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Impact of Janani SurakshaYojana (JSY): A study across two Delhi hospitals

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Abstract

This paper attempts to understand the functioning of Janani Suraksha Yojana (JSY) in New Delhi. The study involved a primary survey of the JSY beneficiaries in two major districts of Delhi. The results of the survey suggest that the scheme has not been very successful in facilitating institutional delivery in Delhi. The scheme has failed to benefit the poor and the underprivileged groups and its limited benefits have only reached the better off households. The implementation of the scheme also has been uneven and faulty and many beneficiaries face delays in receiving benefits. However, the transition towards the direct benefit transfer (DBT) method of payment shows promise in improving implementation of the scheme.

Introduction

India is an emerging super power in the world. Despite the enormous growth of the economy, the health indicators of the country fail to reflect this growth. There has been some improvement but there is a long way to go before we meet the international standards. With the second highest population in the world, India also holds the highest position in number of births per year (27 million) in the world (Ronsmans et al, 2006). But ironically, we also have a very high infant mortality rate (38 deaths per 1000 live births in 2015) and maternal mortality rate (174 deaths per 1, 00, 000 live births in 2015) (World Bank 2015). In a step towards achievement of the millennium development goal 4 (reduction of child mortality rates) and the millennium development goal 5 (improvement of maternal health), Janani Suraksha Yojana “a safe motherhood program” was launched on 12 April 2005 in India (NHM 2015).

Janani Suraksha Yojana is a conditional cash transfer scheme and is a part of National Rural Health Mission, now National Health Mission, which also includes various other new schemes like Janani Shishu Suraksha Karyakarm and Accredited Social Health Activist (ASHA) program in order to achieve a sizeable reduction in neonatal, infant and maternal mortality. The scheme is completely funded by the central government and is fully operational in all the Union Territories and states of India (especially the low performing states). According to the institutional delivery rate, states were classified into high performing states (with more than 25% institutional delivery rate) and low performing states (with 25% or less institutional delivery rate). Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Rajasthan, Orissa, Assam, Jammu and Kashmir are low performing states. The remaining states are grouped in high performing states (NHM 2015).

A special feature of this scheme was the active involvement of the ASHA worker who bridged the gap between the pregnant women (scheme beneficiaries) and the Government (providers). The ASHA plays a crucial role right from

identifying the pregnant women to registration for Antenatal check-ups (ANC), assistance in ANC including medication (like iron folic acid tablets, tetanus injection), referral to the nearest health centre for institutional delivery and complete immunization of the newborn. ASHA workers also receive cash assistance on the basis of the number of institutional deliveries assisted and immunizations completed. The pattern of cash assistance provided to the beneficiary and the ASHA in low and high performing states as per National Health Mission guidelines is mentioned in Table 1.

Category of States	Rural Area			Urban Area			Eligibility Criteria
	Mother	ASHA*	Total	Mother	ASHA**	Total	
Financial Assistance for Institutional Delivery							
Low Performing States (LPS)	Rs.1400	Rs.600	Rs.2000	Rs.1000	Rs.400	Rs.1400	Available to all women regardless of age and number of children for delivery in government /private accredited health facilities
High Performing States (HPS)	Rs. 700	Rs.600	Rs.1300	Rs.600	Rs.400	Rs.1000	Available only to BPL/SC/ST women regardless of age and number of children for delivery in government /private accredited health facilities
Financial Assistance for Home Delivery							
LPS	Rs.500	Nil	Rs.500	Rs.500	Nil	Rs.500	Available only to BPL women who prefer to deliver at home regardless of age and number of children
HPS	Rs.500	Nil	Rs.500	Rs.500	Nil	Rs.500	

* Rs. 600/ per delivery in rural area includes Rs. 300 for antenatal component and Rs. 300 for facilitating institutional delivery

** Rs. 400/ per delivery in urban area includes Rs. 200 for antenatal component and Rs. 200 for facilitating institutional delivery

Source: Report of the Directorate of Health

Table 1: Cash transfer pattern under Janani Suraksha Yojana

This paper attempts to explore the ground realities of the JSY scheme on the basis of a primary survey conducted in two regions of Delhi i.e. Mongolpuri and Uttam Nagar between October to December 2015. The aim is to understand the implementation of the scheme and carry out a critical analysis so as to identify the bottlenecks in the scheme and suggest remedial actions for its improvement.

Background

Numerous studies have been conducted in order to understand the implementation of JSY and whether or not it has been successful in encouraging institutional deliveries and hence instigating a decline in infant and maternal mortality. A primary cross sectional study conducted in select villages of four districts of Rajasthan shows that JSY is not merely a cash incentive to promote institutional delivery but also has an impact in changing the psyche of the women opting for it, who are found to be more informed and attentive towards pre-natal and postnatal care (Purohit et al 2014). They conclude that it is necessary that the health system recognizes this positive role of the scheme in changing the behaviour of the community towards healthier child birth practices. That JSY has been successful in promoting institutional delivery care is also shown by a study on the performance of JSY in backward districts spread across seven "low performing states" in the country (Dongre and Kapur 2013). They find that JSY is working reasonably well, concluded on the basis of the proportion of women receiving incentives after delivering in a government facility, location of receiving incentives, mode of payments and payment of bribes. Apart from increasing institutional deliveries, the implementation of JSY has led to a significant improvement in provision of antenatal care (Lim et al. 2010), who analysed data from the national district level household surveys conducted over the period 2002-2004 and 2007-2009. But they have also pointed out that the benefit of the scheme does not always reach the poorest and the most backward sections of the society and there is a strong need to target the most disadvantaged women. They have also highlighted the poor quality of antenatal care and the need to improve it by better monitoring and time to time evaluations. Another study examines the presence of socio-economic inequalities in access to institutional delivery care after the implementation of the JSY (Randive et al 2014). It was found that although inequality persists, it has reduced since the implementation of the scheme. Also, inequality in male literacy, availability of emergency obstetric care (EmOC) and poverty explain 70% of the inequality in access to institutional delivery. Although the conditional cash transfer scheme has encouraged the utilization of health services, it has done so in favour of the non-poor. Moreover, even the decline in MMR was slower in the poorest areas. The authors conclude that in order to move closer to achieving equity, the cash incentive should be supplemented by access to provision of quality healthcare services and better targeting of the disadvantaged groups.

Some studies show that JSY places undue emphasis on institutional delivery and ignores other aspects of pregnancy, which are equally important in determining maternal and child health outcomes. One such study found no significant association between MMR and JSY scheme based on the study of tertiary referral hospital in Madhya Pradesh over nine years (Gita et al 2010). According to the paper, JSY solely focuses on promoting institutional delivery without

recognizing the importance of antenatal care (ANC) in reducing maternal morbidity and mortality. Poverty, illiteracy, casual acceptance of child bearing and shortage of trained and dedicated health professionals are major hurdles in provision of quality ANC. The authors stress the importance of spreading the cash incentive throughout the length of the pregnancy starting from ANC, to bring about a significant change in MMR via JSY. Even the objective of promoting institutional delivery is not being adequately fulfilled and it has been found that the high out of the pocket expenditure (OOPE) during normal and caesarean delivery is a major constraint for pregnant women and it restricts them to opt for institutional delivery since the incentive money might not be enough. According to them, there is a need to increase the coverage and more efficient implementation of the JSY scheme so as to reduce the burden of OOPE and to promote institutional delivery in the country.

The importance of providing the cash incentive in installments to both the beneficiary and the health worker has also been recognized in another study (Bose 2007) who critically analyses various aspects of the JSY by conducting field visits to villages of Orissa, Madhya Pradesh and Rajasthan. He concludes that unless the health infrastructure and access to healthcare is strengthened in the country, cash transfer schemes like the JSY will not help in reducing maternal mortality and that a few other steps need to be taken in order to bring about an impact on the MMR. These include providing some of the incentive money in advance to encourage ANC, provision for insurance in JSY and steps to reduce risk of infection at home after delivery and so on. According to the paper, the scheme predominantly focuses on disbursement of money and calls for a more humane approach to healthcare. Another cross-sectional survey conducted to explore the difference in the utilization of JSY in rural and urban slums showed that the utilization of JSY was very low in rural areas (Sharma et al 2011). Also, they point out that it was preferable to make payments to the beneficiaries as well as the ASHA workers in installments so as to ensure their involvement and participation in all aspects of the maternity benefit scheme. They also suggest regular monitoring of ASHA's services and provision of timely transport facilities to the beneficiaries.

This study intends to add to the existing body of literature on JSY by observing the implementation of the scheme in a so called 'high performing' union territory of Delhi. Keeping in mind the issues discussed above, some of the objectives are to identify the characteristics of the JSY beneficiaries in terms of literacy, age, awareness about the scheme, caste category etc, to understand the role of ASHA workers in the implementation of the scheme, to understand the registration and documentation procedure related to the scheme, to analyse the proportion of

beneficiaries who have received the cash incentive under the scheme and to compare the performance of the scheme in the light of above factors in two different regions of Delhi viz Mongolpuri and Uttam Nagar.

Methodology

The research attempts to understand the implementation of Janani Suraksha Yojana more closely. The aim is to observe the effectiveness of the scheme at the ground level. The data is collected using primary survey done by a group of four researchers in two different regions of Delhi. Due to limitations of data availability and paucity of time and resources the study could only include Delhi sample. The sample is a random selection from hospitals in two different regions of Delhi.

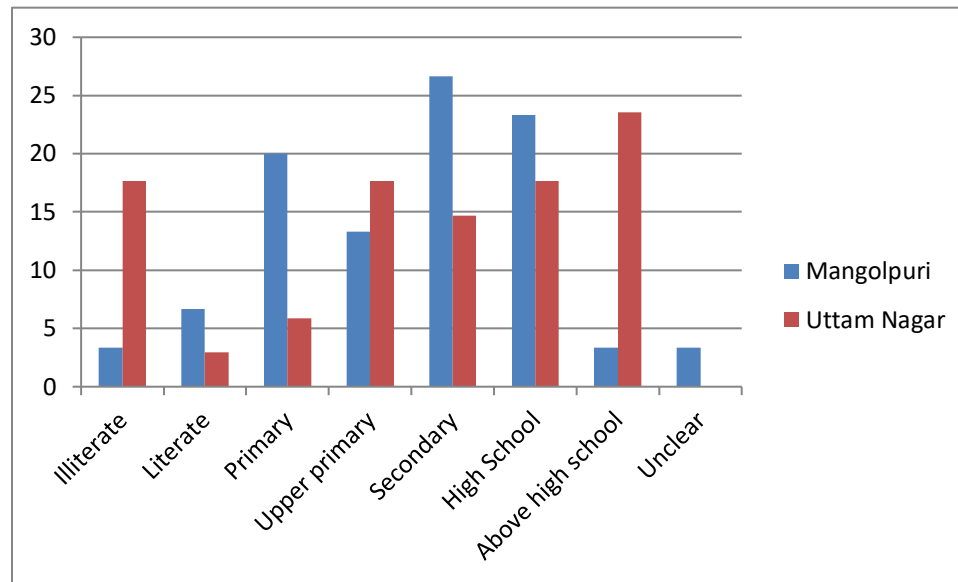
Sampling Design & Technique: The size of sample was restricted to 64 beneficiaries due to time and resource constraint. The survey was conducted between October-December 2015. The target population was the females who have registered for Janani Suraksha Yojana scheme and are residents of Mongolpuri and Uttam Nagar districts of Delhi.

Multi-stage sampling design which has two stages in the survey is used for data collection. For the first stage, convenience sampling method was used and for the second stage, census was used as the sampling procedure. At stage I, we selected Delhi for the evaluation of the scheme. It is a convenience sample which was chosen due to paucity of time and resources. Thus, the results of the study cannot be generalized to make conclusion for the scheme at a national level. At stage II, we selected two districts of Delhi i.e. Mongolpuri and Uttam Nagar. These districts were selected on the grounds of having two big hospitals (Bhagwan Mahavir hospital in the Mongolpuri district and Deen Dayal Upadhyay in the Uttam Nagar district respectively) serving these district's patients. Official permission was granted for access to the hospital records by the director of Ministry of Health. This sample has a judgment sampling design. These hospitals were selected and recommended by the Director based on his judgment of good record keeping in these hospitals and also better availability of patients. Census method was used in both the districts to collect data from every beneficiary who fits in the inclusion criteria of the study.

Key Findings and Discussion

In our sample, about 46.9% women were interviewed from Mongolpuri area and 53.1% were from Uttam Nagar. The majority of beneficiaries interviewed in the two areas of Delhi i.e. Mongolpuri and Uttam Nagar are housewives with varied levels of literacy. While only 3.3% women were illiterate in Mongolpuri, 17.65% were illiterate in Uttam Nagar. Many women had high school and above high school degrees, but none of the women were working outside home.

The proportion of women attaining different education levels in both these regions is shown in the figure below (Figure 1).



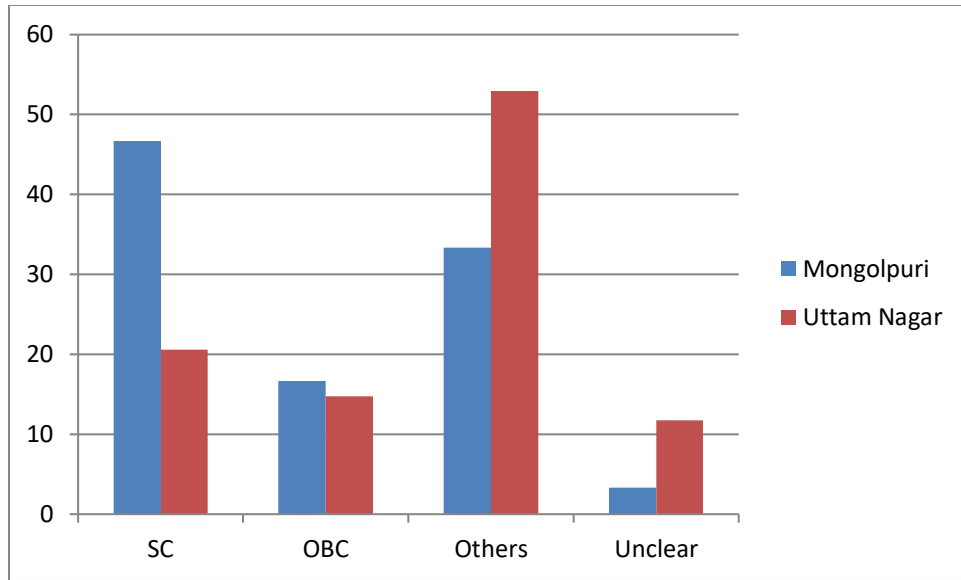
Source: Own calculations

Figure 1: Proportion of beneficiaries with different education levels

In Mongolpuri, majority of the women (56.9%) belonged to the age group 25-30 years while majority of women (52.9%) in Uttam Nagar belonged to 20-25 age groups. In both areas, there are negligible women in the age group below 20 years and above 35 years.

There was predominance of above poverty line and upper caste women among the beneficiaries of the scheme. Although the scheme has been primarily implemented for promoting institutional deliveries among people belonging to the schedule castes (SC), schedule tribes (ST) and other backward classes (OBC) in the high performing states, a substantial proportion of the beneficiaries belong to upper castes in both Mongolpuri as well as Uttam Nagar. The caste composition of the households in both these regions is shown in the histogram below (Figure 2).

Also, in Mongolpuri, 90% of the beneficiaries came to know about the scheme from the hospital itself while in Uttam Nagar, most of the beneficiaries (97%) were made aware of it by ASHA workers, suggesting that the ASHA workers were more pro-active in spreading awareness about the scheme in Uttam Nagar than in Mongolpuri.



Source: Own calculations

Figure 2: Caste composition of the beneficiaries

Another interesting observation is that while 84% of the beneficiaries interviewed in Mongolpuri have received the payment incentive of Rs 600, only 65% had received it in Uttam Nagar (see Table 2 below). From the figures, we can see that the transition to Direct Benefit Transfer (DBT) has actually helped people with receiving their payments. Half the beneficiaries in Uttam Nagar, who are still utilising other modes of payment have not received their payments yet.

Mode of transfer	Mongolpuri		Uttam Nagar	
	Percentage using this mode of transfer	Percentage who received payment	Percentage using this mode of transfer	Percentage who received payment
Cash	20	100	11.76	50
Cheque	33.33	0	29.41	50
DBT	30	100	58.82	92.86
Others	16.67	100	0	0

Source: Own calculations

Table 2: Percentage of beneficiaries supposed to receive payment through each mode of transfer and the percentage who actually received the full amount

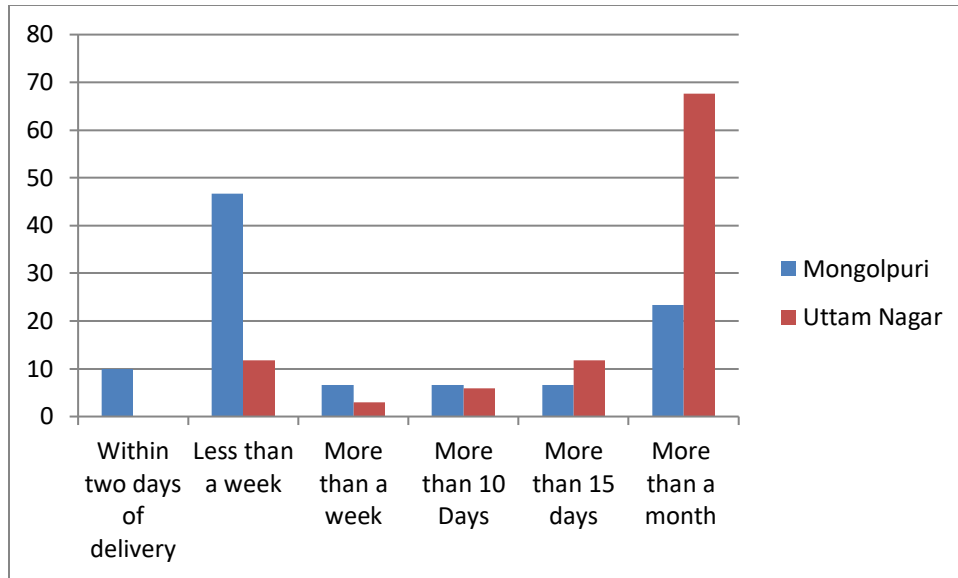
As far as the role of ASHA workers is concerned, it was observed that in Mongolpuri, only 63% of beneficiaries interviewed knew who an ASHA worker and her duty was as compared to a staggering 97% of beneficiaries in Uttam Nagar. This is also reflected in the observation that in Mongolpuri, only 30% of the beneficiaries were assisted by the ASHA during the length of the pregnancy which includes the antenatal and the postnatal checkups whereas this percentage is around 54% for beneficiaries staying in Uttam Nagar. Further, only 3.3% women used ambulance as the mode of transport to reach the hospital in Mangaolpuri while 26.6% used ambulance in Uttam Nagar area. Also, majority of them commuted through vehicles other than public transport and personal vehicles, mostly auto rickshaws spending on an average Rs.50-100 per trip. Table 3 shows the percentage of beneficiaries using different modes of transport to reach the hospital in Mongolpuri and Uttam Nagar respectively.

	Mongolpuri	Uttam Nagar
Own Vehicle	27	29
Public Transport	0	35
Ambulance	3	24
Auto Rickshaw	70	12
Total sample	32	32

Table 3: Proportion of beneficiaries using different modes of transport in Mongolpuri, in %

Source: Own calculations

In Uttam Nagar, approximately 67.7% beneficiaries received the JSY money after more than 30 days of delivery while in Mongolpuri, 46.7 % beneficiaries received the JSY amount within a week. This may again be due to variations in the transition to DBT in the two areas. Figure 5 shows the proportion of beneficiaries receiving the amount with different periods of delay from the date of conception.



Source: Own calculations

Figure 3: Proportion of beneficiaries having different time gap between delivery and receipt of JSY amount

Additional Observations

Apart from the key findings mentioned above, some interesting qualitative insights were obtained from the study. It was observed that most of the beneficiaries did not know about the scheme in detail. They just knew the name and what monetary benefits they were entitled to receive. The beneficiaries found the registration a little complicated due to a lot of paper work as well as long waiting queues. It was observed that majority of the beneficiaries did not have a bank account prior to getting pregnant. Most of the beneficiaries reported that they had to make several rounds to the hospital for availing the benefit amount. On an average, an individual beneficiary spends about Rs.65/- for one way. Most of the beneficiaries reported that on the day of the delivery they were accompanied by their family members. A few beneficiaries reported ASHA's assistance to the hospital on the day of delivery. Most of the beneficiaries also complained about the bad infrastructure and sanitation in the hospital. More than one woman was allotted one bed which they had to share even during the time of delivery. Moreover, the toilets were reported to be unclean. It has also been found that the scheme does not seem to be fulfilling its purpose of promoting institutional delivery. Most of the beneficiaries reported to have chosen institutional delivery even in the absence of the scheme. In fact, only those who opt for institutional delivery register themselves for the scheme.

Discussion and Conclusion

The survey was conducted in two densely populated localities of New Delhi with an aim to understand the functioning of the Janani Suraksha Yojana. Broadly, **three issues** need to be mentioned.

Firstly, a lot of people don't know much about the scheme and its objectives. The idea was to promote the phenomenon of institutional deliveries among under privileged sections of the population where deliveries are still being done in unsanitary and unhygienic conditions without proper supervision. The aim was to bring about a decline in the maternal mortality rate (MMR). However, the survey finds out that only those people who opt for institutional delivery in the first place know about the scheme and have registered for it. Thus, there is a need for spreading more awareness about the scheme among the target population and the ASHA worker can play an important role in doing this.

This brings us to our **second** issue which is that the work done by the ASHA worker is unsatisfactory. The outcome of the survey shows that the role played by the ASHA in the facilitation of the scheme is at best mixed with them being very active in Uttam Nagar to having a very low presence in Mongolpuri. The role of the ASHA includes everything from telling people about the scheme to assisting a pregnant woman during the period of her pregnancy and ensuring child immunization. Thus, a proper functioning of the scheme would require the ASHA worker to offer her services more effectively. This can be encouraged if the ASHA worker is incentivized sufficiently.

Finally, although a significant number of beneficiaries interviewed have received the payment promised under the scheme within a week in Mongolpuri, the same is not true for beneficiaries in Uttam Nagar. One reason the scheme seems to be performing better in Mongolpuri compared to Uttam Nagar might be due to higher literacy among Mongolpuri residents that could have made it easier for them to adopt the digital mode of payment. The response to the scheme could also have been higher among Mongolpuri residents because of better understanding of its benefits. Thus, a smooth transition to the DBT system can greatly improve the efficiency of the scheme. Also, the amount of the monetary incentive needs to be increased significantly for both the beneficiary and the health workers in order to promote better participation.

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Declaration

We declare that the authors of the article are in the order in which listed; and the article is original, and has not been published, and has not been submitted for publication elsewhere.

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