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EVALUATION OF JANANI SURAKSHA YOJNA UNDER NATIONAL RURAL HEALTH MISSION IN KASHMIR VALLEY

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Mother and child constitute a priority group in a community. They comprise of approximately 57.5% of the total population and constitute a vulnerable group. **(1)** Maternal mortality and infant mortality are the main health indicators of any civilized society. **(2)**The universal declaration for human rights of 1948 in *Article 25* stressed that "Motherhood and childhood are entitled to special care and assistance"**(3)**

Women constitute about half of the human resource potential and overall development of a country is incomplete without them. The place of delivery is an important aspect of reproductive health care. Quality of care received by the mother and baby depend upon the place of delivery. If proper care is not taken during this child bearing process, it affects the overall health, especially the reproductive health of the women as well as the health of the new born child.**(4)**

Each year, approximately eight million women suffer pregnancy- related complications and over half a million die. 99% of all maternal deaths occur in developing countries.**(5)** Every five minutes, one women in India dies due to pregnancy related complications amounting to one lakh maternal deaths and ten lakh newborn deaths every year**.(6)**

India contributes significantly to the global burden of maternal deaths, more than 20% of maternal deaths occur in India. Pregnant women in India die due to a combination of various factors such as poverty or ineffective and unaffordable health services.**(7)**

Five major direct complications of pregnancy and childbirth that account for more than 70% of maternal deaths in Asia are haemorrhage (38%), sepsis (11%), hypertensive disorders and obstructed labour (5%),unsafe abortions (8%), and other conditions(33%).**(8)**

The Maternal Mortality Rate (MMR) is currently 212/100,000 live births (SRS-2007–09) and Infant Mortality Rate is currently 47/1000 live births (census 2011).(**9**) Infant mortality has declined from 1593 in 1960 to 44 in 2011.**(10)** The latest census of India estimates on maternal mortality Sample Registration System (SRS) 2004 reports and National Family Health Survey (NFHS-3) findings show that country, although, may not be able to achieve the goals set in National Population Policy is at least making progress in the right direction. The maternal mortality has come down from 540/lac live births, the Infant Mortality Rate (IMR) has reached a national level of 57/1000 live births. The MMR has been static at that level for almost a decade up to 2000. These estimates represent a steady but gradual improvement in India over the previous 15 years. However, at this rate, India would not be able to achieve the goal of reducing the MMR by ¾ of 1990 level by 2015 as envisaged in Millennium Development Goal (MDG). Keeping in view the prevailing status, attempts have been made to understand the mechanism of maternal mortality in India. Antenatal care, skilled birth attendance and institutional deliveries have been identified as an important contributor for reducing MMR in India**.(11)**

During the first round of the survey in the year 1992-93 it was seen that only about 25% of the institutional deliveries were conducted at the National Level. In 1998-99, it increases to 34%, at the time of NFHS-3 conducted in 2005-06 it increased to 41% only. The place of birth (at home or in an institution) and the type of assistance available (untrained or trained) have improved over years. In 1992-93 only 25.5% of births were attended by skilled health personnel where as in 2009 it was 79.6% and is expected to reach 90% by 2015. Successive programme since the 1980 have been attempted to address the high maternal mortality rate

(MMR) & Infant mortality rate (IMR) such as Reproductive and child health (RCH II, April 2005), that focuses to decrease maternal and child morbidity and mortality and Child Survival and safe motherhood (CSSM) that lay emphasis on specific districts where maternal and infant mortality rates are higher than the neonatal average**.(4)**

As per the performance review of NRHM(2013) in J&K, the JSY scheme has shown rapid growth in the last four years, with 7771 beneficiaries in 2008-2009 to 13265 beneficiaries in the year 2011-12. About 4.57 lakh beneficiaries have been benefited under JSY till December 2012.60% of the deliveries are being escorted by ASHAs.**(11)**

Maternal mortality remains a serious public health problem in developing countries and it is prioritized as one of the MDG. The adoption of MDG, specially goal 5, renewed global emphasis on reducing maternal mortality**.(12)**

In the light of millennium Development goals (MDG), National Population Policy (NPP) and National Health Policy (NHP), the Government of India, Ministry of Health and family welfare launched NRHM on April 12, 2005**. (13)** It aimed to provide accessible, affordable and quality health care services to the rural population with special focus on 18 states with poor health achievements particularly to the poor and vulnerable section of the society. **(14)** In April 2005, under the umbrella of National Rural Health Mission (NRHM) in response to the slow and varied progress in improvement of maternal and neonatal health, the Government of India launched a scheme known as Janani Suraksha Yojna (JSY). The scheme is a safe motherhood intervention. The scheme aimed to reduce maternal and infant mortality by promoting institutional deliveries.**(15)**

With annual expenditure of 8.8 billion rupees and an estimated 7.1 million individual beneficiaries in 2007-08,JSY is one of the largest conditional cash transfer programme in the world and represent a major Indian health programme**.(16)** As on March 31, 2010, the number of beneficiaries in the year 2009-10 stood at 92.29 lakhs (23 million**). (17)**

Conditional Cash Transfer (CCT) is a type of social assistance program specifically designed or empowering poor households to avail preventive health services. Money is a powerful incentive to change behaviour. **(17)** It is an initiative of Demand side Financing (DSF) wherein the government transfers money only to the person who meet certain criteria. In India, schemes such as "DSF schemes" are seen as innovative financing mechanisms, and are aimed at improving maternal and child health**.(18)** Some examples of DSF schemes include–Chiranjevi yojana, Janani Suvidha yojna, Mamta, Sarva Swasthya Mission (maternity vouchers).**(19)**

Janani Suraksha Yojna is a 100% centrally sponsored scheme and is being implemented in all states and union territory. Under the scheme, there is provision for cash assistance at delivery and during the post delivery period. It is a demand and supply side pay for programme (P4P) for promoting save delivery.**(11)** The primary component of Janani Suraksha Yojna are Early registration, Micro-Birth Planning, Referral transport(home to health institution and back), Institutional birth, post delivery visit and reporting, family planning advice and Mother and Child Health counselling.**(19)**

JSY introduced health workers, called ASHA (Accredited Social Health Activist) who serve as a link between the government and pregnant women.**(20)** Institutional delivery means giving birth to a child in a medical institution under the supervision of trained and competent health worker where there is availability of more amenities to handle the

situation and save the life of the mother and child. **(4)** The role of ASHA is to facilitate pregnant women to avail services of maternal care, escort her at the time of delivery and arrange for referral transport. She is supposed to help women to get at least 4 antenatal check up, arrange immunization of new born baby, do postnatal visit with ANM and counsel for initiation of breast feeding.**(21)** This scheme has been modified from earlier NMBS (National Maternity Benefit Scheme, 2001) and is now being run as a part of NRHM scheme.**(14)**The scheme is specifically targeted at schedule caste and schedule tribe (SC/ST), urban slum and rural poor population. The states have been stratified in LPS (Low Performing State) having low institutional delivery rates and HPS (High Performing States) for cash incentive. Special focus has been given to LPS which include 8 EAG (Empowered Action Group) Assam and Jammu & Kashmir**.(11)**

JSY has built in incentive for Mother and ASHA. As per the guideline, in Low Performing State, a women gets a cash incentive of Rs. 1400 & 1000 per institutional delivery in rural and urban areas respectively. ASHA gets an incentive of Rs. 600 & 200 in rural and urban areas respectively. In High Performing State, Rs 700 is paid to mother and ASHA in rural area only. Those mother preferring to deliver at home/ had home delivery are entitled to cash assistance of Rs 500/ per delivery. The incentive is paid to women who have delivered in government hospital. Apart from this, flexibility have been given to evolve Public Private Partnership (PPP) mechanism and accredit private health institution for providing institutional delivery services. Besides, it subsidized the cost of caesarean section for management of obstetric complication up to Rs. 1500/ per delivery to the government institutions where government specialist are not in position. There is also a provision of reimbursement

for any out of pocket expenses incurred for transportation to and from the health care facility. The financial assistance to the mother should be disbursed at the medical facility itself. The money is to be paid to the mother and not to any other person. JSY programme has been implemented in all states, but each state has the authority to adapt and modify the programme to best fit in its local context.**(21)**

Some changes have been made from time to time after feedback from the ground implementation such as removal of age restriction, doing away with restriction on birth order and need for BPL certificate**. (14)**

Recent initiative taken by the government in this respect include:- MAA TUJHE SALAM launched by J&K government in January 2011 to provide free hospital services for pregnant women and children up to 5 years in government health care institutions.**(22)** JSSK launched on 1st June 2011 provide free entitlement to ensure better facilities for women and child health by providing free service at the time of delivery such as free Drugs, diagnostics etc**.(23)** The scheme is being implemented in all government hospital of the state including medical colleges and SKIMS Soura**.(12)**

In other countries conditional cash transfer programme have been implemented to incentivise the use of health services in low income and middle income countries like Latin America, Bangladesh, Nepal, Indonesia etc.**(24)** Large scale Conditional Cash Transfer Scheme (CCT) programs are provided to influence the birth outcomes. CCTs such as *Oportunidades* (previously *PROGRESA*) program include free health care such as prenatal care and care at delivery. **(25)**

With a population of over 1.1 billion, India represents a large segment of the countries that is working toward global and regional targets for improved maternal and new born health**. (26)**.

Rationale for the Study

Jammu and Kashmir is among the Low Performing Sate (LPS) as per JSY guideline. This study is first of its kind in Kashmir valley for evaluating the various component of the scheme and to see whether it is functioning in the right direction (as per the guidelines) at the grass root level.

Munjail Monika et al;(4) Health and Population; Perspective and Issues. Vol.32(3) 131-140,2009 in a study titled "comparative analyses of institutional and non-institutional deliveries" in Mohali district in Punjab found that in a survey conducted in 1992- 93, 25% of the deliveries were conducted at institutions, in 2005-06 it increased to 52%. The main reason for home delivery was home delivery being easy and convenient (74%) and due to cultural factors(68%).

Sanjeev K Gupta et al (Jan 2008);(5) International journal of current Biological and Medical Science, 1(2):06-11 conducted a study in N.S.C.B medical college, Jabalpur during 2007-2008 with a sample size of 300 beneficiaries and found that 67% of the respondents arrange their own vehicle for transportation for delivery, only 17.33% were motivated by ANM/ASHA/ Dai for institutional delivery**.**

Mohapatra B et al; (28) Health and Population: Perspective and issues, Vol 31(2),12-125,2008 carried out Assessment of the functioning and impact of JSY in Orissa. The study revealed that at the district, block and sub-centre level there was a shortage of medical and paramedical staff and inadequate facility for institutional delivery, but the available staff were well trained. IEC activities were implemented efficiently. ASHA and HW were playing a major role in generating awareness regarding JSY**.**

Devadasan Narayanan et al (Jan 2008) **(7)** carried out a study in four Indian states to determine how the JSY is functioning in the fields and whether it meets its original objective of increase in institutional deliveries. They found that there is some evidence to suggest that

institutional deliveries have increased due to JSY, but there were some weaknesses in the scheme. Women were not aware of the scheme in some states. The documentation process had become very cumbersome and there was delay in getting cash benefit and some received partial amount**.**

Stiphen S Lim et al (June 2010)(29) Lancet, vol 375, issue 9730 in his study "Impact and evaluation of conditional cash transfer in India" assessed the receipt of financial assistance from JSY and the affect of JSY on antenatal care, in- facility births, perinatal, neonatal and maternal deaths. They found that implementation of JSY in 2007-08 was highly variable by state from less than 5% to 44% of women giving birth & receiving cash payment from JSY. The scheme had a significant effect on increasing antenatal and in- facility birth. JSY payment was associated with a reduction of 3.7 perinatal deaths per thousand pregnancies and 2.3 neonatal deaths per thousand live birth**.**

Lahariya Chandrakant (Jan 2009)(11) Indian journal of community medicine/volume 34/ issue 1 found that institutional deliveries have been identified as an important contributor for reducing MMR. They came with the conclusion that JSY has made significant impact on the rate of institutional deliveries, even in low performing states**.**

Hanmanta Wadgave et al (Dec 2009)(16) did a study to explore the reasons of missed opportunities of Janani Suraksha Yojna benefits among the beneficiaries in slum areas of Solapur, western Maharashtra. Out of the 3212 women, 360(11.20%) were eligible for getting the benefit of JSY. Among the 360, only 118 (32.78%) women got the benefit of JSY. 242(67.22%) missed the opportunity due to lack of awareness of JSY & IEC efforts in the implementation of JSY, divulging most of the poor eligible women from their rights of JSY benefits**.**

The National Institute of Health and Family Welfare, **(10)** in collaboration with the UNFPA, has undertaken a rapid appraisal of the various health interventions under the NRHM with the concurrence of government of India. These rapid appraisals were conducted in low performing states, namely Madhya Pradesh, Uttar Pradesh, Orissa, Jharkhand and Chhattisgarh. The study came with the conclusion that further training is required for ASHA for resolving the practical problems in the field. Further there was lack of orientation of the health staff other than ASHA. Less than half of both the beneficiary as well as non-beneficiary mothers knew about the various aspect of JSY scheme The JSY scheme are perceived as useful by majority of beneficiaries. Majority of the stake holders perceive monetary assistance as a big advantage. Most of the beneficiaries felt the lack of transparency in money distribution, problems of communication and transport.

Kauser Sarah (April 2011) (25) carried out a policy analyses exercise ((PAE) to study the effort to eradicate infant mortality through JSY since the introduction of the scheme. Comparing the country to its neighbours and similar income countries, India is lagging behind. Evidence of support for the scheme shows that the coverage of beneficiaries of Janani Suraksha Yojna has increased from around six lakh in 2005-2006 to nearly one crore in 2009-10, the benefits being already reflected by the decline in maternal and neonatal mortality rate**.**

A rapid appraisal on functioning of Janani Suraksha Yojna in south Orissa was conducted by **Malini Shobana et al.(30)**Health and Population: Perspectives and Issues; 2008; vol 31(2),126-131. The study revealed that there was lack of orientation of the health staff other than ASHA on JSY.ASHA played a major role in motivation for institutional delivery in two-thirds of cases. Most of the utilizers express problems of

communication and transport. Non- availability of 24x7 facility and lack of staff were the major deterrents for mothers in assessing JSY services**.**

Ahmed Khurshid et al (Aug, 2009) (31) carried out a rapid appraisal of NRHM in Baramullah district. Overall 3/4th of the respondents had full knowledge about JSY scheme. Regarding the source of information, 41% of the respondents have heard it from Radio/ TV, 40% from ASHA, 11% from Anganwadi centre (AWC) and doctor, 6% from ANM and 23% from other source. Only 15% have heard about the scheme well before they were pregnant. 76% were registered during their 5th month or later and only 2% in the 1st or 2nd month.57% of the beneficiaries had sought the help of ASHA in getting the card and 29% during their Antenatal check –up. 88% of deliveries were institutional delivery and 12% had home delivery. Transport was arranged by ANM/ ASHA in only 5% of cases. 76% have received the incentive at government health centre, 6% at AWC and 18% at home by ASHA/ ANM. The study came up with the conclusion that there has been increase in institutional deliveries. It was observed that 90% of deliveries took place in health institution**.**

Qurat-ul-Ain, 2010(32) did a study on availability and utilization of services under National Rural Health Mission in selected block of Budgam. The study reveals that only 10.6% of recently delivered women had Antenatal Check-up by health worker out of which 97% had check up at health facility. 89% were institutional deliveries and 10.6% women delivered at home. Regarding Postnatal check- up, only 2% were visited by a health worker within 2 weeks after delivery for postpartum care. Immunization Coverage was fairly good with 54.4% coverage from Sub-Centre, 20% from Primary Health Centre and 19.5% from Community Health Centre. Money was paid to only 3.5% of recently delivered women**.**

Study was conducted by **Population Research Centre, Mohanlal Sukhadia University Udaipur (2008)(14)** with an objective to examine the implementation status of Janani Suraksha Yojna in selected district of Rajasthan. It was based on Interview of 200 beneficiaries, 30 stakeholders, three FGD; Informal discussion and observations. ASHA'S have poor knowledge about JSY related concepts, components, provision and process. ASHAs were not being informed about the beneficiaries visit to the health centre for delivery. Majority of beneficiaries were registered within three months, received three antenatal check up, used IFA tablets, postnatal check up, have trained ASHA in their village, received cash amount and ASHA was with her at the time of delivery. Majority of beneficiaries were pre aware about at least one of the aim of JSY**.**

KHAN M.E. et al(21) The journal of Family Welfare, vol 56, special issue-2010 studied the impact of JSY on selected family health behaviour in Rural Uttar Pradesh. The introduction of the JSY has helped to increase the rate of institutional delivery significantly. 88% of the women were aware of the JSY and incentive. However, only 71% knew ASHA of their village. Among women who have delivered in a public facility, around 79% had received the full incentive of Rs 1400/-, about 18% did not receive any incentive money and 4% received less than the recommended amount (Rs 250-750). Among the women who delivered in a public facility, 43% received help in ANC registration and in 75% of cases the ASHA accompanied the women to the facility. Only 8% of ASHA helped in arranging transportation and less than $1/5^{th}$ of women were visited by ASHA for postnatal check up. Preference for institutional delivery was safety of mother in 59-74% of cases and child Care by 55-73%.

Panja Kanti Tanmay et al;(33) Indian Journal of Public Health, Volume 56, Issue 1, January - March, 2012. A cross- sectional study was conducted in Bankura district of West Bengal among 324 women through 40 cluster technique to find out institutional delivery rate, utilization of JSY during antenatal period and relation between cash benefit and institutional delivery. Overall institutional rate was 73.1% and utilization of JSY among eligible women was 50.5%. Institutional delivery (84.0%), consumption of 100 Iron Folic acid tablets (46.0%) and three or more antenatal check –ups (91.0%) were better in women who received financial assistance from JSY during antenatal period. JSY came out to be significantly associated with institutional deliveries**.**

Dongre Ambrish; Version (18) August 27, 2010 evaluate the short term effects of JSY. Results indicate that in the initial one and a half years of its operation, scheme did not have any effect on disparity between the targeted and non targeted states. But beginning from 2007, the targeted states have shown much larger improvements in the institutional deliveries, leading to a decline in the gap between targeted and non targeted states.

Sharma Parul et al (May 2009) (34) did a comparative study of utilization of JSY in rural areas and urban slum communities of Dehradun. Out of the total number of married women who delivered at government hospital, 78.42% were registered, 83.64% of these women belonged to urban slums. 29.21% women went for three ANC visits and the proportion was higher for urban slums. 48.31% women consumed hundred IFA tablets and the proportion was high (79.41%) in rural women. JSY utilization was low in rural areas(38.7%).

Gopalan S Saji et al; (35) BMC Health Services Research 2012, 12:319 conducted a study in the district of Gajapati, Nayagarh and Mayurbhanj

division. The study explores JSY's potential to enhance women's financial assistance to maternal health care, its effect on household, out of pocket spending on maternal health care and its influence on community health worker's performance motivation. The number of institutional deliveries, antenatal and post natal care visits increased after introduction of JSY. The financial incentive provided partial financial risk protection as it could cover only 25.5% of maternal health care cost in rural areas and 14.3% in urban areas. The existing level of financial incentives and systemic support was inadequate to motivate the volunteers optimally on their performance**.**

Mandal K Dilip et al :(36) BMC Proceedings 2012,6(suppl 1);03 evaluated JSY in South 24- Parganas district of West Bengal. The study reveals that 57% of mothers were registered within 12 weeks of pregnancy, 85.9% completed at least 3 antenatal care visits and 96.9% had completed one dose of tetanus toxoid injection. 78% were registered under JSY and 73% got benefits under three antenatal care visits of 49% mothers who delivered in health care institution, 51% got financial benefits for referral transport as well as institutional delivery after childbirth. 90% knew that some financial benefit was given to pregnant mothers, but only 64% mothers had heard the name of JSY.

Chaturvedi Sarika and Bharat Randive (37);Indian Journal Of Community medicine 2011 Jan- Mar ;36(1):21-26 did a cross sectional study in Ahmadnagar district of Maharashtra to understand the issues in the design and implementation of the PPP s for EmOC under JSY. The study identifies barriers to women in accessing the benefit and difficulties faced by administrators in implementing the scheme. There were no PPPs executed in the study district. The scheme does not include all life - threatening complications of pregnancy and child birth, but restricted to

caesarean deliveries. The authors recommend capacity and expertise of the government at different levels in designing and managing contracts**.**

Sidney Kristi et al; (38)http:// www. Reproductive-Health-Journal.com/ content/9/1/2; carried out a study among women giving birth in 30 villages in Ujjain District in Madhya Pradesh. Majority of the deliveries took place within the JSY program; 90% of the women had prior knowledge about the program. Most of the mother's receive cash incentive within two weeks of delivery. Women who were uneducated, multiparous or lacked prior knowledge of the JSY program were significantly more likely to deliver at home.

Concurrent Assessment of JSY scheme in selected states of India, 2008(39) was carried out by Ministry of health and family welfare Government of India through UNFPA in Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh. Findings of the study indicate that awareness about JSY among mothers living in rural areas was fairly high in all the states. It was 95% in Rajasthan and ranged from 76-87% in other states. The combined estimates of five states indicate that 55% of the births in the past one year occurred in institution and the direct beneficiaries of JSY were 47%. Regarding the duration of stay at the institution only in Madhya Pradesh, 67% of beneficiaries stayed for more than 48 hrs. A high proportion of beneficiaries in Rajasthan, Orissa and Madhya Pradesh(93,89 and 83% respectively) reported having received money. 75% of mothers in Bihar and Uttar Pradesh had received money after delivery. 39% received it at time of discharge in Madhya Pradesh while it was lower in other states. Majority of the women were being helped by ASHA at the time of registration, 75% accompanied the women at the time of delivery while postnatal care and advice on breast

feeding was very weak. Overall, the study indicate a huge increase in institutional deliveries in the low performing states.

Program evaluation of the Janani Suraksha Yojna was done by **Ved Rajani et al (2012)(40)** in three district of eight EAG (Empowered Action Group) states categorised as high performing, poor performing and tribal districts on the basis of institutional deliveries during 2008-09. The study shows that over 50% of women who had previous delivery at home has opted for institutional delivery. There was significant out of pocket expenses. Private sector accounted for 12.5% of all deliveries. For complication private sector provided 60% of care.

An appraisal of Janani Sahyogi Yojana was carried by **Pal D.K. et al; (31)**Health and Population: Perspective and issues, Vol. 31 (2),85-93,2008 in four district of Madhya Pradesh namely Bhopal, Jabalpur, Chhindwada and Indore. The study revealed that the PSP's (Private Service Provider) who adopted multiple motivational strategies e.g., meetings with ASHA's and AWW's, free out-patient services for Below Poverty Line(BPL),publicity through media etc were successful in getting more number of case as compared to those who did not adopt such strategies. Motivational charges for institutional deliveries was very effective in increasing the institutional deliveries in private hospitals.

Centre for Operation Research and Training (CORT) ; Jan 2008(42) conducted assessment of JSY to understand the process of implementation of the program, involvement of ASHA and experience of JSY beneficiaries in three district of Basti, Raibareli and Saharanpur of Uttar Pradesh. Findings shows that 33% of ASHA's did not receive any payment until the date of survey. only half of ASHA's knew about complication during pregnancy. 84% said that they would refer the pregnant women to FRU, while 16% said that they would tell the

pregnant women to consult the ANM next day. 46% of ASHA had accompanied an average of 3.8 JSY cases for institutional deliveries. All ASHA's met ANM, followed by AWW (98%), PHC staff (65%) and PRI members (43%). The beneficiaries learnt about JSY during various stages of pregnancy, however 14% learnt about the same only after delivery. Nearly half got registered in 1st and 2nd trimester. Women on an average had 3.1 antenatal check up. Husband (48%), mother-in-law (30%) and ASHA's (12%) accompanied the beneficiaries for ANC visit. Half of the beneficiaries did not receive the cash. 31% felt that cash assistance received was not sufficient and had to spend a substantial amount out of their pockets**.**

Concurrent Evaluation of JSY-II (Feb, 2009) **(43)** was done by State Institute of Health and Family Welfare, Jaipur in eight selected district of Rajasthan- Ajmer, Banswara, Baren, Balmer, Bharatpur, Gagannagar, Jalore and Pali. 43.9% of ASHA's have facilitated minimum of two antenatal check up, 54.7% had three postnatal visits. 67.6% of beneficiaries consumed 60- 100 IFA, 75% got payment after 24-48 hours. 71.5% stayed at the facility for 12-48 hours. 49.5% got themselves escorted by ASHA/ANM out of which 42% did not stay at the institution.

Gour Neeraj et al (Feb 2009) (44) did a desk review to assess the impact of JSY on various MCH indicators in district Gwalior, India. Findings show that there has been a significant increase in the number of institutional deliveries after inception of JSY which was around 48.8% in 2003-2004, it increase upto 50% and 73.1% year in 2006-07 and 07 -08 respectively.

Concurrent evaluation of NRHM(2009)(45) in three districts of Jammu & Kashmir reveal that 70% of deliveries of last child deliveries took place in a medical institution. 13% of the home deliveries were accessed

by health personnel. 40% of the JSY registration took place in 1st trimester. 35 % of JSY beneficiaries reported staying in hospital for less than one day.

An assessment of JSY in rural Uttar Pradesh, India by Diya Tiwari (46) shows that 96% of the women were aware about JSY. Main source of information was ASHA in 77.8% cases. Majority of the delivery were conducted in Government hospital. 85.7% of the mothers received the money. 53.1% of the mother received money at the time of discharge.

Sahni B, Sobti et al (47) observed that 41.46% antenatal females had received at least three antenatal check-ups; 86.74% were found to be fully-immunized with T.T Whereas IFA intake was recorded for only 32.62% of the females. Overall, 29.12% of the total pregnant females received full antenatal care.

Kristi Sidney et al (13) in his study found that Ninety percent of the women had prior knowledge of the JSY program. The women learned about the program through the public health facility (40%), the village crèche worker (30%) or the ASHA (21%).The majority of deliveries (318/418; 76%) took place within the JSY program; 81% of all BPL mothers delivered in the program. Seventy percent program deliveries occurred in a CHC and 26% in the district hospital. The main reasons reported for delivering in the program were because the facility was close to the home (44%), motivated by the JSY cash incentive (24%) or the perception that good services were available at the program facility (17%). All mothers that delivered in a JSY facility received the cash benefit; 86% received it within two weeks of delivering in a facility. Of the 342 mothers that delivered in a facility 37 were referred to another facility. Most referrals (n=29) were to the district hospital from lower level public facilities**.**

Ashok Mishra, Chandrakant Lahariya et al (2007-2008)(48) did a study to assess the functioning of the VRJKBY to understand the influence of this scheme on the level and status of institutional deliveries and also to know the client satisfaction. Approximately half of the beneficiaries never heard about the VRJKBY. Less than half of the AWWs/ANMs also do not know about the scheme. The AWWs and ANMs are the main source of information for the beneficiaries. The beneficiaries have admitted to receiving cash/cheque in the range of Rs. 1,000 to 2400. The time period for the distribution of money is at the time of discharge to one month.

A Rapid appraisal of functioning of ASHA under NRHM in Cuttack, Orissa (2007-2008) was done by **Saraswati Swain et al (49)** Over half of the ASHAs say that the ANMs support them in counseling the mothers on ANC/PNC, immunization, exclusively breastfeeding and family planning (66%)

As per the findings of **Programme Evaluation of NRHM in 7 states (50)** Hardly 8.8% of pregnant women had registered within first trimester, whereas majority of pregnant women got registered between 3-6 months (46%) and 7-9 months (45%). Majority of the antenatal checkups are being reported to be done either at Sub-centres (SCs) or Primary Health Centres (PHCs). Patterns of utilization seem to be similar in almost all the seven states under the purview of the study. Blood check-ups are reported to be relatively much higher in states like Uttar Pradesh (31.7%) and Madhya Pradesh (15.6%) and is reported to be quite low (less than 2%) in almost all the other five states. Reporting of different checkups under ANC services like BP, height, weight and urine have been reported to be satisfactory. Further, overall 93 % of pregnant women have reported being vaccinated with Anti-Tetanus vaccine and it was 100% in case of J&K and

more than 90% in case of remaining states except Uttar Pradesh (79.8%). The type of delivery reported by the mothers comprised of 96% as normal deliveries with only 4.2% as complicated/Caesarean. Maximum utilization of the PNC services have been reported in Tamil Nadu (90.8%) and minimum in J&K (30.8%).

1. To assess the knowledge and utilization pattern of JSY beneficiaries.
2. To assess the service coverage of the target population under Janani Suraksha Yojna
3. To identify the shortcoming, if any in the implementation of scheme.
4. To assess the Role of ASHA's /ANM's, district, block and divisional official in the implementation of Janani Suraksha Yojna scheme.

The study is based on the evaluation of Janani Suraksha Yojana (JSY) scheme which is one of the world's largest Demand Side Financial (DSF) incentive programme under NRHM. The study has been done across three block of Kashmir valley.

STUDY PERIOD: The study was done for a period of one year from April 2012 to March 2013.

STUDY DESIGN: A field based cross sectional study.

STUDY AREA: Srinagar, Pulwama and Budgam district of Kashmir valley.

SAMPLING TECHNIQUE: Multi-stage Random sampling was done involving following stages:-

Kashmir valley is arbitrarily divided into three zones:- Central, South and North Zone.

a) **Stage 1 - Selection of districts**

At first stage, one district was selected randomly by lottery method from each zone.

b) **Stage 2- Selection of blocks:-**Frame of blocks in the selected district was formulated out of which 10% of the blocks were selected randomly, that came out to be one block per district. Thus, three blocks from three districts were randomly selected.

c) **Stage 3- Selection of sub- centres:-** From each of the selected block level PHC, by line listing all the sub-centres in the block, 20% of the sub-centres were taken on random selection basis.

In the three districts, three PHC'S, seven SC's and all villages or Mohallas of selected Sub-Centre were selected for the study.

The list of selected districts, blocks and villages in the study are given in table 1.

Table 1: Selected Districts, Blocks and Villages under study

District	Block	PHC	Sub- centres	No of Villages
Srinagar	Hazratbal	PHC Hazratbal	1 Shahanpora 2 Aabidal 3 Nandpora	18 18 11
Pulwama	Pampore	PHC Kakapora	1 Lelhar 2 Narbal	5 4
Budgam	Ompora	PHC Nasrulopora	1 Chandpora 2 Gariand	3 3

Study Area

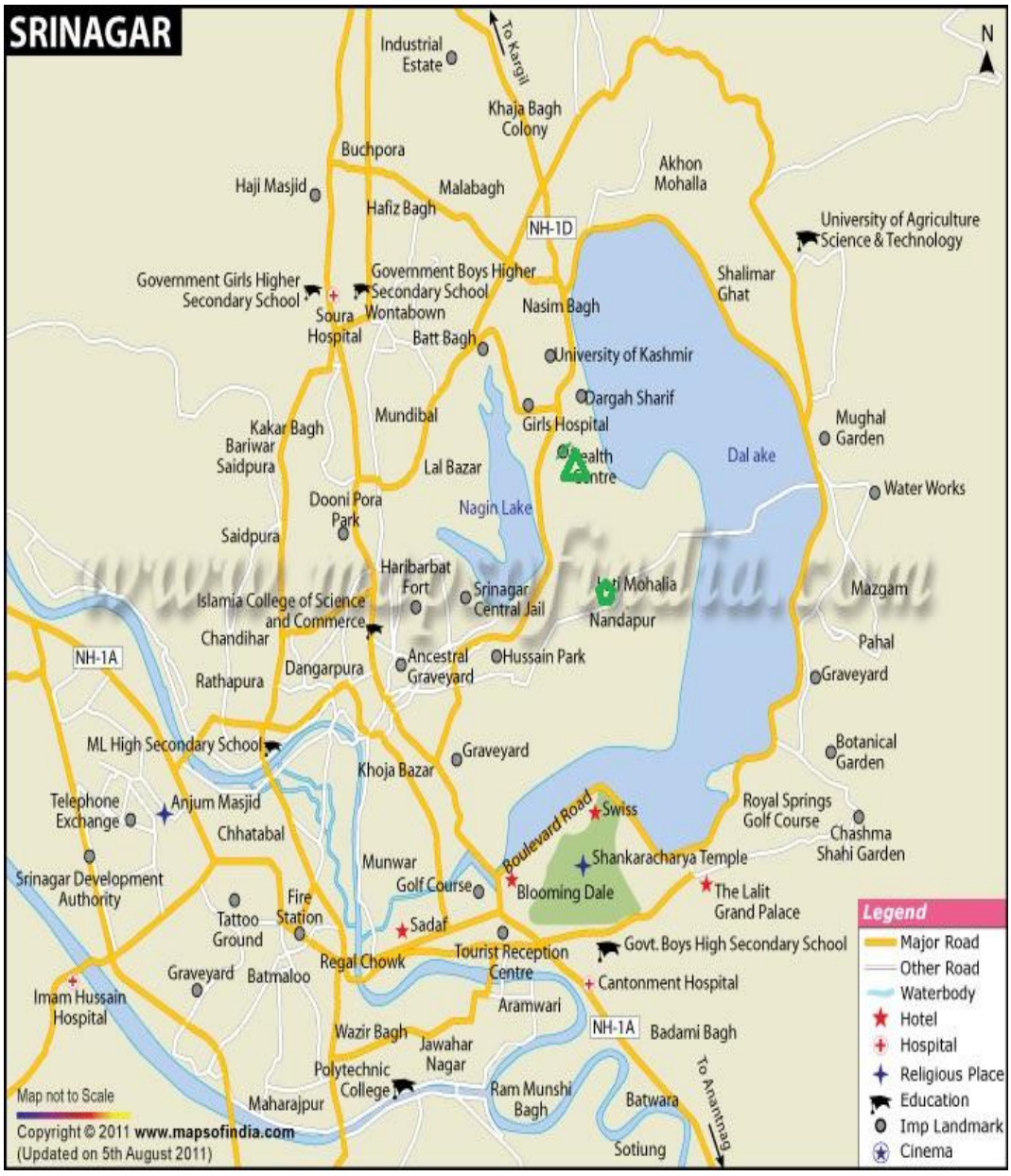
Three districts of Kashmir valley were selected randomly which were Srinagar, Budgam and Pulwama district.

District Srinagar: It is situated in the centre of Kashmir valley surrounded by 5 districts. In the north, it is flanked by Ganderbal, in the south by Pulwama and in the north- west by Budgam. It has a population of around 12.70 lacs (Census 2011) and is spread over an area of 294 sqkms. There are 74 health centres in the district. It comprises 2 tehsils namely Srinagar north and Srinagar south and 136 revenue villages.

Block Hazratbal was randomly selected for the study.

- Hazratbal block is predominantly an urban block.
- It has four PHC's and 12 sub centres.

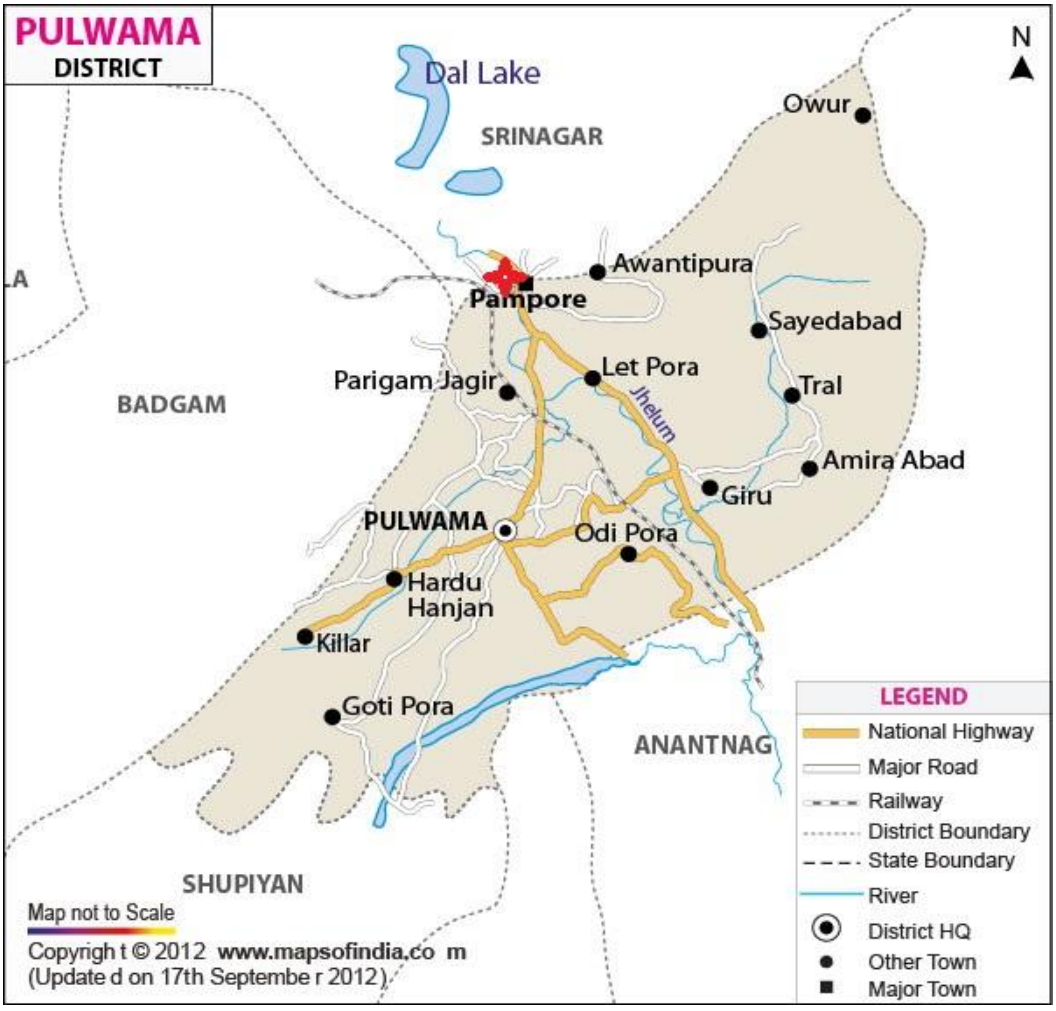
- Total population of Hazratbal block as per survey report 2012 is 82,721.
- Out of 12 subcentres, 20% of subcentre i.e., three subcentre were selected randomly namely subcentre Aabidal, Nandpora and Shahanpora.



**Source:www.maps of india.com*

Pulwama district: It is bounded by Srinagar in the north, by Budgam and Poonch district in the west and by Anantnag district in the south east. As per census 2011, Pulwama has a population of 5.7 lacs. It has 129 health centres. It is divided into three zones (Pulwama and Pampore comes under zone 1st). The district is divided into 4 tehsils: Pulwama, Pampore, Shopian and Tral which have been further divided into six community block Tral, Killer, Pampore, Kakapora and Pulwama.

Kakapora block was selected randomly amongst the block. It is located 20km from Srinagar. Further, 2 subcentre: subcentre Lelhar and Narbal were selected for the study.



Source:www.maps of india.com

District Budgam: It is situated to the north west of Srinagar. Total population is 7,30,753 (census 2011).The district is divided into 5 tehsils: Charari Sahrief, Beerwah, Budgam, Chadora and Khansahib tehsil.

District Budgam consists of 8 blocks: Beerwah, Nagam, Budgam, B.K.pora, Khan Sahib, Khag, Narbal and Chadoora. Out of the entire district, Block Ompora of District Budgam was selected randomly.

PHC Nasrulapora was taken randomly and 2 sub centres: Sub centre Chandpora and Gariand was finally selected for the study.

Source:www.maps of india.com

Study Respondents

The following service providers were selected from the identified districts, blocks and villages.

(1) At divisional, district and block level

- Divisional Monitoring and Evaluation Officer (DMEO)
- Divisional Accounts manager. (DAM)
- District Accounts Manager. (DAM)
- Deputy CMO.
- Block Accounts Manager. (BAM) (n=1)
- Monitoring and Evaluation Officer (MEO) (n=2)
- Program Manager (PM) (n=2).
- Medical Officer Incharge of PHCs. (n=2)
- Stakeholder were interviewed for the following purpose
    1) To get information about the fund flow mechanism from state to district and to lower level of service delivery system.
    2) To assess the implementation of the scheme and adaptation as per the guideline of JSY.

(2) Programme implementers at community level:-

12 FMPHW's/ ANM and 22 ASHA's of the selected villages

At village level:- Recently delivered beneficiaries (Those who have delivered within the last one year).A total of 349 beneficiaries were interviewed during the entire study period.

Evaluation:-

The study was completed under two components:-

1) The institutional service providing component, that is, the working pattern of the sub-centre, the functioning of service provider ASHA and its controlling authority such as sub-centre in- charge

(ANM) and zonal medical officer, Block Evaluation and medical officer, programme manager at the block, district and divisional level.

2) Evaluation of the beneficiary:-

   Actual services received by the beneficiary, by way of service coverage of the target population in the sub-centre area and by assessing Knowledge and utilization.

Study Tools:- Five different questionnaire (close and open ended) were used in the study.

1) Questionnaire for beneficiaries.
2) Questionnaire for ASHA
3) Questionnaire for ANM/ FMPHW
4) Proforma for In charge NRHM at PHC
5) Proforma for Programme implementers at block, district and division office, NRHM.

Method of Data Collection

Primary and Secondary data sources were used for data collection.

Primary data was collected from all the women who had delivered in the previous one year from all the villages of selected sub centres at the time of evaluation. House to house visits were done and eligible women were interviewed after taking informed consent.

For secondary data, Sub-centres was visited for scrutinizing the records regarding MCH activities for the last one year. Besides, available records regarding the operational mechanism and utilization of the services under JSY at PHC, CHC, district and block level were collected.

Data were collected from various service providers and beneficiaries using pretested semi-structured questionnaire.

Data Analysis:- Data was entered in Microsoft Excel (2007) and was analysed after generating frequency tables using SPSS 16.0 Results were expressed in proportion.

The findings of beneficiaries from sub centres area of three block who had delivered within one year of the study period are presented.

Background information of mothers.

Table 1: Age distribution of recently delivered women in selected Sub centres

Age of JSY beneficiaries in completed years	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
< 20	5	2.8	5	6.2	1	1.1	11	3.1
20 -25	50	27.6	22	27.5	12	13.6	84	24.0
25- 30	81	44.8	28	35.0	49	55.7	158	45.2
30- 35	36	19.9	15	18.8	24	27.3	75	22
35 – 40	9	5.0	10	12.5	2	2.3	21	6.0
Total	181	100	80	100	88	100	349	100
Mean age (in years)	28.2		29.2		29.2			

Mean age of the women was 28.2 years for Hazratbal block and 29.2% for Ompora and Pampore block. Most (45.2%) of the women were aged between 25- 30 years followed by 24% in the age group of 20- 25 year. Only 6 percent of the mothers were found to be older than 35 years across all the block.

Table 2: Literacy status of studied women

Level of Education	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
Illiterate	151	83.5	59	73.8	52	59.1	262	75.0
Primary (5th standard)	8	4.5	8	10	7	7.9	23	7
Middle (8th standard)	13	7.2	7	8.7	13	14.8	33	9.4
High school(10th standard)	4	2.2	4	5	13	14.8	21	6.0
Higher secondary(11-12th standard)	5	2.8	2	2.5	3	3.4	10	3
Total	181	100	80	100	88	100	349	100

Majority of the women were illiterate (75 %). It was highest for block Hazratbal (83.5%). Only 3% had studied up to higher secondary level.

The proportion of women belonging to Below Poverty Line (BPL) accounted for 16.9 %. Antodaya Ann Yojna (AY) constitutes 0.9% in Aabidal area of block Hazratbal, Srinagar.

Table 3: Percentage distribution of recently delivered women as per monthly income of the family

Income of the family/ month	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
< 5000	100	55.2	31	38.8	16	18.2	147	42.1
5001-10000	74	40.9	30	37.5	36	40.9	140	40.1
10001- 20000	3	1.7	8	10	22	25.0	33	9.4
20001 – 30000	4	2.3	11	13.6	10	11.3	25	7.1
30001 – 40000	0		0	0	4	4.5	4	1.1
Total	181	100	80	100	88	100	349	100

Regarding the income, 42.1% of the women had their family income less than 5000, 40.1% between 5001- 10,000, while 9.4% had their income between 10,001- 20,000, 7.1% 20,001 – 30,000 and only 1.1% > 30,000

Table 4: Recently delivered women who ever heard about JSY

Heard about JSY	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	N	%	n	%	n	%
Yes	162	89.5	80	100	88	100	330	95.5
No	19	10.5	0	0	0	0	19	4.5
Total	181	100	80	100	88	100	349	100

Out of total 349 women, 95.5% had heard about JSY.

Table 5: Source of information about JSY

Source of information about JSY (n=330)	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	N	%	n	%	n	%
ASHA	130	80.2	78	97.5	48	55	256	77.5
AWW	8	4.9	0	0	0	0	8	2.4
ANM	16	9.8	1	1.2	8	9	25	8
Others*	8	4.9	1	1.2	32	36.3	41	12.4
Total	162	100	80	100	88	100	330	100

***** Relative, friends, radio, TV etc.

Major source of information came from ASHA (77.5%) followed by other sources like TV, radio, friends and relatives (12.4%) and ANM (8%)

Table 6: Time when the beneficiary heard about JSY

Time when heard about JSY (n=330)	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
Before pregnancy	115	63.5	49	61.3	45	51.1	209	63.3
During pregnancy	47	26	31	38.7	43	48.8	121	37
Total	162	100	80	100	88	100	330	100

63.3% heard about the scheme before pregnancy and 37 % during pregnancy.

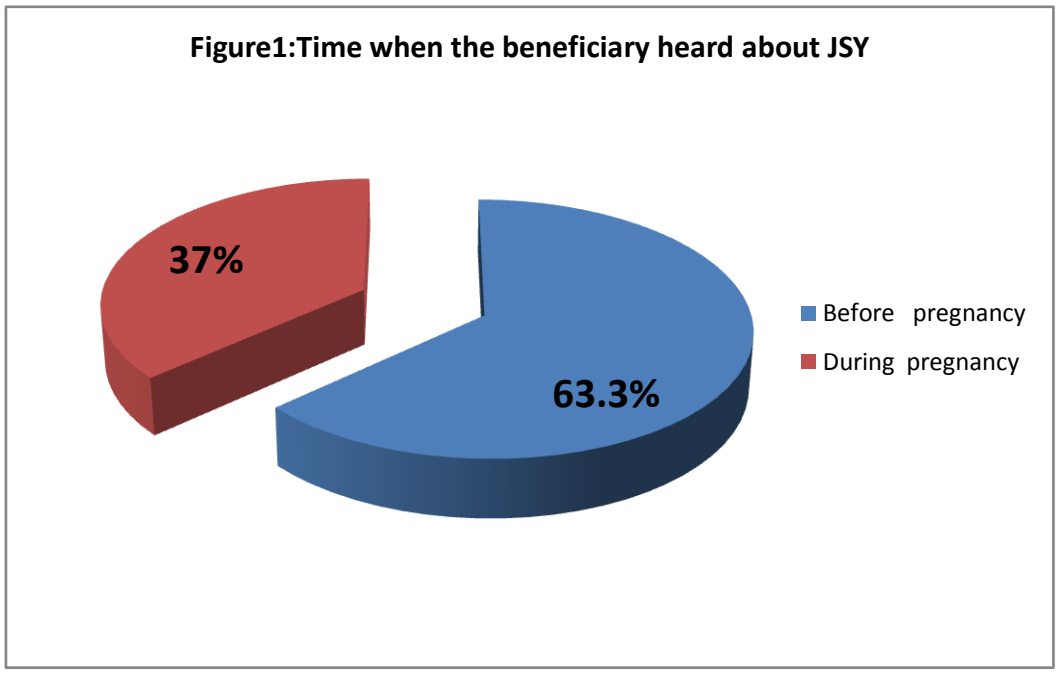


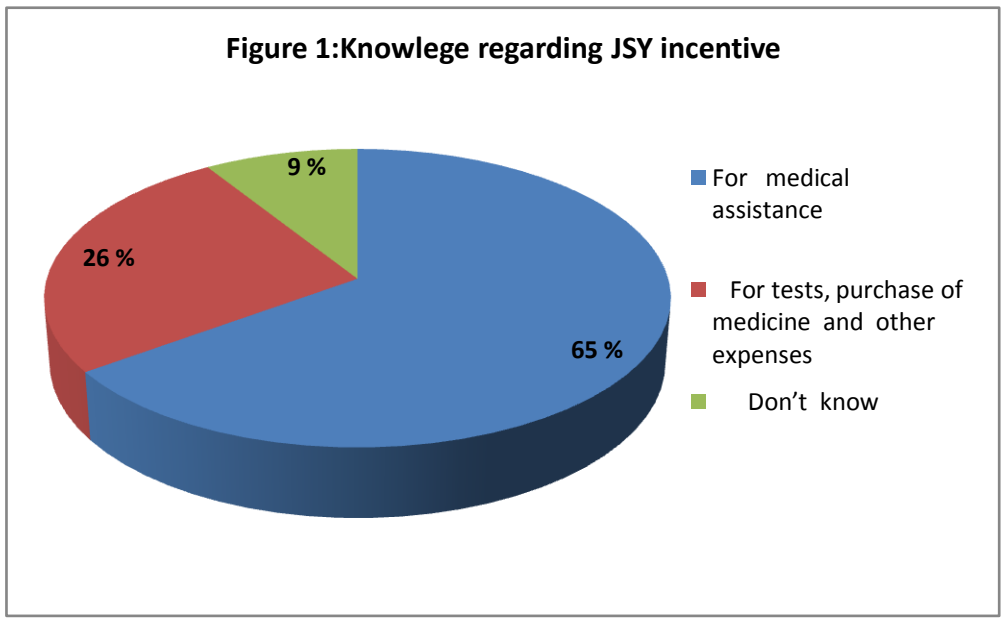
Table 7: Knowledge of women regarding the various component of JSY

Knowledge about JSY	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
ASHA to facilitate them	51	28.1	8	10	3	3.3	62	18
Money is paid for transportation of pregnant females to the health facility at the time of delivery	0	0	0	0	0	0	0	0
Money is given to mothers for delivering in government institution	130	71.8	72	90	85	96.6	287	82.2
Postnatal services are provided	0	0	0	0	0	0	0	0
Total	181	100	80	0	88	100	349	100

82.2% stated that money is being paid for delivering in the hospital while 18% opined that a post of health worker, ASHA has been created to help the women. None of the beneficiaries were aware about other aspects like provision of transportation cost in going to hospital at the time of delivery and care during postnatal period.

Table 8: Purpose of providing cash assistance as perceived by beneficiaries

Main purpose for which money is being given in JSY	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
For medical assistance	80	44.1	73	91.2	74	84	227	65
For tests, purchase of medicine and other expenses	71	39.2	6	7.5	14	15.9	91	26
Don't know	30	16.5	1	1.2	0	0	31	9
Total	181	100	80	100	88	100	349	100



Most of the women (65%) felt that money is being given for maintenance of mother and child health at the time of delivery. While 26% opined that it is given for expenses for Drugs, tests and intake of nutritious food at the time of delivery. 9% had no idea about the money being provided under the scheme.

Table 9: Percentage distribution of women as per registration

Particular		Block						Total	
		Hazratbal		Ompora		Pampore			
		n	%	n	%	n	%	n	%
Time of registration/ Stage of pregnancy when women got registered for JSY	1st trimester	136	75.1	79	98.8	87	98.9	302	86.5
	2nd trimester	45	24.7	1	1.2	1	1.1	47	13.4
	3rd trimester	0	0	0	0	0	0	0	0
	Total	**181**	**100**	**80**	**100**	**88**	**100**	**349**	**100**
Person who did registration	Doctor	143	79.1	3	3.8	0	0	146	41.8
	ANM	34	18.8	76	95	76	86.3	186	53.2
	ASHA	2	1.1	1	1.2	12	13.6	15	4.2
	Others*	2	1.1	0	0	0	0	2	.5
	Total	**181**	**100**		**100**	**88**	**100**	**349**	**100**
Place where respondent was registered	District hospital	45	24.8	2	2.4	0	0	47	13.4
	Sub district hospital	2	1.1	1	1.2	0	0	3	.8
	PHC	32	17.9	0	0	0	0	32	9.16
	Subcentre	97	53.5	77	96.2	88	100	262	75
	Others**	5	2.7	0	0	0	0	5	1.4
	Total	**181**	**100**	**80**	**100**	**88**	**100**	**349**	**100**

**LHV, **AWC, private clinic and hospital*

Table 9 depicts process of registration of women under JSY.

Majority of women (86.5%) got registered themselves in 1st trimester of pregnancy and 13.4% in 2nd trimester. 53.2% of women were registered by ANM and doctor did registration in 41.8% of women while a meagre amount (4.2%) got registered with the help of ASHA.

Regarding the place of registration, 75% were registered at sub-centre, 13.4% at District hospital followed by 9.16% and 8% at PHC and Sub - district hospital respectively.

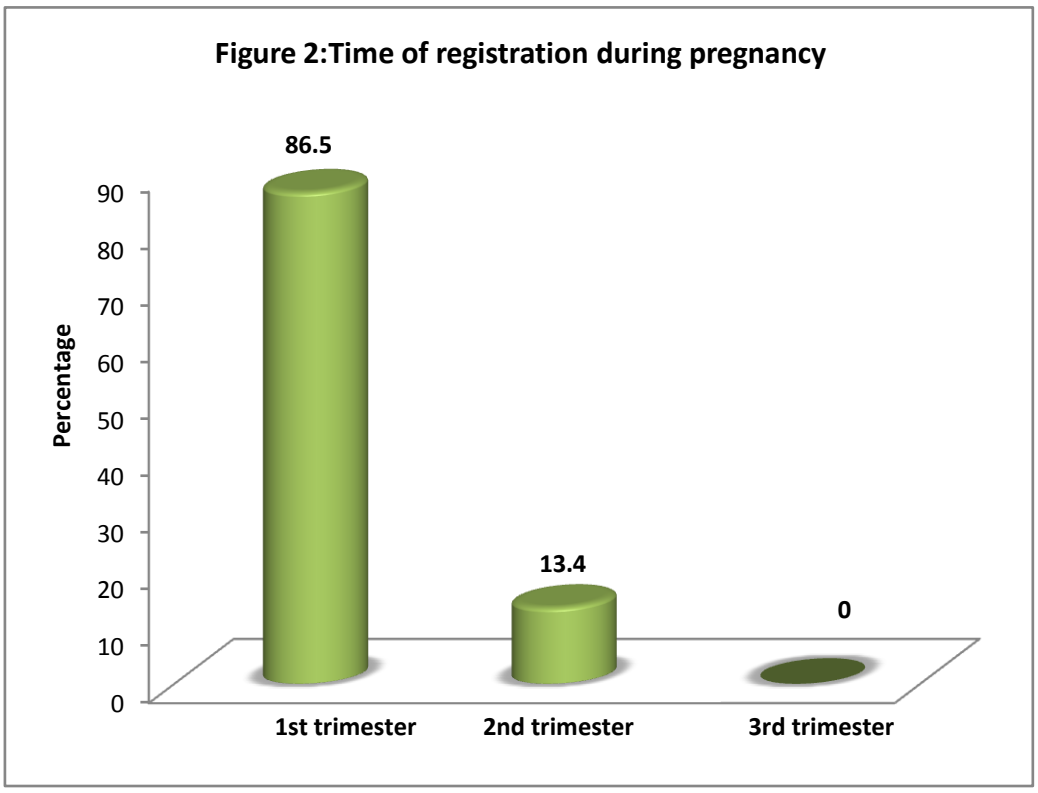


Table 10: Number of home visit paid by the health worker during antenatal period.

No of visit by Health worker	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
One time	110	60.7	50	62.5	60	68.1	220	63
Twice/thrice	40	22	20	25	16	18.1	76	22
Many times	31	17.1	10	12.5	12	13.6	53	15
Total	181	100	80	100	88	100	349	100

63% of recently delivered women were visited only once, 22% twice or thrice and only 15% were visited many times by health worker during pregnancy.

Table 11: Number of facility based antenatal check up underwent by the studied women (%)

Number of times antenatal check up was done	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	N	%
Not done	0	0	0	0	0	0	0	0
Twice	1	.6	1	1.2	1	1.1	5	1.4
Thrice	3	1.7	9	11.2	8	29.1	29	8.4
Four and more	177	97.8	70	87.4	79	89.8	315	90.2
Total	181	100	80	100	88	100	349	100

Out of total 349 recently delivered women, 90.2% had more than four antenatal check up. It was highest (97.8%) for block Hazratbal. 1.4% had done antenatal check up twice which is less than the minimum recommended antenatal visit.

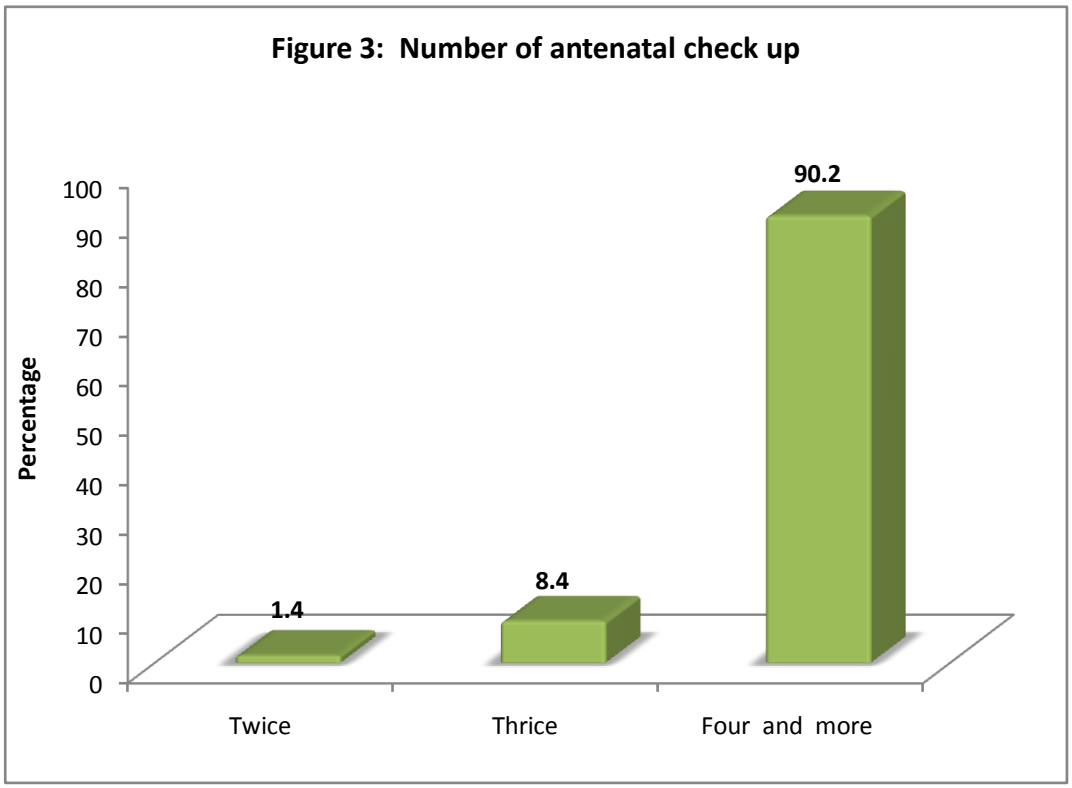


Table 12: Studied women as per the place of antenatal check up (%)

Place of antenatal check up	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	N	%
District hospital	20	11.0	0	0	3	3.4	23	6.59
CHC	11	6.0	0	0	0	0	11	3.15
PHC	22	12.1	2	2.5	20	22.7	44	12.6
S/C	114	62.9	78	97.5	60	68.18	252	72.2
Others*	14	7.7	0	0	5	5.6	19	5.4
Total	181	100	80	100	88	100	349	100

**Private hospital and clinic*

Majority(72.2%) had antenatal check-up at sub centre followed by 12.6% at PHC and only 6.59% and 3.15 % at district hospital and CHC respectively. 5.4% did their check up at Private hospital and clinic.

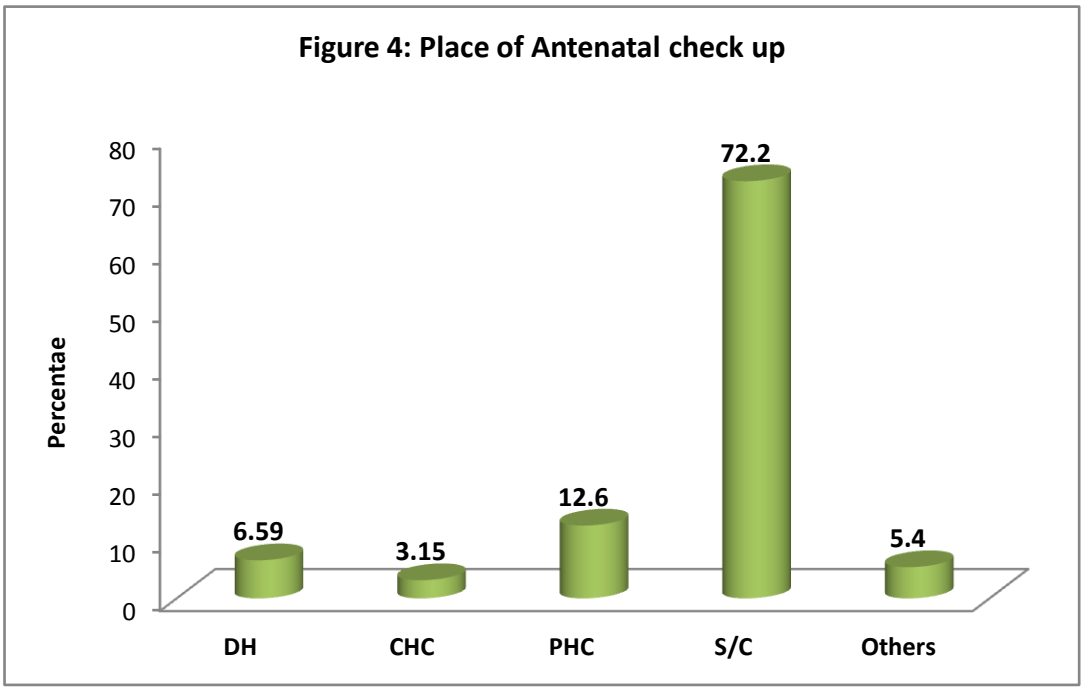


Table 13: Studied women as per the weight measurement during Antenatal visit

Weight measurement	Block						Total	
	Hazratbal		Ompora		Pampore			
	n=80	%	n=30	%	n=60	%	n	%
At every visit	35	43.7	12	40	20	33.3	67	39.4
occasionally	45	56.2	18	60	40	66.6	103	60.5

Weight measurement at every visit was done for only 39.4% of women and it was highest for Hazratbal block while weight were checked occasionally during antenatal visit in 60.5% cases.

Table 14: Frequency of Blood pressure check up during antenatal period.

BP taken	Block						Total	
	Hazratbal		Ompora		Pampore			
	n=101	%	n=50	%	n=28	%	n	%
At every visit	90	89.1	40	80	21	75	151	84.3
occasionally	11	10.8	10	20	7	25	28	16

Majority (84.3%) had their Blood Pressure checked at every antenatal visit while 16% had occasional check up.

Table 15: Recently delivered women as per the administration of Tetanus Toxoid

Number of Tetanus Toxoid received	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
Twice	154	85	78	97.5	81	92	313	89.6
Booster	27	14.9	2	2.4	7	8	36	10.5

89.6% of beneficiaries received two doses of Tetanus toxoid injection and 10.5% received booster dose

Table 16: Source and consumption of IFA tablets during pregnancy (%)

Particular		Block						Total	
		Hazratbal		Ompora		Pampore			
		n	%	n	%	n	%	n	%
Source of IFA tablets	Government	119	65.7	77	96.2	86	97.7	282	81
	Private	62	34.2	3	3.7	2	2.2	67	19
	Total	**181**	**100**	**80**	**100**	**88**	**100**	**349**	**100**
Consumed 100 Iron Folic Acid	Yes	149	82.3	76	98.8	76	86.3	301	86
	No	32	17.7	4	1.2	12	13.6	48	14
	Total	**181**	**100**	**80**	**100**	**88**	**100**	**349**	**100**

81% got tablets from government health centres while 19% had to purchase from private clinic. 86% consumed recommended Iron Folic acid tablets i.e., 100 tablets while 14% did not.

Table 17: Distribution as per the complication during antenatal period

Complication during pregnancy	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
Yes	40	22.0	8	10	22	25	70	20
No	141	77.9	72	90	66	75	279	80
Total	181	100	80	100	88	100	349	100

Out of the total 349 women 20% had one or other complication during pregnancy. It was highest for block Hazratbal.

Table 18: Recently delivered women as per the place and mode of delivery (%)

Particular		Block						Total	
		Hazratbal		Ompora		Pampore			
n=349		n	%	n	%	n	%	n	%
Beneficiaries by place of delivery	PHC	12	6.62	10	12.5	9	10.2	31	9
	CHC and district hospital	20	11	35	43.7	23	26.1	78	22.3
	Tertiary care Hospital	125	69	25	31.2	50	56.8	200	57.3
	Private hospital	20	11.0	8	10	6	6.8	34	9.7
	Home	4	2.2	2	2.5	0	0	6	1.8
	Total	**181**	**100**	**80**	**100**	**88**	**100**	**349**	**100**
Type of delivery	Normal	65	36	41	51.2	40	45.4	146	41.8
	Caesarean	115	63.5	39	48.7	48	54.5	202	58
	Assisted vaginal delivery	1	.6	0	0	0	0	1	0.2
	Total	**181**	**100**	**80**	**100**	**88**	**100**	**349**	**100**

Majority of the delivery (57.3%) took place at tertiary care hospital. 9% at PHC and 22.3% at CHC and district hospital. Private hospital accounted for 9.7% and home delivery occurred in 1.8% cases. Out of total 349 studied women, majority had caesarean section (58%). Mode of delivery was normal in 41.8% cases. Only a meagre proportion of deliveries (0.2%) were reported having assisted vaginal delivery i.e., vacuum.

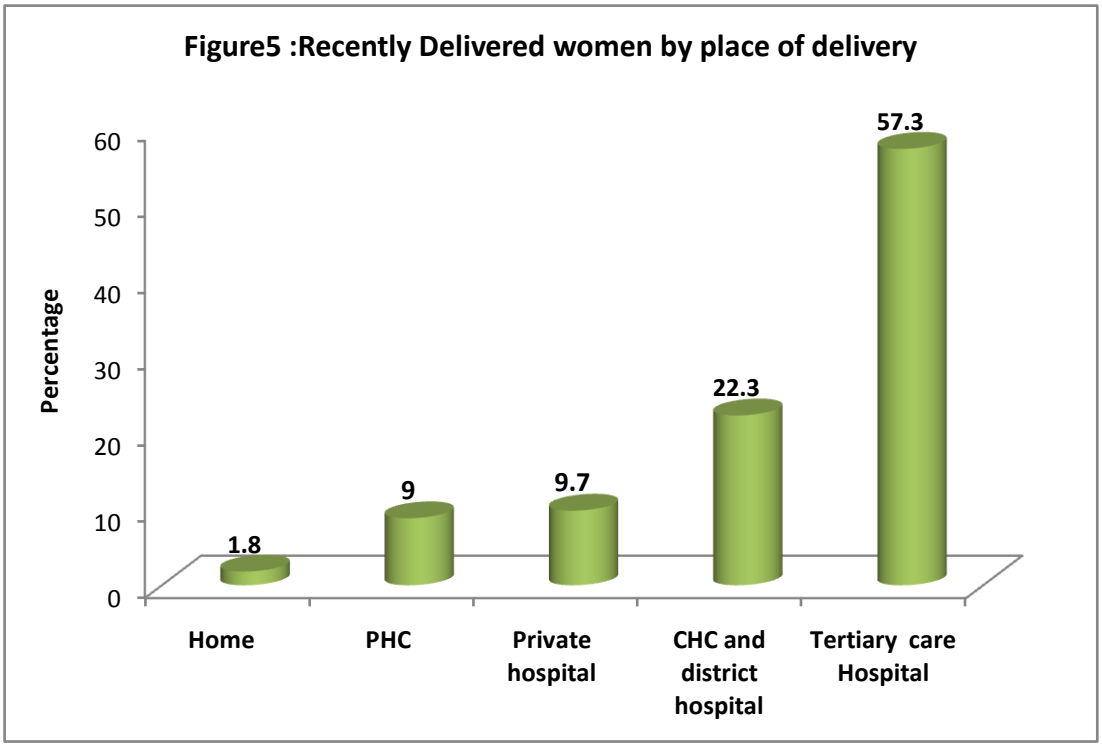


Figure5 :Recently Delivered women by place of delivery
Percentage
60
50
40
30
20
10
0
1.8
9
9.7
22.3
57.3
Home
PHC
Private hospital
CHC and district hospital
Tertiary care Hospital

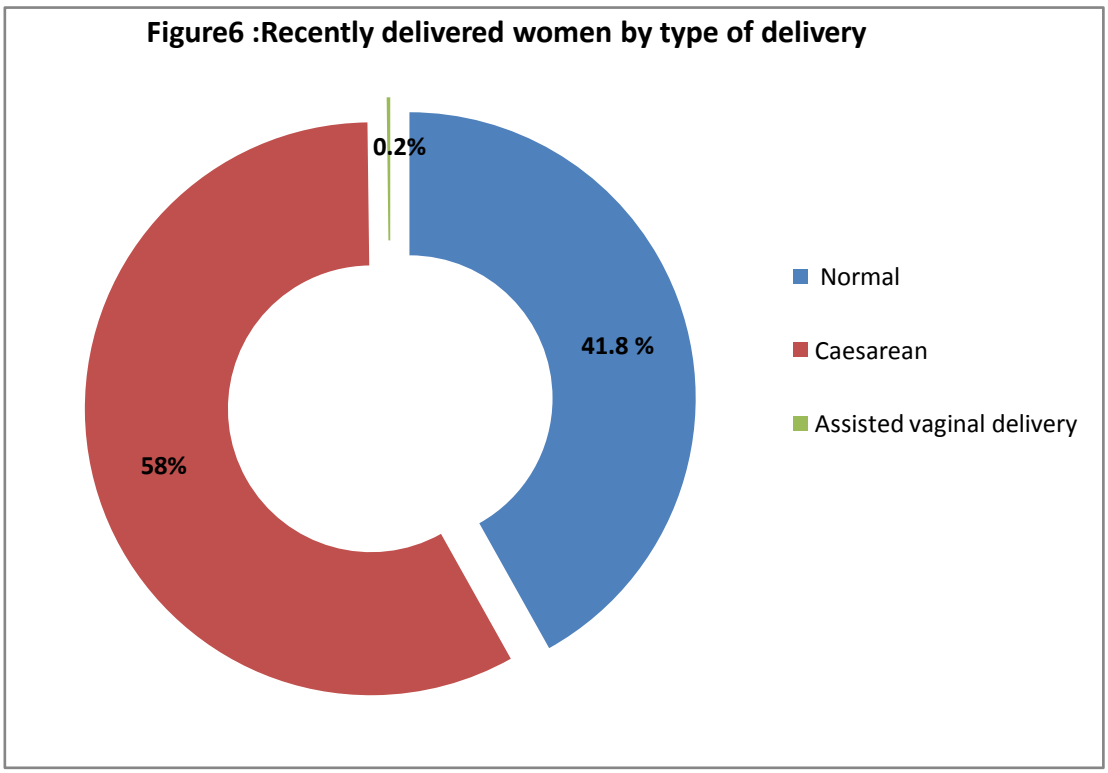


Figure6 :Recently delivered women by type of delivery
0.2%
41.8 %
58%
Normal
Caesarean
Assisted vaginal delivery

Table 19: Source of motivation for institutional delivery (%)

Motivation for institutional delivery*	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
ASHA	80	44.1	58	72.4	65	73.8	203	58.1
AWW	4	2.2	0	0	2	2.27	6	2
ANM	40	22	8	10	9	10.2	57	16.3
Doctor	53	29.2	14	17.5	3	3.40	70	20
Others*	4	2.2	0	0	9	10.2	13	3.7
Total	181	100	80	100	88	100	349	100

**others: relative, friend and neighbour, TV, Radio etc*

ASHA were the source of motivation(58.1%) followed by doctor in 20% cases and ANM (16.3%) while 3.7% cases got motivated through other channels like TV, radio, friends, relative. 2% of women were motivated by AWW.

Table 20: Reason for opting institutional delivery among studied women

Reasons for opting institutional delivery	Block						Total	
	Hazratbal n= 177		Ompora n = 78		Pampore			
	n	%	n	%	n	%	n	%
Money available under JSY	46	25.4	10	12.8	20	22.7	76	22.1
Better access to institutional delivery	25	13.8	0	0	0	0	25	7.2
Better care for mother and child	52	28.7	63	80.7	47	53.4	162	47.2
Support provided by ASHA	40	22	5	6.4	15	17	60	17.4
Previous child was born in an institution	14	7.2	0	0	6	6.8	20	5.8
Total	177	100	78	100	88	100	343	100

Safety of the mother and child (47.2%), money available under JSY (22.1%), support provided by ASHA (17.4%), access to institutional delivery (7.2%) were the main motivating factor for opting institutional delivery. 5.8% had their previous child born in an institution and so had good experience about the past pregnancy.

Table 21: Reason for not opting institutional delivery (%)

Reasons for women to deliver at home.	Block						Total	
	Hazratbal		Ompora		Pampore			
	n =4	%	n=2	%	n	%	n	%
No nearby institution for delivery	0	0	1	1.2	0	0	1	17
Nobody to take care of my family	2	50	0	0	0	0	2	33.3
Untimely delivery	2	50	1	1.2	0	0	3	50
Total	4	100	2	100	0	0	6	100

Out of the 6 women who delivered at home, the main reason were untimely delivery for 50% of women. 33.3% of the women had nobody to look after the family. Inaccessibility of institution was reported by 17% of women

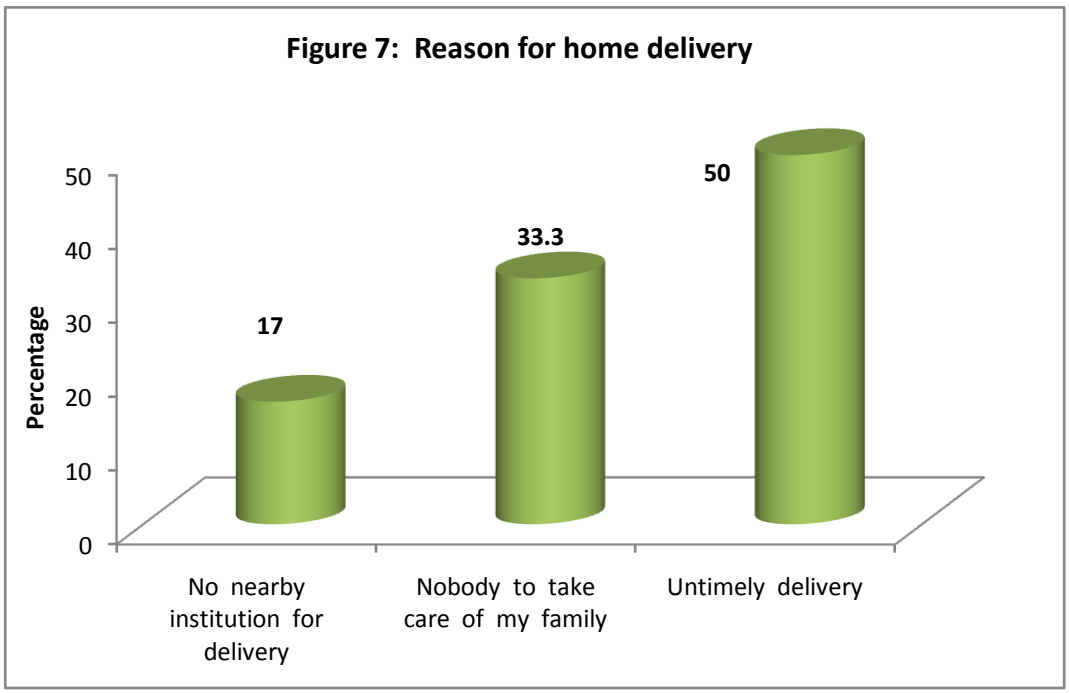


Table 22: Percentage of women by outcome of delivery

Outcome of delivery	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
Live born	180	99.4	79	98.8	88	100	347	99.4
Still born	1	0.6	1	1.2	0	0	2	0.5
Total	181	100	80	100	88	100	349	100

Out of the total studied women, 99.4% had live born babies while 0.5% had still born babies one each in block Hazratbal and Ompora respectively.

Table 23: Number of days women stayed at the hospital at the time of delivery

No of days stayed in the institution	Block						Total	
	Hazratbal		Ompora		Pampore			
	n=177	%	n=78	%	n	%	n	%
One day	17	9.6	40	51.2	29	32.9	86	25
2-3 days	67	37.8	14	17.9	26	29.5	107	31.1
3- 4 days	93	52.5	24	30.7	33	37.5	150	44
Total	177	100	78	100	88	100	343	100

Table 23 depict the number of days women stayed at the institution at the time of delivery. 31.1% of the mothers reported staying from 2-3 days. While 44 % stayed for a period of 3-4 days. 25% stayed for one day against the norm of minimum stay of 2 days.

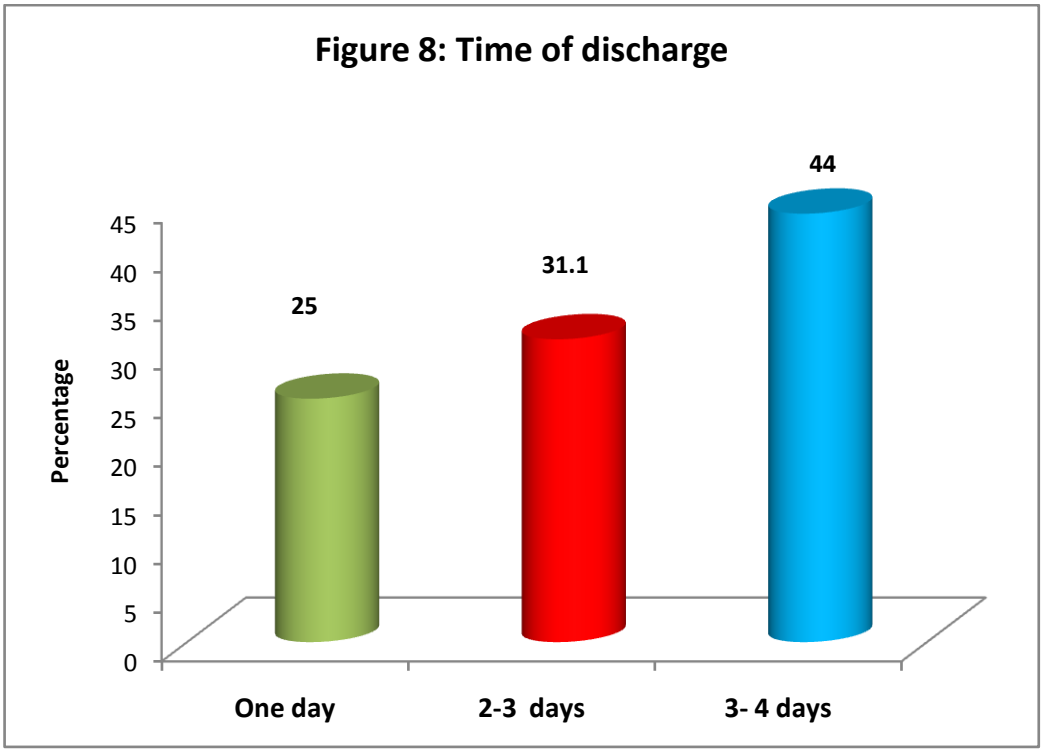


Table 24: Distribution as per the quality of service available at the place of delivery

Particular n= 343		Block						Total	
		Hazratbal		Ompora		Pampore			
		n=177	%	n=78	%	n	%	n	%
Promptness in attending the patient	Immediate	130	73.4	73	93.5	82	93.1	285	83
	delayed	47	26.5	5	6.4	6	6.8	58	17
	Total	**177**	**100**	**78**	**100**	**88**	**100**	**343**	**100**
Person who conducted the delivery	Doctor	170	96	72	92.3	71	80.6	313	94
	Others *	7	3.9	6	7.6	7	7.9	20	6
	Total	**177**	**100**	**78**	**100**	**88**	**88.5**	**333**	**100**
Overall facility	Good	80	45.1	74	94.8	88	100	242	71
	Poor	97	54.8	4	5.1	0	0	101	29.4
	Total	**177**	**100**	**78**	**100**	**88**	**100**	**343**	**100**
Whether satisfied with the services provided at the institution	Yes	90	50.8	70	89.7	88	100	258	73
	No	87	49.1	8	10.2	0	0	95	27
	Total	**177**	**100**	**78**	**100**	**88**	**100**	**353**	**100**
Reasons for no satisfaction	Rude staff	20	22.9	3	37.5	0	0	23	24.2
	Poor quality of service**	67	77	5	62.5	0	0	72	76
	Total	**87**	**100**	**8**	**100**	**0**	**0**	**95**	**100**

**others: Nurse, ANM **Poor quality of service: No cleanliness.*

Sharing of bed (overcrowding), poor toilet and poor food facility. 83% of women were attended in less than half an hour. Doctors conducted deliveries in 94% and 6% were attended by ANM and nurses. overall facility like cleanliness in and around the hospital, good attitude of the staff, counselling services for immunization, breast feeding, family planning was satisfactory for 71% of respondents while 29.4% felt that toilet facility was poor. Overall 73% of the women were satisfied with the services provided at the hospital but dis satisfaction was reported by 27%. The reasons were rude attitude of the health staff (24.2%) and poor quality of service (76%) like poor toilet and food facility, lack of cleanliness and overcrowding of patients.

Table 25: Distribution of women as per the receipt of incentive

Receive the incentive	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
Yes	136	75.1	49	61.2	59	67	244	70
No	45	24.9	31	38.7	29	32.9	105	30
Total	181	100	80	100	88	100	349	100

Table 25 present the distribution of women as per the receipt of JSY incentive. 70% had received incentive at the time of study while 30% did not received any incentive.

Table 26: Time of receipt of incentive by beneficiaries (%)

Time of receipt of incentive (n=70)	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
At the time of discharge	7	5.1	0	0	2	3.3	9	3.6
Within a week after discharge	7	5.1	5	10.2	4	6.7	16	6.5
More than a week after discharge	122	89.7	44	89.7	53	89.8	219	90
Total	136	100	49	100	59	100	244	100

Among the women who received the monetary incentive (70%), further probing was done to know about the timing of receipt of incentive. Most of the women (90%) got money more than a week after discharge ranging from 15 days to 9 months. 6.5% got money within a week after discharge and only a meagre proportion of 3.6% was paid at the time of discharge as per the guidelines.

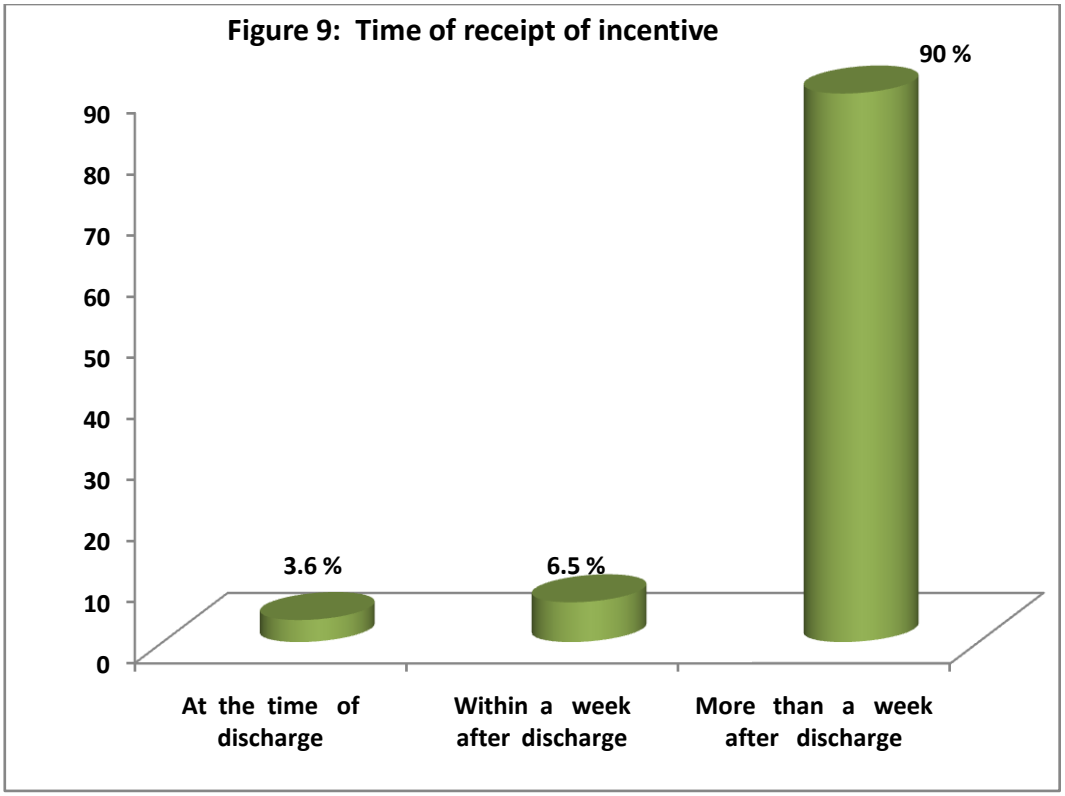


Table 27: Amount received as incentive by women

Total amount received (in Rs)	Block						Total	
	Hazratbal		Ompora		Pampore			
	n=136	%	n=49	%	n=59	%	n	%
1000	39	28.6	5	10.2	30	50.8	74	30.3
1400	93	68.3	42	85.7	29	49.1	164	67.2
500	4	2.9	2	4	0	0	6	2.1
Total	136	100	49	100	59	100	244	100

67.2% of the mothers who delivered in government institution received Rs 1400/- and Rs 1000 by 30.3% while all the beneficiaries (2.1%) who had home delivery got Rs 500 as incentive. None of the woman who delivered at private facility received the incentive.

Table 28: Recently delivered women by place of receipt of incentive

Particular	Block						Total	
	Hazratbal		Ompora		Pampore			
	n=136	%	n=49	%	n=59	%	n	%
At CHC/ PHC	28	20.5	5	10.2	25	42.3	58	23.4
At home	4	2.9	2	4	0	0	6	2
At district hospital	97	71.3	42	85.7	30	50.8	169	68.4
Sub centre	7	5.1	3	6.1	4	6.7	14	6

Majority (68.4%) of the women received money at district hospital and 23.4% got incentive at CHC/PHC while 6% got their payment at sub centre. 2% of the women who had home delivery got incentive at home.

Table 29: Problem faced by women regarding the receipt of incentive

Difficulties faced in receiving money	Block						Total	
	Hazratbal		Ompora		Pampore			
	n=22	%	n=28	%	n=6	%	n	%
Had to Make several contacts *	17	77.2	8	28.5	2	33.3	27	48.2
Others**	5	22.7	20	71.4	4	66.6	29	52
Total	**22**	**100**	**28**	**100**	**6**	**100**	**56**	**100**

** delay in disbursement, payment at other places ** Had to make informal payment, had to wait for many months.*

Regarding the experience in getting money, out of 244 women, 57 women faced problem in getting the amount. 52% had to make informal payment and had to wait for several months. 48.2% had to make several contacts due to delay in disbursement and payment at other places.

Table 30: Person who disburse the cheque for the beneficiaries

Person who disburse the money	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
ANM	20	14.7	8	16.3	43	72.8	71	29
Accountant	96	70.5	26	53	9	15.2	131	54
Medical officer	20	14.7	15	30.6	7	11.8	42	17.2
Total	136	100	49	100	59	100	244	100

Accountant/ clerk was the main source of cash disbursement (54%) followed by 29% of women who got money through ANM and 17.2% through medical officer.

Table 31: Mode of transport used to reach the place of delivery (%)

Mode of transportation used to reach the place of delivery	Block						Total	
	Hazrarbal		Ompora		Pampore			
	n=177	%	n=78	%	n=88	%	n	%
Hired vehicle	154	87	62	79.4	65	73.8	281	81.9
Personally owned	14	7.9	7	8.9	13	14.8	34	10
By ambulance	9	5	9	11.2	10	11.4	28	8.1
Total	177	100	78	100	88	100	343	100

81.9% used hired vehicle to reach the place of delivery and 10% by personally owned vehicle. 8.1% got free ambulance service under Janani Shishu Suraksha Karyakaram (JSSK) and it was similar across the entire block.

Table 32: Recently Delivered women by reimbursement for transportation.

Beneficiaries who got reimbursement	Block						Total	
	Hazrarbal		Ompora		Pampore			
	n=177	%	n=78	%	n=88	%	n	%
Yes	136	76.8	49	62.8	59	67	244	71.1
No	41	23.1	29	37.1	29	32.9	99	29
Total	177	100	78	100	88	100	343	100

Out of total beneficiaries (343), 71.1% got reimbursement for transportation while as 29% did not.

Table 33: Distribution as per the distance covered to reach the place of delivery

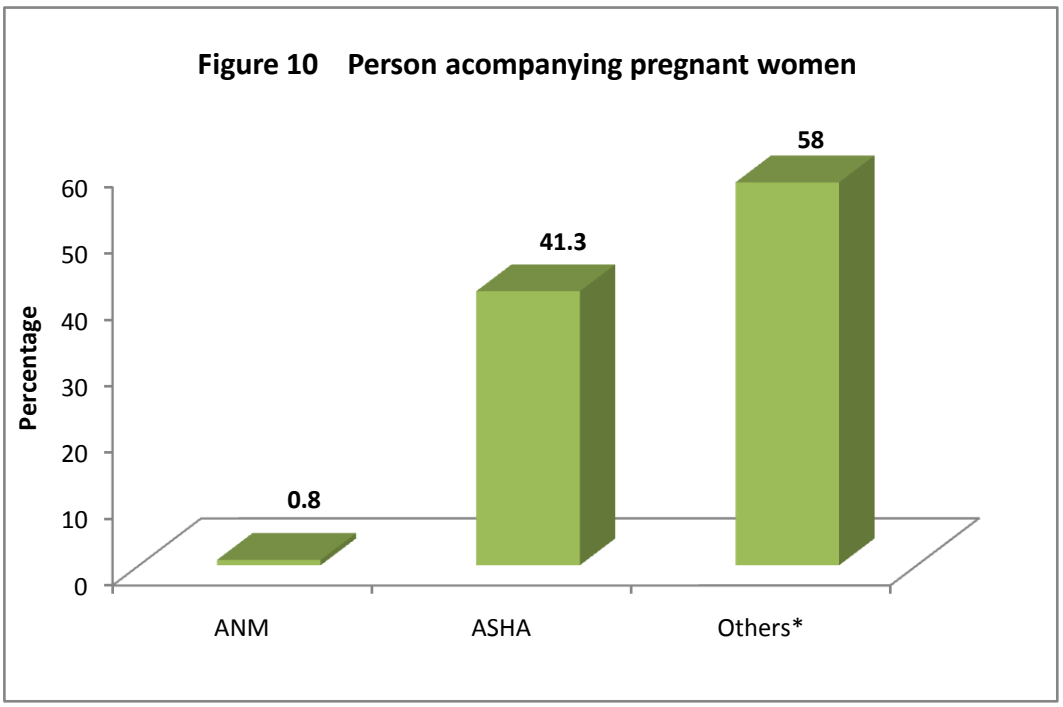
Distance of the place of delivery from residence in km	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
< 5 km	60	33.8	3	3.8	9	10.2	72	21
5-10km	110	62.1	44	56.4	13	14.8	167	48.6
10-20 km	7	3.9	12	15.3	5	5.7	24	6.9
> 20 km	0	0	19	24.3	61	69.3	80	23.3
Total	**177**	**100**	**78**	**100**	**88**	**100**	**343**	**100**

Regarding the distance covered to reach the place of delivery, 48.6% women had to travel a distance of 5-10 km, 6.9% between 10- 20 km. While more than 21% had to cover < 5km and 23.3 > 20 km to reach the institution.

Table 34: Person who accompanied women at the time of delivery

Person who accompanied women at the time of delivery	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
ANM	2	1.1	1	42.3	0	0	3	0.8
ASHA	70	39.5	33	1.2	39	44.3	142	41.3
Others *	105	59.3	44	56.4	49	55.6	198	58
Total	**177**	**100**	**78**	**100**	**88**	**100**	**343**	**100**

**Others: Family members.*



Majority (58%) of the women were accompanied by spouses, mother in law and other family members. ASHA facilitated in arranging transport and accompanied women in 41.3% cases but only few of ASHA stayed with women till delivery. Few of the women (0.8%) were facilitated by ANC.

Table 35: Receipt of BCG vaccination (%)

Received BCG vaccination	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
Yes	179	99	79	98.7	87	99	345	99
No	2	1.1	1	1.2	1	1.1	4	1.1
Total	**181**	**100**	**80**	**100**	**88**	**100**	**349**	**100**

99% had received BCG vaccination at the time of study and 1.1% haven't received vaccination at the time of study.

Table 36: Percentage of women who were visited for postnatal check up

Postnatal check up	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
Yes	53	29.2	21	26.5	48	54.5	122	35
No	128	70.7	59	73.7	40	45.4	227	65
Total	181	100	80	100	88	100	349	100

Only 35% of women were visited by health worker and ASHA during postnatal period.

Table 37: Number of home visits during postpartum period

No of postnatal visit	Block						Total	
	Hazratbal		Ompora		Pampore			
	n=53	%	n=21	%	n=48	%	n	%
Once	35	66	11	52.3	28	58.3	74	61
Twice	15	28.3	7	33.3	15	31.2	37	30.3
Thrice and more	3	5.6	3	14.2	5	10.4	11	9
Total	53	100	21	100	48	100	122	100

Majority of the women(61%) were visited only once during postnatal period. 30.3% were visited twice and only 9% had been visited more than three times for postnatal check up.

Table 38: Studied women who got advice for breast feeding during postnatal period.

Advice for breast feeding	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
Yes	170	93.9	73	91.2	79	89.7	322	92.2
No	11	6	7	8.7	9	10.2	27	8
Total	181	100	80	100	88	100	349	100

Most of the women (92.2%) were counselled about the benefits of breast feeding by Doctor, ANM and ASHA at place of delivery and at sub centre.

Table 39: Women who got advice regarding family planning (%) during postnatal period

Advice for family planning	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
Yes	70	38.6	15	18.7	35	39.7	120	34.3
No	111	61.3	65	81.2	53	60.2	229	66
Total	**181**	**100**	**80**	**100**	**88**	**100**	**349**	**100**

Only 34.3% got advice regarding various family planning methods at the time of delivery and during postnatal period.

ASHA

Table 40: Age profile of ASHA in selected block

Age	Block						Total	
	Hazratbal		Ompora		Pampore			
	n=10	%	n=6	%	n=6	%	n	%
> 20	3	30	0	0	0	0	33	63.4
20- 25	1	10	1	16.7	2	33.3	4	7.6
25-30	4	40	2	33.3	1	16.7	7	13.4
30-35	1	10	3	50	3	50	7	13.4
35-40	1	10	0	0	0	0	1	2
Total **Mean**	**10**	**100**	**6**	**100**	**6**	**100**	**52**	**100** **28.6**

Background characteristics of ASHA

In all 22 ASHA were interviewed across the entire block. Most of the ASHAs (63.4%) were of the age group less than 20years followed by 13.4% in both 25-30 and 30-35 years age group. The mean age of ASHA was 28.6 years.

Table 41: Education profile of ASHA

Education	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	N	%
Middle (8th standard)	6	60	2	33.3	2	33.3	10	45.4
High school(10th standard)	3	30	2	33.3	3	50	8	36.6
Higher secondary (11- 12th standard)	1	10	2	33.3	0	0	3	13.6
Graduate	0	0	0	0	1	16.6	1	4.5
Total	10	100	6	100	6	100	22	100

45.4% of ASHA had read upto middle class, 36.6% upto high school, 13.6% up to high school and only 4.5% had done graduation

Table 42: Distribution of ASHA as per marital status

Marital status	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
Married	5	50	5	83.3	6	100	16	73
Unmarried	5	50	1	16.6	0	0	6	27.2
Total	10	100	6	100	6	100	22	100

Regarding Marital status, most of the ASHAs interviewed were married (73%) while 27.2% were unmarried.

Table 43: Percentage distribution of ASHA as per the year of selection

Year of selection	Block						Total	
	Hazaratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
2005	3	30	0	0	2	33.3	3	15
2006	2	20	4	66.6	2	33.3	8	40
2007	1	10	2	33.3	1	16.6	4	20
2011	4	40	0	0	1	16.6	5	25
Total	**10**	**100**	**6**	**100**	**6**	**100**	**20**	**100**

Less than 15% started working as ASHA in the year 2005. Majority of the ASHA(40%) were selected in the year 2006 followed by 20% in 2007 and 25% were newly selected in 2011.

Table 44: Mode of selection of studied ASHA (%)

Ways got selected as ASHA	Block						Total	
	Hazaratbal		Ompora		Pampore			
	n	%	n	%	n	%	N	%
Approved / selected by village head	5	50	3	50	3	50	11	50
Selected by village health committee	4	40	1	16.7	2	33.3	7	31.8
ANM got me selected	1	10	2	33.3	1	16.7	4	19
Total	**10**	**100**	**6**	**100**	**6**	**100**	**22**	**100**

Most of ASHAs (50%) were selected/ approved by the village head. 31.8% got selected with the help of village health committee and 19% were recommended by ANM.

Table 45: No of villages served by ASHA

Villages served by ASHA	Block						Total	
	Hazaratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
1 Village	0	0	5	83.3	0	0	5	22.7
2 Village	1	10	0	0	3	50	4	18.1
3 Village	6	60	1	16.7	3	50	10	45.4
4 Village	3	30	0	0	0	0	3	14
Total	10	100	6	100	6	100	22	100

45.4 % of ASHA served 3 villages, 14% about 4 villages while 22.7% served only one village.

Table 46: Distribution of ASHA as per Residence

Residence	Block						Total	
	Hazaratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
Same locality	10	100	6	100	5	83.3	21	95.4
Different locality	0	0	0	0	1	16.6	1	5
Total	**10**	**100**	**6**	**100**	**6**	**100**	**22**	**100**

Majority (95.4%) of the ASHA belong to the same locality i.e., sub centre area, while 5% came from nearby villages and town.

Table 47: Population served by ASHA in selected areas.

Population served	Block						Total	
	Hazaratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
1st ASHA	1000	9.25	405	5	716	11.3	2121	9.5
2nd ASHA	1100	10.1	760	9.5	818	12.9	2678	12
3rd ASHA	1150	10.6	887	11.1	950	15	2987	13.4
4 th ASHA	1200	11.1	1300	16.2	1214	19	3714	16.6
5 th ASHA	1674	15.5	2106	26.3	1210	19	4990	22.4
6th ASHA	1800	16.6	2526	31.6	1424	22.4	5750	26
7th ASHA	500	4.6						
8th ASHA	550	5						
9th ASHA	851	7.8						
10th ASHA	975	9						
Total	**10,800**	**100**	**7984**	**100**	**6332**	**100**	**22,240**	**100**
Average	1080		1330		1055		3706	

On an average ASHAs of Hazratbal block served a population of 1080 followed by 1330 and 1055 in Ompora and Pampore block respectively.

Table 48: Percentage distribution as per the training received by ASHA's

Particular		Block						Total	
		Hazratbal		Ompora		Pampore			
		n	%	n	%	n	%	n	%
Received Training regarding JSY	Yes	8	80	6	100	4	66.6	18	82
	No	2	20	0	0	2	33.3	4	18.8
	Total	**10**	**100**	**6**	**100**	**6**	**99.9**	**22**	**99.9**
How many times did you received the training	Module 4&5	2	25	1	16.6	2	50	5	28
	Upto5th module	6	75	5	83.3	2	50	13	72.2
	Total	**8**	**100**	**6**	**100**	**4**	**100**	**18**	**100**

Regarding JSY only 82% received training and 18.8% who were newly selected did not receive any refresher training on JSY. Out of those who received the training, 72.2% had undergone upto 5^{th} modular training while 28% who were newly appointed got training of module 4^{th} &5^{th} .

Table 49: Information provided by ASHA to beneficiaries(%)

Information provided by ASHA*	Block						Total	
	Hazaratbal		Ompora		Pampore			
	Yes	No	Yes	No	Yes	No	Yes	No
Date of expected delivery	10	0	6	0	6	0	22	100
Date of next check up	10	0	6	0	6	0	22	0
Place of referral if complications arise	4	40	0	0	6	100	10	45.4
Emphasize on having baby in institution	10	0	6	0	6	0	22	100

**Multiple response*

Table 49 depicts the various information provided by ASHA to the expectant mother. All the ASHAs inform mothers about the date of next check up, expected date of delivery and about institutional delivery. while only 45.4% tell women about the place of referral in case some complication arise.

Table 50: Services provided by ASHA to pregnant women (%)

Particular*	Block						Total	
	Hazaratbal		Ompora		Pampore			
	Yes	No	Yes	No	Yes	No	Yes	No
Help in registration	10	0	6	0	6	0	22	100
Help in antenatal check up	10	0	6	0	6	0	22	100
Inform about JSY	10	0	6	0	6	0	22	100
Help her in getting the JSY payment	10	0	6	0	6	0	22	100
Arrange transportation at the time of delivery	5	5	4	6	3	7	12	54.5
Accompany her for delivery	4	6	2	8	5	5	11	50
Stay with her at institution at the time of delivery	2	8	0	10	5	5	7	31.8
Provide postnatal services	3	30	2	33.3	3	50	8	36.3
Help in getting immunization	10	0	6	0	6	0	22	100
Advice her on breast feeding	5	5	3	7	6	4	14	100
Counsel her about family planning	3	7	2	8	2	8	7	31.8

***Multiple response*

All the ASHAs identify women in early pregnancy, help them in registration, give information about JSY, provide full range of antenatal services, counsel about breast feeding, motivate mother to undergo institutional delivery and facilitate them for timely immunization of child. Only 54.5% help women in arranging transport at the time of delivery and 50% of ASHAs escort women to place of delivery while only 31.8% stayed with the women during the last one year. Postnatal services are being provided by 36.3% of ASHA. Only 31.8% Counsel Women about family planning in postpartum period.

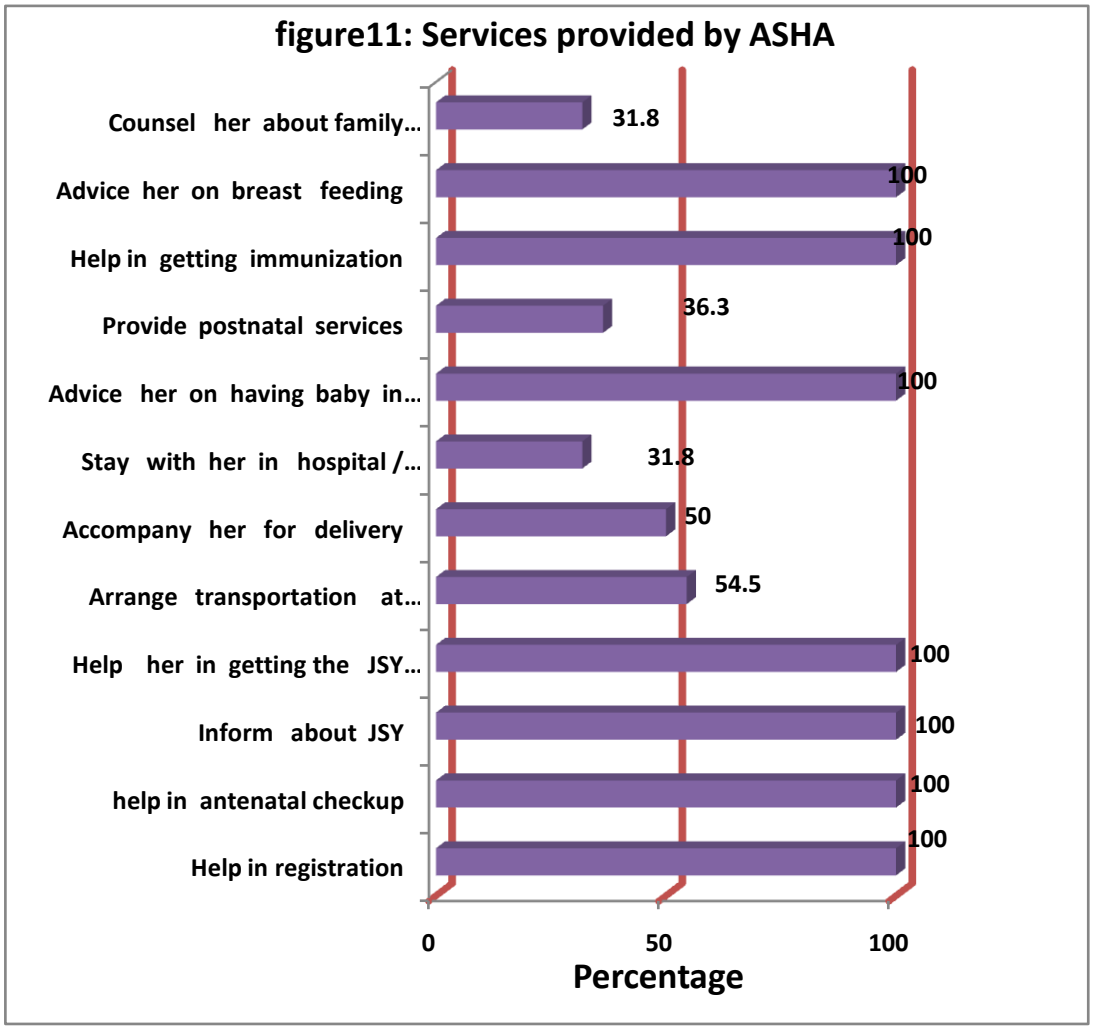


figure11: Services provided by ASHA
Counsel her about family...
Advice her on breast feeding
Help in getting immunization
Provide postnatal services
Advice her on having baby in...
Stay with her in hospital /...
Accompany her for delivery
Arrange transportation at...
Help her in getting the JSY...
Inform about JSY
help in antenatal checkup
Help in registration
31.8
100
100
36.3
100
31.8
50
54.5
100
100
100
100
0
50
100
Percentage

Table 51: Cash remuneration received by ASHA across the entire block.

Particular		Block						Total	
		Hazaratbal		Ompora		Pampore			
		n	%	n	%	n	%	n	%
Received JSY money regularly	Yes	0	0	0	0	0	0	0	0
	No	10	100	6	10	6	100	22	100
ASHA received cash incentive for all the activities	Yes	0	0	6	100	6	100	12	55
	No	10	100	0	0	0	0	10	45.4

All the ASHAs reported that none of them received money on time and they had to make several contacts for getting the money.None of them got money for immunization services and was pending since March 2012.

Table 52: Knowledge of ASHA regarding various component of Mother and child care

Particular*	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
Swelling of hand & feet	6	60	4	66.6	3	50	13	59
Excessive Vomiting	4	40	2	33.3	1	16.6	7	31.8
Weak/no movement of foetus	9	90	5	83.3	5	83.3	19	86.3
Visual disturbance	4	40	3	50	4	66.6	11	50
Excessive bleeding	10	100	6	100	6	100	22	100
Anaemia	8	80	5	83.3	4	66.6	17	77.2
Convulsion	7	70	3	50	3	50	13	59
Abnormal position of foetus	2	20	1	16.6	2	33.3	5	22.7
High fever	3	30	2	33.3	1	16.6	6	27.2
Backache	3	30	3	50	2	33.3	8	36.3

**Multiple responses*

Table 52 shows the knowledge of ASHA regarding the complication during pregnancy. All the ASHAs were knowing bleeding as major complication of pregnancy. 86.3% cited decreased or no movement of the foetus as common complication followed by anaemia (77.2%),convulsion & swelling of hand and feet (59%) visual disturbance (50%) backache (36.3%), excessive vomiting (31.8%), abnormal position of the foetus & high fever (22.7%) as other pregnancy related complications.

Figure12:Knowledge of ASHA about various complication during pregnancy

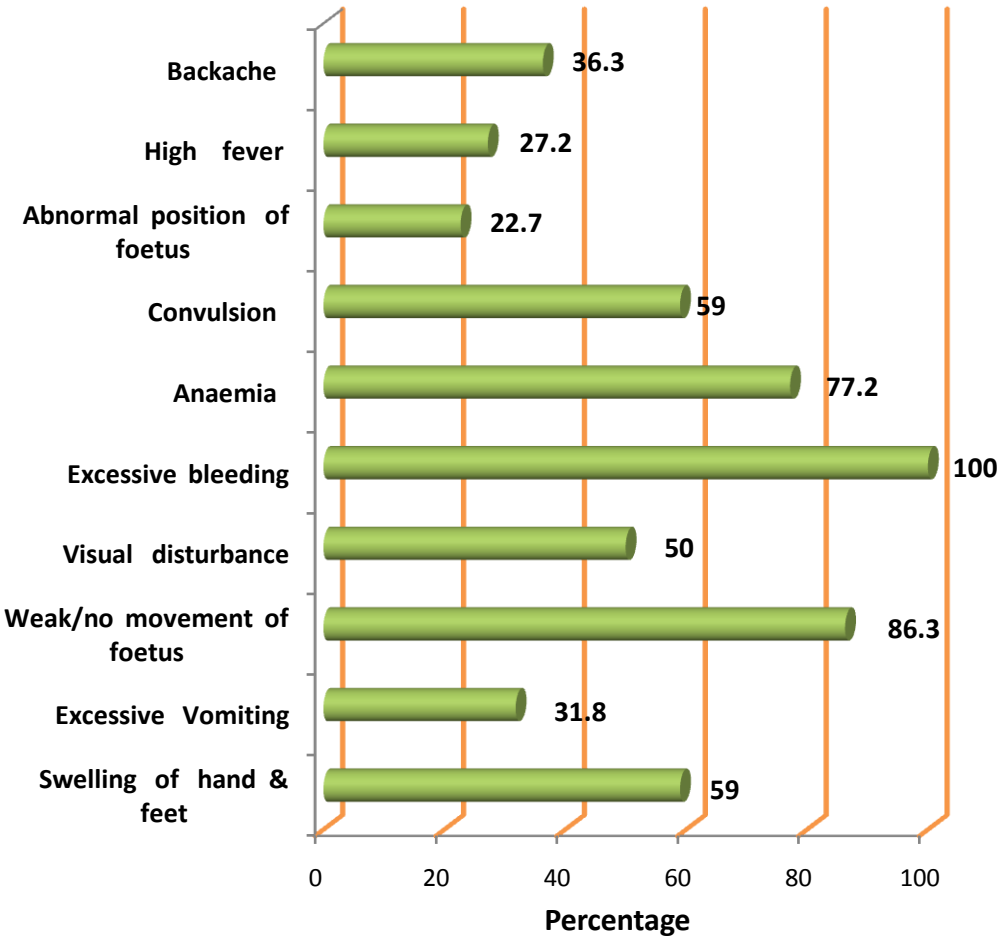


Table 53: Management by ASHA in case of complication among pregnant women

Particular	Block						Total	
	Hazaratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
Immediately refer her to the nearest hospital	3	30	4	66.7	3	50	10	45.4
Ask ANM first	7	70	2	33.3	3	50	12	56
Total	**10**	**100**	**6**	**100**	**6**	**100**	**22**	**100**

45.4% of ASHAs refer the women immediately to the nearest hospital in case of any eventuality. Most of them (56%) seek the advice of ANM first before referring to higher facility.

Table 54: Challenges faced by ASHA

Particular*	Block						Total	
	Hazaratbal		Ompora		Pampore			
	Yes	No	Yes	No	Yes	No	Yes	No
Other ASHAs take away my case	1	9	0	6	1	5	2	9
My family do not support my work	3	7	4	2	3	3	10	45.4
Opposition from beneficiaries in case of delay in receiving incentive	10	0	6	0	6	0	22	100
Rude attitude of the staff at the place of referral.	8	2	5	1	4	2	19	86.3
Opposition from illiterate people in the community	3	7	2	4	1	5	6	27.2
Women are not ready to take IFA tablets	5	5	4	2	4	2	13	59
women do not inform me at the time of delivery	7	3	4	2	3	3	14	63.6
ANM put up much burden	3	7	3	3	2	4	8	36.3

**Multiple response*

Majority of the ASHAs (63.6%) reported that they face a lot of problem in getting incentive. In many cases (59%) women were not ready to take IFA tablets as per the recommended dose. 45.4% reported having little or no support from their family. 36.3% of ASHAs stated that ANM put up their work burden on them at times. 86.3% were dis-satisfied with the rude attitude of health staff at the place of referral especially district hospital where they feel humiliated many times. While in 9% of cases, other ASHA interfere with their work while they were on leave.

Table 55: Person supporting ASHA in her work

Particular	Block						Total	
	Hazaratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
ANM	10	100	6	100	6	100	18	100
AWW	5	50	3	50	2	33.3	8	44.4
PHC staff	10	100	4	66.6	4	66.6	14	77.7
Health and Sanitation committee	7	70	4	66.6	6	100	17	77.2
Official at block level	10	100	6	100	6	100	100	100

44.4 % get support from AWW.77.7 % are being helped by PHC staff.77. 2% are supported by village health and sanitation committee. Few of them get help from NGO and community member.

Table 56: Shortcoming perceived by ASHAs and Suggestion to improve the services

Particular *	Block						Total	
	Hazaratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
Incentive should be more	10	100	6	100	6	100	22	100
Should get monthly payment	7	70	6	100	3	50	16	72.7
Should provide IEC material and fund for role play	5	50	3	50	0	0	8	36.3
Reorientation training from time to time	10	100	6	100	6	100	22	100
Good behaviour of staff at the place of delivery	7	70	4	66.7	3	50	14	63.6
Arrangement for transportation	6	60	5	83.3	4	66.7	15	68.1
Should get regular supply of ASHA kit	8	80	4	66.7	6	100	18	81.8
Facilities for ASHA at the place of delivery	6	60	3	50	4	66.7	13	59

**Multiple Responses*

All the respondents felt that the cash assistance should be more and that they should get reorientation training from time to time to update their knowledge. 81.8% felt that ASHA kit should be adequately and regularly supplied to them as per guideline. 72.7% stated that they should get payment in the form of salary. Need for transportation/ free ambulance service especially in inaccessible area and at odd hours was opined by 68.1% of the respondents. 63.6% of ASHAs felt that they should be treated well at the place of delivery and should get good recognition. 59% suggested of having accommodation facility like "ASHA GREH" for ASHAs at the place of delivery. While 36.3% felt that funds should be provided for better publicity at village level for IEC material and for role play to facilitate the expectant mother.

ANM

Table 57: Percentage distribution of ANM as per the training received under JSY

Particular n= 11		Block						Total	
		Hazratbal		Ompora		Pampore			
		n	%	n	%	n	%	n	%
Received training under JSY	Yes	2	50	2	50	3	100	7	64
	No	2	50	2	50	0	0	4	36.3
	Total	**4**	**100**	**4**	**100**	**3**	**100**	**11**	**100**
Number of times training received	Once	1	50	1	50	1	25	3	43
	Twice	1	50	1	50	2	75	4	57
	Total	2	100	2	100	3	100	7	100

In all 11 ANM were interviewed. 50% of the respondents were appointed under NRHM and 50% under state cadre. 64% received training regarding JSY while 36.3 % did not receive any reorientation training except the induction training. Out of those ANM who got training, 57% had received training twice and 43% only once.

Table 58: Planning of MCH Services by ANM at sub centre

Particular*	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
Estimate women to be registered	4	100	4	100	3	100	11	100
Estimate pregnant women likely to undergo ANC	4	100	4	100	3	100	11	100
Estimate and decide number of women to be taken for delivery	4	100	2	50	2	75	8	72.7
Estimate number of children to be taken for immunization	4	100	4	100	3	100	11	100

**Multiple response.*

All the ANM do proper planning every month like estimating women likely to undergo registration, number of women to be mobilized for antenatal check up and number of target children to be covered every month. 72.7% estimate and decide number of women to be taken for delivery.

Table 59: Antenatal Services provided at sub centre

Services*	Block						Total	
	Hazratbal		Ompora		Pampore			
	Yes	No	Yes	No	Yes	No	n	%
BP Measurement	4	6	4	2	3	3	11	100
Checking of weight at each visit	1	9	2	4	1	5	4	36.3
Timely and adequate supply of IFA	0	10	0	6	2	4	2	18.1
Provide Tetanus Toxoid injection	4	6	4	2	3	3	11	100
Counsel women about breast feeding	4	6	4	2	2	4	10	90.9
Counsel women about family planning	1	9	1	5	2	4	4	36.3
Urine test	0	10	0	6	0	6	0	0
Haemoglobin estimation	0	10	0	6	0	6	0	0
Abdominal examination	2	8	3	3	2	4	7	63.6

**Multiple response.*

All the ANM stated that the beneficiaries are provided Injection Tetanus toxoid. Blood pressure is checked at every visit, 90.9% counsel women about breast feeding. Equal proportion of ANM (36.3%) counsel beneficiaries about family planning and record weight. Iron and folic acid is supplied by 18.1% only due to shortage of supply. 63.6% were trained enough to do abdominal examination. Test like urine test and haemoglobin was not done at any of the sub centre. Postnatal component was the most neglected element with only a meagre proportion of ANM making rare home visit only in case where a women experience some complication in the postpartum period.

Figure 13 :Antenatal services provided at subcentre

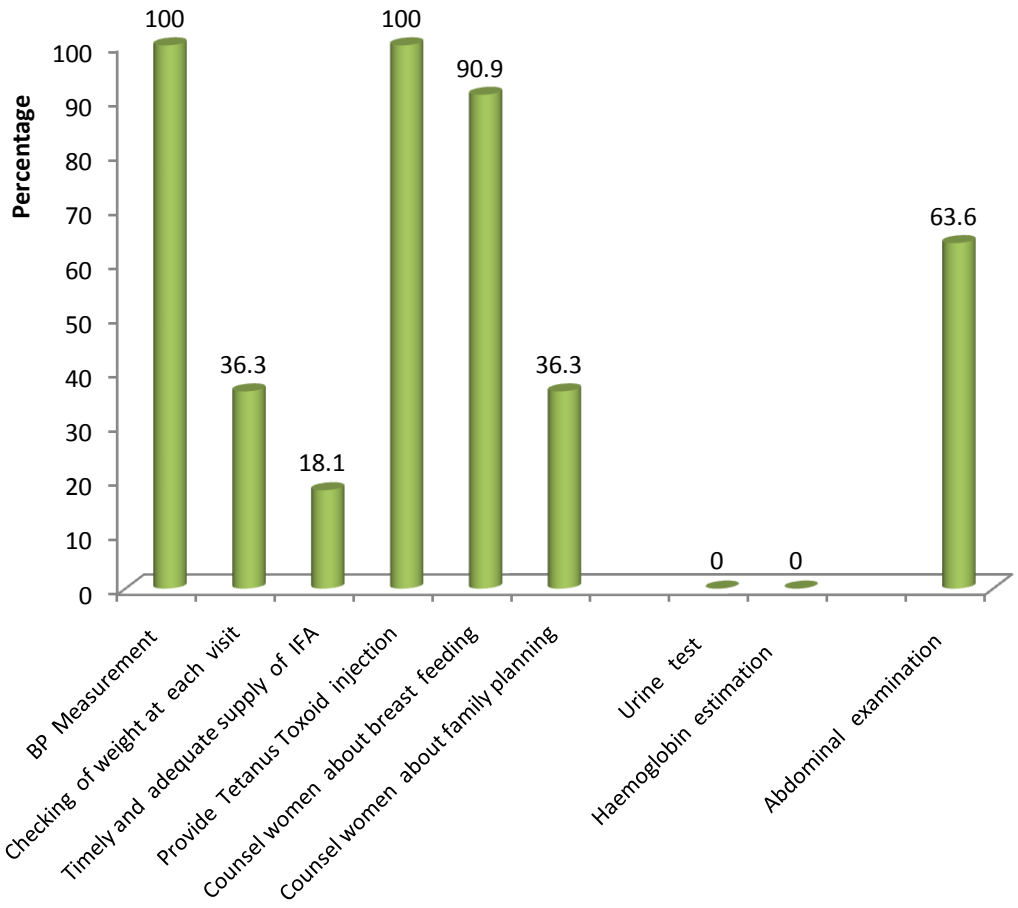


Table 60: Number of Antenatal cases registered at selected sub centre

Particulars	Block						Total	
	Hazratbal		Ompora		Pampore			
	n	%	n	%	n	%	n	%
Cases registered during the last one year	155	85.6	73	91.2	75	85.2	303	86.8

86.8% of the beneficiaries got registered at sub centre across all the block with highest registration at block Ompora during the last one year.

Table 61: Limitation in service delivery as reported by ANM.

Shortcoming*	Block						Total	
	Hazratbal		Ompora		Pampore			
	Yes	No	Yes	No	Yes	No	n	%
Non Availability of funds on time	4	6	4	2	3	3	11	100
No Disbursement of JSY fund at sub centre	4	6	4	2	3	3	11	100
Lack of Reorientation Training	2	8	1	5	3	3	6	54.5
Lack of Publicity by IEC material	2	8	0	6	1	5	3	27.2

**Multiple responses*

All the ANM felt that fund should be disbursed at sub centre level for the convenience of mother and ASHA. Money should be available on time. 54.5 % opined that there should be refresher training. 27.2% stated lack of publicity by IEC material at grass root level.

Programme and financial management of JSY

Regarding the implementation of the scheme as per the Guidelines, Information was collected from program implementers who included stakeholders at PHC, district, block and provincial level. Attempt was made to understand the fund flow and management aspects of JSY. The stakeholder were interviewed about their knowledge, planning aspect, orientation course undertaken for capacity building of field workers, disbursement of funds to the beneficiaries, record maintenance, system of reporting, monitoring and supervision of the programme. Besides this, problem encountered by the official at work and the shortcoming perceived by the stakeholders at ground level were explored. Details of the interview are mentioned in the discussion section.

The World Health organization(WHO) estimates that, of 536,000 maternal deaths occurring globally each year, 136,000 take place in India**(51)**. Infant mortality is also high at 44 per 1000 *(SRS October, 2012).* Developing countries accounted for 99% of deaths. The millennium development goal (MDG's) 4 & 5 in 2000 re- emphasize the importance of 75% reduction of maternal mortality ratio and reduction of Infant mortality by 2015.**(52)**

Studies have shown that utilization of maternal and child health services (MCH) by the rural community has not reached as desired. Under the minimum need programme, Government of India (GOI) launched NRHM on 12th April, 2005. The main aim is to protect and promote the health of its citizen and mother and child in particular.

Quality antenatal and postnatal care is the key to reduce maternal deaths. JSY is a safe motherhood intervention under NRHM. Its main focus is to reduce maternal and infant mortality and morbidity by emphasizing on institutional delivery. It offers cash assistance to the eligible beneficiaries to remove financial barriers hindering access to comprehensive maternity and newborn care.

The present study has been conducted to assess the JSY coverage of recently delivered mother, to assess knowledge and utilization pattern of the beneficiaries. Further, attempt has been made to understand the functioning and shortcoming in the implementation of the scheme. Role of ASHA in JSY and service provider like ANM and Programme implementers at various level were also explored.

349 beneficiaries across three block were interviewed to understand their background, source of information and awareness about JSY, kind of support received from service provider like ASHA, ANM and others. The study also tried to examine the receipt of cash incentive, difficulties faced in getting the benefits, and client satisfaction regarding the quality of services at the health facility.

Background information of mothers shows that the mean age of the women was 28.9 in block Hazratbal and 29.2 years for Ompora and Pampore block. Most (45.2%) of the women were aged between 25- 30 years. As per the report of *Ahmad Khurshid et al***,** 29% of women were aged 20-24 years, 36% 25-29 years and 21% in the age group of 30-34 years.**(31)**

Majority of the women were illiterate (75 %) in the present study. The reason being cultural factors like gender bias in rural areas due to orthodox thinking. While 47% of JSY beneficiaries had no formal education as per the findings of Centre for Operation research and training *(CORT)* in Uttar Pradesh.(**42)**

The proportion of women belonging to Below Poverty Line accounted for 16.9 % in the present study. In terms of housing characteristics, around 68.2% were living in pucca house and only 13.2% in kuccha house. These two indicators reflect the economic condition of the selected women. According to the study done in five selected states of India by *field agencies development & research services New Delhi (May 2009***) (53)** In Rajasthan, 40-60% of mothers were living in kuccha house. The proportion of women belonging to BPL category was highest in Bihar (70%) and lowest in Rajasthan (29%).

Antenatal Care

Awareness about the JSY scheme among mother

The use of maternal health care services remains low despite continuous effort to strengthen the infrastructure, Drug supply and human resource capabilities. The government has introduced many schemes relating to maternal and child health. Still many fail to access the services due to lack of awareness and knowledge. Awareness in the present study refers to time when women heard about the scheme & knowledge about various component of JSY i.e., information and understanding of different aspect of the scheme. Present study shows that 95.5% of women were aware about JSY out of which 63.3% heard about the scheme before pregnancy and 37% during pregnancy. Similar results have been reported in a study conducted by *Kristi Sidney* in her study**(13).**The findings of my study are in contradiction to the study titled "Janani Avam Bal Suraksha Yojana" done by *CORT (Centre for Operation Research and Technique, Vadodra, 2008)in Bihar* where 82% of the women heard about the scheme during pregnancy, 14% after delivery and 4% before being pregnant**. (54)**

Major source of information came from ASHA (77.5%) followed by other sources like TV, radio, friends and relatives(12.4%) and ANM (8%) in the present study. The results are consistent with the findings of *Sharma Parul et al* where ASHA was the main source of information in rural areas (48.9%) and neighbours and friends were the main source of information in urban slum.**(34).** The study results contradict the findings of *Sidney et al* **(36)** where the source of information was through public health facility in 40% of mothers, village crèche worker in 30% and ASHA in only 21%. Study by *Ashok Mishra et al* (2008) shows that AWW and ANM were the main source of information**.(48)**

Knowledge regarding the various component of JSY among recently delivered women

In the present study 82.2% stated that money is being paid for delivering in the hospital while 18% opined that a post of health worker, ASHA, has been created to help the women. None of the beneficiaries were aware about other aspects like facility for transportation cost in going to hospital at the time of delivery and support during postnatal period. The study results are in accordance with the findings of *Vinod Kumari et al* where some essential advantages perceived by beneficiaries were safe delivery at PHCs and CHCs, payment of Rs 1400 to the mother in rural area after delivery, and transport facilities. **(55)** However, *Shobana Malini et al* in her study found that less than half of the beneficiaries were having knowledge on various aspects of the JSY scheme like provision for escort by ASHA, stay during hospital delivery etc**.(30)** Also *Tanmay Kanti Panja et al* study results contradict the results of our study **(33)**

Purpose of paying incentive as perceived by mothers

Most of the women (65%) in the present study felt that money is being given for medical assistance at the time of delivery. While 26% opined that it was given for expenses for Drugs, tests and intake of nutritious food at the time of delivery. 9% had no idea as to why the money is being provided under the scheme. *Sanjeev K Gupta et al* reported that only 13% of mothers had knowledge about JSY and its benefit. 87% knew that there is a scheme in which money is given after institutional delivery.**(5)**

Registration & Utilization of ANC services by recently delivered women

Early Registration and regular check up is essential to avail the benefits under JSY as well as in recognition of at risk mothers and for timely and

appropriate interventions. It is also important for monitoring of the activities.

Majority of women (86.5%) got registered themselves in 1st trimester of pregnancy and 13.4% in 2nd trimester.All the women were registered at either public/private health facility. The results are consistent with the findings of *Banerjee B (2003) et al* where registration was found to be 100%.

Registration was done by ANMs (53.2%) followed by Doctors (41.8%) across the entire block. Registration by Doctors was highest for block Hazratbal (79.1%) which is the field practice area of Government Medical College Srinagar. It was observed that antenatal care was provided at sub-centre level by doctors at all the three selected sub centres at block Hazratbal.**(56)**

In the present study, 63 % of recently delivered women were visited only once, 22% twice or thrice and 15% were visited many times by health worker during pregnancy**.** Similar pattern was observed by *Zurat ul Ain* **(2010**) where only 10.6% of women ever had antenatal check up at home by health worker and only 47.6% had been visited by the health worker only once during the entire course of pregnancy**.(32)**

The study found that 90.2% had more than four antenatal check up and it was highest for block Hazratbal. 1.4% had done antenatal check up twice which is less than the minimum recommended antenatal visit. The findings contradict the estimates of *DLHS-3*, where almost 50% of women aged 15-49 years had at least three antenatal care visit**. (57)** Findings of NFHS III indicates that 52% of mothers had at least three antenatal check up.**(58)** While the results are supported by *Padam, Yadav RJ (2000)* where 89% of the women had antenatal check-ups among which 62% had more than 3 antenatal checkup**.(59)**

Regarding the place of antenatal check – up. Majority (72.2%) had received antenatal check-up at sub centre followed by 12.6% at PHC and only 6.59% and 3.15 % from district hospital and CHC respectively. 5.4% did their check up at Private hospital and clinic. While *Z. Khan et al* in their study reveal 52.5% of mothers had at least one antenatal check up at a government or private facility**.(60)** The results of present study are in accordance with the "Assessment of JSY in Himachal Pradesh'' by *CORT* where 74% had three or more Antenatal check up. 34% at DH/ SDH,32% at sub centre and 16% at home /PHC**. (61)**

Intervention during pregnancy

Regarding the various component of antenatal care the study reveal that Weight measurement on regular basis was done for 39.4% of women. Blood pressure was monitored regularly during antenatal visit in 84.3 % of studied women. Haemoglobin and urine test was done in 100% of women across all the blocks. However, these tests were not available at any of the sub -centre as per the norms. This reflects the lack of facility or trained manpower at the sub centre level as per IPHS standards. Contrary to the present study *Dilip K Mandal et al* **(36)** reported that blood pressure was recorded in 72% mothers, weight and haemoglobin was measured for 88% and 42% mothers respectively. While 87.1% of women had their weight recorded and haemoglobin estimation was done at subcentre level in a study done by *SIHFW (JSY –2)* **(43)**

Present studies reveal that 89.6% of beneficiaries received two doses of Tetanus toxoid injection and 10.5% booster dose. Regarding the source of getting Iron Folic acid tablets, 81% got tablets from government health centres while 19% had to purchase from private sector. 86 % consumed Recommended Iron Folic acid tablets i.e., 100 tablets while 14% did not. The reason for non compliance was due to bad taste and epigastric

discomfort. Shortage in supply of IFA tablets was reported across the entire block. Similar results have been shown during the **"***Large scale evaluation of JSY" by population council (2011)* **(62)** and as per the report of district level household survey *(DLHS)- RCH (2002-2004)* and during rapid "Assessment of Knowledge, Attitude and Behavoiur (KABP) on continuum of care" in Jaipur**. (63)** In contrast to the present study, *Ahmad Imtiyaz (2003)* in his study found that 76.5% of women had to purchase IFA from private source.**(64).** An article review by *A Chatterjee and VP Pailey* reveal that overall, in India, educated women are more likely to receive a full course of IFA and receive Tetanus toxoid **(65)**

Place and type of delivery among recently delivered women

The main focus of JSY scheme is on institutional delivery

Majority of the delivery (57.3%) took place at tertiary care hospital, 9% at PHC and 22.3% at CHC and district hospital. Private hospital accounted for 9.7% and home delivery occurred in 1.8% cases. PHC provide institutional delivery services (24x7) but low (9 %) with most of cases referring to Tertiary care hospital. Basic emergency obstetrics (BemOC) and newborn care was not available at any of the PHCs. Major portion of delivery occurring at tertiary care hospital signifies the need for improving the provision of services and functioning of primary level of health facilities (PHCs, CHCs) in terms of trained manpower like gynaecologist and anaesthetist and infrastructure to reduce the heavy workload on the Tertiary Care Hospitals. As per the report of *District level Household Survey-3(2007-08*) for Tamil Nadu where 94.1% deliveries were conducted at institution and 5.7% were conducted at home. **(66).**Similar results were also found in the study done by *Himashree Bhattacharya et al* **(67)** and Rapid review of the evidence under USAID Traction Project by

Stephen Kinoti (2011), **(68),** as per the findings of "An assessment of ASHA and JSY" by *CORT (2007) in Rajasthan,* **(69**) Study by *CORT (2007) in West Bengal* **(70)**, *Kanti S Vora* (71) and *Geeta s et al* **(72)**

The accepted rates for caesarean section are between 5-15% as per the *Program evaluation of JSY* **(73).**But in our study 58% of beneficiaries had undergone Ceasarian section. Reason could be because of higher percentage of women opting for caesarean section, previous history of caesarean section and high percentage is Driven by bigger monetary benefit to private service provider. Mode of delivery was normal in 41.8% cases. Only a meagre proportion of deliveries (0.2%) were reported having delivery through assisted procedure i.e, vacuum. In contrast, *Program evaluation of JSY* shows that 4.7% had deliveries by caesarean section and 84% had normal delivery. Assisted vaginal delivery accounted for only 0.4% of deliveries**. (73)**The proportion of women undergoing caesarean section was higher than expected (8%) in a study done by *D K Pal et al* **(31).** *Nupur Chaudhary et al (2010)* reported 88.2% normal delivery and 11.4% caesarean section & 0.2% assisted delivery in a study conducted in resettlement colony of Delhi.**(74)**

Source of motivation for institutional delivery Findings of the present study reflect the role of ASHA in motivating women for institutional delivery. ASHA were the source of motivation in 58.1% followed by doctor in 20% cases and ANM (16.3%) while 3.7% cases got motivated through other channels like TV, Radio, friends, relative and 2% of women were motivated by AWW. In contradiction to the present study, as per the *concurrent evaluation of JSY –II by SIHFW, Jaipur (2008)* **(43)** ASHA motivated women in 8.6% of cases. Similarly, *CORT* did assessment of

JSY in *Madhya Pradesh (2007)* where only 8% or less beneficiaries were motivated by ASHA.**(75)**

Reason for opting institutional delivery

Safety of the mother and child (47.2%), money available under JSY (22.1%), support provided by ASHA (17.4%), access to institutional delivery (7.2%) were the main motivating factor for opting institutional delivery. 5.8% had their previous child born in an institution and so had good experience about the past pregnancy. The findings of our study are in accordance with study of *Khurshid Ahmed* in Baramullah, where better care for the mother and newborn were the reasons for opting institutional delivery by 47% of respondents**(31).** Similar findings have been shown by *M.E. Khan et al* in their study**(21).** While, the study by *CORT in Bihar* reveal that money available under JSY(86.5%) followed by better access to institutional delivery were the reasons for preferring institutional delivery**.(54)**

Reason for Home delivery Out of the 6 women who delivered at home, the main reasons were untimely delivery & non availability of transportation for 50% of women. 33.3% of the women stated that they had nobody to look after the family. Inaccessibility of institution was reported by 17% of beneficiaries of sub centre Aabidal in block Hazratbal which is an urban slum in the midst of Dal Lake with connectivity only by a kuccha road. The results are consistent with the findings of *Kristi Sidney et al(36* **)** where Non availability of transportation (65%) was the reason for home delivery. In contradiction to my findings, *Monica Munjail et al,* found cultural practices(68.3%) followed by inadequate systems including a shortage of supplies and Drugs in hospitals (25.6%) as reason for undergoing home delivery**.(4)**

Out of the total studied women, 99.4% had live born babies while 0.5% had still born babies one each in block Hazratbal and Ompora. Similar study by *Deoki Nandan et al* (Functioning &Impact of JSY in Orissa) reported one delivery resulting in still birth**.(76)**

Duration of Stay at the institution: 25% of the mothers reported staying for less than recommended period of two days. The reason being request from family members for early discharge and inconvenience due to overcrowding of bed. 44 % stayed for 3-6 days. While Findings of *Sanjay K Rai* reveal that most of the mothers were discharged within 24hrs and half of them 3 hours after delivery in some cases of normal delivery **(52)**.similarly, as per the report of *concurrent evaluation of JSY –II***,** 41% had stayed for mandatory period of 24-48hrs while 37% were discharged within 24 hrs.**(43)**

Client Satisfaction: User satisfaction means sense of security, positive interpersonal interaction and the efficiency with which the work is organized. The study tried to assess the quality of services at the place of delivery and overall client satisfaction. The services were measured in terms of following dimensions: Time taken to attend the respondents after reaching the institution, person attending the delivery, availability of other facilities, client satisfaction and reasons for dis - satisfaction. 83% of women were attended in less than half an hour. Doctors conducted 94% of deliveries and 6% were attended by ANM and nurses. Overall facility like cleanliness in and around the hospital, good attitude of the staff, counselling services for immunization, breast feeding, family planning was satisfactory to 71% of respondents while 29.4% felt that toilet facility was poor. Overall 73% of the women were satisfied with the services provided at the hospital but dissatisfaction was reported by 27%. The reasons were rude attitude of the health staff (24.2%) and poor

quality of service (76%) like poor toilet and food facility, lack of cleanliness and overcrowding of patients. Findings of the study mimics study by *Ahmad Khurshid et al* where majority (92%) were satisfied with the services provided to them at the health facility **(31)** and *Bhat et al(2007)* where 89% of Chiranjeevi clients and 87% of non-Chiranjeevi clients were satisfied with the service provision at the health facilities.**(77)**. In contradiction, result of *Program evaluation of JSY* found that 170 out of 2759 stated that they would not come back next time for delivery. 76 were not satisfied with the treatment received, an equal number were not satisfied with the amenities available at the hospital and were not happy as they could not afford to purchase Drugs from outside**.(73)**

The Time of receipt of JSY Incentive

An important component of JSY scheme is to provide monetary incentive to the women who deliver in an institution. As per JSY guidelines, women who deliver in government or accredited private hospital are entitled to get JSY benefit. Further, women of BPL household are paid some amount even for home delivery. Incentive should be paid before discharge at the place of delivery. Present study reveal that 70% had received incentive at the time of study while 30% did not received any incentive due to various reasons like delay in receipt of fund, delivery at private institution and many of women went to their parents home at the time of delivery in other district. Only 3.6% got money at the time of discharge as per the guidelines. Majority had to wait for time period ranging from fifteen days to nine months. This shows that money is not disbursed as per the guidelines and majority had to visit several times to get the incentive. There is a need to include some of Private hospital under the cover of JSY so that the beneficiaries who are entitled to get incentive can make their own choice at the time of delivery and get

benefit as per guidelines. While a Study conducted by *CORT in Bihar* reveal that 61% got late payment, 22.7% within a week after delivery and only 14% immediately after delivery**.(54)** Findings of *JSY evaluation* reveal 5.5% of women getting payment on the same day of delivery, 30% within 3 days and 39% within 15 days of discharge which is in contrast to the findings of the present study.**(73)**

More than 67.2% of the mothers who delivered in government institution received Rs 1400/- as incentive. 30.3% got Rs 1000/- as incentive. All the women(2.1%) who had home delivery got Rs 500/- as incentive, though late. While as *Ahmad Khurshid et al* in his study in Baramullah found that more than 61.5% of the mothers who delivered in an institution in all the blocks received Rs 1400/- as incentive. 37.7% got Rs 1000/- as incentive while 0.7% receive less than Rs 1400/- as they had to make informal payment while receiving the cheque**.(31)**

Regarding the experience in getting money, out of 244 women, 58 (23.4%) women faced problem in getting the amount. 48.2% had to make several contacts due to delay in disbursement. Few had to make informal payment at the time of receipt of the cheque. 11% of women had difficulty in getting the money as per the study of *CORT in Himachal Pradesh* due to late payment and frequent contacts to get the amount**(54)**.The findings of *CORT* in Bihar reveal that, 5% encountered problems like frequent visit to the health facility due to late payment and inconvenience due to cumbersome procedure for producing the documents**.(61)**

Medical officer in charge of NRHM at CHC/ PHC and accountant/ clerk was the main source (54%) of cash disbursement followed by 29% of women who got money through ANM. While, ANM was the main source

of disbursement (58.7%) followed by MO at CHC & PHC (25.6%) during assessment of JSY in *Bihar by CORT.* **(61)**

Mode of transportation and distance covered by beneficiaries to reach the place of delivery and the delay (second delay) in accessing the health care during delivery depend on early recognition of signs of labour and problems, arranging transport and time taken in travelling at the time of delivery. As per the norms of NRHM, every JSY beneficiary is entitled to receive money for transportation to reach the health facility at the time of delivery. In the present Study, 81.9% of beneficiaries used hired vehicle to reach the place of delivery, 10% had personally owned vehicle. 8.1% got free ambulance service under JSSK and free service was received almost equally by women in Ompora and Pampore block. However, result of *Syed Ahmad Khurshid et al (2009)* shows that 80% of women had used private vehicle and 16% had arranged other mode of transportation at the time of delivery. Government ambulance was utilized by only 4% of beneficiaries**.(31)**

48.6% women had to travel a distance of 5-10 km and 6.9% between 10-20 km from residence to the place of delivery. While more than 20% had to cover either > 5km or < 20 km to reach the institution. It was observed that many of the studied women went to district and tertiary care hospital at their own will or referral from peripheral hospital(PHCs/CHCs) due to lack of Basic EmOC Services. The findings are in accordance with *concurrent assessment of JSY* where 20-40% of women had to cover 5-10 km at the time of delivery. Public private partnership(PPP) model such as *Janani Express Yojna (JEY)* in Madhya Pradesh which provide 24 hours transport facility at field level for obstetrics emergency can be introduced. **(78)** The study finds that there were no PPP executed for EmOC provision across all the block.

Person accompanying JSY beneficiaries to the health institution

Majority (58%) of the women were accompanied by spouses, mother in law and other family members. ASHA facilitated in arranging transport and accompanied women in 41.3% cases but only few of ASHA stayed with women till delivery. The reason being due to engagement with their own work, refusal from family members, rude attitude of staff at place of referral and unavailability of ASHA GREH at many places. Few of the women (0.8%) were facilitated by ANM **(79)**

The findings are consistent with the findings of *SIHFW (2008)* where ASHA escort and stay with the mothers during and after delivery (24hrs) in 42.5% cases**. (80)**The results are in contradiction to the study done in *West Bengal (2007) by CORT* where mothers and husband accompany and stayed in 83 % and 81% women respectively**. (70)** While a study by *public health resource society, New Delhi* in Jharkhand, Orissa and Bihar (2009), found that ASHA stayed through delivery and till the mother reached home. In many cases ASHA was reported to have stayed for more than 3 days due to complications and delay in delivery.**(81)**

Postnatal Care:

Only 35% of women were visited by health worker and ASHA during post partum period. Postnatal care need to be emphasized by proper monitoring. The findings are in agreement with that of *DLHS-III data for UP* where 34% of currently married women aged 15-24 years received a postnatal check up within 2 weeks of delivery **(82).** Similar findings have been reported by *M.E. Khan et al, DM Satapathy et al* (2006-2007)**(66)** and *Manish K Singh et al* (2008)**.(83)**. The findings of DLHS-III (2007-2008) shows that 69.2% of recently delivered women received postnatal care within two weeks of delivery unlike the findings of present study.**(57)**

According to the report of program evaluation done by *Indian Clinical Epidemiological Network of India (CLEN) and Population foundation of India(2009-2010)* the health workers visited a majority of the postpartum mothers at home at least once. The share was larger for Sahiyas (ASHA) followed by ANM and least by AWW. **(69)**

99% had received BCG vaccination at the time of study. 1.1% had not received BCG vaccination at the time of study and accounted for those who delivered at home. One child was not immunized at 8 months at sub centre area of Aabidal due to lack of co-operation and unfavourable attitude due to false belief. The results are in accordance with the findings of *National Family Health Survey-3, J&K (2005-06)* **(59)** where BCG coverage was found to be 90.9%. Similar pattern have been reported by *Neera Jain et al(2008)* in their study **(84)** and *Suri S.P, Singh Bhupinder* in a study conducted in R.S Pura block of Jammu. **(53)**

Most of the women (92.2%) were counselled about the benefits of breast feeding by Doctor, ANM and ASHA at place of delivery and at subcentre. 34.3% were counselled about various family planning methods at the time of delivery and during postnatal period. While in a study by *M.E Khan et al* 69% got advice for promoting early and exclusive breast feeding in 26% cases and advice on postpartum contraception was seldom given**.(21)** In another reports by *India CLEN and PFI (2009-10)* all the mothers were counselled about family planning and immunization but advice on breast feeding were not emphasized during postnatal visit**.(69)**

Asha

Accredited social health activist is a community based functionary appointed under NRHM. She is a trained female health activist in the community. As per guidelines, under ASHA scheme, one ASHA has to

be in place for a population of 1000 in non tribal area and 1500 in tribal area. She should be primary resident of the village with formal education upto class 10th in nontribal area and 8th standard in tribal area**.(85)** She should preferably in the age group of 25-45 years and married/ widow/ divorced. ASHA are provided performance based incentive as per the amount fixed for each completed activity. NRHM aims to have a village based female ASHA in 18 high focus states including J& K which are LPS with respect to institutional deliveries. She mobilize women for immunization, safe delivery, newborn care, prevention of water borne and common diseases, improved nutrition and promotion of household toilets**.(86)**

The present study elicited the relevant information about their background characteristics and their role in supporting mothers for getting maternal and child care services and facilitating them for antenatal check up, institutional delivery and immunization services.

In all 22 ASHA were interviewed across the entire block. Most of the ASHA (63.4%) were of the age group less than 20 year followed by 13.4% in both 25-30 and 30-35 years. The mean age of ASHA was 28.6,+- 2.23. This reveals that younger ASHAs were selected while the proper age group for selection would have been 25-45 years as per the guidelines. The results are similar to the study conducted by *Martin Abel et al (2008-2009*) in Rajasthan, where approximately 50% of ASHAs were below the age of 25 years**.(87)**Present study reveal that 45.4% of ASHA had read upto middle class, 36.6% up to high school, 13.6% up to higher secondary school and only 4.5% had done graduation. In contrast, study in *Sundernagar et al* reveals that 70% of the ASHAs had an education level between 8th and 12th class**.(88)**

Regarding Marital status, most of the ASHAs interviewed were married (73%) while 27.2% were unmarried. While according to findings of *Deoki nandan in UP(2008)*91.7% ASHA were married. The share of unmarried was just 1.7 percent**.(89)**

15% started working as ASHA in the year 2005. Majority of the ASHA(40%) were selected in the year 2006 followed by 20% in 2007 and 25% were newly selected in 2011. The results of our study are in accordance with the study done by *Doeki Nandan et al(2008)* where less than 10% got recruited in 2005, followed by 40-50%% in 2007 and 30-40% in 2008. **(89)**

Mode of selection: As per the guideline, the selection process envisages that CDMO is the district nodal officer and MOs I/C of PHCs/ CHCs is the block nodal officer for selection of ASHAs.**(85)**

Majority of ASHAs (50%) were selected/ approved by the village head. 31.8% got selected with the help of village health committee and 18.1% were recommended by ANM. It was observed that no hard and fast rules were followed so far as the selection of ASHA is concerned. Few of the ASHAs got selected through influential person across all the block. The results are in contradiction to the findings of *Vandana Kanth et al,* PRI members were involved in selection of ASHA in Bihar, Rajasthan and Uttar Pradesh while in Chattisgarh, almost the entire village was involved in selection process. **(90)** 43.75% were selected on the recommendation of ANM and 15 (31.25%) were selected directly either on recommendation of MLA, DC, CMO or BMO and 14.58% were selected by recommendation of village head as per the study of *Nighat et al (2012)***(91)**

The ASHA are provided modular training after their selection as per the national guidelines. 28% who were newly recruited received modular 4&5 training while 72.2% had underwent training upto module 5. Also in a study in *Rajasthan (2007)* 95% of ASHAs interviewed attended the induction training. Regarding JSY only 81.8% received training and 18.8% who were newly selected did not receive any refresher training on JSY. While in *concurrent assessment of JSY in selected states(2008)* **26% of** *women in Bihar and Rajasthan* 18% have not received any training. **(39)**

Information provided by ASHA to the Beneficiaries during Pregnancy

One of the important component of ASHA is to provide timely and relevant information to the pregnant women. All the ASHAs inform mothers about the date of next check up and expected date of delivery while only 45.4% tell women about the place of referral in case some complication arise. None of them decide the place of delivery except advising for institutional delivery. In Kashmir, for cultural reasons or otherwise, most of them women used to stay at their parents home after delivery. Because of this, ASHA gets demoralize as they do not get any incentive at the end in spite of motivating and escorting women during antenatal period. *Kristi Sidney et al* found that only a minority of ASHA decide the place of delivery (17%) as these decision were to be taken by husband or household members**.(36)**

Support Provided by ASHA to the Beneficiaries Regarding JSY Related Activities

The ASHAs were enquired about the facilitation regarding various maternal and child health services and specific JSY activities

In the present study all the ASHAs identify women in early pregnancy, help them in registration, give information about JSY, facilitate and accompany full range of antenatal services, counsel about breast feeding, motivate mother to undergo institutional delivery and timely immunization of child. Only 54.5% help women in arranging transport at the time of delivery and 50% of ASHAs escort women to place of delivery while only 31.8% stayed with the women during the last one year. The reason was due to opposition from in-laws, non availability of facilities and rude attitude of hospital staff. Postnatal services are being provided by 36.3% of ASHA. Only 31.8% Counsel Women about family planning in postpartum period. Attempt should be made to motivate the beneficiaries and ensure uptake of family planning services at grass root level. In contrast to this, study by *Saraswati Swain et al (2008)* reveal that 92.5% accompany pregnant women, 84% counsel women on postnatal care and safe delivery, 68.8% helps in registration and 80% mobilize for immunization. Motivation of couple for family planning was least**.(92)**

The results of present study is consistent with the findings of *Heema Bhat* which shows that ASHAs were very particular about their job responsibilities like registration of pregnant women, ANC/PNC and immunization while they neglect other activities. ASHAs ignore others activity which are not incentive Driven**.(67)**

The payment of ASHAs is linked with various services provided by them to the pregnant women, mothers and children. The study tried to explore two dimensions of their payment: whether they get incentive on time and are paid for all set of activities.

All the ASHAs reported that none of them received money on time and they had to make several contacts for getting the money. None of them got money for immunization services and was pending since March 2012.

Further they were not paid for the old registered cases due to implementation of JSSK as the old cases did not have ID number on their card. Dis satisfaction was reported by majority of ASHAs and many of them were planning to opt out. Similar results were found in a study on *rapid appraisal of functioning of ASHA under NRHM in Orissa (2008)* where majority of ASHAs were not getting incentive on time. Nearly a quarter of ASHAs had not got incentive for more than six months. **(15).** While as per the results by *CORT in Bihar (2008)* **85**% of ASHAs received cash remuneration on time. Most of them received incentive for attending JSY beneficiaries, immunization of children and counselling for family planning while few were paid for DOTs treatment and for promoting sanitary latrine**. (54)**

ASHA are supposed to know about the complications that the women are likely to experience during pregnancy, so that they can recognize the problems at earliest and seek timely help from functionaries and do requisite referral.

All the ASHAs were knowing bleeding as major complication of pregnancy 86.3 % cited decreased and no movement of the foetus as common complication followed by anaemia(77.2%), convulsion & swelling of hand and feet (59%),visual disturbance (50%) backache (36.3%), excessive vomiting (31.8%), abnormal position of the foetus & high fever (22.7%) as other pregnancy related complications. There is need to train ASHAs so that they can identify danger signs in pregnancy and facilitate women for timely consultation and referral. In contradiction to the findings of present study, *P Garg et al* reveal that majority of ASHAs cited vomiting (80.95%) and swelling of hands and feet (69.52%) as common complication during pregnancy and 31.42% stated that they would ask the pregnant women to consult the ANM next day**(93).**

45.4% of ASHAs refer the women immediately to the nearest hospital in case of any eventuality. Most of them(56%) seek the advice of ANM first before referral Similarly as reported by CORT in a study in Madhya Pradesh, 33% of the ASHAs said that they would take her to nearest First Referral Unit (FRU), 34% reported that they would refer to FRU.36% said that they would ask the women to consult the ANM next day. **(61)** In contrast, 75.4% of ASHAs said that they would immediately refer the women to the nearest FRU and 49.2% would ask her to consult ANM next day as per the report of *CORT (2008) in Bihar.* (**54)**

Challenges faced by ASHAs while working

All the ASHA faced problem as far as the receipt of JSY money is concerned as they had to make several contact due to delay in disbursement of fund. Moreover, most of ASHAs had to spend half of the amount they get as incentive for travelling expenses which cause them a lot of inconvenience in terms of money and time.

Majority of the ASHAs (63.6%) reported that they face a lot of problem in getting incentive as many of the beneficiaries do not inform them at the time of delivery due to lack of co operation.They do not get the entitled money at the end, in spite of doing all JSY related activities. ASHAs felt demoralize due to such situation and felt that they should get money on break up basis as incentive for the other set of services like registration, Tetanus toxoid injection, intranatal and postnatal care. A study on community health workers (CHWs, called Swasthya Sebika) in Bangladesh by *Nirupam Bajpai et al* suggest that financial incentives are the primary motivating factor and that high Drop-out rates are largely due to the dissatisfaction with the pay levels in proportion to the amount of time invested.**(94)** Findings of our study mimics the findings presented by *Martin Abel et al (2008-2009)* where inadequate and untimely release of

compensation was the most significant challenge as reported by 45% ASHA respondent**.(91)**

Further, in the present study, in many cases (59%) women were not ready to take IFA tablets as per the recommended dose as they felt discomfort on taking these pill and stated that it is not of superior quality. Irregular supply of Drugs (ASHA kits) was problem encountered by most of the ASHAs. 45.4% reported having little or no support from their family as they get less amount for too much work and because of temporary post. 36.3% of ASHAs stated that ANM depend on ASHA and do less field visit. 86.3% were dis-satisfied with the rude attitude of health staff at the place of referral especially district hospital where they feel humiliated. 9% stated that other ASHA interfere / take up their case. The results of present study is consistent with the Study conducted by *Hema Bhatt* which shows that ASHA provide all the approved services of ANC and immunization but fail to get the incentive if she missed the opportunity to accompany the mother at the time of delivery. This was due to lack of communication or unwillingness of the beneficiaries to inform her at the time of delivery**.(67)**

Non availability of the Drugs kit on time, Gradual loss of skills due to lack of refresher training, visiting many times to enquire the status of their incentives were the problems encountered as per the study conducted by *Public Health Resource society, New Delhi (2009).* **(95)** While the results of the present study are in contradiction to results of *CORT(2007) in Orissa* where 32.1% do not get money on time and 20.9% do not got support for immunization of their child. **(95)**

Support needed by ASHA

Community participation and inter sectoral convergence are the key components in NRHM. To provide effective and optimum service, ASHA cannot work in isolation; they need support from other functionaries. Under NRHM, officials at various levels like block officials, village panchayat, NGOs, SHG, health department and CBOs have specific roles and responsibilities in the implementation of ASHA intervention and JSY.

In the current study all the ASHAs sort help of ANM and block level official in many JSY related activities,

44.4 % got support from AWW.77.7 % are being helped by PHC staff and village health and sanitation committee.(VHSC) The ASHAs attend monthly meeting at PHC every month and discuss JSY related issues and visit CHC every week for up-dation of ID No of beneficiaries. At Sub centre, they do frequent visit as and when required. Besides, most of the ASHA visit AWC twice a month. Findings are consistent with the report of *Deoki Nandan et al* where ASHAs needed support from ANM followed by Medical officers and AWW**.(99)** The findings are in contradiction to the study conducted by *CORT (2008) in Uttar Pradesh* where all ASHA reported having interacted with ANMs and Anganwadi worker(98%) followed by PHC members (65%) and PRI(43%).**(42)**

ANM

ANM are the key functionary for execution of JSY related activities besides ASHA. NRHM seeks to provide two ANMs at each subcentre. In all 11 ANMs were interviewed. Half of the respondents were appointed under NRHM and half under state cadre. In the current study 64% ANM received training regarding SBA while 36.3 % did not receive any training except the induction training as many of the AMNs were newly appointed under NRHM and were not aware about various component of

the scheme at the time of study. SBA training was imparted to the ANMs on rotation basis quarterly every year and they stated that their turn was yet to come. The findings are similar to the report of *SIHFW, Jaipur* where only 46.7% had SBA training at some point in time. **(21)**While *Concurrent evaluation of JSY-II (2008)* findings reveal that 68% of ANMs reported no training regarding SBA**.(43)**

ANM are supposed to provide a package of services regarding maternal and child health services and micro planning at sub centre level as per guidelines.

ANMs across all the block do proper planning every month like estimating number of women who are likely to undergo registration, number of women to be mobilized for antenatal check up and number of target children to be covered under immunization every month. 72.7% of ANMs estimate number of women to be taken for delivery. All the ANM stated that fund are not disbursed at sub centre for ASHA and beneficiary under JSY except in case of home delivery and few exceptional cases of pending payment. As per the findings of *Karnataka state health system resource centre and centre for population dynamics (2012)* except for two sub centres, none of the other sub-centres were carrying out activities under JSY Scheme. Identification and registration of pregnant women for JSY is done on daily basis, supervision in preparation of micro birth plan by ASHA/ ANM is done on weekly basis. Besides, beneficiaries were explained about JSY on daily basis during ANC visit, disbursement of funds and maintenance of JSY fund is done at sub centre level.**(96)** Findings of the current study are in accordance with that of *Shanti Goplan, Rekha D et al* where ANM and ASHA prepare the expected deliveries list by 21st of every month. The JSY fund is disbursed at sub- centre level.**(97)**

ANM is supposed to provide specific protection and health promotion interventions like Tetanus toxoid injection and Iron Folic acid, do antenatal examination, postnatal visit, minor investigation like haemoglobin estimation and urine test and delivery at the sub centre.

All the ANM stated that they provide Injection Tetanus toxoid and monitor blood pressure at every visit. 90.9% counsel women about breast feeding Equal proportion of ANM (36.3%) counsel beneficiaries about family planning and record weight at each visit. Iron and folic acid is supplied by 18.1% only due to shortage of supply. 63.6% were trained enough to do abdominal examination. Test like urine test and haemoglobin was not available at any of the sub centres and no delivery was ever conducted at any of the sub centre. The reason was due to lack of infrastructure (labour room)as per the IPHS . 70% of the sub centre were in rented building. Those ANM who were trained for SBA are likely to loose their skill during their tenure at these sub centres. Postnatal component was the most neglected element with only a meagre proportion of ANM making rare home visit only in case a women experience complication in the postpartum period. It seems that ANM were doing more of paper work and less field visit. They had become more or less dependent on ASHA for almost all the field work. There is need to demarcate the role of ANM and ASHA and strict monitoring at Sub centre level.

Similarly, Only 35% of the ANM check Blood pressure, Haemoglobin estimation and urine test as per the findings of *Ahmad Khureshi et al.* **(31)**

In contrast to the findings of present study, *SIHFW during concurrent assessment of JSY –II* found that weight measurement was done by 82.8%, blood pressure by 76.1%, Haemogloin by 68.9%, urine test by 57.2%, Injection Tetanus toxoid by 83.9% and IFA by 83.9%.97.5% do follow

up of deliveries and provide postnatal care. The average number of JSY cases resulting into institutional delivery for a sub centre was 3**.(43)**

One of the important component under JSY scheme is early registration of pregnant women preferably at grass root level. 86.8% of the beneficiaries got registered at sub-centre across all the block. Similarly**,** *Khurshid Ahmad et al* in his study found that half of the sub centre have registered pregnant women within 3 months of pregnancy**.(31)**

Record keeping: Maintenance of records is an essential part of any programme. Mother and child tracking register, immunization register and register of beneficiaries who received the incentive was maintained at all the sub centre but overwriting and false entry was observed at few subcentre. None had maintained Postnatal register. In contrast to this, *Ahmad Khurshid et al* results reveal that only 58% of sub centre maintain ANC register, 75% immunization register and 25% have maintained their PNC register. 11% stated that a register is kept for maintenance of expenditure incurred on JSY beneficiaries.**(31)**

JSY has been in operation since 2005. The ANM were asked about the perceived loopholes/ shortcoming regarding the scheme.

All the ANM felt that fund should be disbursed at sub centre level for the convenience of mother and ASHA. Besides money should be available on time. 54.5 % opined that there should be refresher training. 27.2% stated the lack of publicity by IEC material at grass root level. Besides, Most of the ANMs appointed under NRHM have not received their salary from the last few months at the time of study. Majority of the ANMs felt that they are overburdened with the paper work and get less time for field visit. Similar problems were reported in a study conducted in *Karnataka* where 40% ANM s reported that Sub centre fund do not arrive on time.

More than 60% complained that they do not get their remuneration on time. 60% reported that record keeping has become time consuming reducing the amount of time to be spent in field.

In nut shell, major findings in the current study reflect the dependence of ANMs on ASHA. They have shifted almost all the activities except for the paper work and field visit in particular to ASHAs. Besides, ASHAs reported of rude attitude and dominating them by ANMs at some of the sub centre. There is a need to demarcate the area of activities between the two workers**.(98)**

Programme and Financial Management of JSY

Regarding the implementation of the scheme as per Government of India guidelines attempt was made to interview all the stakeholder at Sub centre, PHC, Block, District and provincial level. Various aspect like knowledge about the programme, orientation course undertaken, planning activities, financial management, mechanism of fund flow, monitoring, supervision and evaluation of the programme were explored.

As per the guidelines, provincial level is headed by Divisional Nodal officer. An interview was conducted to know his role. The district nodal officer is responsible for overall planning and implementation of JSY at district level. Other personnel like Progamme Manager, Block Monitoring and Evaluation officer, Program Manager and Accounts Manager at district and block level were involved in the whole process. But as a whole the prime function for the scheme like preparing annual implementation of plan, budgeting, monitoring, guidance and supervision were managed and monitored through divisional nodal officer from time to time.

Stakeholder at block, district and divisional level were well acquainted with every aspect of latest JSY guidelines. However Medical officer had limited knowledge about various component of JSY such as payment to BPL beneficiaries for delivering in accredited private hospital, hiring and payment for doctor from private sector in case of non availability of doctor at public sector, hiring of vehicle for transportation of beneficiaries as per PPP model, account and record keeping etc. All the activities related to JSY were being carried by other NRHM staff with the exception of medical officer at two PHC of block Hazratbal.

Financial budget is framed at provincial level as per the requirement on the basis of submission of utilization certificate by sub ordinate institution. The state submit the requirement report to Ministry of Health and family welfare (MoHFW). The state contribution to the budget is 10% while the rest is met by MoHFW through state health society. At district level, District Health Society disburse funds to all the institutions and subsequently to the beneficiaries and ASHAs. Transfer of funds is done via electronic transfer depending upon the availability of funds on annual basis or bi annually on instalment basis. Paucity in receipt of fund has been observed at times due to non submission of utilization certificate. Also delay in release of funds by GOI occurs when the state government delay approval of share of 10% of budget to the centre government. In such situation fund is diverted from RCH flexipool and salary of un appointed official under NRHM. At some places, they wait for release of fund. Amount received for each year varies as per the approval of budget sheet. Maintenance of funds is done by District accounts manager at district and block level and staff appointed under NRHM at PHC level. Fund flow is chanalized through district who are

also responsible for maintaining financial transaction details and other activities.

Monitoring and supervision of the scheme is being managed at provisional level by nodal officer. Monthly meetings are conducted at District, Block and PHC level to check the reports and to discuss programme related issues. Besides, Field visit/subcentre visit is done every month on rotation basis across the entire block. There is an inbuilt system for internal monitoring wherein 4 personnel have been appointed one each for Leh, Kargil, Central and South Kashmir. District monitors from state health society go for supervision frequently. Chief Medical Officer (CMO) visits different areas on 15th of every month and District Programme Management Unit (DPMU) on 13th of every month on rotation basis. Monitoring of record keeping is done through MCTS and HMIS at block as well as district level. At times, officials randomly call beneficiaries to ensure that they get the exact amount. Grievance redressal has been set up recently where beneficiaries can lodge their complaints through helpline toll free number.

As stated earlier, Monitoring and supervision is done by visiting sub centre and PHC on specified date. Rather than visiting sub centres, both external and internal monitoring team should make surprise visit at village and randomly check some of the beneficiaries to strengthen and validate the report and activities at grass root level. Besides community participation by involvement of community members like village head, members of village health and sanitation committee, NGOs etc. would help to increase the effectiveness of the program.

“On the job re orientation Training” on Skilled Birth Attendant is being imparted to Medical officer ISM, Staff Nurse and ANM for a period of 21

days in every district as per the schedule. Training for ASHA on latest module 6& 7 are being conducted in phase manner in every district.

Evaluation is done by physical Verification. Audit is being conducted across the entire block on annual/ quarterly /half yearly and monthly basis. IEC material is being displayed in local language at CHC, PHC, SD and DH. However no information in the form of charts, poster and hoardings could be seen at sub centre and village level.

There were some problem which the stakeholders perceived as barrier in the implementation of the scheme such as lack of adequate infrastructure and manpower, non availability of fund on time, less salary for staff, incomplete and incorrect documentation (Fake entry) at times by field level workers and ASHA. This signifies the need for proper monitoring at grass root level.

JSY is being implemented as per national guidelines and Programme implementation plan (PIP) 2013 J&K to some extent **(99)**. However, much needs to be improved. The problems encountered by beneficiaries, service provider and stakeholders need to be addressed in future for smooth functioning of the scheme which in turn would have good impact in reducing Maternal and Infant mortality in the long run which is the prime focus of NRHM and MDG.

The present study was conducted in three districts of Kashmir valley to evaluate the functioning of a scheme for safe motherhood Scheme called "Janani Suraksha Yojna". The study made an attempt to assess the awareness, utilization pattern, service coverage of beneficiaries and involvement of stakeholders at various level in the implementation of the scheme. Further, gaps, if any, in implementation was identified. The methodology adopted for the study was Multistage sampling wherein, three districts were selected randomly at first stage out of which three blocks and subsequently 20% of the sub centre falling under each PHC was selected for the study. In all 349 RDW women, 22 ASHAs and 11 ANMs were interviewed across all the block.

Awareness among mother was quite good as 94.5% of mothers had heard about JSY before pregnancy. However, they had limited knowledge about the various component provided under the scheme. Majority of them (86.5%) got registered in early pregnancy. Sub centre accounted for 75% of registration. Antenatal coverage was quite good. 92% had more than 4 antenatal check up, out of which 72.2% had done antenatal check up at sub centre. Coverage of Injection Tetanus Toxoid was 100%. Recommended IFA intake was followed by 86.2% and 19.1% had to purchase from market as it was not available at the subcentre. 98% had undergone institutional delivery and 1% home delivery. Better care for mother and child care (47.2%) was the most cited reason for institutional delivery followed by money available under JSY (22.1%). Reason for home delivery was untimely delivery and non availability of other person to take care of the family at the time of delivery. Government hospital accounted for 90.3% of deliveries and private hospital 9.7%. It was

noteworthy that Caesarean section accounted for 57.2% of deliveries. ASHA was main source (58.1%) of motivation for institutional delivery. 91.2% of deliveries were conducted by doctors. Outcome of delivery was 99.4% for live born babies and 0.5% for still born babies. Majority(31.4%) had stayed for a period of 3-6 days while 25% stayed for only one day. 73% were satisfied with the overall services at the place of delivery. Reason for dis- satisfaction was rude attitude of the staff(24.2%) and poor quality of service (75.7%).only 69.9% of RDW receive incentive at the time of study, out of which 89.7% got the money more than one week after discharge. 48.2% had to make frequent visits to get the money. 53.6% got money through accountants, 29% through ANM. 17.2% through MO I/C of NRHM. Most (81.9%) of the beneficiaries used hired vehicle for transportation and 8.1% got free ambulance service. 48.6% had to travel 5-10km to reach the place of delivery. Husband, mother in law accompany women in majority of cases(57.7%) and ASHA in 41.3% case at the time of delivery. Only 34.9% of the beneficiaries were visited by health worker or ASHA during postnatal check up. BCG coverage accounted for 98.8% and 92.2% were counselled for breast feeding and 65.6% for family planning during postpartum period.

22 ASHAs were interviewed across the entire selected sub centre. Most(63.4%) of them were middle pass & married (72.7%) with age less than 20 years. 40% of them had worked as ASHA for more than 6 years. Selection of 50% of ASHA was through recommendation of village head. 81.8% received training for JSY at one or other time. The coverage of services was 100% for registration, Antenatal check up, immunization and counselling for breast feeding. Delay in receipt of incentive was reported by most of the ASHAs. As far as their knowledge is concerned,

86.3% cited decrease or no movement of foetus as common complication followed by anaemia (77.2%) & others. 54.5% of the ASHAs seek the advice of ANM before referral in case women face any complication during antenatal period. Various problems encountered by ASHAs while working were delay in receipt of incentive, lack of support from family members and rude attitude of the staff at the place of referral etc. ASHAs work in coordination with various service providers at sub-centre, PHC & Block level. It was observed that ASHAs mainly focus on incentive and make fake entries at times in the MCH card. Besides they neglect other component of the scheme like counselling services postnatal care and other activities which were not incentive driven.

11 ANM were interviewed to assess the working pattern and service provision at the sub-centre level. 63.6% ANM were trained for SBA. However, most of the newly appointed ANM had not received training for SBA except the induction training. Services provided include early registration, Antenatal check up, provision of IFA and TT injection and timely referral of high risk mothers. Delivery and Minor Investigation like Hb, urine test was not done at any of the sub-centres. Besides, the study identified gaps in service delivery component such as postnatal visit, counselling for family planning and field visit on the part of ANM. Registers and record keeping was maintained up to date. Salary of ANM appointed under NRHM was pending from the last many months.

Stakeholder at PHC, CHC and district level were interviewed to understand their role and management regarding JSY related activities. Monthly meeting are held every month at PHC to discuss the program related issues. The transfer of fund is through electronic transfer and beneficiaries are being paid via payees account after fulfilling all the requisite formalities. Funds are disbursed at the place of delivery though

late payment had been done in majority of the cases. The list of beneficiaries is displayed at every PHC to ensure transparency as per the guidelines.

Regarding monitoring and supervision periodic field visit at sub centre and checking of records and reports are done at monthly meeting at block and district level. Maintenance of funds is done by District accounts manager at district and block level and staff appointed under NRHM at PHC level. Estimation for fund requirement each year is done on the basis of total population, Birth rate and trends in institutional delivery during the previous one year. Budget is prepared as per the fund requirement of district and the utilization certificate from lower level. Irregularity in receipt of fund was reported by all the stakeholder due to various reasons. They either wait for the fund to arrive or they divert it from other sources.

Continuous monitoring is done through MCTS and HMIS at block and district level. The respondents at block level reported the lack of human resources. At times, it becomes cumbersome for them to overcome the workload. Less salary was the reason for dis satisfaction at block level. Incomplete documentation, false report by ASHAs and ANMs and delay in receipt of utilization certificate at times are the common problems encountered by the stakeholder. Evaluation is done by physical verification. Online toll free grievance redressal mechanism has been set up recently to address the issues of beneficiaries.

The evaluation has assessed the reach of the scheme, awareness and utilization pattern of JSY beneficiaries and implementation of the scheme at various level. The study also identified the difficulties faced in the implementation of the scheme and role played by ASHA, ANM and other stakeholders.

Regarding the awareness, majority had heard about the scheme before pregnancy. All the women had limited knowledge regarding various component of JSY. There is need to make women aware by counselling during ANC visit and through IEC material like posters, charts, role play in local language as large chunk of the women are illiterate.

As far as the utilization of services is concerned, most of them got registered during 1st trimester and had underwent antenatal checkups more than four times. Registration at sub centre was around 75%. Home visit by health workers is almost negligible. It seems as if the ANM had place their responsibilities to ASHA and doing more of clerical work. There is a need to demarcate the role and responsibility of ANM and ASHA. Around half of women were monitored for BP and weight measurement at each visit. All the women received required TT injection as per the recommendation. Some of the women took less than recommended 100 IFA tablets. Motivation is needed to ensure that women keep compliance throughout pregnancy. Majority of the deliveries were institutional except two cases where home delivery had occurred. Majority of the delivery occurring at tertiary care and district hospital reflect the lack of infrastructure and manpower and basic EmOC services at primary health care facilities which needs up gradation as per IPHS standards. More than half of women had undergone caesarean

section which is three times more than expected. ASHA was the main motivator for opting institutional delivery. However, escorting the pregnant lady and stay during pregnancy was meagre. Few of the beneficiaries were dissatisfied with the rude attitude of the staff and poor quality of services at the hospital. Postnatal care was the most neglected component. Only 87% of women had received incentive at the time of survey. Most of the women got incentive after one week of delivery and many had to make several visit to get the amount. Delay in receipt of fund was observed across all the blocks.

Regarding the age profile of ASHA majority of them were in the lower age group. All of them were educated as per guidelines. Quarter of ASHAs were unmarried. Half of them were selected on approval by the village head. On an average, ASHA served a population of more than 1000 with the exception of Sub centre Aabidal of block Hazratbal where only 2 ASHAs were available for a population of more than 6000. There is a need to rationalize the ASHAs as per norms in this particular area. Majority of them had received training up to module 5. ASHAs provide constellation of services related to mother and child health. However, they encounter many problems like delay in receipt of fund, lack of co-operation by women at the time of delivery, barrier due to cultural factors, non availability of Drug kit on time and rude attitude of hospital staff.

ANM are posted at every sub centre as per the guidelines. Micro planning is being done every month. Field visit and postnatal check up was meagre. Basic laboratory tests like urine and haemoglobin was not done at any of the studied sub centres. Overall, there is a need to upgrade the Sub centre as per IPHS standard.

Monitoring, Evaluation and Supervision is being done as per the Programme Implementation Plan of NRHM.**(99)** The stakeholder encounter problems at times such as delay in the receipt of fund due to non submission of utilization certificate from lower level, incomplete documentation and over reporting from field level worker, lack of manpower for various managerial activities and lack of training among field level worker in record keeping and maintenance.

Recommendation

- Field visit to be emphasised by demarcating the role and responsibility of ASHA and ANM
- To lower the caesarean section rate to the minimum recommended level.
- Timely receipt of fund for beneficiaries ASHAs and ANMs as per guidelines.
- Flexibility in payment of fund across the entire district.
- Postnatal services need to be emphasized.
- Recruitment and rationalization of ASHA as per norms at sub centres.
- Capacity building of newly recruited ANMs.
- Up gradation of sub centres, PHCs and CHCs as per Indian Public Health standard.
- Accreditation of Private Hospital as per the guidelines.

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99. Operational Guidelines for state Programme Implementation Programme Jammu & Kashmir NRHM (2012- 13)

ANNEXURE-I

RECENTLY DELIVERED WOMEN

Background Information

1) Name of the district:-
2) Name of the block:-
3) Name of the sub-centre:-
4) Name of the village and locality:-
5) Personal details:-

Name of the mother:- Age:-

W/o:-

Religion:-

Status of the family:-

Educational qualification:-

Income of the family:-

House:-

Family:-

Awareness and Registration :-

Q1	Did you ever heard about Janani Suraksha Yojna?	Yes/ No
Q2	If Yes, when did you hear about Janani Suraksha Yojna ?	Before being pregnant. During pregnancy.
Q3	From whom did you heard about the scheme?	ASHA AW W ANM Others (friends, relative, media)
Q4	Did you know about the timing of registration?	Yes No
Q5	If yes, when did you did your registration ?	1st Trimester 2nd Trimester

		3rd Trimester
Q6	Did the health worker visited you during antenatal period?	Yes No
Q7	If yes, How many times did health worker visited at your home?	
Q8	Who did the registration?	Doctor ANM ASHA AWW
Q9	Where were you registered?	District/ Sub- District Hospital CHC PHC Sub centre Other place (AWC/ private clinic/hospital)
Q10	What do you know about the type of facility provided under the scheme?	Health worker (ASHA) is there to help them. Money is paid for transportation. Money is paid for institutional delivery. Availability of 24x 7 delivery services. Availability of doctor in case complication arises. Private hospital have been approved for free delivery Services. Support is provided for post natal care. Any other…
Q11	What do you think is the main purpose of the scheme?	Medical assistance For diet,drugs etc. Don't know

Antenatal Services

Q12	How many times did you go for antenatal check-up?	One time Two times Three times Four times Not done
Q13	Why didn't you go for antenatal check-up?	Unaware of the services provided Centre is far away from my place I did not felt the necessary Due to financial reasons Poor quality of services at the centre No time to go Not permitted to go by family members
Q14	Have you did the check-ups at the same centre throughout pregnancy?	Yes / No
Q15	Where did you go for antenatal check-up?	District hospital CHC PHC S/C Others(private clinic & hospital) None
Q16	Did ASHA accompany you during antenatal check- up?	Yes / No
Q17	Was your weight measured when you were pregnant?	Yes / No
Q18	If yes, how many times?	At every visit occasionally
Q19	Was your Blood Pressure measured when you were pregnant?	Yes /No
Q20	If yes, how many times?	At every visit Occasionally
Q21	Were you given Iron Folic Acid tablets during your pregnancy?	Yes / No
Q22	From where did you got the tablets?	Government hospital Had to purchase on my own.

Q23	Did you consume all the Iron Folic Acid tablets?	Yes /No
Q24	Did you receive Tetanus Toxoid?	Yes / No
Q25	Number of Tetanus Toxoid Received?	Twice Booster
Q26	Did you suffered from any complication during pregnancy?	Yes / No

Place of Delivery

Q27	Where was the baby delivered?	Home Institution:- Sub- centre. PHC CHC SDH DH Private facility.
Q28	Who advised you for institutional delivery?	ASHA AWW ANM Doctor. Others (dai, relative, friend or neighbour)
Q29	What were the reasons for home delivery?	Home is convenient. No need since the pregnancy was normal No nearby institution for 24x7. Cost of institutional delivery. Institution is far off. Nobody in family to take care of my family. Untimely delivery.
Q30	What were the reasons for opting institutional delivery?	Money available under JSY. Better access to institutional delivery. Better care for mother and newborn

		child. Support provided by ASHA. Previous child was born in an institution.

Intranatal Period

Q31	What was mode of delivery?	Normal Ceasarean Others(assisted delivery)
Q32	What was the outcome of Delivery?	Live born Still born
Q33	How many days did you stayed in the institution?	
Q34	How much time did it took to attend you after admission?	Immediately Delayed
Q35	Who conducted the delivery?	Nurse Doctor Others. (specify)
Q36	How was the toilet facility?	Good facility. Poor facility.
Q37	Were you satisfied with the overall services provided at the institution?	Satisfied. Not satisfied.
Q38	What were the reasons for no satisfaction?	Rude staff. Poor quality of service.
Q39	Did you receive any incentive under JSY?	Yes / No
Q40	When did you receive the incentive?	At the time of discharge. Within a week after discharge. More than a week after Discharge.
Q41	How much amount did you received as incentive?	< 1400 Rs 1400 >1400

Q42	Did you face any problem in receiving the money?	Yes/No
Q43	If yes, what difficulty do you face?	Had to make several contact Others
Q44	Where did you receive the incentive?	At home Sub centre CHC/PHC DH
Q45	Who paid you the money?	Accountant Medical officer Others .

Transportation

Q46	How far was the place of delivery?	Less than 5 km 5- 10 km. 10-20 km. More than 20km.
Q47	What was the mode of transportation?	Hired vehicle. Personally owned. By Ambulance.
Q48	Who facilitated in arranging the transport?	ASHA ANM Others.
Q49	Who accompanied you at the time of delivery?	

Postnatal Care

Q50	Did ANM and ASHA visit you within 6 weeks of delivery?	Yes / No
Q51	If yes, How many times?	
Q52	Were you given education /counselling regarding breast feeding after delivery?	Yes/ No
Q53	Did your child got BCG immunization?	Yes/ No
Q54	Were you given education /counselling regarding family planning after delivery?	Yes / No

ANNEXURE – II

ASHA SCHEDULE

Q1	Name of the district	
Q2	Name of the block	
Q3	Name of the sub-centre	
Q4	Name of the village/ locality	
Q5	Name of the ASHA	
Q6	Age	
Q7	Marital status	
Q8	Educational qualification	
Q9	Total population served by ASHA	
Q10	Number of villages served by ASHA	
Q11	In which year were you selected as ASHA?	
Q12	How were you selected as ASHA?	On recommendation of village head Selected by village health committee On recommendation by ANM Others.
Q13	Which place do you belong?	Same locality. Others (specify)
Q14	How far is your residence from the centre?	

Status of Asha

Q15	Did you receive any training?	Yes/No
Q16	How many times have you been trained after the initial round of training?	Modular training
Q17	What do you know about various component of mother and child health?	
Q18	What information do you provide the beneficiaries?	
Q19	What are the complication women face during pregnancy ?	
Q20	Do you face any difficulty while carrying your work?	Yes /No
Q21	What challenges you usually face while carrying your work?	
Q22	What are your suggestions to improve the performance of ASHA as per your experience?	

Receipt of Incentive

Q23	Are you getting incentive for your work?	Yes /No
Q24	Do you get it in time?	Yes /No
Q25	Who pay you the incentive?	ANM MO LHV of PHC/ CHC Others(clerk, accountant)

Support Provided To Pregnant Women

Q26	How many JSY cases have you facilitated during the last one year?	
Q27	What help do you provided the pregnant women?	Arrange her registration Arrange antenatal check-up and TT injections. Arrange supply of Iron Folic acid tablets. Inform about JSY Helped her in getting the incentive Decide and arrange place of delivery Arrange transportation to reach the institution. Stayed with her at the institution. Advice her on breast feeding practices Help in getting immunization.
Q28	What do you think are the reasons behind home delivery?	Due to non availability of health facility nearby. Lack of transportation facility. They find it more convenient Rude attitude of staff Family/ cultural reasons Others
Q29	What do you do in case women develop complication during antenatal period?	Immediately take her to nearest PHC/SD/DH Consult the ANM Take her to govt accredited private hospital Others(send to ISM/ quack/dai /hakim)

Support from Other Functionaries

Q30	Did you ever needed support from other functionaries?	Yes /No
Q31	If yes, Who supported you in your work?	ANM AWW PHC Staff VH &SC Official at block level
Q32	How frequently do you meet the stakeholders?	Daily Weekly As per the requirement

ANNEXURE- III

ANM / IN- CHARGE NRHM SCHEDULE

Background Information

Date of visit:-

Name of the district:- Name of the block:-

Sub centre:- Population catered by the centre:-

Appointed under:- NRHM

State Government

Q1	Did you receive any training regarding the scheme?	Yes / No
Q2	How many times did you receive the training?	Once Twice Many times
Q3	How many cases have been registered under JSY during the last one year	
Q4	Do you prepare monthly work schedule	Yes / No
Q5	If yes, what do you include in your schedule? (Microplanning)	Estimate pregnant women to be taken for ANC. Estimate number of women to be taken for delivery. Number of children to be taken for immunization
Q6	Do you submit the report every month?	Yes/ No
Q7	What are Services provided at sub-centre regarding mother and child health at sub-centre?	
Q8	Any suggestions to improve the functioning of the scheme?	

ANNEXURE-IV

MEDICAL OFFICER / IN- CHARGE NRHM PHC / AD

Background Information

Date of visit:-

Name of the district: - Name of the block:-

Location of PHC: - Population covered by PHC:-

No of sub- centre under PHC:-

Q1	How do you estimate the number of beneficiaries for meeting the fund requirement for the year?	From Birth Rate Total pregnancy Institutional delivery in previous year
Q2	When do you receive the funds?	Annually Instalments(half yearly, quarterly)
Q3	How do you receive it?	In cash By cheque/ Demand Draft
Q4	Was there a delay or paucity in receiving the fund?	Yes / No
Q5	If yes, how do you manage the situation?	Wait for the fund. Delay the payment Divert fund from other plans/ scheme
Q6	How do you review the functioning of the scheme?	Conduct monthly meeting Check report Do field visit
Q7	Do you have fixed schedule for field visit?	Yes/No
Q8	Do any member from higher authorities Visit	Yes/ No

	the centre to supervise JSY related activities?	
Q9	Who maintain the documents and registers?	ANM Others(LHV, clerk, accountant)
Q10	Do you what do you do in case you find any loopholes?	Manage at my own level Report to higher authorities
Q11	Do you think JSY scheme has made a difference in terms of institutional delivery?	Yes / No
Q12	What are your suggestions to provide better quality service under the scheme?	

Performance

Q13	Has Audit been carried so far?	Yes / No
Q14	If yes, how many times during the last one year?	Yearly/ half yearly

ANNEXURE- V

DIVISIONAL NODAL OFFICER

Date of visit:-

Name of the district:-

Total no of CHC, PHC/ AD and sub- centre under the district:-

Financial Management

Q1	How do you meet the fund requirement for services?	As per the submission of report from PHC, CHC and Sub- centre As per the delivery record of previous year Estimate from the birth rate
Q2	What is the mode of disbursing the incentive ?	
Q3	Is there a fix amount to be disbursed for CHC, PHC and Sub - centre ?	Yes / No
Q4	If yes, how much for respective centre?	
Q5	How often do you receive the fund?	Annually / on instalment basis.
Q6	What is the mode of fund receipt?	Demand Draft Cash Cheque
Q7	Did you face any shortage of funds?	Yes / No
Q8	What do you think are the reasons for delay in receipt?	
Q9	How do you utilize the fund?	Incentive for mother and ASHA Provision of Drugs For transportation For IEC activities
Q10	Who maintain the documents and registers?	Statistical officer. District programme manager. Others(clerk, nurse)

Monitoring and Supervision

Q11	Do you conduct meeting regarding the scheme?	Yes / No
Q12	If yes, how frequently?	
Q13	How do you review the work?	Conduct monthly meeting Check reports Do field visit
Q14	How frequently do you go for supervision?	
Q15	What do you think is your work as supervisor?	Just supervision Training of MO and paramedics Report in case of delay in receipt Conduct meeting Conduct IEC activities To conduct awareness generation campaign other
Q16	Do any member from higher authority visit to supervise and check out JSY related activities?	Yes / No
Q17	If yes, specify?	
Q18	Is there a grievance cell/ complaint box?	Yes/ No

Availability of Service

Q19	Is there any hindrance in the implementation of the scheme?	Yes / No
Q20	If yes, what are the reasons?	
Q21	What are your suggestions to provide quality service under the scheme?	

Q22	Has there been any orientation programme for MO,ASHA and paramedical staff during the last one year regarding JSY?	Yes / No
Q23	Nominated state and district nodal officer for JSY	Yes No
Q24	JSY action plan included in state and district NRHM action plan	Yes No
Q25	GOI sanctioned fund to state and state sanctioned to district	Yes No
Q26	Timely and properly monitoring and evaluations performed	Yes No
Q27	Wide publicity of JSY benefits	Yes No
Q28	IEC materials printed and distributed	Yes No
Q29	Fund flow is timely and proper	Yes No
Q30	List of private institutions displayed at CHC/ PHC/ SC wall or notice board	Yes No
Q31	State authorities sanctioned budget in time	Yes No
Q32	Payment made in to clients	Cash Cheque Directly in their account