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# INDIA

## EXTENSION OF MATERNITY PROTECTION:

## INITIAL ASSESSMENT OF JANANY SURAKSHA YOJANA (JSY) IN ORISSA

**ILO Subregional Office for South Asia, New Delhi**

**April 2008**

# INITIAL ASSESSMENT OF JSY IN ORISSA

**December 2007**

# A Study Report

**Commissioned by:**

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# List of Acronyms

| | |
|---|---|
| ADMO | Additional District Medical Officer |
| AIDS | Acquired Immuno-Deficiency Syndrome |
| ANC | Ante-Natal Care |
| ASHA | Accredited Social Health Activist |
| AWW | Anganwadi Worker |
| BEE | Block Extension Educator |
| BMO | Block Medical Officer |
| BPL | Below Poverty Line |
| BPMU | Block Programme Management Unit |
| BPO | Block Programme Organiser |
| BTT | Block Training Team |
| CDMO | Chief District Medical Officer |
| CHC | Community Health Centre |
| CMO | Chief Medical Officer |
| DHH | District Headquarter Hospital |
| DPM | District Programme Manager |
| DPMU | District Programme Management Unit |
| FRU | First referral Unit |
| FW | Family Welfare |
| GoI | Government of India |
| GoO | Government of Orissa |
| HIV | Human Immuno-Deficiency Virus |
| HPS | High Performing State |
| HSC | Health Sub-Centre |
| HW | Health Worker |
| IAS | Indian Administrative Service |
| IFA | Iron Folic Acid |
| IEC | Information, Education and Communication |
| IRS | Indo Residual Spray |
| JSY | Janani Suraksha Yojana |
| LHV | Lady Health Visitors |
| LPS | Low Performing State |
| MCH | Maternal & Child Health |
| MCH | Medical College & Hospital |
| MIS | Management Information System |
| MO | Medical Officer |
| MoH&FW | Ministry of Health and Family Welfare |
| NHFS | National Family Health Survey |
| NGO | Non Governmental Organisation |
| NRHM | National Rural Health Mission |
| PHC | Primary Health Centre |
| PPP | Public-Private Partnership |
| PSU | Programme Support Unit |
| RCH | Reproductive Child Care |
| RKS | Rogi Kalyan Samitis |
| SAB | Skill Attendant at Birth |
| SBA | Skilled Birth Attendant |
| SC | Scheduled Caste |
| SDH | Sub Divisional Hospital |
| SDMO | Sub Divisional Medical Officer |
| SHG | Self Help Group |
| SPMU | State Programme Management Unit |
| SRS | Sample Registration System |
| ST | Scheduled Tribe |
| TBA | Traditional Birth Attendant |
| TFR | Total Fertility Rate |
| ToT | Training of Trainers |
| TTBA | Trained Traditional Birth Attendant |
| UT | Union territory |

# Introduction

One of the most daunting challenges still faced by India today is to find ways to guarantee all citizens an appropriate level of health care in terms of access and quality regardless of ability to pay. For a variety of reasons, India has failed in overcoming the huge health exclusion phenomenon still affecting an ever-increasing work force operating in the informal economy. The public delivery of health care generally remains under-financed, insufficient, ill-equipped and poor in quality. To this day, basic health indicators still stand very low as compared to many other developing countries in Asia and a wide gap remains to be bridged in order to provide an appropriate level of health protection, including maternity protection, to the most disadvantaged segments of the population.

Although recognized as a major priority, maternity protection remains in short supply in India, reflecting the huge social security divide between the formal and informal sectors. As early as 1948, the Employees' State Insurance Scheme (ESIS) provided the lower income segments of the formal economy workers a wide coverage, including maternity protection in the form of: maternity leave, free health care services and medical bonus against confinement expenses. Although including a similar range of maternity benefits, the Maternity Benefit Act, 1961, only applied to wage earning classes of people employed in comparatively stable work in larger establishments such as factories, mines and plantations. These provisions considerably restricted its benefits (In 2000, the number of maternity benefits paid to women workers in factories and plantations came to a mere 20,000).

For the workers operating in the informal economy, most women were left to their own devices to obtain a minimal level of maternity protection with only a few benefiting from the first maternity protection initiatives taken by some State Governments which set up welfare funds in the early 80s. Among the various states using this occupation-based mechanism, Kerala, truly played a pioneering role in promoting maternity protection. Various Welfare Funds such as those targeting the coir workers (1987), the cashew workers (1988) and the construction workers (1989) were the first to provide maternity cash benefits ranging from Rs 200 to Rs 500 per child.

New initiatives came from various civil society organizations that were willing to set up local micro-insurance schemes to address the specific health protection needs of their members. The Self-Employed Women's Association (SEWA) was one of the very first to include in its insurance benefit package a cash benefit for its members (Rs 300 per child). Several other community-based micro-insurance schemes such as Raigarh Ambikapur Health Association (RAHA) in Chhattisgarh, Amul Dairy Co-operative in Gujarat, Voluntary Health Services (VHS) in Tamil Nadu, or People Rural Education movement (PREM) in Orissa, followed suit and provided some maternity protection benefits, either in the form of cash benefits upon delivery or partial insurance cover of costs related to pregnancies and deliveries. Other organizations, such as CINI-ASHA (Kolkata) and Seva Mandir (Udaipur) chose another path and experimented with maternity vouchers which extended the protection to ante-natal and post-natal while taking the firm stand of empowering poor women. The entry of private players in the insurance market in 2000, although sparking many product developments and extending significantly the outreach in rural areas paid scant attention to maternity protection needs of poor women workers. Completely overlooked at first, this need had to wait until 2004-05 to be partly fulfilled with some insurance products extending their health benefits to simple deliveries, often under harsh conditions such as age bars and number limitations by insurance companies. All in all, the progressive extension of maternity protection through private actors only reached a few and remained very limited both in scope and level of benefits.

Overall achievements in the public sector, even after a longer experience period remained mixed as well. In 1995, the Central Government launched the National Maternity Benefit Scheme (NMBS) as one of the three components of its National Social Assistance Programme. Under the NMBS, women belonging to a household Below the Poverty Line were eligible to receive a cash benefit of Rs 300 (later to become Rs 500) up to two live births, 8 to 12 weeks before delivery. From the outset, this scheme was characterized by under-utilisation, long delays and procedural complications. Over the next ten years the number of annual beneficiaries never exceeded 1.5 million as compared to an initial annual target set at 5.7 million. On April 1, 2001, the administration of the NMBS was transferred to the Department of Family Welfare, with the result that the total number of beneficiaries further dropped to an ever-low 420,000 in 2004-05. Based on converging evidence that the NMBS everywhere did very little to improve maternity protection, the scheme evolved in 2005 into a new programme called Janani Suraksha Yojane, still fully sponsored by the Central Government.

As part of the National Rural Health Mission focusing first on low performing states, the safe motherhood intervention called "Janani Surakshsa Yojana" aimed at promoting institutional deliveries in order to reduce maternal and neo-natal mortality. To achieve this goal, the scheme was originally designed as a Conditional Cash Transfer mechanism, relying both on the intervention of newly appointed social health activists (ASHAs) and on the massive utilization of public health facilities at all levels. Although based on a set of standard guidelines, some states choose to introduce several adjustments to the original design to better adapt this programme to their specific context. This innovative maternity protection scheme elicited a wide interest among the international community. In order to develop more practical information on its relevance and impact, UNFPA carried out a rapid assessment of the slightly modified scheme called "Chiranjivee Yojana" implemented in Gujarat; GTZ developed a comparative analysis of the experiences conducted in West Bengal, Assam and Himachal Pradesh and the ILO, on the basis of its previous interventions, choose to focus on the states of Orissa and Jharkhand.

The present document represents a very first attempt to develop some more practical knowledge on the key issues related to the design and implementation of the JSY scheme in Orissa. In a highly non-regulated and segmented health sector, prior evidence when offering any type of health protection to the poor suggests that there is a risk of "dual service delivery" resulting in a skewed coverage and the additional disadvantage in terms of accessing quality health care services. With its present limitations, an initial assessment may already identify and flag some issues of concern that deserve to be dealt with. One such concern is represented by the parallel implementation of two nation-wide health protection programmes targeting the same population ie. the Janani Suraksha Yojana (Ministry of Health & Family Welfare) and the new heath insurance scheme called Rashtriya Swasthya Bima Yojana launched in 2007 by the Ministry of Labour and Employment, which still leaves between the two some health protection needs to be addressed and certain operationalisation problems to be overcome.

There is clearly a need for more in-depth analysis, extending the assessment to realities at the ground level, though some surveys among the beneficiaries of the scheme. This broadened scope should be the hallmark of the next intervention planned in Jharkhand. Bringing together more evidence-based knowledge should allow the various organizations concerned to play a fruitful advocacy role towards the policy makers with the ultimate goal of seeing the JSY evolving into a full protection scheme much closer to the provisions included in the Maternity Protection Convention (C 183) adopted by the ILO in 2000, which for the first time also considered the specific needs of the women employed in the informal economy.

# Chapter 1

# Objectives, Scope and Limitations of the Study

## 1.1 Study rationale

Under the National Rural Health Mission (NRHM), the Government of India launched a 100% centrally sponsored scheme viz. Janani Suraksha Yojana (JSY) with effect from April 12, 2005. The main objectives of JSY are to reduce maternal and neo natal mortality by promoting institutional delivery for making available medical care during pregnancy, delivery and post delivery period. The scheme aims to promote institutional deliveries among pregnant women living below the poverty line in all the states and union territories (UTs) of the country emphasising on the low performing states (LPS) through referral, transport and escort services. Provision of cash assistance with delivery and post delivery care for women to have better outcomes of pregnancy and childbirth is the hallmark of JSY.

In order to achieve the goals under JSY, one of the important strategies proposed by the Government of India was to identify the female accredited social health activist (ASHA) for a population of 1000 in every village to act as an effective link between the public health system or government accredited private health institutions and poor pregnant women in 10 low performing states (LPS) which have institutional delivery rates below 25 percent. These LPS include Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Rajasthan, Orissa, Assam and Jammu & Kashmir. In these LPS, the scheme focuses on poor pregnant woman both in rural as well as urban areas with special dispensation. In the remaining states and UTs categorized as high performing states (HPS), where anganwadi worker (AWW), traditional birth attendant (TBAs) or ASHA like activists could be engaged and be associated with JSY.

Being volunteers, ASHAs are entitled of getting a performance-based compensation package for promoting reproductive and child health services through institutional deliveries, enabling universal immunisation and other health care interventions.

For the effective implementation of JSY and ASHA at the state level, Ministry of Health and Family Welfare (MoHFW), Government of India (GoI) developed detailed ASHA guidelines that include institutional arrangements, eligibility criterion and cash assistance for institutional and home delivery for low and high performing states, roles and responsibilities of ASHAs, linkages between ASHA, ANM and Anganwadi workers, training of trainers and training of ASHAs, compensation package and fund flow mechanism. At the same time, the states are allowed to design the operationalisation of the intervention based on ground realities. One of the important features of this scheme is to enable the state governments to evolve public-private partnership (PPP) mechanism and accredit private health institutions for providing institutional delivery services.

The JSY and the ASHA interventions have been in operation in the states for more than a year with different stages of implementation. Orissa is one of the 10 LPS where institutional delivery rate was 23% in the year 1998-99 as per the NHFS-II. Therefore, Orissa has been considered as one of the priority states for JSY which has linked to ASHA intervention both in rural as well as urban areas.

ILO is currently documenting various mechanisms (health insurance, maternity voucher, cash transfers, etc.) that are being used in different South Asian countries to provide maternity protection benefits to women operating in the informal economy, hence contributing to the progressive extension of social protection and to the achievement of some of the Millennium Development Goals (reduction of maternal and infant mortality).

In Orissa, both ASHA intervention and JSY are in operation since December 2005. To understand the status of implementation and the process adopted for operationalisation in Orissa, ILO, Sub-regional Office for South Asia, New Delhi, commissioned a short initial assessment study to a professional organisation viz. We The People, New Delhi.

### 1.2 Objective of the study with regard to ASHA and JSY

1. Review adaptation of the national guidelines by the state of Orissa and its operationalisation;
2. Study programme management process and institutional arrangements established for implementation of the schemes;
3. Analyze funds flow mechanisms from state to district and to lower levels of service delivery system and reimbursement;
4. Achievements and issues pertaining to JSY and ASHA intervention in the state;
5. Assess the overall relevance of the cash transfer system when trying to address the health protection requirements of mothers to be.

### 1.3 Study Design

Keeping in mind the above objectives, the assessment of ASHA and JSY was carried out through a structured questionnaire in consultation with ILO, Sub-regional Office, New Delhi. Data and information were gathered by using the questionnaire and through interviews of the concerned state government officials as well as collecting the information from the secondary sources available with the Mission Directorate (NRHM). Since the study took place over a very short period, the collection of data and information pertaining to the above specific objectives, it was restricted to an interaction with senior officials of the state associated with the NRHM. The findings presented in this report are based on the interactions with these officials and available secondary data gathered during the visit.

### 1.4 Study Area

The study was undertaken at the state capital- Bhubaneswar where the interactions were made with the higher level state government officials based at the state headquarters associated with the NRHM that includes Mission Director, Director (Family Welfare) and Mission Directorate (NRHM).

### 1.5 The Sample

The sample for the study included the state officials associated with the scheme including the Mission Directorate (NRHM), Director (Family Welfare), and State Programme Manager, NRHM-JSY, State Data Officer, NRHM and State IEC Consultant, NRHM.

### 1.6 Time line

The duration of the study was for 15 days including the submission of report which was started on 27$^{th}$ November 2007 with a field visit to Bhubaneswar.

### 1.7 Presentation of the Report

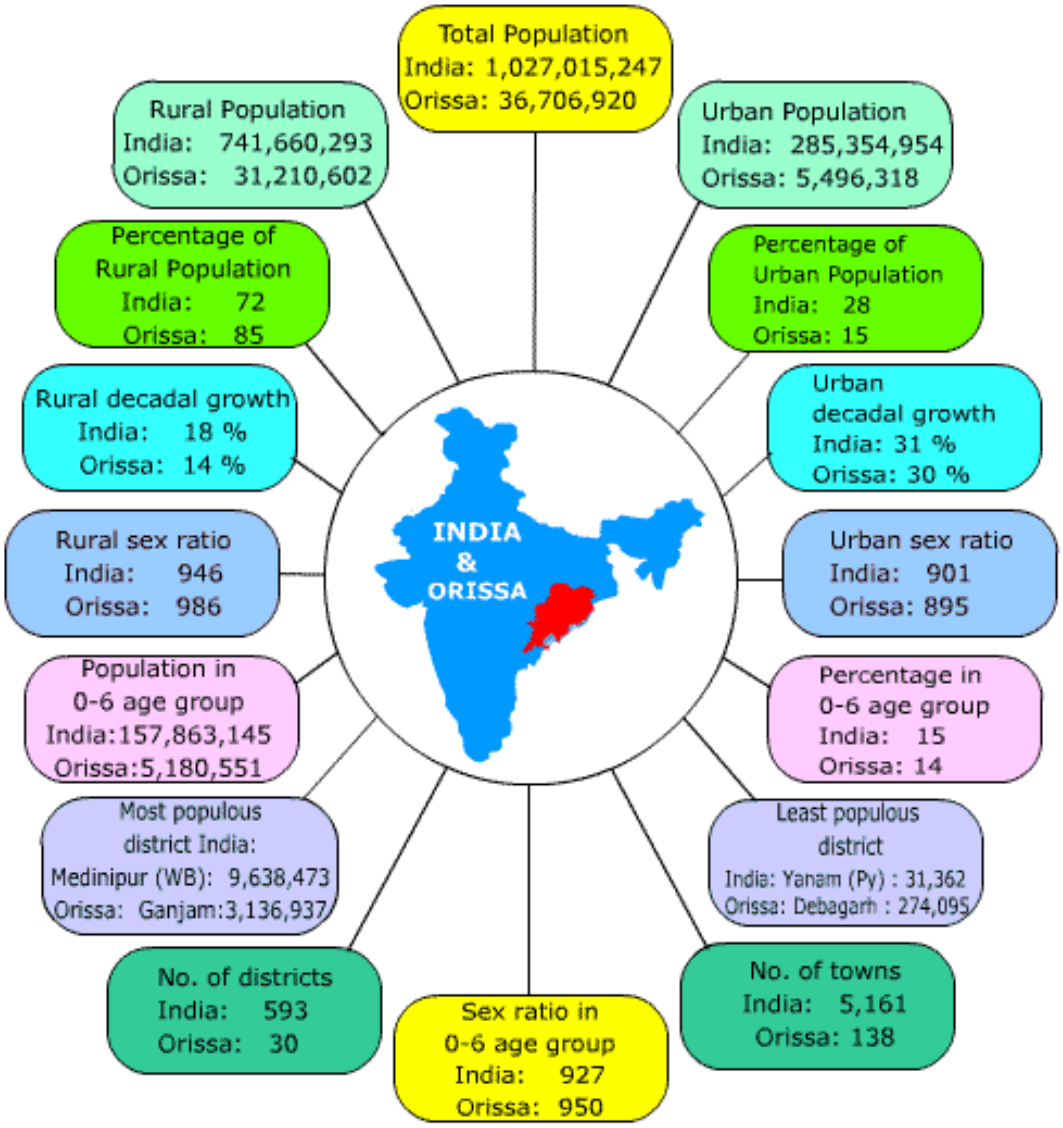
The report has seven chapters including a general presentation as Chapter 1. Chapter 2 highlights the main social and health indicators in Orissa, Chapters 3 and 4 review the adaptation of the national guidelines by the state of Orissa in relation with JSY and ASHAs and on the programme management process and institutional arrangements established for implementation of the schemes. Chapter 5

analyzes funds flow mechanisms from state to district and to lower levels of service delivery system and reimbursement, Chapter 6 focuses on achievements and impacts, whereas Chapter 7 elaborates some conclusions and recommendations pertaining to JSY and ASHA development perspectives in the state.

# Chapter 2

# Health Status in Orissa

## 2.1 Demographic Profile of Orissa at a Glance




Source: Department of Panchayati Raj, Government of Orissa, 2001

## 2.2 Socio-economic Profile

With a total population estimated at 37 million, Orissa remains today one of the poorest and least developed states in the country. According to the Planning Commission, about 47% of the population belongs to the Below Poverty Line. The incidence of the scheduled tribe and scheduled caste in Orissa constituting about 39% of the state population, which is far higher than the country's average of 23%, accounts for one of its most distinctive features.

Orissa occupies 4.74% of India's landmass and houses 3.58% of the country's population. The State comprises of 3 revenue divisions, 30 districts, 58 sub-divisions, 171 tahasils, 314 community

development blocks, 6234 gram panchayats[1] and 51,349 villages. Nearly 85% of its population live in the rural areas and mostly depend on agriculture and allied activities for their livelihood. The State is highly rich in mineral resources and has abundant water resources.

The population of Orissa, which was 316.60 lakh in 1991, has increased to 368.05 lakh in 2001 exhibiting a decennial growth rate of 16.25 percent as against 20.06 percent in the previous decade and 23.86 percent at all-India level. The density of population, which was 203 per sq.km. in 1991 has increased to 236 per sq.km. in 2001 and is much lower than the all-India average of 313 per sq.km. The state has witnessed increase in the literacy rate from 49.10 percent in 1991 to 63.08 percent in 2001. The male and female literacy rates have gone up to 75.35 percent and 50.51 percent respectively in 2001.

As per 2001 Census, Scheduled Castes and Scheduled Tribes population in the State, were 60.82 lakh and 81.45 lakh respectively, which were 16.5% and 22.1% of the total population of the State as against 16.2% and 22.2% in the previous census in 1991. The decennial growth rate of SC & ST population during 1991-2001 was 18.6% and 15.8% respectively. As per 2001 Census, the sex ratio among SC & ST population was 979 and 1003 respectively as against 936 and 978 at all-India level.

With the increase in population and consequent addition to the labour force, supply of labour continues to outstrip demand resulting in increase in level of unemployment and underemployment. The occupational classification as per 2001 Census shows that the total workers in the State account for 142.76 lakh constituting 38.79% of the total population of the State. Out of the total number of workers, main workers accounted for 67.2%. The main workers comprise of cultivators (35.8%), agricultural labourers (21.9%), household industries workers (4.2%) and other workers (38.1%). The proportion of male workers to male population and female workers to female population in 2001 stood at 52. 5% and 24.7% respectively.

Growing unemployment particularly the phenomenon of educated unemployment is one of the burning problems of the State. It has been estimated that the total backlog of unemployment at the beginning of 2005- 06 was of the order of 9.90 lakh person-years. With 1.89 lakh person-years of additional labour force during the year and 1.97 lakh person-years of employment generation during 2005-06, it is expected that the level of unemployment by the end of 2005-06 will be of the order of 9.82 lakh person-years. As per the Live Register maintained by employment exchanges, at the end of 2004, the number of educated unemployed in the State was 7.45 lakh, which comes to 86.73% of the total number of applicants of 8.59 lakh. The number of registrations made in employment exchanges during 2004 was 267,337 and vacancies notified was 1,760.

Source: Economic Survey 2006, Government of Orissa, http://orissa.gov.in/p&c/eco2006

## 2.3 Vital health indicators

Despite gradual improvements brought to the health sector, the state is still facing a huge health infrastructure deficiency and acute shortage of health facilities. In spite of the progress made in the health sector by the state government, still the state is lagging behind the national health indicators with regard to birth and death rate, infant mortality rate, maternal mortality rate and life expectancy at birth. A comparative analysis of vital health indicators of Orissa and India is presented below.

[1] Institution of local self-governance at the village level.

| Table 1: Comparative analysis of vital health indicators of Orissa and India | | |
|---|---|---|
| **Indicators** | **Orissa** | **India** |
| Birth rate/ 1000 population (SRS 2005) | 22.3 | 23.8 |
| Death rate/ 1000 population (SRS 2005) | 9.5 | 7.6 |
| Infant mortality rate/ 1000 live birth | 65 (NFHS-3)<br>75 (SRS-2005) | 58 (NFHS-3)<br>58 (SRS-2005) |
| Maternal mortality rate/ 1000000 live birth | 358 (SRS-2003) | 301 (SRS-2003) |
| Life expectancy at birth (Census 2001) | 61.64 years | 62 years |

## 2.4 Progress as per NHFS III

The state has made substantial progress in the health sector since almost last one and half decade, as per National Family Health Survey. Table- 2, reveals that infant mortality rate (IMR) has been reduced from 112 in 1992-93 to 65 in 2005-06. The MMR also slightly reduced from 367 in 1998-99 to 358 in 2005-06. The institutional deliveries have gone up to 39% in 2005-06 from 14% in 1992-93, whereas complete ANC has increased from 35% (1992-93) to 61% (2005-06). The safe deliveries have gone up to 46.4% (2005-06) from 19% (1992-93).

| Table 2: Progress in various health indicators | | | | |
|---|---|---|---|---|
| **S.N.** | **Indicators** | **NHFS I (1992-93)** | **NHFS II (1998-99)** | **NHFS III (2005-06)** |
| 1 | Infant mortality rate/ 1000 live birth | 112 | 81 | 65 |
| 2 | Maternal mortality rate/ 1000000 live birth | | 367 | 358 |
| 3 | Institutional Delivery (%) | 14 | 23 | 39 |
| 4 | Complete ANC (%) | 35 | 48 | 61 |
| 5 | Safe deliveries (%) | 19 | 33.4 | 46.4 |
| 6 | Total Fertility Rate (TFR) | 2.9 | 2.5 | 2.4 |
| 7 | Complete Immunisation (%) | 36 | 44 | 52 |

# Chapter-3

# Adaptation & Operationalisation of JSY in Orissa

This chapter discusses and highlights the adaptation of national JSY guidelines in the state of Orissa and the necessary modifications or changes made by the state government in its operationalisation, keeping in views the ground realities in the state. The findings are based on in-depth interviews with the Mission Director (NRHM), Director (Family Welfare), State Programme Manager (JSY) and State IEC Consultant (NRHM). Moreover, a comparative analysis was made between the state and national JSY guidelines to highlight the major changes with regard to JSY operationalisation.

## 3.1 Adaptation of JSY Guidelines

While doing a comparative analysis between the national and state JSY guidelines, it has been found that the state has developed detailed operational guidelines for the implementation of JSY. Important features of the JSY guidelines for the state are presented below:

### *3.1.1 Eligibility for financial assistance:*

All pregnant women delivering in government health centres like sub-centre, PHC, CHC/ FRU/general wards of sub-divisional, district and state hospitals and government medical colleges are entitled for cash assistance. In case of accredited private institutions, only those families who have genuine BPL cards (as per the last approved BPL census) or SC/ST certificate (issued by concerned Tehsildar) are eligible for the benefits under JSY. Deliveries taking place in Municipal hospitals will also get covered under the JSY benefits like any government institutions.

### *3.1.2 Financial assistance for institutional delivery*

Table 3: Provision of financial assistance for institutional delivery

| Rural Area | | Total | Urban Area | | Total |
|---|---|---|---|---|---|
| Mother's package (Rs.) | ASHA's Package (Rs.) | (Rs.) | Mother's package (Rs.) | ASHA's Package (Rs.) | (Rs.) |
| 1400 | 600 | 2000 | 1000 | 200 | 1200 |

If pregnant women choose to deliver in an accredited private institution, the mother would receive her entitled cash however, the scheme does not provide for ASHA package in such cases.

### *3.1.3 Disbursement of cash assistance to beneficiary for institutional delivery:*

a. The financial assistance to the mother would be provided effectively at the institution itself mainly to meet the cost of delivery.

b. Separate bank account would be managing the JSY funds in the nearest nationalised bank for JSY under the concerned Rogi Kalyan Samiti, in order to streamline payment of JSY in all the health institutions where delivery is taking place.

c. The payment of Rs.1000 or above made to the beneficiary for institutional delivery would be through cheque not in cash. The cheque would be jointly signed by the Medical Officer and paramedic staff like staff nurse or health worker (female), preferably the most senior in the

hospital. The signatories for the different categories of health institutions in Orissa are outlined below:

Table 4: Signatories for different type of health institution

| S.N. | Type of Health Institution | Signatories |
|---|---|---|
| a) | District Headquarters Hospital | Chief Matron & Medical Officer (In-charge) of PP Centre |
| b) | Capital Hospital | Chief Matron & Medical Officer (In-charge) of PP Centre |
| c) | Rourkela Government Hospital | Chief Matron & Medical Officer (In-charge) of PP Centre |
| d) | Medical College Hospital | Chief Matron & Medical Officer (In-charge) of PP Centre |
| e) | Municipality Hospital | Chief Matron & Medical Officer (In-charge) of PP Centre |
| f) | Block PHC/ CHC | First Medical Officer and Second Medical Officer. In case of the above is not present then BPO/ any person nominated by the Medical Officer can sign the cheque. |
| g) | PHC (New) | Medical Officer and the staff Nurse/ Pharmacist |

### *3.1.4 Delivery at a Government Health Institution (for Rural Beneficiaries)*

All mother irrespective of age, birth order, or income group (BPL & APL) would get cash assistance of Rs.1400/- in one go at the time of delivery.

a) In case of delivery at sub-centre and PHC (New), the payment would be made by ANM/ ASHA of the area where pregnant mother resides.

b) In case of delivery at CHC/ block PHC & area hospital, the payment would be made by the medical officer of the institution. For this purpose, a referral slip issued by ASHA/ ANM/ MO of the area where the pregnant mother resides has to be brought by the mother along with MCH-JSY card.

c) In case of delivery at sub-divisional/ municipal/ district headquarter hospital/ state head quarter hospital and government medical colleges, the payment would be made by an authorised representative of the SDMO/ ADMO/ CMO/ Superintendent at the time of delivery. Here again, a referral slip issued by ASHA/ ANM/ MO of the area where pregnant mother resides along with MCH-JSY card need to be produced by the pregnant woman for availing benefits under JSY. The referral slip will be retained by the head of the institution, where delivery has taken place, for further reference.

d) Mothers residing in rural areas but accessing urban government or private accredited facilities etc. for delivery will be eligible for cash assistance of Rs. 1400/-.

e) Payment of pregnant women should be done in one instalment only.

### *3.1.5 Delivery at Government Health Institutions (for urban beneficiaries)*

a) Mother's residing in urban areas and accessing urban government facilities like area hospital/ municipal hospital/ sub-divisional hospital/ district head quarter hospital/ state head quarter hospital/ government medical colleges etc. will be entitled for a cash benefit of Rs.1000/- to be paid by medical officer (in-charge)/ SDMO/ CDMO/ college superintendent and their authorized representatives at the time of delivery.

b) For the purpose of JSY benefit, the mother has to bring along JSY-MCH card and a referral slip issued by the medical staff of the government institution/ accredited private institution who have conducted 3 ante natal check-ups. CDMO/ CMO/ superintendent have to make necessary arrangement for the purpose.

c) In urban areas where ANM is not available, proof in support of receiving 3 ANC check-ups, immunisation of TT-2/ booster from any registered medical practitioner (Government/ private) would be accepted for cash assistance under JSY. The referral slip will be retained by the head of the institution, where delivery has taken place for further reference.

d) For delivery in any accredited institution (Private and PSU), only genuine BPL card & SC/ST certificate is valid and no substitution shall be accepted.

e) Payment of pregnant women should be done in one instalment only.

Disbursement of money to expectant mother going to her mother's place for delivery should be done at the place she delivers. The entitlement of cash should be determined by the referral slip carried by her and her usual place of residence. This is applicable both in rural as well as urban areas.

### *3.1.6 Delivery at an Accredited Private Institution*

a) Only those institutions which have been duly accredited by the district authorities will come within the purview of JSY under NRHM.

b) A pregnant woman choosing to deliver in an accredited private health institution will have to produce a genuine BPL or SC/ST certificate in order to access JSY benefits. Substitution of BPL cards or SC/ST certificate by any other document is not permitted.

c) A pregnant woman could carry a referral slip from ASHA/ ANM/ MO and MCH-JSY card for accessing benefits under JSY. The referral slip will be retained by the institution for further reference.

d) Disbursement of cash to mother should be done through the ANM/ ASHA channel and the money available under JSY should be paid to the beneficiary only and not to any other person or relative.

e) Such accredited private institution would also be responsible for any post-natal complication arising out of the cases handled by them.

f) The accredited private institution should not deny their services to any referred targeted expectant mother.

g) Every month accredited private health centre would prepare a statement of JSY-delivery/ ANC/ obstetric complication case handled by them in the prescribed format and send it to the

local medical officer along with the referral slips for sample verification by concerned MO/ ANM/ ASHA/ AWW.

### *3.1.7 Compensation for Sterilisation*

If the mother or husband, of their own would undergo for sterilisation, immediately after the delivery of the child, compensation money available under the existing family welfare scheme should also be disbursed to the mother at the hospital itself.

### *3.1.8 Assistance for Home Delivery*

BPL Pregnant women aged 19 years and above preferring to deliver at home by a trained traditional birth attendant (TTBA) or skilled birth attendant (SBA) is entitled to cash assistance of Rs. 500/- per delivery. Such cash assistance is available only up to 2 live births to use the cash assistance for pregnant women's care during delivery or to meet incidental expenses of delivery. The disbursement of cash would be done at the time of delivery or around 7 days before the delivery by ANM/ASHA/AWW.

Birth certificates issued by competent authority, voter ID card, school leaving certificate or EC register can be referred to ascertain age of the pregnant mother.

For the purpose of availing JSY benefits during home delivery by a poor beneficiary who have not been given a BPL card, Antodaya Anna Yojana cards can be substituted, if the same is issued to pregnant woman.

Disbursement will be made only for 2 live births and not for still births

In case of delivery which has taken place on the way to a hospital, the same will be treated as an institutional delivery provided the mother & the child are subsequently admitted to the hospital for post delivery care. Otherwise, all such cases will be treated as home delivery for the purpose of JSY benefits.

### *3.1.9 Subsidizing cost of caesarean section or management of obstetric complications:*

Generally PHCs / FRUs / CHCs etc. would provide emergency obstetric services free of cost. Where Government specialists are not available in the government health institution to manage complications or for Caesarean Section, assistance up to Rs. 1500/- per delivery could be utilized by the health institution for hiring services of specialists from the private sector.

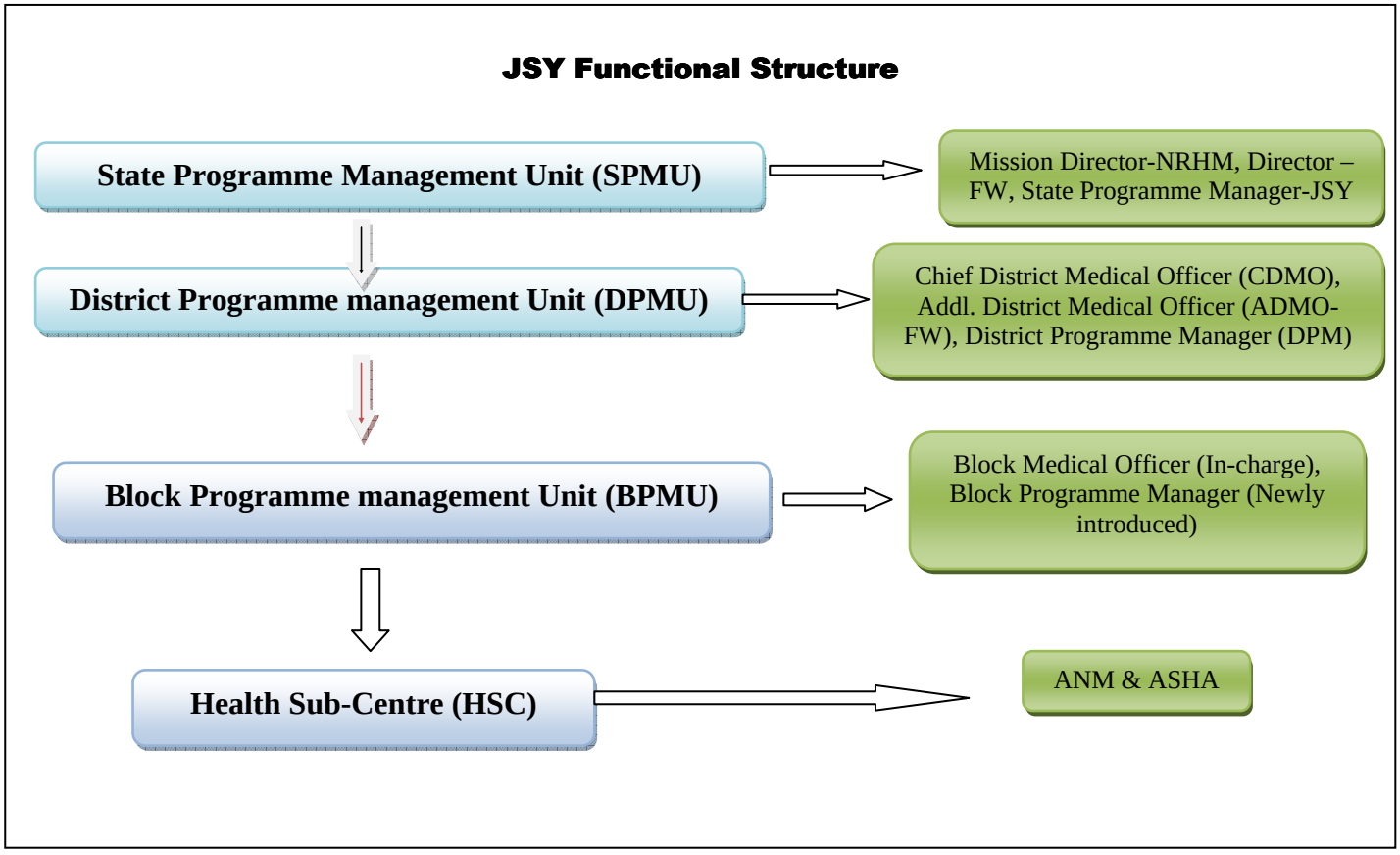
If a specialist is not available or that the list of empanelled specialists is very few, specialist doctors working in the other government set-ups may even be empanelled, provided his/ her services are spare and he/she is willing. In such a situation, the cash subsidy can be utilized to pay honorarium or for meeting transport cost to bring the specialist to the health centre.

It may however be noted that a panel of such doctors from private or government institutions need to be prepared beforehand in all such health institutions where such facility would be provided and the pregnant women are informed of this facility, at the time of birth planning. The panel of specialists for the above purpose should be approved by CDMO of the district in advance.

### 3.2 Operationalisation of JSY Guidelines: Programme Management Process

The JSY State Programme Management Unit is headed by the Mission Director (NRHM), an IAS officer working in this position since October 2006. Prior to his appointment, one of the senior medical doctors of the state was working as mission director. In a short span of time, four mission directors were changed since the launch of the programme in December 2005. The present Secretary (Health and Family Welfare), Government of Orissa after his appointment, selected an IAS officer to be the director of NRHM in the state. Since then a lot of progress has been made in JSY scheme.

Most of the officials interviewed were of the opinion that there has been lot of enthusiasm across board. They are getting very good support and cooperation from the present Secretary and Mission Director and at the same time they have been taking keen interest in addressing and resolving issues pertaining to JSY. The State Programme Manager said that professionals are getting into the system with lot of experience in their respective fields due to which the efficiency has also been improved over the years. Attrition is becoming very low. It has also been found that the state programme manager and state MIS officer have more than 10 years experience of working in the NGO sector on the related issues, so as with other officials. 72 out of 75 officials of NRHM are working on contract. A few officials said that efficiency of the staff is high because they are contractual staff and the renewal of contract is based on their performance. Therefore, they have to stand and deliver.




Mission Director (NMRM) and Director /GW) administer the implementation of JSY. The state programme management unit is responsible for overall coordination, implementation of JSY, operations and financial management, programme and financial monitoring and management of database for JSY. Mission Director (NRHM) handles grievances at the state level. Directorate (Family Welfare) provides technical support to JSY.

At the district level, CDMO is the chairperson of the DPMU. Other members include ADMO (FW) and District Programme Manager (DPM). CDMO and ADMO (FW) administer the implementation of JSY at the district level. DPMU is responsible for performance and financial monitoring. Grievances at the district level are handled by the CDMO. At the block level, Block Medical Officer (in-charge) is responsible for the implementation of JSY. However, the Block Programme Managers were appointed recently by the state government to work with BMO in tandem. At the sub-centre level, ANM, AWW and ASHA are responsible for promotion of JSY at the village, gram panchayat and sub-centre level. Even though on paper, ASHAs are accountable to the Sarpanch of the concerned gram panchayat, functionally, they are however accountable to the concerned ANMs, as they receive their financial dues from ANMs. Under the RCH programme, 21 mother NGOs, 163 field NGOs and 2 service NGOs were identified to provide various health related services. These NGOs were also assigned responsibilities to promote JSY in their respective area of operation.

The State Programme Manager said that NRHM is one of the most important programmes of the state government. JSY has always been the priority under NRHM. Sensitisation of CDMOs and BMOs generally happens in their monthly meetings and they also discuss issues, performance and targets in these meeting. Besides, the other health officials under Ayush programme and block programme organiser are also oriented about JSY and there is a separate module on JSY for these trainings. Furthermore, the PRI members are also oriented about JSY and JSY has been the front runner of any health related activities in the state as told by the State Programme Manager.

While referring to the problems faced by the state programme management unit, the Director (Family Welfare) said that the health institutions are overcrowded due to increase in number of institutional deliveries and at the same time there is shortage of doctors and paramedical staff in these institutions, which needs attention from the state government in order to handle the increase in percentage of institutional deliveries. At times doctors and paramedical staff are overburdened. There has been limited or no incentives provided to the doctors or paramedical staff. Avenues for promotion and rewards are also limited. Therefore, it is pivotal to appoint more doctors on contractual basis. At the same time, more incentives need to be provided to the doctors and paramedical staff. Opportunity for promotions and rewards along with revision of pay scale are needed in order to strengthen the scheme.

# Chapter 4

# Adaptation and operationalisation of ASHA intervention in Orissa

## 4.1 Adaptation of ASHA intervention

Based on the national guidelines issued by the Government of India with regard to roles and responsibilities of ASHA, institutional arrangements, selection and training of ASHAs, working arrangements, linkages with ANM and AWW, compensation to ASHAs, fund flow mechanisms and evaluation, the state government have issued specific guidelines for ASHA's intervention in the state, keeping in view the above components, as there was provision for the state government to modify the guidelines of ASHA as the ground realities. This chapter is divided into two parts, first part would highlight the adaptation of the national guidelines for ASHA intervention in the state and the second part would address the operationalisation of ASHA intervention.

### *4.1.1 Role of ASHA or other link health worker associated with JSY would be to* :

a) Identify pregnant woman as beneficiary of the scheme and report or facilitate registration for ANC,

b) Assist the pregnant woman to obtain necessary certifications wherever necessary,

c) Provide and / or help the women in receiving at least three ANC checkups including TT injection, IFA tablets.

d) Identify a functional Government health centre or an accredited private health institution for referral and delivery,

e) Counsel for institutional delivery,

f) Escort the beneficiary women to the pre-determined health centre and stay with her till the woman is discharged,

g) Arrange to immunize the newborn till the age of 14 weeks,

h) Inform about the birth or death of the child or mother to the ANM /MO,

i) Post natal visit within 7 days of delivery to track mother's health after delivery and facilitate in obtaining care, wherever necessary.

j) Counsel for initiation of breastfeeding to the newborn within one-hour of delivery and its continuance till 3-6 months and promote family planning.

k

Work of the ASHA or any link worker associated with Yojana would be assessed based on the number of pregnant women she has been able to motivate to deliver in a health institution and the number of women she has escorted to the health institutions.

### *4.1.2 Package for ASHA*

In rural areas, ASHA would be entitled for the following packages**:**

a) Cash assistance for referral transport to go to the nearest health centre for delivery. It should not be less than Rs. 250/- per delivery. It would, however, be the duty of the ASHA and the ANM to organize or facilitate in organizing referral transport, in conjunction with Sarpanch / ward member, Gram Sabha, etc.

b) The transactional cost is to be paid to ASHA in lieu of her stay with the pregnant women in the health centre for delivery to meet her cost of boarding and lodging etc. Not more than Rs. 150/- can be paid for this purpose. ASHA can spend this money out of the cash available with her which can be adjusted against advance on production of necessary certificate from Medical Officer (in-charge) where delivery has taken place.

c) Cash incentive to ASHA: This should not be less than Rs.200/- per delivery in lieu of her work relating to facilitating institutional delivery. Generally, ASHA should get this money after her post natal visit to the beneficiary and once the child has been immunized for BCG.

d) Expectant mother reaching any institution for delivery of her own (without the help of ASHA) should get transport cost (limited to Rs.250/-) out of ASHA package immediately after reaching the institution on registration for delivery.

e) In case ASHA has provided ANC but could not accompany the pregnant mother due to some exigencies(to be recorded), but has arranged one escort to accompany and stay till delivery and discharge to mother is done, ASHA package can be delivered to her after completion of post natal care as prescribed.

f) Under no circumstances the total payment under a, b & c above can exceed Rs.600/-.

g) It must be ensured that ASHA gets her last payment within 7 days of the delivery, as that would be essential to keep her sustained in the system.

h) The scheme does not provide for ASHA package in case of home delivery and delivery in any accredited private institution.

i) All payments to ASHA should be done by ANM only.

j) Besides getting Rs.600 for institutional delivery, ASHAs are entitled to receive the following compensation packages:

- motivation for sterilisation (vasectomy & tubectomy) @Rs.150 per case
- Immunization @Rs.150 per session
- DOTs provider @Rs.250 (on completion of treatment in six months)

## 4.2 Operationalisation of ASHA

The implementation of ASHA in the state had been initiated in a phased manner in all the 30 districts and 314 blocks of Orissa, with the launch of JSY in December 2005. The information about the ASHA intervention was disseminated to the districts through the CDMOs conference held at Bhubaneswar. Through the district level review meeting, the blocks were communicated about the scheme. Besides, letters, government orders and guidelines were issued to the districts for implementation of the scheme. The details of ASHA are presented below:

| Table 5: Number of ASHAs selected in Phases | | | |
|---|---|---|---|
| S.N. | Year | Target | Accomplished |
| 1 | 2005-06 (Phase 1) | 12730 | 12730 |
| 2 | 2006-07 (Phase 2) | 21594 | 21502 |
| | Total | 34324 | 34231 |

Table 5 shows that in the first phase (2005-06), the state government achieved 100% target, whereas in the second phase, the result was 99.72%.

### *4.2.1 Selection of ASHA*

As per the state guidelines, the selection criteria for ASHA are as follows:

a) She should be a local resident of the concerned village;

b) Her minimum educational qualification should be 8th grade. However, in the tribal or backward areas, she should have studied till 5th grade.

c) Should be married/ widowed or divorced;

d) Should be in between 19-35 years of age.

As explained by the State Programme Manager for JSY, the local community generally decides, what kind of person they want to take as ASHA, keeping in mind the above selection criteria. ANM and Block Medical Officer (in-charge) facilitate the process of selection for ASHA. ANM and the Block Extension Educator (BEE) inform about ASHA scheme to the villagers and SHGs in the meeting for nominating suitable candidates for selection of ASHA. In the next meeting, SHGs present at least 3 names for selection. ANM and BEE suggest SHG members present in the meeting, to select one out of the three shortlisted candidates by consensus. If there is no consensus, the groups are asked to choose ASHA either by vote by raising their hands/secret ballot or by lottery. She also said that in most of the cases, ASHAs were selected through consensus. The State Programme Manager, explained that the earlier idea was that all the 34,324 targeted ASHAs were to be selected in three years with an estimate of one-third ASHAs every year. However, in the first year they have selected 12,730 (37%) ASHAs in the state. Moreover, in the 2nd year, they tried to cover the remaining 21,594 ASHAs instead of taking it to the third year. As a result of these efforts, they were able to select 21,502 (62.64%) ASHAs and a total of 34,231 (99.64%) in two years. In remaining 92 cases, there was dispute of which only in one case, the matter is pending in the court.

Director (Family Welfare), GoO said that besides the above selection criteria, preference is also given to woman belonging to a community, which has large percentage of population living in that village in terms of religion, scheduled castes or scheduled tribal population. For example, if the village has got large percentage of scheduled castes or scheduled tribal population, preference is given to woman belonging to that community. It is due to the fact that the acceptance of ASHA by the community or villagers would be high, as he said. At the same time, ASHA should easily approach and motivate the pregnant women and their family for institutional delivery. Director (Family Welfare) as well as State Programme Manager echoed that at times even finding a suitable candidate for ASHA who studied upto 5th grade in tribal or backward areas is difficult. In such cases the next best candidate is selected by the SHGs.

### *4.2.2 Training of ASHAs*

For providing trainings to ASHAs, the orientation trainings of district trainers for ASHAs were conducted since the initiation of JSY in December 2005. In the first phase of the orientation programme, 277 trainers were trained out of a target of 300 trainers across the state held in 2005-06. In the second phase held in 2006-07, 282 of the 300 targeted persons were trained as district trainers for providing training to ASHAs. Besides, a state level ToT for the Skill Attendant at Birth (SAB) was organised in which 171 out of 180 identified persons attended. Two days zonal level ToTs for OG special and medical officer (in-charge) were also organised at the state level. 210 out of 240 identified members attended this training. Moreover, two days district levels ToTs to create at least three trainers at each district who in turn can provide training to ASHAs were also conducted. 74 out of 150 attended this training. 15 days hands on training for the staff nurse was also organised, in which 85 out of 2,136 identified staff nurses, have already undergone the training. Similar situation can also be found in case of ANMs and LHVs trainings, where 20 out of 8041 identified ANMs and LHVs have attended the 21days hands on training organised by the state government.

In the first phase, all the 12,730 ASHAs were selected had gone through a one-week induction training of the Module-I. The induction training of ASHAs for the Module II, III & IV held in the first phase, 8,150 out of 12,730 ASHAS were trained for a continuous period of 16 days. BTT of ASHA for Module I, 3,140 ASHAs were trained and also the same number of ASHAs had gone through training of BTT of ASHA for Module II, III & IV. The second phase of training of the newly selected 21,501 ASHAs for the Module I and Module II, III & IV, have been in progress. The details of all training activities are presented below:

Table 6: Training of Trainers (ToTs) and Training of ASHAs and other officials involved in JSY for the financial years 06 & 07

| S.N. | Category of Training Conducted | Target | Trained | Remark |
|---|---|---|---|---|
| 1 | 1st orientation training of district trainer of ASHAs | 300 | 277 | |
| 2 | 2nd orientation training of district trainer of ASHAs | 300 | 282 | |
| 3 | Induction training of ASHAs (Module I) (Phase I) | 12730 | 12730 | |
| 4 | Induction training of ASHAs (Module I) (Phase II) | 21594 | 17477 | |
| 5 | Induction training of ASHAs (Module II, III & IV) | 12730 | 8150 | |
| 6 | BTT of ASHAs (Module I) | 3140 | 3140 | |
| 7 | BTT of ASHAs (Module II, III & IV) | 21594 | | On progress |
| 8 | State level ToT for the Skill Attendant at Birth (SAB) | 21594 | | On progress |
| 9 | Two days zonal level ToTs for OG special and medical officer (in-charge) | 180 | 171 | |
| 10 | two days district levels ToTs to create at least three trainers at each district | 240 | 210 | |
| 11 | 15 days hands on training for the staff nurses | 2136 | 85 | |
| 12 | 21days hands on training on ANM and LHVs | 8041 | 20 | |
| 13 | Orientation programme of district programme and programme management unit officials of JSY | 240 | 210 | |

### *4.2.3 Compensation Package for ASHAs*

As per the national and state guidelines of JSY, all payments to ASHA should be made by the concerned ANM only. As mentioned earlier as per the state guidelines, ASHAs are entitled for performance based compensation package to be disbursed by ANM for referral transport, transactional cost, cash incentive for institutional delivery, motivation for sterilisation (vasectomy & tubectomy), immunization and for providing DOTs. ANMs do the performance monitoring of ASHAs and accordingly releases payment. The fund for the same is kept in a joint account of ANM and sarpanch/ naib sarpanch, whichever is a lady. This joint account is different from the joint account already being operated for keeping untied fund. The ANM sends monthly report with regard to both physical and financial progress in the prescribed format to the Block Medical Officer (in-charge) by the 2nd of every month.

Table 7: Incentives received by ASHA since 2005-06 to October'07

| SN. | Scheme/ Programme | Year | Amount (Rs. in lakhs) | Number of cases |
|---|---|---|---|---|
| 1 | JSY | 2005-06 | 21.126 | 3,169 pregnant women |
| 2 | JSY | 2006-07 | 385.777 | 70,814 pregnant women |
| 3 | JSY | 2007 | 482.55 | 104,188 pregnant women |
| 4 | Immunization | 2007 | 18.99 | |
| 5 | Sterilisation | 2007 | 2.45 | |
| 6 | Volunteer IRS | 2007 | 0.26225 | 134 IRS Campaign |

It has been found that in future ASHAs would be trained in diarrhoea prevention and management, involvement in malaria detection and treatment in 50 endemic blocks of 21 districts on pilot basis and they would also be trained on HIV/ AIDS related issues.

# Chapter 5

# Fund Flow Mechanisms and Monitoring Processes

## 5.1 State provision for fund flow mechanisms

As per the state JSY guidelines the fund flow mechanisms from the state to the district, block level health institutions and to the sub-centre level is as follows:

### *5.1.1 Fund arrangement under JSY*

a) For Government Medical College / Capital Hospital / RGH Rourkela, fund will be placed directly from Mission Directorate to the head of the institution which will be kept in a separate account under the supervision of governing body of the college or Rogi Kalyan Samiti of the hospital.

   Superintendent, Medical colleges, CMOs of the institution would make assessment of the number of deliveries taking place and the requirement of fund and communicate the same to the Mission Directorate.

   The utilization certificate has to be submitted to the NRHM Directorate from time to time for release of further funds.

   For availing benefits under JSY, beneficiary has to produce referral slip from the ANM/MO of the area of her native place.

b) For Block PHC/CHC/Area Hospital /Municipal Hospital / Sub-Division /District Head quarter hospital.

   The district should allocate sufficient amount of money (based on the load of delivery in these institutions) for each of these institution. This fund should be kept in a separate account under the supervision of the concerned Rogi Kalyan Samiti.

### *5.1.2 Flow of fund*

a) District Authorities would advance Rs.10,000/- to each ANM as recoupable impressed money for JSY fund.

b) This money would be kept in a joint account of ANM and Sarpanch / Naib Sarpanch, whichever is a lady. This joint account is different from the joint account already being operated for keeping untied fund. ANM would 'roll' the entire amount by advancing suitable minimum amount as assessed by her in advance to ASHA/AWW and later should recoup it from the medical officer (in-charge), Block out of JSY fund parked by the district authorities. The process of recoupment should be simple with proper checks so as to be able to disburse the cash to the pregnant women in time.

c) Wherever the post of ANM is vacant, the HW(M) / LHV / Additional ANM as decided by Block medical officer (in-charge), will operate the joint account along with Sarpanch / Naib Sarpanch.

d) ANM will advance fund, as per the requirement to each ASHA / AWW and get the expenditure statement reconciled in the monthly meeting.

e) ANM will be solely responsible for recoupment of all the advances given to ASHA / AWW.

## 5.2 Status of fund utilisation under JSY

### *5.2.1 Formation and Funds utilisation by Rogi Kalyan Samiti*

Under JSY, Rogi Kalyan Samitis were formed at the capital hospital, district headquarters hospitals, sub-divisional hospitals and PHCs/ CHCs in order to supervise the work of JSY emphasising on fund utilisation. The details of the Rogi Kalyan Samiti are presented below:

Table 8: Formation of Rogi Kalyan Samiti

| SN. | Institution | Target | Achievement |
|---|---|---|---|
| 1 | DHH/ Capital Hospital/ RGH Rourkela | 32 | 32 |
| 2 | SDH | 22 | 22 |
| 3 | PHC/ CHC | 348 | 341 |
| 4 | PHC (New) | 1,162 | 338 |

Rogi Kalyan Samitis (RKS) have also utilised fund for activities like purchase and repair of equipment, minor repair/ modification, maintenance, wage for sweeper and others, purchasing water purifiers and generators, emergency lights and getting services of security guards. Rogi Kalyan Samitis as on October 2007 received Rs. 520 lakhs for the above activities. However, the expenditure by these samitis was found to be Rs. 199.548 lakhs. Still a large percentage of the fund has been unutilised.

### *5.2.2 Fund utilisation by the sub-centres*

Table 9: Fund utilisation at sub-centre level

| Year | Target | Account opened | Funds utilised (Rs.) | % of fund utilised |
|---|---|---|---|---|
| 2005-06 | 5927 | 5927 | 488.18 lakh | 82 |
| 2006-07 | 6241 | 6165 | 276.43 lakh | 45 |

## 5.3 State provision for monitoring of JSY

### *5.3.1 Monthly meeting at Sub-centre Level*

For assessing the effectiveness of the implementation of JSY, monthly meeting of all ASHAs / AWWs related health link workers working under an ANM should be held by the ANM, possibly on a fixed day (may be on the third Friday) of every month, at the sub-center or at any of Anganwadi Centers falling under the ANM's area of jurisdiction. If Friday is a holiday, meeting could be held on following working day.

### *5.3.2 Sector Level*

At the sector level there shall be regular monitoring of JSY activities during the sector meetings under the supervision of the medical officer. In the meeting ANMs shall discuss the performance of JSY in her area.

### *5.3.3 Preparation of Monthly Work Schedule*

In the monthly meeting, the ANM, besides reviewing the current month's work vis-à-vis envisaged activities, should prepare a Monthly Work Schedule for each ASHA / village level health worker on following aspects of the coming month:

- **Feed back on previous month's schedule**

a) Number of pregnant women missing ANCs.

b) No. of cases, ASHA/Link worker did not accompany the pregnant women for Delivery.

c) Out of the identified beneficiary, number of Home deliveries.

d) No. of post natal visits missed by ASHA.

e) Cases referred to First Referral Unit (FRU) and review their current health status.

f) No. of children missing immunization.

- **Fixing Next Month's Work Schedule (NMWS) : To include-**

i. Names of the identified pregnant women to be registered and to be taken to the health center / Anganwadi for ANC.

ii. Names of the pregnant women to be taken to the health centre for delivery (wherever applicable).

iii. Names of the pregnant women with possible complications to be taken to the health center for check-up and/or delivery.

iv. Names of women to be visited (within 7 days) after their delivery.

v. List of infants / newborn children for routine immunization.

vi. To ensure availability of imprest cash.

vii. Check whether referral transport has been organized.

### *5.3.4 Reporting*

For the purpose of monthly reporting the ANM is to report both physical and financial progress in a prescribed format to the Medical Officer by the 2nd of every month. Further, after compilation, the Medical Officer shall report the performance of the scheme in a prescribed format to the CDMO of the respective district by the 5th of every month in a prescribed format. The CDMO shall report the progress under JSY to the Mission and the Nodal Officer by the 7th of every month.

## 5.4 Operationalisation of monitoring mechanism for JSY

Every month ANMs through their monthly meetings prepare a monthly progress report of the concerned sub-centres and send it to the Block by every 25th of the month. The block consolidates SC reports and sends the report on every 5th of the succeeding month to the district. At the same time PHCs and CHCs also send their data to the district. District programme management unit prepares the

district report and sends it to state NRHM by 10th and the state compiles the report by 15th of every succeeding month. Districts level data has been shared through compact disks (CDs) to the state. Reporting formats at each level has been designed and developed by the state programme unit and shared for consolidation of data. The SCs share the data in the given format through hard copies, whereas many of PHCs and CHCs, share data either through emails or through CDs. State programme management unit said that 276 out of 314 blocks have the dialup network connections. Moreover, the state is in the process of developing online data collection and compilation.

NRHM has been in talks with NIC to launch this initiative through www.nic.in/ NRHM. In order to manage data at the block level, data entry operator will be recruited soon, as told by the SPMU. The Block Programme Organisers will validate and authenticate the data at the block level. Earlier ANMs were reporting on a 52 pages format on a regular basis, which was reduced to 11 pages in the form of book for reporting by ANMs. The ANMs were provided one day training of maintaining database. Around 90% of the SCs are reporting regularly. Mauyrbhanj and Ganjam districts which have 26 and 25 blocks respectively find it difficult to maintain the database and sending report regularly due to large number of blocks.

### 5.5 Strengthening Health Management Information System

In order to strengthen health management information system, the SPMU has developed improved information system through integration of various formats and provided training and orientation to the functionaries involved, in management of such information. It has also introduced community based monitoring system.

### 5.6 Accreditation of private health institution

In order to increase choice of delivery care institution, a number of private health institutions as well as hospitals belonging to private & public sector undertakings, Central Government as well as Christian Missionaries can be accredited to provide delivery service. A guideline for this purpose has been framed. So far the state government has accredited 17 Medical institutions in the state under the JSY scheme.

### 5.7 IEC for awareness generation

In order to create awareness among the people especially in the rural, backward and remotest of part of the state, the state has launched extensive IEC campaign throughout the state through print and electronic media. The state has used radio, television and regional newspapers to spread the message of ASHA and JSY. However, the state has designed and developed uniform literatures for wall paintings for creating awareness amongst the population living in the backward areas where 70% of the population don't get a chance to watch television, as said by the state IEC consultant.

He said that wall painting has been proved as one of the powerful medium of communication in these areas where it is displayed in very prominent locations and people are able to see these painting time and again for a longer period. He also said that prior to his joining, there was no guideline for wall paintings and IEC fund was considered as easy money to siphon. He has developed eighteen point guidelines for wall painting and also designed uniform literature with colours, size, text, of the materials, location, etc. to be painted on the wall for better output and longer stay on the wall. A copy of the same is attached in Annexure-2.

IEC department has developed very stringent systems and procedures for IEC along with robust monitoring system. The department has also provided a CD to each block along with the text and

design for painting. For example, sq.ft. cost of painting was Rs.10/- earlier which was reduced to Rs.6/- along with specific parameters due to which the success rate of wall painting is more than 90%. Block Extension Educators (BEE) are responsible for IEC activities. BEEs shortlists locations and walls for wall paintings which is reviewed by the block officials and then send a final list to the district administration. Finally the district outsource professional agency through a bidding process to do the wall painting with the prescribed guidelines. In Khaurda district, the district administration has got the deal with Rs.3.75 per sq.ft., whereas in Kendrapada district, it was Rs. 5.00/-. It has not only generated competition but promoted quality with competitive price. He also said that IEC budget has increased two fold since last two years from Rs.1.73 crores (2006-07) to Rs. 2.98 crore (2007-08) under NRHM of which Rs. 36 lakh is earmarked for JSY.

IEC Department also used folk media for spreading the message. Communication experts were hired for developing the script who worked with the medical professional in doing so. The script was then pre-tested at the field level and finally shows were organised at the village level for awareness generation. Besides, the senior state NRHM officials also participated in addressing issues and questions of the people through a live Gramsat programme. These gramsat programmes are organised through video conferencing by linking gram panchayats with block, district and state level. The district administration facilitates these programmes to bring stakeholders into a common platform where they can directly pose questions and issues to the state officials through video conferencing.

# Chapter 6

# Impact of JSY

## 6.1 Impact of JSY with regard to institutional delivery

The institutional delivery in Orissa has been increased significantly since the beginning of the scheme in 2005-06. As per table 10, the percentage of increase in institutional delivery in 2006-07 as compared to 2005-06 was 13.94%. Whereas, till October 2007, it has been increased to 65% as compared to 2006-07. It is also evident that the percentage of home delivery has been on the decline in 2007-08 as compared to the last year. In response to this State Programme Manager said that the state is also planning to study the reason why there has been reduction in number of home deliveries in 2007-08. She said that as per the national and state guidelines, in case of home deliveries ASHAs do not receive any incentives which could be one of the reasons why ASHAs tried to promote more institutional deliveries to get more incentives. Therefore, it is important to study the reasons for increase in institutional delivery.

There has been significant increase in percentage of allocation of funds for providing financial assistance to mothers as well as to ASHAs. One of the primary reasons for increase in institutional deliveries is due to the incentives provided to mothers and ASHAs. At the same time ASHAs also played a pivotal role in motivating pregnant women for institutional delivery. As mentioned above, the rate of home deliveries is on the decline, whereas there has been substantial increase in institutional deliveries since last three years. For the cash assistance to mothers, the state government has been issuing bearer cheques in the name of the beneficiaries instead of cash. At the beginning of the scheme, incentives to mothers were given in the form of cash but due to misappropriation of fund, bearer cheques have been issued to the beneficiaries.

Table 10: Achievements in institutional delivery (Rs. in lakhs)

| Year | Mothers Assisted | | | Accompanied by ASHA | Financial assistance to mother | Incentive to ASHA |
|---|---|---|---|---|---|---|
| | Institutional Delivery | Home | Total | | | |
| 2005-06 | 21,126 | 5,281 | 26,407 | 3,169 | 195,48 | 14.26 |
| 2006-07 | 151,452 | 75,752 | 227,204 | 70,814 | 2,023.65 | 385.777 |
| 2007-08 (Till Oct'07) | 232,749 | 46,013 | 278,762 | 104,188 | 2,864.85 | 482.55 |
| | 405,327 | 127,046 | 532,373 | 178,171 | 5,083.98 | 882.587 |

## 6.2 Status of institutional delivery vis-à-vis types of institutions

Table 11 reveals that there has been substantial increase in institutional delivery in 2006-07 as compared to the last year. The percentage of increase of deliveries in Primary Health Centres (New) has been the highest among all the hospitals in Orissa i.e. 69 percent. PHCs (New) are the newly established single doctor PHCs set-up by the state government mostly in the rural and backward areas. In PHC/ community health centres, percentage of deliveries has been increased to 44% in 2006-07. At the district and sub-divisional hospitals also there has been an increase in the number and percentage of deliveries, standing at 18 and 25 percent respectively.

Table 11: Types of health institutions where delivery took place

| SN. | Institution | No. of Institutional Deliveries | | Increase in % |
|---|---|---|---|---|
| | | 2005-06 | 2006-07 | |
| 1 | DHH | 80,238 | 94,755 | 18 |
| 2 | SDH | 29,238 | 36,424 | 25 |
| 3 | PHC/CHC | 99,881 | 144,085 | 44 |
| 4 | PHC (New) | 6,207 | 10,519 | 69 |

## 6.3 District wise status of institutional deliveries

Table 12: District wise status of institutional deliveries (2006-07)

| SN. | Districts | Percentage of increase in institutional deliveries |
|---|---|---|
| 1 | Malkangiri & Gajapati | 80 & above |
| 2. | Raygada, Kalahandi & Boudh | 60-80 |
| 3. | Kandhamala, Ganjam, Nabarangpur, Balesore & Bargarh | 40-60 |
| 4. | Sundargarh, Jharsuguda, Sambalpur, Deogarh, Anugul, Sonpur, Bolangir, Nuapada, Koraput, Keoonjhar, Dhenkanal, Jajpur, Mauyrbhanj, Bhadrak, Kendrapada, Cuttack, Jagatsingpur, Puri, Khorda, Nayagarh, | Less than 40 |

Gajapati and Malkangiri, the two backward districts have recorded more than 80 percent increase of institutional deliveries in 2006-07 as compared to 2005-06. Malkangiri district has recorded 107% growth in 2006-07. Raygada, Kalahandi and Boudh districts have recorded the increase in percentage of institutional delivery in between 60-80 percent in the same year. Table 12 reveals that only a few backward districts have witnessed more than 60 percent increase in institutional deliveries. However, more than 60 percent of the districts in Orissa have recorded less than 40 per cent increase in institutional deliveries.

### 6.4 Status of institutional delivery vis-à-vis home delivery

Annexure 1 reveals that the total number of deliveries took place in 2006-07 were 227,204 of which 151,921 (67 per cent) cases were institutional deliveries and remaining 75,283 (33 per cent) were home deliveries. Of the 151,921 cases of institutional deliveries, 70,814 (only 47 percent) cases have been assisted by ASHAs. It reveals that still 53% of the institutional deliveries made in 2006-07 have not been covered by ASHAs. Moreover, almost one-third of the deliveries in Orissa are still taking place at home.

# Chapter 7

# Conclusions and Recommendations

## 7.1 Conclusions

The study on the initial assessment of JSY and ASHA intervention in Orissa has analysed the adaptation of national guidelines of JSY and the status of implementation of the said scheme in Orissa. As the study was limited to the analysis of the secondary data available with the state government and interview of the senior state level officials involved in management of JSY, therefore the findings and conclusions are based on the data and information gathered from the above sources. Hence there is a need to confront this data and information with other sources.

The state had launched JSY in 2005-06 which is now being implemented in all districts. While adapting the national guidelines of JSY, the state has developed detailed guidelines for implementation of JSY. Keeping in mind the ground realities and geographical conditions, the state has evolved detailed operational modalities in order to assists officials, functionaries and institutions to effectively discharge their duties and responsibilities. The national guidelines with regard to the selection of ASHAs have been modified in terms of age and educational qualifications especially for the tribal and backward areas.

NRHM is one of the most important agenda of the state government while JSY has always been the priority under NRHM. Findings suggest that there is high level of motivation amongst the staff working at the state level under NRHM. It has been found that there has been lot of enthusiasm across board, the staff under state NRHM unit are getting very good support and cooperation from the present Secretary and Mission Director. At the same time the senior officials have been taking keen interest in addressing and resolving issues pertaining to JSY. The professionals are getting into the system with lot of experience in their respective fields due to which the efficiency has also been improved over the years. Attrition is becoming very low. It is also evident that senior officials working under this scheme have substantial experience of working in the NGO sector, which has added value to JSY. A large percentage of the staff are working on contract due to which their efficiency level is high. It is due to the fact that their contract is renewed based on their performance, which enables them to stand and deliver. However, it has been found that at times there have been conflicting situations between the permanent employee of the government and contractual staff. The performance of the contractual staff has been affected due to non-cooperation, indifferent and apathetic attitude of the government staff who are supposed to be the fellow colleagues. This is due to the difference in age, educational qualification and efficiency level of contractual staff vis-à-vis the government staff.

Findings also suggest that the advance of Rs.10,000/- given to ANM as recoupable impressed money for JSY fund is kept in a joint account of ANM and Sarpanch / Naib Sarpanch, whichever is a lady, which is a distinct feature in Orissa and a step forward towards enabling women's participation in the scheme.

Even though on paper, ASHAs are accountable to the Sarpanch of the concerned gram panchayat however functionally they are accountable to the concerned ANMs, as they receive their financial dues from ANMs. The NGOs involved under the RCH programme were assigned responsibilities to promote JSY in their respective area of operation. 34,231 (99.64%) of 34,324 ASHAs have been

identified under this scheme in two years which is well before the stipulated time of achieving the target in three years. Training programmes of ASHAs have also been conducted at various levels in different phases.

One of the important steps initiated by the state government with regard to cash incentives to the beneficiaries was the introduction of bearer cheques which has reduced the misappropriation of funds.

In order to strengthen the health management information system, the SPMU has developed improved information system through integration of various formats and provided training and orientation to functionaries involved in the management of such information. It has also introduced community based monitoring system.

So far the state government has accredited 17 medical institutions in the state under the JSY scheme and is in the process of accrediting a greater number of medical institutions.

In order to promote awareness about JSY especially in the tribal and backward areas, the state government has developed robust system, procedures and guidelines for mass communication through wall paintings, other print and electronic media by optimally utilising available resources. This has resulted in effectiveness of awareness generation and reduction in misutilisation of funds.

The main objective of JSY is to reduce the maternal and infant mortality by promoting institutional deliveries especially in the low performing states. In this context, the state of Orissa has made considerable improvement in the last two years, i.e. in 2005-06 and 2006-07. The number of institutional deliveries has gone up to 285,783 (2006-07) from 215,564 (2005-06) an increase of 33 per cent in one year. Malkangiri district recorded the highest percentage of increase in institutional deliveries in 2006-07, i.e. 107 per cent, whereas in Ganjam district it is more than 80 per cent. Raygada, Kalahandi & Boudh have recorded institutional deliveries in between 60-80 per cent, whereas Kandhamala, Ganjam, Nabarangpur, Balesore & Bargarh recorded an increase in between 40-60 per cent. However, in 20 districts, the increase in institutional deliveries is less than 40 per cent. This suggests that still a large percentage of the districts are lagging behind in improving their performance, which needs further attention under this scheme. However, there has been noteworthy improvement in overall institutional deliveries at the state level since last two years, after the launch of JSY.

It is also evident that the IMR and MMR have also declined since the launch of JSY in the state. The IMR has gone down from 81 (1998-99) to 65 (2005-06) as per NHFS II and III. In the corresponding period the MMR has also declined from 367 to 358.

### 7.2 Recommendations

- The health institutions are overcrowded due to increase in number of institutional deliveries and at the same time there is shortage of doctors and paramedical staff in these institutions, which needs attention from the state government in order to handle the increase in percentage of institutional deliveries at present and in future. At the same time quality of institutional deliveries can also be questioned in the context of increasing number of deliveries over the years. Thus, performance based incentivised systems need to be introduced and institutionalised for the doctors and paramedical staff for improving their efficiency, motivation and able to perform better. The national guideline on JSY is also silent on this aspect. It is evident from the study that there has been significant increase in the percentage of institutional deliveries over the years since the launch of the programme, therefore, without incentivising doctors and paramedical staff, and adding number of medical professionals for the increasing workload would have serious repercussion in future. Therefore, it is important

for the union and state government to revisit the guidelines and design effective strategy to address this important issue. It is pertinent to note that the doctors and the paramedical staff are the backbone of this scheme. Motivation of these personnel is the key to success of JSY.

- Under national and state guidelines of JSY, there has been provision for subsidising cost of caesarean section and management of obstetric complications which is up to Rs.1500/- per delivery to be utilized by the health institution for hiring services of specialist from the private sector or bring empanelled doctors from government hospitals for paying their honorarium or meeting their transport cost. However, it is important to prepare the database of how many such cases have been served by the health centres, how many private or empanelled doctors have been hired and what was the amount spent per case over and above the stipulated amount of Rs.1500/- in a financial year. This would give lot of insight in revisiting the guidelines with regard to, whether the stipulated amount is sufficient for caesarean section and management of obstetric complications. It is also evident that in the far flung backward or rural areas across the country, the doctors are unwilling or hesitant to serve for long time and many of the health centres in these areas are lying vacant for months. In this context, getting specialist from the private sector or bring empanelled doctors from government hospitals is important and crucial during emergencies. Therefore, union and state governments need to take necessary measures to ensure safe deliveries.

- Moreover, in the event of predictable complicated case, the beneficiary and her family should be informed well in advance, may be during the ANCs about the expected expenditure to be incurred in case of complications as well as the contributions required from the family for such cases. Thus, the beneficiary may contribute certain pre-fixed expenses and also avail the copayment option for her delivery. This will not only help the beneficiary to arrange her contribution but will also reduce health hazards. The co-payment mechanism would be the best alternative during the time of emergency, so that there is no surprise or uncertainty for the family with regard to untoward expenses and they can also be prepared in advance to take care of such expenditure. A part of the co-payment could also be given as incentives to the doctors and the paramedical staff attending to the beneficiary. This would also motivate the medical personnel to serve better and promote competition among the doctors and health providers to provide quality services.

- Cash benefit is the hallmark of JSY from the beneficiaries' perspective. In spite of such cash incentives, more than 20 out of 30 districts in Orissa have recorded less than 40% increase in institutional deliveries. Therefore, it is important to assess the overall relevance of conditional cash benefit in institutional deliveries which implies that the beneficiary is only entitled to get the cash benefit when she registers in nearby health institution, go for at least 3 ANC check-ups and institutional delivery. In light of the above, the scheme might introduce the maternity voucher scheme with pre, during and post natal care coupons that can be used by the beneficiary at different stages of pregnancy and also after delivery. At the same time, she could have a choice to go to a good hospital/ clinic for her treatment. Based on the satisfactory services rendered and upon producing such maternity vouchers, hospital/ clinic could be reimbursed. At the same time the doctors who provided quality services can also be incentivised. It would not only empower women to take decision in choosing right hospitals/clinic for getting better services – becoming real clients - but also enable doctors to offer quality services. A pilot project may be initiated in one of the low performing districts or blocks of Orissa to see the impact of such initiative for further replication.

- Under JSY, the role of ASHA is to arrange in immunizing the newborn till the age of 14 weeks. However, in spite of such provisions a large percentage of the newborn has not yet

been covered under JSY. At the same time the IMR in Orissa is still very high which is much more than the national IMR rate. As per SRS 2005, IMR in Orissa was 75 as compared to the national IMR i.e. 58. Therefore, the scheme needs to pay attention in providing health care facilities to the infants beyond 14 weeks. These extended services should at least cover a period of 1 year from birth especially in the low performing states.

- In light of the above, it is indeed necessary to have synergy between JSY and the newly launched National Health Insurance Scheme (NHIS) of Government of India under the aegis of Ministry of Labour and Employment. NHIS provides health insurance to the BPL workers in the unorganised sector that constitute about 93% of the total work force in the country and their families up to a unit of five. Thus, NHIS could be able to bridge some remaining health protection gaps such as pregnancy related illnesses and provide post natal health care services to the mother and the new born child. It is also important to note that these two schemes are managed by two different ministries of the government of India viz. Ministry of Health and Family Welfare for JSY and Ministry of Labour and Employment for managing NHIS. Moreover, these two schemes were conceived separately at different times with different objectives. Therefore, there is a need for the government to introspect whether these two schemes can be integrated in order to provide better health services to the poor (beneficiaries and their family) for a long time.

- As the study was only restricted to do the initial assessment of JSY based on the available secondary data and interview of the state officials involved in the project, it is crucial to better understand the ground realities and perception of the stakeholders and document lessons, case studies, innovations, issues and challenges which would add value to the scheme. Thus, more in depth analysis is still required by selecting a few districts including the high and low performing ones for the field study with all actors involved from both the public and private sectors.

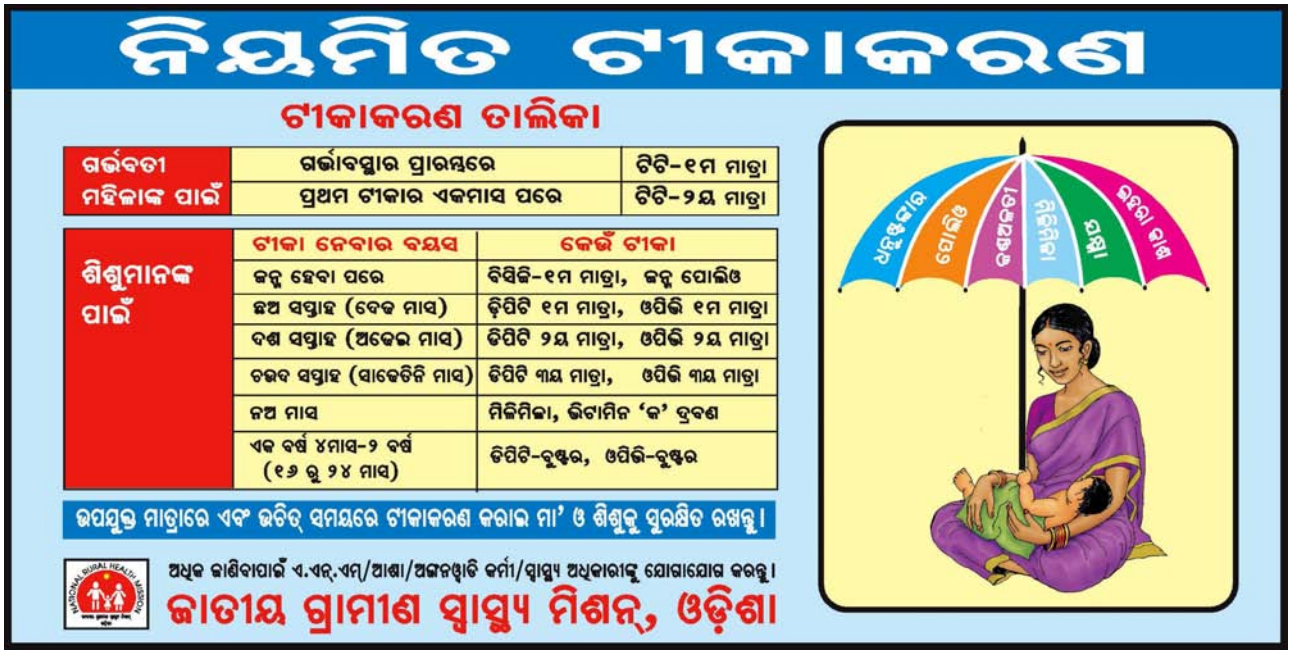
# Annexures

Annexure-1

**JSY for the Year 2006 – 2007**

| SL.NO. | District | Beneficiary | | Institutional delivery | Home Delivery |
|---|---|---|---|---|---|
| | | Total | Assisted by ASHA | | |
| 1 | Angul | 8254 | 1421 | 4038 | 4216 |
| 2 | Balasore | 11409 | 4205 | 10457 | 952 |
| 3 | Baragarh | 6904 | 3433 | 5560 | 1344 |
| 4 | Bhadrak | 4577 | 1930 | 2949 | 1628 |
| 5 | Bolangir | 10063 | 4887 | 8267 | 1796 |
| 6 | Boudh | 2000 | 651 | 755 | 1245 |
| 7 | Cuttack | 11009 | 4819 | 8564 | 2445 |
| 8 | Deogarh | 2165 | 711 | 1091 | 1074 |
| 9 | Dhenkanal | 8334 | 920 | 6371 | 1963 |
| 10 | Gajapati | 5093 | 338 | 1907 | 3186 |
| 11 | Ganjam | 7245 | 3629 | 5140 | 2105 |
| 12 | Jagatsinghpur | 5766 | 1321 | 4925 | 841 |
| 13 | Jajpur | 8808 | 4323 | 8236 | 572 |
| 14 | Jharsuguda | 2822 | 562 | 1306 | 1516 |
| 15 | Kalahandi | 12183 | 3221 | 4918 | 7265 |
| 16 | Kandhamal | 6696 | 1781 | 4208 | 2488 |
| 17 | Kendrapara | 11086 | 3097 | 5971 | 5115 |
| 18 | Keonjhar | 12550 | 4212 | 7808 | 4742 |
| 19 | Khurda | 9782 | 4559 | 8435 | 1347 |
| 20 | Koraput | 4569 | 1278 | 2402 | 2167 |
| 21 | Malkanagiri | 3981 | 1527 | 1726 | 2255 |
| 22 | Mayurbhanj | 18049 | 1161 | 7789 | 10260 |
| 23 | Nawarangpur | 4045 | 1273 | 2089 | 1956 |
| 24 | Nayagarh | 4492 | 793 | 2339 | 2153 |
| 25 | Nuapada | 3235 | 280 | 1375 | 1860 |
| 26 | Puri | 12354 | 6506 | 11287 | 1067 |
| 27 | Rayagada | 7739 | 729 | 4540 | 3199 |
| 28 | Sambalpur | 5302 | 2652 | 4825 | 477 |
| 29 | Sonepur | 4609 | 1104 | 2716 | 1893 |
| 30 | Sundargarh | 11614 | 3491 | 9458 | 2156 |
| 31 | CMO, Capital Hospital | 97 | | 97 | 0 |
| 32 | SCB Medical Collecge | 187 | | 187 | 0 |
| 33 | VSS Medical College | 64 | | 64 | 0 |
| 34 | MKCG Medical College | 62 | | 62 | 0 |
| 35 | RGH, Rourkela | 59 | | 59 | 0 |
| **Total** | | 227204 | 70814 | 151921 | 75283 |

IEC Material for Wall Painting




# Questionnaire

## INITIAL ASSESSMENT OF OPERATIONALISATION OF ASHA AND JSY IN ORISSA

### I. Adaptation of the national guidelines for JSY

1. Is there any change in the national guidelines while adapting the JSY for the state of Orissa? Yes/ No
2. If yes, please elaborate the kind of changes made thereof?
3. Please provide the state guidelines for the JSY.

### II. Operationalisation of JSY

4. When was JSY implemented in the state?
5. In how many districts JSY has been implemented so far?
6. In how many blocks JSY has been implemented so far?
7. What is the functional structure for JSY at the state, district, block, GP and village level (please provide the organisational structure for JSY)?
8. Who administers the implementation of JSY in the state, district, block, GP and village level?
9. Who is responsible for promoting JSY at the GP and village level?
10. Has there been any role of NGOs/ CBOs in JSY? If yes, please elaborate.
11. Has there been any role assigned to gram panchayat for JSY? If yes, please elaborate?
12. Is there any IEC material developed by the state government on JSY for creating awareness? Yes/ No
13. If yes, please provide the same.
14. What are the medium used for creating awareness about JSY?
15. Was there any training organised for the officials/ representatives working under JSY? If yes, please elaborate the process at state, district, block and GP level.
16. Please provide the training design, date & duration of trainings, training materials distributed.

### III. Adaptation of the national guidelines by the state of Orissa for ASHA

17. Have there been any changes made in the national guidelines for the selection of ASHA for the state of Orissa? Yes/ No
18. If yes, please elaborate the kind of changes made thereof?
19. Please provide the state guidelines for the selection of ASHA.

### IV. Operationalisation of ASHA

20. Are there any guidelines developed for operationalising ASHA in the state (which include defining roles & responsibilities, institutional arrangements, selection process and training of ASHAs, working arrangements, linkages with Anganwadi workers, ANM; compensation to ASHAs, fund flow mechanisms to ASHAs and monitoring and evaluation)? If yes, please elaborate

21. Is there any IEC materials developed by the state government to create awareness about ASHA? Yes/ No

22. If yes, please provide the same.

23. What is the selection procedure for ASHA? please elaborate

24. What is eligibility (Mandatory & obligatory) criteria's for ASHAs? please elaborate

25. Has there any specific eligibility (Mandatory & obligatory) criteria's developed for ASHAs in tribal or backward districts? please elaborate

26. How many ASHAs are currently working?

27. How was the information about ASHA disseminated from state to district to block to GP and villages? please elaborate

28. What are the roles and responsibilities of ASHAs? Please elaborate/ share a copy of the same

29. What is the institutional arrangement for ASHAs?

30. Was there any training organised for the ASHAs? If yes, please elaborate the process at state, district, block and GP level.

31. Please provide the training design, date & duration of trainings, training materials distributed.

32. Is there any linkage between ASHAs, ANMs and Anganwadi workers? If yes, please elaborate

33. What is the compensation package provided to ASHAs? Please provide the details

34. What is the fund flow mechanism from the state, district, block and how it reaches to ASHAs?

35. What are the mechanisms for providing cash assistance to the beneficiaries?

**V. Programme Management Process**

36. Is there a state core team for JSY?

37. If yes, who are the members of the team?

38. What are their roles and responsibilities? Please elaborate or share a copy of the same

39. Is there a District core team for JSY?

40. If yes, who are the members of the team?

41. What are their roles and responsibilities? Please elaborate or share a copy of the same

42. Is there a Block core team for JSY?

43. If yes, who are the members of the team?

44. What are their roles and responsibilities? Please elaborate or share a copy of the same

45. Is there a GP/ village committee for JSY?

46. If yes, who are the members of the committee?

47. What are their roles and responsibilities? Please elaborate or share a copy of the same

**VI. Monitoring & Supervision**

48. Who monitor the implementation of JSY state, district, block, GP and village level?

49. Who does the performance and financial monitoring of JSY at the state, district, block and GP level, please elaborate?

50. Do you have a format for performance and financial monitoring of JSY? If yes, please share a copy.

51. How the data is gathered for performance and financial monitoring of JSY from village to the state level?

52. Who maintains the database at state, district, block and GP level, please elaborate?

53. Who monitors and supervises the work of ASHAs at the village or GP level and in urban areas?

54. Would you like to share any other information on this scheme?

# INITIAL ASSESSMENT OF OPERATIONALISATION OF ASHA AND JSY IN ORISSA

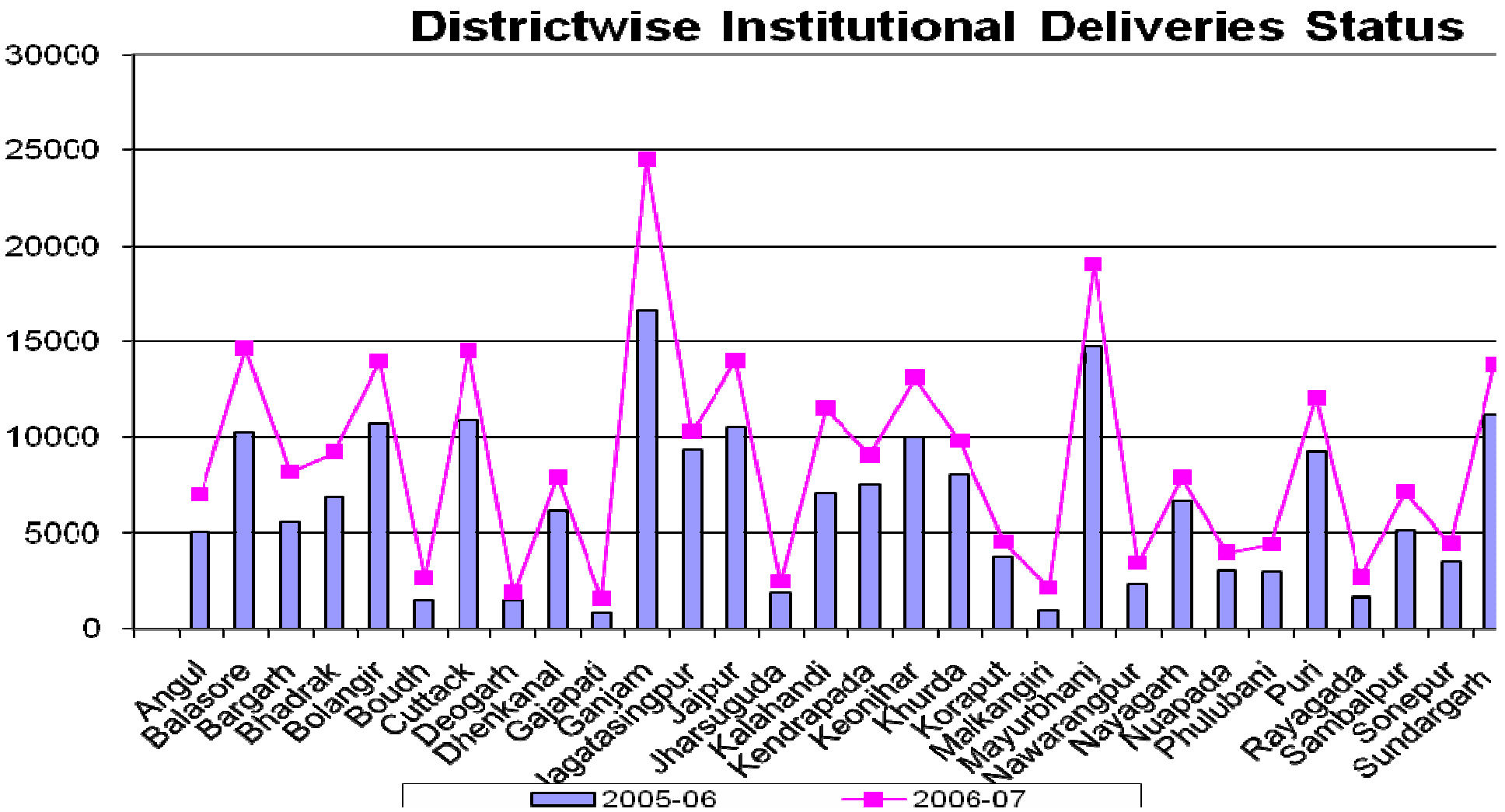
| NUMBER OF JSY REGISTERED DURING January – September 2007 | | | | | | | | | | | | Total Number of JSY Beneficiaries |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Rural | | | | Urban | | | | Total | | | | |
| SC | ST | GEN | Total | SC | ST | GEN | Total | SC | ST | GEN | Total | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 (1+5) | 10 (2+6) | 11 (3+7) | 12 (4+8) | 13 |
| **Quarter Ending March'07** | | | | | | | | | | | | |
| 27225 | 44370 | 103472 | 175097 | 8043 | 12246 | 31818 | 52107 | 35298 | 56616 | 135290 | 227204 | 227204 |
| **Quarter Ending June'07** | | | | | | | | | | | | |
| 16455 | 18436 | 45022 | 79913 | 3931 | 3106 | 14366 | 21403 | 20386 | 21542 | 59388 | 101316 | 101316 |
| **Quarter Ending September'07** | | | | | | | | | | | | |
| 27521 | 21880 | 66304 | 115705 | 5417 | 2829 | 16073 | 24319 | 32938 | 24709 | 82377 | 140024 | 140024 |
| **NUMBER OF JSY REGISTERED DURING January – September 2007** | | | | | | | | | | | | |
| 43976 | 40316 | 111326 | 195618 | 9348 | 5935 | 30439 | 45722 | 53324 | 46251 | 141765 | 241340 | 241340 |

| OUT OF 13, NUMBER OF WOMEN OPTING INSTITUTIONAL DELIVERIES January- September 2007 | | | | | | | | | | | | Total No. of Institutional deliveries under JSY | Total Number of beneficiaries assisted by an accredited worker (ASHA) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Rural | | | | Urban | | | | Total | | | | | |
| SC | ST | GEN | Total | SC | ST | GEN | Total | SC | ST | GEN | Total | | |
| 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 (14+18) | 23 (15+19) | 24 (16+20) | 25 (17+21) | 26 | 27 |
| **Quarter Ending March'07** | | | | | | | | | | | | | |
| 18583 | 26149 | 71657 | 116389 | 5502 | 7328 | 22233 | 35063 | 24085 | 33477 | 93890 | 151452 | 151452 | 70814 |
| **Quarter Ending June'07** | | | | | | | | | | | | | |
| 13675 | 15321 | 37417 | 66413 | 3267 | 2581 | 11940 | 16942 | 17902 | 17902 | 49357 | 84201 | 84201 | 31770 |
| **Quarter Ending September'07** | | | | | | | | | | | | | |
| 21335 | 16962 | 51403 | 89700 | 6222 | 3250 | 27934 | 27557 | 27557 | 20212 | 69865 | 117634 | 117634 | 53853 |
| **NUMBER OF WOMEN OPTING INSTITUTIONAL DELIVERIES January – September 2007** | | | | | | | | | | | | | |
| 53593 | 58432 | 160477 | 272502 | 14991 | 13159 | 62107 | 79562 | 69544 | 71591 | 213112 | 353287 | 353287 | 156437 |

| District wise Institutional Deliveries Status | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | DHH | | | SDH | | | Block CHC/PHC/AH | | | PHC(New) | | | | | Total | | |
| Sl.No | Name of the District | 2005-06 | 2006-07 | % increase | 2005-06 | 2006-07 | % increase | 2005-06 | 2006-07 | % increase | 2005-06 | | 2006-07 | | % increase | 2005-06 | 2006-07 | % increase |
| | | | | | | | | | | | Delivered | No. | Delivered | No. | | | | |
| 1 | Angul | 2841 | 3539 | 25 | 1244 | 1324 | 6 | 678 | 1433 | 111 | 332 | 6 | 681 | 8 | 105 | 5095 | 6977 | 37 |
| 2 | Balasore | 3338 | 4163 | 25 | 463 | 672 | 45 | 5379 | 8222 | 53 | 1038 | 3 | 1571 | 5 | 51 | 10218 | 14628 | 43 |
| 3 | Bargarh | 2008 | 2550 | 27 | 252 | 421 | 67 | 2926 | 4445 | 52 | 388 | 9 | 773 | 18 | 99 | 5574 | 8189 | 47 |
| 4 | Bhadrak | 2623 | 3032 | 16 | | | | 4100 | 5727 | 40 | 180 | 6 | 494 | 8 | 174 | 6903 | 9253 | 34 |
| 5 | Bolangir | 2958 | 3863 | 31 | 5331 | 6638 | 25 | 2358 | 3304 | 40 | 35 | 4 | 157 | 9 | 349 | 10682 | 13962 | 31 |
| 6 | Boudh | 764 | 1051 | 38 | | | | 619 | 1297 | 110 | 129 | 3 | 291 | 3 | 126 | 1512 | 2639 | 75 |
| 7 | Cuttack | 949 | 1082 | 14 | 2771 | 3545 | 28 | 6826 | 9362 | 37 | 340 | 9 | 510 | 8 | 50 | 10886 | 14499 | 33 |
| 8 | Deogarh | 940 | 995 | 6 | | | | 579 | 761 | 31 | 22 | 3 | 103 | 3 | 368 | 1541 | 1859 | 21 |
| 9 | Dhenkanal | 3038 | 3494 | 15 | 454 | 553 | 22 | 2281 | 3269 | 43 | 358 | 7 | 584 | 11 | 63 | 6131 | 7900 | 29 |
| 10 | Gajapati | 408 | 654 | 60 | | | | 363 | 721 | 99 | 99 | 11 | 202 | 11 | 104 | 870 | 1577 | 81 |
| 11 | Ganjam | 1443 | 2218 | 54 | 3012 | 3266 | 8 | 12042 | 19042 | 58 | 160 | 3 | 0 | 0 | | 16657 | 24526 | 47 |
| 12 | Jagatasingpur | 3276 | 3614 | 10 | | | | 6043 | 6542 | 8 | 17 | 1 | 112 | 2 | 559 | 9336 | 10268 | 10 |
| 13 | Jajpur | 2448 | 3346 | 37 | | | | 7021 | 9061 | 29 | 1011 | 11 | 1581 | 14 | 56 | 10480 | 13988 | 33 |
| 14 | Jharsuguda | 1464 | 1680 | 15 | | | | 188 | 511 | 172 | 201 | 9 | 235 | 9 | 17 | 1853 | 2426 | 31 |
| 15 | Kalahandi | 2170 | 2197 | 1 | 1405 | 2058 | 46 | 3475 | 7260 | 109 | | | | | | 7050 | 11515 | 63 |
| 16 | Kendrapada | 3617 | 4380 | 21 | | | | 3719 | 4347 | 17 | 216 | 6 | 327 | 6 | 51 | 7552 | 9054 | 20 |
| 17 | Keonjhar | 1852 | 1875 | 1 | 3297 | 4051 | 23 | 4430 | 6509 | 47 | 401 | 17 | 679 | 21 | 69 | 9980 | 13114 | 31 |
| 18 | Khurda | 2086 | 2456 | 18 | | | | 5854 | 7176 | 23 | 122 | 2 | 149 | 5 | 22 | 8062 | 9781 | 21 |
| 19 | Koraput | 1367 | 1092 | -20 | 1224 | 1348 | 10 | 1194 | 2104 | 76 | 0 | | 11 | 2 | | 3785 | 4555 | 20 |
| 20 | Malkangiri | 655 | 845 | 29 | | | | 341 | 1156 | 239 | 10 | 4 | 81 | 8 | 710 | 1006 | 2082 | 107 |
| 21 | Mayurbhanj | 4739 | 4906 | 4 | 4985 | 6380 | 28 | 4471 | 6889 | 54 | 560 | 9 | 854 | 11 | 53 | 14755 | 19029 | 29 |
| 22 | Nawarangpur | 861 | 1164 | 35 | | | | 1291 | 2079 | 61 | 170 | 1 | 156 | 1 | -8 | 2322 | 3399 | 46 |
| 23 | Nayagarh | 2173 | 2544 | 17 | | | | 4398 | 5219 | 19 | 82 | 8 | 116 | 10 | 41 | 6653 | 7879 | 18 |
| 24 | Nuapada | 1172 | 1336 | 14 | | | | 1881 | 2632 | 40 | | | | | | 3053 | 3968 | 30 |
| 25 | Phulubani | 1088 | 1321 | 21 | 538 | 743 | 38 | 1272 | 2140 | 68 | 66 | 12 | 195 | 16 | 195 | 2964 | 4399 | 48 |
| 26 | Puri | 3525 | 3833 | 9 | | | | 5715 | 8146 | 43 | 4 | 2 | 86 | 4 | 2050 | 9244 | 12065 | 31 |
| 27 | Rayagada | 781 | 815 | 4 | 347 | 316 | -9 | 513 | 1513 | 195 | | | | | | 1641 | 2644 | 61 |
| 28 | Sambalpur | 2060 | 2276 | 10 | 960 | 1671 | 74 | 1872 | 2626 | 40 | 266 | 11 | 571 | 12 | 115 | 5158 | 7144 | 39 |
| 29 | Sonepur | 1652 | 1971 | 19 | | | | 1837 | 2470 | 34 | | | | | | 3489 | 4441 | 27 |
| 30 | Sundargarh | 1987 | 2209 | 11 | 2955 | 3438 | 16 | 6215 | 8122 | 31 | | | | | | 11157 | 13769 | 23 |
| **Total** | | **60283** | **70501** | **17** | **29238** | **36424** | **25** | **99881** | **144085** | **44** | **6207** | **157** | **10519** | **205** | **69** | **195609** | **261529** | **34** |

**Health Institution wise Deliveries Status**

| Sl.No | Name of the District | 2005-06 | 2006-07 | % increase | 2005-06 | 2006-07 | % increase | 2005-06 | 2006-07 | % increase | 2005-06 | | 2006-07 | | % increase | 2005-06 | 2006-07 | % increase |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | Delivered | No. | | | | | 5358 | **-1** |
| 2 | RGH, Rourkela | 2006 | 2851 | 42 | | | | | | | | | | | | 2006 | 2851 | **42** |
| 3 | SCB, MCH | 5744 | 6866 | 20 | | | | | | | | | | | | 5744 | 6866 | **20** |
| 4 | VSS, MCH | 2341 | 2613 | 12 | | | | | | | | | | | | 2341 | 2613 | **12** |
| 5 | MKCG, MCH | 4479 | 6566 | 47 | | | | | | | | | | | | 4479 | 6566 | **47** |
| | **Total** | **80238** | **94755** | **18** | **29238** | **36424** | **25** | **99881** | **144085** | **44** | **6207** | **157** | **10519** | **205** | **69** | **215564** | **285783** | **33** |


Districtwise Institutional Deliveries Status
30000
25000
20000
15000
10000
5000
0
Angul
Balasore
Bargarh
Bhadrak
Bolangir
Boudh
Cuttack
Deogarh
Dhenkanal
Gajapati
Ganjam
Jagatasingpur
Jajpur
Jharsuguda
Kalahandi
Kendrapada
Keonjhar
Khurda
Koraput
Malkangiri
Mayurbhanj
Nawarangpur
Nayagarh
Nuapada
Phulubani
Puri
Rayagada
Sambalpur
Sonepur
Sundargarh
2005-06
2006-07