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Janani Surasksha Yojana: Impact on Socio-Economic Conditions among Beneficiary Families

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Abstract- Government of India introduced Janani Suraksha Yojana (JSY) in 2006 under the umbrella of National Rural Health Mission by modifying National Maternity Benefit Scheme. Primarily, created for integrating cash assistance with antenatal care during the pregnancy period, institutional care and immediate post-partum period, this program has been successful in bringing down Infant mortality rate (IMR) and Maternal mortality rate (MMR) in India. While abundant literature is available on the facilitating and increased number of institutional delivery because of JSY, little is available on the beneficence of the cash assistance. This paper is based on a quantitative research to find out the socio-economic role of the program in terms of awareness, implementation and changes in the beneficiary families. The study has been conducted in the two districts, Nawada and Araria of Bihar selected on the basis of their contrasting health outputs. With response rate of 94.67 per cent, the total sample under study was 142 women registered as beneficiaries with the local health service providers. The results of the study reflected a high level of awareness among women accessing and community at large. Involvement of ASHA worker in program is considered to be a philanthropic work (66.2%). It is also to be considered that this awareness level about the program is among the women who have availed the services of JSY. However with regards to cash incentives, only 68% of the participants have received incentive of which only 69% have collected it themselves. Only 67.7% is registered for antenatal check-up. Reflecting upon the changing social status, 61% have provided a positive response of upward movement in the community describing the facilitative nature in building the educational and livelihood standard of the family. Undoubtedly the program is a beneficial inclusive initiative of the government helping families move up the social ladder. The two regions in spite on contradictory health outcomes had similar responses about JSY. However red-tape incidents were also reported reflecting the need of amendments in the process of implementation.

Index Terms- Incentives, Institutional deliveries, JSY, Maternal health, socio-economic impact

I. INTRODUCTION

India is recorded to have 30 million pregnancies a year of which 27 millions are delivered [1], 15% of which are to develop complications with Haemorrhage (38%), Sepsis (11%), Hypertension disorders (5%), obstructed labor (5%), abortion (8%) and other conditions. Maternal Mortality and morbidity along with infant conditions are critical aspects for sexual and reproductive health status of country but also the society living in. The National family Health survey –III states the reduction in the MMR rates from 424 to 254 in last two decades. Though National Maternity benefit scheme existed in the country, the Planning commission through an evaluative report declared it to be ineffective in reducing the MMR. [1] Suggestions were provided for divided two-time cash assistance and more for girl child delivery. Accordingly, the Ministry of Health and Family Welfare, Government of India declared the Janani Surksha Yojana modifying the National Maternity Benefit Scheme under the broader umbrella mission- National Rural Livelihood Mission. This program targets to provide cash assistance with antenatal care during pregnancy period, institutional care during delivery and immediate post-partum period, to all pregnant women above or 19years old belonging to Below Poverty Line (BPL) families. The success of this program depended on the institutional deliveries. The NFHS data in three rounds showed the increase of institutional deliveries from 26.1 per cent to 33.6 per cent and in 2006 increase to 40.8 per cent. An assessment of JSY by NIHFW and UNFPA indicated a huge increase of institutional deliveries in low-performing states which led to the popularity of the program. [2]. Anirudh K Jain reflected upon the several impact assessment survey by governmental and non-governmental research organizations establishing the fact that number of births in hospital was increasing. [3]. However little literature is available about the socio-economic development of the families/individuals after accessing the services in JSY. This research paper deals with the impact of JSY in socio-economic conditions of families especially mothers as direct beneficiaries of the program.

II. RESEARCH QUESTION

JSY had identified 10 states as Low Performing States (LPS) to implement the program; they are namely Uttar Pradesh, Uttaranchal, Madhya Pradesh, Chhattisgarh, Rajasthan, Bihar, Jharkhand and Orissa along with Assam and Jammu and Kashmir. The literature available on JSY implementation and change described how researches have been majorly conducted in the states of Rajasthan, Jharkhand and Orissa. Bihar in spite of being a fragile state in terms of health outcomes has been not looked up by research units. The state of Bihar records a MMR of 312 per 100,000 live births compared to national average of 254 [4] and 56 as IMR compared to national count of 52 [4]. JSY has been reported to have successfully reduced the IMR and MMR in the country with the increase in institutional deliveries

to 41% countrywide. [1] However the subsequent years have not shown much a change in Bihar which has only 34% institutional deliveries.[5] But it is to be noticed that JSY as a program has penetrated to the communities in Bihar and has brought in the institutional deliveries to the stated percentage. Thus in research an attempt has been made to find out the impact of socio-economic status in reference to being beneficiaries of JSY in the state of Bihar. In doing so, two districts with different and contrasting geographical-demographic composition has been identified. While Nawada has good health indicators by being geographically located nearer to Patna, Araria is 450 kms away and catastrophically prone to floods. Thus the political map location and the natural climatic conditions have marked Nawada as 4th rank in state ranking in Health indicators leaving Araria in last few districts. [5] The researcher taking in reference of the difference in the districts' health outcome performing factor is trying to tap the experiences of the women beneficiaries of the two states.

The specific objectives of the study are:

- To find the level of awareness level about JSY by identifying how and where they women came to know about JSY
- To find out the extent of the JSY program implementation through the experiences of the women beneficiaries in terms of access
- To identify the changes in the family socio-economic structure and status after accessing JSY

III. METHODOLOGY

A. *Research Design*

The study design is a triangulation of quantitative-qualitative methodology. The qualitative aspects include finding out level of awareness and a numerical representation have been collected from the study population to describe the extent of awareness and accessibility. The qualitative methodology was developed to explore and record the experience of the women beneficiaries. The research also has a paradigm of looking into aspects from Feminist perspective. In this research a feminist approach was adopted to understand the subjective experiences, perceptions of the women participants of the village

B. *Sampling*

A purposive sampling has been applied in three stages: Selection of number of: panchayats → villages → households. The selection of panchayats was random but the villages under the study were on the basis of the number of JSY beneficiaries as provided by the District Health Societies. The respondent sample size is 10% of the household beneficiaries in each village. The total sample size is 142. With a non-response rate of 5%, the total sample size is 150. The respondents of the study are individual women who have received and thus registered under the JSY scheme of the panchayat.

C. *Data Collection tools*

The tools used in the research have been within the scope provided by the research design and method perspective. In this research data collection, a methodological triangulation has been used. Methodological triangulation is the base of combination of tools of data collection. Herein a complex method of data collection is been practiced; the sources of data has been both secondary and primary which has also determined the tools for data collection.

The primary tools of data collection involving direct connection with the participants are in-depth interview and focus group discussions (FGD). The secondary data sources have varied from District Health Society reports, gazetteers and public documents of Bihar State health Society, Public Health Resource Network and National Health System Resource Centre.

D. *Data Analysis*

The data collected were entered into the SPSS (Statistical Package for Social Sciences). Data has been analyzed by creating frequency table and cross tabulation. The qualitative data has been manually analyzed under the themes of awareness, accessibility and societal change.

IV. RESULTS AND DISCUSSION

Considering the objective to explore and count the experiences of the women beneficiaries of the program, 100% of the respondents are female. Out of 142 respondents, 53.5 per cent belong to the age group of 20 to 25 years while 37.8 per cent were from 26 to 30 years of age group. Only 8.5 per cent were from the age group of 31-35 years. It was important for the researcher to tap the social background of the respondents who had availed the services of JSY. Thus the social category was asked in the interview; 56.8 per cent of the respondent belonged to the Scheduled Caste with 34.7 per cent belonging to Other Backward Castes (OBC). Interestingly only 6.4 per cent women were from general category household, with the least per cent of respondents from Scheduled Tribe (2.1%). As social factor, religion is critical in facilitating health seeking behavior; 91.8 per cent of the respondents were followed Hinduism and remaining 8.2 per cent were Muslims. The area had no Christian or any other religious communities. Education is another crucial social factor in determining the awareness level and pro-nature towards utilization of health services. 56.8 per cent are illiterate (never gone to educational institutes), 19.6 per cent are literate and 13.7 per cent have completed primary education. 81.9 per cent of respondents were engaged in daily labor work and 14.6 per cent in farms; only 3.5 per cent were homemakers without any economic work engagement.

Considering the sample size as 10% of the beneficiaries from specific villages, the ratio of accessing health facilities is 1:1 with a minimal difference by the district from Nawada more by 0.7 percent. Thus the records of beneficiaries described in spite of geographical differences, the services of JSY reached both the districts without any socio-cultural boundary.

100 per cent of the respondents participating in the study belonged to below poverty line (BPL) household. The family size was critical in this study to understand the strength as well as dependants of the household and the impact of that on the JSY access. But the study revealed that it had no direct connect as families with 4 to 6 members maximum participation in JSY (54.3%) while 2.4 per cent respondents were from family size having 13 to 15 members. However the respondents wherein the

work force was least (1-2 members in the family) had maximum availed the JSY services (79.3%).

A. Awareness Level and Implementation Benefits from JSY

The study aims at determining the awareness level of the beneficiaries through the information on source of knowledge on JSY scheme, extent of knowledge. All (100%) knew about JSY and thus registered for benefits but not all knew the name or specifications of the scheme. For 72.7 per cent respondents, the source of information was the neighbors. This reflects the community level awareness about the scheme; if not specifications but the existence of the scheme have reached the community. 18.4 per cent had ASHA as their source, 6.2 per cent as members of family and 2.7 per cent knew from the primary health care centre (PHCs). The respondents (100%) also knew about the amount for institutional delivery which is Rs. 1400/- but least (5.3%) knew of the 24*7 government facility for delivery.

B. *Extent of implementation of the scheme*

Out of 142 respondents, 68% had received JSY incentive at the time of discharge and 32% after six months to one year after the delivery. Undoubtedly that is the sign of delay in dispensing funds among the beneficiaries. The incentive in 47.89 per cent of cases was paid through cash and the rest (52.11%) is via check. The respondents have however referred to have paid 'service charges' of Rs 200-300 to the health functionaries. However the success of the scheme could be defined by the fact that the mothers themselves receive the incentive. 69 per cent have answered to have received by self the amount, while 21 per cent and 10 per cent have received through husband and other family member respectively. This percentage of women receiving by self is high because of the guideline established for disbursement of checks by the health post in the name of the beneficiary. [6]

JSY is not only about incentive but also critical in facilitating antenatal care among their registered mothers. Among the respondents, 67.7 per cent were registered with the nearest sub-centre while 32.3 per cent were never registered. The frequency of ante natal care visits have also been very low with the maximum respondents (49.5%) visiting only two times. For post natal care, 58.4 per cent have been registered and thus received some level of help.

The JSY in Bihar have definitely decreased the home deliveries by virtue of increasing the institutional deliveries through its community reach. [7] The current study confirms the fact of increasing community involvement in the implementation of JSY in terms of registering for the scheme and facilitating institutional delivery. But considering the low registration of ante natal and post care among already JSY registered mothers, there is a huge population untouched by JSY.

C. *Socio-economic Impact of JSY*

JSY caters to the pregnant women of the BPL families in all states specifically to the low performing states. [6] The study tries to measure the social movement after accessing the JSY services by identifying the monetary changes in terms of expenditure and investment on different aspects associated with baby birth and pregnancy.

Before introducing the JSY scheme, 42.8 per cent respondents had spent up to Rs 500 on antenatal care but this had dropped to 6.4 per cent spending Rs 500. Also the amount of expenditure had decreased to less than Rs 500. But there has been an increase in households (26.4% to 45.6%) spending upto Rs 2000 on deliveries services. However this is not self expenditure but a share of the incentive provides help to the families to spend on the delivery services. With the increase in institutional deliveries, cost for transport facilities has increased by 20 per cent from Rs 400 to Rs 600. This is included in the total expenditure on the delivery services.

The study data reveals that 21.5 per cent of the respondents spend the incentive amount on general expenses of the household. A total of 46.8 per cent spend the money on health expenses comprising both minor and major disease of family members. Critical was to find on whom the money was spent but the respondents refused to reveal. However some proportion of the money is saved for the future of the children; 12.4 per cent of respondents considered spending money on child's education while 6.2 per cent on post natal care of the new born. The female participants in the FGD put forward that the money cannot be used in appropriate way in different heads as the amount is not substantial for meeting all needs associated with the new born. The concern regarding the amount has been spoken about also in the context of Rajasthan JSY beneficiaries [8] wherein they used the amount for antenatal care and transportation for deliveries only.

The amount was, nevertheless providing financial support to the families registered under JSY. 78.9 per cent expressed their belief on JSY and its assistance in the family health expenditure. This has helped them directly or indirectly to be in a better financial condition.

V. CONCLUSION

JSY beneficiaries in the two districts have shared similar experiences. In spite of the district geographical and health rank differences, the scheme of JSY has reached to the marginalized. The majority of the respondents from Scheduled castes and OBC explain the extent of reach. JSY has been able to reach out through the community engagement. Unlike Orissa, [9] wherein community media was used to create awareness, here word of mouth has been efficient in bringing in more families under the scheme. The scheme has definitely made critical impact increasing the institutional deliveries in the state of Bihar from 13.3 to 18.6 [10, 1] and specific to these two districts. On the contrary, keeping in mind the Bihar state MMR 312 per 1 00 000 births, it is to be reminded that the JSY has reached only a few sections. In spite of its current good reach, many more sections of the population are to be touched, motivated and registered with JSY.

The major component of JSY is the cash incentive to the mothers. The PHRN in 2009 found in their study about delay of cash payment beyond one month of delivery. In our research 68 per cent have received on delivery; one major reason for such improvement is the disbursement of amount by the check not cash. But complexity arises with the fact who receives the amount. Herein among the respondent population, 69 per cent receives amount by self. It is mandatory as the checks bear the respective names, which has disabled the husbands or any other

member of the family. The study has not been able to tap the decision making power after collecting the amount.

The study acknowledges that the cash assistance provided has provided certain support in health expenditure of the families of the beneficiaries. They can spend it on transport cost for facilitating institutional deliveries. In a study in Rajasthan, the women have expressed the lack of transport facility and the increasing cost in transportation as a major barrier in institutional delivery. [8] Thus the cash assistance in these districts helping in transportation cost could indicate the increasing institutional delivery and reducing financial burden as a whole.

The study as nevertheless identified areas of improvement of the JSY implementation. Not always a cash incentive could lead to socio-economic development. Health is crucial for development; the Government must take extensive effort to build in infrastructure nearer to the communities or enhance commuting facilities. Aasish Bose supporting this wrote 'reduction of maternal mortality should focus on creation of health infrastructure and ensuring road connectivity in rural areas rather than merely dolling out money to poor families.' [11] Even in the provision for cash assistance, payment at different stages is to be encouraged than single time disbursement. Focus must be given on Antenatal cash assistance based on perinatal and antenatal check-ups.

VI. ETHICAL CONSIDERATION AND LIMITATION

Reproductive Health and sexuality is a taboo for discussion among the rural population in Bihar. Critically when it is the female members discussing delivery and other activities related to baby birth, it is under discussed. In a patriarchal society, it is not considered indecent for the females to talk about their delivery and birth conditions. Ethical limitations of not asking too personal question as it is considered as individual domain of decisions related to birth and caring was kept in mind. A formal consent was received from the female beneficiary taking part in the study along with consent from the male counterparts.

Language being a limitation, both Hindi and Maithili were used in collecting data. However the study due to cultural limitation and language barrier could not touch on details of decision making factors and players in determining the utilization of the JSY incentive. Thus this provides scope for further research on exploring the factors determining social ladder movement of the beneficiaries after JSY registration and access to the amount.

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