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Experiences with Janani Suraksha Yojana in Uttar Pradesh: Analysis of case studies by SAHAYOG and partners[i]

Introduction

Uttar Pradesh has among the highest maternal deaths in the country, with an MMR of 517 (2002-2003)[ii]. According to this estimate, around 30,000 women needlessly lose their lives each year in Uttar Pradesh alone, due to lack of appropriate and timely services. The government has made several programmes and schemes to address this. As part of the National Rural Health Mission, the JSY or Janani Suraksha Yojana[iii] has been in effect in Uttar Pradesh (UP) from 31 August 2005, with a modification from 24 November 2006.[iv] The objective of the scheme[v] was to reduce maternal mortality by providing a cash incentive to low income pregnant women to get registered with the public health system and to attend health institutions for childbirth, such as the Sub-centre, PHC/ CHC/ FRU/ general wards of district and state hospitals or accredited private institutions. Currently, institutional deliveries in UP are increasing very slowly from 7.8% in 1998 to 10.1% in 2003 (Registrar General of India, ibid).

The logic behind providing the JSY was as follows: given that pregnancy registrations will enable tracking of outcomes, and maternal deaths occur especially during childbirth or immediately after, if all pregnant women are tracked by providers and motivated so that most deliveries occur in institutions, most women's lives can be saved through skilled care and appropriate management of the complications. However, this logic is based on the assumption that there is sufficient institutional capacity and willingness to handle the demand for maternal health services. This merits a close look at the demand and the supply of maternal health services in Uttar Pradesh.

Extent of maternal health care in Uttar Pradesh

In terms of the demands for institutional capacity, there are approximately 5-6 million births taking place in Uttar Pradesh each year; apart from about 1 million complications[1] in pregnancy, abortion, delivery and post-partum stage. In terms of facilities, UP has 7 Government Medical Colleges & Hospitals, 53 District Hospitals, 13 Combined Hospitals, 388 Community Health Centres, 823 Block PHCs, 2817 Sub Block PHCs apart from 20521 Sub Centres. The private sector has four Medical colleges & Hospitals and 4913 male / female hospitals/ nursing homes at district level (GoUP, 2005[vi]). The question is whether these facilities can provide services for a total of roughly 7 million demands for institutional maternal services every year, including skilled or specialized services for the one million complications.

The quality and adequacy of services provided is also under question: according to the UP Facility Survey[vii] conducted by GOI in 2002-2003, less than 20% CHCs surveyed in Uttar Pradesh had even 60% of the basic equipment needed to handle an obstetric emergency, and barely a third had 60% of the qualified medical staff required. In terms of accessibility, the State Planning Commission points out that – "the population covered

[1] Based on a rough estimate that 15% of all pregnancies have complications

by a Sub-centre in the State is 7080 and the average distance is 3.4 km. while the country average is 5109 and 1.3 km. It is estimated that 11% of people in Uttar Pradesh are not able to access medical care due to locational reasons." Further, "only 9 percent of the State's population actually makes use of this facility for treatment of ordinary ailments and people mostly have to depend on private healthcare." (GoUP, 2005)

Assessment of the implementation of JSY in UP

The implementation of the JSY scheme in UP has been monitored by the group of organizations working within the WHRAP[2] partnership in UP. These organizations, through the rural women's network Mahila Swasthya Adhikar Manch in seven districts, were able to identify and conduct detailed documentation of around 20 cases of adverse maternal health outcomes (from October 2005 to April 2007) in which their maternal healthcare-seeking history was investigated in some detail. The documentation assessed:

i. How far the JSY had succeeded in having pregnant women registered (and tracked)
ii. How far it motivated women to attend institutions for safe childbirth
iii. Whether the institutions are providing improved maternal health services within the NRHM.

A similar set of case studies[viii] was documented in 2003-2004, when women's organizations of six districts of Uttar Pradesh had similarly identified twelve case studies that examined how maternal health services being sought and received by rural women. The study of these twelve earlier case studies of 2003-2004 showed denial of services and information to women, an absence of accountability of the public healthcare system, and women's recourse to unregulated and unskilled private providers, all leading either to maternal death or prolonged ill-health. These earlier case studies may serve as a kind of baseline for the current post-NRHM assessment. A comparison of the two sets of cases can more clearly bring out the changes that have taken place within the state, since the NRHM was launched in 2005, the JSY scheme put into place, and additional workers, like the ASHA were deployed.

Findings

The NRHM was meant to strengthen primary care in rural areas and improve women's access. After it had been launched, these case studies indicate that in some cases, rural populations know about their entitlements (such as JSY), and families do decide to take women for institutional delivery. ASHA workers are present in certain villages, and some do accompany the women to the institutions. However, despite these changes at the level of community awareness, maternal health service provisioning has not significantly changed according to these case studies. The following is a detailed analysis of the cases that were documented.

TEXT BOX 1–

☞ Rani of Banda was pregnant for the ninth time (April 2007), yet received no special advice from the health provider who gave her TT injections. Although the ASHA

[2] WHRAP is the Women's Health and Rights Advocacy Partnership, South Asia, a project partnership anchored by ARROW Malaysia. SAHAYOG is one lead partner in India

took her to the CHC, the staff did not admit her or give her a referral, so finally she was compelled to have a home delivery and lost her baby for the third time. Despite having attended an institution, she did not get the JSY money. She developed a post-partum complication but there was no check-up by her local health provider.

- ☞ Maya of Kushinagar (Nov- Dec 2006) was seeking an abortion at the PHC, but was not given correct advice on where to get safe abortion services. As a result she died of post-abortion complications.
- ☞ Hazrat-un-Nisha of Azamgarh (September 2006) went to the PHC for her seventh delivery but like Rani and Maya she was a victim of the fatal lack of contraceptive information and services.

At the outset it appears several women do have contact with a provider as they get TT injections and are presumably registered with an ANM. However, women and/or their families in Uttar Pradesh do not receive adequate information about routine care, danger signs or where to seek services in pregnancy, abortion, childbirth and post-partum stages. The women are also not receiving counselling or information about contraception which leads to unwanted multiple pregnancies, sometimes with fatal consequences. In the earlier set of pre-NRHM case studies as well, it is noted that accurate information about routine care, danger signs and where to seek health care services for pregnancy, abortion, delivery and post-partum stage was not provided to the woman and her family decision maker; neither was counseling provided on contraceptives: for example Ramadevi of Hardoi (June 2003) was in her seventh pregnancy when she lost her life (Women's Voices, 2004:15).

The withholding of accurate information on safe abortion is noteworthy as the ANMs appear to have a vested interest in misguiding women who are desperate to end the pregnancy. Abortion services are still being provided illegally by ANMs doing private practice. The ANMs demanded money with impunity from Nirmala of Baraipur as she went from one PHC to another: first Rs. 500 for the abortion and then 1000 for treatment of complications. Maya of Kushinagar (December 2006) lost her life due to an unsafe abortion even though she went to her local PHC and then to the Mother and Child Health Centre. In the pre-NRHM case studies, the earlier case-studies also show that women lose their lives due to botched abortions provided by their local ANMs: -Munni of Kanpur and Radha of Sitapur both lost their lives after approaching their local PHC for abortion services (Women's Voices 2004: 18). Unfortunately, the earlier case-studies indicate that this silence extends even to complications arising from spontaneous abortions or miscarriages, which require medical care.

TEXT BOX 2 –

- ☞ When Mamta of Chandauli went into labour (April 2006) her family took her to the PHC
- ☞ When Babita of Chandauli went into labour in March 2007, the TBAs of the village took her to the PHC for referral and tried to prevent the ANM from demanding informal payments

- When Nirmala of Azamgarh went into labour in February 2007, the family did call in an ANM from the local PHC
- When Manju of Lucknow went into labour in January 2007, her family took her to the Maternal Health Centre (Urban PHC) twice, although it was quite far away
- When Parvati of Banda started labour in November 2006, her family called in the local ANM Chintamani
- When Jaydevi of Mirzapur had a retained placenta (October 2006) her family took her to the local PHC
- Durmati (August 2006) and Susheela of Kushinagar were taken to the PHC by their families when they went into labour

Despite this lack of information, the case studies above (Box 1 and 2) indicate that pregnant women's families do seek skilled providers and institutional care; either on their own, or as advised by TBA's (Dais) or local informal (quack) providers. This belies the popular belief that it is the delay of decision-making at the level of the community or family that leads to maternal deaths. Similar behaviour has been noted in the earlier pre-NRHM case studies about Suman of Sitapur, Nankai and Fulmati of Lucknow, where the families although non-literate, knew the woman should be taken to a hospital for safe delivery (Women's Voices 2004: 19).

Text Box 3

- Susheela of Kushinagar (January 2006) visited a CHC, a private nursing home and a hospital during labour
- Asha of Azamgarh (September 2006) visited three providers before she died of ante-partum complication
- Meena of Mirzapur (October 2006) visited three providers while in labour
- Alimun-nisha of Chandauli (October 2005) was treated by four providers for prolonged labour
- Urmila of Mirzapur (August 2006) consulted three providers before she died of post-partum complications
- Mamta of Chandauli (April 2006) was attempting to reach her third provider when she delivered her dead baby on the road

However, it is of concern that families do not have accurate information on where to seek care in emergency or when complications occur and this has not changed even after the NRHM has been launched. The first provider contacted is often the one not capable of handling the complication; more often than not it is a local ANM or private doctor/quack. Thus precious time is wasted moving the women from one provider to another, despite the lack of proper transport and resources. In the pre-NRHM case studies, the case of Somari Devi of Mirzapur is a tragic story where even with scarce resources, she attempted to access five providers for treating her post-partum complication, and yet she died (Women's Voices 2004:17).

Text Box 4
Quality of institutional care:

a. Refusal to admit into the institution

- ☞ Rani of Banda (April 2007) was an obvious high-risk case in her ninth delivery yet the CHC staff refused to admit or refer her
- ☞ Gita and Rani of Banda had to deliver their babies at home since the CHC staff refused to admit them in labour
- ☞ Manju of Lucknow and Mamta of Chandauli had to deliver their babies on the street despite attending hospitals for delivery

b. Oxytocin injections

Oxytocin injections were possibly given during labour to several women without medical supervision by ANMs – Sahidun (Feb 07), Alimun-nisha of Chandauli (October 05), Savita of Chandauli (February 2007), Nirmala of Azamgarh (Feb 2007), Parvati of Banda (November 2006) and many others

c. Lack of diagnostic skill and absence of timely referral

- ☞ 18-year-old Nirmala of Azamgarh (Feb 2007) and Jaydevi of Mirzapur (August 2006) both died because the ANM was unable to recognize a life-threatening complication (retained placenta) or refer it in time: in both cases the ANMs preferred to manually remove the placenta without anaesthesia, leading to almost immediate death
- ☞ Hazrat died after her seventh delivery at the PHC because the providers were unable to refer her in time as a high-risk case;
- ☞ Asha of Chandauli died because the ANM consulted was unable to recognize her life-threatening ante-natal complication or refer her in time
- ☞ Maya of Kushinagar died (December 2006) because the PHC was unable to treat her post-abortion complication
- ☞ Savita and Mamta of Chandauli both lost their babies because the ANM was unable to recognize that labour had started;
- ☞ Parvati of Banda lost her baby because the ANM and the local informal provider (quack doctor) gave her an IV line for four hours causing shivering and discomfort, but not facilitating the delivery

When providers are consulted or when women do reach institutions, they are either denied services, or the available services are largely unskilled or irrational. There is also a high incidence of the use of an injection for the woman in labour, which is possibly oxytocin. There continues to be poor diagnosis and management of complications in pregnancy, abortion, childbirth and the post-partum stage. Women continue to die of conditions that could have been managed if the providers had been prepared, willing and skilled. Unfortunately, this is similar to the pre-NRHM scenario where routine and emergency services for pregnancy, abortion, delivery and post-partum stage were not available, accessible, affordable, appropriate or sensitive. In addition they were neither effective in saving lives nor ethical.

Text Box 5 – Informal payments:

- Babita of Chandauli (March 2007) was asked for Rs 500 as a share of the JSY money by the ANM at the PHC
- Sharmila of Kushinagar (January 2007) was asked for Rs 500 by the ANM at the PHC for her delivery but never given the JSY
- Jaydevi of Mirzapur (August 2006) was asked for Rs 600 by the ANM at the PHC to manage the retained placenta
- Nirmala of Kushinagar was asked for Rs 500 by the ANM at the PHC to do her abortion and then Rs 1000 by another ANM to treat post-abortion complications
- Durmati of Kushinagar (August 2006) was asked for Rs 1000 by the ANM at the PHC for doing her delivery
- Alimun-nisha of Chandauli (October 2005) was asked for Rs 5000 by the doctor at BHU before he took her case
- Manju of Lucknow (January 2007) was asked for Rs 10,000 by the doctor at the urban maternal health centre before her case could be admitted to the hospital

Despite the trouble women take to reach the institutions for maternal health services, the demand for informal payments continues to be fairly high. Whether it is a normal delivery, a post-partum complication, an abortion or an operation, women are invariably expected to pay providers. Families who earn daily wages for a living cannot afford these payments and are pushed deep into debt when they try to access maternal health services, as with the families of Savita and Alimun. The demand for informal payments is also linked to denial of services, as with Manju (Lucknow).

It is an unfortunate repetition of the pre-NRHM scenario: where Nankai and Fulmati of Lucknow were denied health services and delivered babies outside the hospital as they could not meet the demand for informal payments. Bhori of Chitrakoot was denied services for her post-miscarriage complications and was verbally abused, Suman of Sitapur received physical and verbal abuse during her hospital delivery apart from demands for payments. As Suman said, these traumatic experiences of being asked for large sums of money when it is a desperate matter of life and death will deter future users from approaching state health providers for maternal complications (Women's Voices 2004: 19). Thus provider demands for informal payments enhance future risk of women dying at home without accessing skilled care.

Text Box 6

- Rani (April 2007) and Shyama (Nov 2006) of Banda both developed fever after delivery; both lost their babies
- Rajmati of Banda has been bleeding since January 2007 after her still-birth
- Mamta of Chandauli (April 2006) had bleeding and weakness after delivering a breech baby on the road

Women who have had contact with providers for routine ante-natal care (TT injections) do not receive proper post-natal care and follow-up, and are often compelled to seek post-partum care from private providers at their own cost. This indicates that the pregnant women have not been tracked for recording the outcome of the pregnancy, and their

contact with the provider is an opportunity lost. Those women who had no contact with a provider during their pregnancy (for routine ante-natal care) also lost their lives, like some of those who did have contact with a provider: Asha of Azamgarh (Sept 2006) and Nanhaki of Mirzapur (August 2006) both developed ante-natal complication and finally died; Urmila of Mirzapur (August 2006) developed post-natal complications after her fourth delivery and died.

Conclusion

The above analysis of case-study documentation was meant to assess:

- How far the JSY has succeeded in having pregnant women registered (and tracked)
- How far it motivated women to attend institutions for safe childbirth
- Whether the institutions are providing improved maternal health services within the NRHM.

The case studies indicate that even after the launch of the NRHM and the implementation of the JSY scheme, the contact with providers for TT injections is not leading to registration and counselling for safe delivery or tracking fatal outcomes or near-misses. The ANMs continue to withhold information and engage in illegal and fatal practices, and are still not referring the women to institutions.

Even a year and a half after it has been announced in UP, the Janani Suraksha Yojana is still not reaching all women. Therefore, it is not clear to what extent it is motivating women to attend institutions for safe childbirth. However, the communities appear to be readily prepared to attend institutions to ensure safe birth or safe abortion (see Box 2 above).

At the level of institutional willingness to handle deliveries, there are still cases of women being denied maternal healthcare although they arrive at institutions for delivery. The institutions are not providing skilled care and appropriate management including timely referral of complications. The private sector continues to be totally unregulated and provides irrational therapy. The demand for informal payments continues to be fairly high. Poor diagnosis and management of complications in pregnancy, childbirth and the post-partum stage also persists. Abortion services are still being provided illegally by ANMs doing private practice. In addition, there is a high incidence of the use of an injection for the woman in labour, which is possibly oxytocin. Women continue to die of conditions that could have been managed if the providers had been prepared, willing and skilled.

Recommendations to strengthen maternal health service provision within NRHM

Based on the analysis of case studies mentioned above, the following recommendations are suggested in order to strengthen the provision of maternal health services under the NRHM: check punctuations on this list.

1. At the point of first provider contact (such as routine ANC), the following information may be given to women and their families:

- ☞ Entitlements under NRHM to women and their families, including the JSY and support of the ASHA
- ☞ Comprehensive information on safeguarding maternal health: this should include adequate information about routine care, danger signs
- ☞ Where to seek appropriate services in pregnancy, abortion, child-birth and post-partum stages
- ☞ Information about the dangers of oxytocin used without medical supervision to hasten delivery
- ☞ Couples and women also need counselling, information and services about contraception

2. Widespread information dissemination on safe abortion – its legality and where services are safely available
3. Improvement of the quality of institutional care, including –
   - ☞ Systems of community monitoring of the services, facilities and service providers, feedback mechanisms
   - ☞ Community monitoring of demands for informal payments, irrational drug use etc; strict departmental action upon feedback
   - ☞ Periodic social audit with the involvement of people's representatives
   - ☞ Skill-building of ANMs and PHC staff to recognize and deal with complications and management of timely referral
4. Creating a method to track each pregnancy and follow it through to six weeks after delivery or post-abortion, recording of adverse outcomes on a no-fault basis (ANMs will not disclose information that leads to punitive action).

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31 July 2007

Endnotes

[i] This paper acknowledges the contributions made by the partner organisations of SAHAYOG across several districts of Uttar Pradesh in collecting the information in various districts of Uttar Pradesh. The effort was supported by the WHRAP project managed by ARROW and supported by DANIDA

[ii] Registrar-General India, Report of the Technical Group on Population Projections constituted by the National Commission on Population, Office of the Registrar General and Census Commissioner India, 2006.

[iii] This translated literally means 'maternity protection scheme'

[iv] The related GO was passed by the Government of UP (GoUP) on 24 November 2006 ref no. 2916/5-9-06-9 (113)/05 signed by A.K. Mishra Principal Secretary GoUP

[v] It is described as "a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women" - As seen on the website of the MoHFW of the GOI on 7 April 07, http://mohfw.nic.in/dofw%20website/JSY_features_FAQ_Nov_2006.htm

[vi] Department of Planning (GoUP), Note on Health Sector in Uttar Pradesh, Government of Uttar Pradesh, December 2005

[vii] Facility Survey National Report under Reproductive and Child Health Project Phase II 2003 (published on Internet at IIPS website on RCH – seen on 15 April 2007) - http://www.rchindia.org/fs_india.htm

[viii] Women's Voices, KRITI and other organizations, Lucknow (SAHAYOG: unpublished) 2004, prepared towards the National Shadow Report for CEDAW