



Knowledge Brief

Health, Nutrition and Population Global Practice

JANANI SURAKSHA YOJANA – INDIA'S CONDITIONAL CASH TRANSFERS FOR POOR PREGNANT WOMEN

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KEY MESSAGES:

- In 2005, one in every five maternal deaths and one in every three neonatal deaths worldwide occurred in India. Although the maternal mortality ratio (MMR) is declining, India is not on track to achieve related Millennium Development Goal (MDG).
- Differences in reproductive health outcomes exist across states and regions and by income and social groups. Disparities stem from supply and demand issues. In 2005, the government launched the National Rural Health Mission (NRHM) to improve maternal and infant mortality rates.
- The Janani Suraksha Yojana (JSY)—the world's largest conditional cash transfer (CCT) program for poor pregnant women—aims to increase institutional deliveries by reducing financial barriers to access and to narrow disparities by targeting weaker states and the poor.
- Institutional deliveries have doubled in low-performing states and so has skilled birth attendance for socially disadvantaged groups.
- Obstetric services, 24/7 primary health centers (PHCs), and first referral units are more widely available.
- The key lessons from the JSY program include: fine-tuning supply-side inputs based on local needs; focusing continuously on quality improvements; providing a package of reproductive and child health (RCH) services in addition to safe delivery; and constantly monitoring and evaluating the equity program's impact.

Reason for Response

In 2005 about one in every five maternal deaths and one in every three neonatal deaths globally occurred in India (Lim, 2010). Two out of three deaths were reported from the eight Empowered Action Group¹² (EAG) states and Assam, states that are home to 48 percent of the population (National Family Health Survey-3). Institutional deliveries accounted for only about 40 percent of the births – 30 percent or lower in these nine states; 60 percent of deliveries took place without skilled birth attendance and most deaths occurred within 48 hours of birth.

Inequities by social class and gender were also stark: less than 40 percent of Scheduled Caste and about 28 percent of Scheduled Tribe women – both socially disadvantaged groups – had access to skilled birth attendance; and this figure was equally low at 27.5 percent for women from the lowest wealth quintile (District Level Health Survey 2).

The RCH Strategy

A multipronged approach was needed to achieve reproductive health goals, and to make the quantum shift required to achieve the MDGs. And so, the national government put in place strategic interventions, including RCH I (1997-2004), and RCH II, launched in 2005 and folded into the NRHM (2005-12, later extended to 2017) (Empowered Program Committee, 2012; Rajan et al, 2010).

These interventions were supported by strategies to increase access to care, including, on the supply side, emergency referral transport, upgraded institutional care, and pilots for financing and program management; and on the demand side, the JSY, a demand-side strategy providing poor and vulnerable women with CCTs to raise their access to institutional delivery.

JSY

JSY – using community-level “link” volunteers (Accredited Social Health Activists or ASHAs) – was launched in April 2005. What it is, what it does, and how it does it is shown in box 1.

Since its inception, RCH flexipool expenditures – a proxy for JSY expenditures – have grown from less than USD 50 million in 2005-06 to over USD 1,000 million by 2012-13 – indicating the importance of JSY within the NRHM.

How has JSY performed on its objectives and contributed to larger outcomes?

It is difficult to directly measure the impacts of JSY, as there was no impact evaluation built into the program design, making it hard to substantiate any categorical statements on JSY’s impact. However, program data and data from large-scale surveys conducted during implementation indicate substantial increases in access to services.

BOX 1: WHAT IS JSY?

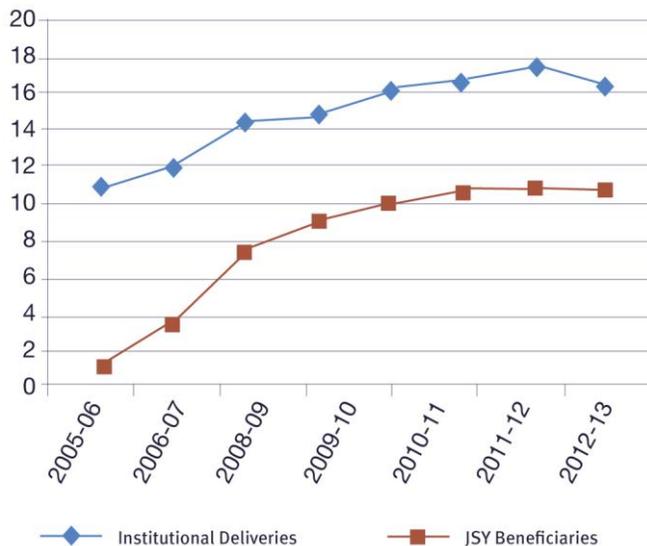
Program	JSY is a demand- and supply-side (mixed) pay for performance program with a focus on (i) CCTs to poor pregnant women for institutional delivery at a public facility or an accredited private facility; and (ii) vouchers to the community outreach workers –ASHAs – for delivering certain RCH services.
Beneficiaries	The target groups are poor pregnant women, particularly those in the EAG states and Assam, those below the poverty line, and those in marginalized communities.
Cash assistance structure	The ASHA package includes incentives for motivating women to have an institutional delivery; costs for accompanying women to the institution for delivery; and organizing transport for women to the facility.
Payment rules and guidelines	The Auxiliary Nurse Midwife (ANM)/ASHA is responsible for ensuring that beneficiaries receive their payment in one instalment at the time of delivery.
Monitoring and verification	Goals for institutional delivery are set by the ANM, based on village-level data, and a workplan for the ASHA is then developed. Progress reports are presented by the ANM to the Primary Health Center Medical Officer each month, which are then consolidated and submitted to district-level nodal officers. The district reports are sent bi-annually to the nodal officer of government.
Implementation arrangements	Each state’s health mission is responsible for establishing implementation committees at state and district levels. Their role includes monitoring, supply of materials, ensuring quality of care, distribution of applicable guidelines, addressing grievances, and settling legal cases.

Source: NRHM website, accessed March 31, 2014; and Boateng K. India: Results Based Financing at the World Bank; https://www.rbfhealth.org/system/files/RBF_India.pdf.

INCREASING INSTITUTIONAL DELIVERIES AMONG THE POOR AND VULNERABLE

Both the number of institutional deliveries and the proportion of JSY beneficiaries grew steadily after 2005 (Figure 1).

FIGURE 1: INSTITUTIONAL DELIVERIES AND PROPORTION OF JSY BENEFICIARIES (MILLION)



Source: NHM website; accessed March 30, 2014.

State-level data also show large gains in the number of deliveries at public sector health institutions. Institutional deliveries increased by 55.4 percent from 10.8 million in 2005-06 to 16.8 million in 2009-10. Institutional deliveries more than doubled overall in the EAG states; in Jharkhand, Chhattisgarh and Bihar, institutional deliveries went up by 4, 3, and 2 times, respectively.

The goal for deliveries by skilled providers, to be achieved by 2012, was set at 60 percent, with a lower goal for EAG states of 45 percent. The results of the Annual Health Survey (2011) indicate that all EAG states achieved the goal, and Assam, Madhya Pradesh, Orissa, and Rajasthan exceeded the goal for non-EAG states at 70, 82, 75 and 76 percent, respectively. Skilled birth attendance almost doubled for scheduled caste groups between 2002-04 and 2009; and slightly more than doubled for scheduled tribes and those in the lowest wealth quintile over the same period.

ASHAS

ASHAs play a key role in JSY as they are the community's first point of contact with the health system under JSY. An independent assessment of JSY commissioned in 2007 in a number of states found that

the ASHAs were effective in promoting institutional delivery, mobilizing transport for women, accompanying her and counseling on breastfeeding. However, limitations in coverage, and lack of skills and external support all serve to reduce their potential effectiveness.

QUALITY OF CARE AND SUPPLY-SIDE IMPROVEMENTS

RCH II envisaged several improvements in the delivery of services. Progress was good, although uneven across states.

Targets under RCH II were to operationalize 50 percent of all PHCs as 24/7 PHCs; and operationalize all district hospitals and community health centers as first referral units. All states have shown an increasing trend, but unevenly: the all-India average is about 40 percent of all PHCs offering 24/7 services and about 20 percent of first referral units doing Cesarean sections.

According to the plan, all district hospitals (673) and community health centers (4,535) were to be made first referral units. Achievement nationally was 46.1 percent, and all states showed an increase. Achievement of EAG states was 28 percent but there was wide variation, from 11.2 percent in Jharkhand to 51.9 percent in Bihar.

Lessons learned

While the data shows that there have been substantial increases in antenatal and intrapartum care, probably contributing to reductions in perinatal and neonatal deaths (Lim et al, 2010), there are yet several issues that need to be addressed:

ACCESS

- JSY increased access to RCH services, but was mostly limited to institutional deliveries. Constraints contributed to variation in uptake of JSY, such as distance from a health facility. These constraints need to be addressed.
- The role of the ASHA varies across states, suggesting that the JSY needs to be even more flexible than currently.
- Government at all levels - central, state, and district – plays an important role in program implementation and oversight. All levels need to be strengthened to ease the supply-side constraints that have affected access to services. A well-designed supply-side results-based financing (RBF) program would have helped.

QUALITY

- Experience of implementing JSY shows that CCTs are a good vehicle for enhancing access to services, but improving quality of care requires substantial supply-side investments as well as robust design. This would entail a package of services that includes ensuring 24-hour stay of women after delivery; greater focus on newborn care; better counseling for child health and nutrition, as well as postpartum family planning. Also, importantly, a system of quality improvement should be set up.

EQUITY

- There are persistent equity issues in uptake of JSY, manifested, for example, in receiving payment; in receiving the full range of services; in perinatal and neonatal mortality; and in the fact that the data indicate that the poorest and most vulnerable women are not consistently the most likely to receive benefits under JSY. The reasons for this need to be identified and addressed directly.

IMPLEMENTATION, MONITORING AND EVALUATION

- More robust payment and verification systems need to be designed and implemented, which will likely require heavy investments of time, effort and resources.
- Measuring impact on health outcomes remains problematic given the paucity of data. Turning this around will require a strengthening of systems for regular monitoring and oversight; and building systematic evaluation into program design.

End Notes

1 Empowered Action Group (EAG) states are those with relatively poor health indicators as well as weak institutional capacity. The differentials between the better-performing and lagging states prompted Government of India to create the EAG, to provide targeted guidance and assistance to these eight states.

2 These states are Bihar, Jharkhand, Uttar Pradesh, Uttarakhand, Rajasthan, Orissa, Madhya Pradesh and Chhattisgarh.

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*This HNP Knowledge Brief highlights the key findings from the HNP Discussion paper "**Case Study on Good Practices in Reproductive Health: Janani Suraksha Yojana – Conditional Cash Transfers for Poor Pregnant Women in India**" written by Shreelata Rao Seshadri and Vikram Rajan (forthcoming).*

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