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Case Report

Factors Responsible For Low Access and Utilizationof Janani Sureksh Yaojan (Scheme for Institutional Delivery) Among Rural Women : A Case of South Karnataka - India

D.C. Nanjunda
Faculty, Centre for Social Exclusion and Inclusive Policy,University of Mysore, Mysore - 06, India.

*Corresponding Author : D.C. Nanjunda, Centre for Social Exclusion and Inclusive Policy,University of Mysore, Mysore - 06, India.
Mobile : +91 98809 64840, E-mail : anthroedit@ymaill.com

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Abstract

This paper examines the access and low utilization ofJanani Sureksh Yaojan(JSY) in the selected rural parts of south Karnataka at the overall level and also separately for the SCs women and identifies crucial factors that hinder and facilitate access to the scheme and the factors that are play crucial role in theunderutilization of the health servicesand caste issues SC women beneficiaries. This paper predominantlyemphasis on the caste discrimination in terms of accessing the public health services and in the end, enlists all the likely measures to combat this discrimination. This study has been conducted in oneof the backward district of the sate Chamaraj nagar –south India. Thisarticle concludes that there are an assortment of factors causing low access and utilization of JSY service including the caste and other factors. It is further ascertain in that JSY is not just about promoting institutional deliveries rather programme objectives for diminution of maternal mortality and morbidity can be achieved when particularly rural women arefacilitating to receivethe quality delivery and post-partum care services.

Introduction

As we are aware maternal health is a majorbarometer of functional health system in any society. Maternal health must drop dressed as a part of range of care that links indispensable maternal, newborn and child health services. There are however, vital issues like lack of sufficient government health infrastructure, comprehensive obstetric services, sufficient numbers of doctors etc for mothers and newborn care (Guptha, 2003).The United Nations Millennium Summit adopted the Millennium Development Goalsas a reply to the world's most important development challenges. The main goal of MDG is to reduce the Maternal Mortality Ratio (MMR) by three quarters between 1990 and 2015. The MMR, defined as number of maternal deaths per100,000 live births, has declined from 398 in 1997-98 to 301 in 2001 - 03 in India, as per the estimates provided by Sample Registration System. However, analyzing the statistical data for the year 2000, WHO, UNICEF and UNFPA produced a report in 2003 showed that the world average for MMR was 400 /100,000 live births while the average for developed regions was 20 /100,000 live births and for developing regions 440 /100,000 live births (WHO, 2002; UNICEF, 2003; UNFPA, 2003) produced a report. However some report says MMR in India is 200 deaths/100,000 live births (UNFPA,2010).

Further, support and fortification of maternal & child health has been one of the major important health developmental objective in many countries across the globe still mothers continue to die. “Maternal Mortality Ratio (MMR) was 400 for the globe, developed nations (only 9)1 while India reported 212/100,000 live births. IMR stood at a high of 47/1000 birth (SRS- 2011) with majority of maternal and child deaths occurring in five northern states of Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh” (Sachdeva and Malik,2012).

Janani Suraksha Yojna (for Institutional Delivery and safe motherhood) is a government of India's' vital scheme for speedy decreasing maternal and infant mortality rates with a specific focus on escalating institutional and safe deliveries for the families belongs to the below poverty line (BPL) category in the country. JSY is a part of National Rural Health Mission (NRHM) covering all pregnant women who belongs to the true BPL group, are over 19 years of age or those who have had two live births. Janani Suraksha Yojana (JSY) is safe motherhood interference programme which was perversely known as national maternity benefit scheme. The basic objective of JSY scheme is reducingmaternal and neo-natal mortality by increasing institutional delivery among the poorpregnant women including post-partum care particularly focusing BPL family. It is learnt that JSY is a 100 % centrally funded scheme.

Further, the key purpose of JSY will be achieved through the payment of a cash incentive to the woman if she delivers in a government hospital or in an accredited private medical centers 'or even at home. According to the existing eligibility criteria, any woman from thelow performing States (LPS), irrespective of poverty status(BPL/APL), is eligible for certain amount of cash incentives. Further, in case of high performing and developed states(HPS), normally a woman has to be over 19 years of age and should be below the poverty line (Dongre and Kapur, 2013)

A study in one district in Karnataka indicate that after JSY more than 85 per cent of the deliveries had taken place in public hospitals and 15 per cent of the birth took place at home. Itshows gradual declining of traditional birth systems in rural parts. The reasons for choosing hospital based deliveries; people felt improved access to modern health care institutions delivery at door steps and an enhanced care for young mother and babies. Also people felt proving free medicines also a key issue here (Mutharayappa, 2010).

It is found that JSY is playing a vital role in changing demographics of reproductive health care in India. It has become more useful for the rural poor women. After JSY, institutional deliveries have dramatically increased in various parts of the country as shown in some studies (Hota. 2010; Guptha 2003). More interesting issue is that the quantity of public versus private health care deliveries has changed which is a good sign in case of public health delivery system. Before implementing JSY, about 65% of births were in the private sector and 35% in the public sector health institution. The share of the privates sector was more! However, few studies (Mohanty,2013)have opined that since the implementation of JSY, the proportions have now reversed whereas 65% of births in the public sector and 35% in the private sector are now taking place. This is a huge success mark in the entire scheme and an achievement in case of JSY. Yet, the key aim of JSY is fairness in addition to quality medical coverage and the conditional cash payments do not cover the private sector (Mohanty,2013).

The other vital part of JSY is engaging Accredited Social Health Activist (ASHA), a village level health worker as an effectual connection between the Government and pregnant women. One ASHA will normally cover a village with just about 1000 population. The key role of ASHA worker is to make easy pregnant women to get services of maternal care and dispose referral transport. ASHA also help out the pregnant women inpre-registration, PHC identification of complicated pregnancies (if any), providing at least three antenatal care services. Also she will facilitate post natal care organizing suitable referral facility and arrange for transport for pregnant mother in case needed (Sharma and others,2012). It is suggested that JSY scheme should have many more benefits including vaccinations for new diseases and providing free health insurances to both child and the baby. This paper examine the reason of underutilization of the scheme and the caste factors affecting in accessing health devilry services in a rural districts of the state.

Objective

1. This paper examines the low access and utilization of JSY scheme in Chamaraja nagar districts of Karnataka state andalso to find out the factors which hinders the SC women in accessing the scheme effectively.

Methodology

Thesampling for this study was 123 women beneficiaries selected randomly from the various hospitals (SC/PHC/CHC and private hospitals) in Chamaraj nagar Districts-South Karnataka.For the selection of the samples, Three private health centers, Three primary health centers one sub-centre were selected using multistage random sampling method. A standardized data-collection tool was designed, pretested, and finalized. The data were collected to include information on age, parity, area of residence, type of antenatal care, socioeconomic status (SES), educational status, caste, difficulties in accessing the scheme, and different causes of maternal mortality and morbidity. Etc. The study used a cross-sectional research method which allowed the researchers to integrated interview, and the actual survey for the data collection.

Result and Discussion

Table 1 : Socio-economic Status of the Respondents

Variables	N=123	Percentage	X^2	P
Age			23.512	0.000
Just above 20	23	18.6		
22-25	55	44.7		
25-30	45	36.5		
Educational level		12.781	0.000	
Primary education	32	26.0		
High school	40	32.5		
College	15	12.0		
Illiterates	36	29.2		
Family Income (in Rs.)		125.67	0.000	
7,000-10,000	59	48.0		
10,000-20,000	41	33.3		
Above 20,000	23	18.6		
Social group			22.670	0.000
SC	40	30.7		
ST	11	9.0		
OBC	72	60.2		
Domicile			26.890	0.000
Local	87	70.7		
Inter district	30	24.3		
Interstate	6	4.8		
Number of deliveries				
First	78	63.4		
Second	45	36.5		

Table : 2 What are the Causes of Maternal Mortality and Morbidity, etc

Level	Frequency	%	X^2	P
Unsafe Home delivery	23	18.6	12.531	0.00
Hospital delivery	19	15.4		
Different Health care seeking behaviour	21	17.9		
Lack of health infrastructure in rural parts	33	26.8		
Negligence /carelessness of mothers	14	11.3		
Superstitious beliefs	13	10.5		
Total	123	100.0		

Table 3 : Difficulties Faced by Women during Registration for JSY

Level	Frequency	%	X^2	P
Requested service providers for help several times	11	9.0	11.678	0.00
Demanding for money	21	17.9		
Avoidingservice because of the caste/ religion of the women	36	29.2		
Negligence /carelessness	34	27.6		
Making Unnecessary delay and other reasons	21	17.0		
Total	123	100.0		

Table 4 : Reasons for Not Taking Pre natal care

Level	Frequency	%	X^2	P
Lack of information from the service agency	21	17.9	21.45	00
Lack of family support	11	9.0		
Superstitious beliefs	5	4.5		
Felt that it was not necessary	9	7.3		
Old type of health behavior	25	20.3		
Distance factor	5	4.5		
Poor quality service at the health centers	21	17.0		
Non availability of ultrasound, blood and urine test in the health centre	20	16.2		
Total	123	100.0		

Table 5 : Reasons for not Receiving Post natal care

Level	Frequency	%	X^2	P
Lack of information from the service provider	33	27.5	31.50	0.00
Traditional health behavior	13	10.5		
Distance factor/poor transport service	14	10.8		
No transport facility available	31	25.2		
Absences lady staff at SC/PHC	11	9.0		
No time to go to the health centers	21	17.0		
Total	123	100.0		

Table 6 : Reasons for Opting baby Delivery at Home

Level	Frequency	%	X^2	P
Family customary	23	18.0	22.413	0.00
Unavailability of institutional service at the locality	6	4.8		
Unaware of available services	31	25.2		
Feeling comfortable	27	22.0		
Safer than hospitals	11	9.0		
Distance factors	7	4.9		
Poor quality service at the health centers	9	7.3		
Absences of lady physicians				
atSC/PHCs	9	7.3		
Total	123	100.0		

Table 7 : Difficulties faced in Registration for JSY Services on the Basis of Caste Status

Level	Frequency	%	X^2	P
ASHA does not visit my home because of remote area	34	27.6	22.780	0.00
ASHA belongs to an upper caste	39	31.7		
Lack of awareness because ASHA does not visit Dalit locality	21	17.0		
Meeting was held in upper caste locality so hesitation in going there.	29	23.5		
Total	123	100.0		

Table 8 : Difficulties faced in Accessing Ante-natal Care Services Due to the Caste Status

Level	Frequency	%	X^2	P
Anganwadi worker avoids calling SC women for monthly meeting /village health and nutrition day (VHND)	31	25.2	21.635	0.00
ASHA from the higher caste visits houses less frequently as compared to others	26	21.1		
Lack of information and less awareness about ante-natal facilities and its benefits.	31	25.2		
Health workers avoid physical touch of the child	16	13.0		
Humiliation due to the caste factor	19	15.4		
Total	123	100.0		

Table 9 : Difficulties Cited by the SC Women in Accessing post natal Care Services Due to Caste Status

Level	Frequency	%	X^2	P
Indifferent treatment because of caste issue when compare to others	43	40.0	27.931	0.00
Avoid touching newborn babie for weighing and other test	25	20.3		
Avoid touching children while immunization	10	8.0		
Ask someone from the SC community to give polio drops to children to avoid touching SC children.	32			
Abusing , causing delay etc	13	26.0		
Total	123	100.0		

Discussion

Maternal health is a vital parameter of any healthy society. Truly speaking the JSY is not just about promoting and increasing institutional deliveries only. Apart from this the major objective of this scheme is to reduce the maternal mortality and morbidity and this can be achieved when women coming to obtain quality delivery and post-partum care service especially in rural parts without nay hassles. It is found that even today some rural people preferring deliver babis at home because of customary, unavailability of institutional service at the locality, unaware of available services, distance factors, poor quality service at the health centers, and absence of physicians at SC / PHC etc. Next, it is found that people are not showing interest to get pre and post natal service because of lack of information from the service agencies because, lack of family support, superstitious beliefs old traditional health behavior , distance factors, poor quality service at the health centers, non-availability of ultrasound, blood and urine test in the Govt. health centres etc. Further, this study has shown than despite the best effort by the Govt. there are various crucial factors for the low utilization of the scheme. During the registration stage itself, they are facing problems including persistent pleading the health workers for the help several times, negligence /carelessness because of poor status, abusing, demanding for money, avoiding service because of the caste factors, making unnecessary and intentional delay etc. Hence some people are not showing interest in opting JSY benefits.

Moreover, there are some widespread problems facing by the beneficiaries belonging to the Dalith community. It is reported that Dalith/ST women are severely being discriminated and humiliated in the name of caste in rural

parts. It is one of the main reasons for the low access to this service by the margins. Also SC woman are being severally discriminate by the ASHA workers (facilitators) at various levels including pre-registration, anti and postal natal care service, cash assistance etc. ASHA workers normally don't visits SC women beneficiaries' houses/localities because of caste factors and SC women are not getting advice whenever required and she will not be invited for any health related meetings. Also Anganwadi worker avoids inviting SC women for monthly meeting of Village Health and Nutrition Committee (VHND). Because of all this issues SC women are lacking vital information and less awareness about ante-natal facilities and its benefits. Some time health workers avoids physical touching of the child of a SC woman.

Conclusion

There is substantial increase in institutional delivery in rural parts but there are wide variations because of various problems. The above discussion clearly pointed out that JSY have some impact on increasing institutional delivery and especially in PHC, CHC/Rural hospital in Chamaraj nagar districts. Similarly, education and standard of living, occupational status, income level, played an important role on increase in institutional delivery and in getting benefits of JSY scheme. It also shows significant percentage of women still preferring home delivery and whereas caste discrimination is rampant in providing required service. There is an urgent need to bring some policy options including upgrading sub-centers, establishments more PHC in the SC pre-dominated areas, recruitment of ASHA workers belong to SC community, framing administrative rules compelling ASHA works to visit SC dominated localities etc.

References

1. Gupta R K. Institutional and non-institutional deliveries in some slum areas of Delhi. Indian journal of community medicine. 2003; 24: 147-152
2. Gupta R K. Institutional and non-institutional deliveries in some slum areas of Delhi. Indian journal of community medicine. 2003; 24: 147-152
3. Kruk M E, Rocker P C, Mbaruka. Community and health system in rural Tanzania A multi level analysis. Health policy. 2010 Jun; 26(3): 173-89
4. Kesterton A, Cleland J. Institutional delivery in rural India The relative importance of accessibility and economic status. BMC pregnancy and child health. 2006; 41(6): 51-6
5. Mohapatra B,Datta U, Sanjay Gupta, Tiwari V K, Vivek Adhiah. An assessment of the functioning and impact of JSY in Orissa. Publication journal archives.2008; 31(2): 235-9
6. Manish K Singh, Singh J V, Ahmd N, Reema Kumari, Khanna A. Utilizations of ASHA services in relation to maternal health. Indian journal of community medicine.2009 May 26; 45:262-8
7. Prasanna Hota. Concurrent assessment of JSY in Bihar. United National Population Fund. 2008; 21(4):132-46
8. Punia Anita, Jewin R B, Rana Vidya. Pattern of deliveries in rural areas of district Harayana. The interval Journal of Epidemiology. 2004;9:154-9
9. Shobha Malini, Tripathi, Poonam Khattar, Nair K S. A rapid appraisal of functioning of JSY. Publication journal archives.2008;31(2):282-86