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A qualitative study of factors impacting accessing of institutional delivery care in the context of India's cash incentive program

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ABSTRACT

Not all eligible women use the available services under India's Janani Suraksha Yojana (JSY), which provides cash incentives to encourage pregnant women to use institutional care for childbirth; limited evidence exists on demand-side factors associated with low program uptake. This study explores the views of women and ASHAs (community health workers) on the use of the JSY and institutional delivery care facilities. In-depth qualitative interviews, carried out in September-November 2013, were completed in the local language by trained interviewers with 112 participants consisting of JSY users/non-users and ASHAs in Jharkhand, Madhya Pradesh and Uttar Pradesh. The interaction of impeding and enabling factors on the use of institutional care for delivery was explored. We found that ASHAs' support services (e.g., arrangement of transport, escort to and support at healthcare facilities) and awareness generation of the benefits of institutional healthcare emerged as major enabling factors. The JSY cash incentive played a lesser role as an enabling factor because of higher opportunity costs in the use of healthcare facilities versus home for childbirth. Trust in the skills of traditional birth-attendants and the notion of childbirth as a 'natural event' that requires no healthcare were the most prevalent impeding factors. The belief that a healthcare facility would be needed only in cases of birth complications was also highly prevalent. This often resulted in waiting until the last moments of childbirth to seek institutional healthcare, leading to delay/non-availability of transportation services and inability to reach a delivery facility in time. ASHAs opined that interpersonal communication for awareness generation has a greater influence on use of institutional healthcare, and complementary cash incentives further encourage use. Improving health workers' support services focused on marginalized populations along with better public healthcare facilities are likely to promote the uptake of institutional delivery care in resource-poor settings.

1. Introduction

Although the Millennium Development Goals (MDGs) expired in 2015, India is still far from achieving MDGs 4 (reduce child mortality by two-thirds) and 5 (reduce maternal mortality by three-quarters) (Paul, et al., 2011). As of 2013, there were 52.7 under-five deaths per 1000 live births (Government of India, 2013a) and 167 maternal deaths per 100,000 births (Government of India, 2013b). These deaths were concentrated among lower socioeconomic groups, who report lower levels of accessing of institutional maternal and child healthcare (Pathak et al., 2010; Save The Children, 2010). In 2005 the Government of India launched Janani Suraksha Yojana (JSY), an integral component of National Rural Health Mission (since 2013 the program has been called the National Health Mission [NHM]), to promote the use of maternal and child healthcare facilities. The JSY, launched by modifying the

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existing National Maternity Benefit Scheme, uses cash incentives to expectant mothers and Accredited Social Health Activists (female community health workers, known as ASHAs) to reduce maternal and neo-natal mortality by promoting institutional delivery. The larger institutional framework of NHM complements the JSY cash incentive by providing comprehensive healthcare, including ante-natal and post-natal services, transport to facilities, and support services from ASHAs. It includes several support services administered by community health workers to encourage pregnant women to use healthcare facilities for childbirth, along with at least three ante-natal check-ups (Government of India, 2014c).

Program implementation was split into 18 high-focus (deprived) and 10 low-focus (developed) states, determined by economic and maternal and child health (MCH) indicators (Government of India, 2014c). In high-focus states, all pregnant women are eligible for the JSY cash incentive of Indian rupee (INR) 1400 (US$1 ≈ INR 68) per birth, and benefits are paid irrespective of birth order, age and socioeconomic position. In low-focus states, the cash incentive is INR 700, and is limited to women below the poverty line, as well as scheduled caste/tribe women (Government of India, 2014a). Those who registered under the JSY but delivered at home are entitled to cash assistance of INR 500 per delivery. In addition, across all states, the JSY provides a transport allowance (INR 300) to eligible expectant mothers who reach healthcare facilities for delivery without the help of ASHA for transport. For expectant mothers reaching facilities with an ASHA's assistance, this amount is provided to the ASHA for arranging the transport (Government of India, 2014c, 2015a). The cash incentive is deposited in the bank account of expectant mother. To complement the JSY, the Government of India launched Janani Shishu Suraksha Karyakram (JSSK) on 1st June 2011 with a provision of free transport, diagnostics and drugs to mother and newborn (Government of India, 2015a).

The NHM and its JSY program are implemented in partnership with the state government health departments, with organizational support through officers and health committees at the district, block, and community levels. Every village in the country employs an ASHA to provide support services to women and children. ASHAs are selected from the same village of residence as the expectant mothers. ASHAs are trained to work as an interface between the community and the public health system. They are the first port of call for any health-related demands of deprived sections of the population, especially women and children, who find it difficult to access health services (Government of India, 2014b). ASHAs are entrusted to i) identify pregnant women, ii) facilitate the provision of at least three ante-natal checkups and facility-based childbirth, iii) arrange to immunize the newborn until the age of 14 weeks, iv) make a post-natal visit within 7 days of delivery to track mother's health, v) provide counsel for initiation of breast-feeding to the newborn within one hour of delivery, and continuing for 6 months, and vi) promote family planning (Government of India, 2006). ASHAs are financially incentivized to encourage institutional births (INR 600 per institutional delivery) (Government of India, 2010a, 2010b, 2014c; Lim et al., 2010; Paul, 2010). From 2009 to 2010 onwards, several state governments revised the JSY guidelines to also promote the provision of ante-natal care. For instance, in 2009, the Chhattisgarh government made ensuring the provision of ante-natal care one of the eligibility conditions for payment of incentives to ASHAs (Government of Chhattisgarh, 2009).

Since its implementation, uptake of the JSY cash incentive has not been very high, particularly in the eight high-focus 'empowered action group' states, where of women who gave birth, only 18 percent received the JSY financial benefit in 2007–08 (International Institute for Population Sciences [IIPS] and Macro International, 2010) and 49 percent received the benefit in 2011–12 (Vellakkal et al., 2016). In these states, there was an increase in use of healthcare facilities for childbirth in the post-JSY periods–65 percent of all women who gave birth had used institutional delivery care facilities in the post-JSY period of 2011–12 as compared to 25 percent of all women who gave birth in the pre-JSY period of 2000–04. Yet many pregnant women were not using the available services (Vellakkal et al., 2016). This observation raises an important question: why do many eligible women not use institutional delivery care facilities to receive the JSY cash incentive?

Extant research has pointed to some possible explanations. Low levels of information communication and education activities with emphasis on MCH is associated with lower utilization of the JSY, especially in rural areas (Sharma et al., 2011). In a rural area of Varanasi of Uttar Pradesh, lower level of awareness about the JSY was reported among women of reproductive age group, with a significant negative effect of factors like literacy status of pregnant women and their spouses (Kaushik et al., 2010). In the Ujjain district of Madhya Pradesh, the non-availability of transportation, and maternal perceptions that previous non-institutional deliveries were 'easy' were also associated with the non-use of the JSY (Sidney et al., 2012). In the state of Jharkhand, although some women were willing to opt for institutional delivery, several obstacles prevented uptake of the JSY cash incentive and institutional delivery care, such as poor infrastructure, poor quality of care, difficulties in accessing cash incentive, and corruption in disbursement of incentives (Rai et al., 2011). Varied perception of eligibility guidelines in different states, awareness of the program, the amount disbursed, documentation, delays in disbursement to beneficiaries and low or irregular financial incentives to ASHAs were reported as the operation barriers of the JSY (Zodpey and VK, 2014). A study in the state of Madhya Pradesh reported environmental factors that impeded skilled birth attendance, including a chaotic delivery environment, lack of staff preparedness, and unfriendly behavior of staff towards patients (Chaturvedi et al., 2015). Regional imbalances in the quality of the health infrastructure also endure, with high-focus states lagging behind in implementation as compared to low-focus states (Bhattacharyya et al., 2012; United Nations Population Fund- India, 2009).

On the other hand, a recent large-scale household survey revealed that 59 percent of the women from high-focus states were aware of the JSY (UNICEF, 2009). Awareness of the JSY was higher among women from below the poverty line families (64 percent) than above the poverty line families (58 percent), and scheduled caste and scheduled tribe women had higher awareness of the program than women of general caste (UNICEF, 2009). An evaluation study in the states of Uttar Pradesh, Madhya Pradesh, Jharkhand, Orissa, Assam, Jammu & Kashmir, and Tamilnadu showed that since the inception of National Rural Health Mission there was marked improvement of basic health infrastructure with adequate supply of human resource, material, drugs, equipment, and transport system (Planning Commission, 2011).

Against this backdrop, this paper explores the factors impacting the accessing of institutional delivery care facilities in the context of the JSY cash incentive and the NHM. We use qualitative in-depth interviews in the three JSY high-focus Indian states: Jharkhand, Madhya Pradesh and Uttar Pradesh.

2. Materials and methods

2.1. Study design

This is a cross-sectional qualitative study. Individual face-to-face in-depth interviews (IDI) were conducted.