providers towards JSY scheme and it its beneficiaries.

**Chapter V** summarises the key findings of the study and discuss them. The chapter tries to bring forth critical factors which are affecting the efficient

performance of JSY program in the study area and resulting in high maternal and neo natal mortality.

# Chapter- 1

## 1.1 Maternal Mortality in the World and India

In 2013, the global maternal deaths were estimated around 289 000 maternal deaths. The decline since 1990s till 2013 was recorded 45 per cent. The Sub Saharan Africa Region alone accounted for 62 per cent of global maternal deaths followed by Southern Asia at 24 per cent. Whereas at country level the two countries accounted one third of global maternal deaths, are India 17 per cent (50000) and Nigeria 14 per cent (40000). The maternal mortality rate is highest in the sub-Saharan African countries which alone accounts for 62 per cent (179000) of maternal deaths in the world. It is followed by South Asia with 24 per cent (69000). One further learns that the MMR in the developing regions (230/100000) is 14 times higher than in the developed regions (16/100000) (World Health Organization et al. 2014 p.1).

### 1.1.1 Maternal Health as a Goal of ICPD Programme of Action

The International Conference on Population and Development (ICPD) was held in 1994 in Cairo. In this conference, population issues were best addressed to people-centred approaches rather than exclusively demographic rationales. This led to a paradigm shift in population policies and programmes that were traditionally focussed on controlling population growth. Further, the conference adopted Programme of Action that addressed population issues in broader contexts of reproductive health and development (UN 1994). Acknowledging the intersection of ‘population and health’, the Programme of Action mainly focussed on reproductive health and its linkages with development. This programme also allowed a reproductive health approach that focuses on meeting individuals need while respecting their rights((WHO 2000).

Later, during the Millennium Summit (2000), held at the United Nations in New York, leaders of 189 countries unanimously adopted the Millennium Declaration (United Nations General Assembly, 2000); which led to the articulation of eight specific Millennium Development Goals (MDGs). Maternal Mortality was of concern in both the ICPD Programme of Action

and the Millennium Summit because it is “a sensitive development indicator with unacceptably large cross country differential”. Improving maternal health and reducing maternal mortality due to maternal causes were foregrounded among the adopted goals and targets in both ICPD Programme of Action and MDGs (WHO 2000 p.X1).

In ICPD Programme of Action, Maternal Health was an essential goal- The Programme stated:

To promote women’s health and safeguard motherhood; to achieve a rapid, substantial reduction in maternal morbidity and mortality and reduce the differences observed between developed and developing countries and within countries. On the basis of commitment to women’s health well- being, to reduce greatly the number of deaths and morbidity from unsafe abortion; to improve the health and nutritional status of women, specially of pregnant and nursing women.” It is recommended that “Countries should strive to effect significant reduction in maternal mortality by the year 2015; a reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015 (WHO 2000 p.X-1).

The ICPD Programme of Action was the first and the most comprehensive international policy document to promote the concept of reproductive rights and reproductive health. In this summit, the major recommendation came into the picture that population programme should make available comprehensive reproductive health service that were earlier integrated and coordinated with each other and with other health services. Henceforth it promoted a women-centric approach and rejected the use of incentives and targets in family planning services (Nair Sexton & Kirbat 2006).

A study “*A decade after Cairo: Women’s Health in a free market Economy*” (Nair, Sexton, & Kirbat, 2006) highlights that though a decade has passed since the programme of Action was implemented, the target is still far from being achieved. The study states that this trend could be owing to either lack of political will on the part of the government or less/limited funding. However, it also explains that one cannot ignore the role of several other

forces that have contributed to such a trend including decline/collapse of health services in many countries. The inherent conditions determining women's health and their control over childbearing have become worse. As a result, many positive trends related to health of women and children the world over have been reversed, while reproductive health and rights remain threatened; specifically for poorer women, migrant women and women of colour (Nair et al. 2006).

### **1.1.2 Definition of Maternal Death**

WHO defines Maternal Death as:-

*“The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes”*(World Health Organization 2012 p.4).

The lifetime risk is defined as:

*“The Probability that at least one woman of reproductive age (15-49) will die due to child birth or puerperium assuming that chance of death is uniformly distributed across the entire reproductive span”*(Simple Registration Survey 2011).

### Box 1.2

#### Maternal Mortality Ratio, Maternal Mortality Rate and Life Time Risk of Maternal Death

Maternal Mortality Ratio (MMR)	=	$\frac{\text{Number of maternal deaths to women (15-49 years)}}{\text{Number of live births to women (15-49 years)}} \times 100000$
Maternal Mortality Rate (MM_rate)	=	$\frac{\text{Number of maternal deaths to women (15-49 years)}}{\text{Number of living women (15-49 years)}} \times 100000$
Lifetime Risk of Maternal Death	=	$1 - (1 - \text{MM\_rate}/1,00,000)^{35}$

Source: (SRS 2006)

#### 1.1.3 Dimension of Problems in Developing and Developed Countries

Most of the developed countries had already reduced their maternal mortality to less than 30 deaths per 100000 live births by 1990. This reduction was gained through extensive improvements in Public Health, housing and sanitation, improvements in antibiotics, uterotonic agents, and improvements in blood transfusion, improvements in midwifery, number and tracings and making easy of abortion law (Lawson & Keirse 2013). Studies also show that majority of maternal deaths occur in the developing world, especially in Africa and Southern Asia where health infrastructure is inconsistent, least or occasionally non-existence (Lawson & Keirse 2013).

Two international bodies have produced regular reports on the estimation of global maternal mortality separately through using different statistical methods for several years. First one is the Maternal Mortality Estimation Inter-Agency

Group (MMEIAG) which is referred to as the WHO group, and second one is Institute for Health Metrics and Evaluation (IHME) an academic body based at the University of Washington, Seattle, USA, funded by Bill and Melinda Gates Foundation. IHME, in its most recent analysis estimated the maternal mortality in 187 countries, whereas WHO group determined for 181 countries worldwide. The two bodies used different statistical methods to arrive at the estimation of the National Maternal Mortality (Lawson & Keirse 2013). This could be demonstrated, by the fact that according to the WHO groups in 2008, Kuwait, El Salvador and North Korea had maternal mortality ratio of 9, 110 and 250 respectively whereas according to IHME it was 26, 37 and 64 respectively (Hogan et. al, 2010). Further, in 2011 the IHME group reported that 15 countries simply had no national data or civil registration system or any method to identify maternal deaths. Henceforth, it is very difficult to obtain reliable data on maternal deaths (Hogan et. al. 2010). The above study shows that due to high maternal mortality countries have taken the initiative to obtain the accurate figure so that policymakers can take a good decision regarding declining MMR.

**Table 1.1**

**Estimates of maternal mortality ratio (MMR, maternal deaths per 100 000 live births), number of maternal deaths, and lifetime risk, by United Nations MDG region, 2013**

Region	MMR	Range of MMR Uncertainty		Number of Maternal Deaths	Life Time Risk of Maternal Death 1 in:
		Lower estimate	Upper estimate		
World	210	160	290	289000	190
Developed regions	16	12	23	2300	3700
Developing regions	230	180	320	28600	160

**Source:** (World Health Organization et al. 2014)



The report *Trends on Maternal Mortality: 1990-2013* published by WHO groups in 2014 reflects that the current global maternal mortality rate is 210 per 100000 live births, and it accounted total 289000 maternal deaths globally. It further notified that the Maternal Mortality Rate is high in the developing regions (230 per 100000 live births), and the range of MMR uncertainty falls, between 180 to 320 maternal deaths per 100000 live births. According to the report, in the developing regions Sub-Saharan Africa has the highest maternal mortality, followed by Oceania; 510 and 190 per 100000 live births respectively and largest Life Time Risk of Maternal Deaths; 1 in 38 and 140 respectively (World Health Organization et al. 2014).

#### **1.1.4 Millennium Development Goal 5**

Under the Millennium Development Goals (MDGs), Maternal Health being an important public health issue got more attention worldwide. Maternal health is one of the areas in which the gap between the rich and the poor is clearly visible. In the developed countries, almost all births are attended by skilled health personnel while, in the developing countries, less than half the women receive such care during childbirth. During pregnancy, the disparities in access to care are also prominent. For instance, the richest households are 1.7 times more likely to visit a skilled health worker at least once before birth than the woman belonging to poorest households (MDG Goals Report 2010).

#### **Box 1.1**

#### **MDG Goal 5**

#### **MDG Goal 5: Improve Maternal Health**

**Target 5.A:** Reduce by three quarters, between 1990 and 2015, the maternal Mortality ratio

Indicators for monitoring progress

5.1 Maternal mortality ratio

5.2 Proportion of births attended by skilled health personnel

**Target 5.B:** Achieve, by 2015, universal access to reproductive health

5.3 Contraceptive prevalence rate

5.4 Adolescent birth rate

5.5 Antenatal care coverage (at least one visit and at least four visits)

5.6 Unmet need for family planning

MDG 5 is focused on improving maternal health worldwide and the target for this goal is to, *'Reduce Maternal Mortality Ratio by three-quarters between 1990 to 2015, and Achieving Universal Access to Reproductive Health by 2015'*. For achieving good maternal health, it is highly imperative to ensure the quality of reproductive health services and well-timed interventions to facilitate safe passage to motherhood (United Nations 2010).

### **1.1.5 Progress towards MDG 5**

Under MDG Goals, a country will be considered 'on track' if the average annual percentage decline between 1990 and 2013 is 5.5% or more (World Health Organization et al. 2014 p.27). If the average annual decline in MMR is between 2% and 5.5%, the country is considered to be making progress. Countries with an average annual decline of less than 2% are regarded as having made 'insufficient improvements and countries with rising MMR have been categorized as making 'no progresses (ibid.). Between 1990 and 2013, all regions experienced a decline of 37 per cent or more in MMR. The highest reduction in 23-years period, was in Eastern Asia (65%) followed by Southern Asia (64%), Northern Africa (57%), South-eastern Asia (57%), Oceania (51%), sub-Saharan Africa (49%), Caucasus and Central Asia (44%), Western Asia (43%) and Latin America and Caribbean (40%) (World Health Organization et al. 2014 p.26). At the country level, 19 countries have experienced 75 per cent reduction in MMR between 1990 to 2013, which had achieved MDG 5 by 2013 such as Belarus (96% reduction in MMR); Maldives (93%); Bhutan (87%); Cambodia (86%); Israel (84%); Nepal (76%) and Rwanda (76%); while two countries, India at 17 per cent (50000/100000) and Nigeria at 14 per cent (40000/100000), accounted one third of all global maternal deaths between years 1990 to 2013 (World Health Organization et al. 2014 p.26).

Some countries took special initiatives to reduce their MMR through different strategies. One such country was Cambodia that prioritized preventing maternal and newborn deaths through an Emergency Obstetric and Newborn

Care (EmONC) Improvement Plan. The plan required an enabling environment and included referral systems, communication, transport, equipment, drugs and other supplies. This enabling environment was eventually able to support the effective delivery of a broader range of health services. Another country Rwanda deployed community health workers and volunteers to address immediate, urgent health needs. At the same time, to build a health professional workforce Rwanda invested in its long-term vision (World Health Organization et al. 2014).

The high incidence of maternal deaths has been of growing concern to the programme managers and policy-makers especially in developing countries like India. To reduce the high burden of global maternal deaths, global leaders promised to extend every possible efforts and started Safe Motherhood Initiative in 1987 followed by International Conference on Population and Development in 1994 which is also known as the Cairo Conference. It was a remarkable effort from the international body, in a series of protocols, to reduce the maternal mortality (Rai & Singh 2015). Further it was endorsed in 2000 with Millennium Development Goals by the global leaders from 190 countries, and again re-emphasized the importance of getting better maternal health in MDG5 and a target of 75 per cent reduction in maternal mortality, was fixed by the year 1990 to 2015 (Paxton A & Wardaw T 2011, cited in Rai & Singh 2015). Under the MDG India reduced the MMR by 66 per cent from an estimated 600 to 200 maternal deaths per 100,000 live birth, the average annual decline of 5.2 per cent was recorded during the period 1990-2010 (WHO 2012).

#### **1.1.6 Nutritional Aspect of Maternal Mortality in the developing world**

A study by Rush David (2000), “Nutritional maternal mortality in developing world”, shows that, where maternal mortality rate is greater than hundred fold, the risk of maternal deaths are much higher than industrialized countries. Further the author found that the essential causes of maternal mortality in developing world are induced abortion, puerperal infection and pregnancy induced hyper tension. In addition to this, risk of death is usually increased, with severe anemia (Hb<70 or 80 g/L) and found, with mild and moderate a

little evidence of increasing risk (Rush 2000). However, the current programmes of universal iron supplementation are likely to have much effect on severe anemia. Further, author argues that, nutritional and public health practices are often not effectively integrated. Obstructed labour is far more common in short women. Unluckily, nutritional strategies for increasing adult stature are nearly non existence; after three years of age supplemental feeding, stature appears to have a little benefit and possibility it could be harmful at later age (Rush 2000).

In the 1987, Safe Motherhood Conference in Nairobi, the Director General of WHO, stated in his key notes, the role of malnutrition in undermining maternal well being. Director also pointed out that, girls become more severely malnourished than the boys, that is, the leading cause of maternal deaths in women. Further, he pointed out, this malnutrition may result in chronic iron deficiency anemia (Rush 2000). This clear reference to the malnutrition components is further proposed in maternal health programme. The study by Rush (2000), also states that, the rate of severe anemia is extremely high among pregnant women in India. In addition author Rush (2000), also highlights that, in a survey in Gujarat the prevalence of anemia was found to be increased among pregnant women, from 23 per cent to 30 per cent between first trimesters to third trimester. For all cases the rate of anemia was 83 per cent and 93 per cent respectively. Similarly, the rate of severe anemia was found in Maharashtra to be 32 per cent and 47 per cent between first trimester to third trimester (Rush 2000). Another study conducted in Punjab shows that 86 per cent of the women were found anaemic and consternation rate was 58 per cent (Zucker et al. 1994, cited in Rush 2000). A recent study conducted in Maharashtra in a medical college by Patil et al. (2013) shows that one third maternal death occurred in primi gravid within 24 hours from admission. Additionally, 28.57 per cent of the women died from haemorrhage and 12.69 per cent of the women from hyper tension, which were the two major direct causes of maternal deaths among the women. Severe anemia contributed more than one third (33.33%) of the maternal deaths as most in direct cause (Patil et al. 2013). Another recent study conducted in Bidar District in Karnataka shows that among 60 per cent of the maternal

deaths, anemia (24%) was found to be the leading indirect cause of maternal deaths followed by cardiac disease and no awareness of ANC (Patil & Jyotsna 2015).

The above studies highlight the concern regarding high maternal deaths in developing countries, where major causes of maternal deaths are direct obstetrics causes and among indirect causes major leading cause of maternal deaths is severe anemia. It has been shown that the negligence of nutritional aspect of health has its own importance to the women's well being.

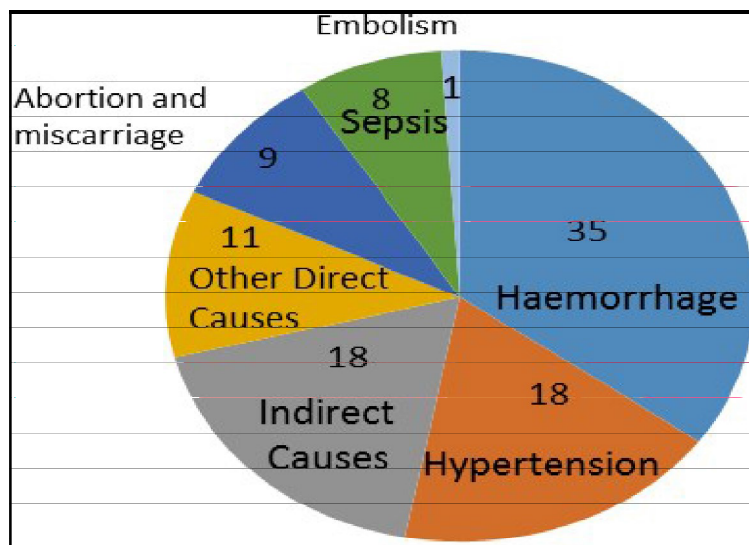
### **1.1.7 Causes of Maternal Deaths**

A study by Cook et al. (2001), refers three essential causes of maternal mortality: (i) **Medical Causes:** Medical causes consist of direct medical problems and pre-existence or coexistence of medical problems that are aggravated by pregnancy such as malaria and anemia. (ii) **Health System Law and Policies:** Health System Law and Policy have a crucial role and far-reaching implications on availability, accessibility, acceptability and quality of reproductive services. (iii) **Underlying Socio-legal Condition:** Socio-legal condition includes social stigma surrounding sexual behaviour, and seasonal peaks in women's workload. Also, gender biases in the structure and culture of health service provision further increases these risks. Gender studies also show that maternal mortality is intricately related to a broad range of factors that affect women's lives on a day to day as well as long term basis. It includes value placed by women and by their families and communities on women's health, their economic position, and access to education and information and their capacity to take autonomous decisions.

*Utilization of health services is affected not only by access but also by demand for services, which is determined largely by socioeconomic factors, personal health beliefs, and perceptions of illness (V. Mishra & Retherford 2008).*

Figure 1.1

Causes of Maternal Deaths in developing regions, 1997/2007(Percentage)



Source: (United Nations 2010 p.31)

Figure 1.1 highlights that, the leading cause of maternal mortality in the developing regions are, Haemorrhage (35 %), followed by Hypertension (18 %) which is accountable for half of the maternal deaths (53%) in new mothers. Indirect and Direct Causes are the major problems that lead to high maternal deaths among women. **Direct causes** such as obstructed labour, complication of anaesthesia or C-section and ectopic pregnancy contribute 11 per cent of the total maternal deaths (which occurs during pregnancy or after child birth) on the other hand **Indirect causes** include malaria, HIV/AIDS, and heart disease and they account for 18 per cent of total maternal deaths (United Nations, 2010). It is remarkable that majority of these deaths can be prevented, for instance, those occurring due to Haemorrhage (which accounts for one-third of maternal deaths). These deaths can be avoided through a range of interventions, and can be managed by a skilled health care provider with adequate equipment and supplies.

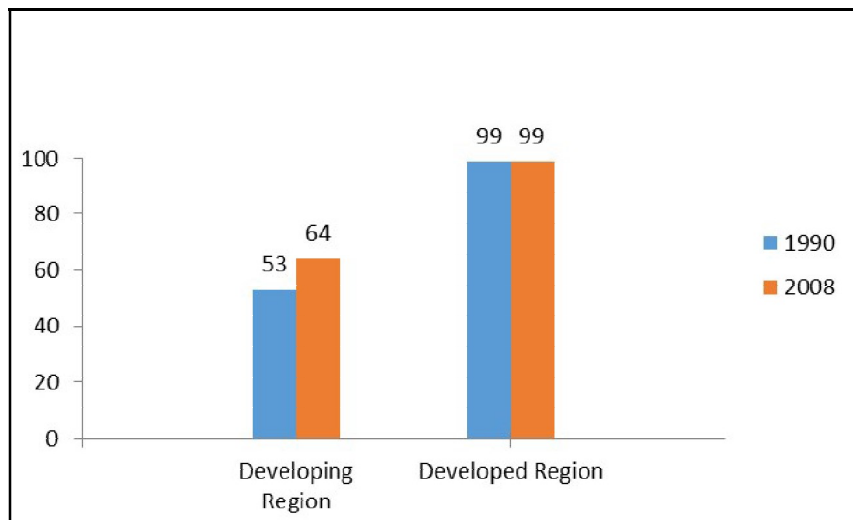
### 1.1.8 Use of Skilled Health Personnel in Developed and Developing Regions to prevent Delivery Complication

United Nations published a report in 2011 titled as '*The Millennium Development Goals Report 2011*' which shows that significant progress has been gained towards maternal mortality reduction in several regions across the globe. But pregnancy-related health risk for women in several regions is still high such as in Sub-Saharan Africa and Southern Asia region. The report also highlights that in developing countries maternal mortality dropped by 34 per cent between years 1990 to 2008, from 440 maternal deaths per 10,00000 live births to 290 maternal deaths (United Nation 2011 p.29).

During delivery, the presence of trained health professionals is very necessary to reduce maternal mortality. A trained health professional can manage delivery complications through medical intervention at the right time such as heavy bleeding or if there is any severe complication can identify early and refer to the higher level of care. In spite of increases in trained health professionals, in Sub-Saharan Africa and Southern Asia, coverage remains low where most of the maternal deaths took place(United Nation, 2011).

**Figure 1.2**

**Proportion of Deliveries attended by Skilled Health Personnel among Developing Region, 1990 and 2008 (%) \*\***



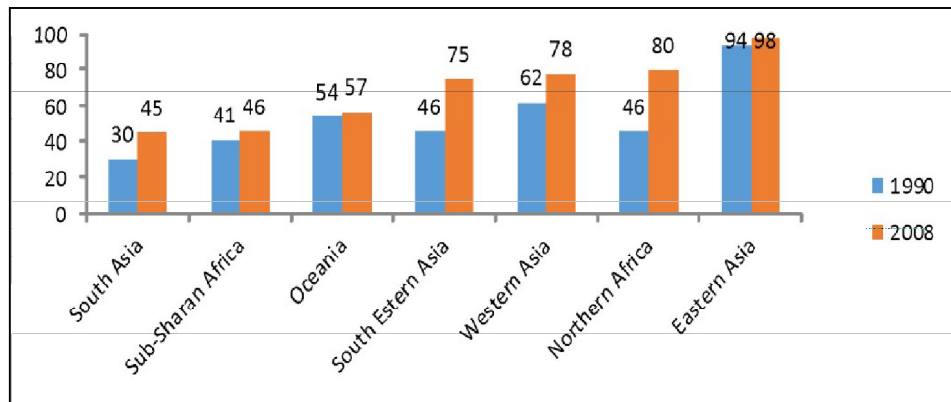
**Source:** (United Nations, 2010)

\*\*Includes only deliveries in health care institution

The UN study (2010) shows that, the proportion of women in the developing countries who received skilled assistance during delivery increased from 53% in 1990 to 63% in 2008, while in the developed countries it was 99% in the same years 1990-2008 (United Nations 2010 p.31).

**Figure 1.3**

**Proportion of Deliveries attended by Skilled health Personnel region wise, 1990 and 2008 (%)**



**Source:** (United Nations 2010)

Figure 1.3 shows variations across regions for the proportion of deliveries that were attended by skilled health personnel. During the period of 1990 and 2008, a dramatic encouraging change was measured in two regions; South Eastern Asia and Northern Africa. However in other regions (such as Sub-Saharan Africa followed by South Asia and Oceania), the progress was not much adequate. The study also shows that the rural-urban gap in employment of skilled care personnel also narrowed during childbirth. Over the period, more women received skilled assistance during delivery, and it was also measured that disparity between rural and urban areas by 1990. In Southern Asia, three times more urban women were receiving skilled care during delivery than their rural counterparts. After a couple of years, in 2008 it was noted that the gap between urban and rural women's access to skilled care

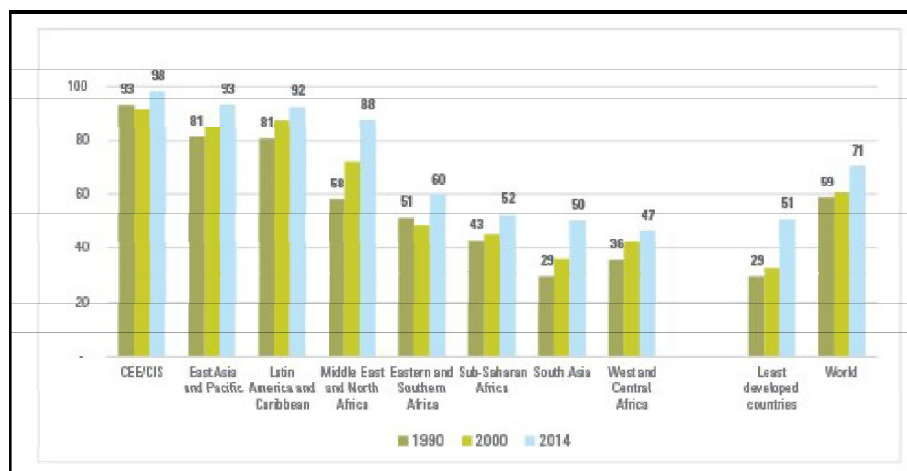


during delivery has reduced. Despite such improvements, inequalities persist in some regions such as the Sub-Saharan Africa, Southern Asia and Oceania, where skilled care attendance is the lowest, and the maternal mortality is the highest. The disparity was also witnessed among the wealthiest and the poorest households. The widest gap was found in two regions: Southern Asia and sub-Saharan Africa where the most affluent women were attended five times and three times more respectively than their rural counterparts. This trend was also noticed in developing countries as a whole. In all the regions, continuous efforts were being made to provide antenatal care to pregnant women. The most remarkable gain was recorded in Northern Africa where 70 per cent women saw skilled health personnel at least once during their pregnancy (United Nations 2010 p.31).

A study by Zureick Brown et al. (2013) also shows that the annual number of maternal deaths during 1990 and 2008 worldwide declined by 34 per cent. During this period, maternal deaths reduced approximately from 546000 to 358000 globally. The study also reflects that as a whole the maternal mortality rate (MMR) of the world has declined by 34 per cent and the World MMR has reduced from 400 to 260 maternal deaths per 100000 live births. It also establishes that during this period, the majority of the global burden of maternal deaths shifted from Asia to sub-Saharan Africa (Zureick-Brown et al. 2013).

**Figure 1.4**

**Percentage of births attended by skilled health personnel by region, 1990, 2000 and 2014**



**Source:** UNICEF global databases 2015 based on MICS, DHS and other nationally representative sources. **Note:** Global estimates are based on a subset of 111 countries, covering 62% of births in 2014. Regional estimates represent data from countries covering at least 50% of regional births. Data coverage was insufficient to calculate the regional average for CEE/CIS. Adopted from <http://data.unicef.org/maternal-health/delivery-care>

UNICEF (2015) “*Delivery Care Current Status + Progress*” report shows that skilled care during childbirth and emergency obstetric care when needed are two most critical intervention required to ensure safe motherhood. This report highlights that one-third of the birth took place without skilled attendants globally. Report also shows that, in low and middle income countries, in 2014 more than 40 million unattended birth were recorded, in which about 90 per cent of the unattended births were in South Asia and sub-Saharan Africa (UNICEF 2015).

Figure 1.4 shows that in spite of substantial progress over last two decade during pregnancy and delivery, insufficient or non-existence of care is primarily accountable for the annual deaths of an estimated 289000 mother and 2.8 million newborn in the first month of life (UNICEF 2015).

### **1.1.9 Emergence of Conditional Cash Transfer Programme as an effective tool for poverty alleviation**

In the developing countries, poverty has led to several causes which have a great impact on the countries health indicators. During the 1990 in Latin America and the Caribbean, to elevate the poverty Conditional Cash Transfer emerged as a tool to combat with the poverty. Until the 1990s, the social protection was chiefly systematized to the work-related social insurance (Stampini & Tornarolli 2012). To reduce the vulnerability of worker to the life events was the main purpose of these schemes. However, it resulted in the form of self and informal unemployment. These schemes became a failure, to reach a larger part of the population and could not bring down poverty. When Latin America and the Caribbean faced a structural crisis before the 1990s, unemployment and informality rates were increased quickly. In this context, there was a need of complementary social assistance, and in the late 1990s the emergence of Conditional Cash Transfer came into the picture.

Conditional Cash Transfer (CCT) was endogenous innovation from Latin America and the Caribbean (LAC). Primarily it was initiated, in Brazil and Mexico by late 1990s. The primary objective of CCT was to reduce extreme poverty and growth of human capital (Stampini & Tornarolli, 2012). The study by Stampini & Tornarolli (2012), further elaborated that, CCT has spread out in 18 countries and regions and by the year 2011, covered as many as 129 million beneficiaries. CCT programme included health checkups for children, school attendance, complete vaccination records, pregnant women and lactating mothers and participation in a training session that was focused on nutrition and health. In the Latin America and the Caribbean (LAC), 'PROGRESA' was the first nationwide CCT programme in Mexico which was launched in 1997 and later renamed as '*Oportunidades*' in 2001. Soon it was followed by Honduras that launched a CCT programme '*Programa de Asignacion Familiar* (PRAF),' in 1990s as an unconditional cash transfer programme, to which condition on health and education were added in 1998 followed by Mexican CCT programme. The first half of 2000 witnessed second wave of CCT programme, which included countries such as Costa Rica (2000), Nicaragua (2000), Colombia (2002), Jamaica (2002) and Ecuador

(2003) (Stampini & Tornarolli 2012 p.8). The third wave of CCT programme was launched in 2005-06, that included countries like Argentina, El Salvador, Panama, Peru, Bolivia, Costa Rica and Targeted Cash Transfer programme was started in Trinidad and Tobago. In the last addition countries like Guatemala's *My Familia Progressa* (MIFAPRO) and Uruguay's *Programa de Asignaciones Familiares* were added in 2008 and during 2009 two more countries, Argentina and Bolivia were added in the family of Conditional Cash Transfers. Further in 2010, Honduras started *Bono 10,000*, as CCT programme (Stampini & Tornarolli 2012 p.8). The study by Stampini & Tornarolli (2012), highlights that, over the period 200-11, the largest CCT programme in Brazil, Colombia and Mexico have achieved the coverage rates of around 50-55 per cent of the poor. At the same time, it was seen that, economic growth, contributed to reducing the incidence of the poverty. Furthermore CCT resulted, with increasing number of CCT beneficiaries that overtook the number of the poor in the region (LAC) in 2006, with using international poverty line of USD PPP 2.5 (US Dollar Purchasing Power Parity). The higher coverage was accompanied by increasing levels of leakage<sup>1</sup>. The share of non-poor beneficiaries rose from 46 to 65 per cent in Ecuador over the period of 2004-10 and from 40 to 61 per cent in Mexico over the period 2002-10 (Stampini & Tornarolli 2012 p.1). In addition to the level of the education of beneficiaries and participation in formal labor participation also increased. The emergence of CCT programme has given a new pathway to the developing countries to combat with poverty as well as improving education level and access to health care facilities to the poor and marginalised people.

#### **1.1.10 Summary**

Maternal Death has many causes, and it is therefore highly crucial to act on several aspects together to combat it. One of the important being the need for improvement in the social status of women and ensuring that they receive the same care and attention as boys in their families receive. The above-discussed studies show that maternal deaths are occurring in low-resource settings and

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<sup>1</sup> **Levels of leakage** is defined as the percentage of beneficiaries that are not poor (Stampini & Tornarolli 2012).

majority of sufferers are from the lower socio-economic background. On the one hand, direct causes such as haemorrhage, sepsis are the leading cause of maternal deaths that have contributed half the maternal deaths in developing region, and on the other hand among indirect causes anemia has become the most leading cause of maternal deaths. Several studies (Rush 2000, Patil et al. 2013, Patil & Jyotsna 2015) have pointed out the importance of nutritional aspect of maternal deaths which has been negligible over the period. Most of the deaths are avoidable but due to lack of care health care facility such as infrastructure, emergency obstetrics care, lack of referral system, lack of skilled health care providers, maternal deaths still have been become major problem major problem to the developing countries. Women living in a large family size face a greater risk of dying during pregnancy than those living in a traditionally smaller family size (Royston & Armstrong 1989).

## **1.2 Maternal Mortality in India**

### **1.2.1 Introduction**

India is a fastest growing economy in the world with a population of over 1 billion people. Its annual economic growth has averaged about 8 per cent to 9 per cent in recent years (USAID Global Health 2008). India is still very much in the development transition, with over 700 million of its people living on less than \$2 a day (USAID Global Health 2008). This rooted poverty has led to India's Under Five Mortality Rate (U5MR) of 74/1000 which indicates that almost 2 million young children die each year (that is equal to one-fourth of all the world's infant and child deaths). India accounts for approximately one fourth of the world's maternal deaths – (almost 1200000 women a year). So increasing the survival and health of mother and children is essential for improving the future of the country and addressing the political challenges that are represented by this inequity (ibid.). During the period of 2005-2006, the National Family Health Survey had established progress in indicators of maternal health. The USAID substantially supported this Survey. This

development identified significant progress in key health services; the use of antenatal care and trained health personnel at birth significantly improved. Despite the improvement in antenatal care and trained health personnel during 2005-06, half of the Indian women had given birth at home without skilled attendants (USAID Global Health 2008).

Child Survival and Safe Motherhood have been issues of concern for the policy makers as well as programme managers in India since Independence. Despite several important steps and initiatives taken to improve maternal health throughout the decades, the Maternal Mortality Rate remains high and far from the expected outcome.

A study by WHO (2010), globally estimated 287000 maternal deaths, in which India alone accounted for 19 per cent of the total maternal deaths. Over the last decade, there has been an explicit decline in Maternal Mortality Rate in India. The MMR decreased by 35% from 327 deaths per 100000 births in 1999-2001 (SRS, 2006) to 212 in 2007-09 (Registrar General of India, 2011). The current MMR is still high and unacceptable.

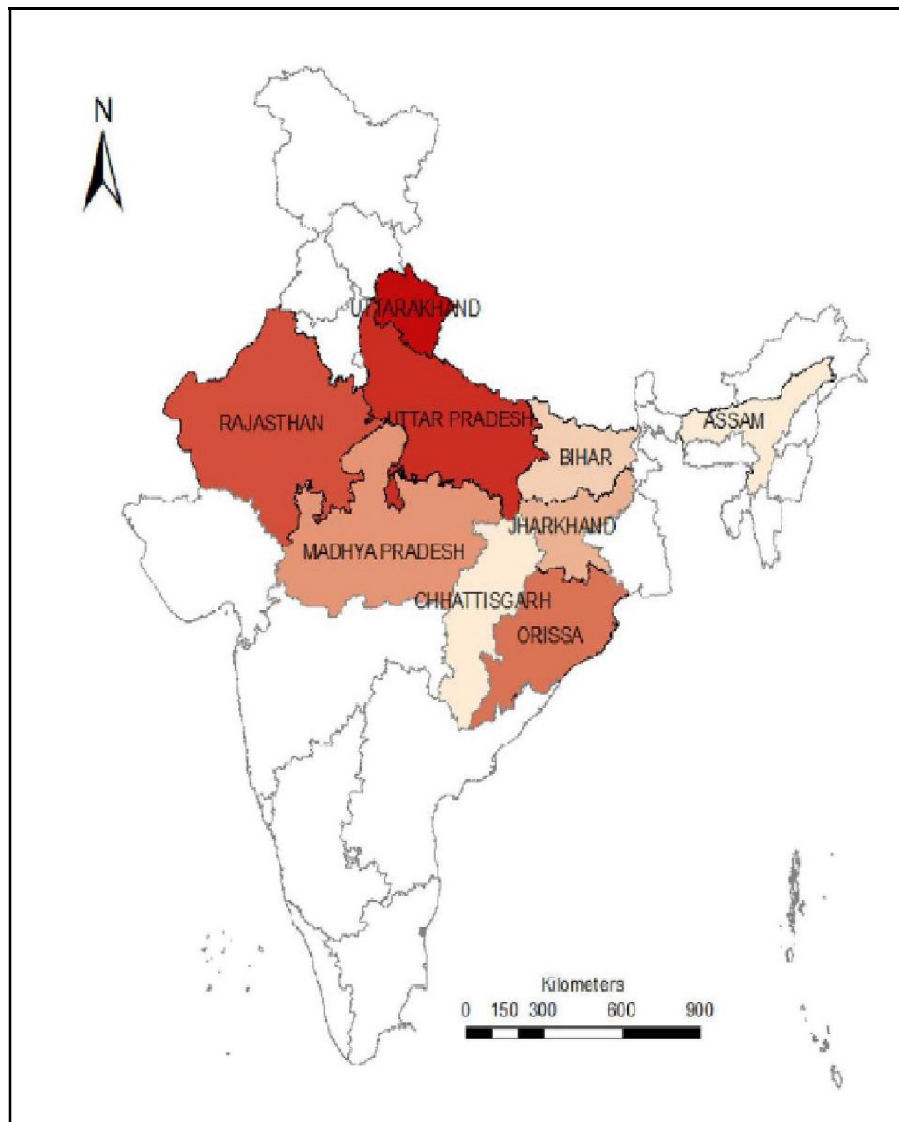
### **1.2.2 Continuation of High Load of Maternal Mortality in India**

In the Indian context, there are regional variations related to the MMR. There are three large states such as Kerala, Tamil Nadu and Maharashtra with the MMR of 81, 97 and 104 per 100000 births respectively. These states have achieved the MDG 5 Goal target. The Simple Registration System (SRS 2003) data shows that there has been a considerable decline in maternal mortality during 1999-2003. It also reports that about one-fourth (22.9 %) of the total maternal deaths in the country are reported from Uttar Pradesh/ Uttaranchal- the states which account for nearly 14 per cent of total live births and about 9 per cent of adult female population (SRS 2003). During this period, the subtotal of Empowered Action Group (EAG) and Assam accounted for 64.8 per cent of the total maternal deaths, subtotal of Southern States accounted for 10.2 per cent and others subtotal estimated 21.3 per cent of total maternal deaths. In these nine states (see Figure 1.4), the MMR estimates are still in the range of 258-390 (SRS Registrar General of India 2011). A recent study also stated that the EAG and Assam account for 62% of the global burden of

Maternal Mortality; having relatively high MMRs and Infant Mortality Rate (IMR) and birth rates than the national average of 212/100000 live births, 50/1000 births and 22.5/1000 population respectively (Randive et al., 2013). These states come under Empowered Action Group (EAG) states. Figure 1.4 indicates that among EAG states, Rajasthan still has high maternal mortality. Further author describes that only 37 per cent of the population of the block belonged to the marginalized caste and scheduled tribe (7%), majority (74%) of the maternal deaths occurred among these two social groups (Iyengar et al. 2009). The majority of the population were found lacking with basic amenities. The author further added the difference between numbers of children born and alive entails a high level of child mortality (Iyengar et al. 2009). It was found that the majority of the women (77%) died in the postpartum period, of them 48 per cent died within seven days of childbirth. At the same time another 29 per cent died within 8-42 days after childbirth and women (16%) who died in the postpartum period they died within six hours of childbirth. This implies a very high risk during delivery and within few hours of childbirth. The most common cause was found to be postpartum haemorrhage, followed by sepsis, TB, and anaemia (Iyengar et al. 2009).

**Figure 1.5**

**Nine States with high Maternal Mortality Rate**



**Source:** (Randive, Diwan, & Costa 2013)



**Table 1.2**

**Maternal Mortality in India since 1990- 2013**

<b>Year</b>	<b>Maternal mortality ratio(MMR)</b>	<b>Maternal Deaths</b>	<b>Number of AIDS-related indirect maternal deaths</b>	<b>Live births</b>	<b>Proportion of deaths among women of reproductive age that are due to maternal causes (PM)</b>
	Per 100000 live births (lb)	Numbers	Numbers	Thousands	Per cent
2013	190 [130-300]	50,000	310	25,568	6.7
2005	280 [180-340]	73,000	480	26,196	9.2
2000	370 [240-560]	97,000	270	26,697	12.1
1995	460 [300-720]	123,000	60	26,689	15.5
1990	560 [360-870]	148,00	6	26,632	19.2
Annual % change					
1990-2000	-4.1				
2000-2013	-5.0				
1990-2013	-4.6				
<p>World population prospect: the 2012 revision, New York, Population Division, Department of Economics and Social Affairs, United Nation Secretariat, 2013.  <b>Source:</b> World Health Organization et al. 2014, pp 16)</p>					

Table 1.2 shows trends of maternal mortality through the period 1990-2013 It shows that the Maternal Mortality has reduced from 1990 2013 to some extent. This reduction was measured after several interventions at the programme level and through new policy to improve maternal and child

health. MDG Goal 5 is largely dependent on developing countries in which India alone has contributed high maternal death.

**Table 1.3**

**Age Distribution of Maternal Deaths from 2001-03 and 2007-09, Special Survey of Deaths**

Age Group	Maternal Deaths			Non-maternal Deaths		
	2001-03*	2007-09#	2010-12@	2001-03*	2007-09#	2010-12@
	%	(%)	%	(%)	(%)	%
15-19	12	9	7	14	12	12
20-24	29	36	39	15	16	16
25-29	21	27	28	13	13	13
30-34	20	14	17	12	13	12
35-39	12	9	7	14	14	12
40-44	4	5	2	14	16	15
45-49	1	1	0	17	16	19
<b>15-49</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Source:\* (Simple Registration Survey, 2006), Sample Registration System. (2011). Maternal & Child Mortality and Total Fertility Rates Sample Registration System (SRS) Office of Registrar General, India, (July), Simple registration Survey. (2013). *Special Bulletin On Maternal Mortality In India 2010-12*. New Delhi. Office Of Registrar Gene, & Ral India. (2011). *Special Bulletin On Maternal Mortality In India 2007-09*. New Delhi.

Simple Registration Survey (2006) shows that among age groups of 20-24 and 25-29 collectively have contributed to half of the Maternal Deaths and SRS 2011, data also shows that these age groups have contributed to more than half of maternal deaths and it also similar in SRS 2010-12 preceding years (see Table 1.3). Non- Maternal Death is high among the age group 40-44 and 45-49. These two age groups are more prone to high maternal deaths.

The EAG states accounts three-quarters of India's maternal deaths and 12 per cent of global maternal deaths (Ng et al. 2014) having higher MMR and higher Life Time Risk than other states (see Table 1.5).

**Table 1.4**

**Maternal Mortality Ratio (MMR); India, EAG & Assam and Southern States and Other States (2004-06 and 2007-09)**

<b>India &amp; Major States</b>	<b>MMR 2004-06</b>	<b>MMR 2007-09</b>
<b>India Total</b>	<b>254</b>	<b>212</b>
Assam	480	390
Bihar/Jharkhand	312	261
Madhya Pradesh/Chhattisgarh	335	269
Orissa	303	258
Rajasthan	388	318
Uttar Pradesh/Uttarakhand	440	359
<b>EAG and Assam Subtotal</b>	<b>375</b>	<b>308</b>
Andhra Pradesh	154	134
Karnataka	213	178
Kerala	95	81
Tamil Nadu	111	97
<b>South Subtotal</b>	<b>149</b>	<b>127</b>
Gujarat	160	148
Haryana	186	153
Maharashtra	130	104
Punjab	192	172
West Bengal	141	145
Other	206	160
<b>Other Subtotal</b>	<b>174</b>	<b>149</b>

**Source:** Maternal & Child Mortality and Total Fertility Rates, Sample Registration System (SRS) Office of Registrar General, India, 7th July 2011.

Table 1.4 represents that state wise MMR. Assam, Uttar Pradesh, Rajasthan and Madhya Pradesh are having a high maternal mortality rate in comparison to other states.

### 1.2.3 Levels of Maternal Mortality by the Regions

Government data shows, three quarter of maternal death is concentrated in the EAG states (see table 1.5).

**Table 1.5**

**Levels of MMR by Regions, 2007-09**

Region	MMR	Life time risk	Per cent share of female population	Per cent to total maternal death
EAG State	308	1.1%	48.0	61.6
Southern state	127	0.3%	21.0	11.4
Other States	149	0.4%	31.0	27.0
India	212	0.6%	100	100

Source: (Simple Registration System 2011)

### 1.2.4 Causes of Maternal Mortality

Simple Registration System 2003 presents that among the direct causes of maternal deaths in India, haemorrhage (38%) is the leading cause, followed by sepsis (11%), hypertensive disorder (5%), obstructed labour (5%), abortion (8%) and other causes (33%). Same trends were witnessed in EAG states and Assam where Haemorrhage and Sepsis were responsible and contributed more than half of the total maternal deaths (SRS 2003).

**Table 1.6**  
**Causes of Maternal Deaths from 2001 -2003 Special survey of Deaths**

Maternal Causes	India %	EAG and Assam %	South %	Other %
Haemorrhage	38	37	30	40
Sepsis	11	11	17	10
Hypertensive Disorder	5	4	13	6
Obstructed Labour	5	5	9	4
Abortion	8	10	4	3
Other Condition	33	33	26	37

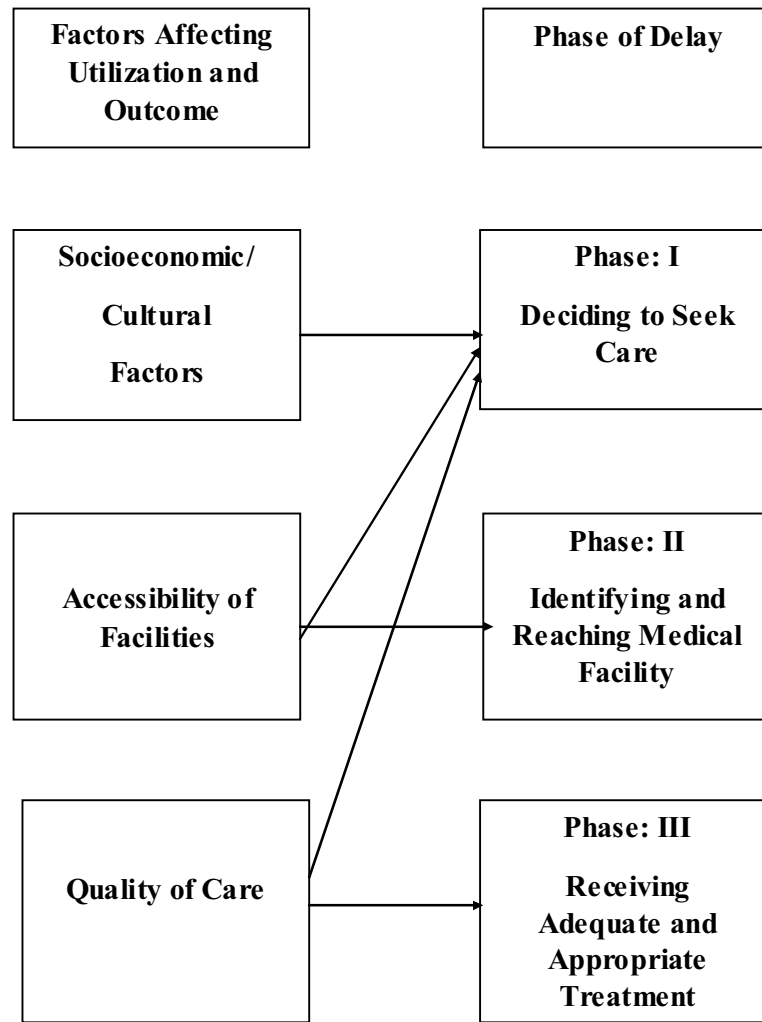
**Source:** (SRS 2003)

Study shows that rural communities with most of the population are steeped in the traditional beliefs and practices (GOI 2006, cited in Kalter et al. 2011). Most of the people in rural areas are unaware regarding danger signs which indicate the need of urgent care in pregnancy and childbirth, where best to seek care, with husbands sometimes neglecting to take their wives due to cost or other priorities. In this case travel to nearest health centre is often a distant ride over rough roads, if transport can be found and payment arranged and health system reform can be slow in achieving meaningful coverage. Many women are still living far from effective health care services at an appropriate facility (Thaddeus, S., & Maine, D. 1994). To tackle these problems, a conceptual framework was proposed by Thaddeus and Maine to address the maternal morbidity and mortality. This framework focuses on three important factors behind maternal morbidity and mortality. First one is socioeconomic and cultural factors which include women's status in household and society, i.e., her educational and economic status etc. The second most crucial factor is access to facilities which depends on distance and transportation facility etc. The third important factor is the quality of care issues, which depends up on the availability of staff and trained health care provider, availability of drugs and equipment etc. These three factors have led to the three crucial delays, first delay is deciding to seek care, second one is identifying and reaching the

medical facility and third one is receiving adequate and appropriate treatment (Thaddeus & Maine 1994).

The SRS (2003) data presents that direct obstetric causes such as haemorrhage, sepsis, hypertensive, obstructed labour and abortion have contributed more than 75 per cent maternal deaths. Even these maternal deaths can be averted through medical intervention at the right time. Delaying in these direct obstetric causes due to the socio economic factors, would be a cause of maternal mortality. It envisages that delaying various factors are responsible for these delays. **Delay Phase I: Delay in deciding to seek care:** It has been seen in most of the cases decision would be taken by spouse, mother-in-law, relatives and family members. It also depends on individual's autonomy in the family to take decision for seeking care. **Delay Phase II: Identifying and reaching medical facility:** It includes accessibility of facilities factors such as allocation of a health facility, a distance of health centre, travel time home to a health facility and also includes transportation of cost and condition of roads. **Delay Phase III: Receiving adequate and appropriate treatment:** This phase includes factors related to the quality of care issues such as referral system, availability of trained health personnel's shortage of drugs equipment supplies, etc.

**Figure 1.6**  
**The Three Delays Model**



(**Source:** Thaddeus, S., & Maine, D. (1994). Too far to walk: Maternal mortality in context. *Social Science and Medicine*, 38(8), 1091–1110. doi:10.1016/0277-9536(94)90226-7)

A study by Imrana Qadeer titled “*Reproductive Health: A Public health Perspective 1998*”, has highlighted the causes of maternal mortality in India. Qadeer (1998) discussed three particular groups of causes of death in India: communicable disease, maternal causes and anemia. “*Communicable disease does not kill only general population but also remains the second major killers of women in the 15-45 age group*” (Qadeer 1998).

Overall, the haemoglobin levels of women who died in 1994-96 were much worse than those observed in women who died a decade before. Similarly in the same time period maternal deaths among women with severe anaemia (<4 gm %) were high compared to decade before. (Berer & Ravindran 1999). A study by WHO (1992) shows that if haemoglobin level is less than 4gm %, then the risk of sudden heart failure is very high (up to 40 per cent of all causes) (WHO 1992). Another recent retrospective study was conducted in rural tertiary care hospital in central India between 2006 to 2010. The study highlights that the major cause of maternal deaths were haemorrhage (31.9%), toxemia (24.4%) and anaemia (14.9%). Further it was found that the majority of the deaths took place between 22 to 29 years of age. Further it was recorded that 73.19 per cent of the maternal deaths took place due to direct obstetric causes while indirect causes contributed more than one third (26.8%) of the maternal deaths. The major causes such as haemorrhage, sepsis, severe anemia were preventable (Yadav, Namdeo, & Bhargav, 2013). Another study shows eclampsia, pre-eclampsia and anemia are the most common underlying cause of maternal deaths (Gupta et al. 2012). The study further states three-fourth of the women were found to have some form of the anemia. In addition the study further states that anemia is the major risk factor for maternal mortality. The high prevalence of anemia can also be seen as a reflection of poor quality of antenatal care service.

### **1.2.5 Social Determinants of health and its impact on Women's Health**

Women - who belong – to lower socio-economic background are more prone to maternal deaths than women from higher socio-economic background (Pathak & Mohanty 2010, Gupta et al. 2012, Iyengar et al. 2009). Three most important adjoining determinants of the health status are nutrition, access to safe drinking water and education that have an impact on both infectious disease and vital health statistics. These are closely related to poverty and marginalization. The economic and social conditions of the people determine their health under which they live. These are the 'societal risk conditions' rather than individual risk factor that increase or decrease the risk for disease (UNICEF 2008).



### **1.2.5 Summary**

The chapter highlights issues of high maternal mortality in the developing countries which is one of the major causes of concern among international health community from very long time. Despite several steps taken by the international community to reduce maternal mortality it is still high taking life of several women's every year in the developing countries.

Major cause for maternal deaths in developing countries are direct obstetric causes but indirect causes of maternal deaths such as poor nutrition and presence of anaemia among poor marginalized household are leading causes for maternal death. Maternal mortality in India is very high particularly in EAG states despite several programmes launched by government of India in last few decades to improve maternal and child health and decrease MMR. Emergency Obstetric Care (EmOC) and conditional cash transfer programmes (CCT) are some of the major initiatives launched by government of India to reduce maternal deaths. But high rate of MMR in the country question such initiatives and overall government strategy to improve maternal and child health in the country.

## CHAPTER- 2

# EVOLUTION OF MATERNAL AND CHILD HEALTH (MCH) PROGRAMME IN INDIA

### 2.1 Introduction

*“Pregnancy is an important period in many women’s lives and a period where they may consider their own health as well as that of their future child<sup>2</sup>”*

In India population growth is one of the concern issues for government of India since independence 1948. As a result immediately after independence Family Planning Association of India was formulated in 1949 (Phukan 2014). In 1951, Government of India launched its first family planning program with the objective to control rising birth rates and stabilize population growth for sustaining the national economic growth (National Health Mission Government of India 2013). Family planning was the major activity of the programme till 1977, but in the following period it was changed to family welfare programme. Under this new moniker, maternal and child health became an integral part of Family Planning Programme. The primary aim was a reduction in the birth rate which has a direct relationship with decrease in infant and child mortality.

During the sixties and seventies under MCH, maternal and child health services were focused on antenatal care and high-risk approach. The primary focus was on good antenatal service along with a high-risk approach that will help in reducing maternal mortality, while the other focus area was Trained Birth Attendants (TBAs) for conducting safe delivery (Mawalankar 1999). It was assumed that training of birth attendants would help in reducing maternal

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<sup>2</sup> Petersen, I., Mccrea, R. L., Lupattelli, A., & Nordeng, H. (2015). Women’s perception of risks of adverse fetal pregnancy outcomes: a large-scale multinational survey. *BMJ Open*, 10. doi:10.1136/bmjopen-2014-007390

mortality, but after several years of use, this approach was found to have not much impact in reducing maternal mortality, which was still high in many of the developing countries including India. Later on Emergency Obstetric Care (EOC) was introduced to tackle the high rates of maternal deaths and its socio-medical factors. The EOC approach main purpose was to prevent maternal deaths resulting from delivery complications. Through a cost-effective intervention strategy EOC, tried to address complications develop during delivery. The difficulty was, to find out which mother will develop the complication. Therefore, high-risk approach was not of much help (Mawalankar 1999, p.2). It was also shown that with the high-risk approach many more women will be referred, who will ultimately have normal deliveries and thus discredit the referral process. Further, it was demonstrated that maternal death happened after few hours to few days of developing a complication. It was also shown that, once a major obstetric complication, which can cause death develops, even a trained TBA or nurse cannot do much at home as many of these complications require surgical interventions, injectable antibiotics and other aggressive treatment. Therefore if obstetric complications are treated efficiently, the mortality could be considerably reduced (Mawalankar 1999 p.2-3).

## **2.2 RCH Programme**

In the 1994, after the International Conference on Population and Development, India has undergone importance change in the Family Welfare Programme. The programme has been reoriented as Reproductive Child Health towards the holistic approach. The 'target free approach' of the programme was implemented through out the country in 1996. The essence of the programme was subsequently renamed the community needs assessment (CAN) approach, was to modify the system of monitoring the programme and make it diamond-driven system in which a worker would assess the need of the community in the beginning of the each year. The National Population Policy 2000, insist the commitment of Government of India to philosophy of decentralized of planning through Panchayati Raj Institution, which provides a policy framework to prioritising strategies to meet the RCH need. After implementation of RCH, Government of India expected to provide quality

services and achieve multiple objectives. The Government of India desired to reorient the programme and strengthen the services at outreach level. Further this approach required decentralization of planning of the services at the basic core level which is district. To collect the data on reproductive and child health survey was existed in 1995, which covered 504 districts. The data shows that, the coverage of ANC of found below than 20 percent. Of the 15 district in this group, nine districts were from Bihar, three from Arunachal Pradesh, one from Jammu & Kashmir, Sikkim, Madhya Pradesh and Uttar Pradesh. While in 196 districts (40 % of the Total districts in India) were found ANC coverage more than 80 per cent. The data on utilization of the antenatal care shows that, 20 per cent of the women were visited by ANM at their residence for providing ANC while 32 per cent of the women received ANC from public hospital and 26 per cent of the women received from private health care facilities. Further data highlights, in the first trimester one third of the women visited for ANC, 28 per cent in the second trimester, 7 per cent in the last trimester and remaining 35 per cent of the women did not receive the ANC at all. The coverage of shows that, 40 per cent of the women received minimum three ANC visits (RCH RSH 1998-1999).

The second phase of RCH came on 1<sup>st</sup> April 2005. The primary objective of the programme was to bring out a change in three main important health indicators- reduction of total fertility rate, infant mortality rate and maternal mortality rate with the outcome vision of achieving MDG goals.

*“It was the time of political transition at the national level in 2004, when in general election the ‘United Progressive Alliances’ (UPA) came to power and included maternal mortality reduction as one of the commitments in the Common Minimum Programme, it also helped in making maternal health as a priority at national and state level”*(Tej, Ram et al. 2013).

In order to realize the promises enunciated in the Common Minimum Programme, the prime minister of India launched the NRHM in April 2005, with the aim of reducing maternal mortality to 100 per 100000 live births by 2012. The central government started providing additional funds to the states governments for motivating states.

The National Rural Health Mission was introduced as a flagship scheme of United Progressive Alliance (UPA) government in 2005-2006, to address the need of the rural population through an architectural correction of the health system. The mission has completed its deadline in 2012. (Tej, Ram Jat et al. 2013). A major stricture in access was identified in the low demand and uptake for institutional deliveries. The proportion of institutional deliveries during this period showed an increase from 26% to 41%; skilled birth attendance increased from 33% to 47%; yet more than half of the women continued birthing at home. To improve the low demand, JSY came with a Conditional Cash Transfer Programme. Notably, cash transfer programmes have emerged recently as newer ways of addressing the chronic problem of underutilization of health and social services particularly among the vulnerable group (Randive et al. 2013).

### **2.3 Background of Janani Suraksha Yojana (JSY)**

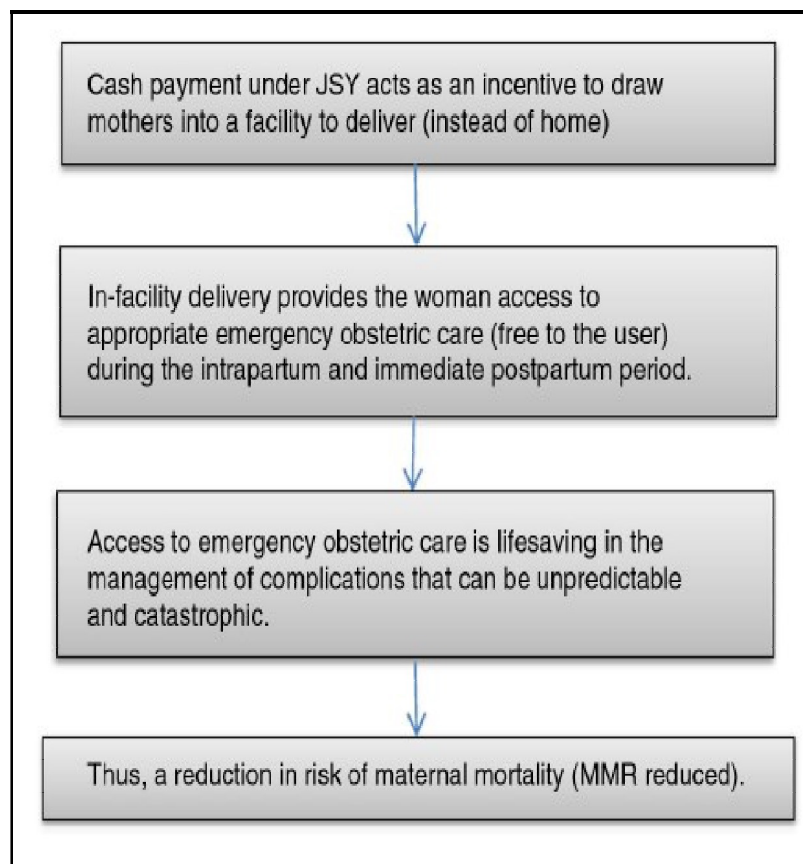
One of the more high-profile components of the NRHM is the Janani Suraksha Yojana (translated as “Safe Motherhood Scheme”) (Mazumdar et al. 2011). Janani Suraksha Yojana is safe motherhood intervention under National Rural Health Mission (NRHM). This scheme was the revised version of the National Maternity Benefit Scheme (NMBS), which was introduced in 1995 under National Social Assistance Programme. In Hindi language, *Janani* means mother, *Suraksha* means protection and *Yojana* means scheme (Gupta et al. 2012). The primary objective of this scheme was reducing maternal mortality and neonatal mortality by promoting institutional delivery among poor pregnant women. The JSY was launched by the Prime Minister on 12<sup>th</sup> April 2005. It is being implemented in all states and Union Territories (UTs), with particular focus to low performing states. The scheme is entirely centrally sponsored. It integrates cash assistance with delivery and post-delivery care (MOHFW 2006).

From 2008, Janani Suraksha Yojana (JSY) became completely functional in all the states of India. Institutional deliveries provide easy access to skilled assistance, drug, equipment and referral transport (Pardeshi et al. 2011). The objective of this scheme is reducing maternal and neo-natal mortality by

promoting Institutional delivery through Conditional Cash Transfer (CCT) (Stampini & Tornarolli, 2012) among poor pregnant women (Sachdeva & Malik 2012). JSY is the most important component of the NRHM, and one of the largest conditional cash transfer programs in the world (Ambrish 2010). The Figure 2.31 shows the rationale of JSY programme for promoting institutional delivery through cash payment.

**Figure 2.1**

**The rationale of Janani Suraksha Yojana(JSY) programme to promote institutional deliver**



**Source:** Ng, M., Misra, A., Diwan, V., Agnani, M., Levin-rector, A., & Costa, A. De. (2014). An assessment of the impact of the JSY cash transfer program on maternal mortality reduction in Madhya Pradesh, India. *Global Health Action, 1*, 1–10

The Janani Suraksha Yojana was launched in 2005, to improve maternal and child health through institutional delivery. This scheme was initiated to address the barriers in utilizing health facilities for birthing among poor and

marginalized women through an intervention designed by using a community-based a woman worker called as Accredited Social Health Activist (ASHA). The core part of the JSY Scheme was the conditional cash transfer through the cash incentive attract to the poor and marginalized house hold women for birthing in health facility. After the implementation of JSY in 2005, the number of institutional deliveries has increased. During RCH-1 (1992-1993), the rate of institutional birth was only 25.5 per cent and 34.2 per cent were assisted by health care providers at country level, where as in Uttar Pradesh institutional delivery was only 11.2 per cent and 17.2 per cent were assisted by doctors/LHV/ANM/Nurse or other health care providers. NFHS-2 (1998-1999) data reveals that in Uttar Pradesh 15.2 per cent deliveries were conducted at public health institutions that were assisted by health care providers. Though the figures show slight increased compared to previous years, it has not had much impact on MMR of Uttar Pradesh. In this series DLHS-2 (2002-2004) provided finding regarding institutional birth that was recorded 22 per cent. The report shows that majority (83.6%) of the home birth took place among SC population. This report also highlighted the disparity between rural and urban areas. DLHS (2007-08) data reveals that only one-fourth (25%) of the deliveries were conducted at the public health facility in UP. Latest SRS (2011) data shows that among Empowered Action Group States, Uttar Pradesh is still having high MMR 259 per 100000 live births (MMR 2007-09).

A recent study by UNFPA "*Concurrent Assessment of JSY in selected States*", 2009, shows that even in Uttar Pradesh most (75.9%) of the women are aware of JSY scheme and majority (90.2%) of the women know about ASHA, but only only 47.5% women gave birth at public health institution (half (52.5%) of the women gave birth at home ). A study by Pathak & Mohanty (2010), in Uttar Pradesh, shows that there was no significant increase in the use of ante natal care among the poor mother during the period 1992 to 2006 and the use of ante natal care declined over the peirod of timeBut within the same time period the study recorded an increase in skilled birth assistance perfomed largely by priavte health care providers.

During birth, assistance of trained skilled professional has remained low particularly for the poor women. During the 2005, 75 per cent of the births assisted by skilled health professional were of women belonging to the richest quintile, while only 13 per cent of the women from poorest quintile were assisted by skilled health professional. This difference was also recorded between rural and urban population. Over the period from 2005-2006, the use of trained health professional has increased from 15 per cent in 1992-1993 to 21 per cent in 2005-2006. Another study was conducted recently in EAG states that shows, institutional deliveries have increased across the EAG states from 22.9 percent to 33.4 per cent between DLHS-2 and DLHS-3 (Paul & Chellan, 2013). Another study shows that, institutional deliveries have increased among the poor illiterate women after the introduction of JSY, while earlier these women were preferring home birth, but study shows in comparison to total delivery their proportion is still small (Gupta et al. 2012). Another study shows that, low awareness among the women is the one of the major reasons for low utilization of the services (Banerjee 2003). To understand the client dissatisfaction regarding the services Banerjee (2003) states that, inconvenient timing and long waiting time are the most common problem in the free services. Further author states for dissatisfaction of the client there may be another reason such as non availability of the services round the clock at the health centre, unavailability of the medicine or unavailability of the staff during the illness, probably they should private health care practitioner (Banerjee 2003). A study was conducted in Aligarh, in two slums that show, majority of the the deliveries took place where there is no proper arrangement for birthing and majority (78% in slum A, 84.8% in slum B) of the deliveries were conducted by untrained birth attendants (Khan et al. 2009). Author found several barriers to choose the home birth such as family tradition (47.2%), economic constraints (16.3%) and rude behaviour of health staff (17%). In addition to choosing place of birth various reasons were found such as perceived complication during the pregnancy and availability of skilled attendance for women who visited health care facility, while the main reason for opting private health care was found to be perceived skilled attention given to them (53%), good behaviour of the staff (17.6%) and closeness to the home (17.6%) (Khan et al. 2009). Factors such as physical accessibility of health care



facility, socio-cultural background, cultural norms and affordability are the major reasons for low utilization of maternity services.

In Uttar Pradesh within the district, there is also variation within the institutional delivery and MMR. Uttar Pradesh is divided into 18 Mandal/Zones, and Faizabad is one of them. Faizabad Mandal holds four districts, Ambedkarnagar, Barabanki, Faizabad and Sultanpur. Among all Mandal, Faizabad Mandal has highest MMR followed by Basti Mandal, 437 and 403 per 100000 live births respectively (AHS 2011-12). Sultanpur District is one of the districts from Faizabad Mandal. DLHS-3 (2007-08) data shows institutional delivery within Faizabad Mandal is also not much satisfactory. Among Faizabad Mandal, Sultanpur district recorded 36.6 per cent institutional deliveries were registered, and 61.8 per cent deliveries were conducted at home. DLHS-3 data also shows that half of the districts in Uttar Pradesh are below than the state average (25%) of safe delivery. The percentages of institutional deliveries range from 7.1 per cent in Baharich district lowest and Azamgarh 49 per cent highest. In this context, the researcher wants to look what are the barriers that are preventing to availing JSY services among population, perception of women regarding institutional birth and experiences and opinion of health care providers regarding JSY scheme.

## **2.4 A Review of JSY other Study**

JSY emerged as a large demand side financing programme (DSF) in India in 2005, with an explicit focus on promoting institutional deliveries, especially among poor and marginalized households (Sidney et al. 2012). This programme is first of a kind, which, implemented on a large scale by the government of India, has created demand for different health services. In the initial phase most of the demand side financing programmes were mainly focused on vulnerable groups and have provided incentives for poverty alleviation, child education, immunization and nutrition. DSF programmes have had varied scales of implementation, from a small-scale pilot programme to larger nationwide programmes, like the examples from Mexico

(PROGRESA/Opportunities program in Mexico), Brazil (the Bolsa Familia) and others in Latin America and from the Caribbean (Stampini & Tornarolli 2012). The most typical cash interventions are intended to supplement traditional “supply-side” financing by channeling resources directly to users (Hunter et al. 2014).

In India, most of the maternal deaths occur due to complications in pregnancy. Majority of the deaths are due to direct causes such as haemorrhage (38%) and sepsis (11%), which contribute to half of the maternal deaths in the reproductive age group (15-45) (SRS 2003). To deal with these complications, between 1992 to 2006, the Indian Ministry of Health and Family Welfare focused on strengthening health system infrastructure to better support emergency obstetric care (EmOC) services (Sidney et al., 2012). “Skilled Attendance” during childbirth often got equated with childbirth in health facilities, which has become a core component of the efforts to reduce maternal mortality.

## **2.5 Choosing Place of Delivery**

A study by Pardeshi et al. (2011), in Nanded district of Maharashtra, describes choosing the place of delivery in the first phase of the National Rural Health Mission. The study shows that the proportion of deliveries has increased from 42 per cent in 2004 to 60 per cent in 2009. A significant rise was also observed in the proportion of institutional deliveries (69 vs. 45%) in the NRHM period compared to pre NRHM period (Pardeshi et al. 2011). The study further shows that institutional delivery has increased in public hospital from 24 per cent to 39 per cent, while private hospitals have shown an increase in institutional delivery from 18 per cent in 2004 to 30 per cent in 2009. The increases in the institutional deliveries show that, the proportion of deliveries, assisted by trained health personnel, increased from 50 per cent in 2004 to 70 per cent in 2009, which shows a significant increase in the proportion of delivery after NRHM. Moreover, the study observed that, throughout the study period only 10 per cent of the deliveries were assisted by health personnel (Pardeshi et al. 2011). Das et al. (2011) have criticised the study of, Lim et al. (2009) argue that, that, India’s conditional cash transfer

programme has achieved the approximate their objective, increase in institutional deliveries and it overall objective to improve maternal and neonatal health outcomes then JSY would be significant not only for India but worldwide (Das, Rao, & Hagopian 2011). Furthermore, the author found ambiguity in recording of the enrolment of JSY, as in the third round of the District Level Household Survey there was only one question in individual questionnaire pertaining to JSY. The question was, “did you receive any government financial assistance for delivery care under the Janani Suraksha Yojana (JSY) / State particular schemes” (question 239 and variable v239). Many women gave positive answer to this question and the response was ambiguously interpreted, even responses of women who gave childbirth in 2004 and 2005, two years before implementation of JSY scheme were included in the study which further increases the inappropriateness of the data collected for JSY under District Level Household Survey (Das, Rao, & Hagopian 2009). DLHS- 3 data shows that even though most of the PHCs are open for 24 hours a day, only a few of them had a referral system to the higher level of care. It is further argued that to prevent maternal mortality, if lifesaving services are essential, and then provision of caesarean section and blood transfusion are the most important. However, the study by Das et al shows that, these facilities were found only in very few centres in rural areas and even then the quality of care was rather poor (Das et al. 2011).

## **2.6 Utilization of JSY services**

The study of JSY in Dehradun, in rural areas and urban slums, shows that, the utilization of JSY service was found to be low in rural areas i.e. 38 per cent (Sharma, Semwal, & Kishore 2011). However, the study further shows that most (78.2%) of women were registered within 12 week of pregnancy. Furthermore, only 29.2 per cent of the women went for three antenatal care check-ups or more. Consumption of IFA tablets was found to be quite high in Kerala (98%) (S. Sumitra 2006, cited in Sharma, Semwal, & Kishore 2011).

Another study by Ramakant Sharma (Rajasthan 2006-07, cited in Sharma, Semwal, & Kishore 2011) also shows the consumption of IFA tablets to be slightly lower (86.5%) in Rajasthan (Sharma et al. 2011). Another study done

in Madhya Pradesh shows that, after the implementation of JSY, the number of beneficiaries have increased; more than two-third of women from rural background were found to be opting for institutional childbirth (Gupta et al., 2012). The study found that, women who had adopted institutional birth, had at least primary level education and institutional deliveries are higher among illiterate and women belonging to lower socio economic groups (Gupta et al., 2012).

Another study conducted by Kumar et al. (2012), in Agra District of UP, showed an increase in antenatal registration from 61.6 per cent to 95.6 per cent in JSY period. It was also reported that early registrations of pregnancy have increased from 26.6 per cent in pre-JSY period to 72.8 per cent in JSY period. Before JSY, complete ANC i.e. three visit, two doses of TT were almost non-existent. In addition, deliveries in government facility were found to have doubled from 25.5 per cent in pre JSY period to 53.2 per cent, and antenatal coverage showed increase from 46 per cent to 69 per cent in JSY period(Kumar et al. 2012).

## **2.7 Assessment of Janani Suraksha Yojana in the Selected States**

The Ministry of Health and Family Welfare, Government of India, through UNFPA, commissioned a concurrent assessment of the JSY scheme in large states, namely Madhya Pradesh, Bihar, Orissa, Rajasthan and Uttar Pradesh. All together these states constitute 39 per cent of the total population of the country. This assessment report shows the success of JSY scheme through an increase in institutional deliveries, particularly among families belonging to low economic categories(UNFPA - India, 2009). The findings of this study highlight that awareness about JSY scheme among new mothers was high in rural areas i.e. 95 per cent in Rajasthan. In other states, it was between 76-87 percent. Collectively, 81 per cent of the mothers were aware about the scheme. Most of the mothers received information from ASHA and some from their family members and relatives. The awareness of JSY scheme was low (61%) in UP. In comparison to the other four states, the knowledge among mothers in UP about accredited private hospitals which provide institutional delivery

services under the JSY was relatively high (66 percent), while in MP, Orissa, and Rajasthan it ranged from 6 to 11 per cent and in Bihar it was around 25 per cent (UNFPA - India 2009 p.10). Findings of the assessment report highlighted that, during 2008, institutional deliveries among public and accredited private health facility were recorded as 68 percent in MP and 67 per cent in Orissa, while in the same reference year (2008) it was recorded as 59 percent in Rajasthan, 49 percent in Bihar and the lowest in UP, 48 per cent. Further, the study shows that institutional delivery rose from 37 per cent to 48 per cent in Uttar Pradesh during 2008. Collectively it was found that 55 per cent of institutional deliveries took place in government health facilities and 47 per cent in accredited private health facilities in five states during 2008 (UNFPA - India, 2009 p. 10-11).

## **2.8 Institutional delivery and Maternal Mortality Rate in India**

The Government of India initiated JSY scheme to reduce maternal mortality with the promotion of institutional delivery. The first formal statistical impact evaluation of JSY was conducted by Lim et al. (2010) across the whole country.

An observational study was conducted by Gupta et al. (2012) in Madhya Pradesh, India, in tertiary care hospital, before and after implementation of JSY scheme, with sample of women presenting for institutional delivery. Study shows that, overall institutional deliveries increased by 42.6 per cent, including those, among rural, literate, primary literate person of poor socioeconomic strata (Gupta et al. 2012). Study further shows that the major causes of maternal mortality were eclampsia, pre-eclampsia and severe anaemia, both before and after implementation of JSY. The study found that anaemia was the most common morbidity factor. Among women who had given institutional births after the implementation of JSY, there were significant increases in eclampsia and pre-eclampsia, antepartum haemorrhage (APH), postpartum haemorrhage (PPH) and malaria (Gupta et al. 2012). In addition, the author argues that the scheme has increased institutional delivery of at-risk mothers, and therefore has the potential to reduce maternal morbidity and mortality and improve child survival, in turn ensuring equity in maternal healthcare in India (Gupta et al., 2012). The study also showed that overall

maternal mortality ratio (MMR) in the study population was increased. Further, maternal mortality was noted to be high (57.7% to 70.8%), in the 21-30 years age group, more than half of the maternal deaths were in illiterate women; it was also observed that in multigravida, maternal mortality was found to be low after implementation of JSY. However, the high number of cases of eclampsia indicated poor antenatal care services and poor and untimely referral (Gupta et al. 2012). Though JSY has witnessed to increasing the institutional delivery at the same why it has become failure to reduce the maternal mortality, even states like Madhya Pradesh government implemented Additional Cash Transfer Programme to cover the household below the poverty line, but study shows

Another recent study by Randive et al. (2013), among nine EAG states, shows that, after the inception of JSY, there is a change in the proportion of institutional delivery. Institutional deliveries have increased in nine states from a pre-programme average of 20 per cent to 49 per cent in the five years. Although the proportion of deliveries did increase, the degree of increment varied across the states (Randive et al. 2013). The study covered 284 study districts from nine EAG states and found that on average each district had a population of 1.7 million with varying proportion of poverty, literacy and urbanisation. The institutional birth rate ranged between, 16.8 per cent to 95.5 per cent (mean 56.2%), which demonstrates a wide variation in utilization of JSY services. The maternal mortality rate was found to be in the range of a minimum of 183 to the maximum of 451. The districts with higher fertility rates and a higher level of scarcity had a lower proportion of institutional births, while, districts with higher literacy and urbanization were found to have positive correlation. The proportion of the vulnerable population did not show much influence on uptake of institutional births. The study also shows that institutional delivery and C-section deliveries were negatively correlated (Bharat Randive et al. 2013). The proportion of deliveries have increased, but the author found there was no strong correlation between increasing institutional delivery and decline in MMR in the selected district ( Randive et al. 2013).

Another study in Madhya Pradesh shows that, the proportion of the deliveries have increased from 23.9 per cent in 2005 to 55.9 per cent in 2010 in the many districts of Madhya Pradesh. It was found that proportion of JSY supported institutional deliveries rose from 14 per cent in 2005 to 80 per cent in 2010, while declines in MMR was not found to be significantly associated with the proportion of increasing institutional deliveries in the study districts (Ng et al. 2014). Further study shows a large inter-district variation; the percentage decline was found ranging from 34.8 per cent to 2 per cent. The author argues that various reasons could be behind the limited effect of the programme on maternal mortality, but a possible explanation could be the poor quality of care provided to mothers attending health facility for child birth. In addition, many reports show that only a small proportion of the public health facilities have blood storage units or the provisions for conducting a caesarean section, both key life-saving functions (Ng et al. 2014).

## **2.9 Summary**

Maternal and child health (MCH) initiatives in India have evolved under the ambit of Family Planning Programme with focus on improving reducing maternal and child mortality and stabilizing the population. Over the decades government of India have launched several maternal and child health programmes with changes in approach and strategies to reduce maternal and child mortality. Earlier MCH strategies were focused on provision of antenatal care, high-risk pregnancy approach and Training of Birth Attendants (TBAs). But these strategies were not successful in decreasing the maternal mortality in the country. Later on a major shift occur in MCH strategies with focus on Emergency Obstetric Care (EmOC) to tackle high maternal mortality and its socio- medical factors through increases in institutional deliveries. The Reproductive and Child Health programme phase I and phase II in 2005 initiatives are focuses on EmOC approach to strengthen institutional capacities to provide efficient emergency obstetric care services. But despite such initiatives there was not much increase in institutional deliveries and decrease in maternal and child mortality. The major reason for failure of MCH strategies was exclusive focus on strengthening the supply side of MCH

services through improving institutional capacities and not the demand side through reducing socio economic and cultural barriers in accessing maternal and child health care services. As a result there has always been a misbalance between supply and demand sides of MCH services.

Janani Suraksha Yojana (JSY) is one of the significant initiatives under RCH launched in 2005 to increase the demand side of MCH services. Janani Suraksha Yojana (JSY) focuses on increasing institutional deliveries through Conditional Cash Transfer Programme (CCT). The program aims to address chronic underutilization of maternal and child health services particularly among vulnerable groups through transfer of cash on institutional deliveries.

The program is one of the most important components under National Rural Health Mission (NRHM) initiatives to improve maternal and child mortality and is one of the largest conditional cash transfer programs in the world

Analysis of the program and its effectiveness in increasing institutional deliveries and reducing maternal mortality by various research studies shows that over the years of implementation of scheme there has been an increase in number of institutional deliveries particularly among illiterate, poor socio economic group's women in rural areas compared to urban areas. But the program has not been able to reduce maternal and neo-natal mortality. The association between increase in institutional deliveries through a cash transfer scheme and decrease in maternal mortality is weak. There are several loopholes for this weak association at the program level implementation and in reducing the barriers to access for effective utilization of MCH services. Major direct causes of maternal mortality are still eclampsia and pre-eclampsia, antepartum haemorrhage (APH), postpartum haemorrhage (PPH) and malaria and others. Major indirect causes of maternal mortality are anemia and under-nutrition among pregnant women. Low institutional capacity and poor quality of care provided before, during and after institutional delivery to mothers and their new born child increases the risk of maternal mortality. Furthermore poor women from low socio economic groups coming to institutional deliveries are already sick and weak to have a safe and healthy delivery. Thus supply and



demand side factors and weak implementation of the program in states such as Uttar Pradesh has resulted in high maternal and neo-natal mortality.

## **Chapter- 3**

### **Methodology**

#### **3.1 Research Methodology**

##### **3.1.1 Conceptual Frame work**

The study is conceptualised within the back drop of rising maternal mortality in Uttar Pradesh state (UP) and implementation of Janani Suraksha Yojana (JSY) in the state to reduce maternal and infant mortality rate via a cash transfer scheme. The JSY scheme removes access barriers related to accessing institutional deliveries from health care institutions. Uttar Pradesh has 72 districts and each districts are divided into 18 mandals (group of district). The study is conceptualised in Kurebhar Block in Sultanpur district of Faizabad mandal in UP. The Sultanpur district of Faizabad mandal in UP is one of the district among others where despite implementation of JSY scheme under National Rural Health Mission (NRHM) maternal mortality has not been reduced.

The present research captures data on perceptions and utilization of JSY maternal and child health care services and its monetary benefits from the health care institutions from both health providers perceptives and women beneficiaries perceptives under JSY scheme. The study collected data from both women beneficiaries under JSY scheme who gave birth at the health institutions and at home. The study captures perceptions of health care providers working at the health care institutions and grass root ASHA health workers delivering maternal and child health care services to the population under JSY scheme. The study collect data on perception on JSY scheme and barriers in accessing JSY scheme maternal and child health care services from women respondents. The collect data on preceptions of Health care providers on JSY scheme and its contribution in increasing insttutional deliveries for decreasing maternal mortality. The study overall examines the relationship

between implementation of JSY scheme and its role in increasing institutional deliveries for decreasing maternal mortality state (UP).

### **3.1.2 Objective**

#### **Broad Objective**

To study Janani Suraksha Yojana (JSY) scheme from both the health care providers and beneficiaries perspective for identifying the barriers to the utilization of the scheme and its role in institutional birth in Kurebhar Block in Sultanpur District Uttar Pradesh.

#### **Specific Objectives**

1. To understand the perspective of beneficiaries availing JSY scheme.
2. To identify the barriers that, exist in access to JSY scheme.
3. To document the perceptions of Health Care Providers about JSY Scheme and its contribution to Institutional Delivery.
4. To examine the relation between JSY and Institutional Delivery.

### **3.1.3 Sampling**

The study has selected institutions, villages, and respondents using purposive sampling. Nine villages under the study were purposively selected from Kurebhar Block in Sultanpur district of Faizabad mandal in UP. From each nine villages health care institutions was selected for the study. These health care institutions consist of Primary health centres; Additional Primary health centres and Sub-Centre in each village according to population norm (see Table 3.1). Data for the study is collected from both JSY beneficiaries and health care providers at the health care institutions and health care worker working in the villages.

### **3.1.4 Selection of Respondents**

The researcher has purposively selected nine villages where 10 or more than 10 institutional deliveries have been conducted in last one year. From each village selected 10 beneficiaries under JSY scheme were purposively selected

as respondents of the study from the list of JSY beneficiaries provided by ASHA village level health care worker.

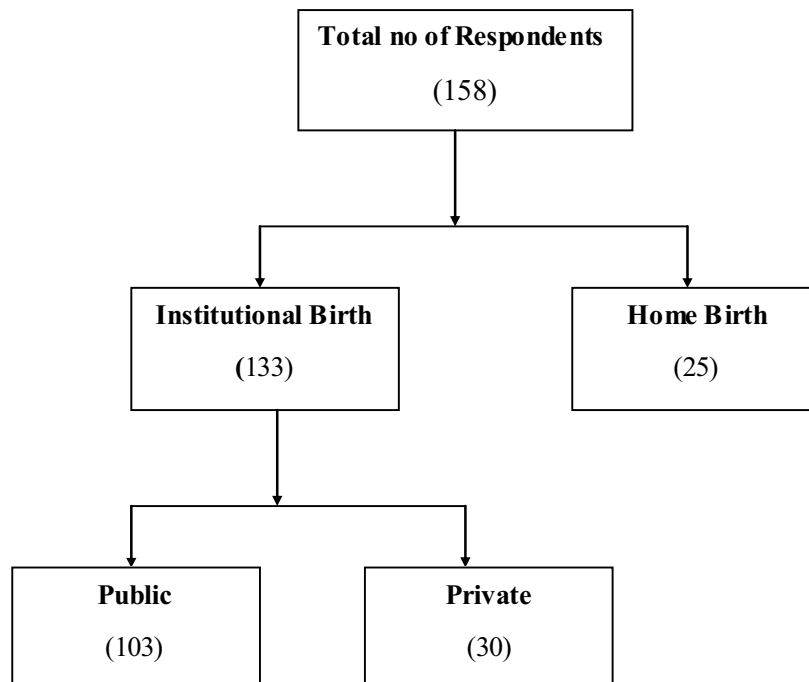
The researcher selected nine ASHA workers from each villages for collecting information of health care providers perceptions regarding JSY scheme but only five ASHA workers were interviewed as others were not available at the time of collecting the data.

The unit of analysis of the study was women (in reproductive age group 15-49 years) had given birth at health care institution in last one in the villages selected for this study.

There were some women who gave home birth under JSY scheme in the villages selected for this study. But such women were not registered as JSY beneficiaries by ASHA in the JSY beneficiaries register and do not come to health institutions to collect JSY monetary benefits. Thus women's giving home births does not get any monetary benefits under JSY scheme. The study also collected data on women's giving birth at home and their perceptions on JSY scheme and its utilization pattern.

**Figure 3.1**

**Sample Size**



The figure 3.1 highlights out of 158 delivered cases 133 were institutional delivery and 25 home births. Further among institutional delivery out of 133 delivered cases 103 were public institutional delivery and 30 were private.

### 3.1.5 Selection of Institutions

Institutions have been chosen purposely after reviewing the facility of institutional delivery. Accordingly, the PHC Kurebhar, one Additional PHC Sudanapur and three Sub-centres have been considered for the present study. All the nine villages come under one PHC. However, there are two, Additional PHC, in the vicinity of these nine villages. But only one Additional PHC offers maternity services. All the nine villages come under the catchment area of three Sub-centres but only two of them are presently functional. These institutions had altogether good numbers of institutional delivery and were geographically accessible.

**Table 3.1**

#### Selection of Institution

<b>Primary Health Centre</b>	<b>Additional Primary Health Centre</b>	<b>Sub Centre</b>
<b>Sudanapur PHC Kurebhar</b>	1. Additional PHC Sudanapur	1. Sub Centre Katka Khanpur
		2. Sub-centre Mahilo Ashapur
		3. Sub Centre Kharsoma

Among the five health institutions, several medical and non-medical health care providers have been interviewed such as Medical Officer In charge (MOIC), Health Education Officer (HEO), Lady Health Visitor (LHV), Auxiliary Nurse Midwife (ANM), Lab Technician, Anganwadi Supervisor (AWS), Anganwadi Worker (AWW), ASHA Worker and Ambulance Service Providers. The details are shown in Table 3.2.

**Table 3.2****Institution and Healthcare Provider covered under the Study**

Health Institution	No. of Unit	Type of Health Care Provider								
		MOIC	HCO	LT	ANM	LHV	ASHA	AWW	AWS	Ambulance Service Provider.
PHC	1	1	1	1	1	1	-	-	1	1
APHC	1	-	-	-	1	-	-	-	-	-
SC-1	1	-	-	-	1	-	1	1	-	-
SC-2	1	-	-	-	-	-	1	1	-	-
SC-3	1	-	-	-	-	-	3	1	-	-
Total	5	1	1	1	3	1	5	3	1	1

**3.1.6 Type of Data and Tools of Data Collection**

Both primary and secondary data have been used. Primary data regarding the socio-economic background, utilisation of JSY services and institutional delivery (both public and private) and home birth details were collected by using semi-structured interview schedule. In-depth interviews were conducted with new mothers to obtain detailed pathway of care utilised. The interview guide was used to collect the in-depth details regarding utilization of JSY services their experience with institutional/home births, the behaviour of health care providers and access, barriers and other traditional and home remedies performed. To understand the dynamics, between home births and institutional births, case study method has been used.

In all the villages total 25 women gave, home birth. From these 25 cases of home birth only four women were purposively selected under the study to collect their perceptions on JSY and utilization of maternal health care services. The study collected data on women perception on difficulties that they faced while availing JSY services and reasons for adopting home birth and institutional birth at private health care facilities.

To understand the perception of health care providers, regarding JSY scheme and their beneficiaries, Seventeen Key Informants Interviews were conducted with medical and non-medical health care providers such as MOIC, HEO, Lab Technician, LHV, ANM, ASHA workers, Anganwadi Supervisor, Anganwadi workers and Ambulance Service Provider. To understand the quality of care issues, health institutions visit were done.

In addition to this secondary data has been collected from different sources such as; books regarding JSY, Reproductive health, etc, published Journal Articles, Government Reports of District Level Household Survey (DLHS), ASH (Annual Health Survey), NFHS, SRS, NRHM, District Gazetteer and United Nations Children's Fund report, World Health Organization Report

### **3.1.7 Data Analysis**

After data collection, Quantitative data were entered in M-S. Excel, further analysis was done in Special Package for Statistical Software (SPSS- 21). Tables, bar diagram, pie chart have been used to show the demographic profile of the respondents and distribution of the JSY services among the population. Qualitative data were analyzed by organizing details under various domains such as the general profile of the respondents, household details, and history of previous and current birth and reasons for a home birth. Further comparison was done among four case studies using the domains.

### **3.1.8 Ethical Consideration**

Ethical clearance for the study was taken from the Centre of Social Medicine and Community Health, School of Social Sciences, Jawaharlal Nehru University, New Delhi. The participation to the researcher was voluntary, and the respondents were clearly informed about the purposive of the study that the study was conducted for academic research purpose and is part of researchers MPhil course. Involvement in the research does not ensure any monetary or other benefits to the respondents and the data collected for the study will be used only for research purpose of the study. The participation in the study of participants was on voluntary and participants were asked for informed verbal consent for collecting the data of study.

### 3.1.9 Limitation

Since the study was conducted within limited time which is one year and with limited resources the study findings are to be reviewed taking into account the limitations of the study. The researcher faced many limitations while collecting data of the study. These limitations were-

- During the time data collection, ten of the respondents were not available at their home at the time of collecting the data for the research by researcher. Some of them had gone to work outside, and other went to their maternal home. However according to their availability the researcher visited again to their houses and if the respondent were available data was collected.
- The study was conducted during the month of December. The weather conditions during the month were extremely cold for collecting data. As a result many women were not ready to come out of their houses with their newly born babies.

Researcher has to persuade the women for the collecting data for the study. After much effort from the researcher side women agreed to come out for only for five and ten minutes only. Within this limited time frame, the researcher tried to collect information regarding availing of JSY services and their experiences of institutional birth. Thus details other than the experience of birth and availing JSY services were collected from the respondent's mother-in-law.

- Fifteen respondents were unwilling to give information regarding family planning practices particularly to a male researcher. For such cases ASHA worker was asked by the researcher to collect information on family planning practices.
- In the case of questions regarding monthly income, some of the respondents replied that they never calculated their monthly income, thus based on nature of work respondents and their family members and their wages the researcher helped them to calculate their monthly income. Thus data on respondents and their household's socio economic status of must be reviewed within this limitation of the study.



## **3.2 Demographic profile of the village and the respondents**

In this section of the chapter, we present the demographic profile of the village and the selected respondents.

### **3.2.1 History and District Profile of Sultanpur**

The district is named after its headquarters town Sultanpur. In ancient days, this town was known as Kusapura or Kusbhawanpur after the name of its founder Kusha, son of Rama (District Gazetteers 1982 p.1). Till about the close of the 13<sup>th</sup> century, the town was reportedly held by the Bhars, when two brothers, Saiyid Muhammad and Saiyid Ala-ud-din, horse dealers by profession, offered some horses for sale to its Bhar chieftain. The latter seized horses and put the two brothers to death, news of which prompted Ala-ud-din Khalji to set out himself to punish the Bhars. He overpowered the Bhars by trick after almost a year's unsuccessful siege and old town of Kusbhawanpur, was reduced to ashes and a new town called Sultanpur, so named from rank of victor rose upon its ruin (District Gazetteers 1982)<sup>3</sup>.

At that time, chief land owning families of the time were the Rajputs of various clans who had 76.16% of the total land area. . Among them Raghuvanshies and the Rajkumar's together held over one-fourth of the district, while their kinsmen, the Bachgotis and Rajwars owned 11.4% and 3.4%, respectively. The Sultanpur districts of Uttar Pradesh represent a complex array of the physical and geopolitical environment, well known for geo-hydrological, biological, aesthetic and cultural values (District Gazetteers 1982, p. 1).

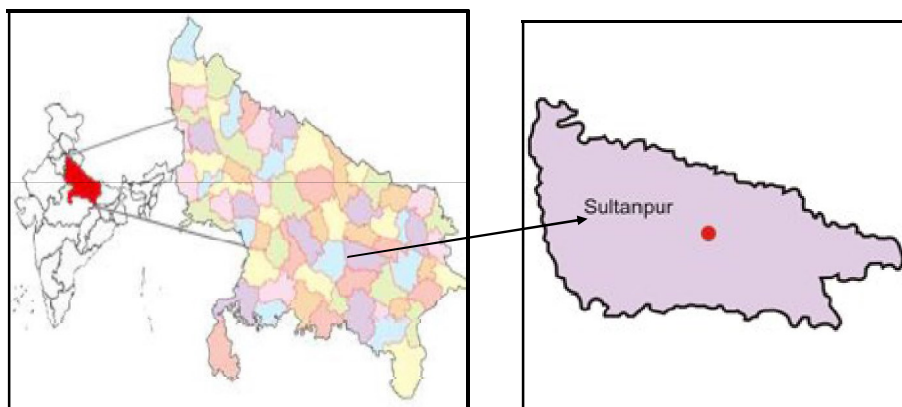
### **3.2.2 Location & Boundaries**

The District of Sultanpur lies on both sides of river Gomati between LAT. 25<sup>o</sup>59 and 26<sup>o</sup>40'N and 81<sup>o</sup>32'E and 82<sup>o</sup>41'E. District Faizabad bounds it on the north, district Azamgarh and Jaunpur on the east, the district of Pratapgarh on the south and district of Rae Bareli and Bara Banki respectively on the west and north- west (District Gazetteers 1982).

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<sup>3</sup> The Sultanpur District Gazetteer published in 1982 which sheds some light on the history and origin of the district.

**Figure 3.2**  
**Sultanpur District Map**



**Source :**<http://www.districtsultanpur.com/index.aspx>(accessed on 05/05/2015).

### **3.2.3 Area**

The average length of the district is about 129km and the extreme breadth from north to south is about 61 km. The district stands 38<sup>th</sup> in the State in respect of the area, which in 1971, according to the central statistical organisation was 4424 sq. km. The total geographic area of the district is 2672.89 km<sup>2</sup> (District Gazetteers 1982). From the administrative point of view, the district has been divided into 7 Tehsils, 24 blocks, 1 Nagar Palika and 4 Town areas. There is also 1 Lok Sabha seat and 5 Vidhan Sabha Seats (Census 2011).

### **3.2.4 Population**

According to census 2011 Sultanpur had the population of 37, 97117 of which male and female were 19, 14586 and 18, 82531 respectively.

**Table 3.3**  
**Demographic Profile of Sultanpur**

<b>Demographic Profile</b>	<b>2001</b>	<b>2011</b>
Population	3,214,832	3797117
Female literacy rate	40.86	58.28
Sex Ratio (per 1000)	980	983
Child Sex Ratio (0-6 age)	941	922
Birth rate	22.8*	22

**Source:** <http://www.census2011.co.in/census/district/550-sultanpur.html>  
[\\*http://mohfw.nic.in/WriteReadData/l892s/3503492088FW%20Statistics%202011%20Revised%2031%2010%2011.pdf](http://mohfw.nic.in/WriteReadData/l892s/3503492088FW%20Statistics%202011%20Revised%2031%2010%2011.pdf)

Census 2011 data shows that a change of 18 per cent in the population was gained compared to population as per 2001. The literacy rate has increased among the male and female population than previous census 2001 (from 40.86% in 2001 to 58.28% in 2011 in female). Though female literacy rate remains low than male literacy. The Data reveals that female sex ratio has improved than previous years, but child sex ratio has declined sharply from 941 in 2001 to 922 in 2011.

In addition to, Annual Health Survey Fact Sheet 2012-2013 data highlights that in Uttar Pradesh, Devi Patan Mandal<sup>4</sup> have highest MMR (366/100000) and having highest lifetime risk (1.7%) followed by Faizabad<sup>5</sup> with second highest MMR (364/100000) and with 1.5 per cent lifetime risk. Data also revealed that among the age group 20-24 years were having large proportion (30) of maternal deaths across the all-district in Uttar Pradesh (Registrar General of India, 2012).

### **3.2.5 Health Care Facility in Sultanpur**

Sultanpur District has a good number of the health care institution to provide a health facility to the population of the entire district. In Sultanpur District,

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<sup>4</sup> Under Devi Patan Mandal four district: Bahaich, Shrawasti, Balrampur and Gonda

<sup>5</sup> Under Faizabad Mandal four District: Barabanki, Faizabad, Ambedkar Nagar and Sultanpur

there are 232 Sub -Centres, fifty-four Primary Health Centres, eleven Community Health Centres and two district hospitals.

### **3.2.6 Block Profile**

Sultanpur district has twenty-four community development blocks. Out of twenty-four blocks, Kurebhar is having a first position in infrastructure facilities and socioeconomic development, purposively selected for the present study. A study by Bhatia & Rai (2004), highlights that, in Uttar Pradesh among 380 community development (CD) blocks from 32 district, Kurebhar stands first rank in case of infrastructure facilities and socioeconomic development in states as well as in district also. In regards number of institutional delivery after district hospital, PHC Kurebhar has first position (as per Medical Officer In-charge PHC Kurebhar). Having good position among all blocks in district, home deliveries and private institutional birth is still taking place in Kurebhar block. In this block, there is a small market, development office, police station, railway station and health centre. Being a town area and close to the villages, people have the opportunity to earn from small scale industries such as biscuit factory, furniture factory, etc. Kurebhar comes under Isuli Vidhan Sahabha Constituency and Sultanpur Lok Sabha Constituency. It is situated between Ayodhya and Prayag National Highway 96 and 23.5 kilometres in the north of the district headquarters.

In Kurebhar block there is no community health centres (CHC). Primary health centre (PHC) is only health care institutions available for delivering health services to the whole population. But Kurebhar block PHC is very well functional health care institutions delivering health services at the grassroots level to the population in comparison to other blocks. In addition to there are a traditional healer, private practitioner, quack, and some small registered clinics providing health care services to the village members in the villages. Most of the villagers are daily wage labourers therefore it is not possible to avail health care services from public health institutions. Thus other informal and private health care providers are easily accessible health practitioners by villagers at any time for health care services.

**Table 3.4**

**Health Care Facility in Kurebhar Block**

PHC	1
APHC	4
SC	19
Village	77
ASHA	195
AWW	205
ANM	24

**Source:** as per Health Education Officer PHC Kurebhar, \*1<sup>st</sup> April 2014 to 21<sup>st</sup> January 2015.

**3.2.7 Study Village**

In Kurebhar block, there are 77 Village Panchayats; out of these nine were purposively selected for the study (see table 3.5). The detailed list of beneficiaries of 77 village panchayats, obtained from PHC. After that, only those village were selected purposively, having ten beneficiaries or above.

**Table 3.5****Profile of selected villages and number of cases**

Village Name	Frequency	No of House holds	Total Population	Total Male	Total Female	Location form maternity centre
Inayatpur	25	353	2212	1070	1142	
SudnaPur	15	106	727	390	337	N
Kharsoma	20	298	1629	843	786	N
Bhagwanpur	10	149	810	407	403	F
Diwakarpatti	20	101	651	326	325	F
Beethal Pur	11	57	420	208	212	F
Hajipur	20	81	471	231	240	F
Lakhaicha	16	176	955	473	482	F
Bajhna	21	455	2608	1321	1287	N
Total	158	1821	10483	5269	5214	
Source: <a href="http://www.censusindia.gov.in/Census_Data_2001/Village_Directory/View_data/Village_Profile.aspx">http://www.censusindia.gov.in/Census_Data_2001/Village_Directory/View_data/Village_Profile.aspx</a> , <a href="http://censusindia.gov.in/pca/cdb_pca_census/Houselisting-housing-UP.html">http://censusindia.gov.in/pca/cdb_pca_census/Houselisting-housing-UP.html</a>						

N= near, F=far,

Table 3.5 shows that, out of nine villages only two villages have high sex ratio and remaining have low sex ratio. In village Sudnapur there is an Additional PHC and two private clinics and three quacks near the village in a market which is very close to Additional PHC. Sub-centre is available in two villages, Kharsoma and Bajhna, while remaining six villages have no health care facility. Health centres are far from the villages more than two to three kilometres, so people used to visit nearest private practitioner and private health care providers also to avail the care.

### 3.2.8 Demographic profile of the respondents

This section includes age, education, religion, social category, type of family; family size, age at marriage and age at co- habitation of the respondents. Table 3.7 highlights that, more than half (55.1%) of the respondents were between age of 22-26 years, 3.8% belonged to 18-21 years age group and less than half (41.1%) of the respondents were between the age group of 27-31 years and 32-38 years. The data highlights that, more than one third (32.3%) of the women were illiterate, one-fifth (21.8%) of the women had completed up to lower primary education and rest had education above the level of high school. Most (76.%) of the respondent were from hindu religion while less than one fourth (23.4%) of the respondents were from muslim community.

Further it was found most (72.8%) of the respondents were owning land but size of land was fragmented among the population. More than one fourth (27.2%) of the respondents, were not owning land. Because of small land size most (79.7%) of the respondents were dependent on daily wage labour. This factor is also true for women's husband occupation. More than half of respondent's husbands (57.6%) were also daily wage labourers.

**Table 3.6**

#### **Demographic Profile of the Respondents**

<b>Age group</b>	<b>Frequency (n)</b>	<b>Percent (%)</b>
18-21years	6	3.8
22-26 years	87	55.1
27-31 years	44	27.8
32-38 years	21	13.3
<b>Education</b>		
Illiterate	51	32.3
Lower Primary	33	20.9
Upper primary	18	11.4
High school	21	13.3
Higher secondary	10	6.3
Graduate	25	15.8

<b>Religion</b>		
Hindu	121	76.6
Muslim	37	23.4
<b>Social Category</b>		
SC	41	25.9
ST	4	2.5
OBC	94	59.5
General	19	12.0
<b>Type of Family</b>		
Joint	110	69.6
Nuclear	48	30.4
<b>Family Size</b>		
3 to 5 members	42	26.6
6 to 8 members	72	45.6
9 to 11 members	30	19.0
12 to 14 members	9	5.7
15 to 17 members	5	3.2
<b>Age at Marriage</b>		
Below Legal Age (<18)	57	36.1
Above Legal Age (>18)	101	63.9
<b>Age at Cohabitation</b>		
Below Legal Age (<18)	49	31.0
Above Legal Age (>18)	109	69.0
<b>Occupation</b>		
House Wife (HW)	32	20.3
Daily Wage Labour (DWL)	126	79.7
<b>Ownership of land</b>		
Yes	115	72.8
No Land	43	27.2
<b>Land Amount</b>		
No Land	43	27.2
Below 1 Bigha	32	20.3



1 to 2 Bigha	14	8.9
2 to 4 Bigha	23	14.6
4 to 5 Bigha	26	16.5
Above 6 Bigha	20	12.7

Source: Primary Data

**Table 3.7**

**Household Details**

<b>Monthly income</b>	<b>Frequency (n)</b>	<b>Percent (%)</b>
Below 3000 rupees	28	17.7
3001 to 5000 rupees	87	55.1
5001 to 7000 rupees	13	8.2
7001 to 10000 rupees	11	7.0
10001 and above rupees	19	12.0
<b>Ration card</b>		
Antodaya	48	30.4
BPL	54	34.2
APL	49	31.0
No Ration Card	7	4.4
<b>House ownership</b>		
Self	158	100.0
Rented	-	-
<b>Type of house</b>		
Thatcher	16	10.1
Kuchha	64	40.5
Semi Pucca	38	24.1
Pucca	40	25.3
<b>No. of Rooms in the house</b>		
One room	62	39.2
Two rooms	33	20.9

Three rooms	26	16.5
Four rooms	22	13.9
Above four	15	9.5
<b>Electricity status</b>		
Yes	124	78.5
No	34	21.5
<b>Source of drinking water</b>		
Own hand pump	142	89.9
Well	4	2.5
Government hand pump	12	7.6
<b>Distance of source of drinking water</b>		
Below 20 meters	132	83.5
20 to 50 meters	16	10.1
Above 50 meters	10	6.3
<b>Toilet Facility</b>		
Yes	19	12.0
No	139	88.0
<b>Fuel used for Cooking</b>		
Wood	116	73.4
Cow dung	14	8.9
Kerosene oil	13	8.2
Gas	15	9.5
<b>Agriculture Production</b>		
Yes	99	62.7
No	59	37.3
<b>Live Stock</b>		
Yes	62	39.2
No	96	60.8
<b>Assets*</b>		
Yes	41	25.9
No	117	74.1

Conti..

<b>Type of job performed by husband</b>		
Daily wage labourer	91	57.6
Farming	47	29.7
Self-employed	20	12.7
*Only Motor vehicle that was used as a mode of transportation other things are excluded from this category		

**Source:** Primary Data

Table 3.7 reveals that, most (72.8%) of the respondent's monthly income was below five thousand rupees; only less than one-third (27.23%) women earned between five thousand to ten thousand rupees and majority (74.7%) of the respondents fell below poverty line. Almost half (50.6%) of the respondents were living in thached and in kuchha houses. Most of the respondents were having electricity connection. Majortity (89.9%) of the respondents were using handpump for safe drinking water. A few (12%) of the respondents were found having toilet facility. For cooking food majority of the women(73.4) used fuelwood while a few (9.5%) of the women used liquified petroleum gas (LPG). More than half (62.5%) of the women work as daily wage labourers working on agricultural fields. Less than half (39.2%) were having live stock for their family consumption. One fourth (25.9%) of the women reported they have some mode of transportation such motorcycle, trycicle etc., which they used durinf delivery.

## **CHAPTER 4**

### **FINDINGS**

#### **4.1 Study findings**

For the present study, the sample comprised 158 households from nine villages that covered various socioeconomic groups. Primary respondents were from reproductive age group fifteen to forty-five years. Data analyzed with the help of Special Package for Statistical Software (SPSS version-21). This chapter is divided into two sections; first section deals with the earlier history of pregnancy and utilization of JSY services which covers Antenatal, Intranatal and Post natal care. The section also includes the perception of beneficiaries and providers on JSY service. Second section deals with the access and barriers which affect the utilization of JSY services.

##### **4.1.1 Infant mortality and living children**

Field study shows a high prevalence of infant mortality among respondents studied and it is high among the younger age (see table 4.1). This section deals with the history of infant mortality, still birth, abortion and details about living children.

**Table 4.1****History of Infant Mortality (as per Respondents)**

<b>History of infant deaths</b>	<b>Frequency (n)</b>	<b>Percent (%)</b>
Yes	29	18.4
No	129	81.6
<b>Number of Infant deaths experienced</b>		
Single child	23	14.6
Two children	4	2.5
More than two children	2	1.3
Zero	136	86.1
<b>Age at child at the time of death</b>		
Within 3 months of birth	14	8.9
3 to 6 months of birth	9	5.7
Up to 6-12 months of birth	6	3.8
<b>Still birth</b>		
Yes	17	10.8
No	141	89.2
<b>Abortion</b>		
Yes	12	7.6
No	146	92.4
<b>Place of abortion (N=12)</b>		
District hospital	2	16.7
Private hospital	9	75.0
Home	1	8.3

Table 4.1 highlights that, out of 158 respondents, 29 had a history of infant death. Only a few (7.6%) of the respondents had reported a history of abortion. Most (75%) of the abortions, took place at private hospital, few (16.7%) were done at District Hospital and only one woman said that, she had aborted at home after consuming medicine that her husband had given to her. About the infant mortality Medical Officer in Charge revealed:

*“I cannot tell the exact figure, but major causes of infant mortality are asphyxia and low birth weight. The route cause is anaemia, if the mother is anaemic then chances of risk is high for child mortality.”*

**-Medical Officer in Charge PHC Kurebhar (Anexture-1)**

**Figure 4.1**

**Number of total living children**

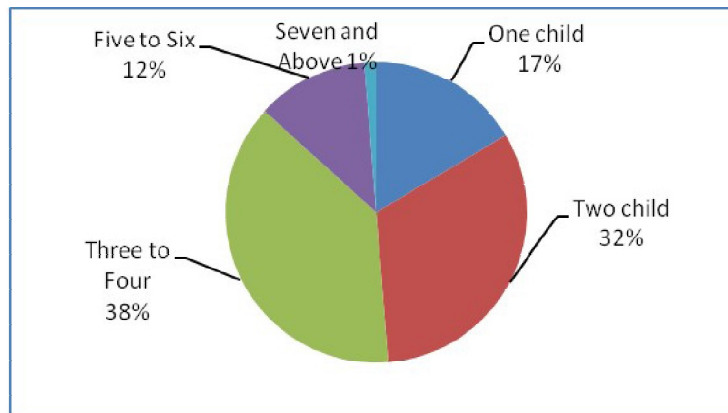


Diagram 4.1 revealed that, less than half (48%) women had one to two living children, more than one-third (38%) had three to four living children and few (13%) women had more than five children. Present data shows that, more than half (55.1 %) of the respondents were in the age group 22-26 years (see table 3.6) hence the number of the children might increase in coming years.

#### **4.1.2 Utilization Pattern of JSY Services**

Janani Suraksha Yojana is a conditional cash transfer scheme, which ensures the quality of maternal health care during antenatal, intra-natal and immediate postnatal care along with referral services and transportation assistance. This scheme is being delivered by the health workers at the village, sub-centre, PHC, CHC and district levels. This section will highlight the utilization patterns of various services under the scheme.

### 4.1.3 Antenatal Care

According to RCH-1 checking of the blood pressure and weight, and abdominal checkups are the essential for the antenatal care. Antenatal care constitutes one of the key elements towards initiatives to promote safe motherhood (ASH 2012-2013).

Respondents revealed that ANC checkups included administration of Tetanus Toxoid injection, distribution of iron folic acid tablets. Though the entries of blood pressure and weight records were found on most of the JSY cards but women reported that these measurements were not performed during ANCs. These show that there are some discrepancies in the provisioning of the health service system and the experience of the beneficiaries. During the antenatal care day, ANM only administered Tetanus Toxoid, no anymore checkups, during the field visit, it was also observed that, at vaccination day ANM left the centre early, if any wage labourer pregnant women delayed to reach at centre after her work, she would not be able to get vaccination that day due to their field work. In this she had to wait for next vaccination day.

**Table 4.2**

#### Socioeconomic status of the respondents and utilization of ANC services

Socio-economic indicators	Utilization of ANC components (N=158)					
	BP	Weight	Blood test	Abdomen examination	Two doses TT	100 plus IFA tablets
Social group	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)
SC	4.9 (2)	2.4 (1)	14.6 (6)	0.0 (0)	85.4 (35)	0.0 (0)
ST	0.0 (0)	0.0 (0)	0.0 (0)	0.0 (0)	100.0 (3)	0.0 (0)
OBC	25.5 (24)	24.5 (23)	26.6 (25)	13.8 (13)	95.7 (90)	3.2 (3)
General	68.4 (13)	73.7 (14)	73.7 (14)	57.9 (11)	100.0 (19)	21.1 (4)

<b>Education</b>						
Illiterate	5.9 (3)	3.9 (2)	5.9 (3)	0.0 (0)	90.2 (46)	0.0 (0)
Lower- primary	18.2 (6)	18.2 (6)	30.3 (10)	6.1 (2)	90.9 (30)	0.0 (0)
Upper- primary	50.0 (9)	50.0 (9)	50.0 (9)	27.8 (5)	94.4 (17)	5.6 (1)
High school	23.8 (5)	23.8 (5)	33.3 (7)	19.0 (4)	100.0 (21)	23.8 (5)
Higher secondary	50.0 (5)	50.0 (5)	50.0 (5)	40.0 (4)	100.0 (10)	2.5 (4)
Graduate	44.0 (11)	44.0 (11)	44.0 (11)	36.0 (9)	96.0 (24)	4.0 (1)
<b>Monthly income</b>						
Below 3000 rupees	11.5 (10)	10.3 (9)	16.1 (14)	4.6 (4)	90.8 (79)	0.0 (0)
3001 to 5000 rupees	35.7 (10)	35.7 (10)	32.1 (9)	21.4 (6)	100.0 (28)	3.4 (3)
5001 to 7000 rupees	23.1 (3)	23.1 (3)	30.8 (4)	15.4 (2)	92.3 (12)	3.6 (1)
7001 to 10000 rupees	45.5 (5)	45.5 (5)	54.5 (6)	36.4 (2)	100.0 (11)	9.1 (1)
10001 and above	57.9 (11)	57.9 (11)	63.2 (12)	42.1 (4)	94.7 (18)	10.5 (2)
<b>Land ownership</b>						
No Land	3.1 (1)	3.1 (1)	12.5 (4)	0.0 (0)	87.5 (28)	0.0 (0)
Below 1 Bigha	14.0 (6)	14.0 (6)	20.9 (9)	2.3 (1)	90.7 (39)	0.0 (0)
1 to 2 Bigha	21.4 (3)	21.4 (3)	21.4 (3)	21.4 (3)	100.0 (14)	0.0 (0)
2 to 4 Bigha	26.1 (6)	21.7 (5)	21.7 (5)	17.4 (4)	95.7 (22)	0.0 (0)
4 to 5 Bigha	42.3 (11)	42.3 (11)	42.3 (11)	34.6 (9)	96.2 (25)	19.2 (5)
Above 6 Bigha	60.0 (12)	60.0 (12)	65.0 (13)	35.0 (7)	100.0 (20)	19.2 (2)



Table 4.2 reveals that a low utilization of JSY services was recorded, among poor, marginalized women. It was found that, among SC & ST population a very a few (4.9%) of the women's blood pressure was measured, followed by weight (2.4%) and blood test (4.6%) respectively. The majority (85.4%) of the women were administered with two doses of TT and among ST population it was found hundred per cent that gives a positive sign to provide a good immunization to the pregnant women. The other indicators such as education level, monthly income and occupation of the mother, had the same impact on to be a low utilization of the JSY. The only one component two dose of TT was found to some extent at a satisfactory level.

Further data highlights that, among OBC social group, one-fourth (25.5%) of the women received blood pressure checkups followed by weight (24.5%), blood (26.6%), abdomen examined (13.8%) respectively. The majority (95.7%) of the women reported for two doses of TT and very a few reported for consuming hundred plus iron folic acid tablets. The vast difference was noted in General population I all components. In this group, most (68.4%) of the women received blood pressure checkups, followed by weight measuring (73.7%), blood test (73.7%), abdomen examination (57.9%) respectively. In addition to, hundred per cent of the women received two doses of TT and more than one fifth (21.1%) of the women consumed hundred plus IFA tablets.

Present data also highlights that women who had education up to upper primary level they received some checkups such as 50 per cent blood pressure examination, followed by 50 per cent weight, 50 per cent blood test, 27 per cent abdominal examination and 94.4 per cent were administered with TT respectively.

Regarding IFA tablets consumption, it was found among graduate women very low (4%) than the women (23.8%) who had education level high school. Present data reveals a very low utilization of the JSY services were found except two doses of TT, among the poor, vulnerable group of the women.

**Table 4.3**

**Details of initial phase of pregnancy**

<b>Pregnancy detection</b>	<b>Frequency (n)</b>	<b>Percent (%)</b>
First month	3	1.9
Second month	102	64.6
Third month	46	29.1
Fourth month	2	1.3
Fifth month	5	3.2
<b>Pregnancy detection kit used by respondents</b>		
Yes	100	63.3
No	58	36.7
<b>ANC services received at</b>		
Public	133	84.2
Private*	25	15.8
<b>Awareness about JSY</b>		
Yes	26	16.5
No	132	83.5
<b>Registration of pregnancy</b>		
Yes	158	100
No	-	-
<b>Registered with whom</b>		
ANM	144	91.1
ASHA	8	5.1
Staff Nurse	6	3.8
<b>If any difficulty faced during registration</b>		
Yes	2	1.3
No	156	98.7
<b>Ultrasound test**</b>		
Yes	68	43.0
No	90	57.0
<b>Cost of ultrasound check-up (N=68)</b>		
Less than ₹500	29	42.6
₹500 to ₹700	33	48.5
₹700 to ₹1000	4	5.9
₹1000 and above	2	2.9
* Private is not under the scope of this study. ** Only done at private clinics, N/A = Not Applicable, all 158 respondents were registered at public hospital but 25 women had availed antenatal care services from private health care also.		

(N=158)

Table 4.3 shows that, more than half (64.1%) of the respondents came to know about their pregnancy in the second month, and as low as 1.8% of the women came to know in the first month. More than half (64.1%) of the women used Pregnancy Kit to confirm their pregnancy. Though most of the respondents (84.7%) did not know the name of the scheme, but they knew that if they give birth of their child at government hospital they will get some money.

*“Most of the women are not aware regarding JSY programme. There is a communication gap within public and administration”.*

***-Medical Officer in Charge PHC Kurebhar (Anexture-1)***

*“The criteria for selection of these ASHA, during JSY implementation, education level was very low as eligibility a criterion that is why sometimes they would not be able to communicate with the family members and with the community also”.*

***-Health Education Officer PHC Kurebhar (Anexture-1)***

Most of the respondents (91.8%) were registered by ANM and a few (3.5%) were recorded by Staff Nurse. Most of (98.8%) the respondents did not face any problem during registration of pregnancy. Some of the women from poor socio-economic background said that, they had to pay ₹20-30 to the ANM for JSY card during registration. There were few (15.8 %) women who visited private health institutions or physicians at various gestational periods. Though these women were availing antenatal care services from public hospital but, they also attended private health care institution also as the ANM in the public hospitals didn't treat them well, as a result they had to pay from their pocket for availing the facilities at the private health care, which ranges from 1000-2500 rupees. .

A large number of women (43%) were recommended for ultrasonography by ANM. Most of these women were from poor socio- economic background whose monthly income was below five thousand. Most of the women believed that if they did not go through checkups something wrong would happen to them and their child and then they will be held responsible for any

miss happening by the ANM, so women felt that ultrasound testing is must for them. As the ultrasonography testing facilities in the government institution is not located anywhere nearby, women had to travel more than twenty kilometres from the PHC to reach district hospital to avail the service. Therefore, women were always reluctant to get the testing done in district hospital. However several small private clinics and pathology centres had come up within three hundred meters near PHC, these clinics and centres were the preferential facilities for women to avail ultrasound facilities. Some of the respondents also said that, with the recommendation from ANM and some ASHAs they had to pay a lesser amount of money for the ultrasound test in the private clinic in the vicinity of the village. It implies that the health care providers had linkages to these small clinics. Women who had no complications during the whole period of pregnancy were also recommended to go for ultrasonography test. Such practices had also contributed to an increased out of pocket expenditures on antenatal care.

**Table 4.4**

**Distribution of components of ANC checkups among women (N=158)**

ANC services	Frequency (n)	Percent (%)
<b>Gestation period for first checkup</b>		
Between 3 to 4 months	116	73.4
Between 5 to 6 months	37	23.4
Between 7 to 8 months	5	3.2
<b>Check up by whom</b>		
Staff Nurse	7	4.4
ANM/LHV	150	94.9
Nurse/Midwife	1	.6
<b>Place of ANC checkups</b>		
During VHND at village	76	48.1
Sub Centre	8	5.1
Additional PHC	35	22.2
PHC	30	19.0
District Hospital	9	5.7

<b>Number of ANC checkups completed by women</b>		
One check ups	10	6.3
Two checkups	144	91.1
Three checkups	4	2.5
<b>Satisfaction with ANC services by women</b>		
Satisfied	79	50.0
Not satisfied	79	50.0

Table 4.4 reveals that, most of the women (73.4%) had availed their first Antenatal care check-ups between three to fourth month of the pregnancy, less than one-fourth (23.1%) between five to six months and very few (3.3%) at seven to eighth month of the pregnancy most of the check-ups (94.9) were conducted by Auxiliary Nurse Midwife/ Lady Health Visitors (ANM/LHV) and as low as 4.4 per cent, were done by staff nurse. Less than half (48.1 %) of the ANC check-ups, were performed during the Village Health Nutrition Day in village premises, less than one-fourth (22.2%) at Additional PHC, few (5.7%) at district hospital and very few (5.1%) of the women were provided at Sub-centres (SCs). Very few (2.5%) women completed three ANC checkups and majority of them (91.1%) had received minimum two ANC checkups. After getting feedback about ANC care services through different public health centres, only half (50%) of the respondents reported to be satisfied with the services. Few of the reasons for dissatisfaction stated by respondents were as follows: Whenever women from poor socioeconomic background visited the health centre for their antenatal checkups, ANM did not pay much attention during the examination, unavailability of medicines

**Table 4.5****Utilization of ANC services by respondents at public healthcare institutions (N=158)**

ANC services (components)	Yes		No	
	Freq uenc y	Perce nt (%)	Freque ncy	Percent (%)
Weight measured	38	24.1	120	75.9
Height measured	15	9.5	143	90.5
Blood Pressure measured	39	24.7	119	75.3
Urine test	39	24.7	119	75.3
Blood test	45	28.5	113	71.5
Abdomen examined	24	15.2	134	84.8
Breast examined	-	-	158	100.0
HIV testing performed	-	-	158	100.0
Two doses of TT provided	148	93.7	-	-
TT Booster	10	6.3	-	-
100 + IFA tablets consumed	7	4.4	151	95.6
Advised on personal hygiene	27	17.1	131	82.9
Advised on diet and nutrition	30	19.0	128	81.0
Educated about danger Sign	10	6.3	148	93.7
Expected date of delivery given	146	92.4	12	7.6

Table 4.5 reveals that ANC services have been poorly utilized. The data shows that,, weight and height were recorded for less than 25% of the women. In Kurebhar block at PHC and other public health centres, Sphygmomanometer (to measure Blood Pressure) was available yet as few as (24.7%) respondents blood pressure was recorded. Out of 158 respondents less than one-fourth (24.7%) of the women, got their blood testing, a few (15.2%) of the respondents had abdomen examination and less than one- fourth (24.7%) of the women underwent urine testing at public health institutions.

*“Since 1<sup>st</sup> January 2014 haemoglobin test has been made compulsory for every pregnant woman”.*

***- Health Education Officer (HEO) PHC Kurebhar (Anexture-1)***

*“Very few women visit for a pregnancy test, only those women who are sent by the ANM for pregnancy confirmation come for these tests. During ANC if ANM have a doubt regarding any women having anemia she refers her to me for blood check-up. In all pregnancy cases, we do not perform blood test but only on a recommendation by the ANM.*

***-Lab Technician (Anexture-1)***

None of the respondents underwent through breast examination and HIV testing while HIV test is available at PHC Kurebhar as well as the district hospital.

*“Few months’ back I got training on testing HIV but till now no pregnant women underwent this check-up”.*

***-Lab Technician (Anexture-1)***

The majority (93.7%) of the women received two doses of Tetanus Toxoid. A few (4.4%) women consumed more than hundred Iron Folic Acid Tablets (IFA Tablets), and the majority (95.6%) of the respondents had consumed partially. It was found that less than half (43.7%) of the women did not consume a single tablet of Iron Folic Acid (IFA). The main reason for non-consumption was, non-availability of IFA tablets (42.4%), and for partial use various reasons were found such as vomiting (8.9 %) followed by loose motion (11.4 %), bad taste (24.7%), forget to eat (10.8%) respectively.

Only (17.1%) women received counselling on personal hygiene and advice on diet and nutrition (19%). During antenatal care visit very few (6.3%) women

were educated on danger signs related to their pregnancy. The majority (92.4%) of the women were given expected the date of delivery.

**Table 4.6**

**Socioeconomic background of the respondents and place of birth (N=158)**

Socio-economic Indicators	Place of birth					
	Sub Centre	APH C	PHC	Distric t Hospital	Home Birth	Privat e Institution
<b>Social ID</b>	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)
SC	2.4 (1)	24.4 (10)	26.8 (11)	2.4 (1)	36.6 (15)	7.3 (3)
ST	0.0 (0)	0.0 (0)	50.0 (2)	25.0 (1)	25.0 (1)	0.0 (0)
OBC	11.7 (11)	19.1 (18)	29.8 (28)	12.8 (12)	9.6 (9)	17.0 (16)
General	0.0 (0)	10.5 (2)	5.3 (1)	26.3 (5)	0.0 (0)	57.9 (11)
<b>Monthly income</b>						
Below 3000 rupees	3.6 (1)	14.3 (4)	39.3 (11)	21.4 (6)	14.3 (4)	7.1 (2)
3001 to 5000 rupees	6.9 (6)	23.0 (20)	28.7 (25)	12.6 (11)	23.0 (20)	5.7 (5)
5001 to 7000 rupees	15.4 (2)	23.1 (3)	23.1 (3)	0.0 (0)	0.0 (0)	38.5 (5)
7001 to 10000 rupees	9.1 (1)	9.1 (1)	9.1 (1)	18.2 (2)	0.0 (0)	54.5 (6)
100001 and above	10.5 (2)	10.5 (2)	10.5 (2)	0.0 (0)	5.3 (1)	63.2 (12)
<b>Land ownership</b>						
No Land	2.3 (1)	20.9	25.6	11.6	30.2	9.3 (4)



		(9)	(11)	(5)	(13)	
Below 1 Bigha	0.0 (0)	25.0 (8)	34.4 (11)	3.1 (1)	25.0 (8)	12.5 (4)
1 to 2 Bigha	0.0 (0)	14.3 (2)	57.1 (8)	0.0 (0)	14.3 (2)	14.3 (2)
2 to 4 Bigha	26.1 (6)	4.3 (1)	30.4 (7)	26.1 (6)	8.7 (2)	4.3 (1)
4 to 5 Bigha	11.5 (3)	24.2 (8)	3.8 (1)	15.4 (4)	0.0 (0)	38.5 (10)
6 Bigha and above	10.0 (2)	10.0 (2)	20.0 (4)	15.0 (3)	0.0 (0)	45.0 (9)

Table 4.6 highlights the socioeconomic status of the respondents and their preference for places for childbirth. Present finding highlights that, across the social groups, found a huge variation. It was found that, among social group SC & ST most (61.5%) of the women opted home, for the childbirth. It was recorded that, more than one third (36.6%) of the women gave birth at home. Most of the home birth took place in those households who were holding land below than two bigha. The data shows more than half (57.9%) of the General category of the women preferred private healthcare institution. With the increase of monthly income preference for private health care institution is also increased, with 63.2 per cent of the women from the income category of ₹10001 and above opted private health care institution. Similar kind of trends is also visible among land holding category with 45 per cent private institutional births among the women with land above than six bigha. It was found that, landholding had a great impact on the choosing place of delivery; because of land holding was the underlying source of their earnings in the rural population.

Present finding shows women who belonged, SC& ST social group were found more vulnerable regarding the choice of place of birth. Women those who were belonged upper socioeconomic strata, with higher monthly income, accessed kinds of public health institutions as well as private health care institution.

**Table 4.7****Socioeconomic status of JSY beneficiaries**

(N=103)	SC	ST	OBC	General	Total number
<b>Education</b>					
Illiterate	35.3 (12)	8.8 (3)	52.9 (18)	2.9 (1)	34
Lower-primary	21.1 (4)	0.0 (0)	78.9 (15)	0.0 (0)	19
Upper-primary	18.2 (2)	0.0 (0)	72.7 (8)	9.1 (1)	11
High school	30.8 (4)	0.0 (0)	61.5 (8)	7.7 (1)	13
Higher secondary	0.0 (0)	0.0 (0)	33.3 (2)	66.7 (4)	6
Graduate	5.0 (1)	0.0 (0)	90.0 (18)	5.0 (1)	20
<b>Type of family</b>					
Joint	18.1 (13)	0.0 (0)	70.8 (51)	11.1 (8)	72
Nuclear	32.3 (10)	9.7 (3)	58.1 (18)	0.0 (0)	31
<b>Occupation of the respondents</b>					
Daily wage labourer	60.0 (12)	15.0 (3)	25.0 (5)	0.0 (0)	20
House wife	13.3 (11)	0.0 (0)	77.1 (64)	9.6 (8)	83
<b>Type of house</b>					
Thatcher	54.5 (6)	27.3 (3)	18.2 (2)	0.0 (0)	11
Kuchha	24.4 (11)	0.0 (0)	75.6 (34)	0.0 (0)	45
Semi Pucca	20.0 (5)	0.0 (0)	60.0 (15)	20.0 (5)	25
Pucca	4.5 (1)	0.0 (0)	81.8 (18)	13.6 (3)	22

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<b>Land holding</b>					
No Land	30.8 (8)	0.0 (0)	61.5 (16)	7.7 (2)	26
Below 1 Bigha	60.0 (12)	5.0 (1)	35.0 (7)	0.0 (0)	20
1 to 2 Bigha	20.0 (2)	20.0 (2)	60.0 (6)	0.0 (0)	10
3 to 4 Bigha	5.0 (1)	0.0 (0)	95.0 (19)	0.0 (0)	20
5to 6 Bigha	0.0 (0)	0.0 (0)	81.3 (13)	18.8 (3)	16
Above 6 Bigha	0.0 (0)	0.0 (0)	72.7 (8)	27.3 (3)	11
<b>Agricultural production</b>					
Yes	16.4 (11)	0.0 (0)	74.6 (50)	13.4 (6)	67
No	33.3 (12)	8.3 (3)	52.8 (19)	5.6 (2)	36
<b>Husband occupation</b>					
DWL	43.1 (22)	5.9 (3)	51.0 (26)	1.9 (1)	52
Farming	2.6 (1)	0.0 (0)	87.2 (34)	10.3 (4)	39
Self employed	0.0 (0)	0.0 (0)	75.0 (9)	25.0 (3)	12
<b>Monthly income</b>					
Below 3000 rupees	0.0 (0)	0.0 (0)	86.4 (19)	13.6 (3)	22
3001 to 5000 rupees	32.3 (20)	4.8 (3)	56.5 (35)	6.5 (4)	62
5001 to 7000 rupees	25.0 (2)	0.0 (0)	75.0 (6)	0.0 (0)	8
7001 to 10000rupees	0.0 (0)	0.0 (0)	80.0 (4)	20.0 (1)	5
10001 and above	16.7 (1)	0.0 (0)	83.3 (5)	0.0 (0)	6

Table 4.7 reveals the socioeconomic background of the JSY beneficiaries. It shows a very clear trend among the different social groups. From sociological perspective in rural areas generally land holding pattern decides the concept of dominant caste.

Here, in present study it was found that major caste was OBC followed by General and SC population respectively. Table 4.7 shows a clear trend, when the land holding size increases among the social groups the representation of the SC& ST population becoming down very quickly, even similar kind of trends is also visible in the education, monthly income, living of the standard etc. So it is important to look here the representation of the OBC among all indicators.

**Table 4.8**  
**Utilization of JSY services by social groups at public hospital (N=103)**

	<b>General</b>	<b>OBC</b>	<b>SC</b>	<b>ST</b>
<b>Month of first ANC</b>				
Between 3 to 4 months	10.4 (8)	64.9 (50)	20.8 (16)	3.9 (3)
Between 5 to 6 months	0.0 (0)	72.7 (16)	27.3 (6)	0.0 (0)
Between 7 to 8 months	0.0 (0)	75.0 (3)	25.0 (1)	0.0 (0)
<b>Place of ANC</b>				
SC	0.0 (0)	100.0 (5)	0.0 (0)	0.0 (0)
Village health nutrition day	4.4 (2)	75.6 (34)	20.0 (9)	0.0 (0)
APHC	4.2 (1)	41.7 (10)	41.7 (10)	12.5 (3)
PHC	21.1 (5)	57.9 (11)	21.1 (4)	0.0 (0)
District Hospital	0.0 (0)	100.0 (19)	0.0 (0)	0.0 (0)
<b>Satisfy with the ANC services</b>				
Yes	9.8 (6)	65.6 (40)	24.6 (15)	0.0 (0)
No	4.8 (2)	69.0 (29)	19.0 (8)	7.1 (3)
<b>ANC components*</b>				
BP	11.8 (2)	76.5 (13)	11.8 (2)	0.0 (0)
Blood Test	13.0 (3)	60.9 (14)	26.1 (6)	0.0 (0)
Abdomen examination	12.5 (1)	87.5 (7)	0.0 (0)	0.0 (0)
Two dose TT	7.8 (8)	67.0 (69)	22.3(23)	2.9 (3)
<b>Escort service by ASHA</b>				
Yes	9.5 (7)	70.3 (52)	16.2 (12)	4.1 (3)

No	3.4 (1)	58.6 (17)	37.9 (11)	0.0 (0)
<b>Place of birth</b>				
Subcentre	0. (0)	91.7 (11)	8.3 (1)	0.0 (0)
Additional PHC	6.7 (2)	60.0 (18)	33.3 (10)	0.0 (0)
PHC	2.3 (1)	65.1(28)	25.6 (11)	4.7 (2)
District hospital	27.8 (5)	61.1 (11)	5.6 (1)	5.6 (1)
<b>Type of birth</b>				
Normal	7.0 (7)	67.8 (67)	22.2 (22)	3.0 (3)
C-section	20.0 (1)	60.0 (3)	0.0 (0)	0.0 (0)
<b>Birth attendants</b>				
ANM	3.6 (3)	67.9 (57)	26.2 (22)	2.4 (2)
Staff Nurse	26.3 (5)	63.2 (12)	5.3 (1)	5.3 (1)

\*Note: The ANC component percentage under each component is who received the particular component out of 103 respondents.

Table 4.8 reveals that majority (64.9%) of the women among OBC social Group received their first ANC care between three to four months. While this proportion was low as 10.4 per cent in General, 20.8 per cent in SC population and 3.9 in ST. Majority (75.6 %) of the OBC women received their ANC during the village health nutrition day, the representation of the other can be seen again as low as 4.4 per cent General and 20 per cent SC population. The representation of the OBC population at different public health centres to avail the antenatal care shows the clear picture that, this section of women are accessing services at, from all the centres. At the satisfaction level of the ANC, OBC women (65.6 %) were more satisfied than others. Majority (70.3) of the women among OBC escorted by the ASHA while it was found as low as in SC and ST population 16.2 (per cent and 4.1 per cent respectively. If we see the place of the birth, similar trends is also visible in place of births among the OBC women.

**Table 4.9****Distribution of Anganwadi supplementary food and reasons for not receiving**

<b>Anganwadi supplement received by pregnant women (N=158)</b>	<b>Frequency (n)</b>	<b>Percent (%)</b>
Yes	79	50.0
No	79	50.0
Total	158	100.0
<b>Reason for not receiving (N = 79)</b>		
Not aware regarding supplementary food	14	17.7
Nobody was at home so could not go AW Centre	12	15.2
Insufficient stock/non-availability	17	21.5
Forget to go Anganwadi Centre	20	25.3
Anganwadi worker doesn't behave well	10	12.7
Not mentioned	06	7.6

Table 4.9 reveals that, less half (50%) of women received the supplements from the Anganwadi centres and half of the women could not receive due to various reasons like ; lack of awareness regarding supplement food (17.7%) followed by poor behaviour of the Anganwadi workers (12.7%), insufficient stock (21.5%) respectively. Regarding insufficient stock one of the one of the Anganwadi worker revealed:

*"Sometimes due to insufficient stock we were unable to distribute supplement food to pregnant and to new mothers. On every Saturday, we distribute supplement food. Sometimes when we have demand for extra supplement from ICDS department at block Kurebhar they say: "Utne me hi kam chalao jitna jitna ek centre ko alot kiya gaya hai."(It means manage it, whatever has been allotted to each centre.*

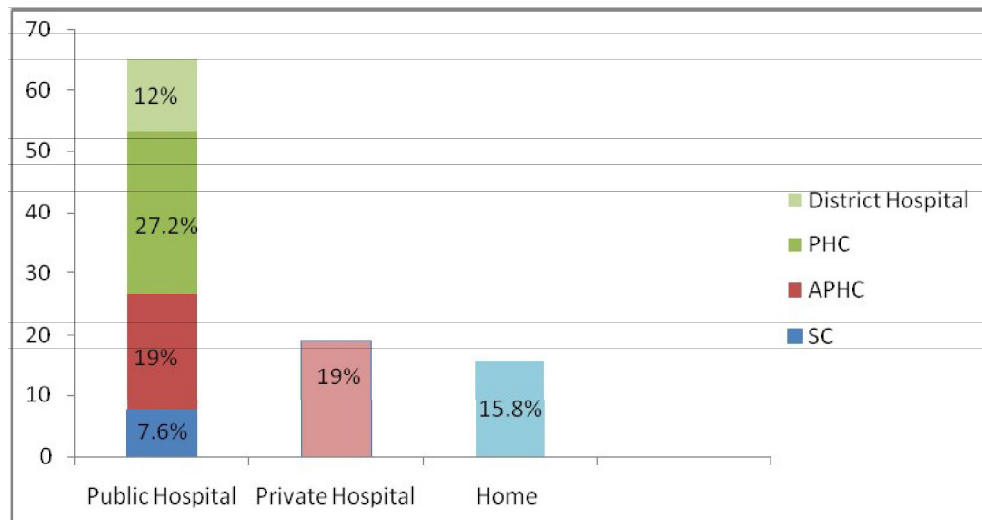
*-Anganwadi Worker (Anexture-1)*

#### 4.1.4 Institutional Birth

This section describes the phenomenon of opting for the Institutional birth by the women and persons who motivated them during their pregnancy to go at a public health institution for childbirth. All 158 respondents had given childbirth during the time of data collection. In the present study only those women were covered who had given childbirth in last one year, on 1 April 2014 to 31 March 2015. All the women were revealed that, they were admitted immediately after reaching each institution.

**Figure 4.2**

**Distribution of place of delivery among public, private and home births**



**Note: (N=158)**

Diagram 4.2. represents that, more than half (65.8%) of the deliveries were conducted at public health institution, less than one-fifth (19.0%) at private health care institution and few (15.8%) of the deliveries were conducted at home. There were thirty women, who delivered at private hospital. Majority of the respondents, decided to opt private health care institution in the last month of the pregnancy, though, they were also registered at public hospitals to avail the antenatal care. Out of thirty respondents one of them replied that, she did not want take any risk regarding their pregnancy because she had lost their

child after birth at PHC Kurebhar in previous delivery, due to improper care after birth. She replied that, for the better care she adopted private hospitals because during antenatal care at government's hospitals much attention was not paid to her. Majority of the respondents reported that ANM was always in a hurry whenever they visited public health centres. At private hospitals, she spent more money than any government hospitals, but she said, she was satisfied with the services that were provided at the private hospital.

**Table 4.10**

**People who facilitated for institutional birth and escort service by ASHA**

<b>Facilitator for institutional birth</b>	<b>Frequency (n)</b>	<b>Percent (%)</b>
ASHA	131	82.9
Family members	18	11.4
Themselves	7	4.4
N/M	2	1.3
Total	158	100.0
<b>Escort Service by ASHA at public hospital (N=103)</b>		
Yes	74	71.8
No	29	28.2
Total	103	100.0

Table 4.10 highlights that majority (82.9%) of beneficiaries were facilitated by ASHA workers and very few (4.4%) motivated by themselves. By the family members around eleven per cent of the women were promoted for institutional births. Out of 103 public institutional deliveries, most (71.8%) of the women received escort service by the ASHA and less than one third (28.2%) of the women could not received escort service by the ASHA.



Regarding the performance HEO revealed that:

*“I am not completely satisfied with the performance of ASHAs. They are doing their job very honestly and carefully. During selection, most of the women were selected from their respective villages, some of them were not the deserving candidates but through some contacts and linkages they got selected. Behind the selection procedure of ASHAs, the reason was that they had contacts with influential people who gave a reference for them.*

**- Health Education Officer (HEO) PHC Kurebhar  
(Anexture-1)**

**Table 4.11**

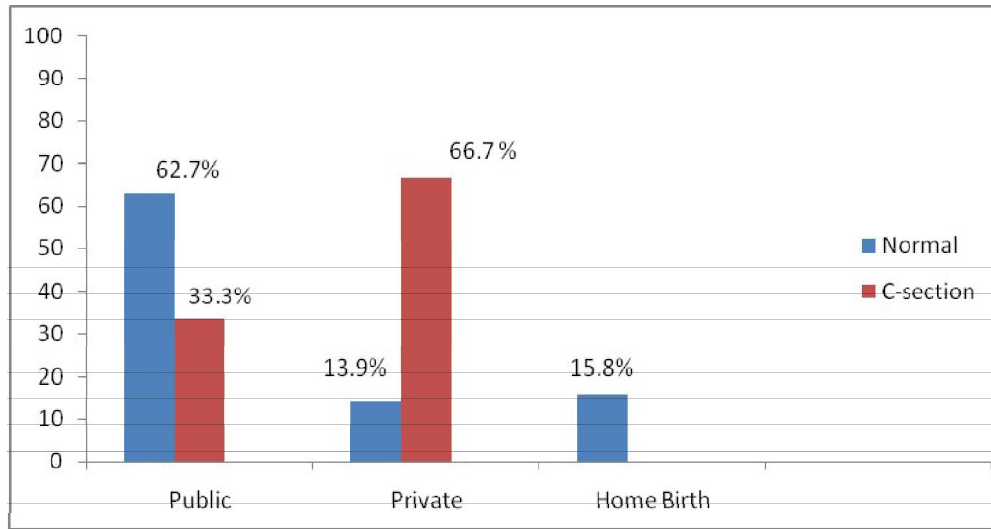
**Type of child births and distribution of C-section at public and private hospitals**

Type of delivery	Frequency	Percent
C- section	12	7.6
Normal	146	92.4
Total	158	100.0
<b>Distribution of C-section at public and private hospital (N=12)</b>		
C-section at public hospital	4	33.3
C-section at private hospital	8	66.7

Table 4.11 shows that, majority (92.4%) of the childbirths were normal and only a few (7.6%) of the respondents were given birth through C-section. Distribution of C-section between public and private hospitals, more than half (66.7%) of the C-section took place at private hospitals, out of twelve only four (33.3%) C-section deliveries were performed at district hospital.

**Figure 4.3**

**Distribution of C-section delivery at public and private**



**N=158**

Diagram 4.3 reveals that, out of 158 respondents, more than half (62.7%) had given normal childbirth at public hospitals, few (13.9%) were at private hospitals and less than one-fourth (15.8%) of the respondents were given normal childbirth at home. C-section was two times higher in private hospitals than a public hospital.

**Figure 4.4**

**Reasons for Home Birth (N=25)**

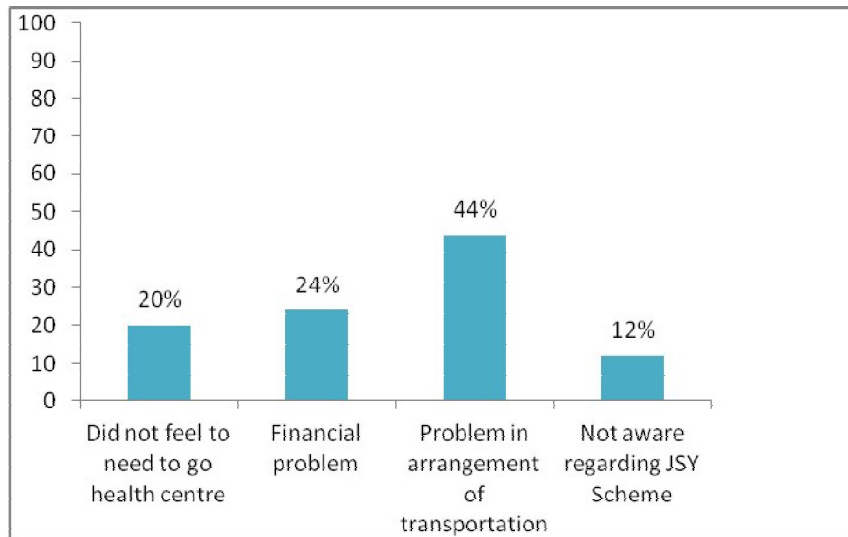


Diagram 4.4 denotes that, less than half (44%) of the women, reported primary cause for home, was arrangement of transportation, second reason was found as financial problem around one-fourth of the mother said and less than one-fourth (20%) did not feel need to go at health centre.

The perception of beneficiaries why they do not feel need to health centre:

*“I never undergone any checkups during any pregnancy, when I come to know that, I am pregnant, then I go for vaccination (for Tetanus Toxoid). After that, I had given birth easily. With the help of Dai, I gave birth to all my children at home, but I gave birth to my one baby at a health facility. On the name of examination health care provider provides only TT vaccination, if they do more enough, will be provide ten to twenty iron-folic acid (IFA) tablets and nothing else.”*

**-Manju 35 years old mother, Sudnapur village (Case-3) (Anexture-2)**

*“I was aware that without taking money ANM would not be conduct childbirth at PHC. They ask for money, we had nothing that time, to pay her at PHC, so I finally decided to give birth at home with the help of Dai”.*

**- (One of the respondents from home delivery, from the field diary)**

While, the response from the providers, stressed on the overload of patients and constraints faced by them in the PHC. One of the ambulance drivers explained this as below:

*“Due to patient load, sometimes we are unable to arrive at the home of pregnant women on time. Some roads are not good, so it takes too much time; we have to be very careful while driving because of ditches on the road. During winter in nights, it is very difficult to pick the cases. Even women do not want to come for delivery at the hospital during winter season in nights due to*

*severe cold and dense fog, in such cases most of the Home Birth take place”.*

***-Ambulance Service Providers (Anexture-1)***

One of the mothers among the home births said that;

*“At public hospital, for birthing they demand for money more than ₹ 500, while in village Dai takes ₹ 150 to ₹ 200 only”.*

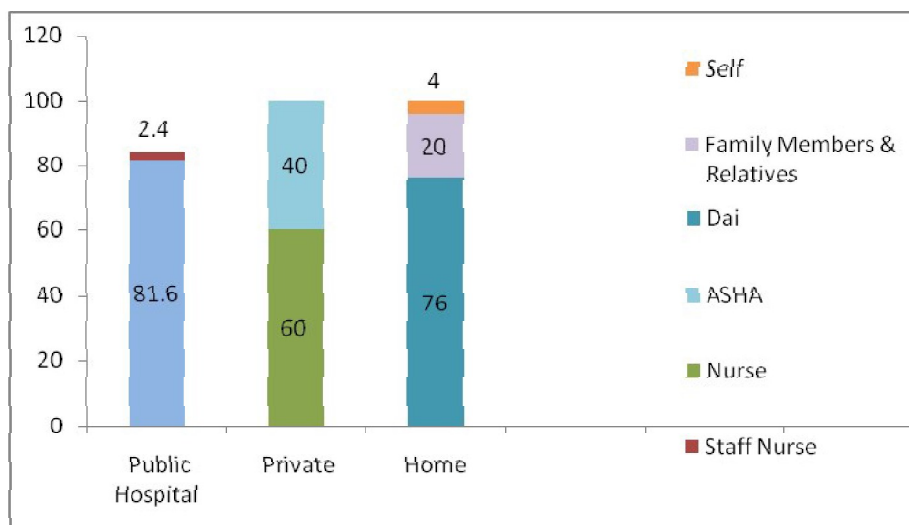
In addition to case study-4 brings the issue of financial barriers to choose home births among the poor and marginalized household women:.

*“We are poor people, we had no money therefore we did not visit hospital, in previous pregnancy I had to borrow money from a landlord, hardly, I returned him, and it took almost one year. Neither I have a mobile phone nor has ASHAs number therefore I could not make contact to her. Since evening I had pain in my abdomen, in late night around at 11 pm I gave birth a male child, with the help of my aunt, who serves as a Dai in their village, so I had called her before my delivery at my home. In the evening I went market before my labor and bought new thread, a new blade and some cotton so that I had not to run here and there to arrange it.”*

***- Nirmala 28 years old mother, Lakhaicha village (Anexture-3)***

**Figure 4.5**

**Distribution of birth attendants at public hospitals, at private hospital and home**



**N=158**

Diagram 4.5 shows that, ANM/LHV conducted majority (81.6%) of the deliveries, less than one-fourth (18.4 %) of the deliveries were conducted by staff nurses at the public hospitals. At private hospital, more than half (60.0%) of the deliveries were conducted by nurses (11.4%) and less than half (40%) of the deliveries, were conducted by an ASHA at their clinic. Most (76.0%) of the child births at home, were performed by Dai, less than one-fourth (20.0%) by self and very few (4.0%) of the deliveries were performed by family members and relatives. It was found that, majority (97.7%) of the respondents said that, during childbirth they did not face any discrimination, only a few (2.3%) had faced discrimination. The discrimination was in term of the behaviour of ANM during childbirth in the labour room, one of the respondents revealed that in labor room ANM talked in a rude manner. However, the researcher observed during public health centre visits that there was discrimination by the birth attendant on the basis of the socio-economic status of women. New mother and her family members were denied telling the truth regarding the behaviour of health care providers they thought that if they tell the reality, it can harm them further in future during next delivery.

In addition to majority (82.9%) of the respondents were said that, AHSA's behaviour was good with them during the period of their pregnancy; a few (11.4%) of the respondents were found not satisfied. The reason for, not satisfaction was revealed by the respondents that, sometimes when they needed help during pregnancy she did not give a response to them.

Even, towards the behaviour of ASHA, Health Education Officer also stated that:

*“Sometimes the ASHA, bring pregnant women only for institutional birth; they do not provide adequate information about JSY services during ANC, only, at the last stage of the pregnancy they accompany to the women for institutional birth, for their benefits, to earn more incentive with maximum number of deliveries”.*

**- Health Education Officer (HEO) PHC Kurebhar (Anexture-1)**

**Figure 4.6**

**Complication faced during childbirth by women**

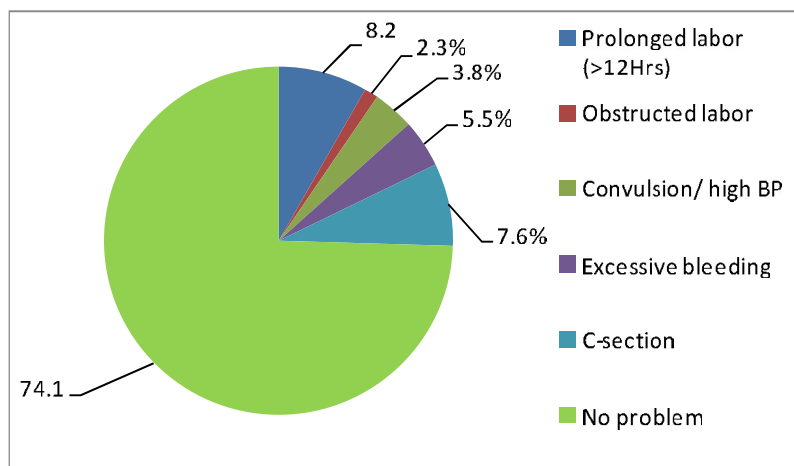


Diagram 4.6 reveals that, out of 158 deliveries, including public, private hospital and home births, thirteen (8.2%) were having prolonged labor, very few (2.3%) obstructed labor and among them twelve (7.6%) had undergone

through C- section. All mothers who developed complication during delivery were referred to the district hospital from PHC.

**Table 4.12**

**Duration of stay at hospital (public and private)**

Place of birth and stay time (N=133)	Below four hours	Five to ten hours	Eleven to twelve hours	Up to 48 hours	3- 10 days
	% (n)	% (n)	% (n)	% (n)	% (n)
Sub Centre	83.3 (10)	8.3 (1)	8.3 (1)	0.0 (0)	0.0 (0)
APHC	56.7 (17)	40.0 (12)	3.3 (1)	0.0 (0)	0.0 (0)
PHC	73.8 (31)	19.0 (8)	4.8 (2)	0.0 (0)	0.0 (0)
District Hospital	0.0 (0)	0.0 (0)	15.7 (3)	63.2(12)	21.1(4)
Private Institution	16.7 (5)	3.3 (1)	0.0 (0)	53.3(16)	26.7(8)

Table 4.12 reveals that duration of stay found destitute than the norms of duration of childbirth (normal 48 hours, C-section 3-7 days). It was found destitute at Sub centre (83.3%) followed by APHC (56.7%) and PHC (73.8%) respectively for normal childbirth. It was found better at district hospital where more than half (63.2%) of the mother, stayed up to 48 hours after childbirth. In the case of C-section, it was good at District Hospital as well as private hospitals. Regarding duration of stay, the majority of the mothers, did not stay, more than four hours at Sub centre, APHC and PHC. The duration of the stay is most important part of postpartum care, because of most of the complication arose either during delivery or after child birth within few hours. The present finding highlights, the concern regarding duration of stay at public hospitals.

Most of the beneficiaries and their family members were reviled regarding duration of stay at public hospital after child birth, due to lack of sanitation, lack of untimely power supply in night, lack of waiting room for the attendants of mother etc. Therefore family members do not want stay more. Family

members think that, if they get discharge from hospital early they can provide better care to the new mother and baby at home.

Whereas the stand of health care providers reviled that, family members and beneficiaries after child birth, they want go early at home they request many times so we have to discharge from hospital. Mothers those had some pain or bleeding, only those stay ten to twelve hours.

While the take of MOIC on the duration of stay at hospital was as below:

*“If I visited the ward, and said to beneficiaries and their family members, for staying at least one day after childbirth, after leaving me the ward, they inform to the ward boy and arranged private van (tempo) and go back to home. In this case they did not feel to take ambulance services, they are in hurried to go back home as soon as possible after child births”.*

**-MOIC PHC Kurebhar (Anexture-1)**

During the discussion with an ANM of PHC Kurebhar, she revealed about the case load and how they manage the situation as below,

*“When patient load increase, we discharge mothers who had given birth in the morning during the same day evening due to lack of beds”.*

**- ANMPHC Kurebhar**



**Figure 4.7**

**Outcome of pregnancy**

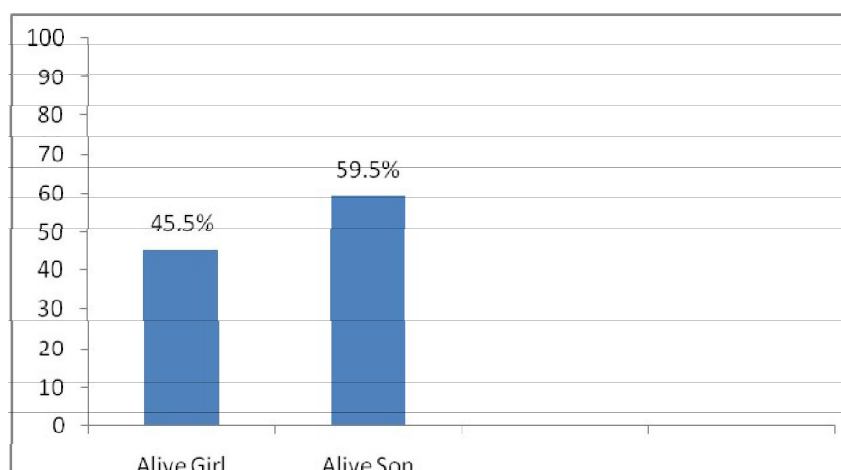


Diagram 4.7 refers that more than half (59.5%) of the outcome of deliveries were a male child, and less than half (45.5%) were a female child. It has given the sense to hypothesize that the number of ultrasound could be the motive for sex selection. Census 2001, data shows that, 0-6 year child sex ratio of Sultanpur district was 934 per one thousand male children, but according to census 2011 child sex ratio has been declined sharply from 934 in 2001 to 921 in 2011 per one thousand male children. A study by Sangari (2015), states that, in regard child sex ratio, according to census 2001, relatively those district were better where technology had not reached, the introduction of ultrasound machine has a great impact on declining in female child sex ratio, such states like Punjab, Uttar Pradesh, Haryana and Gujarat have witnessed after introducing ultrasound machine (Sangari 2015 p.163).

**Table 4.13`**  
**Distribution of Ultrasonography test among the different socioeconomic**  
**groups**

Socio-economic indicators	Ultrasonography		Total N= 158	Outcome of pregnancy	
	Yes	No		Girl	Son
Social identity	%	%		%	%
SC	39.0 (16)	61.0 (25)	41	36.6	63.4
ST	0.0 (0)	100.0 (4)	4	50.0	50.0
OBC	38.5 (36)	61.7 (59)	94	45.7	54.3
General	84.2 (16)	15.8 (3)	19	21.1	78.9
Monthly income					
Below ₹3000	50.0 (14)	50.0 (14)	28	42.9	57.1
₹3001 to ₹5000	29.9 (26)	70.1 (61)	87	41.4	58.6
₹5001 to ₹7000	38.5 (5)	61.5 (8)	13	46.2	53.8
₹7001 to ₹10000	72.7 (8)	27.3 (3)	11	45.5	54.5
₹10001 and above	78.9 (15)	21.1 (4)	19	26.3	73.7

Table 4.13 reveals that there is an enormous variation of ultrasonography test among the different socioeconomic groups of the women. More than half (57.9%) of the women from General preferred private health care institution and majority (84.2%) of the women underwent ultrasonography test. Among this group majority (78.9%) of the outcome was male child while, the female child proportion was found to be as low as 21.1 per cent.

Further, great difference was noted between low economic status and higher economic status of the women, majority (78.9%) of the wome whose monthly income was, ₹10,001 and above preferred a high number of ultrasound test, while, it was also found that, whose monthly income was below than ₹3000, half (50%) of the women also underwent ultrasonography testing. According to Census 2011 data child sex ratio of Sultanpur District, has declined

compared to Census 2001. However, the question arises why an enormous number of ultrasonography test? Though, majority (92.4%) of the women had given normal childbirths.

#### 4.1.5 Postnatal Care

Getting postpartum / postnatal checkups soon after the birth of a baby or within 48 hours is crucial for the health of both the mother and child (ASH 2012-2013).

**Table 4.14**

**First follow-up after birth, place of checkups and satisfaction with postnatal care services**

<b>First follow-up after birth</b>	Frequency	Percent
Within 15 days	30	19.0
Within 20 days	5	3.2
Within 30 days	95	60.1
More than one month	1	0.6
No checkups	29	17.1
Total	158	100.0
<b>Place of Check-up</b>		
SC	37	23.4
APHC	22	13.9
PHC	40	25.3
District	8	5.1
Private hospital	25	15.8
No Check-up	26	13.9
Total	158	100.0
<b>Satisfaction with Services</b>		
Yes	122	77.2
No	36	22.8
Total	158	100.0

Table 4.14 highlights data on first follow-up after birth, place of check-up during postnatal care and satisfaction with the services. More than half (63.3%) of the women, visited health institution between twenty to thirty days, less than one-fourth (19.0%) visited within fifteen days and very few (3.16%) of the respondents visited health institution between fifteen to twenty days for postnatal checkups.

Several public health centres and few private health institutions were approached for post-natal care. At Sub-centre, less than one-fourth (24.4%) of the check-up took place. At APHC and CHC, more than one third (39.2%) check were done, and only very few (5.1%) of the postnatal checkups were performed at the district hospital. At private hospitals, 15.8 per cent checkups were done, and 13.9 per cent of the women did not visit any health centres neither public hospital nor private hospital. Table 4.16 also presents that most of the respondents (77.2%) were satisfied with postnatal care checkups and less than one-fourth (22.8%) were not satisfied.

**Table 4.15****Government financial assistance under Janani Suraksha Yojana**

<b>Under JSY cash incentives received (N=128)</b>	<b>Frequency</b>	<b>Percent</b>
Yes	95	74.2
No	8	6.3
Eligible but not received (Home Birth)	25	19.5
<b>Duration of receiving cash incentive</b>		
After discharge from hospital	20	14.8
Within one week	11	9.4
Within two weeks	25	19.5
Within one month	26	20.3
After one month	13	10.2
Not received	33	25.8
Total	128	100.0
<b>Any problem faced during receiving incentive</b>		
Yes	63	49.9
No	65	50.8

Note: The total numbers of the respondents are 128, including 103 public institutional births and 25 home birth.

Among 158 deliveries, twenty-five was home birth and thirty were private institutional birth hence the total number of beneficiaries was 103. Table 4.15 refers that majority (74.2 %) of the women received the cash incentives, and one-fourth (25.8%) of the respondents had not received due to problems related to lack of producing necessary documents such as ration card and identity proof. No one beneficiary was found among twenty-five respondents who received assistance for home births in Kurebhar block.

JSY has a provision of Assistance for Home Birth. Under JSY scheme, women belonging to BPL category, who are aged nineteen years and above, were preferring to deliver at home by Trained Traditional Birth Attendant or Skilled Birth Attendant (SBA) are entitled to receive cash assistance of Rs.500/- per delivery. This assistance is available only up to two live births,

and the disbursement is done at the time of delivery or around seven days before the delivery by ANM/ASHA/AWW. The rationale behind it is that the beneficiary would be able to use the cash assistance for her care during childbirth or to meet incidental expenses of delivery.

The data refers that only (14.8%) of the women received the cheque while discharging from the hospital who gave birth at the district hospital. Very few (9.4%) of the women received within one week, more than one-third (39.8%) women received between two weeks to one month. One-fourth of the respondents could not get JSY cash incentive due to problems related to identity proof of the mother (such as ration card, and voter ID card) related documents and eligibility criteria for a home birth.

It was found that out of 128 beneficiaries, 103 had given birth at the public hospital, and 25 women gave birth at home these all were eligible for JSY cash incentive. Less than half (49.2%) of the beneficiaries were faced some problem such as delayed in the distribution of cheque. They had to visit three to four times too from long distance to get incentives. Staffs were not present in the hospital at the date of reach hospital ing the date of receiving JSY cash incentive. Only half (50.8%) of the beneficiaries replied they got the incentives easily. It was observed that during data collection there were problems in the distribution of Fourteen Hundred Rupees Cheque of JSY. Beneficiaries visited several times, to get the cheque, sometimes they were said that, the check are not signed so could not be issued and sometimes officials were not present at centre, so the beneficiaries had to return to home. The data reveals that the officials took a long time to provide the JSY cheque to recipients.

Case study-2 brings the issue regarding behaviour of the health care providers towards JSY beneficiaries;

*“For a paper (document), I have to made several contact, they (health care providers) know that in our family in our family no one is literate, that is why they create more trouble for us. It seems like, they had to give from their pocket; it is government scheme if we poor people would be getting it, and it can help useful in other works”.*

**-Manju, 35 years old mother, Sudanapur Village (Anexture-2)**

#### 4.1.6 Role of Ambulance Services in Janani Suraksha Yojana

In every ambulance, there is an Emergency Medical Technician and one Pilot (Driver) to provide the services among the population. At Kurebhar PHC, two ambulances are available namely 102 and 108. Ambulance 102 is being used for the only delivery purpose. For emergency cases, 108 is being used, but it is also carrying delivery cases to the hospital.

**Table 4.16**

##### **Awareness and utilisation of Ambulance services**

<b>Awareness</b>	<b>Frequency (n)</b>	<b>Percent (%)</b>
Yes	148	93.7
No	10	6.3
Total	158	100.0
<b>Source of information</b>		
ASHA	123	77.8
Family members	23	14.6
Self	2	1.3
None	10	6.3
Total	158	100.0
<b>Mode of transportation used at the time of delivery</b>		
Ambulance	38	28.6
Own vehicle	22	16.5
Private van	58	43.6
On foot	9	6.8
Others*	6	4.5
Total	133	100.0
<b>Duration of time taken by ambulance to reach home</b>		
Less than 30 minutes	12	11.7
30 to 60 minutes	15	14.6
More than 1 hour	11	10.7
Did not reach home	65	63.1
Total N=103	103	100.0

<b>Time was taken by ambulance to drop at public hospital</b>		
Below 20 minutes	16	15.5
20 to 30 minutes	10	9.7
Above 30 minutes	12	11.7
<b>If ambulance dropped back at home</b>		
Yes	55	53.4
No	48	46.6
<b>Non-official payment</b>		
Below ₹100	36	35.0
₹100 to ₹200	19	18.4
Zero	48	46.6

\*includes tricycle, rickshaw etc.

Table 4.16 refers that majority (93.7 %) of women were aware of Ambulance services. Most (77.8%) of the women were told about ambulance services by ASHA. For institutional birth, various modes of transportation were used by the respondents. Among 133 institutional birth, only more than one-fourth (28.6%) of the respondents had used ambulance services, close to half (43.6%) of the women had used private van and few (16.5%) women used their vehicle. In comparison to the private van, the usage of ambulances was less.

More than half (63.1%) of the respondents said that, due to the various reasons they could not avail ambulance transportation facility. Some of the respondents reported that they tried to call an ambulance many times, but no one answered the call. Few (6.3%) women said that they were not aware of the ambulance service that's why they used private transportation to reach the hospital. Five respondents also reported that they did not call for an ambulance as it was late in the night, and they assumed that the ambulance would not come in the night. One of the respondents said that, when she called 102 in the late night the ambulance provider did not come and replied that:

*"I do not want travel in this cold and do not want die".*

*-Ambulance service provider (Anexture-1)*



As per respondents, sometimes due to the high load of the patients the ambulance carry 3-4 new mothers to be dropped at home, so most of them avoided to use it. More than half (53.4%) of the women had received transportation assistance after discharge from public hospitals for a drop back at home. Bribe money was taken, by the ambulance driver, more than one third (35%) of the women had to pay nearly hundred rupees and few (18.4%) of the respondents had to pay between hundred to two hundred rupees. The average cost of public transportation was calculated approximate ₹116.

## 4.2 Access and Barriers in service utilization

**Table 4.17**

### Use of private transportation after discharge from the hospital

<b>Women who used private van (103)</b>	<b>Frequency (n)</b>	<b>Percent (%)</b>
Yes	72	69.9
No	31	30.1
Total	103	100.0
<b>Distance of health centre from home (N=103)</b>		
Below 1 kilometre	13	12.6
1-5 kilometres	10	9.7
6-10 kilometres	19	18.4
11-15 kilometres	54	52.4
Above 15 kilometres	7	6.8
Total	158	100.0
<b>Expenditure of private van (N=72)</b>		
Below ₹500	18	25.0
500 to ₹600	20	27.7
600 to ₹800	21	29.2
Above ₹ 800	13	18.1
Total	72	100.0

Table 4.17 reveals that, more than half (69.9%) of the respondents were used private transportation after discharge from the public hospitals. One third of the women revealed that, due to unavailability they could not get service of ambulance after discharge from the hospital.

The catchment area of the PHC is approximate fifteen kilometres. There are eight maternity centres including Additional PHCs, Sub-Centres and PHC. It was found that, only a few (12.6%) of the women reported the distance between the Public Health Centre and their homes was less than one kilometre, more than half (52.4%) of the women revealed that, distance was between eleven to fifteen, and a few (6.8%) of the respondents revealed that distance was above fifteen kilometres.

Expenditures on private transportation were varied according to the distance to the health institutions. The average cost for private transportation was approximately ₹669.

#### **4.2.2 Reason for underutilization of 102 services in Kurebhar block**

Recently, one more Ambulance 102 was allotted to Kurebhar PHC to provide services among population because only one ambulance was not sufficient to carry the high load of patients, but the ambulance was not in use ANM of Katka Khan Pur Sub-centre was informed regarding Ambulance 102 through PHC officials to report all ASHAs who were working under them. When researcher visited Sub-centre Katka Khan Pur and wanted to collect information regarding ambulance services from ANM, replied that she is not aware regarding new ambulance. The researcher had already met the PHC officials and talked about ambulance service to crosscheck this information. It was found that at Sub-centre there was a high load of patients and this centre was not fully functional.

Near the Sub-centre, the Auxiliary Nurse Midwife (ANM) provides childbirth services at her home as a private maternity centre. All such deliveries conducted at her private clinic were recorded as Institutional Birth in her birth register. She also charges a fee for every delivery. Present data shows that, still there is need of awareness regarding ambulance services.

The ambulance provider reviled about the patients load at 102:

*“Still we are not getting any cases since 20 days back. The reason behind it is communication gap; ANM did not inform to any ASHA worker regarding ambulance to inform in the community, that’s why women are unaware about this new ambulance 102. ANM had fear that, if women use 102 then, they can go at any health centre for delivery and in this case only a few of them will be visiting her clinic for birthing and her business would decrease it would be a reason behind underutilization of ambulance services”.*

**-Ambulance driver. (Anexture-1)**

**Table 4.18**

**Non-official payment for institutional birth at public hospitals**

<b>Non- official payment</b>	<b>Frequency (n)</b>	<b>Percent (%)</b>
Yes	86	83.5
No	17	16.5
Total	103	100.0
<b>Amount of non-official payment</b>		
Zero	17	16.5
Up to ₹400	30	29.1
₹400 to ₹800	46	44.7
₹800 to ₹1000	10	9.7

Table 4.18 reveals that majority (83.5%) of the respondents were revealed that they had to pay for birthing at different public health institutions. The average amount paid by the beneficiaries, for availing the JSY service. The average expenditure on transportation was calculated approximately ₹683 per childbirth. Respondents from home births revealed that due to the cost of institutional delivery they adopted home birth. One of the respondents told:

**Table 4.19****Recommended medicine cost (after childbirth at public and private hospital those who purchased)**

<b>Expenditure on medicine in public hospitals</b>	<b>Frequency (n)</b>	<b>Percent (%)</b>
Up to ₹500	25	18.8
500 to ₹1000	42	31.6
1000 to ₹1500	15	11.3
Not Purchased*	21	15.8
Total (N=103)	103	100.0
<b>Expenditure on medicine in private hospitals (N=30)</b>		
Up to ₹500**	12	40.0
₹500 to ₹1500	10	33.3
Above ₹1500	8	26.7
Total	30	100.0

\*= Prescribed for medicine but did not purchase, \*\*= Prescribed by ASHA at "Hope Clinic".

Table 4.19 shows that, almost one third (31.6%) of the respondents were prescribed medicine worth five hundred to one thousand rupees from private medical stores after childbirth and few (18.8%) women purchased medicine worth one thousand to one thousand five hundred rupees. The average cost for recommended medicine in Public Health Centre was approximately ₹525 per beneficiaries.

Less than half (40%) of the women's expenditure on medicine was up to five hundred rupees. Rest more than half spent five hundred to fifteen hundred rupees. The average cost of prescribed medicine in a private hospital was approximate 1100 rupees.

At public hospitals for institutional birth under JSY, the average total expenditure, including prescribed medicine at public hospital (₹747), bribe amount for childbirth (₹683) and expenditure on private transportation (₹525) were came around ₹1855, which was more than the JSY cash incentive.

## Chapter- 5

### Discussion and Conclusion

Government of India launched in 2005, nationwide Conditional Cash Transfer (CCT) programme named '*Janani Suraksha Yojana*' (JSY). The outline of JSY scheme was the same across the country, although the criteria to avail this facility varied according to different states (Randive et al. 2013). Mainly cash incentive among demand-side financing programmes has emerged in recent years as a new tool for addressing chronic problems of underutilization of health and social services among the vulnerable groups. The JSY scheme has completed a decade, the objective of which was to reduce maternal and neonatal mortality through promotion of Institutional deliveries and providing cash incentives to the mothers on giving birth in health institution and with a considerable intervention of involvement of community health worker named as ASHA. These grass root level workers provided an interface between community and health systems to increase the number of institutional deliveries especially among poor socio-economic and marginalized families. The success of JSY scheme depended upon access to the health care facility and institutional delivery among poor households during their pregnancy.

Primarily this study seeks to understand the perception from both- sides, health care providers and beneficiaries towards utilization of *Janani Suraksha Yojana* and Institutional Delivery in Kurebhar Block. In the present study, it has tried to cover women from all socio-economic backgrounds to understand the distribution of JSY scheme among the different social category. The present study has attempted to include access and barriers that have a great impact on utilization of JSY scheme.

#### 5.1.1 Utilization of JSY Services

Most of the respondents interviewed were found to be using antenatal care services from public hospitals. However, the study shows that around four-

fifths of respondents did first check-up only during the 3 to 4<sup>th</sup> month of gestation period. Even though, twenty to twenty-four weeks before the expected date of delivery is the ideal time for first check-up, according to JSY Guidelines, only very few (3.2 %) of the respondents utilized this service. The primary reason for this is that only very few respondents' detected pregnancy in the fourth to fifth month. However, the majority (95.6%) of the respondents who identified pregnancy during the third month availed their first antenatal care within twenty to twenty-four weeks. Interaction with the respondents reveals that, even though they recognized pregnancy early, they do not feel the need of registering immediately. One of the respondents, revealed that when she felt that her abdomen size was increasing, only then she visited the Sub-centre for her first antenatal checkup almost in the sixth month of pregnancy. She further told that ASHAs rarely visited their homes at the beginning of gestation period, but it is only during the last month of pregnancy that she started visiting frequently. There might be other reasons for not registering early the small proportion of the respondents. The weak interaction of ASHAs further leads to maintain the situation. Though most of the respondents (84.7%) did not know the name of the scheme Janani Suraksha Yojana, but they knew if the birth takes place at government hospital they will get some money. A study, by Singh, Khobragade, & Kumar (2014) in Uttar Pradesh found similar trends, only less than one-fourth (16.5%) of the respondents had proper knowledge about JSY scheme and were able to pronounce the correct name of the scheme. Through different sources, some of the women got the information about JSY such as radio and newspaper. One of the respondents said that she got information about JSY through radio advertisement and approached for institutional birth at the PHC.

Under National Rural Health Mission (NRHM), one of the key components of the mission is to create band of female volunteers named as "Accredited Social Health Activist" (ASHA) in each village per 1000 population in identified states (Bomble & Jugnari 2015). To address, the Millennium Development Goals (MDGs) on health-related indicators under the strategy of NRHM, the ASHAs represents three principal roles, such as ASHA as an activist or rights worker; ASHA as a link worker or facilitator; and ASHA as a

community level health care provider. An ASHA, is expected to provide primary medical care with her kit, education, sanitation and surveillance, control of disease by information, antenatal and postnatal services to women, counselling on family planning, safe abortion, child immunization, vitamin A supplementations, change in behaviour in breastfeeding, birth spacing, girl education and care of child specially newborn. Except these, she has other responsibilities, such as performing household survey, working with community for disease control, collaborating with health functionaries, creating awareness on health and its determinants, mobilizing the community towards local health planning and enhancing the utilization of existing health care services (Bomble & Jugnari 2015). At the same time, ASHAs have several other responsibilities related to her family. One of the ASHA workers revealed that it is not easy to cover all households because of much distance from their house. It is found that in a village among nine selected Village Panchayats majority of the respondent told that ASHA never visited their village and households.

In the present study, it was found that the majority (97.8%) of the women got registered between twenty to twenty-four weeks of pregnancy. However, most (94.9%) of the women received their antenatal care by the ANM, which shows a good sign for JSY availing JSY services. It is also found that the majority (91.1%) of the women received two ANC checkups, only very few (2.5%) of the women completed their three antenatal care. Further, it was also revealed that very few (1.3%) of the respondents faced problems during registration of prenatal care, problem was found that they had to pay for JSY card twenty to twenty-five rupees. In addition to, few (15.8%) women also visited private health care institution or physician at various gestational periods though they were availing antenatal care from public hospitals also. The majority of them were not satisfied with the services at public hospitals. For the antenatal care at the private healthcare institution, they had to pay 1000-2500 rupees per visit. However, it indicates the cost of private antenatal care would be increasing out of pocket expenditure on child birth of the respondents

More than half (65.2%) of the deliveries is conducted at public health institutions, and ANM assisted majority (81.5%) of the deliveries. Another

study, (United Nations Population Fund - India, 2009) also supports the present findings, but one significant fact is found that among home births (15.8%) only very few (4%) of the deliveries were assisted by skilled birth attendants, while most (76%) of the deliveries were assisted by local *Dais*. Another study by Khan, Mehnaz, Ansari, Khalique, & Siddiqui (2009), in this area also supports the data of the present study regarding home birth attendants. It is found that when JSY is in its full swing, the un-institutional and unsafe deliveries were still taking place in rural areas. The primary reasons for this were found to be less than half (44%) of the delivery took place due to lack of transportation, more than one-fourth (24%) of the delivery due to financial problem, one-fifth (20%) did not feel the need to go to health centre and twelve percent were not aware regarding the JSY scheme. Study shows that most (74.2%) of the beneficiaries received JSY cash incentive. Another study (United Nations Population Fund - India, 2009) revealed that the majority (93.2%) of the mothers received JSY cash incentive. But out of 128 eligible beneficiaries 8 (6.3%) women from institutional births and 25 (19.5%) from home births could not receive JSY monetary benefits. Beneficiaries who received cash benefits, half (49.2%) of them also further revealed some problems during receiving the cheques. Only 19 (14.8%) women told that they got the cheque immediately after discharge from the district hospital. The major problem was found to be delay in distribution of cheque. Due to delay in distribution one fourth (28.9%) of the mothers received incentive between one to two weeks after childbirth. Rest one-third (30.5%) received after more than two weeks. Further, it was also found that no mothers among home births received monetary benefits under JSY. In the response of cash incentive for home births, Health Education Officer PHC Kurebhar further revealed that no mother had fulfilled the criteria for home births cash incentive that is why they did not issue a cheque. One of the ASHA also revealed that she does not consider home births, but only focuses on institutional births. It shows a great concern regarding distribution of cash incentive and in identifying eligible beneficiaries under JSY scheme. A study by Trivedi et al, 2014, also supports the present findings regarding concerns with distribution of cash benefit at the district hospital. Another study, (United Nations Population Fund - India 2009) in contrast shows that the majority



(95.5%) of the mothers received JSY cash benefits while present study show 74.2 per cent women received a cash incentive.

The data shows that components of ANC have been poorly utilized expect few components. Findings show that the majority (91.1%) of the women received two doses of Tetanus Toxoid (TT) and expected the date of delivery (92.4%). Another study (United Nations Population Fund - India 2009) highlights regarding TT majority (98%) of the women received two doses in Uttar Pradesh, which supports the present finding. It is further, revealed that, only very few (4.4%) of the women consumed hundred plus iron-folic acid (IFA) tablets, majority (95.6%) of them consumed partially while another study (United Nations Population Fund - India 2009) shows that in Uttar Pradesh majority (83%) of the women consumed hundred plus IFA tablets that show a different picture regarding iron folic acid tablets . The distribution and consumption of hundred tablets of IFA during pregnancy is the only intervention to reduce the risk the maternal anemia (Ram, Ram, & Singh 2015). Various reasons were found for partial consumption and non-consumption, among whom the primary reason for non-consumption was non-availability of iron folic acid tablets (42.4%) and for partial consumption reason were considered such as vomiting (8.9%) followed by loose motion (11.4%), bad taste (24.7%) forget to eat (10.8%). It was further, revealed, regarding non-availability of IFA tablets by the pharmacist of PHC, he said;

*In last one year we received IFA tablets once in bulk but more than eight months have passed away, but we did not receive again. However we need to manage from the stocks of IFA tablets at the PHC. We have to show that it is being distributed to the all pregnant women from all health centres in this block. We had ordered for IFA tablets, but they have not sent them till now”.*

**-Pharmacist PHC Kurebhar**

The above explanation shows that, there is a problem in supply side regarding iron folic acid tablets.

### **5.1.2 High use of ultrasound testing and its impact on outcome of pregnancy**

Present findings show that less than half (43%) of the women had gone through ultrasonography testing. Another study conducted in the slums of Greater Mumbai shows a high rate of Ultrasonography test (Sarod, 2015). Though the majority (92.4%) of the deliveries were normal yet, they were recommended for ultrasonography test. The data shows a complex picture of technological intervention and its use among different socioeconomic groups. It is found that, in social groups like other backwards class (OBC), more than half (53.9%) of the women had gone through this ultrasonography testing, while for among SC population and in General it was almost same (23.5%). The most striking thing was that mother's whose monthly income was below five thousand rupees, more than half (58.8%) of them underwent ultrasonography test, after the recommendation of health care providers. It was further revealed by the respondents that they had the perception if they did not underwent ultrasound checkups something wrong would happen to them and their child and then they will be held responsible for any miss happening by the ANM, so women felt that ultrasound testing is must for them.

Indicator education level of the mother shows more than half (51.4%) of the mothers had an education above than high school level who underwent ultrasonography test. Religion wise distribution shows that majority of the women from Hindu religion performed ultrasonography testing, while among Muslim women less than one-fourth (16.2%) of them underwent the test. The majority (92.6%) of the women were found to be housewives from all social categories. The present data highlights the use of ultrasonography testing, and its impact on the outcome of the pregnancy. Further, it was found that women from different socioeconomic backgrounds whose testing was done the majority (64.7 %) of them gave births to the male child.

According to Census 2011 data child sex ratio, has declined in comparison to Census 2001 (from 934 in 2001 to 921 in 2011). However the question arises, why a large number of ultrasonography test? Is ultrasonography testing compulsory for all normal births? The majority (92.4%) of the women had

given normal childbirths only a few were caesarean. The present finding also indicates, the motive behind ultrasonography testing may be sex determination, which would be further leading cause of fertility transition leading to the declining of child sex ratio in Sultanpur district. A another study, by Sangari, (2015), states that according to the Census of India, 2001, the relatively better districts were those where the technology had not reached; the lowest female child sex ratios or female sex ratios at birth were in Punjab, Haryana, Uttar Pradesh, Gujarat and adjoining district where diagnostic clinics and ultrasounds machine were first introduced, followed by Himachal Pradesh and Delhi (Sangari 2015 p.163). However in Census 2001 shows, all states of India except Lakshadweep, Sikkim, Mizoram, Tripura and Kerala registered a decline in female child sex ratio. A further decline, in the female child sex ratio noted in the northern states by an Action Aid and IDRC Survey in 2007 (cited in *The Hindu* 14 December 2007). The Census 2011, provisional data released which show a further decline in female child sex ratio, from 927 in 2001 to 914 in 2011. Author further argued that the late entry of ultrasonography has attributed to decreasing the female child sex ratio in states Arunachal Pradesh, Karnataka, Kerala, West Bengal; more so in Andhra Pradesh, Assam, Bihar, Chhattisgarh, sharply in Goa, Jharkhand, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, Sikkim, Uttar Pradesh and most dramatically in Jammu Kashmir (from 941 in 2001 to 859 in 2010) (ibid.). The connection with the introduction of ultrasonography is crucial in every region. The National Health Family Survey- 3 also showed the pregnancies receiving an ultrasound test were more likely to lead to a lower female child sex ratio (ibid.). The ultrasound scan for detecting genetic abnormalities in the foetus had come to India in the early 1980s. By the late eighties, it had established itself firmly as a tool for determining the sex of the unborn child (Aravamudan 2007, p. 65). In other parts of the world, ultrasonography as a diagnostic and therapeutic tool had contributed immensely to maternal foetal medicine. It was possible to obtain high-resolution images of foetal anatomy and to observe the various activities of the foetus while it was still in the uterus. But in India the ultrasound scan was seen as a kind of miracle machine that could determine the sex of the foetus at the early stage (Aravamudan 2007, pp. 65-66). Another study, states that, in recent

years the music of ultrasound has reached in several part of India, remote tribal area of Rajasthan, Bundelkhand, even where women were better treated such as Assam, Kerala and the Kashmir valley(Singh 2015). Another study states that fertility decline results from the diffusion of contraception, amniocentesis and ultrasonography technology allows sex detection and increase in sex-selective abortion (Mohanty & Rajbhar 2015). It is also found that, one of the mother told regarding son preference, she said “ *ek aakh koyi aakh nhi hoti*” (*it mean both eyes have its importance, in the absence of one eye, it is incomplete, same as she was expecting one more male child, even she had one male child in previous birth*). Another study, also supports the present finding, regarding son preference which further reveals that the declining child sex ratio is linked to fertility changes because of inherent gender bias and son preference across socioeconomic groups in India (Mohanty & Rajbhar 2015).

It is found that, out of 158 deliveries, including public institution, private institution and home deliveries less than one-fourth (19.8%) of the women faced complication that was identified by the trained health personnel that further led to few (7.7%) caesarean births.

All mothers who developed complication during delivery were referred to the district hospital from Sub-centre, Additional PHC, and PHC. Further, it was found that, one of the mothers revealed that when she was referred from PHC to district hospital for C-section due to developed complication, district health care providers told her that doctors are not available so they cannot perform caesarean delivery on that day, and asked her to visit any other public or private hospital in the city of Sultanpur. It is also found, in another study 15.3 per cent of the women were identified for developing complication during delivery (United Nations Population Fund - India 2009) which supports the present findings.

Another striking thing that was found was regarding the duration of stay at public hospitals. Most (61.2%) of the mothers stayed less than six hours after normal childbirth and less than one-fourth (20.4%) of the mothers stayed between six to twelve hours only, at Sub-centre, additional PHC and at PHC. However it was found, excellent at district hospital where all fifteen (100%)

mothers stayed up to forty-eight hours after normal childbirth and four (100%) mother stayed up to 3-7 days after C-section birth. In addition to this, another study regarding duration of stay, by the JSY beneficiaries at institution among five EAG (Empowered Action Group) states indicated that majority (83.9%) of the mothers in Bihar, followed by Uttar Pradesh (73%), Orissa (57%), Rajasthan (57%) and Madhya Pradesh (32.9%) stayed at public health institution below one day respectively which supports present finding (United Nations Population Fund - India, 2009). However, duration of stay after delivery at the hospital remains one of the leading causes of concern, and there is need to pay attention as half of the maternal deaths take place postpartum. It is also found that most of the women knew about the scheme as well as the benefits offered, due to publicity undertaken by government which reflects hidden demand, for institutional deliveries in these states that need to be backed up by high-quality services at health institutions.

Under the JSY scheme, those mothers who had undergone institutional delivery were asked about their experience at the institution in which they delivered their recent child. The majority of the women revealed that they were immediately attended to after their arrival at the facility for childbirth. It is also found that, the majority (81.6%) of the delivery were conducted by Auxiliary Nurse Midwife (ANMs), while only a few (4.3%) by a staff nurse. Another study also supports the present findings(United Nations Population Fund - India 2009). But it was further revealed by the respondent. It was found that all health centres below District level where maternity services are being provided; infrastructure was in a bad condition such as Sub-centre, and PHC, except Additional PHC (new building). Sub-centre is found in an awful condition that was situated in the garden at a separate place from the village. There was no proper water supply, no electricity connection; the bed was broken and there was no real link road to the sub-centre though deliveries were conducted there. Further, one of the mothers revealed when she visited the Sub-Centre for delivery in the night she gave birth to her child in candle light (*dibri*)<sup>6</sup> as there was no proper backup of electricity. It was also further

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<sup>6</sup> In the absence of light using kerosene oil in small bottle with the help of cotton thread for producing light.

revealed that, there is no toilet facility at the Sub-centre, yet in this poor setup deliveries were conducted continuously. The mother further revealed that, due to the poor condition of health centre she did not stay longer than two hours after giving birth to her child. The Additional PHC was constructed few years back but its condition is now similar to the Sub-centre. Even though more than one-fourth (26.6%) of the deliveries were conducted at PHC Kurebhar which is a delivery hub, the present study shows that, of all the mothers who approached this centre, less than half (44.4%) did not stay more than six hours at health centre after birthing. Most of the mother revealed further they did not want to stay longer due to the lack of proper facilities such as sanitation, safe drinking water, and irregularity in electricity supply, lack of beds and lack of care. Further, ANMs revealed that if patient load increases then, they discharge the mothers, who gave births just three- four hours back. Some of the mothers also revealed that they had to buy medicines from the private medical store due to the unavailability of medicines at the PHCs during delivery. The majority of the mothers revealed that their family members also did not want to stay long after birthing at health centre due to lack of services. However, it indicates a primary concern regarding the quality of care at the public health facility to provide a better maternity service under JSY scheme. However, it was found that, majority (82.9%) of the beneficiaries of the JSY were facilitated by the ASHA workers and were satisfied with their behaviour during the pregnancy and delivery. Only a few (11.4%) of the women were not satisfied. They revealed that whenever they needed help ASHA did not give response. It further revealed that while most (71.8%) of the mothers received escort service by the ASHAs, only less than one-third (28.2%) of the mother could not get the escort service. Various reasons for not escorting were revealed. Few of the mothers had no contact number so could not inform the ASHA, some of them told that the ASHA was busy in her family work and in few cases ASHAs reached the health centre directly after delivery. Another study shows only 15.2 per cent women were accompanied by the institutional delivery while per cent study shows in contrast positive increases to accompanying mothers under JSY Scheme (United Nations Population Fund - India 2009).

It was found that, half (50%) of the mothers, received nutritional supplement food from the Anganwadi centre and rest could not get due to various problem such as lack of awareness regarding supplement food (17.7%), followed by ill behavior of the Anganwadi workers (12.7%) and insufficient stock (21.5%). It is found that, nutritional supplement food have been poorly utilised.

Out of 158 deliveries, the majority (92.4%) of them were normal births and 7.6 per cent deliveries were cesarean section. Another study (United Nations Population Fund - India, 2009) also revealed that majority (94.6%) of the deliveries were conducted as normal births only 4.2 per cent were caesarean, which supports present findings. But the distribution of C-sections among public and private was shocking, most (66.7%) of the deliveries were conducted at the private health care institution, only one third (33.4%) is done through caesarean. C-section or surgical deliveries is one example of the medicalization of human body. During childbirth use of medical technologies is a matter of concern in developed and developing countries, including India. It is evident that the development of the application of reproductive technologies is contradictory possibilities for women (Ghosh 2010). However Government of India launched a large Conditional Cash Transfer (CCT) programme named JSY, with the objective of promoting Institutional deliveries to reduce maternal and neonatal mortality throughout the country. It has been witnessed that, overall the number of institutional deliveries have increased by 42.6 per cent across the low performing states (LPS) and high performing states (HPS) after implementation (Gupta et al. 2012). Chiranjeevi Yojana in Gujarat is also another example of increasing number of institutional deliveries as well as C-section deliveries. However, there is a reason to believe that, current rates are part of rising trends, C-section cannot be entirely associated with the increasing numbers of institutional deliveries because there is a strong association between private health care institutions and C-section (Mishra & Ramanathan 2002). Another study, by Potter et al.(2001) also suggest that different rates of caesarean section in public and private patients suggest that non-medical factors, such as economic gain and pressure of private practices, may motivate doctors to perform surgical

deliveries (Potter et al. 2001). Study shows that the power of decision-making in the home and seeking mediated health care were associated with higher maternal education and family income (Potter et al. 2001). With all these arguments, several social scientists have pointed out the increasing medicalisation of maternal health in developed countries as well as in developing countries.

Further data shows that, less than one-fourth (19.0%) of the mothers visited health centre within fifteen days of childbirth and more than half (63.3%) of the women attended health institution between twenty to thirty days after delivery. However, it was found that more than one-third (39.2%) of the checkups were done at PHCs and Additional PHC. At sub centre level health facility less than one-fourth (24.4%) of the checkups took place. It was also found that few (13.9%) of the mothers did not feel the need to approach postnatal care. Another study also states that among five states 84 per cent postnatal services provided to the mothers (United Nations Population Fund - India 2009). But present finding highlights that, postnatal care among JSY beneficiaries, is low as in comparison to previous study

### **5.1.3 Access and Barriers to service utilization**

The present study shows that more than half (55.1%) of the respondents were between the age of 22-26 years, which was major reproductive age group among the population. Annual Health Survey (2012-2013) in Uttar Pradesh data highlights that, the median age at first live birth of women aged 15-49 years is found 22.3 years which supports present finding that majority of the women were laying between 22-26 years age group. Further, data highlights that, more than one third (32.3%) of the women were illiterates and around one-fifth (21.8%) had completed their education up to primary level only and most (79.7%) of the respondents were daily wage labourer it shows the lack of education and proper information regarding the scheme it may be because of ill utilization of JSY services.

However Census 2011, data shows district rural female literacy is only 57.24 per cent that shows a significant concern regarding their education level that would be further cause of barrier in accessing and utilizing services during



their pregnancy. It is found that, majority of the respondents were daily wage labourers even though they had some piece of land. Less than half (47.5%) of the respondents owned land below one bigha, which is found insufficient for agriculture production and their livelihood. Majority of the mothers, who were daily wage labourers revealed that their land was not much fertile; in this case they had to depend upon only daily wages. This same factor was also found applicable for respondent's husband's occupation. More than half (57.6%) of the respondent's husbands were also found to be daily wage labourers. Further, the study revealed that most (72.8%) of the respondents monthly income was below than five thousand rupees and most of them (64.6%) were found below the poverty line. However, the poor socioeconomic background of the respondent was considered as barriers in accessing services under JSY scheme. Further is found that, their socioeconomic background and their education levels have also impacted on awareness about JSY scheme, the majority (83.5%) of the women had incomplete information. Only a few (16.5%) were able to give complete information about JSY scheme. It also indicated that there is need of effort on the provider's side to make them aware regarding the JSY scheme to enhance them to access institutional delivery. Annual health Survey (2012-13) data, highlights that, in Sultanpur District institutional delivery were recorded 64.2 percent while more than one-third (34.2%) of the women gave birth at home and 12.1 per cent in private hospital. When JSY scheme is in full fledged then still home births are happening. Further report (ASHA 2012-13) also highlight that, less than half (47.8%) of the deliveries were assisted by skilled birth attendants at home. In contrast, present findings also highlight that only very few (4%) of the deliveries carried out by trained health personnel remaining by untrained local dai.

Under the scheme JSY, the assistance for transportation services has played a significant role to reach in health facility within time. In the present study, it was found the lack of transportation facility, was a major barrier to accessing the health service for birthing at the public hospital. It is found that the majority (93.5%) of the respondents were considered aware regarding ambulance service, the ASHA informed majority (77.8) of the respondents. It

shows a positive sign regarding awareness of the government transportation assistant facility. But in the present study it was found very low (28.6%) utilization of ambulance services in Kurebhar block. Further, it was found that less than half (43.6%) of the respondents used private transport facility to reach the health facility for birthing that increased their out of pocket expenditure. But more than half (54.1%) of the mothers used private transportation after discharge from hospital to go back home, increased sharply. Further, it was found that less than half (46.2%) of the respondents houses were between eleven to fifteen kilometres, and less than one-third were found within 10 kilometres from a health facility. Bad condition of roads and long distance both were found as a major hindrance to avail the ambulance services. The majority (63%) of the mothers revealed that after calling 102/108 they wait more than one hour but the ambulance did not arrive at respondent's home to pick the mother from home to the health centre. In this case, they had to manage with private transportation. Further, it was revealed that expenditure on transport varied in the daytime and the night. Seasonal factors such as heavy cold and in any emergency cases they were demanded more fare than the average. However the majority of the respondents expressed their views on high expenditure on private transportation, they all said they have to adjust to the situation.

The average expenditure on private transportation was calculated around five hundred twenty-five rupees. In another study among five states, highlights that, the average cost of hiring the vehicle came around Rs. 433 in Assam, while, in remaining states, it came around Rs. 250 to Rs. 300 (United Nations Population Fund - India 2009). At some extent, it qualifies the present findings. Various reasons were revealed by the respondents for low utilization, due to lack of awareness (6.3%), unavailability of ambulances was the primary cause. One of the mothers revealed that when she called 102 in the late night the ambulance provider replied "I do not want to travel in this cold and do not want die". Even, behaviour of ambulance service provider, also restricted to availing the transportation facility, majority of the respondents revealed that, sometimes due to the high load of patient they carry three to four new mothers in an ambulance to drop at home, so most of them avoided using next time.

The majority of the respondents had to pay some amount of money to the ambulance provider, more than one third (35%) of the women were paid below than hundred rupees, and few (18.4%) of the respondents had to pay between hundred to two hundred rupees.

The average cost of public transportation was calculated approximate one hundred sixteen rupees. One of the mothers revealed that when she denied paying money to the service provider, in the way of reaching home ambulance provider said “I will drop you on the way”. However, they had to pay at any cost. Present finding of low use of ambulance services are consistent with another study by Mawalankar et al., (2005), in their study stated that ambulances services have a significant role to provide emergency medical services. Across the many countries the availability of vehicle and their functioning, maintenance, etc. are the major problem. The author further revealed that only 29 per cent of the PHCs in India have a vehicle (IIPS 1999 cited in Mawalankar et al. 2005). Another, report of Government of India also states that in most of the district of Uttar Pradesh, Orissa and J&K were found that Mobile Medical Units were not working and also insufficient emergency transport system is hampering the outreach of health care services (Government of India 2011). The report further states that while in Madhya Pradesh the referral transport services viz. ‘Janani Express Vehicles’ are functioning in all the First Referral Units.

However, it was found that, for institutional delivery and child births, majority (83.5%) of the mothers had to make some payments at public health institution, which included recommended medicine charge and hospital charge for conducting delivery. Another study, also shows that in four states, Bihar, Rajasthan, Orissa and Uttar Pradesh, nearly half of the mothers had to pay some payments at public health facility (United Nations Population Fund - India 2009). The highest payment Rs. 1638 was recorded in Orissa, followed by Rajasthan Rs. 1350, in Uttar Pradesh Rs. 839 and Rs. 718 in Bihar while it was found lowest Rs. 299 in Madhya Pradesh. However, this study among five states supports present finding, which highlights such kind of payments to be around Rs. 683 in the Kurebhar Block. With regards to such kind of payments one of the mothers revealed that she was aware of this payment, but she was

unable to pay this amount, so she decided to give birth at home. Further, it is found that the majority of the respondents revealed that they had to pay some amount of money for birthing in the public health facility.

Further, it was calculated average total cost of Institutional delivery, including private transportation charge, prescribed medicine and other small expenditure such as for food and breakfast, it came around ₹1855, which was more than JSY amount ₹ 1400. If the beneficiaries had used ambulance services then the average expenditure came around , ₹1546. The above explanation regarding payments for institutional birth and expenditures on medicine and transportation indicates it has restricted to the women for institutional delivery that is persisting as a major barrier to avail the JSY service.

### **5.16 Conclusion**

Detailed field data collection permits enough data to analyse the perspectives of beneficiaries availing JSY scheme. Majority of the respondents revealed that during the antenatal care they received only tetanus toxoid injection and iron folic acid tablets and other checkups such as blood pressure measurement (BP), urine test did were not examine. Only some of the respondents received the kind of checkups. Though majority of the births were conducted as normal at institution as well as home but most of the women were recommended for ultrasonography during ANC, and they had to undergo for ultrasonography testing.

Half of the respondents were found satisfied with JSY services. Majority of the JSY beneficiaries were found from the OBC social group. This social group was found dominant in the socio-economic characteristics as well as among JSY services utilization. The detailed literature review along with the primary data collected gave enough space for understanding the barriers that exist in accessing JSY scheme. Present study also highlights that women have desire to give birth at institutions but factors such as poor socioeconomic condition of the household; burden of non official payment for child birth; extra expenditure on transportation and on medicine and the poor behaviour of the health care provider restricted women to give birth at home.

Interview with health care professionals and key informant bring out the perceptions of health care providers about JSY scheme. The perspective of health care providers about JSY scheme is that it is a good program for poor and marginalized women to improve their access for institutional birth. But barriers in accessing JSY services among poor marginalized people limit effective utilization of JSY services and result maternal mortality remains high.

Regarding the programme poor households women were not aware about the scheme. There is still gap large communication gap between public and administration. Present study also brings forth the caste and class differences in accessing maternal and child health care services.

Majority of the home birth took place among marginalized socio economic groups of women. Study highlights issue of dominant caste in villages and their association with the utilization of JSY services. Higher caste and classes are able to efficiently access and utilize JSY services as well as private health providers compared to poor and marginalized women from low socio economic groups.

Further the study clearly brings out the relation between JSY and institutional delivery. JSY scheme has improved number of institutional deliveries in the study area and more women are accessing health facility for the child birthing. But JSY scheme has not been able to reduce maternal mortality rate in the study area which was the fundamental objective behind launching JSY scheme. The objective of JSY would not be fulfil until the section of society still experience problems in accessing health care institutions for birthing in the rural areas. The positive aspect of part of the JSY scheme is financial assistance to mothers which attracted women from home to health care facility for birthing. Several women got the monetary benefits but still there are many inconsistencies in the fund transfer under JSY scheme to the JSY women beneficiaries. This is limiting women in accessing public health facility for their child birth resulting in home deliveries.

## BIBLIOGRAPHY

### Bibliography

- Aravamudan, G. (2007). *Disappearing Daughters The Tredegy of Female Foeticide* (2nd 2014 ed.). Penguin Books India.
- Banerjee, B. (2003). A Qualitative Analysis of Maternal and Child Health Services of an Urban Health Centre, By Assessing Client Perception in Terms of Awareness, Satisfaction and Service Utilization Deptt . of Public Health Administration , All India Institute of Hygiene a. *Indian Journal of Community Medicine, XXVIII*(4), 153–156.
- Bhatia, V. K., & Rai, S. C. (2004). *Evaluation of Socio- Economic Development in Small Areas. Indian Society Of Agricultural Statistics*. New Delhi. Retrieved from [http://planningcommission.nic.in/reports/sereport/ser/std\\_smlarea.pdf](http://planningcommission.nic.in/reports/sereport/ser/std_smlarea.pdf)
- Das, A., Rao, D., & Hagopian, A. (2011). Correspondence India 's Janani Suraksha Yojana : further review There are problems with the paper by. *The Lancet, 377*(9762), 295–296. doi:10.1016/S0140-6736(11)60085-8
- Ghosh, S. (2010). *Increasing trend in Caesarean Section Delivery in India Role of Medicalisation of Maternal Health*. Bangalore.
- Goswami, D., Rathore, A. M., Batra, S., Dubey, C., Tyagi, S., & Wadhwa, L. (2013). Facility-based review of 296 maternal deaths at a tertiary centre in India: Could they be prevented? *Journal of Obstetrics and Gynaecology Research, 39*(12), 1569–1579. doi:10.1111/jog.12099
- Government of India. (2011). *Evaluation Study of National Rural Health Mission ( NRHM ) In 7 States*. New Delhi. Retrieved from [http://planningcommission.nic.in/reports/peoreport/peoevalu/peo\\_2807.pdf](http://planningcommission.nic.in/reports/peoreport/peoevalu/peo_2807.pdf)

- Gowda, P. B., & Jyotsna. (2015). An Audit Of Maternal Deaths. *Journal Of Evidence Based Medicine And Healthcare*, 2(13), 1992–1926.  
Retrieved from [http://www.jebmh.com/latest-articles.php?at\\_id=829](http://www.jebmh.com/latest-articles.php?at_id=829)
- Gupta, S. K., Pal, D. K., Tiwari, R., Garg, R., Shrivastava, A. K., Sarawagi, R., ... Lahariya, C. (2012). Impact of Janani Suraksha Yojana on institutional delivery rate and maternal morbidity and mortality: An observational study in India. *J HEALTH POPUL NUTR Journal of Health, Population and Nutrition*, 30(4), 464–471.
- Hiralal, K., & Asit, C. (2013). Maternal Mortality : A FOGSI Study ( Based on Institutional Data ). *The Journal of Obstetrics and Gynecology of India*, 63(April), 88–95. doi:10.1007/s13224-012-0258-1
- Hunter, B. M., Bisht, R., Chakravarthi, I., & Murray, S. F. (2014). Demand-side Financing What Has India Learnt ? *Economic & Political Weekly*, xlix(2).
- Hogan, M. C., Foreman, K. J., Naghavi, M., Ahn, S. Y., Wang, M., Makela, S. M., ... Murray, C. J. (2010). Maternal mortality for 181 countries, 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5. *The Lancet*, 375(9726), 1609–1623. doi:10.1016/S0140-6736(10)60518-1
- Iyengar, K., Iyengar, S. D., Suhalka, V., & Dashora, K. (2009). Pregnancy-related Deaths in Rural Rajasthan , India : Exploring Causes , Context , and Care-seeking Through Verbal Autopsy. *J HEALTH POPUL NUTR*, 27(2), 293–302. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2761776/pdf/jhpn0027-0293.pdf>
- Khan, Z., Mehnaz, S., Ansari, M. a., Khalique, N., & Siddiqui, a. R. (2009). Existing practices and barriers to avail of maternal healthcare services in two slums of Aligarh. *Health and Population: Perspectives and Issues*, 32(3), 113–123.
- Kumar, V., Kausal, S. K., Mishra, S. K., & Gupta, S. C. (2012). Assesment of the impact of the JSYon Maternal Health Services in rural areas of

Agara District. *Indian Journal of Community Health*, 24(2).

Retrieved from

<http://www.iapsmupuk.org/journal/index.php/IJCH/article/view/120/pdf>

Lawson, G. W., & Keirse, M. J. N. C. (2013). Reflections on the Maternal Mortality Millennium Goal. *Birth*, 40(2), 96–102.

doi:10.1111/birt.12041

Mawalankar V. Dilip. (1999). *Review of the Safe Motherhood Programme in India in the Context of Reproductive Health : Achievements, Issues and Challanges*. Ahmedabad. Retrieved from

[http://vs.lir.iimahd.ernet.in:8080/xmlui/bitstream/handle/123456789/487/WP\\_1999\\_1495.pdf?sequence=1&isAllowed=y](http://vs.lir.iimahd.ernet.in:8080/xmlui/bitstream/handle/123456789/487/WP_1999_1495.pdf?sequence=1&isAllowed=y)

McCarthy, J., & Maine, D. (1992). A Framework for Analyzing the Determinant of Maternal Mortality. *Studies in Family Planning*, Vol. 23(No. 1. (Jan. - Feb., 1992)), pp. 23–33. Retrieved from [http://links.jstore.org/sic/i?sic=0039-3665\(199201/02\)23:1<23:AFFATD>2.0CO;2-H](http://links.jstore.org/sic/i?sic=0039-3665(199201/02)23:1<23:AFFATD>2.0CO;2-H)

Mawalankar V. Dilip, Ramani, K., Patel, A., & Sankar, P. (2005). *Building the Infrastructure to Reach the Care for Poor: Trends, Obstacles and strategies to Overcome them*. Ahmedabad. Retrieved from

<http://www.iimahd.ernet.in/publications/data/2005-03-01mawalankar.pdf>

Mazumdar, S., Mills, A., & Powell-jackson, T. (2011). *Financial Incentives in Health : New Evidence from India ' s Janani Suraksha Yojana 1*.

*London School of Hygiene and Tropical Medicine*. Retrieved from [https://researchonline.lshtm.ac.uk/20618/1/JSY\\_Paper\\_Draft\\_20Sep11.pdf](https://researchonline.lshtm.ac.uk/20618/1/JSY_Paper_Draft_20Sep11.pdf)

Mishra, U. S., & Ramanathan, M. (2002). Delivery-related complications and determinants of caesarean section rates in India. *Health Policy and Planning*, 17(1), 90–98. Retrieved from

<http://heapol.oxfordjournals.org/content/17/1/90.full.pdf+html>



- Mishra, V., & Retherford, R. D. (2008). The effect of antenatal care on professional assistance at delivery in rural India. *Population Research and Policy Review*, 27(3), 307–320. doi:10.1007/s11113-007-9064-3
- Mohanty, S. K., & Rajbhar, M. (2015). FERTILITY TRANSITION AND ADVERSE CHILD SEX RATIO IN DISTRICTS OF INDIA. *JOURNAL OF BIOSOCIAL SCIENCE*, (July). doi:10.1017/S0021932013000588
- Mohanty, S. K., & Srivastava, A. (2013). Cost and utilisation of hospital based delivery care in empowered action group (EAG) States of India. *Maternal and Child Health Journal*, 17(8), 1441–1451. doi:10.1007/s10995-012-1151-3
- MOHFW. (2006). *Janani Suraksha Yojana: Guidelines for Implementation, Government of India*. New Delh. Retrieved from <http://mohfw.nic.in/WriteReadData/1892s/file28-99526408.pdf>
- MOHFW. (2010). *Child Health Programme in India Major milestones in Child Health*. Retrieved from <http://mohfw.nic.in/WriteReadData/1892s/6342515027file14.pdf>
- Nair, S., Sexton, S., & Kirbat, P. (2006). A Decade after Cairo : Women ' s Health in a Free Market Economy. *Indian Journal of Gender Studies*, 171–193. doi:10.1177/097152150601300203
- Ng, M., Misra, A., Diwan, V., Agnani, M., Levin-rector, A., & Costa, A. De. (2014). An assessment of the impact of the JSY cash transfer program on maternal mortality reduction in Madhya Pradesh, India. *Global Health Action*, 1, 1–10. Retrieved from [http://www.globalhealthaction.net/index.php/gha/article/view/24939/pdf\\_1](http://www.globalhealthaction.net/index.php/gha/article/view/24939/pdf_1)
- NHM, Ministry of Health & Family Welfare, Government of India (2013). Retrieved from <http://nrhm.gov.in/nrhm-components/rmnch-a/family-planning/background.html>

Office of Registrar General, India, Maternal & Child Mortality and Total Fertility Rates, Sample Registration System (SRS), 7th July 2011. Adopted from [http://censusindia.gov.in/vital\\_statistics/SRS\\_Bulletins/MMR\\_release\\_070711.pdf](http://censusindia.gov.in/vital_statistics/SRS_Bulletins/MMR_release_070711.pdf)

Pandey, N. (2006). Perceived Barriers to Utilization of Maternal Health and Child Health Services : Qualitative Insights from Rural Uttar Pradesh, India. *Asha*, 1–15.

Pardeshi, G. S., Dalvi, S. S., Pergulwar, C. R., Gite, R. N., & Wanje, S. D. (2011). Trends in Choosing Place of Delivery and Assistance during Delivery in Nanded District, Maharashtra, India. *J HEALTH POPUL NUTR*, 29(1), 71–76.

Pathak, P. K., & Mohanty, S. K. (2010). Does the Safe-Motherhood Programme Reach the Poor in Uttar Pradesh, India? *Asian Population Studies*, 6(2), 173–191. doi:10.1080/17441730.2010.494444

Patil, V. N., Shinde, M. A., Surve, M., & Sonone, S. G. (2013). Maternal Mortality □ A Challenge ? *Journal of Krishna Institute of Medical Sciences University*, 2(1), 2–5. Retrieved from [http://www.jkimsu.com/jkimsu-vol2no1/jkimsu\\_vol2\\_no1\\_jan-june\\_2013\\_58-61.pdf](http://www.jkimsu.com/jkimsu-vol2no1/jkimsu_vol2_no1_jan-june_2013_58-61.pdf)

Paul, L., & Chellan, R. (2013). Impact of Janani Suraksha Yojana on institutional delivery in Empowered Action Group States, India. *South East Asia Journal of Public Health*, 3(2), 4–18.

Petersen, I., Mccrea, R. L., Lupattelli, A., & Nordeng, H. (2015). Women ' s perception of risks of adverse fetal pregnancy outcomes : a large-scale multinational survey. *BMJ Open*, 1–10. doi:10.1136/bmjopen-2014-007390

Phukan, R. S. (2014). Family planning in India – Its History, Programmes, Importance and Impact. Retrieved June 6, 2015, from

<http://www.mapsofindia.com/my-india/society/family-planning-in-india-its-history-programmes-importance-and-impact>

Potter, J. E., Berquó, E., Perpétuo, I. H. O., Leal, O. F., Hopkins, K., Souza, M. R., ... Formiga, D. C. (2001). Unwanted caesarean sections among public and private patients in Brazil : prospective study. *British Medical Journal*, 323, 1155–1158. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC59849/pdf/1155.pdf>

Rai, R. K., & Singh, P. K. (2015). Janani Suraksha Yojana : the conditional cash transfer scheme to reduce maternal mortality in India – a need for reassessment. *WHO South-East Asia Journal of Public Health*, 1(4), 362–368. Retrieved from <http://www.searo.who.int/publications/journals/seajph/whoseajphv1n4p362.pdf>

Ram, F., Ram, U., & Singh, A. (2015). Future Demand For Maternal And Child Health Services From Public Health Facilities In Uttar Pradesh. *The Journal of Family Welfare*, 56(Special Issue), 73–82. Retrieved from <http://medind.nic.in/jah/t10/s1/jaht10s1p73.pdf>

Randive, B., Diwan, V., & Costa, D. A. (2013). India's Conditional Cash Transfer Programme (the JSY) to Promote Institutional Birth: Is there an Association between Institutional birth and Proportion of Maternal Mortality? *PLoS ONE*, 8(6). doi:10.1371/journal.pone.0067452.g001

Registrar General of India. (2012). *Annual health survey 2012-13 Fact sheet*. New Delhi.

Royston, E., & Armstrong, S. (Eds.). (1989). *Preventing Maternal Deaths*. World Health Organization Geneva.

Rush, D. (2000). Nutrition and maternal mortality in the developing world 1 – 3. *American Journal Clinical Nutrition*, 72(1), 212–240. Retrieved from <http://ajcn.nutrition.org/content/72/1/212s.full.pdf+html>

- Sachdeva, S., & Malik, J. S. (2012). Assessment of maternal and child health ( MCH ) practices with a focus on Janani Suraksh Yojana ( JSY ). *GLOBAL JOURNAL OF MEDICINE AND PUBLIC HEALTH*, 1(6).
- Sangari, K. (2015). *Solid : Liquid A (Transns) National Reproductive Formation*. New Delhi: Tulika Books.
- Sarod, V. M. (2015). Does illiteracy influence pregnancy complications among women in the slums of greater Mumbai. *International Journal of Sociology and Anthropology*, 2(May 2010), 82- 94. Retrieved from [http://www.academicjournals.org/article/article1379426427\\_Sarode.pdf](http://www.academicjournals.org/article/article1379426427_Sarode.pdf)
- Sharma, P., Semwal, J., & Kishore, S. (2011). A Comparative study of utilization of Janani Suraksha Yojana ( Maternity Benefit Scheme ) in rural areas and urban slums, 22(2), 18- 21.
- Sidney, K., DeCosta, A., Diwan, V., Mavalankar, D. V., & Smith, H. (2012). An evaluation of two large scale demand side financing programs for maternal health in India: the MATIND study protocol. *BMC Public Health*, 12(1), 699. doi:10.1186/1471-2458-12-699
- Singh, D. B. P. (2015). Sociology of Female Foeticide and Infanticide. Where does the Law Stand? *Gender Forum*, (38), 1-7.
- Singh, P., Khobragade, M., & Kumar, A. (2014). A Study on Awareness about Janani Suraksha Yojana (JSY) among rural married females. *MRIMS Journal of Health Sciences*, 2(1), 40-41.
- Simple Registration System. (2006). *Maternal Mortality in India: 1997-2003 Trends Causes and Risk Factors*. Retrieved from <http://www.esocialsciences.org/Download/repecDownload.aspx?fname=Document120122006530.6240503.doc&fcategory=Articles&AId=753&fref=repec>
- Simple Registration System. (2011). *Special Bulletin on Maternal Mortality in India 2007-09*. New Delhi.

Retrieved from [http://censusindia.gov.in/Vital\\_Statistics/SRS\\_Bulletins/Final-MMR\\_Bulletin-2007-09\\_070711.pdf](http://censusindia.gov.in/Vital_Statistics/SRS_Bulletins/Final-MMR_Bulletin-2007-09_070711.pdf)

Stampini, M., & Tornarolli, L. (2012). *The Growth of Conditional Cash Transfers in Latin America and the Caribbean: Did They Go Too Far?* Retrieved from <http://ftp.iza.org/pp49.pdf>

Tej Ram Jat, Prakash Ramchandra Deo, Isabel Goicolea, Ann-Karin Hurtig, & Miguel San Sebastian. (2013). The emergence of maternal health as a political priority in Madhya Pradesh, India: a qualitative study. *BMC Pregnancy and Childbirth*.

Thaddeus, S., & Maine, D. (1994). Too far to walk: Maternal mortality in context. *Social Science and Medicine*, 38(8), 1091–1110. doi:10.1016/0277-9536(94)90226-7

Trivedi, R., P, A., SP, S., Singh, S., Nath, S., & Saxena, M. (2014). Comparative Evaluation of Cash Benefit Scheme of Janani Suraksha Yojana for Beneficiary Mothers from Different Health Care Settings of Rewa District, Madhya Pradesh, India. *Online Journal of Health and Allied Sciences*, 13(1), 1–4. Retrieved from <http://cogprints.org/9728/1/2014-1-2.pdf>

UNICEF. (2008). *Assessment of Janani Suraksha Yojana in Uttar Pradesh*. Sponsored by: UNICEF, New Delhi.

UNICEF. (2015). *Delivery Care Current Status + Progress*. Retrieved from <http://data.unicef.org/maternal-health/delivery-care>

United Nation. (2011). *The Millennium Development Goals Report 2011*. Retrieved from [http://www.un.org/millenniumgoals/pdf/\(2011\\_E\)MDG\\_Report\\_2011\\_Book\\_LR.pdf](http://www.un.org/millenniumgoals/pdf/(2011_E)MDG_Report_2011_Book_LR.pdf)

United Nations. (2010). *The Millennium Development Goals Report 2010*. New York.

United Nations Population Fund - India. (2009). *Concurrent Assessment of Janani Suraksha Yojana (JSY) in Selected States: Bihar, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh*. New Delhi. Retrieved from <http://countryoffice.unfpa.org/india/drive/JSYConcurrentAssessment.pdf>

USAID Global Health. (2008). *Maternal and Child Health Program Description: India*. Retrieved from [http://pdf.usaid.gov/pdf\\_docs/PdACP009.pdf](http://pdf.usaid.gov/pdf_docs/PdACP009.pdf)

WHO. (2000). X. Population Dynamics and Reducing Maternal Mortality. *Population (English Edition)*, 1–9.

WHO. (2010). *Trends in Maternal Mortality: 1990 to 2008*. Retrieved from [http://whqlibdoc.who.int/publications/2010/9789241500265\\_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf)

WHO. (2012). *Trends in Maternal Mortality: 1990 to 2010*. Retrieved from [http://whqlibdoc.who.int/publications/2012/9789241503631\\_eng.pdf](http://whqlibdoc.who.int/publications/2012/9789241503631_eng.pdf)

World Health Organization, UNICEF, United Nations Fund for Population Activities, World Bank, United Nations, Department of Economic and Social Affairs, & Population Division. (2014). *Trends in maternal mortality, 1990 to 2013: estimates by WHO, UNICEF, UNFPA, The World Bank estimates, and the United Nations Population Division*. Retrieved from [http://apps.who.int/iris/bitstream/10665/112682/2/9789241507226\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/112682/2/9789241507226_eng.pdf?ua=1)

69. Yadav, K., Namdeo, A., & Bhargav, M. (2013). Retrospective study of anemia.pdf. *Indian Journal of Community Health*, 25(1). Zureick-Brown, 70. S., Newby, H., Chou, D., Mizoguchi, N., Say, L., Suzuki, E., & Wilmoth, J. (2013). Understanding global trends in maternal mortality.

*International Perspectives on Sexual and Reproductive Health*, 39(1), 32–41. doi:10.1363/3903213

70. Zureick-Brown, S., Newby, H., Chou, D., Mizoguchi, N., Say, L., Suzuki, E., & Wilmoth, J. (2013). Understanding global trends in maternal mortality. *International Perspectives on Sexual and Reproductive Health*, 39(1), 32–41. doi:10.1363/3903213

## ANNEXURE I

### Key Informants Interviews

#### 4.1 Opinion of Healthcare providers towards JSY scheme

The interview was based on few themes that are as follows: the response towards functioning of Janani Suraksha Yojana Scheme and its impact on maternal health., behaviour of service providers and family members during delivery at PHC, Maternal Mortality and Infant Mortality in Kurebhar Block, scenario/status of Family Planning, access to services and perception of the providers regarding family planning programme, gaps which needs to be focused.

##### 4.1.1 Interview with Medical Officer in Charge (MOIC) PHC Kurebhar

*JSY is an excellent programme for improving maternal and child health. Its provision of cash incentive for Institutional Delivery is a good part of the scheme. According to performance in maternity services Kurebhar PHC has first rank among other PHCs in Sultanpur District.*

**- MOIC, Kurebhar (November 5<sup>th</sup>, 2015).**

#### Behaviour of service provider and family members during and after delivery at PHC

*We provide 24x7 delivery services at this PHC by trained birth attendants. The catchment area of PHC is approximate 13-15 kilometres, but women also visit from other blocks also because of good services and presence of trained health workers. People trust our services and staffs, so usually they prefer not to go to any other place for delivery. If someone has experienced childbirth at this PHC next time, they would want to visit again. We make every*



*possible effort to satisfy the mothers with services and try to provide good care during childbirth and post delivery.*

*During childbirth, we provide a familiar/comfortable environment to the beneficiaries so that pregnant women would not feel uncomfortable in labor room even during their first delivery. Every delivery is important for us, so we pay equal attention to each pregnant woman who visits this centre for delivery. We follow, the entire protocol for a normal delivery and try to convince beneficiaries and their.*

*The family members do not want stay for a long time. After childbirth if mother and baby are healthy they request us to discharge her from the hospital so that they would be able to go home. Mothers who have some vaginal discharge and pain after childbirth agree to stay for a maximum 6-7 hours. In most of the cases, they stay only for 3-4 hours. After being requested for several times, we have to discharge the mother. We cannot force them to stay if they are not agreeing, which creates a hurdle for us to maintain the standard of stay time after normal delivery”*

**- Medical Officer In charge (MOIC).**

### **Maternal Mortality and Infant Mortality in Kurebhar Block**

*“According to the government data maternal mortality is high but after JSY implementation maternal mortality is under control, but still maternal deaths are under-reported. ASHAs are the key informant who reports maternal deaths in their respective villages. For indicators of maternal mortality, we consider causes related to maternity and not any other causes such as cancer, tuberculosis, etc. but right now we have no data on maternal deaths occurred in Kurebhar block”.*

### **Infant mortality in Kurebhar Block**

*“I cannot tell the exact figure, but major causes of infant mortality are Asphyxia and Low Birth Weight. The route cause is anaemia if the mother is anaemic then chances of risk is high for child mortality.”*

*“Majority of the ANMs are more than 55 years old; they are suffering from various problems that do not allow them to walk for greater distance and exert more physical work. Hence, they have their way of completing the given task. They are also not interested to update their knowledge as it will not help them in their career, but this is the need of the hour. They believe that their knowledge is sufficient to deal with the problems of the field. Hence, there are many deaths in this region”.*

### **Scenario of Family Planning, access and perception of the providers**

The planning programme is running in the entire Sultanpur District. Since the beginnings of the programme target population have been females, as per MOIC record shows no male member comes forward to sterilization. In previous years, an incentive in Family Planning, for female sterilization was six hundred rupees to women and eleven hundred to men in Uttar Pradesh. Since 23<sup>rd</sup> October 2014, Ministry of Health and Family Welfare Government of Uttar Pradesh had increased the incentive for sterilization. Through ASHA workers facilitate the women to adopt permanent contraceptives, but usually women ignore it. During the field work it was found that, though, District Hospital organises camps for providing permanent contraceptive but due to the lack of transportation facility, long distance from the villages. One of the mothers revealed that, she visited camp through PHC, but at district hospital due to non availability of the doctors she had to return in the late evening. Further she revealed, after waiting several hours when she came at home she decided that, again she will not attend any camp.

*There are very few women on this block who adopt permanent contraceptive method after two children. I cannot say this block is performing the better-regarding family planning programme, but this block is slightly better than other blocks”.*

**- MOIC PHC Kurebhar**

#### **Gaps which needs to be focus**

*“There is still a gap between poor and rich people in accessing the JSY services. The lack of awareness among poor and marginalized women, have impacted the utilization of JSY services. Lack of communication and knowledge, some home births are taking place.*

*Most of the women are not aware regarding JSY programme. There is a communication gap between public and administration. Now everything is depending on media; there is a need of more advertisement on JSY scheme to spread this information to the needy people. The poor are not availing JSY services due to their poor education and socio-economic condition. Henceforth there is a need for different kind of planning at the administrative level and programme level, to capture these people and their problems primarily, people who belong to BPL category”.*

**- MOIC PHC Kurebhar**

#### **4.1.2 Health Education Officer (HEO)**

Health Education Officer is working as a non-medical staff since 2008 at this PHC. He revealed about JSY scheme; it's functioning, utilization and experience with the ASHAs.

*“ASHAs are an important link between community and health institutions. They provide an interface to the pregnant women between the community and the health centre. They are playing an important role in increasing the practice of institutional delivery under JSY scheme”.*

**-Health Education Officer PHC Kurebhar**

*“Government of India took a good initiative to run such kind of programme under NRHM, specifically for women from the poor and marginalized section to access better maternal health services. Now many poor women can obtain the maternal health services with the help of ASHAs at ground level. Since, I am working here; I have experienced that now several women are visiting the health centre for delivery. Earlier these deliveries were taking place at home, but now most of the women are birthing in health institutions.”*

**- Health Education Officer (HEO) PHC Kurebhar**

**Performance of ASHA in Kurebhar Block (as per HEO)**

*“I am not entirely satisfied with the performance of ASHAs. They are doing their job very honestly and carefully. During selection, most of the women were selected from their respective villages, some of them were not the deserving candidates but through some contacts and linkages they got selected. Behind the selection procedure of ASHAs, the reason was that they had contacts with influential people who gave a reference for them.*

*“The criteria for selection of these ASHA, during JSY implementation, education level was very low as eligibility a criterion that is why sometimes they would not be able to communicate with the family members and with the community also. Health Education Officer, further said that,, among the ASHAs those who are having higher education, approximately 20-30% are working better than ANM; they have more knowledge*

*than ANM regarding JSY scheme benefits and its components and complete information about another governmental programme”.*

*There is a lack of knowledge among some of the ASHAs regarding JSY scheme, which is why still most of the poor women are not able to understand the complete meaning and the objectives of the programme.*

*Sometimes the ASHA, bring pregnant women only for institutional birth; they do not provide adequate information about JSY services during ANC, only, at the last stage of the pregnancy they accompany to the women for institutional birth, for their benefits, to earn more incentive with maximum number of deliveries”.*

**- Health Education Officer (HEO) PHC Kurebhar**

*“Since 1<sup>st</sup> January 2014 haemoglobin test has been made compulsory for every pregnant woman”.*

**- Health Education Officer (HEO) PHC Kurebhar**

Regarding women from a poor socio-economic background he told:

*“They are birthing at home even after so many years of launching the JSY programme. Those who are having better economic condition either they opt District hospital or private health care institutions for delivery.”*

*“This PIIC serves as the main centre in Kurebhar block where maternity services are being provided round the clock but in comparison to patient load, services are not much satisfactory. There are several gaps that are affecting the programme; such as, lack of proper infrastructure, lack of human resource, lack of drugs and equipment, not enough funds, unavailability of doctors, etc.”*

HEO said that, there is proper accommodation facility for the staff, so most of the staff stays out of the campus. It creates a hurdle in providing the services in the absence of doctors at PHC. Further her revealed about the poor and marginalized household women:

*“There is a need for much attention to cover those women who are still far from the programme. We have to look differently to address their issues related to health; we have to strengthen the administration in a functional manner. Medical officers have the whole responsibility of PHC with the clinical work as well as with administrative work. Sometimes they are not able to attend the hospital as they are overburdened with official work and due to this common people suffer”.*

#### **4.1.3 Lab Technician**

The lab technician said that, he is working since last two years at this PHC. He performs six tests that are as follows; Sputum, MP (Mycoplasma pneumonia), HB (Haemoglobin), Sugar, Pregnancy, HIV.

When researcher asked about tests he replied that:

*“Very few women visit for a pregnancy test, only those women who are sent by the ANM for pregnancy confirmation come for these tests. During ANC if ANM have a doubt regarding any women having anemia she refers her to me for blood check-up. In all pregnancy cases, we do not perform blood test but only on a recommendation by the ANM.*

*There are many tuberculosis (TB) patients, in one month 15-20 patients were diagnosed. Right now there are 67-68 positive cases whose treatment is being continued. At this centre, the X-ray machine is not available for the TB patients. There is a problem, so the patients have to spend more money at private clinics”.*

*“Few months’ back I got training on testing HIV but till now no pregnant women had undergone this check-up”.*

#### **-Lab Technician**

It was found that most of the ASHAs and pregnant women were not aware regarding the HIV test during the pregnancy.

#### **4.1.4 Anganwadi Worker**

Four Anganwadi workers were interviewed to know about JSY scheme and ASHA in detail. Anganwadi Worker said that, they got to know about the JSY scheme from their Integrated Child Development Services Department (ICDS). They said they met regularly with ASHA workers and during vaccination day they work with ANM. They told:

*“In community, we create awareness about national programme, identify pregnant women, do timely immunization of children, provide nutritional supplements, organize health camps, discuss about institutional delivery, do door to door visits, register births and deaths and create awareness about hygiene and sanitation.”*

Anganwadi Workers said that:

*“Sometimes due to insufficient stock we were unable to distribute supplement food to pregnant and to new mothers. On every Saturday, we distribute supplement food. Sometimes when we have demand for extra supplement from ICDS department at block Kurebhar they say:*

*“Utne me hi kam chhalao jitna jitna ek centre ko alot kiya gaya hai.”*

(It means manage it, whatever has been allotted to each centre.)

*So during distribution day sometimes few women were returned to home.”*

They told under ICDS department another scheme Indira Gandhi Matritwa Sahyog Yojana (IGMSY) is running in Kurebhar block. Under this scheme, Central Government is providing 6000 rupees cash incentive to those mothers who had given birth to their first and second child in any public health institution but between first and second child gap should be three years and she would have availed all antenatal checkups. They said:

*“We inform to eligible mother to get benefits of this scheme. If any women had given birth to a first child in any public health institution, she would be able to get JSY cash incentive as well as IGMSY cash benefit also. Money has been disbursed in two instalments. During ANC care, she would be able to get 3000 rupees in first instalments and rest 3000 rupees during postnatal care. We have received more forms from our village but after submitting the form in ICDS department very few women got the IGMSY cash incentive. There was an inconsistency in the distribution of cash under IGMSY scheme.*

**-Anganwadi Worker**

#### **4.1.5 Ambulance Service Provider**

Service provider said that:

*“Before being deputed, on ambulances, the GVK<sup>7</sup> provided, fifteen days training to us on how to give first aid to the women on the way if required but we are working since last one year we have no training. I have to do twelve hours duty in one shift; in this block we pick 7-8 cases per day, and sometimes it increases up to 10. At one ambulance there are two Emergency Medical Technician (EMT) and*

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<sup>7</sup> **GVK:** Gunupati Venkata Krishna Reddy, also referred to as GVK Reddy, is the founder chairman and managing director of GVK group. This is a Hyderabad based infrastructure conglomerate that in into several sectors such as energy, resources, airports, transportation, hospitality and life sciences.  
(Source: [https://en.wikipedia.org/wiki/Gunupati\\_Venkata\\_Krishna\\_Reddy](https://en.wikipedia.org/wiki/Gunupati_Venkata_Krishna_Reddy))



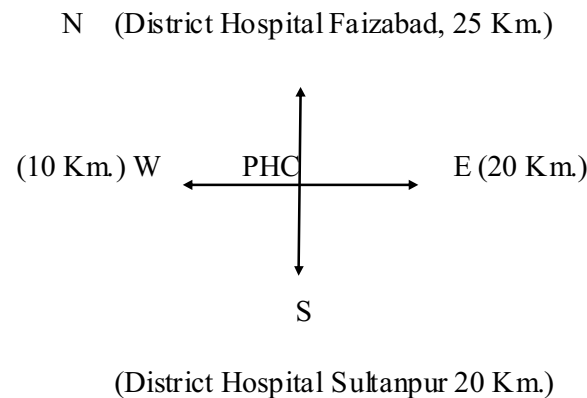
*two drivers (Pilot), we do our job shift wise two people work during the day and two people at night.*

*If a woman is in labor and unfortunately she gives birth in the ambulance we cannot give first aid to them because being a male worker they feel embarrassed. In this case, the ANM asks us just to pick the cases, and they would see the rest at hospital”.*

Regarding more cases he said:

*“Due to seasonal variations sometimes the number of cases increases while in off-season times there are very few instances. In summer, there are more cases during the night and in winter cases are more during the day. During summer, we drop 30-40 referral cases at CHC and District Hospital that is more than 20 kilometres away from PHC Kurebhar. We cover a catchment area of 20-25 kilometres”.*

### **Catchment Area**



The district hospital at Sultanpur and District Hospital at Faizabad, both are located far away from the PHC. Faizabad District is twenty-five kilometres far from PHC towards the north so people usually prefer to visit District Hospital at Sultanpur because it takes less time to reach there. The ambulance provider said:

*“We ask the patient, where she wants to go, PHC or District Hospital then we drop them, but the ANM asks to us to bring cases at PHC first, later if there would be any complication then the women would be referre.*

*For long distance referrals we cannot take a decision without our senior officer’s permission. When we were new, we were not aware of the route and about village’s location then it used to take a long time. But now we know places very well so we can quickly reach and save time. Due to patient load, sometimes we are unable to arrive at the home of a pregnant woman on time. Some roads are not good, so it takes too much time; we have to be very careful while driving because of ditches on the road. During winter nights, it is very difficult to pick the cases. Even women do not want to come for delivery at the hospital on winter nights due to severe cold and dense fog, in such cases most of the Home Birth take place”.*

When ambulance service provider was asked about tip money, he revealed:

*“We do not ask for any money, out of happiness people offer some tip of Rs.50-100 for our breakfast only. We do not ask forcefully for any money.”*

*“Several women have given birth in an ambulance but till now no mother or child has died in the ambulance, we always try to reach the hospital as soon as possible”.*

## ANNEXURE II

### 4.2.1 Experiences of Home Birth Case Studies from the Field

#### Case study -01

##### General Profile of Respondent

Fatima<sup>8</sup> (28 years) is a mother; she is a Muslim. She is illiterate, due to poor economic conditions her parents did not allow her to study. She got married at the age of 15 years since then she was living with her husband. She has three children; one girl child and two sons. Fatima and her husband bear all the responsibilities of their family. She is a housewife; she does her daily chores at home and takes care of her newborn baby. Her elder son is six years old, and younger is three years old. They are not enrolled in the Anganwadi or any primary school to start their primary education.

##### Household Details

Mohammad Riyaz is the name of Fatima's husband. He is 35 years old. He completed his education till 8<sup>th</sup> standard. His family was also suffering from the poor economic situation. He started to work as an agricultural labourer in his village. During the off-season, he migrates to another city for earning as a hawker. He possesses Antodaya Ration card, through he is entitled to thirty-five kg ration from PDS (Public Distribution Shop) shop in a month. They live in a kuchha house of two rooms; entitled to electricity through Rajiv Gandhi Gramin Vidvudat Yojana (RGGVY). For drinking purpose water is drawn from a hand pump that is situated in front of his house. The house has no toilet facility, no land for agriculture and no any livestock. For cooking, they use wood, collected by his wife from a forest that is located at a distance of 500 meters from his house. He does not own vehicle for his use. Usually, he goes on foot for buying vegetables and other goods for daily use. They have no

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<sup>8</sup> Pseudo name of the respondents have used and anonymity has maintained throughout the study.

other source of earning, so they are entirely dependent on daily wages. He said in the village, “I do not get work daily, some days I get work some days I do not. If I get work for thirty days, I can earn Rs. 4000 to 4500 per month at a daily wage of Rs.150 rupees per day.

### **History of previous pregnancy**

Fatima had given birth to her first child at home. Her husband was outside searching for a job. When she was in labor, there was no one at home, and she could not go to the hospital by herself. The Sub-Centre is located at a distance of six kilometres from her house. For delivery of her second child, she visited the Sub-Centre accompanied by her husband. Under JSY (Janani Suraksha Yojana) she received a Rs. 1400 cheque as a cash incentive. During her second child, the ASHA motivated her to go to a public health centre to avail the benefits of Maternal and Child Health Services under JSY scheme.

### **History of current pregnancy**

Fatima came to know about her previous pregnancy in the third month when she started vomiting. She didn't know about pregnancy kit, its uses and availability at sub-centre.

### **Antenatal care visit**

Fatima did not want to visit health centre even though she felt very sick. However due to the family pressure she visited PHC in her seventh month of pregnancy. She said that, in earlier two pregnancies, she did not face any problem that's why she did not go for any check-up. At PHC, ANM enrolled her and provided a JSY card. But when she asked about benefits of JSY card the ANM could not answer well. She said earlier she was not aware of maternal health related facilities and due to the long distance she did not go to the hospital. For small problems or uneasiness, Fatima preferred a private clinic or medical store. After being facilitated by ASHA and her husband she started her ANC checkups at Sub-centre. During her pregnancy, she visited health centre only twice, in every visit she got only two TT (Tetanus Toxoid, 1<sup>st</sup> & 2<sup>nd</sup>) not any other check up like weight, height, BP, blood test urine test, etc. She did not consume IFA tablets because that gave her an upset stomach.

She visited Anganwadi centre also to get the poshahar (Nutrition supplementary food) but never ate it. She said that taste of poshahar was not good enough so she was reluctant to eat it.

### **Reason of home birth**

Fatima came to her mother's house in the seventh month of her pregnancy for childbirth because there was no one to take care of her at her house. One day she felt pain in the abdomen and decided to go health centre, which is twelve kilometres away from her house. She hired a private van and reached PHC on her own in the afternoon and met to LHV (Lady Health Visitor) at PHC. After examination it was found that she was in labor and was advised to get admitted, she was also advised that it might take more than three days. Fatima could not stay alone at PHC, and she decided to go back home. There was no male member to accompany her or make arrangements for childbirth so she thought of delivering her child at home. Fatima reached back late evening. Now her labor pain was getting intense, and she was unable to understand what was happening to her. Two hours later at 9 pm she gave birth with the help of family members. Her mother requested her neighbour to call dai, who lives near the village. He went to inform dai and she came with him. Dai cut the placenta with new blade and took all possible precautions. After that the dai demanded clothes, Rs.150 and some ration. Next morning Dai came again, to collect the things.

After childbirth she did not feel the need to visit the health centre for a check-up, yet they are healthy. One month had passed away, but she did not get her child vaccinated during vaccination day in the village.

### **Case study -02**

#### **General Profile**

Suman (name changed) is a 35-year-old mother from Akhodhi Village in Kurebhar Block. Her social identity is Scheduled Caste and belongs to Kori sub-caste. She lives in a nuclear family with five children and her husband. She has four sons and one daughter. She is illiterate and could not get an education due to her parent's poor economic status. She got married at the age

of ten years after three years she came to her father in law's house to live with her husband after *Gauna*<sup>9</sup>.

### **Household details**

They are destitute. She and her husband earn their living as daily wage labourers. She has one bigha land that is unfertile. So she bought ration either from PDS shop or the market. She has a one room house made of thatcher; there is no toilet facility neither do they own any vehicle. For drinking water, she gets water from own hand pump located at ten meters away from her house. They have no livestock and use woods for fuel.

### **History of previous childbirth**

Before her last child, she had given birth to three children at home and one at PHC. She said that, in previous pregnancies she could not go to the hospital due to lack of money. First three deliveries were conducted at home with the help of a Dai who lives near the village, approximately, 500 meters away from her house. Dai is from the same community. She said, "I never felt any problem during first three pregnancies that Dai had conducted at home; children are safe and healthy now". She said that her relationship with Dai was excellent, so she never tried to go for childbirth at any public institution. Dai came and facilitated in childbirth, and she has a long experience of conducting births at home. During Suman's fourth pregnancy she experienced abdominal pain, so she visited PHC and was suggested to go for some checkups e.g. blood test, urine test ultrasound, etc. She had spent more than 1500 rupees in a private clinic for checkups located in a market near PHC. No check-ups were performed at PHC. After treatment of abdominal pain, she got relief and finally delivered at PHC at that time my husband was with me.

She said that first time she got Rs.1400 for institutional delivery at PHC, but later she had to spend at more than 1400 rupees in PHC on ANM, Dai and for the recommended medicines. She said-

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<sup>9</sup> **Gauna:** In North India Gauna is a ritual ceremony which is performed after marriage, either in the same year of marriage or within three, five years or seven years later and then the bride can stay with her husband.

*“Mujhe chauthe bachhe k samaya taklif thi pet me tabhi gayi block par dikhane, mujhe teen bachho me koyi dikkat nahi huyi jab ki wo ghar par hi huye the, is bar khatra mol nahi lena chahti thi, sab kuchh theek hota to mai asptal jati hi na, use bhi ghar par hi janam deti Dai ki madad se, Humara kafi paisa kharch hua, hum grib majdoor log hai itna paisa kha se layege jitna wo a sptal me magte hai.”*

(I had problem in my abdomen, during my fourth pregnancy that's why I visited block for check up, I had no problem in my earlier three pregnancies even I had given birth at home, this time I did not want take any risk, if everything would have been alright, I would not have gone to the hospital, I would have delivered at home with the help of Dai. I spent so much money; we are wage labourer from where we would be brought this amount of money that is demanded at the hospital.)

#### **History of current pregnancy and experience of home birth**

In her earlier pregnancy, Suman gave birth to three male children at home, this time she was a girl child, but again she gave birth to a male child at PHC. After four children she decided to get sterilized at the hospital and with the help of ASHA she adopted a permanent method, vasectomy from district hospital but later it failed. Three months after sterilization she started vomiting, and she came to know about her pregnancy when she visited PHC. After confirmation of her being pregnant she came back home and gave news of her pregnancy to her husband, who asked her to go for an abortion. Suman refused for it since she was in the fourth month of gestation. The ANM also suggested for abortion if she did not want any more children, but it was too late to abort the foetus. Beside this she had feared abortion, she said that at that time many questions arose in her mind but finally she decided to give birth.

In the fourth month of pregnancy, she registered her with ANM at Sub-Centre. She got two TT (Tetanus Toxoid) but nothing else like Iron Folic Acid tablets; or counselling related to pregnancy and other tests during pregnancy. After sterilization, she became worried towards her pregnancy because she had experienced in her fourth pregnancy that she gave birth at PHC after prolonged labour. So she did not want take any risk at this time. In the last

month of gestation one day, she felt labor pain and asked her husband to take her to the hospital. This time she was not ready for a home birth because she was aware of her pregnancy complications. Her husband called the ASHA to go hospital along with her. ASHA called an ambulance at 102, which came in more than one hour later. She went to a PHC that is twelve kilometres far from her house. When she reached the hospital after examination ANM referred her to a district hospital that is twenty-five Kms. away from the PHC. Ambulance dropped Suman at a district hospital in the evening at 4 pm. After examining staff, nurse asked to admit her and said that, she would need to stay for one more day. After hearing this, she did not agree to stay at the district hospital. It was the month of November and due to heavy cold she requested to her husband to return home. She said-

*“Abhi jyada dikkat nahi hai madam ne bataya hai abhi ek din aur lgega to fir q ek din pehle se yaha ruk ke , ek to thand bhi bahut hai aur ghar par bachhe bhi akele hai, jab kal koyi presani hogi to fir aa jaugi.”*

(I have no more problems, madam (ANM) has told, it will take one day more, and then why would I stay here. One thing is that it is heavy cold today, and no one is at home to taking care, my children, when any complication would arise then I would become again.)

They returned home by ambulance till 6 pm. One hour later she felt that her labour is getting higher, at that time her husband had gone to market to bring some vegetables. Suman said that, how her husband reacted at her to see her again in labour after returning from market:

*“Mai bol rha tha ruk jate hai ek hi din ki to bat hai waha jila asptal me par tumhari samajh me hi nhi aaya, ab daude yaha rat me akele hum, na to koyi gadi milegi itni thand me na hi koyi doctor.”*

(I was saying that we ought to stay at District Hospital; it was a matter of only one day, but you did not understand. Now I have to run here and there in case of some complication, now in this heavy cold neither would be available private van nor any doctor in the night.)



He again called ASHA who said that she will reach in 30 minutes. They tried to go a Sub-Centre which is five kilometres far but since past six months ANM was not conducting any childbirth at this centre, so it remains close. This centre was near their house, so he did not call for an ambulance. Her husband tried to arrange private vehicle but due to bad weather and heavy cold they could not get any. Then he went to the village at a neighbour's house and borrowed a tricycle (called as Reddi or Thela) used for agriculture purpose. Before going at Sub Centre, ASHA talked to ANM, who asked to bring Suman at their house for childbirth. At eight o'clock, they left their house when Suman said that she couldn't bear the pain. Before reaching the centre, she gave birth in the way, to a girl child. That time they were only four hundred meters away from her house, she asked them to return home. Then they called a dai, who lives near her village, she had performed earlier three deliveries also, so she trusted her. The dai cut the umbilical cord with a new blade and tied a new thread.

Next morning Dai again came to get her *Neg*<sup>10</sup>. They gave new clothes and Rs. 200 to her. After delivery, Suman did not visit any public health centre for any checkups but she said that she and her newly born girl child both are healthy.

When the researcher interviewed Suman, it was the 15<sup>th</sup> day of her childbirth and asked about vaccination? She replied:

*“Abhi jab gaon me madam dawa pilane aayegi to chali jaugi, abhi bachhi bhi theek hai, thand jyada ho rahi tabhi ise le k kahi bahar nahi nikal rahi hun”.*

(When ANM, will come today in village, then I will be gone, now my girl child is fine and it is heavy cold today outside, therefore with my baby I am not coming outside.)

She tried to get reimbursement for her failed vasectomy but could not get it. There is a provision for Rs.30, 000 for failure of vasectomy. She requested to Pradhan (Sarpanch of Village) also but nothing helped. . She went many times at PHC, but no one helped her. She said:

---

<sup>5</sup> **Neg:** After delivery whatever family members give to Dai called as Neg-Char, it would be in the form money, clothes or ration.

*“Ek kagaj k liye itna daudate hai bar- bar, unhe pata hai humare ghar me koyi psdha- likha nahi hai is liye aur paresan karte hai, aisa lag raha tha jaise unhe apne ghar se paise dena hai, sarkar ki Yojana hai hum garib majdoor ko mil gaya hota to kuchh kam hi ho jata.”*

(For a paper (document), I have to made several contact, they (health care providers) know that in our family in our family no one is literate, that is why they create more trouble for us. It seems like, they had to give from their pocket; it is government scheme if we poor people would be getting it, and it can help useful in other works.)

Case two highlight that there is a lack of cooperation from health care providers. Those mothers, who are illiterate or less educated from the poor socioeconomic household they face more problems during the accessing the JSY services.

### **Case study -03**

#### **General Profile**

Manju is 35 years old mother who lives in Sudanapur Village of Kurebhar Block. She belongs to Scheduled Caste and sub-caste as Kori. She is illiterate and got married in the early age of fifteen years. Since then she is living with her husband, economically she is indigent and totally depends on a daily wage. There are six members of her family. After two years of marriage, her husband decided to live separate from his parents. Having a nuclear family, she has to bear all the responsibilities by herself. She is also a daily wage labourer, after household work she works in the field.

#### **Household details**

The family of Manju comes under below poverty line. She has a semi-pucca house. They got electricity connection due to their BPL status, for the source of drinking water they depend on a government hand pump that is situated 100 meters away from the house. She has one bigha land that is not fertile; the land produces little bit grains that are not sufficient for her family. The primary source of fuel for cooking is wood. They have no livestock. They have no vehicle. Her husband is also a daily wage labourer who works in a brick kiln

and cut woods either in Uttar Pradesh or sometimes in other states. Four years ago he got injured in the right leg while cutting woods in a forest since then he is unable to do work. Her three children are enrolled in a primary school which is near the village.

### **History of previous childbirths**

Manju has given birth to seven children by the age of thirty-five years. She said that, her three children died after birth, once she gave birth to twins at home. She visited the government hospital and took medicine from the private clinic, but her children did not survive, the reason she told was, that they were unable to breathe due to common cold and died. Now she has four children two boys and two girls.

### **Recent childbirth and experience of home birth**

Due to poverty there is an enormous burden of the family on her. Besides this, because of her husband's injury she has to do work to feed her family. She came to know about her last pregnancy in a fifth month when she started vomiting. She did not use any pregnancy kit for testing. After that, she registered her pregnancy in a fifth month by the help of an ANM and got her first TT at Additional PHC, which is 500 meters away from her house. After registration ANM did not provide a JSY card but gave a slip with mentioned date and asked her to collect the card on her second visit. Manju had never heard about JSY Yojana, but ASHA informed her that if she goes for childbirth at any government hospital then she would be able to get Rs.1400. She said that, usually she avoid going to the hospital for checkups. She never availed proper ANC in any pregnancy she said:

*“Maine kisi bhi bachhe k time koyi bhi janch nahi karayi,  
bus jab pata chalta ki pet me bachha hai to suyi lagwa leti  
thi, fir bachhe aaram se ho jate the, sare bachhe mere ghar  
par hi huye ,Dai ki madat se sirf ek bchha asptal me hua.  
Janch k nam pe suyi hi lagate hai bas bahut kahen to 10-20  
lal goli de degi khane k liye aur kuchh nahi”.*

(I never undergone any checkups during any pregnancy, when I come to know that, I am pregnant, then I go for vaccination (for Tetanus Toxoid). After that, I had given birth easily. With the help of Dai, I gave birth to all my children at home, but I gave birth to my one baby at a health facility. On the name of examination health care provider provides only TT vaccination, if they do more enough, will be provide ten to twenty iron-folic acid (IFA) tablets and nothing else.)

ASHA is from the same village, so she usually visited her house and tried to motivate her for institutional birth. She agreed to go to the hospital for childbirth, but due to work burden and several other responsibilities she could not go. One day she was in labor, it was an evening in the month of November; the weather was also not good due to cold. Her husband was not at home he had gone out of the village for work. So nobody was there to take care of her. Her mother-in-law lived in a separate house near theirs. She sends her elder son to call her. Her mother in-law, came and called Dai to conduct childbirth. Dai also lived in the same village, working at APHC Sudanapur located at a distance of 200 meters from Sudanapur village. Dai attended birth at home and cut down the umbilical cord, and assured that mother and child were fine. Manju did not visit any health centre after 15<sup>th</sup> days of childbirth. She said that as she has to look after the children, she was unable to work, and till the newborn would not be able to crawl, she can't go outside for daily wages.

She said after childbirth one day later her husband came, she was not able to cook food, so her husband was cooking food for the family. She said that she was aware that he can't prepare food every day for the family, so eight days later she started cooking. She said:

*“Maine apne liye aur apne bchho k liye khana bananato  
suru kar diya par sasu maa aur sasur ji k liye nahi bana  
sakti, bachha paida hone se le kar ek mhine tak Sauri<sup>11</sup> me*

---

<sup>11</sup> **Sauri:** Sauri is a kind of practices in many villages of Sultanpur District in Uttar Pradesh, in which after child birth women have to live in a separate room for 20-25 days, she cannot touch the things, which all family members are using in common and even she cannot cook for family members also if other female members are present in family. When, in family someone would be cook for all members, then she would be served to her also, otherwise she has to cook separately. During this period of time she would be considered as untouchable. After completing the duration of 20-25 days, she has to take bath with child then she will be

*rehna padta hai uske bad hi mere hath ka banaya khayegi, ek mahine tak hume sab alag saman istemal karna hota hai use ghar k saman me nahi mila sakte jo sab logo ke liye prayog hota hai, yaha tak ki khane ki chije jaise aachar aadi ko nahi choo sakti, ghar wale bolte hai agar choo dogi to sab kharab ho jayega, ek tarh se Sauri ko ek mhine tak achoot mana jata hai. Isme jo bhi saman ek mhine tak prayog kiya hai use bad me ghar wale saman me nahi mila sakti use last me jo ek mhine tak gaon se bachhe ko Bukwa lagane aur malis k liye aurat aati hai wo le jati hai jaise kapde, bartan aadi aur use Neg me kuchh naye kapde, kuchh paise aur ration bhi dena hota hai ”*

(I started cooking for myself and my children, but I cannot cook to my father-in-law and mother in-law. From the date of childbirth to approximate one month have to live in ‘Sauri’, after that I can cook, for my family members otherwise no one will eat. Whatever I would be prepared I have to use separate vessels. I cannot put it in typical vessels of family members. Even during this period, I cannot touch pots of pickle in which it is preserved. Family members say if I touch it, it would be devastated. The period of ‘Sauri’ is considered as the untouchable duration of time. Whatever, I have used, during this period such as vessels, clothes etc. family members give it to that women (work as a Dai) who comes from rubbing the baby with mustard oil and with grinding raw mustered. She takes all the things with her.)

When had the researcher asked if she had some problems related to health where does she go for treatment? She replied:

*“Jab kabhi taklif hoti hai to ANM k yaha chali jati hoon, wo hamari garibi samajh k kuchh goliya de deti hai aur aaram ho jata hai aur jis din o nahi milti to pas bajar me medical store se le leti hoon.”*

---

considering pure as other family members. The duration of staying separate varied in upper caste, maximum 10- 15 days, while in lower strata it would be up to one month. All things such as clothes, plates etc. whatever she had used, family members usually donate to dai for caring mother and baby during the Sauri period.

(Whenever I feel illness I use to visit ANMs house, she gives some tablets, and after consuming I feel well. She understands my poverty. Whenever she does not be present at her home, then I use to by medicine from a private medical store.)

She also narrated about deaths of her children:

*“jab hamare theen bachho ki maut ho gayi paida hone k bad tab se hamre mann me ek chinta bas gayi hai, kahi inme se kisi ko kuchh na ho jaye yahi dar satata rehta hai.”*

(Ever since my three children died after birth, I have great fear if something would happen wrong with these kids.)

She did not use any contraception nor wants permanent sterilization as there would be no one to do her work-

*“If I did, I would have to sit 4-5 month at home. I am a daily wage labourer, how will I feed my family”.*

#### **Case study -04**

##### **General profile**

Nirmala is a twenty-eight years old mother from Lakhaicha Village; she got married at the age of twenty since then she was cohabiting with her husband. She is illiterate, belongs to Kori sub-caste under Scheduled Caste. She lives in a nuclear family with four members. She is a daily wage labour.

##### **Household details**

She lives in a semi-pucca house; there is only one room. She got the Antodaya Ration Card after many requests to Sarpanch. She receives ration, on this card from PDS (Public Distribution System) shop, fifteen-kilogram wheat and twenty-kilogram rice. In their house, there is no electricity connection. For the source of drinking water, she uses their hand pump located fifty meters away from her house. The house has no toilet facility, no land for agriculture, no livestock or any vehicle. Wood is used for cooking. Her husband is a daily wage labourer. Sometimes in lean season her husband migrates to other places like Delhi, Ludhiana and Punjab for the job.

### **Experience of previous and recent childbirth**

Nirmala said that, this was her second childbirth; she gave birth to her first child in Delhi in a private hospital. She gave childbirth through C-Section; she had to spend more than 8000 rupees. Her husband borrowed money from one of his friends and returned after one year with much difficulty. At that time, her husband was working in Delhi as wage labourers. She said that, despite all checkups, during her first pregnancy she was admitted for twelve days in hospital since the child was delivered through a C-section. They came back to their hometown three days later. When she reached home, she started to feel pain in her abdomen. Her husband took her to a nearest public hospital for treatment. After a prolonged treatment, she got well and started working. She said that, it was very difficult to earn the money for the family because of her illness. After first child, she did not migrate to any city since she is living at home with her child.

She came to know about her last pregnancy in the fifth month. She used a pregnancy kit for testing pregnancy. She was confirmed her pregnancy after the test and when she felt nausea. In the fifth month, she registered her pregnancy with the help of ANM at APHC Sudanapur that is five kilometres away from her house. She knew that if she goes to the hospital for childbirth, she will get Rs.1400. During her last pregnancy, she got only two TT injections at Pradhan's (Sarpanch of Village) house when ANM came on vaccination day to their village. She did not get any tablet of Iron Folic Acid. She told about Anganwadi supplementary nutrition:

*“Anganwadi wali madam bolti hai ki Posahar<sup>12</sup> nahi hai,  
puri delivery me sirf ek packet payi hoon abhi tak, mujhe  
anganwadi k bare me jyada pata bhi nhi hai.”*

(Anganwadi worker says that there are no nutritional food supplements at the Anganwadi centre, during whole pregnancy I got only one packet, I have no more information about Anganwadi centre.)

---

<sup>12</sup> Posahar: Nutritional food supplements which Anganwadi worker distributes at Anganwadi centre to pregnant women and lactating mothers.

She also replied that whenever ANM comes in their village she was in a hurry and did not provide proper ANC. She was well during pregnancy and never felt any problem.

### **Reason for opting Home Birth**

Nirmala said that ASHA visited her house several times and asked for institutional delivery. She said:

*“Hum garib log hai hamare pas paisa nahi tha, isliye aspatal nahi gye,pehle wale bachhe me paisa udhar le k aspatal gayi jise chukane me sal bhar se jyada lag gya wo bhi badi muskil se. Humare pas na hi mobile hai na hi ASHA ka number hai isliye ASHA se baat bhi nahi ho payi, sham se hi pet me dard ho rha tha, rat k 11 baje Buaa ki madad se ladka paida hua ghar pr. Buaa Dai ka bhi kam karti hai apne gao me isliye unhe phle se bula liya tha, sham ko hi bajar se naya dhaga , blade, sabun aur suti kapda mangali thi taki rat me daudna na pade.”*

(We are poor people, we had no money therefore we did not visit hospital, in previous pregnancy I had to borrow money from a landlord, hardly, I returned him, and it took almost one year. Neither I have a mobile phone nor has ASHAs number therefore I could not make contact to her. Since evening I had pain in my abdomen, in late night around at 11 pm I gave birth a male child, with the help of my aunt, who serves as a Dai in their village, so I had called her before my delivery at my home. In the evening I went market before my labor and bought new thread, a new blade and some cotton so that I had not to run here and there to arrange it.)

After childbirth she was fine and did not face any complication during birth nor did she visit any health centre after birth. She said:

*“Sab kuchh to thekk hai isliye aspatal nahi gayi, mujhe ya bachhe ko agar koyi dikkat huyi to jaugi dikhane, itni thand me waise hi jan chali jayegi kaun jaye aspatal me dikhane.”*



(Everything is fine, that is why I did not visit health centre, if I or my baby have any problem then I will visit hospital, we are already dying in this heavy cold, which would be visit hospital for checkups.)

She said that nowadays she is staying at home, cooking food and taking care of her baby; this is her daily routine. Earlier when MNREGA (Mahatma Gandhi National Rural Employment Guarantee Act) was functional, she had an employment but right now she has no work. In those days, she and her husband were working under MNREGA. When the researcher interviewed Nirmala, that day was Pulse Polio Day, and when asked to her, about getting her child vaccinated she replied:

*“Polio pilane se koyi bimari nahi hoti bachho ko iski kya guarantee hai, maine apne pehale wale bachhe ko bhi 2-3 suyi se jyada nahi lgwaya tha aur na hi kabhi jati hun dawa pilane, jiske mote- mote bachhe hai uska bhi kam chal rha hai aur jiskepatle- patle bachhe hai uska bhi kam chal rha hai. ANM suyi lagane k bad garm pani se dhulne ko bolti hai, per koyi dawa nhi deti hai.”*

(What is the guarantee that after Polio Vaccination, no disease would happen to my child, in my previous childbirth, neither my kids were vaccinated more than two-three childbirth nor I go for vaccination to my child. Those who have a healthy baby their work is also going on and those who have a thin child they are also fine. It means how much she is having in her family she has to adjust in that, it does not matter to her and another family is having more than her. ANM says after vaccination, to the child to wash hand but does not give medicine.)

When the researcher asked that, how ANM treated with you during visits related to your illness. She replied:

*“Agar ache se bat nahi kregi aur daryegi to dubara nahi jaugi.”*

(It means if she does not talk to me well, I will not go again at health centre.)

Case four highlights that how socioeconomic condition of a family and lack of awareness regarding scheme would be a barrier in accessing JSY services and as well as birthing in a health facility. Though women have the desire to give

birth, in health facility but, persisting practice of payment for institutional birth, is a major concern for JSY scheme that is preventing to give birth at a health institution, to the poor and marginalized households women. In this scenario grassroots worker efforts would be not fruit full to the JSY scheme, if after making several contacts by the ASHA, a women is not able to go at health facility due to lack of economic crisis, the objective of JSY scheme ‘Safe Motherhood by promoting Institutional Delivery’ would be far away from their goal.

## ANNEXURE III

**Block Level Survey on Access and Barriers to Institutional Birth Schemes: A  
study of Janani Suraksha Yojana in Kurebhar Block in Sultanpur District,  
Uttar Pradesh**

Schedule No: \_\_\_\_\_ Date: \_\_\_\_\_  
State \_\_\_\_\_  
District \_\_\_\_\_  
Tehsil/Taluk/Block \_\_\_\_\_  
Type of Locality \_\_\_\_\_

### ***1.) General Profile of Respondent***

Name of the respondent: _____	
Age. _____	
Age at Marriage _____	Sex _____
Age of Co-habitation _____	Education _____
Religion _____	Community _____
Caste _____	Family Size _____
Type of Family _____	
Occupation _____	

Sex- Male / Female; Religion: Hindu / Muslim; Community- SC / ST / OBC /

General; Type of Family:

Nuclear/ Joint

Address.....

Head of the

Household.....

**2.) Information of Family Members:**

S.N.	F. Members	Relation	Sex	Age	Education	Occupation
i.						
ii.						
iii.						
iv.						
v.						
vi.						
vii.						
viii.						
ix.						
x.						

**3.) Household details**

Ration card status: _____	House ownership: _____
Type of House: _____	Number of rooms: _____
Electrification status: _____	Source of drinking water: _____
Distance: _____	Toilet facility: _____
Land Owned (in beegha): _____	Monthly income: _____
Do you have agricultural production: _____	
Livestock: _____	
Primary source of energy for cooking: _____	
If any vehicle, specifies: _____	

BPL/APL/Andhyodaya/Annapoorna; Self / shared / tenant/other; Puccka/Semi puccka/ Kuccha / Thatched / Other; Hand pump / Own well / Own tank / Pipeline / Other well / Public tap / other; Open ground / Own compound / Own toilet / Other toilet / back water; Gas cylinder / Fire woods / Electricity / Solar stove / others.

**Antenatal care, Natal and Post - Natal Care**

1. During which month did you come to know about last pregnancy?  
.....
2. Did you undergo Pregnancy confirmation test (urine test) during the last pregnancy?  
Yes ( ) / No ( )
3. Did you register your last pregnancy? Yes ( ) / No ( )  
If No, then what were the reasons for not register?  
.....
4. Pregnancy was registered with whom?  
.....
5. Have you ever given birth to a boy or a girl who was born alive but later died?  
Yes ( ) / No ( )  
If yes, how many boys have died? And how many girls died?  
.....
6. Do you have any pregnancy, which terminated in **still birth**?  
Yes ( ) / No ( )
7. Did any of your pregnancy terminate in **spontaneous** or **induced** abortion?  
Yes ( ) / No ( )  
If yes, how many  
.....
8. How many months pregnant were you when you had last induced abortion?  
.....
9. Who advised you for the (last) **induced abortion** and where was the last induced abortion performed?  
.....
10. Do you have JSY card?  
.....

11. Who made your JSY card?

.....

12. Have you faced any problem to making this card?

.....

13. After how many months of last pregnancy you received first antenatal care?

.....

14. Who facilitated or motivated you to avail antenatal care?

.....

15. Did you receive for proper ANC checkups? Yes ( ) / No ( )

If no, tell the region for not a vailing...|

.....

16. Where did you receive antenatal care for last pregnancy?

.....

17. How many times you received antenatal check up during last pregnancy?

.....

**Antenatal checkups**

		Visit							
		1 <sup>st</sup> (Before 16 Week)		2 <sup>nd</sup> (20 to 24 Weeks)		3 <sup>rd</sup> (28 to 32 Weeks)		4 <sup>th</sup> (36 to 40 Weeks)	
ANC component		Yes	No	Yes	No	Yes	No	Yes	No
	Weight								
	Height								
	Blood Pressure								
	Blood test								

A	Urine test								
	Abdomen examination								
	Brest examination								
	Ultrasonography								
B	Two Dose of TT								
	100 plus Iron Folic Acid tablets								
C	Counselling on health promotion								
	Personal hygiene								
	Diet and nutrition								
	About danger sign								

Y=Yes, N=No

**Partial Utilization:** Any of the services availed from the public health facility

18. As part of antenatal care during last pregnancy, were any of the following done at least once?

SN	Part of ANC	Yes	No
1.	Weight measured		
2.	Height measured		
3.	Blood pressure checked		
4.	Blood tested		
5.	Urine tested		
6.	Abdomen examined		
7.	Breast examined		
8.	Two Dose of TT		

9.	100 + Iron Folic Acid Tablets		
10.	Ultrasonography		
11.	Delivery date told		
12.	Nutrition advice given		
13.	Delivery advice given		

21. Was the Antenatal check-up done with enough time or did hurriedly by health personnel?  
 .....

19. Did you receive any supplementary nutrition from the Anganwadi centre during last pregnancy? Yes ( ) / No ( )

If No, why.....

20. When and where, your last child was born?  
 .....

**A. Institution Delivery at Public Hospital**

1. Who facilitated or motivated you to go to health facility for delivery?

- a) Self ( )
- b) AWs ( )
- c) ANM ( )
- d) ASHA ( )
- e) Family Members ( )
- f) Husband ( )
- g) Mother in-law ( )
- h) Mother ( )
- i) Relatives / friends ( )
- j) Other's (specify) ( )

.....

2. Where did she /he advise you to go for delivery?  
 .....

3. How you reached at institution?



- 1) By Ambulance ( )
  - 2) By Own vehicle ( )
  - 3) By Private Van ( )
  - 4) By Others (specify) ( )
- .....

**(In case of government ambulance services 102and 108)**

4. Who told you about government provides free ambulance service to reach hospital?

.....

5. When you called at 102 / 108, how much time it took to reach at your home?

.....

6. How much far away public health centre from your home?

.....

7. How much time ambulance took to reach at centre?

.....

8. If you used private van then how much you had to pay for transportation?

.....

9. Did ASHA provide escort service to you? Yes ( ) / No ( )

10. When you reached at hospital, had you wait for admit?

Yes ( ) / No ( )

If yes then what was the waiting time?

.....

11. Had you normal childbirth or faced any complication?

.....

12. During childbirth, did you experience any of the following problems?

- a) Premature Labour Yes ( ) / No ( )
- b) Excessive Bleeding Yes ( ) / No ( )
- c) Prolonged Labour (More than 12 Hours Yes ( ) / No ( )
- d) Obstructed Labour Yes ( ) / No ( )
- e) Breech Presentation Yes ( ) / No ( )
- f) Convulsion/High BP Yes ( ) / No ( )
- g) Other (specify).....

13. Was the health centre able to handle the above complication during the delivery?

Yes ( ) / No ( )

If no then where they referred for child birth?

.....

14. Did you face any discrimination at hospital with the ASHA, ANM, LHV, Doctors, and Dai (if present) or with any staff of the hospital?

Yes ( ) / No ( )

If yes, what was the experience?

.....

15. What was the behaviour of ASHA and ANM during your pregnancy and child birth period?

.....

16. After child birth how many hours you stayed at hospital?

.....

17. Did you get any check up by doctors within 48 hours delivery?

Yes ( ) / No ( )

.....

18. What was the outcome of pregnancy?

.....

19. Did the ANM take any money for conducting child birth?

Yes ( ) / No ( )

If Yes, how much.....

20. Had you gotten ambulance service for dropping back at your home after discharge from hospital? Yes ( ) / No ( )

21. Did the ambulance service provider take any money for transportation?

Yes ( ) / No ( )

If yes, how much.....

22. Did the first check-up take place after child birth? Yes ( ) / No ( )

If Yes, after how many days.....

23. Where did the first check-up take place?

.....

24. Are you satisfied with the services that were provided during your child birth at hospital?

.....  
 25. During your last pregnancy did you face any health related following problems?

SN	Health Problems during Pregnancy	Yes	No
i.	Swelling of Hands, feet and Face		
ii.	Weakness		
iii.	Visual Disturbance		
iv.	Convulsions not from fever		
v.	Weak or no movements of foetus		
vi.	Abnormal position of foetus		
vii.	Excessive vomiting		
viii.	Hypertension/high BP		
ix.	Jaundice		
x.	Excessive Bleeding		
xi.	Vaginal Discharge		
xii.	Other (specify)		

26. Did you seek treatment for any of these health problems?

27. Yes ( ) / No ( )

If yes, from where did you go for consultation or to seek treatment?

.....

28. Have you used any contraception method? Yes ( ) / No ( )

If Yes, which method.....

29. From where you got the contraception method?

.....

30. Have you received counselling ever on sterilization after two children?

.....

31. Did you receive any Govt. financial assistance for delivery care under the Janani Suraksha?

Yojana (JSY) / State Specific Scheme? Yes ( ) / No ( )

If No, then what problems you faced to get the JSY cash incentives?

.....

What is your opinion, experiences and suggestions towards JSY?

.....

**Section B: Delivery at Private Hospital**

1. What were the reasons to opted private institution for your child birth?

.....

2. Who facilitated to go for private institution?

.....

3. Did you take treatment to the private institution since beginning of pregnancy or decided in the last month of pregnancy?

.....

4. How much for away private institution from your house?

.....

5. How you reached at institution?

.....

6. What checkups took place during your pregnancy?

.....

7. Did you face any problem during your pregnancy?

.....

8. During child birth did you face any complication? Yes ( ) / No ( )

If Yes, what complication.....

9. Did the centre able to handle the complication? Yes ( ) / No ( )

If no what they did or where they referred?

.....

10. Had you normal child birth or through caesarean section?

.....

11. Who conducted your child birth?

.....

12. How many hours you stayed at hospital after child birth and what checkups took place?  
 .....

13. What was the outcome of pregnancy?  
 .....

14. What was the expenditure of child birth at private health care institution?  
 .....

15. Did you barrow money to anyone for delivery?  
 .....

16. Are you satisfied with facilities which you got at private institution?  
 Yes ( ) / No ( )  
 If No why.....

17. What was the experience of child birth at private health care institution?  
 .....

**Section C: Home Birth**

(Those women who were eligible but could not avail JSY benefits.)

1. What were the reasons for not going to health facility for delivery?

Reasons	Yes	No
Cost too much		
Poor quality service		
Too far/ no transportation		
No time to go		
Not necessary		
Better care at home		
Family did not allow		
Lack of knowledge		
Other (specify)		

.....

2. Who conducted delivery at home?

- |                |                  |
|----------------|------------------|
| ASHA           | Yes ( ) / No ( ) |
| ANM            | Yes ( ) / No ( ) |
| Dai            | Yes ( ) / No ( ) |
| Family members | Yes ( ) / No ( ) |
| Neighbours     | Yes ( ) / No ( ) |
| Self           | Yes ( ) / No ( ) |

If ASHA or ANM conducted child birth, did she take any bribe?

Yes ( ) / No ( )

If yes, how much.....

3. During childbirth, did you experience any of the following problems?

- |   |                  |
|---|------------------|
| a. Premature Labour                     | Yes ( ) / No ( ) |
| b. Excessive Bleeding                   | Yes ( ) / No ( ) |
| c. Prolonged Labour (More than 12 Hours | Yes ( ) / No ( ) |
| d. Obstructed Labour                    | Yes ( ) / No ( ) |
| e. Breech Presentation                  | Yes ( ) / No ( ) |
| f. Convulsion/High BP                   | Yes ( ) / No ( ) |
| g. Other (specify).....                 |                  |

4. What precaution was taken during child birth at home?

.....

5. Have you visited health centre after home delivery? Yes ( ) / No ( )

If No, why?

.....

6. At the time of last delivery were the following done?

- |  |                  |
|--|------------------|
| a. Was a Disposable Delivery Kit (Mamta Kit) used?                           | Yes ( ) / No ( ) |
| b. Was the baby immediately wiped dry and then wrapped without being bathed? |                  |
|  | Yes ( ) / No ( ) |
| c. Was a new/sterilized blade used to cut the cord?                          | Yes ( ) / No ( ) |

7. Did you have any check-up within 48 hours after delivery?

.....

8. How many days after delivery did the first check-up take place?

.....  
9. Where did the first check-up take place?  
.....

10. Did any of the following happen when you had the check-up:

- A. Abdomen Examined                      Yes ( )/ No ( )
- B. Advice on Breastfeeding              Yes ( )/ No ( )
- C. Advice on Baby Care                    Yes ( )/ No ( )
- D. Advice on family Planning            Yes ( )/ No ( )
- E. Other (specify).....

11. During the first **6 weeks** after delivery did you experience any of the following health problems?

- High Fever                                      Yes ( )/ No ( )
- Lower Abdominal Pain                      Yes ( )/ No ( )
- Foul smelling vaginal discharge        Yes ( )/ No ( )
- Excessive Bleeding                          Yes ( )/ No ( )
- Other (specify).....

12. Where did you go for consultation or treatment?  
.....

13. Did your child have any check-up after delivery within 24 hours of birth?  
.....

14. How many check-ups take place within 10 days of his/her birth?  
.....

15. Where did first check-up take place for your child?  
.....

16. When did you first breastfeed your child?

Immediately/ within one hour of Birth	Yes	No
Within 24 Hours		
2 to 3 Days		
After 3 Days		
Never Breastfeed		

17. Are you still breastfeeding the child? Yes ( ) / No ( )
18. What was the outcome of pregnancy?  
 .....
19. Did you receive any Govt. financial assistance for Home delivery under the Janani Suraksha Yojana (JSY) / State Specific Scheme?  
 Yes ( ) / No ( )  
 IfNo, what was the region...?  
 .....
20. Have you used any contraception method? Yes ( ) / No ( )  
 IfYes, which method.....
21. From where you got the contraception method?  
 .....
22. Have you gotten counselling ever on sterilization after two children?  
 Yes ( ) / No ( )
23. After counselling did you go through particular method? Yes ( ) / No ( )
24. When and where?  
 .....
25. Did you receive any financial assistance under JSY for home birth?  
 Yes ( ) / No ( )  
 IfNo, why?.....
- 26 What was the experience of home birth?  
 .....

(Thank You very much for giving specious time and important information.)



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