CHAPTER-I

INTRODUCTION

1.1 Background

The continuous and focused efforts by the central as well as state governments in the health sector, particularly during the last one decade, have led to manifold increase in programme inputs both in terms of physical and financial resources. While there has been a significant improvement in services with respect to various health care programmes, especially the reproductive and child health services, yet questions have been raised about the accessibility and quality of services that are offered at the government health outlets.

In order to address various issues concerning the health sector in rural areas, The Government of India launched the National Rural Health Mission (NRHM) in 2005. The primary objective of NRHM was to provide accessible, accountable, affordable, effective and reliable primary healthcare especially to the poor and vulnerable sections of the population. The Mission envisioned equitable and quality health care services to rural women and children in the country with greater emphasis on 18 highly focused states. In an attempt to make primary health care services available, especially, to the poorest and most vulnerable segments of rural society, JSY forms a crucial component of the NRHM. Further, it adopted synergistic approach by encompassing non-health determinants that have a bearing on health such as nutrition, sanitation, and safe drinking water. The mission also aimed to achieve greater convergence amongst related social development sectors.

In accordance with the broad guidelines of the NRHM, the Government of Uttar Pradesh launched the programme in September 2007 with the primary aim of improved health status and quality of life of its rural population with unequivocal and explicit emphasis on sustainable development measures. In order to achieve the objectives of the mission, the Government of Uttar Pradesh has put in place various institutional arrangements to operate, manage and monitor the activities envisaged under NRHM in the state. The initiatives of NRHM have been fully integrated with the day-to-day working of the Medical and Family Welfare department with recruitment and training of required number of ASHAs in the state.

Janani Suraksha Yojana (JSY) one of the important components under the overall umbrella of NRHM is proposed for all the pregnant women in the state of Uttar Pradesh. This includes a cash assistance to the pregnant woman to enable all antenatal care visits during the pregnancy period, institutional care during delivery and immediate post-partum period in a health centre by establishing a system of coordinated care by field level health worker namely ASHA/AWW and ANM with an overall objective to reduce maternal mortality ratio and infant mortality rate.

1.2 Rationale for the present Study

Although there has been a noticeable improvement in health care scenario in Uttar Pradesh but state is still lagging behind several other states in the country. The infant mortality rate (IMR) in Uttar Pradesh is significantly higher (61 per 1000 live births) than that of the country as a whole (47 per 1000 live births) (SRS Bulletin Vol.46

No.1 December 2011). Maternal Mortality Ratio (MMR) is again markedly higher (349 per 100,000 live births) as compared to national level estimates (212 per 100,000 live births) (SRS-2007 - 09). Proportion of institutional deliveries is still very low at 24% in Uttar Pradesh, which is almost half of that of the country as a whole (47%) (DLHS 2007-08). The deliveries taking place at home, more often than not are assisted by untrained personnel, which causes serious health complications both among mothers as well newborn children and thus considered as one of the major factors contributing to higher MMR and IMR in the state.

With this backdrop and the JSY in operation for more than five years the State Government was therefore keen to conduct an Evaluation to assess on ground implementation status of JSY, increase in institutional deliveries, quality of care including issues and challenges, and understand factors and barriers in uptake of institutional deliveries.

CREATE; an agency having team of professionals with considerable experience of carrying out large-scale health and population studies especially in Uttar Pradesh, was invited to undertake the survey in selected districts of Uttar Pradesh with the following objectives.

1.3 Objectives of the study

As per the Request for Proposal (RFP), the specific objectives of the survey were as follows.

- ♠ To estimate the proportion of institutional deliveries compared to home deliveries (at home, institutional- Govt. and institutional-private);
- ♠ To estimate the level of overall JSY coverage.
- ♠ To determine factors and barriers affecting uptake of institutional deliveries and JSY scheme.
- ♠ To examine various components of the functioning of the scheme, including ANC registration, ante natal care, transport, other birth preparedness support, supervision and monitoring.
- ♠ To analyze the process of implementation, including financial disbursement to beneficiaries; assess client satisfaction with JSY scheme.
- ♠ To analyze the perception and process of timely financial incentives received by ASHAs under JSY scheme
- ♠ To assess the quality and extent of post partum newborn and maternal care received by women availing JSY benefits;
- ♠ To assess the status of post partum family planning counseling and actual services provided to the JSY beneficiaries at these institutions.

1.4 Methodology

1.4.1 Study Area

The study was conducted in 15 districts of Uttar Pradesh giving representation to all regions in the state. These districts included Agra, Aligarh, Baghpat, Ferozabad, Hapur, J.P. Nagar, Moradabad, Lakhimpur Kheri, Bahraich, Sant Kabir Nagar, Hardoi, Sulatanpur, Auraiyya, Kanpur Dehat and Mahoba as shown in the state map on page I.8.

1.4.2 Research techniques and tools

In line with the objectives of the study, both the quantitative and qualitative research techniques were used to generate information on all important indicators. All the research instruments were developed by CREATE in Hindi taking into consideration various important aspects of the study to generate information.

However, all the questionnaires and guidelines were submitted to SIFPSA for their inputs and comments. SIFPSA, in turn, has shared these instruments with concerned officials in SPMU-NRHM, GoUP. Subsequently, a workshop was organized at SIFPSA headquarter where the participants representing CREATE, SPMU-NRHM, DoFW, GoUP and SIFPSA discussed all instruments in detail. Based on the feedback received all these tools were finalized by CREATE team. The type of instruments and the specific information that was obtained using these tools is given here as under.

Quantitative Research Tools

Listing Formats: Listing format was obviously developed for listing of households in the selected villages and urban areas. The purpose was to develop a sampling frame of eligible women who had delivered a child (live as well as still birth) between April 1, 2012 and March 31, 2013.

Women Interview Schedule: A structured schedule was developed to canvass to the currently married women age 15-49 years who had delivered between April 1, 2012 and March 31, 2013. It was primarily designed to collect information about their awareness about ASHA working in their village, advice and counseling by ASHA on various maternal and child health care issues, information given by her on JSY and its benefits, utilization of various antenatal, natal, post natal and newborn care services that are being offered at public health outlets under the NRHM. The other important issues that were covered comprised of quality of care during delivery at the Govt. health facilities, receipts of JSY incentive, problems if any faced in getting incentive, satisfaction with the services and role played by ASHA and co-workers such as ANM and AWW.

ASHA Interview Schedule: As ASHA is one of the key elements for the promotion and successful implementation of JSY scheme in rural areas, this schedule was mainly designed to assess her role and responsibilities pertaining to JSY, her interaction with other grass roots workers such as ANM and AWW, help sought and given by ANM in particular in promotion of JSY. The other important issues that were included difficulties encountered in promotion of JSY, institutional deliveries, financial disbursement and related issues like adequacy and timeliness, factors that influence the utilization and suggestions for improving and overcoming bottlenecks in uptake of institutional deliveries.

ANM Interview Schedule: As ASHA is expected to work in collaboration with grassroots health workers, a separate schedule was developed for ANM to get her views, observations and perception about the functioning of ASHAs, extent and

purpose of interaction with ASHAs and the challenges faced by them in promotion of institutional deliveries. The important issues covered were her roles in promotion of JSY including financial disbursement to beneficiaries and ASHA, factors that influence the utilization of institutional deliveries and their suggestions for overcoming bottlenecks and improving JSY.

Qualitative Research Tools

The qualitative tools that were used in this survey include:

- Guideline for discussion with Additional CMO/CMS
- Guideline for discussion with MOIC (PHC/CHC)/UHC

Efforts were made during discussions with aforesaid key officials to gather qualitative information about the implementation of JSY scheme, processes, financial disbursement to ASHAs and beneficiaries and various other aspects. Their views were also sought about bottlenecks if any that may be hampering the successful implementation and enlisting their views to overcome these impediments at different levels for further streamlining in order to achieve the objectives of JSY scheme.

1.4.3 Sampling Design

As has been mentioned earlier, survey was conducted in 15 districts of Uttar Pradesh as shown in UP map. Selection of sample district was done by the client.

Selection of districts: First, all the 75 districts were arranged in ascending order of their JSY performance during the reference period i.e. 2102-13. Then the districts were segregated into three categories viz. poor, average and good based on the performance reported in JSY. First 25 districts were ranked as poor, next 25 as average and remaining 25 as good performing. From each category, 5 districts were selected using the systematic random sampling technique. In this way, altogether 15 districts were selected for the JSY survey.

Selection of PSUs: Sampling of PSUs was done by the SIFPSA and list was provided to the agency both for rural and urban PSUs. Survey was conducted in 300 rural PSUs and 150 Slums of all 15 districts. In all 450 PSUs were covered.

In order to select villages, all villages in the district were divided into three strata e.g. Village with less than 2000 population, Villages having population between 2000 and 4000 and Villages with 4000+ population. Depending on the population fraction 20 villages were selected from different strata using probability proportion to size technique.

However, number of urban PSUs to be selected in each district depended upon the proportion of slums of that district in the universe of slums of all 15 districts taken together. This resulted in the variable number of slum areas covered in each sample district. Altogether, 150 slum areas were covered under the survey.

Selection of Households: As per the RFP, it was decided to cover 25 households in each PSU having eligible women who had given live as well as still births both in rural and urban areas of the district. Systematic Random Sampling procedure was adopted to select required number of such households in each PSU.

In case the number of such households where an eligible woman had given birth during April 01, 2012 and March 31, 2013 was less than the required number of 25 in a PSU; all households identified were covered in that PSU.

Selection of Eligible Women (15-49 yrs.): All the currently married women having given a live or still birth between April 01, 2012 and March 31, 2013 in the selected households were interviewed.

Selection of ANM and ASHA: ASHA working in the sample village was automatically selected for the interview. However, it may be noted here that if there happened to be more than one ASHA, only one was randomly selected and interviewed. In large villages, ASHA who was working in the selected segment was interviewed by the survey team. The ANMs who were catering to the sample village in their sub-centre jurisdiction were interviewed under the study. In all, 300 ASHAs and 300 ANMs were covered under the survey.

Selection of Nodal Officer (JSY), CMS, and MOs (PHC/UHP): Discussions were held with Additional CMO (JSY) and CMS (DH) of all sample districts. In rural areas, discussions were held with the medical officers of PHC/CHC. However, in urban areas, medical officers posted at the UHC/UHP were interviewed by the survey team. Altogether, 60 MOs of PHCs/CHCs and 24 MOs of UHPs/UHCs in selected districts were covered in the study.

Interviews conducted and discussions held with different target respondents have been provided in the following table.

Table-1.1 Sample coverage

Target respondents	Sample	Completed
Quantitative Interviews		
Eligible women interviews	11250	11741
ASHA interviews	300	300
ANM interviews	300	300
Qualitative Interviews/Discussions		
Dy. CMO/Nodal Officer (JSY)	15	15
Chief Medical Superintendent	15	15
Medical Officer I/C (CHC/PHC)	60	60
MO (UHC/UHP)*	30	24

***Six interviews of MO (UHC) could not be conducted for the fact that there was no UHC functional in sample districts viz. Hapur and Kanpur Dehat. In some other places, MOs posted at the UHCs were not available when researchers visited.**

1.4.4 Training of survey teams

Training of investigators was completed in one batch. Classroom training was given by professionals from CREATE. Senior professionals from R&E division also visited during the training and gave their valuable suggestions. More than 50 candidates attended the 6 day training. Besides the discussion on background and aims and objectives of the proposed evaluation study, the classroom training sessions consisted of instructions in interviewing techniques, field procedure for the survey and a detailed review of each item in the questionnaires. Mock interviews were conducted in the classroom and candidates were taken to rural and urban areas as well to provide them firsthand experience of the actual field situations. Every candidate canvassed two questionnaires each in the field. Subsequently, professionals prepared a list of common issues and problems encountered in the field by candidates which was followed by detailed debriefing session in CREATE headquarter so as to remove their doubts. Candidates who had performed well in training/ mock trials were selected for the survey.

After the conclusion of interviewers training a one day briefing session was also held to brief the coordinators, supervisors and field editors. These people were imparted training on canvassing of questionnaires of ASHA, ANM and medical officers. More importantly, a session was also devoted to sensitize them about survey protocols and quality assurance measures.

1.4.5 Data Collection

In all, 10 teams were constituted for the survey with each team comprising one male supervisor, one female editor and 4 female interviewers. These teams were further grouped into Team-A (4 teams), Team-B (3 teams) and Team-C (3 teams). Each team was headed by an experienced professional from CREATE to coordinate and monitor the fieldwork.

Keeping in mind the spread of districts, separate movement plans were prepared for each team. Movement plan with likely dates of visit for each selected district was circulated through the office of the Mission Director, NRHM at the state headquarter, a week prior to launch of survey so as to provide ample time to district authorities to intimate the concerned officials at the district and lower levels to extend desired cooperation during the course of the survey. Moreover, team coordinators followed it up with District Project Managers before the visit. Data collection was done between first week of May 2013 and third week of June, 2013.

1.4.6 Quality Assurance

Quality of the study was maintained at all levels. To begin with, research tools were developed and finalized through due consultation with all stakeholders of the study. Further, all the questionnaires and guidelines were pretested in the field by a team of

senior professionals from CREATE. Survey teams were thoroughly trained by the professionals so as to ensure proper understanding of each and every item in the questionnaires and interviewing techniques. Interviewers selected for the survey were those who had earlier worked in studies pertaining to reproductive and health sectors as also in ASHA studies.

As indicated earlier, all the survey teams were headed by experience professionals of research agency who stayed in the field till the very end. Besides, senior research people from SIFPSA also visited the field and conducted spot-checks and observed interviews conducted by the interviewers.

1.4.7 Data entry, analysis and reporting

All the filled-in questionnaires were regularly sent by the field teams to the Lucknow headquarters of CREATE. After its scrutiny and desk editing, the data entry was undertaken through a customized package prepared in CSPro4.1. The data were fully validated in terms of internal consistency checks before it was analyzed. The data entry programme had most of the in-built checks for quality control. The inconsistencies were sorted out by reexamining.

Data processing was done in-house using SPSS software. Before the data analysis tabulation plan was prepared and discussed with SIFPSA officials. Tables were generated according to the tabulation plans and in-depth interviews were analyzed by the researchers having experience of qualitative research. Report was prepared by senior researchers of the agency.

1.5 Organization of the Report

The report is divided into six chapters including the present one. This chapter discusses the methodology of the study and provides details of the study design, sample size, sampling procedure and coverage of different types of respondents. While Chapter two delineates the background and socio economic characteristics of the households, Chapters three and four discusses the findings from the evaluation wherein awareness and utilization of the JSY scheme, uptake of ante natal, natal and post natal care services, quality of care at the institution as perceived by the mothers who delivered in an institution during the last one year and satisfaction with services are presented. Chapter five shows receipt of benefits under the JSY scheme, timeliness of payment, help received along with problems faced. Further, ASHAs awareness about the JSY scheme, their role and responsibilities, interaction with grassroots workers, counseling of beneficiaries about JSY scheme and its benefits and issues related to their receipt of JSY payment are dealt with in Chapter 6. Chapter six also provides providers perspective on issues related to implementation of JSY, planning, monitoring, IEC activities, transport and barriers in uptake of institutional deliveries, and suggestions for streamlining and strengthening the JSY scheme to achieve its objectives.