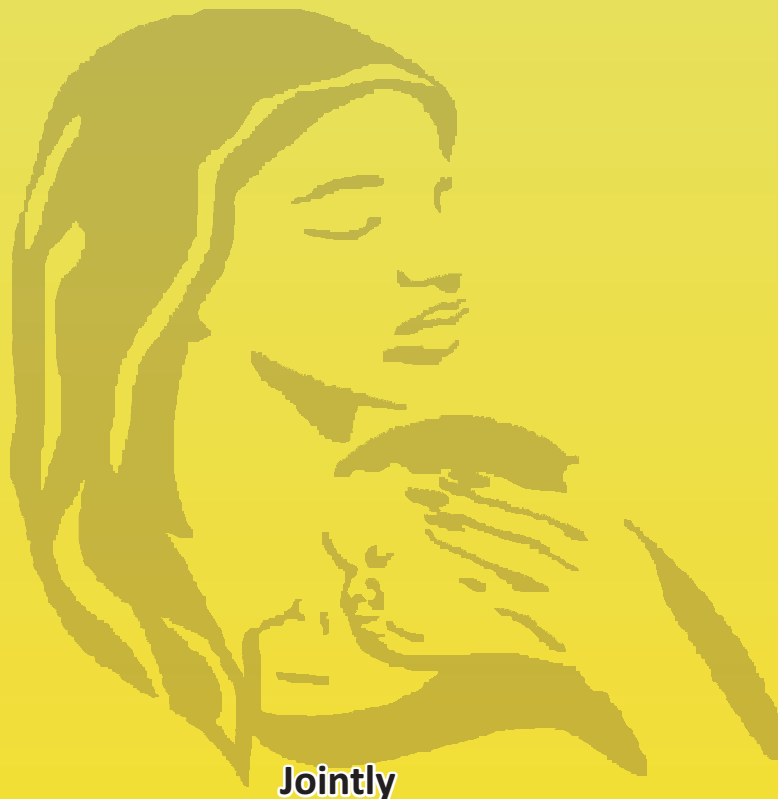


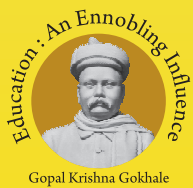


सार्वजनिक आरोग्य विभाग
महाराष्ट्र शासन

EVALUATION OF JANANI SHISHU SURAKSHA KARYAKRAM MAHARASTRA, 2014



Jointly



POPULATION RESEARCH CENTRE

**Gokhale Institute
of Politics and
Economics**

(Deemed to be University)
Pune - 411 004



**State Health System
Resource Centre,
Pune**



राष्ट्रीय आरोग्य अभियान
महाराष्ट्र

AUGUST, 2015

**EVALUATION OF JANANI SHISHU SURAKSHA KARYAKRAM
IN MAHARASTRA, 2014**

GOKHALE INSTITUTE OF POLITICS AND ECONOMICS
(Deemed to be University)
Pune

In Collaboration with

STATE HEALTH SYSTEM RESOURCE CENTRE
PUNE

AUGUST, 2015

CONTRIBUTORS

This report was authored by the following individuals:

POPULATION RESEARCH CENTRE

**VINI SIVANANDAN
R. NAGRAJAN
SANJEEVANI MULAY
ARUN PISAL
AKRAM KHAN
A PRASHIK
R POL
VANDANA SHIVNEKAR**

AND

STATE HEALTH SYSTEM RESOURCE CENTRE, PUNE

**DR. UDDHAO GAWANDE
MRS. MUKTA GADGIL
DR. NETRALI DALVI**

CONTENTS

	Contributors.....	ii
	Acronyms.....	vii
	Acknowledgement.....	viii
	Executive Summary.....	1
Chapter I	Introduction.....	4
Chapter II	Sample design and Sampling.....	7
Chapter III	Background Characteristics and Living Conditions.....	11
	3.1 Background Characteristics of Women.....	11
	3.2 Housing Characteristics.....	14
	3.3 Housing Characteristics by Districts.....	18
	3.4 Marital Status of the Household Population.....	20
Chapter IV	Awareness about JSSK Entitlements.....	26
	4.1 Source of information and awareness about JSSK services.....	26
Chapter V	Antenatal Care, Delivery and JSSK Entitlements during Antenatal Care and Delivery	37
	5.1 Antenatal Check-ups.....	37
	5.2 Pregnancy Complications and Treatment.....	40
	5.3 Delivery Care.....	42
Chapter VI	Neonatal Health and Entitlements under JSSK.....	68
Chapter VII	Home deliveries.....	86
Chapter VIII	Health Facilities.....	93
	8.1 Implementation of JSSK services and limitations.....	93
	8.2 Suggestions from Health Providers.....	94
	8.3 Observations on health facilities visited.....	95
	8.4 Availability of drugs and consumables.....	96
	8.5 Gaps and Challenges.....	100
Chapter IX	Summary and Conclusion.....	102

LIST OF TABLES

Table 3.1	Percentage of respondents by background characteristics according to residence, 2014	13
Table 3.2	Percentage of respondents by housing characteristics according to residence, 2014	15
Table 3.2.1	Percentage of respondents by household possessions, agricultural land and Standard of Living Index (SLI), according to residence, 2014	18
Table 3.3	Percentage of respondents by housing characteristics and living conditions according to residence, 2014	19
Table 3.4	Percentage of respondents by marriage and reproduction according to residence, 2014	21
Table 3.5	Percentage distribution of respondents by number of children ever born (CEB), and mean number of children ever born and living, according to background characteristics, Maharashtra, 2013-14	23
Table 4.1	Age of respondents by awareness and experience regarding JSSK according to residence	28
Table 4.2	Heard about JSSK by background characteristics, 2014	30
Table 4.3	Percentage heard about JSSK by background characteristics according to residence, 2014	32
Table 4.4	Percentage of respondents by awareness and experience regarding JSSK according to districts, 2014	34
Table 4.5	Percentage heard about JSSK by background characteristics according to districts, 2014	35
Table 5.1	Percentage of respondents by place of residence and antenatal care during pregnancy, 2014	39
Table 5.2	Percentage of respondents by antenatal care and complications during pregnancy according to residence, 2014	41
Table 5.3	Percentage of respondents by place of delivery according to residence, 2014	46
Table 5.4	Percentage with knowledge and awareness of free transport facility from home to facility and responses of those who tried to avail free transport facility (Home to facility)	50
Table 5.5	Percentage with knowledge and awareness of free diagnostics and responses of those who tried to avail free diagnostics	54
Table 5.6	Percentage of respondents received/not received free drugs and consumables by awareness, experiences while availing free services according to residence	56
Table 5.7	Percentage of respondents received/not received free blood by awareness, experiences while availing free services according to residence, 2014	58
Table 5.8	Percentage of respondents received/not received free diet by awareness, experiences during their stay in health institution according to residence, 2014	60
Table 5.9	Number of respondents received/not received free diet by awareness, experiences during their stay in health institution according to residence, 2014	62
Table 5.10	Percentage of respondents received free drop back from institution to home according to residence, 2014	64
Table 5.11	Percentage of respondents exempted from all user charges according to residence, 2014	66
Table 6.1	Percentage with newborn care according to residence, 2014	70
Table 6.2	Percentage of respondents with neonates suffering from ailments, treatment received according to residence, 2014	72

Table 6.3	Number of respondents with knowledge and awareness of free transport facility and responses of those who tried to avail free transport facility according to place of residence, 2014	75
Table 6.4	Number of respondents with knowledge and awareness of free essential diagnostics to neonates according to place of residence, 2014	77
Table 6.5	Number of respondents with knowledge, awareness, and reimbursement of free drugs and consumables to neonates according to place of residence, 2014	78
Table 6.6	Number of respondents with awareness, and received/not received free blood for neonates according to place of residence, 2014	79
Table 6.7	Number of respondents received/not received free diet by awareness, experiences during their stay in health institution according to residence, 2014	80
Table 6.8:	Number of respondents received/not received free referral transport during their stay in health institution according to residence, 2014	81
Table 6.9	Number of neonates received free drop back from institution to home according to residence, 2014	83
Table 6.11	Number of respondents with awareness and experiences regarding exemption from all kind of user charges according to place of residence, 2014	84
Table 7.1	Percentage of respondents with home deliveries, post natal and neonatal care according to residence, 2014	88
Table 7.2	Number of respondents with home deliveries, post-natal and neonatal care according to residence, 2014	90
Table 8.41	List of essential drugs unavailable and in short supply in DHs	97
Table 8.42:	List of essential drugs unavailable and in short supply in RH	97
Table 8.43:	List of essential drugs unavailable and short supply in SDH	98
Table 8.4:	List of essential drugs unavailable and in short supply in PHCs	98
Table 8.45:	List of essential drugs available at less than half of the total number of Sub-centres	99

LIST OF FIGURES

Figure 3.1	Educational differentials in respondents by completed years of schooling and by place of residence	12
Figure 3.2	Per cent distribution in rural and urban areas by SLI	17
Figure 3.3	Percentage of respondents (N= 1342) by place of previous and current delivery of mother's with not a first delivery	22
Figure 5.3	Per cent distribution by place of delivery according to residence, 2014	42

Figure 5.3.1	Percent distribution by reasons for not availing government facilities according to residence, 2014	43
Figure 5.3.2	Item wise average expenses incurred by respondents in private facility by place of residence, 2014	44
Figure 5.3.3	Average expense in rupees incurred by respondents (N =738) in private facility by place of residence, 2014	45

ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
AMG	Annual Maintenance Grant
ANM	Auxiliary Nurse Midwife
ARSH	Adolescent Reproductive and Sexual Health
ASHA	Accredited Social Health Activist
DM&HO	District Medical and Health Officer
IMR	Infant Mortality Rate
IPHS	Indian Public Health Standards
IUCD	Intra-uterine Contraceptive Device
JSSK	Janani Shishu Suraksha Karyakram
MMU	Mobile Medical Unit
MHW	Multipurpose Health Worker
MO	Medical Officer
MTP	Medical termination of Pregnancy
MVA	Manual Vacuum Aspiration
NBCC	Newborn Care Corner
NBSU	Newborn Stabilisation Unit
NGO	Non Governmental Organisation
NICU	Neonatal Intensive Care Unit
NRHM	National Rural Health Mission
NSSK	Navjaat Shishu Suraksha Karyakram
NSV	Non Scalpel Vasectomy
SC	Sub-Centre
SNCU	Special Newborn Care Unit
VHSC	Village Health Sanitation Committee

ACKNOWLEDGEMENT

The “Evaluation of Janani Shishu Suraksha Karyakram in Maharashtra”, has been successfully completed with the efforts and involvement of many individuals and organizations that contributed to our field work. We would like to thank all those who were involved in the successful completion of the survey.

At the outset, we are particularly indebted to the National Health Mission (NHM), and Government of Maharashtra for their unwavering collaboration for the success of the project. Our sincere gratitude extends to the current Mission Director, Smt I A Kundan, for her assistance in seeing the project to completion. We wish to thank the Mission Director, instrumental for the completion of the project, providing essential leadership that made possible such a fruitful collaboration from the beginning. We appreciate the thoughtful contributions of Director of health services Dr Satish Pawar, Joint Director (technical) Dr Raju Jotkar, and JSSK Coordinator Dr Pushkar.

We are grateful to SHSRC for its partnership with us. SHSRC was a constant source of support, helpful coordination, and provided valuable inputs throughout the survey. We wish to thank the Dr Uddhao Gawande, Director SHSRC for providing essential leadership that made possible such a fruitful collaboration from the beginning and for the completion of the project. Dr Netrali Dalvi and Mrs Mukta Gadgil provided indispensable support for maintaining perfect coordination with SHSRC as well as communication with government agencies. The insight and JSSK expertise of Dr Konkane greatly strengthened the strategies as well as collaboration with Maharashtra Government.

We further extend our gratitude to Dr Anjali Radkar and Dr. Manasi for their invaluable technical inputs. Using their deep understanding of the health insurance sector provided us guidance during all stages of project sampling and implementation.

We are extremely thankful to Gokhale Institute of Politics and Economics (GIPE), Pune, where Population Research Centre (PRC) is based who played an important role in implementing the survey. We thank Prof. Rajas Parchure, Officiating Director (GIPE) for his valuable support throughout the completion of this survey.

Thanks to all officers and staffs from the government for extending their valuable cooperation and support to the field staff during the fieldwork of this study in their districts/talukas/villages. We express our appreciation for the hard work put in by the field investigators and other field staffs during data collection.

At the outset, we would like to put on record the efforts and overall supervision of PRC team of Arun Pisal, Raj Pol, Akram Khan and A P Prashik for their continuous support. We would also like to acknowledge technical contributions by Mr Satish, Ms. Poonam, Ms. Preethi, Ms. Praniti, Ms Ritu, Ms. Pallavi, Ms. Yogita and Ms. Rupali, all of whom offered invaluable help during field work.

We also received technical and administrative support by Ms. Vandana Shivnekar, Ms Sugandha More and Ms Geetanjali who ensured smooth functioning behind the scenes in data processing, and data compilation, which provided the base in analytical write up of the publication.

Last but not the least, our biggest appreciation goes to the households and special thanks to mothers who participated in the survey and provided their valuable time in responding to the questions with patience and without any expectation. Finally, we are also thank to the village authorities for providing logistic support to the data collection teams.

PRC, Pune

Vini Sivanandan

R. Nagarajan

Sanjeevene Mulay

EXECUTIVE SUMMARY

In order to reduce maternal and infant mortality, Reproductive and Child Health Programme under the National Rural Health Mission (NRHM) is being implemented by Government of India. This is to promote institutional deliveries so that skilled attendance at birth is available, and women and new born can be saved from pregnancy-related deaths. In view of the difficulty faced by the pregnant women and parents of sick new born along-with high out of pocket expenses incurred by them on delivery and treatment of sick new born, the Ministry of Health and Family Welfare (MoHFW) has taken a major policy initiative of providing completely free and cashless services to pregnant women including normal deliveries and caesarean operations and to sick new born (extended to infants) in Government health institutions in both rural and urban areas. The Government of India launched a new scheme called Janani Shishu Suraksha Karyakaram (JSSK) on 1st June, 2011 and all the states have rolled out the scheme immediately. JSSK in Maharashtra was implemented on 7th October 2011 in all the districts of the state. The present study is an attempt to evaluate it to improve its service provisions by identifying its strengths and weaknesses. The specific objectives of the study are:

- To evaluate the adequacy of the infrastructure under JSSK like manpower, equipment, drugs, consumables, IEC, etc. at the selected facilities.
- To evaluate the JSSK through the interview of the beneficiaries of the scheme in selected districts.
- To understand the views/opinions of the health personnel about the implementation of JSSK and the issues faced by them in the selected districts.
- To identify gaps in the implementation of JSSK, if any, and suggest measures for the needful.

Qualitative and quantitative methods have been used for the study. Neonatal mortality is 19-20 per 1,000 live births in Maharashtra. Using the coefficient of variation of the District, IMRs were estimated on the basis of DLHS-3 to determine the sample size. Taking into account the target-groups (tribal, non-tribal and urban slums) and regional representation of the state, the districts of Amravati, Nashik, Pune and Nanded were selected. Total of 550 births were divided into two components: 400 for tribal and non-tribal rural areas, and 150 for urban slums. For tribal and non-tribal rural areas, the next allocation is into two tribal and two non-tribal PHCs with equal (100 births in each PHC) sample-size. From tribal and non-tribal PHCs, generally three or four villages were selected by PPS method with a target of 100 births during the reference period. The number of villages selected by PPS for tribal PHCs was slightly different from non-tribal PHCs.

From the list of slums for the cities, two slums were selected based on the size of the population/number of households – one at the first quartile and another at the third quartile. The sample of 150 births was distributed proportionately in two slums. All the births that have taken

place in the selected sampling units during the reference period of one year prior to the survey, i.e., from 1.12.2012 to 30.03.2014 (till the date of survey) were covered for the study. Out of these births, the information was collected for the beneficiaries under JSSK, i.e., the women who delivered in the public institutions and neonates who were treated at the public facilities for the neonatal illness. The survey is based on a sample of 2266 women that is representative at the state level within the districts at the urban and rural levels, and their slum and non-slum population. The individual response rate was 100 per cent for eligible women.

The evaluation of the scheme was carried out through (a) household survey of beneficiaries using the structured interview schedule, (b) check list for the health facilities to elicit the availability of equipment, drugs and consumables as per the JSSK guidelines, and (c) survey of health personnel involved in the implementation of the scheme at various levels by using a semi-structured interview schedule designed to collect information on background characteristics, awareness and utilisation of JSSK scheme, and home deliveries. A common semi-structured interview schedule is used to collect the data from the health personnel mentioned above. The following information was elicited from them: (a) their role in implementing the scheme, (b) their views on strengths and weaknesses of the scheme, (c) difficulties faced by them, if any, for implementing the provisions under the scheme, and (d) suggestions for increasing the efficiency of scheme. To evaluate the above items, an open ended interview method was used to free-list issues from the concerned staff. This was aimed to help understanding the implementation of JSSK at the ground level as per the requirement of the districts. The interviewers and supervisors for the main survey were given training and all the questionnaires were bilingual with questions in both regional and English languages.

The study indicates that the overall increase in delivery in government health facilities from 49% in previous delivery to 60% in current delivery has led to a decline in home delivery in tribal areas and decline of private deliveries in non-tribal areas and urban slums. The level of awareness about JSSK was the highest in rural areas with 52 per cent and lowest in urban areas with 32 per cent. A majority of the women reported awareness about JSSK entitlements to mothers and only a quarter of women respondents were aware about JSSK entitlement to neonates. Within entitlements very few women were aware of the availability of free blood and referral transport facilities, if required, as compared with other entitlements. So far as the source of awareness of the scheme is concerned, in rural areas they were ANM and ASHAs, and ANM and doctors in urban slums. Very few women were aware of toll free number but most of them were aware of ANM/ASHA number.

Almost all the women received ANC care and near about 65 per cent of them received ANC check up four to six times. Nearly two-thirds of the women in tribal areas delivered babies in government health facilities as compared with 55 per cent women in non-tribal areas and urban slums each. Complication in pregnancy was the major reason quoted by women for delivering in private health facility. The average expenditure incurred private facilities in delivery was in the range of Rs 5000 to Rs 25000 for about 60 per cent of the women.

Although the awareness of free pick up transport facility is high, it is not reflected in the number of women seeking it. Women paid for essential diagnostics such as blood and urine tests in public health facility even with awareness level of as high as 80 per cent. Expenses on USG test were the highest compared with other diagnostic tests. Few women paid for drugs and consumables and the highest expense incurred is higher than the expense incurred on drugs and consumables by women in private facilities. More than 60 per cent women reported that diet service not available at health facility. Free referral transport was not available to most of the women who required it. Overall awareness and utilization of JSSK services needs to be strengthened in urban slums.

Except for awareness regarding exemption from user charges, awareness for other entitlements is limited and almost negligible in the cases of free blood, free referral and drop back transport facilities. Free drugs and diagnostics were not available to all the neonates. It is appreciable that nearly 90 per cent of neonates received check up within the first hour of delivery. Although nearly 85 per cent babies were exclusively breastfed for six months, still nearly 30 per cent neonates were provided other food apart from breast milk within the first three days of birth.

A majority of the home deliveries were out of choice, and the major reason for them was that emergency and health facility was too far. The proportions of home deliveries and of babies weighing less than 2.5 kg were higher in tribal areas than elsewhere.

The study indicates an increase in institutional deliveries which may be attributed to some extent to the popularity of JSSK scheme. However, there is a need to create more capacity in the scheme to cater to this JSSK-induced demand in the future. In addition, enhancing quality of care is an important area which needs to be focused. Variation in the utilization of JSSK services needs to be addressed and future action plan should be made accordingly. Rather than performance-based incentives, they need to be strengthened in areas difficult to reach. Grievance cells may be set up at the levels of both beneficiaries and providers at block levels.

CHAPTER I

INTRODUCTION

BACKGROUND

In order to reduce the maternal and infant mortality, Reproductive and Child Health Programme under the National Rural Health Mission (NRHM) is being implemented by the Government of India. This is expected to promote institutional deliveries so that skilled attendance at birth is available and women and new born can be saved from pregnancy- related deaths. Several initiatives have been launched by the Ministry of Health and Family Welfare (MoHFW), including Janani Suraksha Yojana (JSY) which is a key intervention that has resulted in phenomenal growth in institutional deliveries. More than one crore women benefit from the scheme annually and the outlay for it has exceeded Rs. 1600 crores per year (MoHFW 2013).

However, the phenomenal increase in institutional delivery has not resulted in desired decline in maternal and infant mortality. Still about 56,000 women in India die every year due to pregnancy-related complications. Similarly, every year more than 13 lakh infants die within one year of birth and out of them approximately 9 lakh, i.e., two-thirds of the infant deaths take place within the first four weeks of life. Out of them, approximately seven lakhs, i.e., 75 per cent of the deaths take place within a week of the birth and a majority of them occur in the first two days after birth (MoHFW, 2011).

It is realized that though institutional delivery has increased significantly, the out of pocket expenses being incurred by pregnant women and their families are significantly high. This often acts as a barrier for the pregnant women who still deliver at home as well as for sick neonates on account of poor access to health facilities (MoHFW, 2011). Important factors inhibiting access to health facilities include: (a) user charges for OPD, admissions, diagnostic tests, blood tests, etc.; (b) purchasing medicines and other consumables from the market; (c) in the case of a caesarean operation, expenses can be very high coupled with non-availability of diet in most institutions; and (e) dearth of transport to health facility and back. Out-of-pocket expense for health is an important barrier for poor households to access the institutional health care and it has also an impoverishing effect on households.

In view of the difficulty faced by pregnant women and parents of sick newborn along with high out of pocket expenses incurred by them on delivery and treatment of sick newborn, MoHFW has taken a major policy initiative to provide completely free and cashless services to pregnant

women (including both normal deliveries and caesarean operations) and to sick new born (up to 30 days after birth) in Government health institutions in both rural and urban areas. The Government of India launched the Janani Shishu Suraksha Karyakaram (JSSK) on 1st June, 2011 and all the states rolled it out immediately. Launched from Mewat district in Haryana, it signifies a huge leap forward. It involves a new approach to health care, for the first time placing utmost emphasis on entitlements and elimination of out-of-pocket-expenses for both pregnant women and sick neonates. The initiative entitles pregnant women free delivery in public institutions and no expense to be incurred in delivery including caesarean section besides to and fro transport. Similar entitlements have been put in place for all sick newborns accessing public health institutions for health care till 30 days after birth. This has now been expanded to cover infants. They are also entitled to visit free treatment facilities, besides free transport between home and facilities in case of referral.

KEY FEATURES OF THE JSSK

The new initiative entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery, including caesarean section. The entitlements include free drugs and consumables, free diet up to 3 days during normal delivery and up to 7 days for C-section, free diagnostics, and free blood wherever required. This initiative also provides for free transport from home to institution, between facilities in case of a referral and drop back home. Similar entitlements have been put in place for all sick newborns accessing public health institutions for treatment till 30 days after birth. The scheme aims to eliminate out of pocket expenses incurred by the pregnant women and sick newborns while accessing services at Government health facilities.

As the scheme has been implemented for more than two years by the states, the present study attempts to evaluate its functioning in Maharashtra in order to improve its working by identifying its strengths and weaknesses.

OBJECTIVE OF THE STUDY

The broad objective of the study is to evaluate the functioning of the JSSK with respect to all its dimensions through a field-survey in Maharashtra. The specific objectives are:

- To evaluate the adequacy of infrastructure under JSSK like manpower, equipment, drugs, consumables, IEC, etc.
- To evaluate the JSSK through the interview of its beneficiaries.

- To understand the views/opinions of the health personnel about its implementation and the issues faced by them.
- To identify the gaps in its implementation, if any, and suggest remedial measures.

Women who had given births during the reference period 1.12.2012 to 30.03.2014 (till the date of survey) were interviewed. The survey is based on a sample of 2,266 women as representative at the state level. Within the state Amravati, Nanded, Nashik and Pune districts at the urban and rural levels were selected.

The survey provides trend data on key indicators and includes information on entitlements under JSSK, such as free transport facilities (pick up, referral and drop back), free diagnostics, free drugs and consumables, free blood if required, free diet and exemption from any kind of user charges for both mothers and neonates.

Fieldwork in the four districts was conducted by the Population Research Centre, Pune between December 2013 and March 2014. This report presents key findings of the JSSK survey by place of residence, followed by detailed tables.

CHAPTER II

SAMPLE DESIGN AND SAMPLING

Sample Size: Since one of the main issues in this study is the care of the neonates, we determined the sample size on the basis of the neonatal mortality rate in Maharashtra. Neonatal mortality is 19-20 per 1000 live births in here. Using the coefficient of variation of the District IMRs (on the basis of DLHS-3), the sample size was estimated. It comes out to be 2200 and odd. For the purpose of convenience, we set our target and took 2200 births as the sample size during the preceding year of the survey.

Allocation of the sample size & identification of the sample-units: The study was conducted in four districts and the target sample size in each district was set at 550 births from our target-groups:

- Tribal
- Non-tribal (Rural)
- Urban Slums

In these areas, the problems of neo-natal health-care are expected to be more. Taking into account these target-groups and the regional representation of the state, the districts of Amravati, Nashik, Pune and Nanded were selected. They have all the three target-groups and come from the four major divisions of Maharashtra.

Allocation of sample-size within the districts: Total of 550 births are divided into two components: 400 for tribal and non-tribal rural areas, and 150 for urban slums. For tribal and non-tribal rural areas, the next allocation is into two tribal and two non-tribal PHCs with equal sample-size (100 births in each PHC). From tribal and non-tribal PHCs, generally three or four villages were selected by PPS method with a target of 100 births during the reference period. The number of villages selected by PPS for tribal PHCs was slightly different from non-tribal PHCs. Wherever the size of tribal villages was small, we selected them till we got 100 births as per the data from ANM.

After selecting the villages, the R15 register maintained by ANM at Sub-Centre was referred to identify the women who delivered the child during the reference period from the selected villages.

Slum Sampling: From the list of slums in the cities, two slums were selected based on the size of the population/number of households – one at the first quartile and another at the third quartile. The sample of 150 births was distributed proportionately in the two slums. After selecting the slums, the R15 register maintained by the ANM in the Urban Health Post or the register maintained in the Anganwadi Centre was referred to identify the beneficiaries from the slums.

Reference period: All the births that have taken place in the selected sampling units during the reference period of one year prior to the survey, i.e., 1.12.2012 to 30.03.2014 (till the date of survey) were covered for the study. Out of these births, information was collected for the beneficiaries

under JSSK, i.e., women who delivered in the public institutions and the neonates who were treated at the public facilities for the neonatal illness.

We interviewed 2266 women in Amravati, Nanded, Nashik and Pune districts who gave birth during the reference period of one year prior to the survey to obtain information on pregnancies, antenatal care, deliveries, postnatal care, neonatal care and entitlements under JSSK. The survey is based on a sample of 2266 women that is representative at the state level within the districts at the urban and rural levels, and their slum and non-slum population. The individual response rate was 100 per cent for eligible women.

EVALUATION OF JSSK

The Government of India has provided guidelines for rolling out the scheme in the states. The study collected information on various indicators pertaining to implementation of the scheme for the following items:

- Action taken at the state level.
- Action taken at the district level.
- Dissemination of entitlements in the public domain.
- Ensuring drugs and consumables.
- Strengthening diagnostics.
- Ensuring provision of diet.
- Ensuring availability of blood in case of need.
- Exemption from all kinds of user charges.
- Referral transport.
- Grievance redressal.
- Making the funds available.
- JSSK entitlements in JSY Cards/ANC Cards.

The evaluation of the scheme was carried out through (a) household survey of beneficiaries using the structured interview schedule, (b) check list for the health facilities to elicit the availability of equipment, drugs and consumables as per the JSSK guidelines, and (c) survey of health personnel involved in the implementation of the scheme at various levels by using a semi-structured interview schedule designed to collect information on background characteristics, awareness and utilisation of JSSK scheme and home deliveries. In addition to the above,

A. BENEFICIARY SURVEY

Through the beneficiary survey, the following free entitlements received by the pregnant women and neonates/infants under JSSK were collected and evaluated:

Entitlements for pregnant women:

- Free zero expense delivery.
- Free zero expense in caesarean section.
- Free drugs and consumables.

- Free diagnostics (blood, urine tests and ultra sonography, etc.).
- Free diet during stay in the health institutions (up to three days for normal delivery and seven days in caesarean section).
- Free provision of blood.
- Free transport from home to health institutions.
- Free transport between health institutions in case of referral.
- Drop back from institution to home.
- Exemption from all kinds of user charges including Registration charges.

Entitlements for sick neonates/infants

- Free and zero expense treatment.
- Free drugs and consumables.
- Free diagnostics.
- Free provision of blood.
- Free transport from home to health institutions.
- Free transport between health institutions in case of referral.
- Drop back from institution to home.
- Exemption from all kinds of user charges.

B. AVAILABILITY OF EQUIPMENT, DRUGS AND CONSUMABLES IN HEALTH FACILITIES

In addition to the survey of beneficiaries under the JSSK, the relevant health facilities were visited to examine the adequacy of required equipment, drugs, and consumables. The following facilities were covered for the survey:

- District Hospitals
- Women's Hospital
- One Rural Hospital and one Sub-District Hospital in the selected tribal and non-tribal blocks.
- All the selected PHCs.
- All the Sub-centres under the selected PHCs.

JSSK stipulates provision of the drugs and consumables for normal delivery, C-section delivery and sick neonates in public institutions. The study evaluated the following essential drugs and consumables available in health institutions as per the JSSK guidelines.

- Essential drugs list for ante-natal period for all facilities (nine items).
- Essential drugs list for intra-partum normal delivery (24 drugs and 18 consumables).
- Essential drugs list for postnatal period (15 drugs and consumables).
- Essential drugs list for intra-partum C-Section delivery (16 drugs and seven consumables)
- Miscellaneous drugs (may be required in some cases of C-Section) (15 items).
- Essential drugs list for newborn (14 items).

C. HEALTH PERSONNEL

Following Health personnel were interviewed to know about their role in implementing the scheme and their views on different aspects of JSSK.

- Medical Superintendents/In-Charge of the Hospitals.
- All the ANMs in the selected PHCs and Sub-Centres.
- All the Medical Officers of the selected PHCs.
- Selected Medical Officers in one Rural Hospital and one Sub-District Hospital in the selected tribal and non-tribal blocks.

A common semi-structured interview schedule was used to collect the data from the health personnel mentioned above. The following information was elicited from them: (a) their role in implementing the scheme, (b) their views on strengths and weaknesses of the scheme, (c) difficulties faced by them, if any, for implementing the provisions under the scheme, and (d) suggestions for increasing the efficiency of scheme.

THE STUDY ALSO LOOKS INTO THE FOLLOWING ISSUES:

- **PPP:** Public-private partnership arrangement for provision of different services under JSSK.
- **Diet:** Issues related to outsourcing of diet for the women during their stay in the hospital.
- **IEC efforts** for JSSK made by the district administration as per the guidelines.
- **Referral Transport:** Relevant information was obtained from the Call Centres records, vehicle log books, contractors and their drivers, concerned staff at the facilities and the beneficiaries.
- **Grants under JSSK:** Grants requested by the District in PIP, timeliness of receipt of the grants and adequacy of the grants received.
- **Utilisation of sanctioned grants** under JSSK by the districts and the grants utilised by the facilities.

To evaluate the above activities, an open ended interview method was used to free-list issues from the concerned staff. This was aimed to help understand the implementation of JSSK at the ground level as per the requirement of the districts. The interviewers and supervisors of the survey were given training. All the questionnaires were bilingual, with questions in both regional and English languages.

CHAPTER III

BACKGROUND CHARACTERISTICS AND LIVING CONDITIONS

The Janani Shishu suraksha Karyakram (JSSK) programme is targeted at the mothers and neonates of the population. The utilization of JSSK services provided across the state depends largely on the characteristics of women, their families and living condition. Age of women, marital duration, educational attainment, social background and living standard are important factors which influence utilization of services. With this in view, the JSSK data were collected on demographic characteristics such as current age, age at marriage, number of pregnancies, live births and surviving children from respondents of selected representative households. Information regarding household background characteristics also covered religion and caste, type of house, source of drinking water and possession of consumer durables.

This chapter provides a comprehensive outline of distribution of respondents by present age, age at marriage, duration of marriage, completed years of schooling, pregnancy episodes, children ever born and children surviving, along with social and economic characteristics of households the women represent.

3.1 BACKGROUND CHARACTERISTICS OF WOMEN

The percentage distribution of respondents by age groups, educational level, religion, caste, BPL status and place of residence is shown in Table 3.1. A sample of 2,266 respondents represents the state of Maharashtra in JSSK and 73 per cent of these women are from rural areas belonging to tribal and non-tribal areas.

Among the sample women, Hindus constitute 85 per cent, whereas Buddhists and Muslims constitute seven per cent each. Moreover, Hindu women are found to be residing in rural areas (91 per cent), more in tribal areas (95 per cent) and non-tribal areas (88 per cent) than in urban slums (68 per cent). Muslim women constitute 14 per cent, while Buddhist women constitute 17 per cent in urban slums.

There is not much difference in caste-wise representation by place of residence. It ranges from 12 per cent for Notified Tribes to 29 per cent for Scheduled Tribes. About 22 per cent of the women belong to a scheduled caste with 52 per cent concentrated in urban slums, 14 per cent belong to other backward classes, and 20 per cent to open castes. In rural areas, there are more women belonging to a scheduled tribe (37 per cent) than in urban slums (7 per cent).

There is a clear tribal-non-tribal differential in the educational attainment of women as depicted in figure1. For the respondents, 11 per cent of women are with little education. Women of this category constitute 13 per cent in rural areas (with 18 per cent in tribal areas and 7 per cent in non-tribal areas), while the corresponding figure is 8 per cent in urban slums. Rural-urban gap decreases as the level of education increases. However, within rural areas tribal and non-tribal gaps in level of education are glaring with tribal areas represented largely by women with education upto five to seven years of completed education. But in non-tribal areas women are largely represented

with educational level of eight to ten years of completed education. Overall the median number of years of schooling completed is three in tribal areas and four each in non-tribal and urban slum areas.

BPL status is determined by the availability of ration cards. Among the respondents, 52 per cent belong to BPL status with 63 per cent in urban slums and 48 per cent in rural areas. However, it is surprising that within rural areas, 56 per cent of BPL respondents are from non-tribal areas compared with only 39 per cent in tribal areas.

Figure3.1: Educational differentials in respondents by completed years of schooling and by place of residence

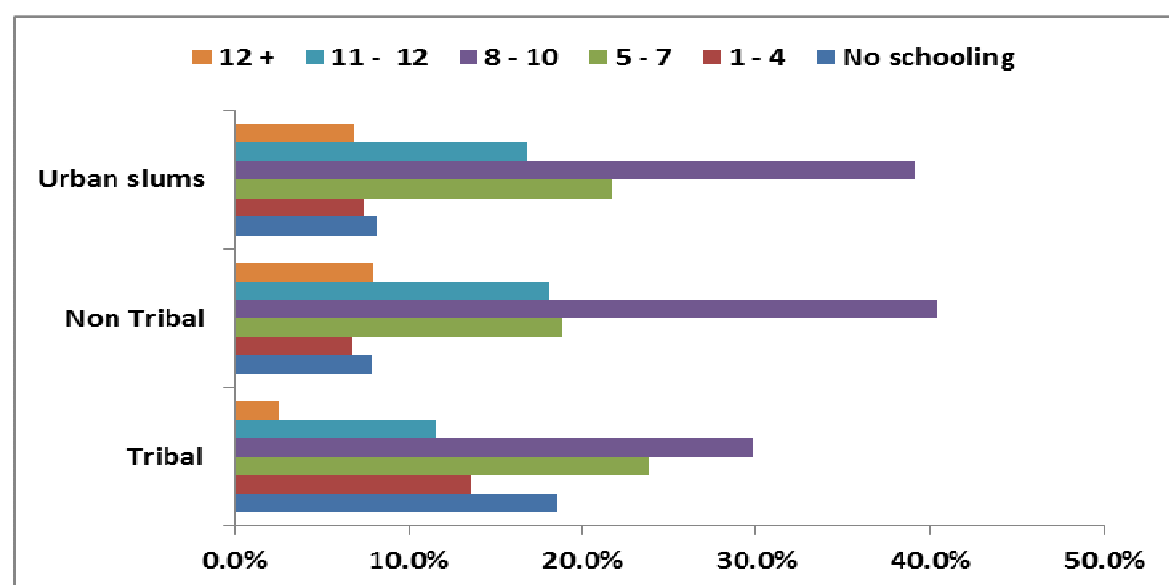


Table 3.1 Respondents by background characteristics
Percentage of respondents by background characteristics according to residence, 2014

Background characteristics	Tribal	Non-Tribal	Tribal + Non-Tribal	Urban Slums	Total
Age					
15-19 years	11.0	10.8	10.9	9.2	10.5
20-24 years	60.0	56.4	58.2	56.0	57.6
25-29 years	23.5	28.2	25.9	28.2	26.5
30-34 years	4.5	3.8	4.2	5.9	4.6
35+	1.0	0.7	0.9	0.7	0.8
Total	100.0	100.0	100.0	100.0	100.0
Education					
No education	18.6	7.9	13.2	8.2	11.8
1-4 years completed	13.6	6.8	10.1	7.4	9.4
5-7 years completed	23.8	18.8	21.3	21.7	21.4
8-10 years completed	29.8	40.4	35.2	39.1	36.2
11-12 years completed	11.6	18.1	14.9	16.7	15.4
13+ years completed	2.6	8.0	5.3	6.9	5.7
Total	100.0	100.0	100.0	100.0	100.0
Median number of years of schooling completed	3.0	4.0	3.5	4.0	4.0
Religion					
Hindu	95.7	88.0	91.8	68.1	85.4
Muslim	2.3	6.7	4.5	14.1	7.1
Christian	0.5	0.0	0.2	0.0	0.2
Sikh	0.0	0.1	0.1	0.2	0.1
Buddhist/Neo Buddhist	1.5	5.2	3.4	17.6	7.2
Total	100.0	100.0	100.0	100.0	100.0
Caste					
SC	6.6	17.0	11.9	52.1	22.7
ST	57.2	19.0	37.8	7.6	29.7
NT	17.5	13.6	15.5	4.6	12.6
OBC	6.6	24.7	15.8	11.8	14.7
Open	12.1	25.7	19.0	24.0	20.3
Total	100.0	100.0	100.0	100.0	100.0
BPL Status					
Yes	39.6	56.4	48.1	63.2	52.2
No	60.4	43.6	51.9	36.8	47.8
Total	100.0	100.0	100.0	100.0	100.0
District					
Amravati	25.1	24.8	24.9	24.8	24.9
Nanded	25.8	25.7	25.8	25.5	25.7
Nashik	24.8	24.8	24.8	25.3	24.9
Pune	24.3	24.7	24.5	24.5	24.5
Total	100.0	100.0	100.0	100.0	100.0
Number	818	839	1657	609	2266
Note: BPL status is checked on the basis of the availability and colour of the ration card.					

3.2 HOUSING CHARACTERISTICS

This section describes the availability of basic amenities in the state. Table 3.2 presents the distribution of households by selected housing characteristics by percentage. Based on building material, type of floor, walls, and roof, households are categorised to have been living into *kachcha*, *semi-pucca* and *pucca* houses.

NFHS 3 shows that a majority of households in Maharashtra live in *pucca* houses (59 per cent). Eighty-four per cent of households (71 per cent of rural households and 97 per cent of urban households) have electricity.

JSSK survey shows that about 35 per cent of the households live in *kachcha* houses, 37 per cent in *semi-pucca* houses and 27 per cent in *pucca* houses. Nearly 41 per cent of the households of urban slums live in *pucca* houses, compared with only 22 per cent of rural households (with 15 per cent in tribal areas and 29 per cent in non-tribal areas). A majority of the households in tribal areas live in *kachcha* houses (53 per cent).

Almost all the households (93 per cent) have electricity as the main source of lighting with urban slums (98 per cent) and non-tribal areas (95 per cent) slightly better than tribal areas (87 per cent).

According to NFHS 3, 58 per cent households have water piped in their dwellings, yards or plots. In addition, 20 per cent of them (14 per cent urban and 26 per cent rural) get their drinking water from a public tap/standpipe. As regards to the source of drinking water, in JSSK survey nearly half of the household get it through public tap/public hand pump/public well, while others get from water piped into residence hand pump in yard/well in residence, and 1.8 per cent get from surface water (spring, river, pond/lake, dam, rain water, tanker). About 63 per cent of the household in urban slums get it through public tap/public hand pump/public well, whereas in rural areas 54 per cent (with 65 per cent in tribal areas and 44 per cent in non-tribal areas) of the household get it from water piped into residence/hand pump, in yard/well in residence.

In NFHS 3, four-fifths of rural households (79 per cent) do not have toilet facilities, compared with 12 per cent of urban households. Similarly, as per JSSK survey, when it comes to sanitation facility, only 25 per cent of the households have own flush toilets with 30 per cent in non-tribal and urban slums areas each and only 16 per cent in tribal areas. About four per cent of the households have shared pit-based toilets or latrines with 13 per cent in urban slums and negligible in rural areas. Near about 19 per cent of the households depend on shared toilets or public/community toilets with 34 per cent in urban slums and 10 per cent in tribal areas and 18 per cent in non-tribal areas. Fifty per cent of the households do not have toilet facility at all. Seventy two per cent of the households in tribal areas and half of the households in non-tribal areas do not have toilet facility, compared with 21 per cent of the households in urban slums.

JSSK survey has also collected data on the types of fuels used for cooking in the households. Thirty-two per cent of the households used liquid petroleum gas or electricity for cooking. However, there is a glaring rural-urban difference in the usage of liquid petroleum gas or electricity for cooking with 69 per cent of the household in urban slums and 18 per cent households in rural areas (with 10

per cent in tribal areas and 25 per cent in non-tribal areas). Nearly 66 per cent of the households in rely on wood fuel and these households are mainly concentrated in rural areas with 89 per cent of the household in tribal areas, 74 per cent households in non-tribal areas as compared to only 26 per cent households in urban slums.

Near about half of the households in tribal and non-tribal areas own the house and a slightly lesser proportion (44 per cent) of the households in urban slums own the house. About 80 per cent of the households have a separate room for cooking. However, in rural areas the corresponding figure is 85 per cent each compared with 71 per cent of households having a separate room in urban slums.

Table 3.2 Housing characteristics
Percentage of respondents by housing characteristics according to residence, 2014

Household and housing characteristics	Tribal	Non-Tribal	Tribal + nontribal	Urban slums	Total
Mean household size	5.7	5.6	5.6	4.8	5.4
Type of house¹					
Kuccha	53.4	28.2	40.7	21.0	35.4
Semi-pucca	31.5	42.6	37.1	37.9	37.3
Pucca	15.0	29.2	22.2	41.1	27.3
Total	100.0	100.0	100.0	100.0	100.0
Main source of lighting					
Electricity	87.9	95.0	91.5	98.5	93.4
Kerosene/Gas/Oils	12.1	5.0	8.5	1.5	6.6
Total	100.0	100.0	100.0	100.0	100.0
Main source of drinking water					
Piped into residence/Hand pump in yard / Well in residence	31.2	55.3	43.4	63.5	48.8
Public tap/Public hand pump/Public well	65.5	44.5	54.9	34.6	49.4
Surface water (Spring, river, pond/lake, dam, rain water, tanker)	3.3	0.2	1.8	1.8	1.8
Total	100.0	100.0	100.0	100.0	100.0
Toilet facility					
Own flush toilet	16.5	30.6	23.7	30.7	25.6
Shared flush/Pub. flush/Own pit toilet	10.8	18.5	14.7	34.3	19.9
Shared pit/Public pit toilet latrine	0.5	0.7	0.6	13.3	4.0
No facility/Bush/Field/Others	72.2	50.2	61.1	21.7	50.5
Total	100.0	100.0	100.0	100.0	100.0
Cooking fuel					
LPG/Electricity	10.6	25.9	18.3	69.5	32.1
Wood/Crop residues/Dung cakes/Coal/Coke/Lignite	89.4	74.0	81.6	26.8	66.9
Charcoal/kerosene	0.0	0.0	0.1	3.8	1.1
Total	100.0	100.0	100.0	100.0	100.0
Percentage owning a house	48.2	51.6	49.9	44.0	48.3
Number of rooms in the house (Mean)	2.4	2.7	2.5	2.2	2.5
Availability of separate room for cooking (per cent)	84.5	85.8	85.2	71.1	81.4
Number	818	839	1657	609	2266

¹Houses made from mud, thatch, or other low-quality materials are called *kuccha* houses, houses that use partly low-quality and partly high-quality materials are called *semi-pucca* houses, and houses made with high quality materials throughout, including the floor, roof, and exterior walls, are called *pucca* houses.

Considering household amenities, such as source of drinking water, type of house, source of lighting, fuel for cooking, toilet facility and ownership of durable goods a composite measure, standard of living index (SLI), is made for the classification of households.

It is calculated by adding the following scores:

Source of drinking water	: 3 for tap (own), 2 for tap (shared), 1 for hand pump and well, and 0 for others;
Type of house	: 4 for <i>pucca</i> , 2 for semi- <i>pucca</i> , and 0 for <i>kachcha</i> ;
Toilet facility	: 4 for own flush toilet, 2 for public or shared flush toilet or own pit toilet, 1 for shared or public pit toilet and 0 for no toilet;
Source of lighting	: 2 for electricity, 1 for kerosene, gas, or oil, and 0 for others;
Main Fuel for cooking	: 2 for LPG gas/electricity or biogas, 1 for charcoal or kerosene and 0 for others;
Source of drinking water	: 2 for pipe, hand pump or well in residence/yard/plot, 1 for public tap, hand pump or well, 0 for other water sources;
Separate room for cooking	: 1 for yes, 0 for no;
Ownership of house	: 2 for yes, 0 for no;
Ownership of agricultural land	: 4 for 5 acres or more of land, 3 for 2.0 - 4.9 acres, 2 for less than 2 acres or acres not known, 0 for no agricultural land;
Ownership of irrigated land	: 2 if household owns at least some irrigated land, 0 for no irrigated land;
Ownership of livestock	: 2 if owns livestock, 0 if does not own livestock;
Ownership of durable goods	: 4 each for car and tractor;
	3 each for colour television, telephone set, refrigerator, computer/laptop, and moped/scooter/motorcycle/auto Rickshaw; and,
	2 each for electric fan, radio/transistor, sewing machine, tape recorder, black and white TV, water pump, bullock cart and thresher, and bicycle; and
	1 each for mattress, pressure cooker, cupboard, cot, chair, table and clock/watch.

The total maximum score was divided by 3 and then equally divided into three categories as low, medium and high;

- a) Low – 0-24,
- b) Medium – 25-48 and
- c) High – 49-73.

Figure 3.2 shows, as per the standard of living index, 22 per cent of the households come under the low standard of living category, 26 per cent belong to medium standard and 51 per cent to high standard of living categories. The proportion of sample households with high standard of living is comparatively higher in urban slums (63 per cent) and non-tribal areas (62 per cent) than in tribal areas (31 per cent). The proportion of households with a low standard of living is 25 per cent in rural households (with tribal areas 37 per cent and non-tribal areas 14 per cent) and 13 per cent in urban slum households. Overall, more than 60 per cent households in non-tribal areas and urban slums belong to high SLI whereas the same per cent belongs to low and medium SLI in tribal areas.

Figure 3.2: Percent distribution in rural and urban areas by SLI

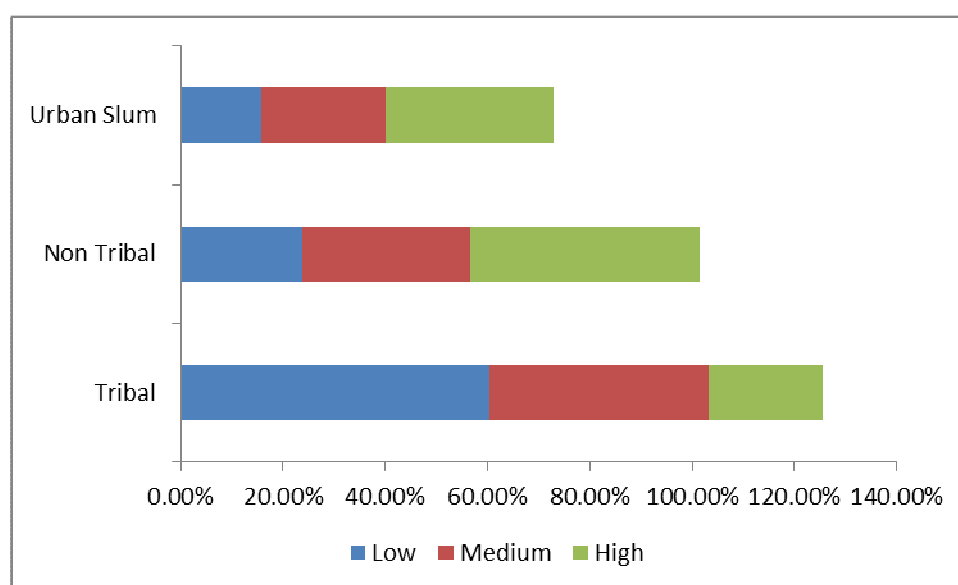


Table 3.2.1 shows nearly 47 per cent of the households have no agricultural land and are largely represented by households in urban slums (85 per cent) than in tribal and non-tribal areas (33 per cent). Irrigated lands are owned slightly more in non-tribal areas (33 per cent) compared with 27 per cent households in tribal areas. Near about 55 per cent households in tribal and non-tribal areas own livestock. Since a majority of the households in urban slums do not own agricultural land, only fewer per cent of households own irrigated land and livestock.

The possession of consumer durables is an indication of a household's socio-economic status. Majority of the households own mattress (97 per cent), clock, chair (86 per cent) and cot/bed (81 per cent). Other durable goods found in the surveyed households are telephone/mobile sets (82 per cent), table (75 per cent), pressure cooker (74 per cent), chair (70 per cent), fan (66 per cent), colour TV set (65 per cent), motorcycle/scooter/auto (40 per cent), bicycles (34 per cent), refrigerator (27 per cent), car/jeep (2.5 per cent), and tractor (3.9 per cent). Ownership of all these items except black and white TV set, water pump, bullock cart, thresher and tractor is more among the urban slum households than among the rural households.

Table 3.2.1 Household possessions, ownership of agricultural land and Standard of Living Index
Percentage of respondents by household possessions, agricultural land and Standard of Living
Index (SLI), according to residence, 2014

Household possessions	Tribal	Non-Tribal	Tribal + Non-tribal	Urban slums	Total
Agricultural land					
No agricultural land	33.6	33.5	33.6	85.7	47.6
Irrigated land only	27.5	33.6	30.6	8.4	24.6
Non-irrigated land only	32.9	25.0	29.0	5.3	22.6
Both irrigated and non-irrigated lands	4.5	7.6	6.1	0.3	4.5
Can't say	1.5	0.2	0.9	0.3	0.7
Percentage owning livestock	56.5	54.7	55.6	8.0	42.8
Standard of living index					
Low	37.3	14.3	25.6	13.1	22.3
Medium	31.1	23.2	27.1	23.5	26.1
High	31.7	62.5	47.3	63.4	51.6
Total	100.0	100.0	100.0	100.0	100.0
Household durables					
Mattress	94.7	99.8	97.3	99.7	97.9
Pressure cooker	53.2	81.8	67.7	94.3	74.8
Chair	72.7	93.3	83.2	94.3	86.1
Cot or bed	65.6	90.1	78.0	89.8	81.2
Table	55.6	85.0	70.5	88.2	75.2
Clock/watch	74.9	93.3	84.2	93.3	86.7
Cupboard	49.6	80.7	65.4	84.6	70.5
Fan	46.6	76.3	61.6	80.0	66.5
Bicycle	25.3	41.2	33.4	37.6	34.5
Radio/Transistor set	2.7	8.7	5.7	10.2	6.9
Tape recorder/CD player	5.7	14.8	10.3	17.4	12.2
Sewing machine	5.3	11.0	8.1	10.7	8.8
B & W TV set	2.1	4.2	3.1	0.8	2.5
Water pump	9.8	20.7	15.3	3.1	12.0
Bullock cart	8.8	11.0	9.9	1.8	7.7
Thresher	1.7	6.7	4.2	3.3	4.0
Telephone/mobile set	70.5	89.4	80.1	87.2	82.0
Refrigerator	16.1	31.9	24.1	35.1	27.1
Colour TV set	48.5	75.9	62.4	75.4	65.9
Moped/scooter/motorcycle/auto	29.1	51.1	40.3	42.5	40.9
Computer/laptop	1.1	3.8	2.5	3.9	2.9
Car	0.6	4.5	2.6	2.1	2.5
Tractor	2.9	6.7	4.8	1.5	3.9
Number	818	839	1657	609	2266

3.3 HOUSING CHARACTERISTICS BY DISTRICTS

The four districts in Maharashtra are not uniform in terms of basic amenities and possession of consumer durables. Table 3.3 presents an inter-district comparison of housing characteristics. The percentage of households living in *pucca* houses is quite low in all the districts except Pune district wherein the households living in *pucca* houses constitute 41 per cent. About 40-42 per cent of the households in Amravati and Nanded districts live in *kaccha* houses compared with 40 per cent households in Nashik district living in semi-*pucca* houses.

Almost 93 per cent of the households in all the four districts have electricity as the main source of lighting and the rest use kerosene as the main source of lighting.

Piped water into residence/hand pump in yard/well is the main source of drinking water in Nanded district (56 per cent) whereas, public tap/public hand pump/public well, is used by half of the households in Amravati, Nashik, and Pune districts.

Largely in all the four districts in Maharashtra, households have inadequate toilet facility with its non-availability at as high as 68 per cent in Nanded district to as low as 32 per cent in Pune district and in nearly half of the households in Amravati and Nashik districts. Nearly, 30 per cent of the households in Amravati and Pune districts have own flush toilets compared with 16 and 21 per cent in Nanded and Nashik districts respectively.

Three-fourth of the households in Nanded district use wood/crop residues/dung cakes/coal/coke/lignite as cooking fuel. It is slightly lesser for households in Nashik district (68 per cent), Amravati district (68 per cent) and little more than half (55 per cent) in Pune district. The percentage of households using liquid petroleum gas/electricity for cooking is about 42 per cent in Pune. In the rest of the districts it is relatively low ranging between 25 and 30 per cent.

Nearly half of the households own a house with 80 per cent having a separate room for cooking. The mean size of a household is nearly 2.4 in all the districts.

Table 3.3 Housing characteristics by Districts
Percentage of respondents by housing characteristics and living conditions according to residence, 2014

Household and housing characteristics	Amravati	Nanded	Nashik	Pune	Total
Type of house¹					
Kuccha	40.6	42.6	34.2	23.8	35.4
Semi-pucca	35.5	38.5	40.4	35.0	37.3
Pucca	23.9	18.9	25.5	41.3	27.3
Total	100.0	100.0	100.0	100.0	100.0
Main source of lighting					
Electricity	91.8	94.2	94.0	93.5	93.4
Kerosene/Gas/Oils	8.2	5.8	6.0	6.5	6.6
Total	100.0	100.0	100.0	100.0	100.0
Main source of drinking water					
Piped into residence/hand pump in yard/well in residence	48.6	56.9	46.2	43.2	48.8
Public tap/public hand pump/public well	50.2	42.6	52.9	52.3	49.4
Surface water (spring, river, pond/lake, dam, rainwater, tanker)	1.2	0.5	0.9	4.5	1.8
Total	100.0	100.0	100.0	100.0	100.0
Toilet facility					
Own flush toilet	30.5	16.8	21.8	33.5	25.6
Shared flush/pub. flush/own pit toilet	18.6	13.9	18.4	29.2	19.9
Shared pit/public pit toilet latrine	2.3	1.0	8.1	4.7	4.0
No facility/bush/field/others	48.6	68.2	51.7	32.6	50.5
Total	100.0	100.0	100.0	100.0	100.0
Cooking fuel					
LPG/electricity	30.5	25.9	30.3	42.0	32.1
Charcoal/kerosene	0.5	0.0	1.2	2.5	1.1
Wood/crop residues/dung cakes/coal/coke/lignite	69.0	74.1	68.5	55.5	66.9
Total	100.0	100.0	100.0	100.0	100.0
Percentage owning a house	49.3	46.6	49.4	48.1	48.3
Number of rooms in the house (mean)	2.4	2.6	2.4	2.5	2.4
Availability of separate room for cooking	80.5	89.2	75.6	80.0	81.4
Total	100.0	100.0	100.0	100.0	100.0
Number	564	582	565	555	2266
¹ Houses made from mud, thatch, or other low-quality materials are called <i>kuchha</i> houses, houses that use partly low-quality and partly high-quality materials are called <i>semi-pucca</i> houses, and houses made with high quality materials throughout, including the floor, roof and exterior walls are called <i>pucca</i> houses.					

3.4 MARITAL STATUS OF THE HOUSEHOLD POPULATION

The JSSK survey collected information on the marital status and reproduction from women who had given birth recently during the reference period. Table 3.4 shows the percentage distribution of respondents by marital status and reproduction as well as by place of residence.

Age at marriage of 1.6 per cent of the respondents is 15 years, which is well below the legal minimum age of 18 years. More than a quarter of the respondents (27 per cent) were in the age group of 15-17 years with 35 per cent of respondents in tribal areas and 22 to 24 per cent respondents in non-tribal and urban slums. Overall, 35 per cent of the respondents in tribal areas and a quarter of the respondents from non-tribal and urban slum areas were below the legal age of marriage. Interestingly, about 48 per cent of respondents in tribal and non-tribal areas as well as 40 per cent respondents in urban slums were in the age group of 18-19 years. This heaping of respondents in the age group 18-19 years highlights the awareness of minimum legal age of marriage among the respondents.

Nearly 60 per cent of the respondents' delivery was not the first delivery. Respondents were asked the place of current and previous deliveries to understand the reason for choosing the type of facilities for the current delivery.

The place of previous delivery was government health facilities in 50 per cent of respondents, which increased, to 60 per cent in the current delivery. The rise of current delivery in government facilities as reflected in figure 3.4 was substantial in rural areas, at 62 per cent an increase from 48 per cent in the previous delivery an increase of almost 14 per cent. However, the rise of delivery in government health facilities was marginal in urban slums from 51 per cent previously to 54 per cent in current delivery. Home delivery decreased strikingly in tribal areas from 24 per cent previously to 14 per cent in current delivery. Increase in delivery in government health facilities and consequently decrease in home delivery may be attributed to the fact of awareness and accessibility to government health facilities and JSSK scheme in tribal areas. The decrease in home delivery is marginal at one per cent in non-tribal areas. Home deliveries in non-tribal areas (9 per cent) and urban slums (10 per cent) were already low in the previous deliveries. Delivery in private facilities declined from 45 per cent in previous delivery, to 31 per cent in current delivery in non-tribal areas, whereas in tribal areas the decline was marginal from 22 per cent of previous delivery to 19 per cent of current delivery. In urban slums the decline was from 35 per cent in previous delivery, to 31 per cent in current delivery. Thus, to a large extent an increase in delivery in government health facilities and awareness about JSSK scheme has led to a decline of home delivery in tribal areas as well as decline of private deliveries in non-tribal areas and urban slums.

In JSSK survey, respondents were asked about the children ever born alive and the number of children surviving. There was hardly any difference in percentage between the two.

Age at first delivery was mainly concentrated in the age group of 17-22 years for nearly 80 per cent of births. Substantial number of births took place in the age group of 17-19 years with 46 per cent in tribal areas compared with nearly 36-37 per cent in non-tribal areas and urban slums. Overall, marriage below the legal minimum age, is taking place and consequently is a proximate determinant of low age of mothers at first delivery.

Table 3.4 Marriage and reproduction
Percentage of respondents by marriage and reproduction according to residence, 2014

Background characteristics	Tribal	Non-Tribal	Tribal+Non-tribal	Urban slums	Total
Age at Marriage					
Less than 15 years	1.3	2.0	1.7	1.5	1.6
15-17 years	34.2	22.4	28.4	24.3	27.2
18-19 years	48.3	47.6	47.9	41.5	46.2
20-21 years	10.6	19.1	15.1	18.9	16.0
22 & above years	5.5	8.9	7.0	13.8	9.0
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	818	839	1657	609	2266
Mean age at marriage	18.02	18.63	18.33	18.87	18.48
First Delivery					
Yes	39.1	41.8	40.5	41.5	40.8
No	60.9	58.2	59.5	58.5	59.2
No. of respondents	818	839	1657	609	2266
Place of previous delivery, if not a first delivery					
Home	24.3	9.9	17.1	10.1	15.3
Government facility	52.8	43.0	48.0	51.7	49.0
Private facility	22.7	45.4	34.0	36.2	34.5
NGO/trust hospital	0.2	1.6	0.9	2.0	1.2
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	498	488	986	356	1342
Place of current delivery , if not the first delivery					
Home	14.3	8.4	11.4	11.0	11.3
Government facility	66.5	58.2	62.4	54.5	60.3
Private facility	19.1	31.8	25.4	31.5	27.0
NGO/trust hosp.	0.2	1.6	0.9	3.1	1.5
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	498	488	986	356	1342
Children ever born (TOTAL)					
1	38.8	42.0	40.4	41.7	40.7
2	38.1	40.6	39.4	37.4	38.9
3	14.8	13.5	14.1	15.8	14.6
4+	8.3	3.9	6.1	5.1	5.8
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	818	839	1657	609	2266
Children surviving (TOTAL)					
0	0.4	0.6	0.5	0.7	0.5
1	40.2	42.8	41.5	42.4	41.8
2	38.4	40.8	39.6	37.3	39.0
3	13.6	12.2	12.9	14.9	13.4
4+	7.4	3.6	5.5	4.7	5.3
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	818	839	1657	609	2266
Age at first delivery					
14-16	2.8	2.1	2.5	3.0	2.6
17-19	46.1	37.1	41.5	36.0	40.0
20-22	40.1	44.7	42.4	39.1	41.5
23-25	8.2	13.5	10.9	15.3	12.0
26-28	1.8	2.1	2.0	5.3	2.9
29+	1.0	0.5	0.7	1.5	0.9
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	818	839	1657	609	2266

Figure 3.3 Percentage of respondents (N= 1342) by place of previous and current delivery of mother's with not a first delivery

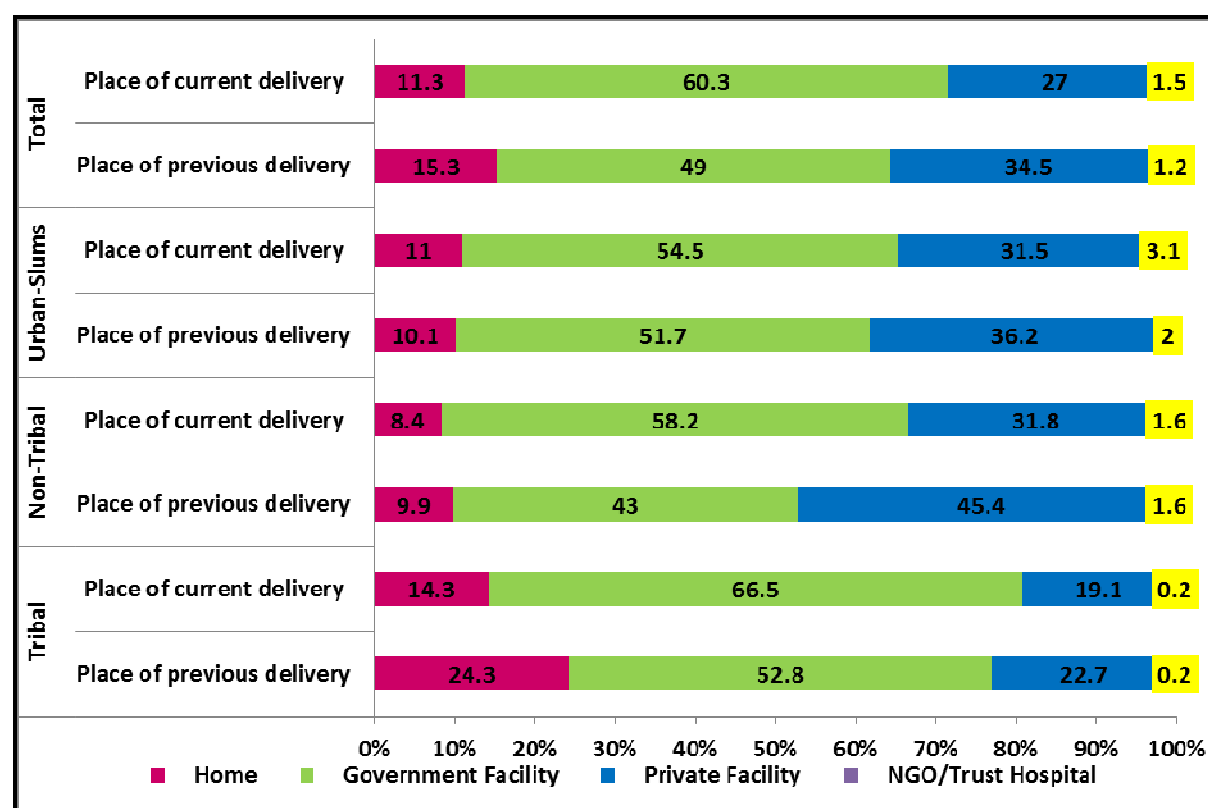


Table 3.5 shows the percentage distribution of respondents by their background characteristics. A look at the mean number of children ever born by age of the women reveals that older women had experienced more average live births than younger women had.

By current age of women, more than 60 per cent of births by women in the age group of 30-34 years and 35-39 years are of the birth order 3, 4, and higher. For women of age group 15-19 years, 86 per cent births are of first order and notably 12 per cent of births are of second order. Strikingly, few respondents (2 per cent) were in the age group of 20-24 years with birth order 4 and above.

Rural-urban difference by birth order was negligible upto birth order 3. From birth orders 4 and above it was 8 per cent in tribal areas, 5 per cent in urban slums, and 4 per cent in non-tribal areas. This indicates, that higher order births are more concentrated in tribal areas, which is evident by mean number of children ever born in tribal areas.

Children ever born vary from 1.7 mean numbers of children ever born in Amravati district to 1.8 in Pune district and 1.9 in Nashik and Nanded districts each. Birth order 4 or more is 4 per cent in Amravati district compared with 8 per cent in Nanded district and 5 per cent each in Nashik and Pune districts each.

The mean number of children ever born to women who are Hindu, Muslim, Christian, Sikh, and Buddhist are 1.8, 2.0, 2.0, 1.5, and 1.8 respectively. The corresponding mean number of surviving children is 1.8, 1.9, 2.0, 1.5, and 1.8 respectively for these religious groups. Looking at the religious differential in birth order distribution it is observed that 10 per cent of births by Muslim women are of birth orders 3 and above. For Hindu and Buddhist women, birth orders 4 and above constitute 5 per cent and 6 per cent respectively.

The average children ever born also vary by caste/tribe of the respondents. For women belonging to scheduled castes, the mean number of children ever born is 1.8, for the scheduled tribes 1.9, for Notified Tribes 2.0, Other Backward Classes 1.6, and open castes 1.8. The corresponding mean number of children surviving was the same except in SCs (1.7) and NTs (1.9). The occurrence of births of order 4 and above are more among NTs (8 per cent) than among STs (7 per cent), other castes women (6 per cent each), SCs (4 per cent) and OBCs (2 per cent).

In Maharashtra, the JSSK shows inverse association between mean children ever born and SLI. Further, the mean children ever born for women classified into low, medium, and high standard of living by SLI are 2.0, 1.7, and 1.5 respectively. Incidence of births of orders 4 and above for women classified by household SLI are 0.9 per cent for high, 3 per cent medium and 9 per cent low living standard households women.

Overall, birth orders of four and above are concentrated in tribal areas, specifically in NTs. Muslim women also showed birth orders of four and above. Birth orders of four and above and mean children ever born are concentrated in Nanded district and with households of low SLI.

Table 3.5 Children ever born and living
Percentage distribution of respondents by number of children ever born (CEB), and mean number of children ever born and living, according to background characteristics, Maharashtra, 2013-14

Background characteristics	Number of children ever born				Mean number of children ever born	Mean number of children living	Number of women
	1	2	3	4+			
Mother's current age							
15-19 years	86.5	12.2	1.3	0.0	1.1	1.1	237
20-24 years	46.6	42.1	9.2	2.2	1.6	1.6	1305
25-29 years	16.8	43.6	28.0	11.7	2.3	2.3	601
30-34 years	8.6	32.4	31.4	28.5	3.0	2.9	105
35-39 years	0.0	33.3	33.3	33.4	3.4	3.4	15
40+ years	0.0	66.7	33.3	0.0	2.3	2.3	3
Residence							
Tribal	38.8	38.1	14.8	8.1	1.9	1.9	818
Non-tribal	42.0	40.6	13.5	3.9	1.8	1.7	839
Tribal+non-tribal	40.4	39.4	14.1	6.2	1.9	1.8	1657
Urban slums	41.7	37.4	15.8	5.1	1.8	1.8	609

Districts							
Pune	41.4	39.6	13.9	5.0	1.8	1.8	555
Nashik	36.6	40.7	17.2	5.5	1.9	1.8	565
Amravati	44.9	39.5	11.0	4.7	1.7	1.7	564
Nanded	40.0	35.7	16.2	8.2	1.9	1.9	582
Religion							
Hindu	40.8	39.5	14.2	5.7	1.8	1.8	1936
Muslim	40.4	29.2	20.5	10.0	2.0	1.9	161
Christian	25.0	50.0	25.0	0.0	2.0	2.0	4
Sikh	50.0	50.0	0.0	0.0	1.5	1.5	2
Buddhist/Neo-Buddhist	40.5	40.5	12.9	6.1	1.8	1.8	163
Caste/tribe							
SC	43.0	38.9	13.6	4.5	1.8	1.7	514
ST	35.4	41.0	16.3	7.2	1.9	1.9	673
NT	33.7	43.2	14.7	8.5	2.0	1.9	285
OBC	51.4	34.2	12.3	2.1	1.6	1.6	333
Open	42.7	36.4	14.5	6.4	1.8	1.8	461
SLI							
Low	33.5	39.1	17.9	9.5	2.1	2.0	865
Medium	44.5	38.8	12.9	3.8	1.8	1.7	1284
High	53.0	38.5	7.7	0.9	1.6	1.5	117
No. of respondents	923	881	330	132	1.9	1.8	2266

SUMMARY

Background characteristics of the respondents reflect differentials in educational levels by place of residence with lower levels of education in tribal areas than in non-tribal areas and urban slums. However, the most revealing was the availability of BPL cards, which was much lower in tribal areas (39 per cent) considering the fact that most of the tribal households belong to low SLI.

The main source of drinking water to nearly two-thirds of the households in urban slums and non-tribal areas is public tap/public hand pump/public well, whereas the same proportion in tribal areas relies on water piped into residence/hand pump in yard/well in residence.

Toilet facility is still lacking in rural areas with 61 per cent of the household having no toilet facility and within rural areas 72 per cent of the households in tribal areas and 50 per cent in non tribal areas are not having toilet facility. In Nanded district 68 per cent of the households have no toilet facility. In tribal areas 53 per cent of the household lives in kuccha houses as compared to 28

percent of household in non tribal areas and 21 per cent of households in urban slums. Rural-urban difference in the usage of liquid petroleum gas or electricity for cooking is substantial with 69 per cent households in urban slums compared with 90 per cent households in tribal areas and 74 per cent households in non-tribal relying on wood for cooking.

Substantial number of women (28 per cent) was below the legal age of marriage and consequently age at first delivery was low. Heaping of respondents in the age group of 18-19 years reflects the awareness of minimum legal age of marriage among respondents.

Increase of delivery in government health facilities in current delivery (60 per cent) as compared to previous delivery (49 per cent). Increase of delivery in government facilities has led to a decline of home delivery in tribal areas (previous delivery 24 per cent; current delivery 14 per cent) as well as decline of private deliveries in non-tribal areas (previous delivery 45 per cent; current delivery 31 per cent) and urban slums (previous delivery 36 per cent; current delivery 31 per cent). Overall, birth orders of four and above are concentrated in tribal areas, specifically among NTs. Muslim women also showed birth orders of four and above. Birth orders of four and above and mean children ever born are concentrated in Nanded district and with household of low SLI.

CHAPTER IV

AWARENESS ABOUT JSSK ENTITLEMENTS

Awareness about the scheme among the target beneficiaries is one of the keys towards the success of any programme. This chapter brings out the findings on awareness and utilisation of the services among the target beneficiaries. The respondents were enquired about the JSSK scheme spontaneously and also probing was done.

4.1 SOURCE OF INFORMATION AND AWARENESS ABOUT JSSK SERVICES

The awareness levels among women who had recently given birth during the reference period were asked about the JSSK scheme and its various components. Their knowledge is presented in Table 4.1. The age of women who heard about JSSK was found to be high in rural areas (52 per cent) than in urban slums (32 per cent). Within rural areas the age of women who heard about JSSK was slightly more in tribal areas (54 per cent) than in non-tribal areas (49 per cent), thereby implying that among respondents 50 per cent of women in non-tribal areas and 70 per cent of women in urban slums never heard about JSSK.

Women, who heard about JSSK were further asked about their source of information about JSSK. There may be more than one source of information. Hence, women were probed about the likely source of information through which they heard about JSSK. The main sources of information about JSSK were ANMs (91 per cent), followed by ASHA (81 per cent), and doctors (49 per cent). ANM (96 per cent), ASHA (81 per cent), and doctors (38 per cent) are the main sources of information in tribal and non-tribal areas. But ANMs (85 per cent) and doctors (61 per cent) are the main sources of information about JSSK in urban slums. A good number of respondents in urban slums also came to know about JSSK from newspaper/pamphlets/posters (15 per cent), relatives (14 per cent) and Radio/TV programmes (13 per cent).

JSSK scheme covers both mothers and neonates. Mothers were further probed about their level of awareness of JSSK scheme to both mothers and neonates. When asked about the details of the scheme, about 62 per cent of women knew about the JSSK scheme provided to mothers compared with only 20 per cent of women who were aware that the JSSK scheme covers sick neonates. However, rural-urban difference was striking in the awareness of the JSSK scheme to mothers with 70 per cent of women in tribal and non-tribal areas each aware of the scheme as compared with only 41 per cent of women in urban slums.

JSSK scheme is composite of essential health components leading to safe and timely delivery and neonatal care such as free pick up transport, diagnostics, drugs and consumables, referral transport (if required), diet, blood (if required) and drop back transport as well as exemption from all user charges. It may happen that a woman may not be aware of each and every component under JSSK or she may be under the impression that certain components such as drugs, diagnostics and diet are available free of cost in government health facilities only. Hence, women were probed

about each of the component under JSSK to find their level of awareness and identify the lacunae in their information component-wise.

Nearly 70 to 75 per cent of women in tribal and non-tribal areas knew about free transport, diet, diagnostics, drugs and consumables, exemption from all user charges and free drop back facilities. However, only a little more than 50 to 60 per cent of women were aware of free blood transfusion and free referral transport in tribal and non-tribal areas. In contrast, among the 32 per cent of women in urban slums who were aware of JSSK, only a little more than 50 per cent of women were aware of free drugs and consumables as well as free diagnostics. Near about 40 per cent of women in urban slums were aware of free diet, pick up and drop back transport facilities as well as exemption from user charges. This variation in awareness reflects that women in urban slums might believe that entitlements such as free drugs and consumables, and diagnostics are available free of cost in government health facilities and not specifically under JSSK scheme. Further, only 29 per cent of women in urban slums were aware of free blood if required and 35 per cent of women were aware of free referral transport.

The awareness levels among the mothers on other important components of JSSK, viz., awareness of free pickup and drop back transport, diagnostics, drugs and consumables, blood and referral transport if required to sick neonates under this scheme were also probed.

A little more than a quarter of the women knew that JSSK scheme covers neonates in tribal and non-tribal areas as compared with a negligible number of women (6 per cent) in urban slums with a little variation in terms of awareness of each component under JSSK for neonates.

The response from mothers on the receipt of toll free number during pregnancy shows that nearly 69 per cent of women in tribal areas and 62 per cent of women in non-tribal areas compared with only 27 per cent of women in urban slums received the phone and toll free numbers during pregnancy. Only 2 per cent of women reported awareness of the toll free number. Among those who were aware of toll free number, nearly 94 per cent of women reported the correct toll free number.

Table 4.1 Awareness about JSSK
Percentage of respondents by awareness about JSSK according to residence, 2014

	Tribal	Non-tribal	Tribal+non-tribal	Urban slums	Total
Heard about JSSK					
Yes	49.8	54.8	52.3	32.2	46.9
No	50.2	45.2	47.7	67.8	53.1
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	818	839	1657	609	2266
Source of information about JSSK					
ANM	95.6	96.7	96.2	85.7	90.9
ASHA	80.3	81.3	80.9	0.0	80.9
Doctor	42.0	34.8	38.2	61.2	49.7
Relative	5.4	6.3	5.5	14.3	9.9
Friend	0.2	0.4	0.3	7.1	3.7
Newspaper/posters/pamphlets	0.7	1.5	1.2	15.3	8.2
JSY Card	0.7	0.4	0.6	1.5	1.0
Radio/TV programmes	3.2	6.3	4.8	13.8	9.3
Health Camp/Anganwadi sevika etc.	2.7	2.8	2.8	2.0	2.4
No. of respondents	407	460	867	196	1063
Awareness of services provided during pregnancy & delivery					
Free transport (home to health facility)	76.7	72.0	74.3	41.2	65.4
Free essential diagnostics for pregnant woman	79.3	76.8	78.0	52.4	71.1
Free drugs & consumables for pregnant woman	78.4	77.1	77.7	50.9	70.5
Free provision of blood for pregnant woman	53.1	54.6	53.8	28.9	47.1
Free diet during stay in the facility after delivery	74.4	71.3	72.8	43.3	64.9
Free transport between facilities in case of referral	63.2	60.1	61.1	35.5	54.6
Free drop back from facility to home after 48 hours' stay	75.1	71.3	73.1	40.9	64.5
Exemption from user charges	71.5	68.1	69.8	41.4	62.1
No. of respondents	818	839	1657	609	2266
Aware about free services provided for sick neonate/infant)					
Free Transport (Home to Facility) for sick neonate	26.8	27.2	27.0	6.2	21.4
Free Diagnostics for sick neonate	27.0	26.7	26.9	6.4	21.4
Free Drugs & Consumables for sick neonate	27.0	26.6	26.8	6.2	21.3
Free provision of blood for sick neonate	23.2	24.2	23.7	6.1	19
Free Transport between facilities (referral)	24.2	24.3	24.3	5.7	19.3
Free drop back from Facility to Home for sick neonate	25.3	25.5	25.4	5.9	20.2
Exemption from all kinds of user charges for sick neonate	25.6	25.4	25.5	6.4	20.3
No. of respondents	818	839	1657	609	2266
Received phone and toll free number during pregnancy					
ANM/ASHA's phone number	69.9	62.7	66.3	27.6	55.9
Aware of toll free number	3.9	2.1	3.0	0.8	2.4
No. of respondents	818	839	1657	609	2266
Toll free numbers as given by respondents					
102	96.9	88.9	94.0	100	94.5
108	0.0	11.1	4.0	0.0	3.6
18002334600	3.1	0.0	2.0	0.0	1.8
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	32	18	50	05	55

Differentials in awareness may be attributed to differential background characteristics. This differential may be crucial on extending and strengthening the awareness about JSSK schemes on a large scale through effective information, education and communication programme.

Table 4.2 presents the distribution of women who have heard about JSSK by background characteristics. Nearly, 60 to 66 per cent of women's in the older age groups of 40 years and above and 35 to 39 years of age have heard about JSSK. Further, 50 per cent of women in the age group of 25 to 29 years and 30 to 34 years of age have heard about JSSK schemes. Only, 40 to 46 per cent of women in the age groups of 15 to 19 years and 20 to 24 years of age have heard about JSSK. It needs to be noted that the sample consist of large percent of women in the age group of 20 to 29 years compared with women in the age group of 35 years and above who had given birth during the reference period.

As seen in Table 4.1, nearly half of the women from rural areas have heard about the JSSK scheme as compared with only 32 per cent of women in urban slums.

District-wise comparison of women who have heard about JSSK shows that 55 per cent of women in Pune district, followed by 51 per cent of women in Amravati district, 41 per cent of women in Nashik district and 39 per cent of women in Nanded district have heard about JSSK.

Number of women who have heard about JSSK varies directly with their level of education except for women with no education. The number of women who have heard about JSSK without education is 41 per cent compared to 34 per cent of women with one to four years of completed level of education. This implies not much difference in the level of awareness about JSSK scheme between women with educational level of one to four years and without education. The number of women who heard about JSSK scheme ranges from 43 to 48 per cent with five-seven and eight-ten years of education to 57 per cent of women with 11-12 years and 12 and above years of completed level of education. Hence, as the level of education increases in awareness about JSSK services also improved.

About 50 per cent of women belonging to Hindu religion were aware of the scheme as compared with 34 per cent of Muslim women and 28 per cent of Buddhist women. This is mainly because Muslim and Buddhist women were mainly residing in urban slums where only 32 per cent of women heard about the scheme as compared with 52 per cent of women in rural areas.

Caste-wise only 38 per cent of SC women respondents heard about JSSK compared with 54 per cent of NT women, 47 per cent of OBC and Open caste women each and 49 per cent of ST women respondents. This again can be attributed to the fact that SC women mainly resided in urban slums where the awareness level is already low.

Awareness by standard of living shows nearly 43 per cent of women from low SLI, 48 per cent of women from high SLI and 49 per cent of women from medium SLI have heard about JSSK. However, only 43 per cent of women having BPL cards heard about JSSK as compared with 50 per cent of women without BPL cards. Overall women in younger age group with lower level of education and residing in urban slums did not heard about JSSK.

Table 4.2 Heard about JSSK by background characteristics, 2014
Percentage of respondents by awareness about JSSK by background characteristics, 2014

Background characteristics	<u>Heard about JSSK</u>		Total
	Yes	No	
Age (years)			
15-19	39.7	60.3	237
20-24	46.2	53.8	1305
25-29	50.1	49.9	601
30-34	51.4	48.6	105
35-39	60.0	40.0	15
40+	66.7	33.3	3
Total			
Place of residence			
Tribal	49.8	50.2	818
Non-tribal	54.8	45.2	839
Urban slums	32.2	67.8	609
Total			
District			
Amravati	51.2	48.8	564
Nanded	39.9	60.1	582
Nashik	41.1	58.9	565
Pune	55.9	44.1	555
Education			
No education	41.0	59.0	268
1-4 years completed	34.3	65.7	213
5-7 years completed	43.1	56.9	485
8-10 years completed	48.7	51.3	821
11-12 years completed	56.2	43.8	349
12+ years completed	57.7	42.3	130
Total			
Religion			
Hindu	49.5	50.5	1936
Muslim	34.2	65.8	161
Christian	25.0	75.0	4
Sikh	50.0	50.0	2
Buddhist/Neo-Buddhist	28.8	71.2	163
Total			
Caste			
SC	38.1	61.9	514
ST	49.6	50.4	673
NT	54.4	45.6	285
OBC	47.1	52.9	333
Open	47.9	52.1	461
Total			
SLI			
Low	43.0	57.0	865
Medium	49.4	50.6	1284
High	48.7	51.3	117
Total			
BPL			
Yes	43.6	56.4	1182
No	50.6	49.4	1084
Total			
No. of respondents	1063	1203	2266

Table 4.3 presents the percentage of women who have heard about JSSK by background characteristics and by place of residence. Both in rural areas and urban slums 56 per cent of women who have heard about JSSK are from the age group 20-24 years, followed by 28 per cent of women in the age group of 25-29 years.

District-wise nearly 30 per cent of women residing in rural areas in Pune district have heard about JSSK, with slightly lesser women (21 to 25 per cent of) women in the other three districts heard about JSSK. In urban slums about 35 per cent of women in Amravati district have heard about it compared with 21 per cent of women in the remaining districts.

Women who have heard about JSSK by educational status shows women with educational level of 5-7 years to 11-12 years of education have heard about JSSK is nearly 80 per cent of women from non-tribal areas and urban slums as compared with 69 per cent of women from tribal areas.

Religion-wise, 93 per cent of Hindu women in rural areas (97 per cent from tribal areas and 87 per cent from non-tribal areas) have heard about JSSK. In urban slums 13 per cent of women who have heard about JSSK are neo-Buddhist.

In tribal areas 60 per cent of ST women, near about a quarter of women belonging to open and OBC castes in non-tribal areas, and 45 SC women residing in urban slums have heard about JSSK schemes.

Majority of women who have heard about JSSK belongs to medium standard of living in non-tribal areas (68 per cent) and urban slums (76 per cent), compared with 57 per cent of women belonging to low SLI in tribal areas. However, only 52 per cent of women in urban slums and 57 per cent of women in non-tribal areas with BPL cards have heard about JSSK. In contrast, 63 per cent of women residing in tribal areas and without BPL cards have heard about it. This is due to the fact that 60 per cent of women in tribal areas do not have BPL cards.

Table 4.3 Heard about JSSK
Percentage of respondents heard about JSSK by background characteristics according to residence, 2014

Background characteristics	Tribal	Non-tribal	Tribal+non-tribal	Urban slums	Total
Age (years)					
15-19	8.4	10.7	9.6	5.6	8.8
20-24	55.8	57.6	56.7	56.6	56.7
25-29	30.0	26.7	28.3	28.6	28.3
30-34	4.7	4.3	4.5	7.7	5.1
35+	1.2	0.7	0.9	1.5	1.0
Total	100.0	100.0	100.0	100.0	100.0
Districts					
Amravati	25.8	25.0	25.4	35.2	27.6
Nanded	23.3	21.1	22.1	20.4	21.8
Nashik	22.1	21.3	21.7	22.4	21.8
Pune	28.7	32.6	30.8	21.9	29.2
Total	100.0	100.0	100.0	100.0	100.0
Education					
No education	16.5	7.0	11.4	5.6	10.3
1-4 years completed	10.3	5.0	7.5	4.1	6.9
5-7 years completed	22.4	17.4	19.7	19.4	19.7
8-10 years completed	31.7	43.0	37.7	37.2	37.6
11-12 years completed	15.7	18.7	17.3	23.5	18.4
12+ years completed	3.4	8.9	6.3	10.2	7.1
Total	100.0	100.0	100.0	100.0	100.0
Religion					
Hindu	97.3	89.1	93.0	78.1	90.2
Muslim	2.0	6.5	4.4	8.7	5.2
Christian	0.2	0.0	0.1	0.0	0.1
Sikh	0.0	0.2	0.1	0.0	0.1
Buddhist/Neo-Buddhist	0.5	4.1	2.4	13.3	4.4
Total	100.0	100.0	100.0	100.0	100.0
Caste					
SC	6.1	17.8	12.3	45.4	18.4
ST	59.5	15.4	36.1	10.7	31.4
NT	16.5	16.1	16.3	7.1	14.6
OBC	6.1	23.5	15.3	12.2	14.8
OPEN	11.8	27.2	20.0	24.5	20.8
Total	100.0	100.0	100.0	100.0	100.0
SLI					
Low	57.0	21.5	38.2	20.9	35.0
Medium	41.3	68.7	55.8	76.5	59.6
High	1.7	9.8	6.0	2.6	5.4
Total	100.0	100.0	100.0	100.0	100.0
BPL					
Yes	36.6	57.4	47.6	52.0	48.4
No	63.4	42.6	52.4	48.0	51.6
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	407	460	867	196	1063

The awareness level among women about the JSSK scheme and its various components and the sources of knowledge about them by districts are presented in Table 4.4. Women who have heard about JSSK by district shows 51 per cent of women in Amravati district, 55 per cent of women in Pune district, 41 per cent of women in Nashik district and only 39 per cent of women in Nanded district have heard about JSSK.

The main sources of information through which the women heard about JSSK were ANM (90 per cent), ASHA (71 per cent) and doctors (38 per cent). Nearly 94 per cent of women in Amravati and Nanded districts and 85 per cent of women in Pune and Nashik districts heard about JSSK from ANMs. About 80 per cent of women in Amravati and Nanded districts and 60 per cent of women in Pune and Nashik districts heard about JSSK from ASHAs. Doctors were also a source of information as 59 per cent of women in Nanded district and nearly 30-34 per cent of women in other districts heard about JSSK from Doctors.

JSSK scheme covers both mothers and neonates, and the awareness level for both mothers and neonates were asked to women. When asked about the details of the JSSK scheme, a majority of the women (60 per cent) knew about the JSSK scheme for mothers and less than a quarter of women were aware of JSSK scheme for sick neonates.

About 65 per cent of women in all the districts knew about free home to facility transport, diet, and drop back facilities except in Nanded district where only 54, 55 and 57 per cent of the women knew about the respective facilities under JSSK scheme. However, availability of free blood transfusion was known to only 47 per cent of women with the lowest number in Nanded district (39 per cent) while in the rest of the districts nearly 50 per cent of women were aware of free provision of blood if required. Further, availability of free referral transport was known to 54 per cent of women with 62 per cent of women from Amravati district, 53 and 55 per cent of women respectively in Pune and Nashik districts, and lowest of 46 per cent of women in Nanded district.

Information regarding awareness levels among the mothers on JSSK services provided to sick neonates was also obtained. Less than quarter of the mothers (20 per cent) knew about the JSSK services for neonates, but this knowledge was mainly confined in Pune district (25 per cent), followed by Amravati (20 per cent), Nashik (19 per cent) and Nanded (12 per cent). Around 55 per cent mothers received phone and toll free numbers, i.e., Pune (60 per cent), Amravati (64 per cent), Nanded (51 per cent) and Nashik (47 per cent).

District-wise not much difference was observed about awareness of JSSK except in Nanded district where the level of awareness in general was the lowest.

Table 4.4 Awareness about JSSK by Districts
Percentage of respondents by awareness and experience regarding JSSK according to districts,
2014

Background characteristics	Amravati	Nanded	Nashik	Pune	Total
Heard about JSSK					
Yes	51.2	39.9	41.1	55.9	46.9
No	48.8	60.1	58.9	44.1	53.1
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	289	232	232	310	1063
Source of Information about JSSK					
ANM	94.5	94.0	84.9	87.7	90.3
ASHA	82.0	78.4	65.1	61.0	71.4
Doctor	34.9	59.1	34.5	29.0	38.4
TV programme	4.5	2.6	7.8	9.0	6.1
Aganwadi sevika, etc.	2.4	1.3	3.0	2.9	2.4
Posters	4.5	1.3	1.7	1.3	2.3
Relative	0.7	1.3	3.0	2.9	2.0
Friend	2.8	0.4	1.7	0.3	1.3
Newspaper	0.7	0.0	3.0	0.3	0.9
Others	1.0	0.4	0.8	2.5	1.4
No. of respondents	289	232	232	310	1063
Aware about the following free services provided during pregnancy and delivery					
Transport (home to health facility)	67.4	54.8	63.9	76.0	65.4
Essential diagnostics for pregnant woman	74.5	66.5	67.6	76.2	71.1
Drugs & consumables for pregnant woman	74.1	64.3	67.8	76.2	70.5
Provision of blood for pregnant woman	49.6	39.5	48.1	51.5	47.1
Diet during stay in the facility after delivery	69.1	55.8	64.4	70.6	64.9
Transport between facilities in case of referral	62.8	46.7	55.6	53.5	54.6
Drop back from facility to home after 48 hrs stay	69.5	57.7	63.5	67.4	64.5
Exemption from user charges	66.3	54.6	61.4	66.5	62.1
No. of respondents	564	582	565	555	2266
Aware about free services provided for sick neonate/infant)					
Transport (Home to Facility) for sick neonate	21.1	12.5	19.8	32.6	21.4
Diagnostics for sick neonate	20.9	12.2	20.2	32.6	21.4
Drugs & Consumables for sick neonate	20.9	12.0	20.0	32.6	21.3
Provision of blood for sick neonate	20.4	11.9	17.3	26.7	19.0
Drop back from facility to home for sick neonate	20.2	11.9	18.9	30.1	20.2
No. of respondents	564	582	565	555	2266
Received information during pregnancy					
ANM/ASHA's phone number	64.7	51.4	47.4	60.2	55.9
Aware of toll free number	3.0	2.7	0.9	3.1	2.4
No. of respondents	564	582	565	555	2266
Toll free number as given by respondents who are aware of the toll free number					
102	100.0	87.5	100.0	94.1	94.5
108	0.0	12.5	0.0	0.0	3.6
18002334600	0.0	0.0	0.0	5.9	1.8
No. of respondents	17	16	05	17	55
Note: Others include JSY cards, pamphlets, radio and health camps					

Table 4.5 presents the age of women by background characteristics who have heard about JSSK and by districts. More than fifty per cent of women who have heard about it are in the age group of 20-24 years with not much difference between districts, followed by 28 per cent of women in the age group 25-29 years with 34 per cent of women in Amravati district and the other three district in the range of 24 to 27 per cent of women.

District-wise rural-urban difference was striking with 85 per cent of women in rural areas heard about JSSK compared with only 18 per cent of women in urban slums. The gap between rural and urban areas in Pune district was striking with only 13 per cent of women in urban slums heard about JSSK compared to 48 per cent of women in non-tribal areas, and 37 per cent of women in tribal areas.

In all the districts, the highest numbers of women who have heard about JSSK were with the educational level of 8-10 years of completed education except in Nanded district where the highest number of women (30 per cent) was with 5-7 years of completed education. Hindus in rural areas (93 per cent) with 97 per cent of women from tribal areas and 87 per cent of women from non-tribal areas have heard about JSSK.

The majority of the beneficiaries who have heard about JSSK by districts belongs to high standard of living and concentrated mainly in Pune district (62 per cent), followed by Nashik (59 per cent), Amravati (51 per cent) and Nanded(45 per cent).

Table 4.5 Heard about JSSK
Percentage heard about JSSK by background characteristics according to districts, 2014

Background characteristics	Amravati	Nanded	Nashik	Pune
Age code (years)				
15-19	4.8	8.2	7.3	14.2
20-24	54.0	59.9	57.3	56.5
25-29	34.9	26.7	27.2	24.2
30-34	4.5	4.3	6.9	4.8
35-39	1.4	0.9	0.9	0.3
40+	4.3	0.0	0.4	0.0
Total	100.0	100.0	100.0	100.0
Place of residence				
Tribal	36.3	40.9	38.8	37.7
Non-tribal	39.8	41.8	42.2	48.4
Urban slums	23.9	17.2	19.0	13.9
Total	100.0	100.0	100.0	100.0
Education				
Education	11.8	18.1	10.8	2.9
1-4 years completed	4.2	12.9	7.8	4.2
5-7 years completed	11.8	30.6	19.0	19.4
8-10 years completed	34.6	23.3	40.5	49.0
11-12 years completed	27.3	9.9	16.8	17.7
12+ years completed	10.4	5.2	5.2	6.8
Total	100.0	100.0	100.0	100.0

Religion				
Hindu	82.4	86.2	95.7	96.5
Muslim	9.3	8.2	2.6	1.0
Christian	0.0	0.4	0.0	0.0
Sikh	0.0	0.0	0.0	0.3
Buddhist/Neo-Buddhist	8.3	5.2	1.7	2.3
Total	100.0	100.0	100.0	100.0
Caste				
SC	21.5	15.5	19.8	16.8
ST	33.2	25.9	33.6	32.3
NT	8.0	29.7	7.8	14.5
OBC	24.6	12.9	6.9	12.9
Open	12.8	15.9	31.9	23.5
Total	100.0	100.0	100.0	100.0
SLI				
Low	24.2	26.7	16.4	14.5
Medium	24.6	28.0	24.6	23.9
High	51.2	45.3	59.1	67.1
Total	100.0	100.0	100.0	100.0
Total	51.2	39.9	41.1	55.9
Number	289	232	232	310

SUMMARY

Differential level in terms of awareness about JSSK was observed for women in rural areas (52 per cent) and urban slums (32 per cent). A majority of women in rural areas were aware about JSSK as compared with women in urban slums. Inter-district comparison shows that a higher proportion of women from Pune (55 per cent) were aware about JSSK than women in Nanded district (39 per cent).

Majority of the women (75 per cent) reported awareness about JSSK entitlements to mothers and only a quarter of women respondents were aware about them to neonates. Within entitlements very few women were aware of the availability of free blood (47 per cent) and referral transport if required (54 per cent) as compared with other entitlements. Women in urban slums were aware of free drugs, diagnostics and diet as compared with other entitlements. This may be attributed to the fact that women may have perceived availability of free drugs and diagnostics in government health facilities.

The main source of information about JSSK in rural areas were ANM and ASHA, whereas in urban slums were ANM and doctors. Very few women (2 per cent) were aware of toll free number, but most of them were aware of ANM/ASHA number.

Women belonging to medium and higher SLI were more aware about JSSK compared with women with lower SLI. Overall awareness about JSSK with each and every entitlement needs to be further strengthened for mothers and specifically for neonates in particular for women in urban slums and in Nanded district.

CHAPTER V

ANTENATAL CARE, DELIVERY AND JSSK ENTITLEMENTS DURING ANTENATAL CARE AND DELIVERY

5.1 ANTENATAL CHECK-UPS

COMPONENTS OF ANTENATAL CHECK-UPS

Essential care during pregnancy is important for the health of the mother and for the development of the unborn baby. ANC care provides a woman with the essential care and information and the importance of using a skilled attendant at birth.

In India, the Maternal Health Programme includes a minimum of at least four ANC visits including early registration and first ANC in first trimester along with physical and abdominal examinations, Hb estimation, and urine investigation, two doses of T.T Immunization and consumption of IFA tablets for 100 days. Accordingly, the first antenatal check-up should take place at least during the first trimester of pregnancy. It includes the provision of at least three antenatal care visits, and various types of ANC care such as measurement of height-weight, blood test, BP test, abdominal examination, pelvic examination, information and guidance on nutrition, expected date of delivery and place of delivery. To assess whether the women had received all the care during pregnancy, information was collected from those women who had recently given birth during the reference period regarding the number of antenatal visits, timing of the first visit and types of ANC care received.

Women who underwent any kind of antenatal check-ups were further asked whether they received each of the several components of antenatal check-ups in all the three trimester during their pregnancy. If they had, the number of times and the month of pregnancy when they first received ANC checkup and the type of service the provider had given them during the check-ups were enquired into. They were also asked whether they have ANC and JSY cards for check-ups. If ANC and JSY cards are available, cards were checked and cross verified with the responses.

Table 5.1 presents the data for women who had given birth during the reference period, includes information regarding the antenatal check-ups they had undergone, number of months of pregnancy at the time of first ANC, number of times ANC services were received, and type of ANC services received according to the place of residence. All measurements and tests are a part of essential obstetric care or are required for monitoring high-risk pregnancies.

Results show that almost all the women received antenatal check-ups. Ninety seven per cent of the women received ANC cards, and 30 per cent of women are registered JSY beneficiaries. Among the women who are registered under JSY, 47 per cent of them reside in tribal areas, 25 per cent in non-tribal areas and only 13 per cent in urban slums. Considering that 63 per cent women in urban slums are below the poverty line, it needs to be examined why only 13 per cent women in urban slums are registered under JSY. Ninety-three per cent women registered under JSY beneficiaries received JSY beneficiary card from the ANMs/health worker.

During pregnancy, almost all the women received antenatal check-ups from public or private health facility. Sixty-seven per cent women received antenatal check-ups at public health facility, compared with 33 per cent women at a private health facility. More than half of the women from urban slums (56 per cent) visited public health facilities for antenatal check-ups that were much lower than women in rural areas (71 per cent) with tribal areas (82 per cent) and non-tribal areas (61 per cent). Generally it is found that government health facilities in urban slums are not as accessible, as in rural areas.

Almost 95 per cent of the women did check- up within first three months of the pregnancy, which is quite good. About, 67per cent of the women received at least 4-6 times antenatal check-ups and 25 per cent of the women received 7-9 times check-ups, which is more or less similar to the result from NFHS-3 with 75 per cent women receiving more than three ANC.

Further probing, was done on the types of antenatal care services received in all the three semesters. Overall, ANC service received was good and women received antenatal care services such as height-weight (98 per cent), blood test (96 per cent), BP checked (95 per cent) and abdominal examinations (92 per cent) as part of the antenatal check-up. Interestingly, 81 per cent women in urban slums received ante natal care such as pelvic vaginal examination compared with 75 per cent women in non-tribal areas and 70 per cent women in tribal areas in first trimester. Subsequently, the percentage of women who received pelvic vaginal examination increased in second and third trimesters with 87 and 91 per cent in urban slums compared with 78 and 86 per cent in tribal areas and to 82 and 91 per cent in non-tribal areas respectively. This result complements those of NFHS 3 wherein women received most of the services needed to monitor their pregnancy like having their weight taken (90 per cent), abdomen examined (88 per cent), blood pressure measured (87 per cent), and blood and urine samples taken (83-85 per cent).

The type of advice received by women who had antenatal check-ups during the reference period of the survey is also presented in Table 5.1. Advice on nutrition was reported by 87 per cent women in urban slums compared with 84 per cent women in tribal areas and 77 per cent women in non-tribal areas. Nearly 80 per cent women from non-tribal area and urban slums reported receiving advice and information on the place of delivery and expected date of delivery whereas the women receiving the same in tribal and non-tribal areas were 73 per cent each.

The proportion of women receiving the ANC care followed more or less the same pattern in second and third trimesters except that information and advice on expected date of delivery, place of delivery, nutrition and pelvic vaginal examination increased to more than 80 per cent in second trimester and to 90 per cent in third trimester.

Overall, percentage of women receiving various types of ANC services increased in third semester as compared to first and second semester.

Table 5.1 ANC Care during Pregnancy
Percentage of respondents by place of residence and antenatal care during pregnancy, 2014

Antenatal Care	Tribal	Non-tribal	Tribal +non-tribal	Urban slums	Total
Have ANC Card	96.6	97.9	97.2	97.0	97.2
Registered JSY beneficiary	47.9	25.5	36.6	13.8	30.5
Received JSY beneficiary card from ANM/Health Worker	92.6	93.9	93.1	94.0	93.2
Visited health facility for ANC	100.0	99.9	99.9	99.8	99.9
Type of facility visited for antenatal check-up					
Public facility	82.0	61.1	71.4	56.1	67.3
Private facility	18.0	38.9	28.6	44.0	32.7
Total	100.0	100.0	100.0	100.0	100.0
No. of months pregnant at the time of first ANC					
1-3 months	92.4	97.7	95.1	95.6	95.2
4-6 months	7.0	2.1	4.5	3.9	4.4
7-9 months	0.6	0.1	0.4	0.5	0.4
Total	100.0	100.0	100.0	100.0	100.0
No. of times receiving antenatal check-ups					
1-3 times	11.4	6.8	9.1	6.7	8.4
4-6 times	65.5	69.3	67.5	65.0	66.8
7-9 times	22.9	23.9	23.4	28.3	24.7
10+ times	0.2	0.0	0.1	0.0	0.1
Total	100.0	100.0	100.0	100.0	100.0
Received at least one antenatal care services during this pregnancy					
1st Trimester					
ANC- Height Weight-Trimester 1	97.6	99.3	98.5	99.3	97.6
ANC - BP-Trimester 1	94.0	95.6	94.9	97.5	95.6
ANC - Blood-Trimester 1	93.1	94.1	93.6	97.3	94.6
ANC - Abdominal check-up-Trimester 1	89.9	92.5	91.3	94.1	92.0
ANC - Expected date of delivery-Trimester 1	73.1	78.4	75.8	81.2	77.2
ANC - Place of delivery-Trimester 1	73.3	81.3	77.4	81.0	78.4
ANC - Nutrition-Trimester 1	77.9	84.5	81.3	87.1	82.8
ANC - Pelvic vaginal examination-Trimester 1	70.5	75.7	73.2	81.8	75.5
2nd Trimester					
ANC - Height Weight-Trimester 2	96.6	98.0	97.3	99.2	97.8
ANC - BP-Trimester 2	96.3	98.4	97.4	99.0	97.8
ANC - Blood-Trimester 2	95.8	97.4	96.6	97.7	96.9
ANC - Abdominal check-up-Trimester 2	94.7	95.6	95.1	97.3	95.7
ANC - Expected date of delivery-Trimester 2	84.2	85.6	84.9	88.4	85.9
ANC - Place of delivery-Trimester 2	86.6	85.9	90.5	90.5	87.0
ANC - Nutrition-Trimester 2	86.5	86.9	88.7	92.9	89.8
ANC - Pelvic vaginal examination-Trimester 2	78.0	82.9	80.4	87.2	82.2
3rd Trimester					
ANC- Height Weight-Trimester 3	98.3	98.8	98.5	99.2	98.7
ANC - BP-Trimester 3	97.8	99.6	98.7	99.5	98.9
ANC - Blood-Trimester 3	97.2	99.3	98.2	99.5	98.6
ANC - Abdominal check-up-Trimester 3	96.6	98.2	97.4	98.7	97.7
ANC - Expected date of delivery-Trimester 3	90.2	91.2	90.7	91.5	90.9
ANC - Place of delivery-Trimester 3	88.3	90.3	89.3	91.0	89.8
ANC - Nutrition-Trimester 3	91.1	94.1	92.6	93.7	92.9
ANC - Pelvic vaginal examination-Trimester 3	86.2	91.9	89.1	91.8	89.8
No. of respondents	818	839	1657	609	2266

5.2 PREGNANCY COMPLICATIONS AND TREATMENT

Complications during pregnancy may affect both women's health and the outcome of pregnancy adversely. Early detection of complications during pregnancy and their management are important components of the safe motherhood programme. In the survey, all the eligible women who had given birth during the reference period preceding the survey were asked if at any time during the pregnancy they had experienced pregnancy-related problems such as swelling of hands/body/face, excessive fatigue, BP, vaginal bleeding, convulsions and prolonged labour.

The information based on women's self reporting is presented in Table 5.2. About 60 per cent of the women were informed about the signs of pregnancy complication. The proportion of such women was relatively more among the women residing in non-tribal areas (65 per cent) than in tribal and urban slum areas (56 per cent each).

More than 90 per cent women were informed by ANM/health workers about pregnancy complications such as swelling of hands/body/face, excessive fatigue and BP. Women who were informed about pregnancy complication such as vaginal bleeding were found to be more in urban slums (92 per cent) compared with women from non-tribal (87 per cent) and tribal (83 per cent) areas. Similarly, women who reported receiving information about convulsion as a sign of pregnancy complication are more in urban slums (89 per cent) as compared with women in tribal and non-tribal areas (80 per cent each). Information on signs of pregnancy complication such as prolonged labour were reported more by women in urban slums (87 per cent) compared with women from non-tribal (79 per cent) and tribal (75 per cent) areas. In general information about pregnancy complications provided by ANM/health worker and awareness of women from urban slums is much higher than women in tribal and non-tribal areas. Almost 72 per cent women received advice about place of treatment in case of pregnancy complication. Women were further asked if they experienced any pregnancy complication during their pregnancy. Major problems reported by women as pregnancy complication during pregnancy were swelling of hands and feet and excessive fatigue (14 per cent each), convulsions (10 per cent) and vaginal bleeding (6 per cent). Pregnancy complication such as swelling of hands and feet were more common and reported by women from urban slums (17 per cent), whereas excessive fatigue (16 per cent) were more common among women from tribal areas. For the last live birth or stillbirth during the reference period preceding the survey, women were asked the number of tetanus toxoid injection received to prevent them and their baby from getting tetanus. About 83 per cent of the women received two tetanus toxoid injections which is appreciable.

Nutritional deficiencies in women are often exacerbated during pregnancy because of the additional nutrient requirements of fetal growth. Therefore, a pregnant woman needs more nutrition than a non-pregnant woman. About 79 per cent women received supplementary nutrition from anganwadi. However, relatively 87 per cent each of women from tribal and non-tribal areas received nutrition from Anganwadis compared with only 58 per cent of women from urban slums. Functioning of anganwadi seems to be less efficient in urban slums than in tribal and non-tribal areas.

Information on receiving iron folic acid tablets/syrup during pregnancy is also exhibited in this table. It shows the number of days women in selected districts consumed IFA supplements for birth during the reference period. Women who reported consuming IFA tablets for 61 to 180 days was 66 per cent. The proportion is appreciable and does not vary much between areas. The percentage of women who received advice on importance of regular check-up, birth preparedness, cleanliness at the time of delivery and keeping the baby warm was around 80 per cent. Seventy-eight per cent of the women received advice on breast-feeding and 68 per cent of them on family planning.

Table 5.2 Percentage of respondents by antenatal care and complications during pregnancy according to residence, 2014

Antenatal care and complications during pregnancy	Tribal	Non-tribal	Tribal + non-tribal	Urban slums	Total
Informed about the signs of pregnancy complications	56.1	65.0	60.6	56.7	59.5
ANM/Health worker told about the following signs of pregnancy complications					
Swelling of legs/body/face	99.3	99.6	99.5	99.4	99.5
Excessive fatigue	99.1	99.1	98.8	99.4	98.2
BP	91.9	96.3	94.0	95.9	94.7
Vaginal bleeding	83.4	87.5	85.4	92.2	87.3
Convulsions	81.2	80.2	80.3	89.5	82.9
Prolonged labour	79.0	75.8	76.9	87.2	79.8
Received advice about place of treatment in case of complication	72.7	74.9	73.8	70.6	72.9
No. of respondents	458	545	1003	345	1348
No. of TT injection received during this pregnancy					
0	0.2	0.1	0.2	0.2	0.2
1	9.8	10.1	10.0	6.6	9.0
2	81.4	82.5	82.0	85.6	82.9
3	8.6	7.3	7.9	7.7	7.9
Total	100.0	100.0	100.0	100.0	100.0
Consumed IFA tablets or syrup during this pregnancy	98.0	97.4	97.7	94.9	97.0
No. of days consumed IFA tablets or syrup					
0	2.0	2.6	2.3	5.1	3.0
1-60	8.7	9.4	9.0	7.1	8.6
61-180	67.6	65.2	66.3	65.2	66.1
181+	21.8	22.7	22.3	22.6	22.3
Total	100.0	100.0	100.0	100.0	100.0
Type of complications during this pregnancy					
Convulsion	13.1	9.8	11.4	8.7	10.7
Swelling of legs/body/face	14.3	13.9	14.1	16.9	14.9
Excessive fatigue	16.3	13.6	14.9	13.0	14.4
Vaginal bleeding	6.7	6.2	6.5	8.2	6.9
Received supplementary nutrition from the anganwadi	87.9	86.2	87.0	58.0	79.2
Received supplementary diet for the entire ANC period	100.0	100.0	100.0	100.0	100.0
Received advice about following, at least once, during meetings with ANM/Health Worker					
Importance of regular ANC check-up	87.7	90.9	89.4	87.7	88.9
Birth preparedness	85.5	89.3	87.5	86.2	87.0
Cleanliness at the time of delivery	81.0	85.0	83.1	83.6	83.2
Keeping the baby warm	77.3	82.7	80.1	81.6	80.5
Breast feeding	74.0	79.1	76.7	80.3	77.6
FP or delaying the next child	66.9	68.4	67.7	67.0	67.5
No. of respondents	818	839	1657	609	2266

5.3 DELIVERY CARE

PLACE OF DELIVERY

One of the important thrusts of the JSSK is to encourage deliveries under proper hygienic conditions under the supervision of trained health professionals. The provision of delivery services in the government health institutions is one of the components of the programme. For each live/still birth during the reference period preceding the survey, the women were asked about the place where their babies were born, who assisted during the deliveries in case of home deliveries, characteristics of delivery, and any problem that occurred during the delivery.

Figure 5.3 shows nearly 55 per cent women in non-tribal areas, 54 per cent women in urban slums and 65 per cent women in tribal areas reported place of delivery as government health facility. Subsequently, 38 per cent of women each in non-tribal areas and urban slums and 22 per cent women in tribal areas reported place of delivery as private health facility. Near about 7 per cent women in non-tribal areas and urban slums each and 13 per cent women in tribal areas reported place of delivery as home. Remoteness and timely access to health facility may be the reason for 13 per cent of home deliveries in tribal areas.

Figure 5.3: Percent distribution by place of delivery according to residence, 2014

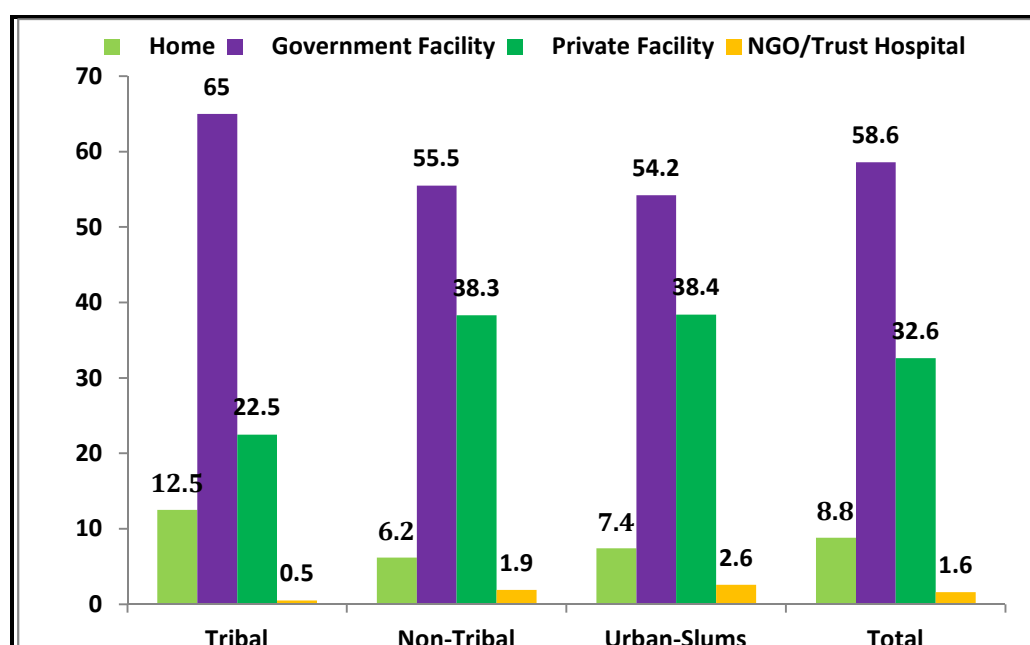


Figure 5.3.1: Percent distribution by reasons for not availing government facilities according to residence, 2014

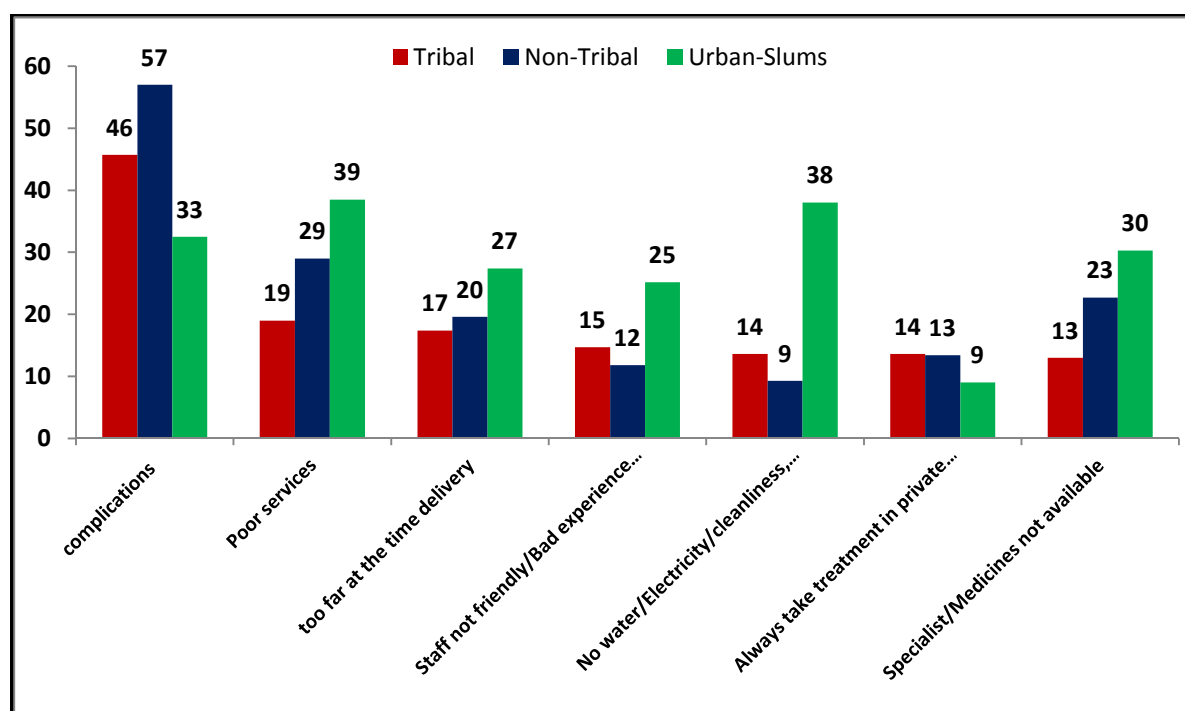


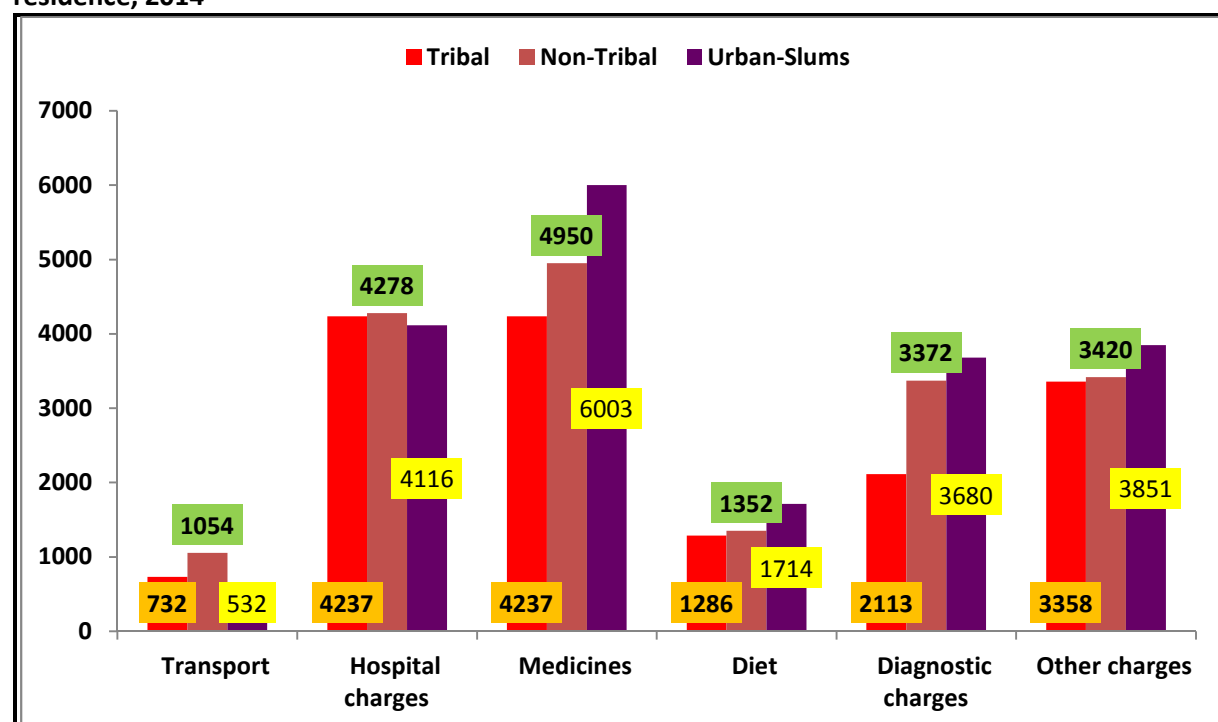
Table 5.3 presents information on the place of delivery as reported by women by place of residence. The percentage of institutional delivery in NFHS 3 was 66 per cent in Maharashtra and in JSSK survey was substantially high (92 per cent). Nearly 58 per cent of the women reported place of delivery as government health institutions, 32 per cent in private health institutions and a small proportion of births (8 per cent) in home. About 92 per cent of the deliveries in urban slums and 89 per cent of them in rural areas took place in health institutions.

Table 5.3 further shows the percentage distribution of women by place of residence who did not deliver in government facility in the reference period preceding the survey. Women were asked the reasons for not availing of government health facility. A little less than half of them (46 per cent) stated that due to complications they went to private facility for delivery. It is surprising to see that 57 per cent of non-tribal women and 45 per cent of tribal women reported complications in pregnancy as the reason as compared with only 32 per cent women in urban slums. Poor services and lack of privacy/cleanliness/water/electricity, were reported by 38 per cent of women, in urban slums. Whereas the same reasons were reported by 19 per cent of women in tribal areas; 29 per cent of women in non tribal areas and 13 per cent of women in tribal areas, and 9 per cent of women in non tribal areas. May be women in urban slums have more alternative sources for delivery and are more conscious about the quality of care. Surprisingly, government facility as being too far at the time of delivery was reported by 27 per cent women in urban slums, followed by 20 per cent women in non-tribal areas and 17 per cent women in tribal areas. Non-availability of specialist/medicine was one of the major reasons reported by women in urban slums (30 per cent) compared with 22 per cent women in non-tribal areas and 13 per cent women in tribal areas. Unfriendly staffs coupled with bad experience with doctor was also one of the major reasons

reported by 25 per cent women in urban slums, followed by 14 per cent women in tribal areas and 11 per cent women in non-tribal areas. Thirteen per cent of women in rural areas and 9 per cent of women in urban slums reported always seeking private facilities as the reason for not availing of government health facility. Other factors contributing for not going to government facilities for delivery were, 'doctor suggested to go to private facilities' (8, 6 and 3 per cent of women in tribal, non-tribal and urban slums respectively), 'government facility closed due to holiday or staff on leave' (reported only in tribal and non-tribal areas with 4 and 1 per cent respectively), 'lack of information about free delivery services' (4 per cent in non-tribal and urban slums areas each and 1 per cent in tribal areas). Overall complications in pregnancy and lack of privacy and poor service were the major reasons reported by women for not delivering in government health facility.

Average expenses incurred in private facility on each of the components such as transport, hospital charges, diagnostics, diet, medicine and other charges were also worked out as reported by women. On an average, a women incurred an expense of Rs 16,000 for delivery in private health facility. The highest expenditure as reported by women and as depicted in figure 5.3.3 was incurred on medicine (Rs 5,031), followed by hospital charges (Rs 4,232), other charges (Rs 3,515), diagnostics charges (Rs 3,193), diet (Rs 1,379) and transport charges (Rs 874). Average expenditure on medicines was reported more in urban slums (Rs 6,003) as compared with non-tribal areas (Rs 4,950) and tribal areas (Rs 4,237). Expenditure incurred on diagnostics in urban slums was (Rs 3,680) and non-tribal areas (Rs 3,372) as compared with (Rs 2,113) in tribal areas. Least expenditure was on transport the average cost of which in non-tribal areas was (Rs 1,054) as compared with non-tribal areas (Rs 732) and urban slums (Rs 532). The average expenditure on medicine was a major factor in the difference between average expenditure in urban slums and rural areas. Overall, the expenses appear to be quite high in general and in urban slums in particular.

Figure5.3.2: Item wise average expenses incurred by respondents in private facility by place of residence, 2014



Further, to evaluate the total expense, the average expenditure incurred was divided into six sub-groups ranging from Rs 500-3000 to Rs 50,000-65,000. Majority of the women as depicted in figure 5.3.4 reported expenditure in the range of Rs 10,001 to Rs 25,000 (29 per cent), followed by Rs 5,000 to Rs 10,000 (28 per cent) and Rs 25,000 to 50,000 (20 per cent). Striking difference in total expenditure was observed by place of residence with 34 per cent of women from non-tribal areas, 22 per cent of women from tribal areas and 30 per cent of women from urban slums reported expenditure in the range of Rs 10,001-25,000. Also, difference by place of residence in total expenditure was observed in the range of Rs 3,001-5,000 reported by only 7 per cent of women from non-tribal areas, compared to 22 per cent of women from tribal areas and 17 per cent of women from urban slums.

Figure 5.3.3: Average expense in rupees incurred by respondents (N =738) in private facility by place of residence, 2014

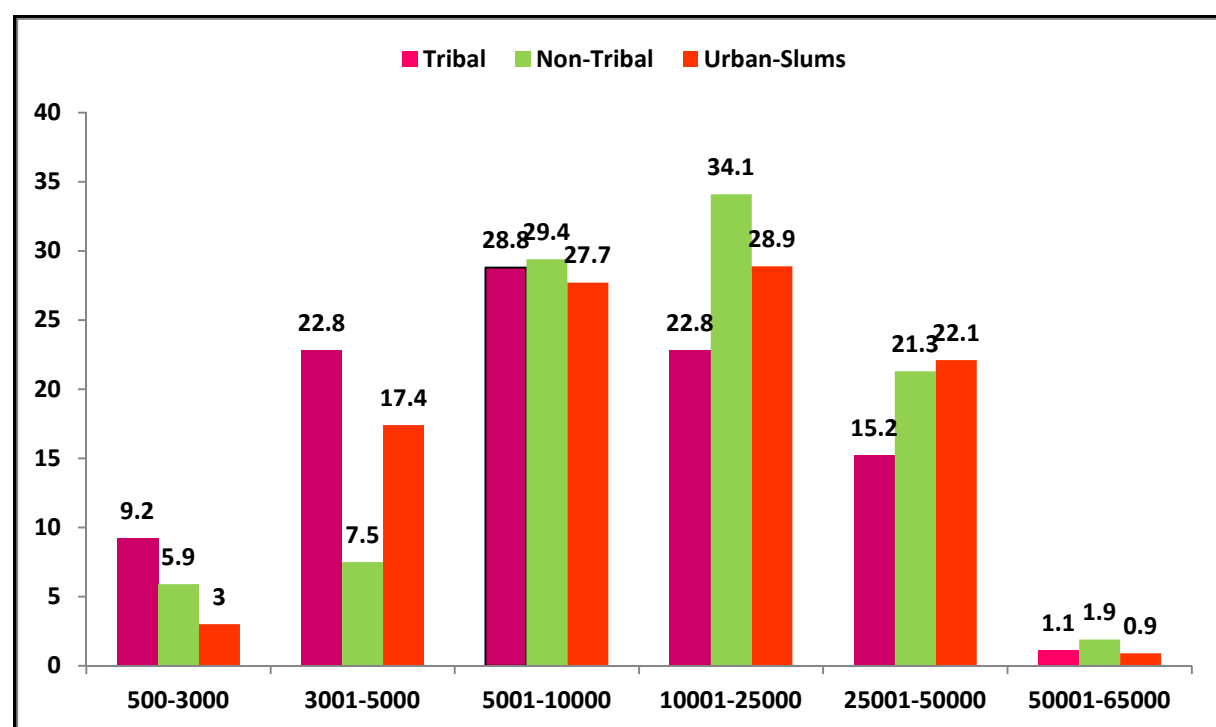


Table 5.3 Place of Delivery
Percentage of respondents by place of delivery and average expenditure incurred on delivery
according to residence, 2014

Delivery and Postnatal Care	Tribal	Non-tribal	Tribal +non-tribal	Urban slums	Total
Place of delivery					
Home	12.5	6.2	9.3	7.4	8.8
Government facility	65.0	55.5	59.0	54.2	58.6
Private facility	22.5	38.3	30.5	38.4	32.6
NGO/Trust hospital	0.5	1.9	1.2	2.6	1.6
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	818	839	1657	609	2266
Reason for not availing government facility for delivery					
Due to complications went to Private facility	45.7	57.0	52.9	32.5	46.4
Poor services	19.0	29.0	25.3	38.5	29.5
Government facility too far at the time delivery	17.4	19.6	18.8	27.4	21.5
Staff not friendly/Bad experience with doctor	14.7	11.8	12.9	25.2	16.8
No water/Electricity/cleanliness, lack of privacy/facilities	13.6	9.3	10.9	38.0	19.5
Always take treatment in private Facility	13.6	13.4	13.5	9.0	12.0
Specialist/medicines not available	13.0	22.7	19.2	30.3	22.7
Doctor suggested to go to private hospital	8.2	6.9	7.3	3.0	5.9
Government facility was closed due to holiday or staff on leave	4.3	1.2	2.4	0.0	1.6
Lack of information about free delivery services	1.6	3.7	3.0	4.3	3.4
Previous experience of govt. hospital was not good	0.0	0.6	0.4	0.4	0.4
Others	0.0	0.6	0.4	0.0	0.3
No. of respondents	184	321	505	234	739
Average expenses incurred on following in private facility (in Rs.)					
Transport	732	1054	963	532	874
Hospital charges	4237	4278	4267	4116	4232
Medicines	4237	4950	4752	6003	5031
Diet	1286	1352	1324	1714	1379
Diagnostic charges	2113	3372	3056	3680	3193
Other charges	3358	3420	3405	3851	3515
Total	13683	17232	15937	16373	16075
No. of respondents	184	320	504	234	738
Total expenses incurred in private facility (in Rs.)					
500-3000	9.2	5.9	7.1	3.0	5.8
3001-5000	22.8	7.5	13.1	17.4	14.5
5001-10000	28.8	29.4	29.2	27.7	28.7
10001-25000	22.8	34.1	30.0	28.9	29.6
25001-50000	15.2	21.3	19.0	22.1	20.0
50001-65000	1.1	1.9	1.6	0.9	1.4
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	184	320	504	234	738

ENTITLEMENTS UNDER JSSK

Under JSSK programme utmost emphasis is placed on entitlements and elimination of out of pocket expenses for pregnant women delivering in public and private health institutions to absolutely free and no expense delivery, including caesarean section and sick neonates. The entitlements include free drugs and consumables, free diet up to three days during normal delivery and up to seven days for C-section, free diagnostics and free blood wherever required. This initiative also provides for free transport from home to institution, between facilities in case of a referral and drop back home after 48 hours of delivery. Similar entitlements have been put in place for all sick newborns accessing public health institutions for treatment till 30 days after birth. This has now been expanded to cover sick infants

This section covers the JSSK entitlements and the level of awareness and utilization of women who had given birth during the reference period by place of residence. Tables 5.4 to 5.11 present the awareness, actual service utilization and expenses incurred by women for each of the entitlements under JSSK by place of residence as reported by women.

It is well proven that a significant number of maternal deaths could be saved by providing timely transport facility. Hence, timely arrangement of vehicle is an important aspect in the safe delivery. Table 5.4 presents the data on first entitlement of free pick up service, i.e., free transport from home to place of delivery by components such as awareness, source of awareness, place of delivery, actual utilization of free transport service, satisfaction, expenditure and reimbursement of amount, if any, on free pick up transport from home to place of delivery as reported by women by place of residence.

Nearly 72 per cent women were aware of the free pick up transport from home to place of delivery. However, only 50 per cent of the women in urban slums were aware of the free pick up transport, as compared with 82 per cent women in tribal areas and 77 per cent women in non-tribal areas.

Major sources of information were ANM (97 per cent), followed by ASHAs (80 per cent), and doctors (31 per cent) in tribal and non-tribal areas. As against this, ANM (91 per cent) and doctors (60 per cent) were the main sources of information for women in urban slums. Other sources of information were relatives/friends (6 per cent), radio/TV (2 per cent), and newspaper/poster/pamphlets (2 per cent). Relative/friend (15 per cent), radio/TV (5 per cent) and newspaper/poster/pamphlets (8 per cent) were mainly reported by women in urban slums.

About 45 per cent of the respondents had gone to their mothers' place for delivery. The distance between the mother's place and health facility was less than 2 km and reported by 30 per cent of women, followed by 22 per cent women reporting distance as two to five km, 20 per cent of women reporting distance as five to ten km, and 16 per cent women reporting distance as ten to 25 km.

About 41 per cent of women in tribal areas reported distance between place of residence to health facility as less than two km, followed by women reporting the distance 2-5km and 5-10km (16 per cent each), and 6 per cent of women reporting the distance between place of residence to health facility as 10-25 km. In non-tribal areas the distance between places of residence to health facility reported to be less than 2 km, 2-5 km, 5-10 km, and 10-25 km (20 per cent each). A quarter of the women in urban slums reported the distance between home to place of residence less than 2 km and 5-10 km, 34 per cent of women reported the distance 2-5 km, and 12 per cent of women reported between place of residence to health facility 10-25km.

Only 28 per cent of the women tried to avail free transport facility, the percentage of which was 43 per cent of women in tribal areas compared with 25 per cent of women in non-tribal areas and a dismal low of 6 per cent of women in urban slums. Ninety-six per cent of the women reached the facility directly from home. It needs to be interrogated why fewer women tried to avail transport facility when more than three-fourths of women in rural areas and 50 per cent of women in urban slums were aware of free transport pick up facility. The need and accessibility for transport service for women residing in remote areas and urban slums is reflected here.

Women who tried to avail of transport facility were further asked who tried to contact the toll free number to avail free transport facility. Forty per cent of women in tribal and non-tribal areas reported that ANM and ASHA tried to contact the toll free number. But 47 per cent of women in urban slums reported that family members tried to contact the toll free number. About 87 per cent of women reported that vehicle was arranged immediately as compared to 8 per cent of women reporting that vehicle was not arranged. Ninety-four per cent of the women were completely satisfied with the time taken by the vehicle to reach residence.

Timely arrangement of vehicle is an important factor in seeking timely health services. Eighty five per cent of the women reported vehicle took less than half an hour to reach the residence after the telephone call was made and 83 per cent of women in tribal areas and 78 per cent of women in non tribal areas reported less than half an hour to reach the facility. However, the same duration of time was reported by 61 per cent of women from urban slums.

Ninety-four per cent women in urban slums reported that relatives accompanied women whereas 74 per cent of women in tribal and non-tribal areas reported the same. When it comes to services of ANM/ASHA, urban women do not seem to get the services as women in rural areas. In tribal areas ANM (9 per cent) and ASHAs (12 per cent) compared with ANM (5 per cent) and ASHAs (20 per cent) in non-tribal areas are accompanied by women in the vehicle.

Ninety five per cent of women reported complete satisfaction with the transport arrangement. Only two cases in tribal and non-tribal areas each and one case from urban areas reported paying for the transport facility. This amount was paid to the driver in one case in non-tribal areas and for petrol/diesel in tribal and urban slum areas.

Women who reached health facility without seeking transport facility were also asked about the mode of transport and expenses incurred in reaching health facility from home. About 93 per

cent of them in urban slums, 77 per cent in non-tribal areas and 54 per cent in tribal areas reached the health facility in private vehicles. Substantial number of women (34 per cent) in tribal areas, (11 per cent) in non-tribal areas and (3 per cent) in urban slums reported reaching the health facility by walking. This may be due to the fact that 41 per cent of women in tribal areas and nearly 20 per cent women in non-tribal areas and urban slums each reported health facility within a distance of 2 km from home. Women from tribal areas (8 per cent), non-tribal areas (7 per cent) and urban slums (3 per cent) reported reaching health facility by own vehicle. Other modes of transport such as public transport and bullock cart were reported by very few women respondents.

Women were further asked the average expenditure incurred on transport facility from home to place of delivery. Nearly 17 per cent the respondents in tribal and non-tribal areas each and 36 per cent women in urban slums reported Rs 51-100 as the expense incurred in travelling. A quarter of the respondents in tribal areas, 29 per cent of women in non-tribal areas and 27 per cent of women in urban slums reported the expenses incurred in reaching health facility in the range of Rs 100-200. One-fourth of the population in urban slums, 17 per cent in tribal areas and 11 per cent in non-tribal areas reported the expenditure in travelling in the range Rs 5-50. Expenses in the range of Rs 200-500 were also reported by 26 per cent of women in non-tribal areas, 19 per cent women in tribal areas and 8 per cent women in urban slums. About 5 per cent of the women reported expenses incurred on transport in reaching the health facility in the range of Rs 200-500 and Rs 501-1000. Notably, 9 per cent women in tribal areas and 4 per cent women in non-tribal areas compared with 1 per cent women in urban slums reported not knowing the transport expenses in reaching the health facility. Near about 50 per cent of the women incurred travel cost of less than Rs 500 in reaching health facility. Only 2 per cent women in tribal and non-tribal areas got the amount reimbursed.

Table 5.4 Free transport (home to facility)

Percentage with knowledge and awareness of free transport facility from home to facility and responses of those who tried to avail free transport facility (Home to facility) , 2014

Background characteristics	Tribal	Non-tribal	Tribal + non-tribal	Urban slums	Total
Aware about free transport facility					
Yes	82.0	77.8	80.1	50.5	72.9
No	18.0	22.2	19.9	49.5	27.1
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	528	450	978	313	1291
Source of Information (Free transport - Home to facility)					
ANM	96.1	99.1	97.4	91.7	96.5
ASHA	77.4	83.4	80.1	0.0	80.1
Doctor	32.8	29.1	31.2	59.9	36.0
Relative/friends	4.4	4.6	4.5	15.3	6.3
Newspaper/poster/pamphlets	0.5	0.6	0.5	8.3	1.8
JSY Card	0.7	0.3	0.5	0.6	0.5
Radio/TV programmes	2.3	1.7	2.0	5.1	2.5
Health camp/anganwadi worker	1.9	1.7	1.8	1.3	1.7
No. of respondents	433	350	783	157	940
Delivery at mother's place					
Yes	43.2	51.1	46.8	41.9	45.6
No	56.8	48.9	53.2	58.1	54.4
Total	100.0	100.0	100.0	100.0	100.0
Distance of facility from your/your mother's residence (Km.)					
0.50-2.00 km	41.1	22.4	32.5	24.3	30.5
2.01-5.00 km	16.3	21.3	18.6	33.9	22.3
5.01-10.00 km	16.9	22.2	19.3	25.6	20.8
10.01-25.00 km	15.0	21.1	17.8	12.1	16.4
25.01-50.00 km	6.3	7.8	7.0	2.9	6.0
50.01-100 km	2.3	4.7	3.4	1.0	2.8
101 -500 km	1.5	0.2	0.9	0.0	0.7
Don't know the distance	0.8	0.2	0.5	0.3	0.5
Total	100.0	100.0	978	100.0	100.0
Tried to avail of free transport facility					
Yes	44.9	25.3	35.9	6.1	28.7
No	55.1	74.7	64.1	93.9	71.3
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	528	450	978	313	1291
Reach the facility					
Directly from home	97.9	93.0	96.6	100.0	96.5
Referred from other facility	2.1	7.0	3.4	0.0	3.5
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	237	114	351	19	370
Contacted on toll free number for arrangement of vehicle by					
Self	5.9	9.6	7.1	10.5	7.3
Family member	8.4	10.4	9.1	47.4	11.1
Neighbour	0.8	2.6	1.1	5.3	1.6
ANM	38.8	44.3	40.5	36.8	40.4
ASHA	46.0	33.0	42.2	0.0	39.6
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	237	114	351	19	370

Response when tried to contact for free transport					
Vehicle was arranged immediately	86.9	87.8	87.2	94.7	87.6
Vehicle was arranged with delay	1.3	1.7	1.4	0.0	1.3
Phone was engaged	1.3	0.0	0.9	0.0	0.8
Nobody attended the phone	0.4	0.9	0.6	0.0	0.5
No mobile range (No network)	1.7	0.0	1.1	0.0	1.1
Vehicle not arranged	8.4	9.6	8.8	5.3	8.6
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	237	114	351	19	370
Time taken for vehicle to reach the residence after the telephone call was made					
Up to 30 minutes	87.6	81.6	85.5	88.9	85.8
31-60 minutes	8.6	15.5	10.9	5.6	10.6
61 minutes and above	3.8	2.9	3.5	5.6	3.6
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	209	102	311	18	329
Satisfaction with the time taken by the vehicle to reach the residence					
Completely satisfied	94.7	93.1	94.2	100.0	94.5
Somewhat satisfied	4.8	6.9	5.5	0.0	5.2
Not satisfied	0.5	0.0	0.3	0.0	0.3
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	209	102	311	18	329
Time taken to reach the facility from the residence					
0-30 minutes	83.3	78.4	81.7	61.1	80.5
31-60 minutes	11.0	13.7	11.9	27.8	12.8
61 minutes and above	5.7	7.8	6.4	11.1	6.7
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	209	102	311	18	329
Accompanying person in the vehicle					
Husband	6.7	1.0	4.8	5.6	4.9
Relative	73.2	74.5	73.6	94.4	74.8
ANM	8.6	4.9	7.4	0.0	7.0
ASHA	11.5	19.6	14.1	0.0	13.4
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	209	102	311	18	329
Satisfaction with the transport arrangement for dropping in at the facility					
Completely satisfied	95.7	94.1	95.2	94.4	95.1
Somewhat satisfied	4.3	4.9	4.5	5.6	4.6
Not satisfied	0.0	1.0	0.3	0.0	0.3
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	209	102	311	18	329
Reasons for not satisfied					
Vehicle was not in good condition	0.0	0.2	0.1	0.0	0.1
Amount paid to any person for availing of this transport facility					
Yes	1.4	2.0	1.6	5.6	1.8
No	98.6	98.0	98.4	94.4	98.2
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	209	102	311	18	329
Amount paid for transport (in Rs.)					
<= 100	0.0	50.0	25.0	0.0	20.0
101 – 500	50.0	50.0	50.0	100.0	60.0
Above 500	50.0	0.0	25.0	0.0	20.0
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	02	02	04	01	05

Amount paid for transport (in Rs.) to					
Driver (no of cases)	0	1	1	0	1
Amount paid for transport (in Rs.) for					
Diesel /Petrol	0.5	0.2	0.5	0.3	0.3
Others	0.0	0.2	0.2	0.0	0.1
No. of respondents	02	02	04	?	
Facility to reach (Those who didn't avail free transport facility)					
Private transport	54.5	77.0	66.3	93.2	74.5
Public transport	1.9	2.0	1.9	1.0	1.7
Own vehicle	8.5	9.5	9.0	2.7	7.1
By walking	34.5	11.5	22.5	3.1	16.5
By bullock cart	0.6	0.0	0.3	0.0	0.2
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	319	348	667	295	962
Total expenses for the travelling (in Rs.)					
5-50	16.9	11.0	13.4	24.8	17.5
51-100	17.4	17.9	17.7	36.4	24.3
101-200	25.6	29.5	28.0	26.9	27.6
201-500	19.3	26.3	23.5	8.7	18.2
501-1000	4.8	5.8	5.4	0.3	3.6
1001-2000	6.3	5.5	5.8	1.4	4.2
Don't know the expenses for transport	9.7	3.9	6.2	1.4	4.5
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	207	308	515	286	801
Amount reimbursed					
Yes	2.4	2.6	2.5	0.0	1.6
No	97.6	97.4	97.5	100.0	98.4
Number	207	308	515	286	801
Note: Reached the facility after referred from other facility were seven cases out of which three deliveries were in government hospital, three in rural hospital and one in SDH.					

During pregnancy and childbirth, investigations are essential for timely diagnostics of complication and likely problem which a woman may face during pregnancy and childbirth. Both essential and desirable diagnostics are required to be conducted free of cost for the pregnant women during ANC which includes investigation prior to normal delivery and c-section. Table 5.5 presents the awareness, source of information, essential diagnostics received during pregnancy and expenses (if any) incurred in availing essential diagnostics as reported by women by place of residence. About 86 per cent women in rural areas compared with 68 per cent women in urban slums were aware of the free essential diagnostics. Major sources of information were ASHAs (75 per cent) in rural areas, and doctors (49 per cent) in urban slums. Thirty-one per cent and 25 per cent women in tribal and non-tribal areas respectively reported doctors to be the main source of information. Other sources of information were relatives/friends (10 per cent), radio/TV (4 per cent), and newspaper/poster/pamphlets (4 per cent) reported by women in urban slums. Most women reported receiving free essential diagnostics such as blood test (93 per cent), urine test (93 per cent) and HIV test (91 per cent) during their pregnancy.

Diagnostics such as ultra sonography test during pregnancy is reported by 68 per cent of women in tribal areas, 82 per cent of women in non-tribal areas, and 94 per cent of women in urban

slums. Among the women who underwent USG tests in urban slums, 82 per cent of women reported paying for USG tests at private facility compared with 94 per cent of women in rural areas. It needs to be investigated whether the accessibility of USG in private facilities in tribal and non tribal areas and urban slums led to the wide gap between tribal and nontribal areas and urban slums in undertaking the USG test. Strikingly, among the women who underwent USG test in urban slums, 7 per cent of the women have to pay for it at public facility. It needs to be examined why the women paid for USG test in public health facility.

Nearly 30 per cent of women in tribal areas reported receiving ECG test during pregnancy, followed by 27 per cent of women in urban slums and 23 per cent of women in non-tribal areas. About 15 per cent of women reported other tests during pregnancy and 16 per cent of them required blood during pregnancy.

About 28 per cent of women in non tribal areas and urban slums paid for blood tests and a quarter of women from non-tribal areas and urban slums paid for urine test in private facilities compared with 14 and 13 per cent of women in tribal areas who paid for blood and urine tests in private facilities respectively. Similarly, 27 per cent of the women in non-tribal areas, 10 per cent in tribal areas and 19 per cent from urban slums reported paying for HIV test in private facilities. Eighteen per cent women from non-tribal areas, 15 per cent from urban slums and 9 per cent from tribal areas also reported paying for ECG tests during pregnancy in private facilities. Few women paid for blood and urine, HIV and ECG test in public health facilities. Only 4 per cent women in urban slums and non-tribal areas each reported paying for blood during pregnancy whereas the same was reported by 2 per cent women in tribal areas. Hence, it appears that women from non-tribal and urban slums have to pay more for diagnostics as compared with women from tribal areas. Nevertheless, it needs to be examined why women paid for diagnostics in public health facilities.

Women were further asked about the expenditure incurred on the diagnostic tests. Nearly 46 per cent women in tribal areas followed by 40 per cent women in urban slums and 30 per cent women in non-tribal areas reported expenses in the range of Rs 50 to Rs 500 for USG test. Thirty-nine per cent women in non-tribal areas, 36 per cent in tribal areas and 31 per cent in urban slums reported the expenses incurred in USG test in the range of Rs 501-1000. Twenty-two per cent women from urban slums and non-tribal areas each and 15 per cent in tribal areas reported the expenditure on USG test in the range Rs 1001-2000.

About 41 per cent of women (Tribal 50 per cent; 38 per cent in non tribal and urban slums) reported paying for blood and urine tests in the range of Rs 151-300 as compared with 38 per cent women in non-tribal areas and urban slums each. About 19 per cent women from tribal areas, followed by 17 per cent women in non-tribal areas and 11 per cent women from urban slums reported paying in the range of Rs 301-450 for blood and urine tests. Twenty-one per cent women in non-tribal areas compared with 11 per cent women from tribal areas and urban slums each reported the expenses on blood and urine tests in the range of Rs 451-600.

Eighty nine per cent of the women in urban slums, followed by 72 per cent from non-tribal areas and 68 per cent from tribal areas reported paying for HIV test in the range of Rs 50-250. Nineteen per cent women from tribal and non-tribal areas each reported paying for HIV tests in the range of Rs 251-500 compared with 6 per cent women in urban slums.

In urban slums 80 per cent of women paid for ECG test in the range Rs 20-250 compared with 60 per cent of women in tribal areas and 62 per cent of women in non-tribal areas. Whereas, 20 per cent of women from urban slums paid for ECG tests in the range 251-500 as compared with 38 per cent of women in rural areas. Overall, expenses incurred on USG test were comparatively higher than other types of diagnostics tests.

Table 5.5 Free diagnostics
Percentage with knowledge and awareness of free diagnostics and responses of those who tried to avail free diagnostics, 2014

Background characteristics	Tribal	Non-Tribal	Tribal + non-tribal	Urban slums	Total
Aware of provision of free essential diagnostics					
Yes	87.9	84.2	86.0	68.1	81.8
No	12.1	15.8	14.0	31.9	18.2
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	528	450	978	314	1292
Source of information about provision of free essential diagnostics					
ASHA	74.4	75.9	75.0	0.0	59.9
Doctor	31.0	25.2	28.4	49.1	32.6
Relative/friend	0.8	0.8	0.8	10.4	2.7
Newspaper/poster/pamphlets	0.2	0.3	0.2	4.2	1.1
JSY Card	0.2	0.0	0.1	0.9	0.3
Radio/TV	1.8	1.6	1.7	3.8	2.0
Anganwadi worker/health camp	1.9	1.9	1.9	0.9	1.7
No. of respondents	464	377	841	212	1053
Received any of the following diagnostic services during pregnancy					
Ultra sonography (USG)	68.0	82.7	74.7	94.9	79.6
Blood Test (incl. Hb)	93.2	92.0	92.6	96.5	93.6
Urine Test	93.6	91.8	92.7	96.5	93.6
HIV Test	91.3	89.6	90.5	94.9	91.6
ECG Test	30.9	23.6	27.5	27.8	27.6
Required blood during pregnancy	16.9	15.1	16.1	16.6	16.2
Any other test (specify)	15.2	13.6	14.4	15.7	14.7
No. of respondents	528	450	978	314	1292
Paid for the diagnostic services ultra sonography					
Paid at public facility	0.6	1.1	0.8	7.1	2.6
Paid at private facility	91.9	95.7	93.8	82.5	90.6
Free of cost at public facility	7.5	3.2	5.3	10.4	6.8
Blood test (incl. Hb)	14.2	28.4	20.8	29.5	22.9
Urine test	13.6	25.0	18.6	26.5	20.7
HIV test	10.2	20.4	14.8	18.9	15.8
ECG test	8.6	17.5	12.1	14.9	12.8
Paid for blood during pregnancy	2.2	4.1	3.1	3.8	3.4

Amount paid for the diagnostic services (Yes cases)					
Ultra sonography (USG) (in Rs)					
50-500	45.9	35.4	40.4	40.6	40.5
501-1000	35.6	38.7	37.2	30.8	35.5
1001-2000	15.1	22.8	19.1	22.2	20.0
2001-5000	2.7	2.5	2.6	5.6	3.5
5001-15000	0.0	0.6	0.3	0.0	0.2
Don't know the expenses for USG	0.6	0.0	0.3	0.8	0.4
Blood (incl. Hb) + Urine test (in Rs)					
50-150	9.4	10.6	10.1	20.9	14.0
151-300	50.9	38.5	43.4	38.4	41.2
301-450	18.9	17.3	17.6	11.6	15.6
451-600	11.3	21.2	17.6	10.5	15.2
601 & above	9.4	12.5	11.3	18.6	14.0
HIV Test (in Rs)					
50-250	68.8	72.1	71.0	89.8	77.2
251-500	18.8	19.1	19.0	6.1	14.8
501 and above	12.5	8.8	10.0	4.1	8.1
ECG Test (in Rs)					
20-250	60.0	62.5	61.5	80.0	66.7
251-500	40.0	37.5	38.5	20.0	33.3
Amount paid for blood during pregnancy (in Rs.)*					
100-400	(1)	(2)	(3)	(1)	(4)
Note: 1. Five cases from Tribal area show expense made for other test 2. No amount was reimbursed for any of the tests done * in parentheses denotes no. of cases					

Drugs and consumables including supplements such as Iron and Folic acid are required to be given free of cost to the pregnant women during ANC and childbirth which includes management of normal delivery, C section and any complication during pregnancy and childbirth. Table 5.6 presents the component like awareness, source of information, essential drugs received during pregnancy and expenses and reimbursement (if any) incurred in availing drugs and consumables.

About 86 per cent of women in rural areas compared to 69 per cent of women in urban slums were aware of free drugs and consumables. The major sources of information were ANM (97 per cent) and ASHAs (76 per cent) in rural areas, and ANM (89 per cent) and doctors (50 per cent) in urban slums. Thirty-four per cent and 30 per cent women in tribal and non-tribal areas respectively reported doctors to be the main source of information. Other sources of information were relatives/friends (17 per cent), radio/TV (3 per cent) and newspapers/posters/pamphlets (7 per cent) for women in urban slums.

About 93 per cent of women reported receiving all drugs and consumables free of cost during pregnancy in tribal areas, compared with 85 per cent of women in non-tribal areas and 71 per cent of women in urban slums. Nearly 19 per cent women in urban slums reported receiving drugs and consumables free of cost partially during pregnancy, compared with 10 per cent women in non-tribal areas and 3 per cent women in tribal areas.

Near about 4 per cent of women who did not receive drugs and consumables free reported purchasing it from private drug stores and consumables. They were further asked about the

expenditure incurred in purchasing drugs and consumables. About 24 women in urban slums followed by 20 women in non-tribal areas and 9 women in tribal areas reported Rs 50-500 as the expenses incurred in purchasing drugs and consumables. Six women from tribal areas, eight from non-tribal areas and 21 in urban slums reported these expenses in the range of Rs 501-1000. Thirty-seven women from urban slums, 15 from non-tribal areas and 35 from tribal areas reported the expenditure in purchasing drugs in the range Rs 1001-5000. None of the women was reimbursed these expenses. Strikingly, expenses incurred in the range of Rs 10,000-25,000 are high and even higher than the expenses incurred by women in purchase of drugs and consumables accessing private health facilities.

Table 5.6 Free drugs and consumables
Percentage of respondents received/not received free drugs and consumables by awareness, experiences while availing free services according to residence, 2014

Awareness and experiences	Tribal	Non-tribal	Tribal+ non-tribal	Urban slums	Total
Aware of provision of free drugs and consumables during pregnancy					
Yes	88.3	84.7	86.6	69.3	82.4
No	11.7	15.3	13.4	30.7	17.6
No. of respondents	528	450	978	314	1292
Know about provision of free drugs and consumables through					
ANM	95.9	99.2	97.4	89.9	95.9
ASHA	75.1	78.7	76.7	0.0	61.1
Doctor	34.1	29.7	32.1	50.7	35.9
Relative/friend	3.4	5.3	4.3	16.6	6.8
Newspapers/posters/pamphlets	0.2	0.3	0.2	7.4	1.7
JSY Card	0.2	0.0	0.1	0.9	0.3
Radio/TV	1.7	2.1	1.9	3.7	2.3
Health camp/Anganwadi worker	1.9	1.6	1.7	1.4	1.7
No. of respondents	466	381	847	217	1064
Receive all drugs and consumables free of cost from the facility					
Yes	93.9	85.8	90.2	71.2	85.6
No	2.7	3.8	3.2	9.3	4.6
Partially	3.4	10.4	6.6	19.5	9.8
No. of respondents	528	450	978	314	1292
Purchased medicines (those who did not receive drugs and consumable)					
Private drug store	100.0	96.9	97.9	97.8	97.8
Other sources	0.0	3.1	2.1	2.2	2.2
No. of respondents	32	64	96	90	186
Amount paid (in Rs.) (no. of cases)					
50-500	9	20	29	24	53
501-1000	6	8	14	21	36
1001-5000	2	1	3	3	6
5001-10000	0	0	0	4	4
10001-25000	15	35	50	37	87
No. of respondents	32	64	96	90	186
Reimbursement for drugs and consumables brought from outside					
Yes	0.0	0.0	0.0	0.0	0.0
No	100.0	100.0	100.0	100.0	100.0
No. of respondents	32	64	96	90	186
Note: Nil reimbursement					

Blood transfusion may be required to tackle emergencies and complications of deliveries such as management of severe anemia, PPH, and C sections, etc. The provision of blood will be free of any cost and without any user charges under JSSK. However, the relatives and attendants accompanying the pregnant women should be encouraged to donate blood for replacement.

Table 5.7 presents components like awareness, source of information, whether blood required, if required whether available free of cost during pregnancy and expenses (if any) incurred in availing of blood.

Compared with other entitlements of JSSK, awareness about availability of free blood was low and only 52 per cent of the women in non-tribal areas, 48 per cent of women in tribal areas and 30 per cent of women in urban slums were aware of free blood, if required. This is most likely as blood is provided only, if required.

The major sources of information were ANM (97 per cent), ASHAs (81 per cent), and doctors (41 per cent) in rural areas, and ANM (89 per cent) and doctors (61 per cent) in urban slums. Relatives / friends (22 per cent) were other source of information for women in urban slums. Only 5 per cent women in urban slums and 3 per cent in rural areas required blood during delivery.

All the women who required blood during delivery received it on time except for one woman in urban slums. Each of the women from tribal and urban slums areas paid for blood in the range of Rs 250-500. But each of the 7 women from tribal and urban slums areas and 6 women from non-tribal areas paid in the range of Rs 501 and above. Only one woman from tribal areas was reimbursed with Rs 100 and above for the blood. Although only few cases of women required blood during delivery among them, half of the women depended on outside source for blood and paid for it.

Table 5.7 Free blood
Percentage of respondents received/not received free blood by awareness, experiences while
availing free services according to residence, 2014

Awareness and experiences	Tribal	Non-tribal	Tribal+ non-tribal	Urban slums	Total
Aware of provision of free blood during pregnancy					
Yes	48.5	52.7	50.4	30.9	45.7
No	51.5	47.3	49.6	69.1	54.3
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	528	450	978	314	1292
Heard about provision of free blood from					
ANM	96.9	98.7	97.8	89.7	96.4
ASHA	79.7	84.0	81.7	0.0	68.3
Doctor	47.7	35.0	41.6	61.9	44.9
Relative/friend	5.5	6.7	6.1	21.6	8.6
Newspapers/posters/pamphlets	0.4	0.8	0.6	3.0	1.0
JSY card	0.4	0.0	0.2	1.0	0.3
TV	1.6	3.0	2.2	2.1	2.2
Health camp/Anganwadi worker	3.1	3.0	3.0	1.0	2.7
No. of respondents	256	237	493	97	590
Require blood during delivery					
Yes	2.5	2.0	2.2	4.5	2.8
No	97.5	98	97.8	95.5	97.2
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	528	450	978	314	1292
Received blood on time(no. of cases)					
Yes	13	9	22	13	35
No	0	0	0	1	1
No. of respondents	13	9	22	14	36
Received blood from(no. of cases)					
Health facility	7	3	10	7	17
Other blood bank	6	6	12	7	19
No. of respondents	13	9	22	14	36
Received free of cost (for those received from the facility) (no. of cases)					
Yes	5	3	8	5	13
No	2	0	2	2	4
No. of respondents	7	3	10	7	17
Received free of cost (for those received from outside the facility)					
No. of respondents	0	0	0	0	0
Amount paid (in Rs.)					
50-250	0	0	0	1	1
251-500	1	0	1	1	2
501 and above	7	6	12	7	20
No. of respondents	8	6	14	9	23
Reimbursement for the blood from the facility					
0	7	6	13	9	22
>100 Rs.	1	0	1	0	1
No. of respondents	8	6	14	9	23
Note: Amount reimbursed at Amravati district in Dharni block in Dhulgat rly PHC.					
No. of cases is given from received blood on time onwards.					

The first 48 hours after delivery are vital for detecting any complication and its immediate management. Care of the mother is essential immediately after delivery and at least upto 48 hours. During this period, the mother is guided for initiating breastfeeding and advised for extra calories, fluids and adequate rest which are needed for the well-being of the baby and herself. Non-availability of diet at the health facilities discourages mothers from staying at the health facilities and most of them prefer returning home immediately after delivery. This hampers adequate care of the women.

Table 5.8 presents the awareness about free diet, source of information about free diet, reasons for not availing of free diet, and if availed the quality and sufficiency of free diet. About 82 per cent of women in non-tribal and 84 per cent of women in tribal areas were aware of free diet compared with 60 per cent of the women in urban slums. Major sources of information were ANM (96 per cent), ASHAs (78 per cent) and doctors (33 per cent) in rural areas, and ANM (92 per cent) and doctors (55 per cent) in urban slums. Relatives/friends (13 per cent) and newspapers/pamphlets/posters (5 per cent) were other sources of information for women in urban slums.

During their stay in the facility, nearly 71 per cent women in rural areas and 55 per cent women in urban slums availed of free diet. Ninety seven per cent of the women reported that the food was sufficient, 96 per cent of women in rural areas and 89 per cent of women in urban slums reported that the quality of food was good and 98 per cent women reported that food was served in time.

Women who did not avail of free diet during their stay in the facility were asked their reasons for it. Near about 60 per cent women in rural areas and 69 per cent women in urban slums reported that the service of free diet was not available during their stay in facility. It needs to be investigated why diet was unavailable and if diet was outsourced whether the availability of free diet was communicated to women during their stay in facility. A quarter of the women reported that they preferred home food during their stay in the facility. Near about 9 per cent women were not aware of free diet service and 10 per cent of women in rural areas reported not staying in the facility for a longer time as the reason for not availing free diet service.

Table 5.8 Free diet during stay for delivery in the health institution
Percentage of respondents received/not received free diet by awareness, experiences during their stay in health institution according to residence, 2014

Awareness and experiences	Tribal	Non-tribal	Tribal+ non-tribal	Urban slums	Total
Aware of provision of free diet during the stay at facility					
Yes	84.8	82.4	83.4	60.1	78.0
No	15.2	17.6	16.6	39.9	22.0
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	528	450	978	313	1291
Heard about provision of free diet from					
ANM	95.5	98.6	96.6	92.0	96.0
ASHA	77.0	79.9	78.0	0.0	63.5
Doctor	35.8	30.1	33.1	55.3	37.4
Relative/friend	2.9	5.1	3.9	13.3	5.7
Newspapers/posters/pamphlets	0.2	0.5	0.3	5.3	1.3
JSY card	0.2	0.0	0.1	1.6	0.4
Radio/TV	1.8	1.6	1.7	2.6	1.9
Health camp/Anganwadi worker	1.7	1.9	1.8	1.1	1.7
No. of respondents	448	371	819	188	1007
Received free diet during stay in the facility					
Yes	69.3	73.6	71.3	55.6	64.5
No	30.7	26.4	28.7	44.4	32.5
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	528	450	978	313	1291
Sufficiency of the food (for those who received free diet)					
Yes, sufficient	97.5	98.2	97.8	95.4	97.4
Yes, somewhat sufficient	2.2	1.5	1.9	3.4	2.2
Insufficient	0.3	0.3	0.3	1.2	0.4
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	366	331	697	174	871
Quality of the food					
Good	96.2	95.2	95.0	89.7	94.5
Alright	3.0	4.8	3.9	9.8	5.1
Bad	0.8	0.0	0.4	0.6	0.5
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	366	331	697	174	871
Food served on time					
Yes	98.6	99.1	98.9	98.9	98.9
No	1.4	.9	1.1	1.1	1.1
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	366	331	697	174	871
Reason for not availing free diet					
Preferred home food	24.1	31.9	27.4	24.5	26.4
Service not available	62.3	60.5	61.6	69.1	64.0
Not aware of diet service	9.3	6.7	8.2	10.1	8.8
Didn't stay for longer time	11.7	9.2	10.7	2.2	7.9
Person stayed with the respondent in the hospital					
Husband	2.4	1.5	2.0	3.5	2.4
Relative	91.7	94.2	92.8	96.5	93.7
ASHA	4.0	3.3	3.7	0.0	2.8
ANM	1.9	0.9	1.4	0.0	1.1
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	528	449	977	312	1289

Significant number of maternal deaths could be saved by providing timely referral transport facility to the pregnant women for normal delivery/c-section.

Table 5.9 presents the information on awareness about free referral transport asked to women who availed free referral transport, source of information about free referral transport, persons who arranged for the referral transport, and if availed whether paid for referral transport, and if paid whether the amount was reimbursed.

About 37 women in tribal areas and 28 women in non-tribal areas were aware of free referral transport compared with only 7 women in urban slums. Major sources of information were ANM (61 women), ASHAs (48 women) and doctors (28 women) in rural areas, and ANM (4 women) in urban slums.

Private transport and own vehicle were the main modes of transport between facilities and was used by 24 and 16 women in tribal areas and 20 and 9 women in non-tribal areas respectively. Nearly eight women used public transport as the mode of transport between the facilities in urban slums.

ANM and staff of the facility arranged transport between the facilities for each of the 18 women in tribal areas and 9 and 18 women respectively in non-tribal areas. But in urban slums transport between the facilities were arranged by ANM and relatives/friends respectively for 5 women.

About 23 women in rural areas and six women in urban slums paid for transport in urban slums. Near about 13 women in rural areas and five women in urban slums paid Rs 251-1000 for transport between the facilities and only one woman in non-tribal areas was reimbursed. Overall, for referral transport women had to rely on private and own vehicle.

ENTITLEMENT 6: FREE REFERRAL TRANSPORT

Table 5.9: Free transport between facilities in case of referral (if applicable)
Number of respondents received/not received free diet by awareness, experiences during their stay in health institution according to residence, 2014

	Tribal	Non-tribal	Tribal + non-tribal	Urban slums	Total
Awareness and experiences					
Aware of provision of free transport facility in case of referral					
Yes	37	28	65	7	72
No	11	8	19	7	26
No. of respondents	48	36	84	14	98
Heard about provision of free transport facility in case of referral					
ANM	34	27	61	4	65
ASHA	27	21	48	0	48
Doctor	20	8	28	0	28
Relative/Friend	5	2	7	2	9
TV	0	1	1	1	2
Anganwadi worker	0	4	4	0	4
No. of respondents	37	28	65	7	72
Mode of transport between facilities					
Private transport	24	20	44	3	47
Public transport	8	6	14	8	22
Own vehicle	16	9	25	3	28
Other	0	1	1	0	1
No. of respondents	48	36	84	14	98
Transport from facility to facility arranged by					
Staff of the facility	19	18	37	3	40
ANM	18	9	27	5	32
ASHA	2	1	3	0	3
Self	9	8	17	5	22
Other	0	0	0	1	1
No. of respondents	48	36	84	14	98
Paid for the transport from facility to facility					
Yes	12	11	23	6	29
No	36	25	61	8	69
No. of respondents	48	36	84	14	98
Amount paid (in Rs.) (for those who paid for referral transport)					
1-250	4	5	9	1	10
251-1000	7	6	13	5	18
1001 and above	1	0	1	0	1
No. of respondents	12	11	23	06	29
Reimbursed the amount paid for transport between facilities					
Yes	0	1	1	0	1
No	12	10	22	6	28
No. of respondents	12	11	23	06	29

Drop back facility alleviates the pressure to leave the health facility earlier than desirable and obviates out of pocket expenses. Table 5.10 presents the awareness about free drop back facilities, source of information about free drop back facilities, number of days stayed in the facility after delivery, reasons for not staying in the facility for 48 hours after delivery, received drop back facilities, waiting time, drop back arranged by, reasons for not availing of drop back, level of

satisfaction for drop back, mode of transport for drop back, payment for drop back, amount paid for drop back and if paid whether reimbursed. Only 51 per cent of the women in urban slums were aware of the free drop back transport facilities, compared with 79 per cent women in tribal areas and 77 per cent women in non-tribal areas.

Major sources of information were ANM (97 per cent), followed by ASHAs (79 per cent) and doctors (34 per cent) in rural areas, whereas in urban slums ANM (90 per cent), and doctors (63 per cent) were the main source of information. Other sources of information were relatives/friends (17 per cent), radio/TV (4 per cent), and newspapers/posters/pamphlets (4 per cent) for women in urban slums.

It is expected that women should stay for at least 48 hours in the facility to receive essential post-natal care. Thirty-three per cent of women in rural areas and 26 per cent of women in urban slums stayed for three days in the health facility. Nearly 17 per cent of women stayed for two days in health facility. Near about 35 per cent of the rural women and 22 per cent of urban slums women stayed for less than two days in the health facility. A substantial number of women stayed for less than 48 hours in the health facility.

It is surprising, that 49 per cent of women in urban slums and 33 per cent of women in rural areas reported that doctors/ANM gave discharge as the main reason for not staying in the health facility for 48 hours after delivery. No provision to stay in health facility was reported by 30 and 22 per cent of women in rural areas and urban slums respectively. The number of women who reported no complication after delivery and hence insisted on discharge was 27 per cent of women in rural areas and 32 per cent of women in urban slums. No one to look after the children at home was also reported by 12 per cent of women in rural areas, 16 per cent of women in non-tribal areas and 17 per cent of women in urban slums. This indicates that awareness and better infrastructure in health facility may increase the number of women staying more than 48 hours in health facilities.

About 55 per cent of women in tribal areas, 41 per cent of women in non-tribal areas and only 14 per cent of women in urban slums reported receiving drop back facility from the health facility.

Nearly 75 per cent of women reported waiting time of 15 minutes for the drop back transport facility. The waiting time was 16 to 30 minutes for 11 per cent of women in tribal areas, 18 per cent of women in non-tribal areas and 9 per cent of women in urban slums. Only 9 per cent of women in urban slums and 4 per cent of women in rural areas reported waiting time to be more than one hour.

Drop back facility was arranged by the staff of health facility for 44 per cent women in rural areas and 59 per cent of women in urban slums. ANM arranged drop back facility for 49 per cent of women in rural areas and 40 per cent of women in urban slums. Most women reported that the level of satisfaction with the transport arrangement to drop back in home completely satisfied (95 per cent).

Women were asked reasons for not availing drop back transport facility. The major reason was that the vehicle was not available. This was reported by 47 per cent of women in tribal areas, 56 per cent of women in non-tribal areas and 67 per cent of women in urban slums. Home near to the facility was the next prominent reason for not availing free drop back transport and was reported by

31 per cent of women in tribal areas, 9 per cent women in non-tribal areas and 3 per cent of women in urban slums. Almost 10 per cent of women in non-tribal areas reported that the driver was not available, while 15 per cent women in urban slums reported lack of information about free drop back facilities.

Women who did not avail of free drop back facilities were asked about their mode of transport for reaching home. Almost 93 per cent of them in urban slums, followed by 79 per cent in non-tribal areas and 57 per cent in tribal areas reported using private vehicle as the mode of transport. Thirty-five per cent women in tribal areas and 11 per cent in non-tribal areas reported walking back to home. Only in two cases in tribal and non-tribal areas each reported the amount reimbursed in the range of Rs 1-300.

Table 5.10: Free drop back from institution to home

Percentage of respondents received free drop back from institution to home according to residence, 2014					
Awareness and experiences	Tribal	Non-tribal	Tribal + non-tribal	Urban Slums	Total
Aware of free drop back facility from institute to home					
Yes	79.0	76.9	78.0	51.3	71.5
No	21.0	23.1	22.0	48.7	28.5
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	528	450	978	313	1291
Heard about provision of free drop back facility					
ANM	95.9	98.6	97.1	90.1	95.9
ASHA	78.8	80.3	79.5	0.0	65.7
Doctor	36.3	32.1	34.4	63.4	39.4
Relatives/friends	4.1	3.5	3.8	17.4	6.2
Newspapers/posters/pamphlets	0.2	0.6	0.4	7.5	1.6
JSY	0.2	0.0	0.1	0.6	0.2
Radio/TV	2.4	2.0	2.2	4.3	2.6
Health camp/Aganwadi worker	1.7	2.3	1.9	0.6	1.7
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	416	346	762	161	923
No. of days stayed in the facility after delivery					
0-1 day	35.0	26.7	31.2	21.7	28.9
2 days	16.9	18.7	17.7	17.6	17.7
3 days	33.0	34.9	33.8	26.5	32.1
4 + days	15.2	19.8	17.3	34.2	21.4
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	528	450	978	313	1291
Reasons for not staying at least 48 hours after delivery					
Facility with no provision of staying	29.4	31.4	30.4	22.6	28.8
No one to look after children at home	12.2	16.4	14.3	17.2	14.6
Food not available for accompanying person	5.0	1.9	3.5	6.5	4.2
No electricity	5.9	4.4	5.2	0.0	4.2
No water	9.5	5.0	7.3	1.1	6.3
Mosquitoes	0.9	0.6	0.8	0.0	0.6
No security, feel unsafe	2.3	0.6	1.5	4.3	2.1
Lack of medical facility (incubator)	0.5	0.0	0.3	0.0	0.2
Doctor/ANM gave early discharge	34.4	32.7	33.6	49.5	36.8
No complication after delivery and patient insisted for discharge	27.6	27.3	27.5	32.1	28.4
Staff on leave/holiday	2.3	1.9	2.1	2.2	2.1
Due to complications doctor referred to private facility	0.5	0.0	0.2	0.0	0.2
Received drop-back facility after discharge from facility					
Yes	55.5	41.3	49.0	14.1	40.5
No	44.5	58.7	51.0	85.9	59.5
Total	100.0	100.0	100.0	100.0	100.0
	528	450	978	313	1291

Waiting time for drop facility after discharge for those who received the service (minutes)					
0-15	79.1	71.5	76.2	75	76.1
16-30	11.5	18.2	14.2	9.1	13.7
31-60	4.8	7	5.6	6.8	5.7
61 +	4.4	3.2	4.0	9.1	4.5
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	293	186	479	44	523
Drop back arranged by					
Staff of the facility	44.0	44.6	44.3	59.1	45.5
ANM	49.1	50.5	49.7	40.9	48.9
ASHA	6.8	4.3	5.8	0.0	5.4
Self	0.0	0.5	0.2	0.0	0.2
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	293	186	479	44	523
Satisfaction with the drop back transports services					
Completely satisfied	95.6	95.1	95.4	95.5	95.4
Somewhat satisfied	4.1	4.9	4.4	2.3	4.2
Not satisfied	0.3	0.0	0.2	2.3	0.4
No. of respondents	293	186	479	44	523
Reasons for not availing drop back transport facility					
Vehicle was not available	47.7	56.1	52.1	67.9	57.6
Driver was not available	8.0	10.6	9.4	3.7	7.4
Vehicle was not in good condition	0.4	3.8	2.2	0.0	1.4
Non-availability of fuel	0.4	0.8	0.6	0.4	0.5
Others	0.0	0.4	0.2	0.0	0.1
Lack of information about free drop back	3.4	9.5	6.6	15.7	9.8
It was told that no drop back facility available	0.4	0.0	0.2	0.0	0.1
Home near to facility	31.2	9.8	20.0	3.0	14
Couldn't call vehicle due to mobile range problem	1.3	0.0	0.6	0.0	0.4
Hospital staff told to arrange vehicle	0.4	1.9	1.2	4.1	2.2
It is NGO/trust hospital (Do not provide free transport)	0.0	0.0	0.0	0.4	0.1
Arranged the vehicle by themselves	5.9	7.2	6.6	4.9	6.0
Patient was in private facility (referral case)	0.8	0.0	0.4	0.0	0.3
No. of respondents	237	264	501	268	769
Mode of transport to reach your home					
Private transport	57.8	79.5	69.3	93.3	77.7
Public transport	2.1	2.7	2.4	1.1	1.9
Own vehicle	4.2	6.1	5.2	3.7	4.7
Others	0.0	0.0	0.0	0.0	0.0
By walk	35.4	11.7	23.0	1.9	15.6
By bullock cart	0.4	0.0	0.2	0.0	0.1
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	237	264	501	269	770
Paid for drop back from facility					
Yes	86.8	87.14	87.0	82.1	85.0
No	13.2	12.9	13.0	17.9	15.0
Total	100.0	100.0	100.0	100.0	100.0
	152	233	385	263	648
Reimbursed for drop back facility					
Yes	1.4	1.0	1.1	0.0	0.7
No	98.6	99.0	98.9	100.0	99.3
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	139	210	349	217	566
Amount reimbursed (in Rs.)					
1-300	100.0	50.0	75.0	0.0	0.7
No. of respondents	02	02	04	0	04
No. of respondents	528	450	978	314	1292

User charges are levied for OPD, admissions, diagnostic tests, blood test, etc. These add up to the out of pocket expenses. There are situations where these pregnant women are misguided and become vulnerable to exploitation by private diagnostic centres for unnecessary investigations. Table 5.11 presents the number of women who paid for registration, amount paid and if paid for any other charges in the facility by place of residence.

About 93 per cent women in tribal areas, followed by 86 per cent women in non-tribal areas and 65 per cent women in urban slums reported not paying any amount for registration in the facility. Nearly a quarter of the women in non-tribal areas and urban slums, and 10 women reported paying in the range Rs 1-5 for registration charges and 35 women and 9 women reported paying Rs 6-10 and Rs 101 respectively over and above registration charges in urban slums.

Table 5.11: Exemption from all user charges
Percentage of respondents exempted from all user charges according to residence, 2014

	Tribal	Non-tribal	Tribal+ non-tribal	Urban slums	Total
Paid for registration charges in the facility					
No	93.4	86.4	90.2	65.2	84.1
Yes	6.6	13.6	9.8	34.8	15.9
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	528	450	978	313	1291
Amount paid (in Rs)					
Did not pay any charge	93.4	86.4	90.2	65.2	84.1
Paid, but amount not known	3.2	2.4	2.9	5.1	3.4
1 – 5	1.9	6.4	4.0	8.0	5.0
6-10	0.0	2.0	0.9	11.2	3.4
11-50	0.8	1.8	1.2	4.5	2.0
51-100	0.2	0.7	0.4	3.2	1.1
101+	0.6	0.2	0.4	2.9	1.0
No. of respondents	528	450	978	313	1291
Paid any other charges in the facility (in Rs)					
Nil	97.7	95.6	96.6	86.9	94.3
Paid but amount not known	0.01	0.01	0.00	0.00	0.01
1 – 10	0.0	0.2	0.1	0.3	0.2
11-50	0.4	0.2	0.3	2.6	0.9
51-100	0.0	1.3	0.6	3.2	1.2
101+	0.9	2.0	1.4	6.7	2.7
No. of respondents	528	450	978	313	1291

SUMMARY

Almost all the women received ANC services and near about 65 per cent of them received ANC check up four to six times which is quite good. Regarding the quality of care, the ANC care was expectedly higher in third semester of the pregnancy than in the first and second trimesters. Awareness about pregnancy complications from health workers was found to be slightly higher among women in urban slums (93 per cent) as compared with women in tribal and non-tribal areas (89 per cent). However, the number of women registered for JSY was dismally low in urban slums

(13 per cent) contradicting the fact that most of the BPL households and women belonging to SCs were residing in urban slums.

Functioning of Anganwadi is unsatisfactory in urban slums and needs to be strengthened by providing essential nutrition and diet. Nearly two-thirds of the women in tribal areas delivered babies in government health facility as compared with 55 per cent women in non-tribal areas and urban slums each. Complication in pregnancy was the major reason quoted by women for delivering in private health facility. The average expenditure incurred for deliveries in private facilities is in the range of Rs 5000-25000 for about 60 per cent of the women.

Regarding entitlements under JSSK, although awareness is high the same is not reflected in the level of utilization and is prominently observed in utilization of free referral transport and free blood, if required. Although the awareness of free pick up transport facility is high, it is not reflected in the number of women seeking as observed in rural areas (35 per cent) and was almost negligible in urban slums (6 per cent).

Women paid for essential diagnostics such as blood test (20 per cent) and urine test (18 per cent) in public health facility even with awareness level as high as 80 per cent of free diagnostics. Expenses on USG test were the highest compared with other diagnostic tests. Few women (3 per cent) paid for drugs and consumables and the highest expense incurred is higher than the expense incurred on drugs and consumables by women in private facilities.

Very few women (2 per cent) required blood during childbirth and most of them have to rely on outside source for blood. It seems that when women required blood, then they are made aware of free blood services by health specialists.

Awareness appears to be provided to women as per requirement. More than 60 per cent women reported that diet service was not available at the health facility. Women had to depend on private or own vehicle for transport between health facilities. It is surprising that only less than half the number of mothers were provided with free drop back transport facility and it was far less with only 14 per cent of women in urban slums provided with free drop back transport facilities. Some women (15 per cent) reported paying user charges, especially in urban slums. Overall, awareness and utilization of JSSK services needs to be strengthened in urban slums. The table given below, presents comprehensively by awareness, utilization, and satisfaction of different entitlements of JSSK.

	Comparison of experiences with all entitlements (free)							
	Transport	Diagnostics	Drugs	Blood	Diet	Referral transport	Drop back transport	User charges
	Tribal area							
Awareness	82.0	87.9	88.3	48.5	84.8	77.1	79.0	77.3
Availed	44.9	92.7	93.9	2.5	69.3	75.0	55.5	93.4
Satisfied	95.7	76.4	93.9	73.0	97.4	75.0	95.6	93.4
	Non-tribal areas							
Awareness	77.8	84.2	84.7	52.7	82.4	77.8	76.9	76.0
Availed	25.3	91.1	85.8	2.0	73.6	69.4	41.3	86.4
Satisfied	94.1	67.9	85.8	66.6	97.5	72.2	95.1	86.4
	Urban slums							
Awareness	50.5	68.1	69.3	30.9	60.1	50.0	51.3	52.9
Availed	6.1	95.9	71.2	4.5	55.6	57.1	14.1	65.2
Satisfied	94.4	69.4	71.2	64.2	94.7	71.4	95.5	65.2

CHAPTER VI

NEONATAL HEALTH AND ENTITLEMENTS UNDER JSSK

NEW BORN CARE

Janani Shishu Suraksha Karyakram (JSSK) is an initiative that aims to reduce out-of-pocket expenses related to maternal and newborn care. The scheme is implemented across the country. It entitles pregnant mothers delivering in public health institutions to absolutely free and no expense delivery, including the caesarean section. Similar entitlements are in place for all sick newborns (first 30 days of life) and now extended to infants accessing public health institutions for treatment. The most vital component in reducing neonatal mortality is quality antenatal care, skilled health personnel attending deliveries and post-natal care for mothers and babies. This chapter examines the key services of the neonatal care and sick new borns, and utilization of entitlement of neonates under JSSK.

The JSSK Survey covers mothers whose last surviving child was born during the reference period, 1.12.2012 to 30.03.2014. The information collected is presented in Table 6.1 about the time taken for the first check up of the baby, time taken for the baby to put to breast, if any drinks given other than breast milk within 3 days of birth, types of drinks given and duration of breast feeding.

Time taken for the baby for first check up after delivery was asked to mother who had given birth during the reference period. About 73 per cent of the mothers reported baby receiving first check up within 12 hours of delivery. Near about 8 per cent each of the mothers from tribal areas and urban slums and 12 per cent mothers from non-tribal areas reported receiving first check up of the baby within two days of delivery. However, 9 per cent of mothers from tribal areas and 6 per cent of mother each from tribal areas and 4 per cent of mother from urban slums reported time taken for the first check up of the baby after delivery to be less than a week. Surprisingly, 5 per cent of mothers from Non-tribal areas and urban slums also reported time taken for the first check up after delivery to be more than a week.

Breast feeding practices have significant effects on the health of both mothers and babies. Mothers are affected through the influence of breast feeding on the period of postpartum infertility. Breast feeding, starting from the time of birth improves the nutritional status of young children and reduces morbidity and mortality.

Table 6.1 shows the breast feeding practices among babies born during the reference period by place of residence. Although the practice of breast feeding is common in Maharashtra, the initiation of breast feeding within an hour of the birth of the child is not always followed. In addition, only 78 per cent are put to the breast within the first day of life, including 52 per cent babies who are started breast feeding in the first hour of life. As recommended by the World Health Organization (WHO), breast feeding should be initiated immediately after birth and should be exclusively continued upto a minimum of six months. NFHS-3 shows only 53 per cent children under six months of age in Maharashtra are exclusively breastfed, as the WHO recommends.

Nevertheless in JSSK survey, 63 per cent of mothers from tribal areas and urban slums each and 56 per cent of mothers from non-tribal areas reported putting baby to breastfeeding for the first time immediately after birth. About 28 per cent of the mothers reported that babies were breastfed within an hour of birth, and near about 3 per cent of mothers breastfed their babies within one day of birth, while 8 per cent of babies were breastfed after one day of birth.

Near about 11 per cent of the mothers residing in tribal areas, 19 per cent residing in non-tribal areas and 14 per cent residing in urban slums reported giving other than breast milk within three days of birth. About 85 per cent of mothers reported that they exclusively breast-fed the babies for six months.

Among the mothers who provided drinks other than baby milk 71 per cent of mothers in urban slums reported providing milk other than breast milk within three days of birth; followed by 27 per cent of women reported providing sugar/glucose water; and 14 and 10 per cent of mothers reported providing honey and plain water respectively within three days of birth. A little more than 52 per cent of mothers from tribal areas reported providing sugar/glucose followed by 45 per cent who reported providing milk within three days of birth. Near about 40-44 per cent mothers from Non-tribal areas reported providing milk and sugar/glucose within three days of birth. Awareness seems to be lacking among mothers of the importance of exclusive breast-feeding, especially in non-tribal areas and urban slums.

When probed further as to who provided these drinks to babies, it is surprising that a large proportion of mothers from rural areas (70 per cent) and mothers from urban slums (77 per cent), tribal areas (68 per cent) reported that these drinks were provided by doctors. Significantly, 35 per cent of mother from tribal areas and 22 per cent mothers from non-tribal areas and 21 per cent of mothers from urban slums each reported that relatives/friends provided them.

Table 6.1 New born care
Percentage with newborn care according to residence, 2014

New born care	Tribal	Non-tribal	Tribal + Non-tribal	Urban slums	Total
Time taken for the first check up of baby after delivery					
Immediately	6.0	3.7	4.9	5.1	5.0
No check up at all	0.8	0.6	0.7	0.5	0.7
< 12 hours	73.0	72.6	72.8	74.1	73.1
<2 days	8.4	12.2	10.1	8.3	9.6
<1 week	8.7	6.0	7.5	6.4	7.2
> 1 week	2.8	4.6	3.6	5.1	4.0
Not reported	0.2	0.2	0.2	0.5	0.3
Still birth	0.2	0.2	0.2	0.0	0.1
Total	100.0	100.0	100.0	100.0	100.0
Numbers	634	518	1152	375	1527
Time taken to put the baby to breast for the first time					
Immediately	63.2	56.2	59.3	63.2	60.6
< Half an hour	21.0	21.8	21.4	19.4	20.9
< One hour	6.5	8.2	7.3	8.9	7.8
< 1 day	3.2	5.3	4.2	2.0	3.6
> 1 day	5.0	7.3	6.2	5.1	5.9
> 3 days	0.7	1.0	0.8	0.7	0.8
> 5 or more days	0.4	0.2	0.3	0.8	0.4
Total	100.0	100.0	100.0	100.0	100.0
# Numbers	815	833	1648	608	2256
Drink given other than breast milk to baby within 3 days after birth					
Yes	11.8	19.1	15.5	14.4	15.2
No	88.2	80.9	84.5	85.6	84.8
@Numbers	814	833	1647	606	2253
Type of drinks given to baby other then breast milk, within 3 days after birth					
Milk	45.3	43.9	44.4	71.3	51.3
Plain water	5.3	7.6	6.7	10.3	7.7
Sugar/Glucose water	52.6	39.5	44.4	27.6	40.1
Gripe water	1.1	0.6	0.8	0.0	0.8
Sugar salt water solution	6.3	9.6	8.3	5.7	7.7
Fruit juice	0.0	0.6	0.4	0.0	0.6
Infant formula	7.4	5.1	6.0	2.3	5.0
Honey	5.3	14.6	11.5	13.8	11.8
Janam Ghuti	1.1	0.0	0.4	0.0	1.1
Numbers	95	157	252	87	339
Drinks other than breast milk was provided by					
Doctor	68.8	70.4	69.2	77.0	71.6
ANM	7.3	10.7	9.6	10.3	9.6
ASHA	1.0	0.6	0.8	1.1	0.9
Relatives and friends	35.4	22.6	28.0	21.8	26.0
Numbers	95	155	250	87	337
Exclusively breastfed for 6 months (babies 6+ months old)					
Yes	84.5	84.9	84.7	84.4	84.6
No	15.5	15.1	15.3	15.6	15.4
Total	100.0	100.0	100.0	100.0	100.0
Numbers	401	390	791	320	1111
Note: 1. * Time taken for first check up at private deliveries are not available. 2. # @Numbers may vary as 4 Still Births & 6 babies died immediately after birth.					

It is widely recognized that a large proportion of infant deaths occurs in the neonatal period (first 28 days of life). Neonatal health can be improved by providing timely intervention and skilled care. Timely recognition of newborn illness and health care may prevent neonatal death. Table 6.2 presents the information regarding neonates suffering from ailments and treatment received by place of residence. Among the neonates a large proportion of babies are in the age group of 6-12 months (55 per cent), followed by a quarter of babies with age less than 6 months. Near about 52 per cent of the babies are male. About 14 percent of the babies surveyed were suffering from ailments.

Mothers were asked the age of the babies at the time of initiation of ailments during the neonatal period. Neonates suffering 7-30 days of birth were reported by nearly 55 per cent of mothers.

Major types of ailments were cough, cold, fever (30 per cent), followed by others (15 per cent), and dehydration and diarrhea (13 per cent). In addition, some babies suffered from Sepsis (10 per cent), followed by low birth weight, Asphyxia and Jaundice (7 per cent each). About 5 per cent babies suffered from gastric trouble, rashes on body and not crying at birth each.

Ninety five per cent of the mothers reported receiving neonatal health care from facilities. While 66 per cent mothers from tribal areas reported receiving neonatal health care from private health facility, and 32 per cent from government health facilities. Fewer mothers in non-tribal areas (9 per cent) and urban slums (13 per cent) received treatment from government health facility. Treatment for neonates from private facility was reported by 89 per cent of mothers in non-tribal areas and 82 per cent of mothers in urban slums.

Patient's choice (30 per cent from rural areas and 46 per cent urban slums) was one of the major reasons for not availing government health facility for treatment of neonates. This was followed by a quarter of mothers in rural areas reporting babies were born in private facility and hence did not seek government health facility. Near about quarter of respondents from urban slums reported poor services as the reason for not seeking government health facility which was also reported by nearly 19 per cent of mothers from rural areas. Reasons were not specified for not seeking government health facility by nearly 10 per cent mothers in non-tribal areas, 9 per cent of mothers in urban slums, and 14 per cent of mothers in tribal areas. Lack of knowledge of free service to sick baby was reported by 13 per cent mothers from non-tribal areas, whereas 12 per cent mothers from urban slums reported government health facility being too far as the reason for not availing it.

Private facility seems to be the most preferred choice by mothers for the treatment of neonates.

Table 6.2 Neonatal Health

Percentage of respondents with neonates suffering from ailments, treatment received according to residence, 2014

Ailments and treatment	Tribal	Non-tribal	Tribal +non-tribal	Urban slums	Total
Baby's age (as per the reference period)					
< 6 months	24.1	26.9	25.5	23.3	24.9
6-12 months	56.1	54.1	55.1	57.0	55.6
12+ months	19.8	19.0	19.4	19.7	19.5
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	818	839	1657	609	2206
Sex					
Male	50.4	54.3	52.3	54.2	52.8
Female	49.6	45.7	47.7	45.8	47.2
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	824	840	1664	611	2275
Suffering from ailments					
Yes	13.0	15.9	14.5	13.0	14.1
No	87.0	84.1	85.5	87.0	85.9
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	818	839	1657	609	2266
Age of baby at the time of ailment					
<7days	47.1	40.9	44.1	45.6	44.2
7-30 days	52.8	59	55.9	54.4	55.8
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	106	132	238	79	317
Ailments					
Cough, cold, fever	36.2	25.0	30.6	31.6	30.4
Dehydration/Diarrhea	14.3	9.8	12.1	20.3	13.9
Sepsis	8.6	9.8	9.2	12.7	10.1
Low birth weight	6.7	5.3	6.0	12.7	7.6
Jaundice	10.5	6.8	8.6	3.8	7.3
Asphyxia	1.9	9.8	5.9	8.9	7.0
Gastric	5.7	5.3	5.5	3.8	5.1
Baby did not cry	1.9	5.3	3.6	7.6	4.7
Rash on face/body	6.7	4.5	5.6	2.5	4.7
Vomiting	2.9	3.8	3.3	3.8	3.5
Pneumonia	0.0	6.1	3.0	2.5	3.2
Others	18.1	14.4	16.2	13.9	15.5
No. of respondents	106	132	238	79	317
Treatment in facility					
Yes	90.6	96.2	94.5	98.7	95.0
No	9.4	3.8	5.5	1.3	5.0
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	106	132	238	79	317
Type of facility					
Government	32.4	9.5	19.4	13.9	17.9
Private	66.7	89.8	79.7	82.3	80.5
Others	1.0	0.8	0.9	2.5	1.3
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	96	127	222	79	301

Reasons for not availing government facility					
Patient's Choice	29.7	30.7	30.5	46.2	34.6
Delivered in private facility, hence baby treated in private facility	23.4	26.3	25.4	13.8	22.2
Poor services	18.8	20.2	19.2	24.6	21.0
Reason not specified	14.1	10.5	11.9	9.2	11.1
Lack of information about free services to sick baby	6.3	13.2	10.7	3.1	8.6
Facility too far	1.6	5.3	4.0	12.3	6.2
Specialist not available	6.3	2.6	4.0	3.1	3.7
Staff not friendly	4.7	2.6	3.4	3.1	3.3
Medicine not available	3.1	3.5	3.4	1.5	2.9
Facility not clean	1.6	3.5	2.8	3.1	2.9
Doctor suggested to go private hospital	4.7	1.8	2.8	3.1	2.9
At the time of emergency private hospital was nearer	1.6	4.4	3.4	1.5	2.9
Facility was crowded	7.8	0.0	2.8	3.1	2.9
Others	1.6	6.1	4.5	1.5	3.7
No. of respondents	64	114	178	65	243
Note: reference period is 1 st of January, 2013 till the date of survey.					

ENTITLEMENTS UNDER JSSK

Under JSSK programme utmost emphasis is on entitlements and elimination of out of pocket expenses for both pregnant mothers and newborns accessing public health institutions. The entitlements include free treatment besides free transport both ways and between facilities in case of a referral, free drugs and consumables, free diagnostics, free blood wherever required and exemption from all kinds of user charges.

This section covers the JSSK entitlements for the neonates and level of awareness and utilization by mothers who had given birth during the reference period and sick neonates by place of residence. The highest risk of mortality is during birth and the neonatal period. Providing timely and efficient neonatal care can reduce mortality and improve the overall well-being of the neonates.

Table 6.3 presents the data about first entitlement of free pick up service to neonates, i.e., free transport from home to health facility by awareness, source of awareness, actual utilization of free transport service, person contacted, satisfaction level, and expenditure and reimbursement of amount, if any, on free pick up transport from home to health institution as reported by mother whose babies suffered ailments during the neonatal period by place of residence.

Nearly half the number of neonate babies mothers residing in rural areas were aware of the free pick up transport from home to place of delivery. However, none of the mothers of 11 sick neonate babies residing in urban slums was aware of it. The major sources of information for women in rural areas were ANM and ASHAs.

Only 15 out of 54 sick neonates' mothers (12 from tribal areas and 3 from non-tribal areas) availed free transport facility from home to health facility for treatment. Except for one sick neonate, transport facility for the other sick neonates were arranged immediately (within 30 minutes) when contacted. All the respondents were satisfied with the time taken for the transport

to reach residence. Timely arrangement of vehicle is an important factor in seeking timely health services. All the respondents reported that the vehicle took less than half an hour to reach health facility. Only one case in non-tribal areas reported paying an amount of Rs 100-500 for transport facility.

In tribal areas, the persons accompanying the mother and sick neonate in the vehicle were ANM (four neonates), ASHA (two neonates), husband (three neonates) and relatives (three neonates) whereas in non-tribal areas ANM (two neonates) and husband (one neonate) accompanied the mother for treatment of sick neonates.

Mothers reported complete satisfaction with the transport arrangement to reach health facility (11 in tribal areas and 2 in non-tribal areas) and somewhat satisfied (one each in tribal areas and non-tribal areas).

Mothers who reached health facility for treatment of sick neonates without seeking free transport facility were asked about the mode of transport and expenses incurred in reaching health facility for treatment of sick neonates from home. Seven mothers in urban slums, three mothers in non-tribal areas and eight mothers in tribal areas reached health facility in private vehicles for treatment of sick neonates. In addition, six mothers in tribal areas, two mothers in non-tribal areas and urban slums each reported reaching health facility for treatment of sick neonates by walking. Also, four mothers from tribal areas, two from non-tribal areas and one from urban slums reported receiving treatment in the same health facility where the delivery took place. Once again, lack of transport availability in tribal areas is reflected.

Mothers were also asked the average expenditure incurred on transport facility from home to health facility for the treatment of neonates. Four respondents in tribal and urban slums each and two mothers in non-tribal areas reported an amount of less than Rs 100 as the expenses incurred in travelling. Two respondents in tribal areas and one mother in non-tribal areas and in urban slums each reported the expenses incurred in reaching health facility in the range of Rs 100-200. Three mothers in urban slums and tribal areas each and one in non-tribal areas reported the expenditure in travelling to be more than Rs 200.

NEONATES: ENTITLEMENT 1 (FREE TRANSPORT HOME TO FACILITY)

Table 6.3 Free Transport Facility for Neonates
Number of respondents with knowledge and awareness of free transport facility and responses of those who tried to avail free transport facility according to place of residence, 2014

Ailments and treatment	Tribal	Non-tribal	Urban slums	Total
Aware of free transport facility to sick neonates				
Yes	16	4	0	20
No	15	8	11	34
No. of respondents	31	12	11	54
Heard about transport facility from				
ANM	14	3	0	17
ASHA	8	1	0	9
Doctor	3	0	0	3
Relatives	2	0	0	2
Friends	0	1	0	1
No. of respondents	16	4	0	20
Availed free transport facility				
Yes	12	3	0	15
No	19	9	11	39
No. of respondents	31	12	11	54
Person contacted on toll free number for arrangement of vehicle				
Self	0	1	0	1
Family member	0	1	0	1
Neighbour	1	0	0	1
ANM	10	1	0	11
ASHA	1	0	0	1
No. of respondents	12	3	0	15
Response of those who tried to contact for free transport				
Vehicle was arranged immediately	11	3	0	14
Vehicle was arranged with delay	1	0	0	1
No. of respondents	12	3	0	15
Time taken to arrange the vehicle (in minutes)				
0-10	8	2	0	10
11-30	3	1	0	4
31+	1	0	0	1
No. of respondents	12	3	0	15
Time taken for vehicle to reach the residence (in minutes)				
0-10	4	1	0	5
11-20	5	2	0	7
21-30	3	0	0	3
No. of respondents	12	3	0	15
Satisfaction with the time taken by the vehicle to reach the residence				
Completely satisfied	12	3	0	15
No. of respondents	12	3	0	15
Amount paid for availing this transport facility				
Yes	0	1	0	1
No	12	2	0	14
No. of respondents	12	3	0	15
Time taken for vehicle to reach the facility (in minutes)				
0-15	3	1	0	4
16-25	6	2	0	8
25-30	3	0	0	3
No. of respondents	12	3	0	15

Who accompanied you in the vehicle				
Husband	3	1	0	4
Relatives	3	0	0	3
ANM	4	2	0	6
ASHA	2	0	0	2
No. of respondents	12	3	0	15
Satisfaction with the time taken by the vehicle to reach the facility				
Completely satisfied	11	2	0	13
Somewhat satisfied	1	1	0	2
No. of respondents	12	3	0	15
Paid for availing this transport facility				
Yes	0	1	0	1
No	12	2	0	14
No. of respondents	12	3	0	15
Amount paid for transport (in Rs.)				
101 – 500	0	1	0	1
Amount paid for transport (in Rs.) reimbursed				
101 – 500	0	1	0	1
Reach facility (Those who didn't avail of free transport facility)				
Private transport	8	3	7	18
Public transport	0	2	0	2
Own vehicle	1	0	1	2
By walking	6	2	2	10
Treated in same hospital	4	2	1	7
No. of respondents	19	9	11	39
Total expenses for the travelling (in Rs.)				
0-100	4	3	4	11
101-200	2	1	1	4
201+	3	1	3	7
No. of respondents	9	5	8	22

Providing essential diagnostics free of cost to neonates is one of the entitlements of JSSK. When a neonate is sick and needs urgent and priority treatment for conditions like pneumonia, infections, etc. treatment should be provided free of cost. Table 6.4 presents the data on components like awareness, source of information, essential diagnostics provided to neonates and expenses (if any) incurred in availing essential diagnostics.

Only 12 out of 54 sick neonates' mothers were aware of the free essential diagnostics out of which 8 mothers were from tribal areas, three from urban slums and only one from non-tribal areas. Major sources of information were ANM and ASHAs in rural areas and ANM and relatives in urban slums.

Sick neonates provided with USG test were reported by four mothers in tribal areas, two mothers in non-tribal areas and three mothers in urban slums. Blood test was done on five neonates from tribal and non-tribal areas each and three neonates in urban slums. Urine test was done for four neonates in tribal areas, five in non-tribal areas, and three in urban slums. HIV test was carried out for two neonates in tribal, non-tribal, and urban slum areas each, and three neonates in tribal areas and two in urban slums underwent ECG test.

Only one mother in non-tribal areas reported paying an amount of Rs 100-350 and one each from non-tribal areas and urban slums reported paying Rs 350-500 for USG test of neonates. One

each of the mothers in urban slums reported the expenses incurred in USG test in the range 501-750 and Rs 750 and above respectively as the expenses incurred in USG test of neonates. One mother from tribal areas reported paying for blood tests in the range of Rs 200-300 as compared with one mother in non-tribal areas and urban slums each paying for blood tests in the range of Rs 100-200. Only one each of the mothers from non-tribal areas and urban slums reported paying in the range of Rs 50-200 and one woman from urban slums paid Rs 200 and above for urine tests of neonates.

ENTITLEMENT 2 (FREE ESSENTIAL DIAGNOSTICS)

Table 6.4 Free Essential Diagnostics for Neonates
Number of respondents with knowledge and awareness of free essential diagnostics to neonates according to place of residence, 2014

Awareness	Tribal	Non-tribal	Urban-Slums	Total
Aware of provision of free essential diagnostics				
Yes	8	1	3	12
No	23	11	8	42
No. of respondents	31	12	11	54
Heard about provision of free essential diagnostics from				
ANM	8	1	2	11
ASHA	6	1	0	7
Doctor	5	0	1	6
Relatives	1	0	2	3
No. of respondents	8	1	3	12
Received the following diagnostic services during stay in the hospital				
Ultra sonography (USG)	4	2	3	9
Blood test (incl. Hb)	5	5	3	13
Urine test	4	5	3	12
HIV test	2	2	2	6
ECG test	3	0	2	5
No. of respondents	31	12	11	54
Received diagnostic (paid/free)				
Paid at public facility for ultra sonography	0	0	0	0
Paid at private facility for ultra sonography	0	2	3	5
Free of cost at Public Facility for ultra sonography	4	0	0	4
Paid at private facility blood test (incl. Hb)	1	1	2	4
Paid at private facility urine test	0	1	2	3
No. of respondents	31	12	11	54
Amount paid for diagnostics services (Rs.)				
Ultra sonography				
100-350	0	1	0	1
351-500	0	1	1	2
501-750	0	0	1	1
751 and above	0	0	1	1
No. of respondents	0	2	3	5
Blood test (incl. Hb)				
100-200	0	1	1	2
201-300	1	0	0	1
301 and above	0	0	1	1
No. of respondents	1	1	2	4
Urine test				
50-200	0	1	1	2
201-and above	0	0	1	1
No. of respondents	0	1	2	3

Free drugs and consumables are a component of entitlement in JSSK. Table 6.5 presents the data on components like awareness, source of information, essential diagnostics provided to sick neonates and expenses (if any) incurred in availing drugs and consumables.

Nine mothers in tribal areas and four mothers in urban slums were aware of the free drugs and consumables for neonates as compared with only one mother in non-tribal areas.

Major sources of information were ANM (nine mothers) and ASHAs (seven mothers) in tribal areas, and ANM and doctors in non-tribal areas and urban slums.

The number of mothers who reported receiving all drugs and consumables free for sick neonates was 29 in tribal areas, nine in non-tribal areas and only three in urban slums. Only one mother each in tribal areas, non-tribal areas and urban slums reported receiving partially free drugs and consumables for sick neonates. Two mothers from tribal areas and three mothers from non-tribal areas and eight mothers from urban slums reported purchasing drugs and consumables from private stores as they did not receive free drugs and consumables. Since JSSK provisions are not applicable to urban slums, people from there are not benefitted.

Mothers were further asked about the cost incurred in purchasing drugs and consumables. Five mothers in urban slums reported Rs 10-200 as the expenses incurred on them. Two mothers from tribal areas and urban slums each and one mother in non-tribal areas reported the expenses in the range of Rs 201-1000. Further, one woman from urban slums and two mothers from non-tribal areas reported the expenditure in purchasing drugs of Rs 1001 and above. None of the mothers received reimbursement for purchasing drugs and consumables.

ENTITLEMENT 3 FREE DRUGS AND CONSUMABLES TO NEONATES

Table 6.5 Free drugs and Consumables to Neonates
Number of respondents with knowledge, awareness, and reimbursement of free drugs and consumables to neonates according to place of residence, 2014

Awareness and experiences	Tribal	Non-tribal	Urban-slums	Total
Aware of provision of free drugs and consumables for sick baby				
Yes	9	1	4	14
No	22	11	7	40
No. of respondents	31	12	11	54
Know about provision of free drugs and consumables through				
ANM	9	1	2	12
ASHA	7	0	0	7
Doctor	3	1	1	5
Relatives	1	0	2	3
Friends	0	0	1	1
No. of respondents	9	1	4	14
Received all drugs & consumables free of cost from the facility				
Yes	29	9	3	41
No	1	2	7	10
Partially	1	1	1	3
No. of respondents	31	12	11	54
Purchased medicines (those who did not received drugs and consumable)				
Private drug store	2	3	8	13
No. of respondents	2	3	8	13

Amount paid (in Rs.)				
10-200	0	0	5	5
201-1000	2	1	2	5
1001+	0	2	1	3
No. of respondents	2	3	8	13
Reimbursement for drugs & consumables brought from outside				
Yes	0	0	0	0
No	2	3	8	13
No. of respondents	2	3	8	13

Blood, if required, for sick neonates should be provided free of cost and it is one of the components of entitlements in JSSK. Table 6.6 presents the data on components like awareness, source of information, whether blood required and if required whether available free of cost, and expenses (if any) incurred in availing free blood. Compared with other components of entitlements, awareness regarding availability of free blood was low and only four mothers in tribal areas and one mother in non-tribal areas were aware of free blood, if required. This is most likely as blood is provided only if required. Major sources of information were ANM and ASHAs (four mothers each) in tribal areas. Only two neonates in tribal areas and one neonate in non-tribal areas required blood under treatment in health facility. All the neonates received blood free of cost from health facility.

ENTITLEMENT 4 FREE BLOOD NEONATES

Table 6.6 Free Blood Neonates
Number of respondents with awareness, and received/not received free blood for neonates
according to place of residence, 2014

Awareness and experiences	Tribal	Non-tribal	Urban-slums	Total
Aware of provision of free blood for sick baby				
Yes	4	1	0	5
No	27	11	11	49
No. of respondents	31	12	11	54
Heard about provision of free blood from				
ANM	4	1	0	5
ASHA	4	0	0	4
Doctor	2	0	0	2
Relatives	1	0	0	1
No. of respondents	4	1	0	5
Require blood during the stay in hospital				
Yes	2	1	0	3
No	29	11	11	51
No. of respondents	31	12	11	54
Received blood from				
Health facility	2	1	0	3
No. of respondents	2	1	0	3
Received free of cost (for those received from the facility)				
Yes	2	1	0	3
No. of respondents	2	1	0	3

Although free diet for neonates is not an entitlement under JSSK, mothers of sick neonates were asked whether they received free diet for neonates during their stay in health facility. Mothers who reported receiving free diet were 16 in tribal areas, 6 in non-tribal areas, and 3 in urban slums. Almost all the mothers reported that the diet was in time received and was sufficient and of good quality. Mothers were asked reasons for not availing of free diet. Most of them (10 in tribal areas, 2 in non-tribal areas, and 3 in urban slums) reported non-admittance in hospital because of not availing of free diet. Three mothers from tribal and non-tribal areas and urban slums each reported preference for home food as the reason for not availing of free diet. Two mothers from tribal areas and urban slums each and one in non-tribal areas reported non-availability of service in health facility as the reason for not availing of free diet. Relatives and husbands mainly stayed with respondents in health facility. Only four ASHAs in tribal areas and one each of ANM and ASHA from non-tribal areas reported staying with the respondents in health facility.

ENTITLEMENT 5 FREE DIET

**Table 6.7 Free Diet during stay with the baby In the health institution (not an entitlement under JSSK)
Number of respondents received/not received free diet by awareness, experiences during their stay in
health institution according to residence, 2014**

	Tribal	Non-tribal	Urban slums	Total
Received free diet during her stay in the facility				
Yes	16	6	3	25
No	15	6	8	27
No. of respondents	31	12	11	54
Sufficiency of the food (for those who received free diet)				
Yes, sufficient	15	6	3	24
Yes, somewhat sufficient	1	0	0	1
No. of respondents	16	6	3	25
Quality of the food				
Good	14	5	2	21
Alright	2	1	1	4
No. of respondents	16	6	3	25
Food served on time				
Yes	15	5	3	23
No	1	1	0	2
No. of respondents	16	6	3	25
Reason for not availing free diet				
Preferred home food	3	3	3	9
Service not available	2	1	2	5
Not admitted to the hospital	10	2	3	15
No. of respondents	15	6	8	29
Stayed in the hospital with respondent				
Husband	7	3	2	12
Relatives	20	7	9	36
ASHA	4	1	0	5
ANM	0	1	0	1
No. of respondents	31	12	11	54

Provision of free referral transport, if required, is a component of entitlement under JSSK. Table 6.8 presents the data on awareness of free referral transport, sources of information about free referral transport, persons who arrange for referral transport, and if availed whether paid for transport, and if paid whether amount reimbursed. Only 9 neonates (seven in tribal areas and two in non-tribal areas) required referral transport out of which only three respondents (two in tribal areas and one in non-tribal area) were aware of free referral transport. The source of information about free referral transport was provided by ANM. Out of the seven sick neonates in tribal areas, four neonates used private transport, two used public transport, and only one used own vehicle. Out of two sick neonates in non-tribal areas, one each used private and own transport as the mode of transport between facilities. Transport between facilities was arranged by staff of the facility for five neonates in tribal areas and one neonate in non-tribal areas and ANM arranged transport between facilities for one neonate in tribal areas. One each of the respondents of sick neonate in tribal and non-tribal areas reported payment in the range of Rs 100-1000 for transport between facilities and only in one case in tribal areas payment of Rs 1000 and above for referral transport was made. Inaccessibility of public transport has led to expensive treatment for tribals.

Table 6.8: Free transport between facilities to neonates in case of referral (if applicable)

Number of respondents received/not received free referral transport during their stay in health institution according to residence, 2014				
Awareness and experiences	Tribal	Non-tribal	Urban slums	Total
Aware of provision of free transport facility in case of referral				
Yes	2	1	0	3
No	5	1	0	6
No. of respondents	7	2	0	9
Source of information about provision of free transport facility in case of referral				
ANM	2	1	0	3
No. of respondents	2	1	0	3
Reached the facility directly from home/referred from other facility				
Referred from other facility	7	2	0	9
No. of respondents	7	2	0	9
Mode of transport between facilities				
Private transport	4	1	0	5
Public transport	1	0	0	1
Own vehicle	2	1	0	3
No. of respondents	7	2	0	9
Referral transport arranged by				
Staff of the facility	5	1	0	6
ANM	1	0	0	1
Self	1	1	0	2
No. of respondents	7	2	0	9
Paid for the referral transport				
Yes	2	1	0	3
No	5	1	0	6
No. of respondents	7	2	0	9
Amount paid for those who paid for the referral transport (in Rs.)				
100-1000	1	1	0	2
1001+	1	0	0	1
No. of respondents	2	1	0	3

Provision of free drop back facilities is a component of entitlement under JSSK. Table 6.9 presents the information on awareness of free drop back facilities, source of information about free drop back facilities, number of days stayed in the facility after delivery, received drop back facilities, waiting time, drop back arranged, reasons for not availing drop back, level of satisfaction for drop back, drop back arranged by, mode of transport for drop back, payment for drop back, amount paid for drop back and if paid whether the amount reimbursed. While none of the mothers in urban slums knew about free drop back transport facilities, six mothers in tribal areas and one woman in non-tribal area were aware of them. Major sources of information were ANM and ASHA (six mothers each) in tribal areas, whereas one woman in non-tribal areas received information from ANM and doctor.

Seventeen neonates in tribal areas, five in non-tribal areas, and three in urban slums stayed for less than an hour in health facility. Five neonates in tribal areas, one in non-tribal areas, and three in urban slums stayed for less than two days in the health facility. Further, five neonates in tribal areas, four in non-tribal areas, and one in urban slums stayed for more than five days in health facility as reported by mothers.

Mothers of 14 neonates in tribal areas, three in non-tribal areas, and only one in urban slums reported receiving drop back facility from health facility. Mothers of seven neonates from tribal areas and two from non-tribal areas reported waiting time of upto 15 minutes for the drop back facility. It was 16 to 30 minutes for five mothers of sick neonates in tribal areas. One mother in non-tribal areas, two mothers in tribal areas and one mother in urban slums reported waiting time of more than one hour. Drop back facility was arranged by the staff of health facility for 10 neonates in rural areas and one neonate in urban slums, whereas ANM and ASHA arranged for it for six neonates in tribal and non-tribal areas each.

Mothers reporting complete satisfaction with the transport arrangement was 17; while somewhat satisfied was one mother from tribal areas. Reasons were also asked for not availing free drop back transport facility. The major reason for it was that PHC vehicle was not available and home was nearby which was reported by 10 mothers in tribal areas, and seven mothers from non-tribal areas and urban slums each.

Further, mothers who did not avail of free drop back facilities were asked the mode of transport for reaching home. Ten mothers from tribal areas, one from urban slums, and six from non-tribal areas reported private vehicle as the alternative mode of transport. Five mothers in tribal areas and one mother in non-tribal areas reported walking back to home. Twelve mothers from tribal areas, nine from non-tribal areas, and ten from urban slums paid for drop back transport. Only one neonate in non-tribal areas reported that the amount was reimbursed upto Rs 500.

Table 6.9 : Free drop back from institution to home to neonates
Number of neonates received free drop back from institution to home
according to residence, 2014

Awareness and experiences	Tribal	Non-tribal	Urban slums	Total
Aware of free drop back facility from institution to home				
Yes	6	1	0	7
No	25	11	11	47
No. of respondents	31	12	11	54
Source of information about provision of free drop back facility				
ANM	6	1	0	7
ASHA	6	0	0	6
Doctor	2	1	0	3
Relatives/friends	1	0	0	1
No. of respondents	6	1	0	7
No. of days/hrs stayed in the facility				
<1 hour	17	5	3	25
<2 days	5	1	3	9
<3 days	3	2	0	5
<4 days	1	0	4	5
5+days	5	4	1	10
No. of respondents	31	12	11	54
Received drop-back facility after discharge from facility				
Yes	14	3	1	18
No	17	9	10	36
No. of respondents	31	12	11	54
Waiting time for drop back facility after discharge for those who received the service (in minutes)				
<15	7	2	0	9
<30	5	1	0	6
30 +	2	0	1	3
No. of respondents	14	3	1	18
Drop back arranged by				
Staff of the facility	8	2	1	11
ANM	5	1	0	6
ASHA	5	1	0	6
No. of respondents	14	3	1	18
Satisfaction with the drop back transports services				
Completely satisfied	13	3	1	17
Somewhat satisfied	1	0	0	1
No. of respondents	14	3	1	18

Awareness and experiences	Tribal	Non-tribal	Urban slums	Total
Reasons for not availing drop back transport facility				
PHC ambulance was not available	5	4	4	13
Vehicle was not available	1	1	3	5
Driver was not available	1	0	0	1
Vehicle was not in good condition	2	0	0	2
Home is near to facility	5	1	0	6
Lack of information about free drop back	3	3	3	9
No. of respondents	17	9	10	36
Mode of transport to reach your home				
Private transport	10	6	9	25
Public transport	0	1	0	1
Own vehicle	2	1	1	4
By walk	5	1	0	6
No. of respondents	17	9	10	36
Paid for drop back from facility				
Yes	12	9	10	31
No	14	2	1	17
NA (Reached home by walk, no expenses)	5	1	0	6
No. of respondents	31	12	11	54
Reimbursed for drop back facility				
Yes	0	1	0	1
No				
Total	12	8	10	30
No. of respondents	12	9	10	31
Amount reimbursed (in Rs.)				
1-500	0	1	0	1

Finally, exemption from all user charges is one of the components of free entitlement under JSSK. Table 6.10 presents the number of mothers who paid for registration, amount paid for registration, and payment of other charges in the facility by place of residence. Three mothers in tribal areas, followed by two mothers in non-tribal areas and three mothers in urban slums reported payment for registration in the health facility.

Table 6.10: Exemption from all kind of user charges
Number of respondents with awareness and experiences regarding exemption from all kind of user charges according to place of residence, 2014

Awareness and experiences	Tribal	Non-tribal	Urban slums	Total
Paid any registration charges				
Yes	3	2	3	8
No	28	10	8	46
No. of respondents	31	12	11	54
Paid any other charges				
Yes	0	0	2	2
No	31	12	9	52
No. of respondents	31	12	11	54

SUMMARY

	Comparison of experiences with all entitlements							
	Free transport	Free diagnostics	Free drugs	Free blood	Free diet	Free referral transport	Free drop back transport	Exemption from user charges
Awareness	20/54	12/54	14/54	5/54	1	3/9	7/54	46/54
Availed	15/54	46/54	41/54	3 children required	25/54	1/3	18/54	52/54
Satisfied	100%	32%	No reimbursement	100%	85%	No reimbursement	100%	Not Applicable

The above summary table shows that except for awareness regarding exemption from user charges, awareness for other entitlements is very low and it is almost negligible in the case of free blood, free referral and drop back transport facilities. Free drugs and diagnostics were not available to all the neonates and this needs examination.

It is appreciable that nearly 90 per cent of neonates received check up within first hour of delivery. Near about 85 per cent of babies were exclusively breastfed for months. Still nearly 30 per cent neonates were provided food apart from breast milk within first three days of birth. Focus should be on exclusive breast-feeding, particularly for mothers in non-tribal areas and urban slums.

CHAPTER VII

HOME DELIVERIES

HOME DELIVERIES

Safe motherhood and childbirth depends on the care and attention provided to pregnant women and newborns, availability of skilled health personnel and health facilities, equipments, medicines and emergency care when needed. The difficulty in reaching mothers and babies who are born at home and provide them with effective and timely maternal and neonatal interventions is matter of concern. The public health midwife's role became more of an institutional delivery assistant and plays a major role in declining maternal and neonatal morbidity and mortality. Cultural beliefs and traditions, distance to health facility, cost of health service, language barrier and other reasons deter a mother from seeking health services and she prefers a home delivery. This chapter deals with home deliveries, opinion of women about the services provided by the government health workers and reasons for not accessing health facilities.

Table 7.1 shows the distribution of women by place of residence having delivered at home, by assistance during delivery, reasons for not going to health institutions, visits by health workers at home, satisfaction with the duration of time spent, and advice provided by health workers. NFHS-3 shows that two out of three births in Maharashtra take place in a health facility; and one out of three takes place at home.

Our survey shows that out of the total births, 8 per cent were home deliveries and among the home deliveries 50 per cent took place in tribal areas and a quarter of deliveries in non-tribal areas and urban slums.

The main reason for not going to health institutions is presented in table 7.1 according to residence. Nearly 69 per cent of the women stated that due to emergency, they could not deliver in health institutions. This was observed more in non-tribal areas (78 per cent) than in tribal areas (65 per cent) and urban slums (69 per cent). About 17 per cent women mentioned 'health facility too far/no transportation' as the reason for home deliveries and is more in urban slums (25 per cent) than in rural areas (tribal areas 13 per cent and non-tribal areas 12 per cent). Probably the availability of free transport is not as available in urban slums as in tribal and non-tribal areas. Not necessary to go health facility for delivery' was also reported by 12 per cent of women and surprisingly the highest proportion for it was reported from urban slums (15 per cent), followed by tribal areas (13.7 per cent). Other factors contributing for not going to health institutions for delivery were 'not customary'(5 per cent), delayed arrival of transport and 'cost too much'(4 per cent each), poor facility, don't trust facility and 'facility not open' (3 per cent each). About 2 per cent of the women did not opt for institutional delivery due to TBA available and their family did not allow each. Thus, emergency and lack of transport facilities were major reasons for home delivery.

Generally assistance during delivery can be provided by medical staff (doctors, ANM/nurses/LHV/ TBA/ un-trained *dais*)/relatives/friends. In Maharashtra, 69 per cent of births during the past five years took place with assistance from a health professional, and 21 per cent

were delivered by a traditional birth attendant. The remaining 10 per cent were delivered by a relative or other untrained person. Notably, only 13 per cent of home births were assisted by health personnel (NFHS3).

Only 6 per cent of home deliveries were attended were assisted by doctors (9 per cent in non-tribal areas, 3 per cent in tribal areas and 6 per cent in urban slums). Dais (TBA) assisted a little more than half of the home deliveries (51 per cent), 44 per cent was attended by relatives and friends, ANM (11 per cent), one per cent by untrained *dais* and one per cent of home deliveries were not attended by anyone. Overall health professionals attended 66 per cent of deliveries that took place at home.

About 43 per cent of women from urban slums, 32 per cent from tribal areas and 27 per cent from non-tribal areas reported the need to take mother or baby to the nearest health facility after delivery.

In rural areas, 74 per cent births at home were visited by health professionals within two months of delivery as compared with 68 per cent in urban slums. While 33 per cent (32 percent in tribal areas, 27 per cent in non tribal areas and 43 per cent in urban slums) of women reported immediate check up after delivery, 17 per cent reported no check up after delivery.

In tribal areas about 77 per cent of women reported the first check up done by ANM, whereas 61 per cent of women in non-tribal areas and little more than half of women (55 per cent) in urban slums reported first check up by doctors.

A little more than half (51 per cent) of women in tribal areas and 40 per cent in non-tribal areas reported home as the place of first check up compared with women in urban slums who reported private hospital, government hospital and home (19 per cent each) as the place of first check up. More than a quarter of women (28 per cent) in tribal areas, 20 per cent in non-tribal areas and 13 per cent in urban slums reported PHC as the place of first check up. Substantial number of women (31 per cent) reported private hospital as the place of first check up in non-tribal areas and 16 per cent women in urban slums reported municipal hospital as the place of first check up. This result implicates the presence of health worker more in rural areas as compared with urban slums. Almost 87 per cent of women reported checking the babies' health at the same time and 91 per cent of the babies who were checked were weighed. Out of the total babies weighed, nearly a quarter number of babies in tribal areas weighed less than 2.5 kg compared with 18 per cent in non-tribal areas and 10 per cent in urban slums. The proportion of home deliveries was higher in tribal areas and the babies weighing less than 2.5 kg was also high in tribal areas. This emphasize the need of emergency care and transportation in tribal areas may reduce the number of home deliveries thereby providing timely and adequate care to newborns.

Table 7.1 Percentage of respondents with home deliveries, post natal and neonatal care according to residence, 2014

Delivery, postnatal, and neonatal care	Tribal	Non-Tribal	Tribal +non-tribal	Urban slums	Total
Reasons for home delivery					
Emergency	65.7	78.4	69.9	68.2	69.5
Too far/no transportation	15.7	13.7	15.0	25.0	17.3
Not necessary to go to facility	13.7	5.9	11.1	15.9	12.2
Not customary to deliver at facility	7.8	3.9	6.5	0.0	5.1
Delayed arrival of transport	4.9	2.0	3.9	4.5	4.1
Costs too much	2.9	5.9	3.9	4.5	4.1
Poor service	3.9	2.0	3.3	4.5	3.6
Facility not open	3.9	0.0	2.6	4.5	3.0
Don't trust facility	3.9	3.9	3.9	0.0	3.0
Husband/family does not allow	2.9	0.0	2.0	4.5	2.5
TAB/dai available	2.9	0.0	2.0	0.0	1.5
No female provider at facility	1.0	2.0	1.3	0.0	1.0
Daily work gets hampered	1.0	0.0	0.7	0.0	0.5
No. of respondents	102	51	153	44	197
Assisted by					
Dai (TBA)	55.9	56.9	56.2	36.4	51.8
Friends/relatives	41.2	39.2	40.5	56.8	44.2
ANM/nurse/midwife/LHW	8.8	13.7	10.5	11.4	10.7
Doctor	3.9	9.8	5.9	6.8	6.1
None	1.0	0.0	0.7	2.3	1.0
Untrained dai	2.0	0.0	1.3	0.0	1.0
No. of respondents	102	51	153	44	197
Need to take mother or baby to nearest health facility after delivery					
Yes	32.4	27.5	30.7	43.2	33.5
No	67.6	72.5	69.3	56.8	66.5
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	102	51	153	44	197
Checked by health personnel within two months of delivery					
Yes	73.9	75.7	74.5	68.0	73.3
No	26.1	24.3	25.5	32.0	26.7
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	69	37	106	24	130
First health check up after the delivery					
No check up	17.6	17.6	17.6	18.2	17.8
Immediately	32.4	27.5	30.7	43.2	33.5
< 12 hours	12.7	11.8	12.4	9.1	11.7
< 2 days	14.7	15.7	15.0	11.4	14.2
< 1 week	12.7	3.9	9.8	4.5	8.6
1 + week	9.8	23.5	14.4	13.6	14.2
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	102	51	153	144	197
Checked first time by					
Doctor	38.1	61.9	46.0	55.6	48.1
ANM/nurse midwife/LHW	77.4	42.9	65.9	50.0	62.3
No. of respondents	84	42	126	36	162
Place of first check up					
Home	51.2	40.5	47.6	19.4	41.4
PHC	28.6	19.0	25.4	13.9	22.8
Private hospital	3.6	31.0	12.7	19.4	14.2
Sub centre	11.9	4.8	9.5	5.6	8.6

Government/women's hospital	1.2	0.0	0.8	19.4	4.9
Municipal hospital	0.0	0.0	0.0	16.7	3.7
Rural hospital	3.6	4.8	4.0	2.8	3.7
SDH	0.0	0.0	0.0	2.8	0.6
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	84	42	126	36	162
Checked babies' health at the same time					
Yes	87.3	86.0	86.8	88.6	87.2
No	12.7	14.0	13.2	11.4	12.8
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	102	51	152	44	196
Baby weighed					
Yes	93.5	84.4	90.6	90.2	90.5
No	6.5	15.6	9.4	9.8	9.5
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	93	45	138	41	179
Weight of baby (in kg)					
< 2.5	25.3	18.4	23.2	10.8	20.4
2.5	74.7	81.6	76.8	89.2	79.6
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	87	38	125	37	162

HOME DELIVERIES BY DISTRICTS

Table 7.2 shows the distribution of women who did not deliver in health institutions during the reference period by districts. Out of the total 197 home deliveries, 58 women from Nanded and Amravati districts each, 42 women in Nashik district and 20 women from Pune district opted for home deliveries.

Reasons were asked for opting for home deliveries. Emergency and hampering of daily work were reported by eleven, seven, ten and six women from Amravati, Nanded, Nashik and Pune districts respectively. Other factors contributing for not going to health institutions for delivery were health facility was too far, no transportation (eight women in Amravati district and eleven women in Nashik district), not necessary to go to facility (five women in Amravati district and three women in Nashik district), delayed arrival of transport (six women in Nashik district) and facility not open (three women in Nanded district). It seems most of the home deliveries are due to emergencies. During the reference period about 40 home deliveries in Amravati, 35 in Nanded districts, 21 in Nashik district and 9 in Pune district were assisted by Dai/TBA. About 19 home deliveries in Amravati, 21 in Nanded districts, 18 in Nashik district and nine in Pune district were assisted by relatives and friends. ANM/nurses/midwives/LHV assisted nine home deliveries in Nanded district, six in Amravati district, five in Nashik district and only one in Pune district. Overall, health professionals assisted 47 home deliveries in Amravati district, 48 in Nanded district, 31 in Nashik district and 12 in Pune district.

About 14 women from Amravati district, 15 in Nanded district, 27 in Nashik district and 10 in Pune district reported the need to take mother or baby to the nearest health facility after delivery. The numbers of mothers and babies visited by health professionals within two months of delivery were 32 in Amravati district, 30 in Nanded district, 24 in Nashik district and nine in Pune district.

Home visit within the first two days of delivery can reduce neonatal morbidity and mortality and are more effective as compared with later visits. The early post natal period (first seven days of life) is also critical for initiating the high impact life saving behaviors, including exclusive breastfeeding.

Fourteen women in Amravati district, 15 in Nashik district 27 in Nanded district and ten Pune district reported immediate check up after delivery. There were 17 women from Amravati district, ten women from Nashik district, seven from Nanded district and one from Pune district who reported no check up after delivery. Twelve women from Amravati district, seven in Nashik district, five in Nanded district and four in Pune district reported receiving health check up within two days. However, 13 women from Nanded district, nine from Nashik district and six from Amravati district reported receiving health check up after more than a week of delivery.

In Amravati, Nanded, Nashik and Pune districts about 42, 31, 15 and 13 women respectively reported that the first check up was done by ANM/nurse/midwife whereas 26 women in Nashik district reported that it was done by doctors.

The numbers of women who reported home as the place of first check up were 28, 19, 15 and five from Amravati, Nanded, Nashik and Pune districts respectively. Seventeen women from Nanded district reported private hospital as the place of first check up. Women who reported PHC as the place of first check up were eight from Amravati district, eleven from Nanded district and nine from Nashik and Pune districts each.

Checking of babies' health and weighing were reported by 57, 50, 44 and 19 women from Nanded, Amravati, Nashik and Pune districts respectively. Out of the total of babies who were weighed nearly 30 babies from Amravati, 28 from Nanded districts, 24 from Nashik district and nine from Pune district respectively weighed less than 2.5 kg. This implies that nearly half the babies delivered at home were underweight and mostly found in Nanded district.

Table 7.2:Home deliveries and postnatal and neonatal care

Number of respondents with home deliveries, post-natal and neonatal care according to residence, 2014					
Delivery, post-natal, and neonatal care	Amravati	Nanded	Nashik	Pune	Total
Intended to deliver at home					
Yes	58	58	42	20	178
No	5	6	7	1	19
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	63	64	49	21	197
Reasons for home delivery					
Emergency	11	7	10	6	137
Too far / no transportation	8	2	11	3	34
Not necessary to go to facility	5	1	3	1	24
Not customary to deliver at facility	2	2	0	4	10
Delayed arrival of transport	0	2	6	0	8
Costs too much	1	1	2	3	8
Poor service	1	2	1	2	7
Facility not open	1	3	1	1	6
Don't trust facility	2	0	2	1	6

Husband/family does not allow	0	0	3	0	5
TAB/dai available	1	0	1	0	3
No female provider at facility	1	0	0	0	2
Daily work gets hampered	11	7	10	6	1
No. of respondents	63	64	49	21	197
Assisted by					
Dai (TBA)	40	35	21	9	106
Friends/relatives	19	21	18	9	66
ANM/nurse/midwife/LHW	6	9	5	1	21
Doctor	1	4	5	2	12
No one	0	0	1	1	2
No. of respondents	63	64	49	21	197
Need to take mother or baby to nearest health facility after delivery					
Yes	14	27	15	10	66
No	49	37	34	11	131
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	63	64	49	21	197
Checked by health personnel within two months after delivery (no cases)					
Yes	32	30	24	9	95
No	17	7	10	1	35
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	49	37	34	10	130
First health check up after the delivery					
No check up	17	7	10	1	35
Immediately	14	27	15	10	66
< 12 hours	4	10	5	4	23
< 2 days	12	5	7	4	28
< 1 week	10	2	3	2	17
1 + week	6	13	9	0	28
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	63	64	49	21	197
Checked first time by					
Doctor	12	32	26	8	78
ANM/nurse/midwife/LHW	42	31	15	13	101
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	46	57	39	20	162
Place of first check up					
Home	28	19	15	5	67
PHC	8	11	9	9	37
Private hospital	0	17	3	3	23
Sub-centre	7	1	5	1	14
Government /women's hospital	3	4	1	0	8
Municipal hospital	0	0	4	2	6
Rural hospital	0	5	1	0	6
SDH	0	0	1	0	1
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	46	57	39	20	162
Checked babies' health at the same time					
Yes	50	57	45	19	172
No	12	7	4	2	25
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	62	64	49	21	196

Baby weighed					
Yes	59	56	44	20	178
No	4	8	5	1	19
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	52	61	46	20	179
Weight of baby (in kg)					
< 2.5 kg	30	28	24	9	90
2.5 + Kg	33	36	25	12	107
Total	100.0	100.0	100.0	100.0	100.0
No. of respondents	46	57	39	20	162

SUMMARY

As reflected from above tables, most of the home deliveries were out of choice and emergency, and health facility being too far. However, 66 per cent of the home deliveries were assisted by skilled health personnel. The proportion of home deliveries was higher as well as the number of babies weighing less than 2.5 kg were high in tribal areas.

Most of the home deliveries were reported from Amravati and Nanded districts, followed by Nashik and Pune districts. The reasons for home deliveries were the same as mentioned above. Home deliveries can be reduced substantially by providing timely transport service and emergency care primarily in tribal areas.

CHAPTER VIII

HEALTH FACILITIES

The government health facilities are expected to provide JSSK services. Health service providers play a key role in communicating and providing JSSK services to the community. They are also expected to provide information on JSSK services and counsel expectant mothers while providing ANC services. A separate section was canvassed for the health providers of the selected health facilities to assess the extent of utilization of JSSK services by eligible women and neonates, and to find out the limitations in providing the JSSK services.

Health Facility Survey was conducted along with the JSSK survey. It includes sub-centres, primary health centres (PHCs), Sub District Hospitals (SDHs), District Hospitals (DHs) and community health centres (CHC) who provide JSSK services. The basic objective of facility survey is to collect data on health personnel, availability of drugs/medicines, equipments, basic ANC care, delivery, post-natal care, communication means and infrastructure at the level of sub-centres, PHC and CHC in order to assess the adequacy, outcome and shortcomings, if any, of JSSK services.

In all the 117 sub-centres (59 tribal, 42 non-tribal and 16 urban areas) covering 20 PHCs (eight in tribal and non-tribal areas each and four in urban wards), seven CHCs, four government/WH, 3DH, four SDH and three THO from the selected four districts were visited and details on JSSK service were collected. Section below gives the comprehensive information furnished by service providers from the facilities visited.

8.1 IMPLEMENTATION OF JSSK SERVICES AND LIMITATIONS:

The facilities visited provide JSSK services. Out of the 96 facilities visited, health service providers from 62 facilities are aware about all the five entitlements of pregnant women under JSSK. Neonatal cares are provided in two each of DHs and WHs, four SDHs and six RHs. However, out of 17 PHCs visited, in 15 PHCs neo-natal care is not available. At RHs and PHCs only one or two warmers are functioning. Consequently, there is a high demand of neonatal care facility in DHs or higher referral facilities. It was observed in DHs that they were treating neonates thrice their bed strength. Neonatal care can be further strengthened at PHC level by providing better infrastructure such as functional equipment and regular training to health staff.

All the facilities provide ANC services. Delivery is conducted in all the facilities except in three SCs (Jalgaon, Deola and Rui), C-section deliveries can be provided at PHC level by providing LSCS training to MOs, thereby reducing the burden on higher facilities and minimizing the loss of time in providing emergency care.

Regarding the adequacy of supplies in the facilities visited, 16 sub-centres, six PHCs and one RH are inadequately supplied. However, all the facilities have adequate stock/supply of essential drugs for JSSK services. In case of provision of free drugs to the patients, providers from 93 facilities responded that free drugs are available for distribution. However, three facilities reported shortage

in supply. Wherever there is a shortage, health service providers ensure timely availability of medicines through RKS funds.

Among the 96 facilities visited, 55 facilities face problem in providing transport services. Prominent problems faced by the users are non-availability of ambulance in time as many times the vehicle had gone to drop the referral patient, drivers are not available in time, low salaries of drivers, lack of phone coverage mainly in tribal and hilly areas, difficulty in reaching these areas and poor road conditions. Except 59 SCs, all the other visited facilities are having vehicle for referral services.

Out of 96 health facilities, only 11 facilities have USG facility. At some of the facilities while USG machine is available, skill manpower is not available to operate it. In SDH, Indapur in Pune district USG is not functioning for the last one year. Fifty-six health facilities provide reimbursement of USG tests.

Free blood and urine tests are provided in all the facilities except in three SCs (Rui, Akole and Kazad) in Pune district. Free diet is provided in all the health facilities except in SCs. User charge is not levied in any of the facilities visited.

When asked about the impact of implementation of JSSK services, a total of 19 facilities reported increase in institutional deliveries, 18 facilities reported a decrease in maternal and infant deaths and 49 facilities reported both. Nearly 34 facilities reported that the present infrastructure is not adequate to provide the JSSK services.

8.2 SUGGESTIONS FROM HEALTH PROVIDERS:

- Awareness of people regarding ANC, delivery, post-natal care and JSSK can be provided through Kalapathak.
- Vehicles and drivers are required for efficiently providing JSSK services. Present salaries of drivers at Rs 6000 a month is insufficient, considering that they have to work at night.
- Available staff is inadequate and hence it is recommended to fill up the vacant slots at the earliest.
- Diet and staying facility for mother/accompanying person should be provided. At present the money available for the diet (Rs 100) is insufficient to provide nutritious diet. Provision of diet can be extended upto SC level.
- Regular supply of medicines is required to provide uninterrupted service.
- Cleanliness needs to be improved through proper IEC.

8.3 OBSERVATIONS ON HEALTH FACILITIES VISITED

NASHIK DISTRICT

All the four facilities (PHCs) visited are located within the village. MOs and other staffs provide good JSSK services to the beneficiaries. IEC material is displayed in the facilities. They are in a good condition and MOs of the respective PHC stays at the headquarters and has good rapport with the local leaders. Overall, PHCs are well maintained and teamwork is good at the facilities. However, out of four PHCs visited, one PHC, Kaluste (Igatpuri block) requires repairs and maintenance.

As an innovative idea prior to the inception of JSSK, MO of PHC (Khamkheda) provided free medicines to pregnant women and drop back to mothers and babies by PHC vehicle from RKS funds. Such an innovation was rewarded by installing solar system in this PHC.

NANDED DISTRICT

All the four facilities (PHCs) visited are located in the vicinity of the village. Two facilities- Ashta PHC of Mahur block and Shivani PHC of Kinwat block- are not in a good condition. Most of the staff was absent on the day of the visit by the PRC. MOs and other staffs do not stay at the facility. Except Shivani PHC, all the other facilities have displayed IEC material of JSSK.

All the facilities visited are having pick up, referral and drop back facility. However, they are facing some constraint about the availability of driver 24x7 due to availability of only one driver. In addition at times there is a high demand of transport. At the time of visit it was reported that the driver has not received his salary for the last 3 months resulting in absence of the driver on call. In addition, drivers are supposed to get Rs. 100/- per month for mobile recharge. This amount is also not paid to them.

Except Hanegaon PHC, remaining three PHC's from Nanded district are not good in terms of JSSK services. The numbers of deliveries at facilities are also decreasing. Reverse is observed in Hanegaon PHC where the number of institutional deliveries has increased from 148 in 2010-11 to 274 in 2013-14. Out of the four PHCs visited for JSSK study, only PHC (Kini of Bhokar block) provides free diet to women who delivered at facilities. At PHCs in Ashta and Hanegaon Rs. 300/- is paid as diet allowance by cash and cheque. At PHC (Shivani) diet is not provided.

At Hanegaon PHC newborn care corner is functioning well. In other facilities equipment is either not functioning or is given for repair since long. In PHC Kini one each of warmer and phototherapy unit although available is not in working condition for the last one year and MO has not reported it to the authorities and labour room does not have an attached toilet. However, IEC material is displayed.

There is also a problem in providing diet @Rs. 100/- per day (two meals, breakfast, and tea). In the village people are not willing to provide meals @ Rs. 100/-

AMRAVATI DISTRICT

All the four facilities visited (Pathred PHC of Achalpur block, Palakhed PHC of Chandur railway block, Tembharsanda PHC of Chikaldara block and Dhulgat railway PHC of Dharani block) are in good conditions. IEC-related materials and transport services are available in all the visited facilities except in Tembharsanda PHC and Dhulgat railway PHC. These PHCs are located in hilly areas and hence there is no mobile range. However, free transport service is provided by reimbursement. All the four PHCs provide free diet and are in good condition.

PUNE DISTRICT

All the health facilities visited provides good service of JSSK except Adiware PHC of Ambegaon block as it is a hilly area without mobile range. SDH, Indapur is located in non-tribal blocks. Although adequate infrastructure is available, the facility does not manage high risk pregnancies and sick neonates and infants are mainly referred to hospitals in Pune. There is a shortage of specialist doctors. Sonography machine is not working for the last one year and is under repair. The facility provides free diet.

Under Kalas PHC one sub-center does not have its own building. In Kalas PHC normal deliveries are conducted but C-section deliveries are referred to private hospitals. In addition educational qualification of PHC pharmacists is 10th grade. PHC provides diet with a limited budget which is a constraint.

Khamgaon PHC is located in Daund block but is functioning in a sub-center building. Although new building has been constructed at Gav Dimode in a new village, the building has not yet been handed over to the Health Department. Hence, only OPD is conducted and deliveries are not conducted. This PHC is near Pune city and is only 35 km from Khamgaon PHC.

Rural hospital, Yavat has pick up and drop back facilities, and diet service is also available. However, high risk pregnancies and sick neonates are not attended and are referred mainly to hospital in Pune.

8.4 AVAILABILITY OF DRUGS AND CONSUMABLES

Expenditure on drugs constitutes more than 70 per cent of the health care cost. Provision of free drugs in public health facilities can bring enormous relief to people and substantially bring down out of pocket expenditure on health. Provision of free essential drugs is one of the most important steps towards mitigating the burden of health care costs.

In addition to the survey of beneficiaries under the JSSK, the relevant health facilities were visited to examine the adequacy of required equipment, drugs and consumables as per the JSSK guidelines. JSSK stipulates the drugs and consumables for normal delivery, C-section delivery and

sick neonates in public institutions. The study evaluated the following essential drugs and consumables available in health institutions as per the JSSK guidelines.

Tables 8.41 to 8.45 present the list of essential drugs available by types of facilities. Tables given below present the list of essential drugs which are either not available or in short supply in less than half the number of total facilities:

Table 8.41: List of essential drugs unavailable and in short supply in DHs (4)

Sr. No	Essential Drugs	No. of facilities available
1.	Inj. Betamethasine sod. Phosphate, IP – betamethasone 4mg per 1ml in 1 ml ampoule	0
2.	Inj. Corboprost	0
3.	Inj. Isoxsuprine 10 mg ampoules	0
4.	Inj. Prostodin	0
5.	Inj. Terbutaline 0.25 mg	0
6.	Tab Domperidone 10mg	1
7.	Tab Folic Acid IP 400 µg	1
8.	Hypodermic Syringe for single use BP/BIS 20 ml	1
9.	Povidone Iodine Ointment IP containing Povidone Iodine, IP 5% W/W; 15g in each tube	1

Table 8.41 shows essential drugs such as Inj. Betamethasine sod. Phosphate, IP – betamethasone 4mg per 1ml in 1 ml ampoule, Inj. Isoxsuprine 10 mg ampoules, Inj. Corboprost, Inj. Prostodin, and Inj. Terbutaline 0.25 mg which are not available in any of the DHs visited. Drugs such as Inj. Betamethasine sod. Phosphate, IP – betamethasone 4mg per 1ml in 1 ml ampoule may be required in C Section cases.

Table 8.42: List of essential drugs unavailable and in short supply in RHs (7)

Sr. No	Essential Drugs	No. of facilities available
1.	Inj. Anti D Immunoglobuline Injection Polyclonal Human Anti RhD Immunoglobuline 300 mg	0
2.	Inj. Betamethasine sod. Phosphate, IP – betamethasone 4mg per 1ml in 1 ml ampoule	1
3.	Inj. Corboprost	1
4.	Inj. Isoxsuprine 10 mg ampoules	1
5.	Inj. Prostodin	0
6.	Inj. Terbutaline 0.25 mg	0
7.	Inj. Thiopentone, Thiopentone 500mg and sodium carbonate	3
8.	Tab Digoxin – Digoxin IP 250 µg/tab	1
9.	Tab Folic Acid IP 400 µg	3
10.	Dinoprostone Gel	1
11.	Ethilon no. 1	2
12.	Hypodermic Syringe for single use BP/BIS 20 ml	2
13.	K-90, Plain Catheter	2
14.	Polyglycolic Acid braided, coated and absorbable, No. 1 on ½ circle round body needle	3
15.	Spinal Needle Disposable Adult as per BIS, 23 Gauze (70-90 mm without hub)	3
16.	Sponges	3

Essential drugs such as Inj. Anti D Immunoglobuline Injection Polyclonal Human Anti RhD Immunoglobuline 300 mg , Inj. Prostodin and Inj. Terbutaline 0.25 mg are not available in any of the RHs visited.

Table 8.43: List of essential drugs unavailable and short supply in SDHs (5)

Sr. No	Essential Drugs	No. of facilities available
1.	Inj. Anti D Immunoglobuline Injection Polyclonal Human Anti RhDImmunoglobuline 300 mg	1
2.	Inj. Betamethasine sod. Phosphate, IP – betamethasone 4mg per 1ml in 1 ml ampoule	1
3.	Inj. Corboprost	1
4.	Inj. Isoxsuprine 10 mg ampoules	1
5.	Tab. Isoxsuprine 10 mg	2
6.	Inj. Prostodin	1
7.	Inj. Terbutaline 0.25 mg	1
8.	Tab Digoxin – Digoxin IP 250 µg/tab	2
9.	Tab Domperidone 10mg	2
10.	Tab/Cap Multivitamin	1
11.	Cord clamp	2
12.	Dinoprostone Gel	1
13.	Ethilon no. 1	2
14.	K-90, Plain Catheter	2
15.	Mucus Sucker(Avalibility)	2

Table 8.43 shows a list of essential drugs available in only one or two SDHs. Essential drugs such as Inj. Anti D Immunoglobuline Injection Polyclonal Human Anti RhD Immunoglobuline 300 mg , Inj. Prostodin, Inj. Terbutaline 0.25 mg, Inj. Betamethasine sod. Phosphate, IP – betamethasone 4mg per 1ml in 1 ml ampoule, Inj. Corboprost, Tab/Cap Multivitamin and Dinoprostone Gel are available in only one SDH.

Table 8.4: List of essential drugs unavailable and in short supply in PHCs (13)

Sr. No	Essential Drugs	No. of facilities available
1.	Inj. Anti D Immunoglobuline Injection Polyclonal Human Anti RhDImmunoglobuline 300 mg	1
2.	Inj. Betamethasine sod. Phosphate, IP – betamethasone 4mg per 1ml in 1 ml ampoule	5
3.	Inj. Corboprost	4
4.	Inj. Isoxsuprine 10 mg ampoules	2
5.	Inj. Prostodin	4
6.	Inj. Terbutaline 0.25 mg	3
7.	Inj. Thiopentone, Thiopentone 500mg and sodium carbonate	1
8.	Tab Digoxin – Digoxin IP 250 µg/tab	3
9.	Tab. Isoxsuprine 10 mg	1
10.	Tab. Misoprostol – Misoprostol IP 200 mcg oral / vaginal	4
11.	Tab/Cap Multivitamin	6
12.	Chromic Catgut- No. 2-0 on round body needle	6
13.	Dinoprostone Gel	1
14.	Ethilon no. 1	3
15.	Hydroxyethyl starch 6% IP – Hydroxyethyl starch 130/04, 6% saline solution for infusion	6
16.	Hypodermic Syringe for single use BP/BIS 20 ml	4
17.	Spinal Needle Disposable Adult as per BIS, 23 Gauge (70-90 mm without hub)	3

Essential drugs such as Inj. Anti D Immunoglobuline Injection Polyclonal Human Anti RhD Immunoglobuline 300 mg , Inj. Thiopentone, Thiopentone 500mg and sodium carbonate, Tab. Isoxsuprine 10 mg. and Dinoprostone Gel are available in only 1 PHC. Drugs such as Thiopentone 500mg and sodium carbonate are required for C Section deliveries.

Table 8.45: List of essential drugs available at less than half of the total number of Sub-centres (48)

Sr. No	Essential Drugs	No. of facilities available
1.	Capsule Ampicillin-Ampicillin Trihydrate IP eq. to ampicillin 500 mg	18
2.	Inj. Adrenaline – 0.18 w/v of Adrenaline Tartrate or Adrenaline Tartrate IP eq. to adrenaline 1 mg/ml; 01ml in each ampoule	1
3.	Inj. Ampicillin IP -Ampicilline Sodium IP eq. To Ampicilline anhydrous 500mg/via	14
4.	Inj. Anti D Immunoglobuline Injection Polyclonal Human Anti RhD Immunoglobuline 300 mg	0
5.	Inj. Betamethasone sod. Phosphate, IP – betamethasone 4mg per 1ml in 1 ml ampoule	0
6.	Inj. Calcium Gluconate, 1 gm, I. V. – 10 ml amp containing 10% calcium gluconate	7
7.	Inj. Cefotaxime – Cefotaxime Sodium IP 1 gm per vial	10
8.	Inj. Compound Sodium Lactate IV I nj. IP (Ringar Lactate) - 0.2% v/v of Lactic Acid (eq 32% w/v of Sodium Lactate), 0.6% w/v Sodium Chloride, 0.04% w/v Potassium Chloride and 0.027% w/v Calcium Chloride ; 500 ml in each plastic bottle	23
9.	Inj. Corboprost	1
10.	Inj. Declophenac, 25 mg in 3 ml	22
11.	Inj. Dextrose IV Inj. - Dextrose eq. To Dextrose anhydrous 5 % w/v 500 m in each plastis bottle	13
12.	Inj. Dopamine – Dopamine Hydrochloride USP 40mg / ml; 05ml in each vial	2
13.	Inj. Frusemide 20 mg	1
14.	Inj. Gentamycin – Gentamycin Sulphate IP eq. to Gentamycin 40 mg/ml; 02 ml in each vial	20
15.	Inj. Hydrocortisone 100 mg amp	0
16.	Inj. Isoxsuprine 10 mg ampoules	0
17.	Inj. Lignocaine Hydrochloride IP 2% w/v; 30 ml in each vial for local anaesthesia	15
18.	Inj. Magnesium Sulphate- Magnesium Sulphate IP 50% w/v; 10 ml vials containing 5.0 gm in total volume	19
19.	Inj. M enadione (Vitamin K3) - Menadione USP 10 mg/ml; 01ml in each ampoule	11
20.	Inj. Methylergometrine- Methylergometrine maleate IP, 0.2 mg/ml; 01 ml in each ampoule	13
21.	Inj. Metronidazole – Metronidazole IP 5 mg/ml; 100 ml in each bottle	8
22.	Inj. Pentazocine Lactate IP, Pentazocine Lactate, IP eq. to Pentazocine 30 mg per ml; 1 ml in each amp	3
23.	Inj. Promethazine, IP Promethazine Hydrochloride 25 mg/ml; 2 ml in each ampoule	1
24.	Inj. Prostodin	1
25.	Inj. Soda Bicarbonate-Sodium Bicarbonate IP 7.5% w/v; 10 ml in each ampoule	6
26.	Inj. Sodium Chloride IV inj. Sodium Chloride IP 0.9% W/V, 500 ml in each plastic bottle in IP	16
27.	Inj. Terbutaline 0.25 mg	2
28.	Inj. Thiopentone, Thiopentone 500mg and sodium carbonate	0
29.	Tab Digoxin – Digoxin IP 250 µg/tab	1
30.	Tab Domperidone 10mg	17
31.	Tab. Isoxsuprine 10 mg	0
32.	Tab. Methyldopa IP eq. to Methyldopa anhydrous 250 mg	13
33.	Tab. Misoprostol – Misoprostol IP 200 mcg oral / vaginal	5
34.	Tab. Salbutamol – Salbutamol sulphate IP eq. to Salbutamol 4mg	7
35.	Tab/Cap Multivitamin	16
36.	Chromic Catgut- No. 1 on round body needle	19
37.	Chromic Catgut- No. 1 on round body needle	13
38.	Chromic Catgut- No. 2-0 on round body needle	5
39.	Dinoprostone Gel	2
40.	Ethilon no. 1	2
41.	Foleys catheter, 16 no BIS, self retaining catheter	22

42.	Hydroxyethyl starch 6% IP – Hydroxyethyl starch 130/04, 6% saline solution for infusion	1
43.	Hypodermic Syringe for single use BP/BIS 10 ml	13
44.	Hypodermic Syringe for single use BP/BIS 20 ml	1
45.	Hypodermic Syringe for single use BP/BIS 5 ml	22
46.	Infusion Equipment BIS, IV set with hypodermic needle, 21 G of 1.5 inch length	20
47.	Intra-cath Cannulas for single use (Intravascular Catheters) BIS Gauze 18, Length 45 mm, flow rate 90 ml per minute	10
48.	Intra-cath Cannulas for single use (Intravascular Catheters) BIS Gauze 20, Length 45 mm, flow rate 90 ml per minute	5
49.	K-90, Plain Catheter	10
50.	Polyglycolic Acid braided, coated and absorbable, No. 1 on ½ circle round body needle	7
51.	Spinal Needle Disposable Adult as per BIS, 23 Gauze (70-90 mm without hub)	6
52.	Sponges	6
53.	Sticking Plaster (Surgical Tape) – 2.5 cm x 9.10 m	24
54.	Suction Tube	13
55.	Surgical Cap	8
56.	Surgical Mask	14
57.	Urobag	8

Out of the total of 76 drugs, 57 drugs are only available in less than half of the facilities, thereby indicating a shortage of drugs. Essential drugs such as Inj. Anti D Immunoglobuline Injection Polyclonal Human Anti RhD Immunoglobuline 300 mg , Inj. Betamethasone sod. Phosphate, IP – betamethasone 4mg per 1ml in 1 ml ampoule, Inj. Hydrocortisone 100 mg amp, Inj. Isoxsuprine 10 mg ampoules, Inj. Thiopentone, Thiopentone 500mg and sodium carbonate and Tab. Isoxsuprine 10 mg are not available in any of the facilities visited. Drugs such as Inj. Betamethasone sod. Phosphate, IP – betamethasone 4mg per 1ml in 1 ml ampoule and Inj. Thiopentone may be required in some C Section cases and hence not available in SCs.

8.5 GAPS AND CHALLENGES

- Diet grant of Rs 100/-at present is insufficient to provide two meals, one breakfast, and tea two times per day.
- As there is only one driver for 24 hours, most of the time after working for the whole day, the drivers sometimes find it difficult to respond at night. Besides, their salary of Rs 6000/- a month needs to be increased considering that they need to be available for 24 hours. If a regular driver goes on leave, provision may be made for another driver to be hired on daily wage basis. Only one vehicle is not sufficient and there may be one more vehicle with two drivers exclusively for JSSK.
- There may be a separate grant for the purchase of medicines specifically for JSSK. At present there is no provision of diet for sick neonates (not an entitlement) as well as for mothers accompanying babies. Since the programme is now extended up to one year for infants, there may be provision of diet for both mothers and infants. There may be a provision to make good the loss of wages for mothers during their stay at the facility.

- Health facilities with heavy workload of delivery may be provided with additional ANM and lady attendant exclusively for JSSK. One ANM may be provided exclusively for pick up and referral services and trained for handling of neo-natal rescue.
- In general it is observed that contractual positions of SN and LHV under NRHM are vacant for four years causing additional burden on the existing staff.
- Provision of blood transfusion and C Section deliveries can be extended upto PHC level, thereby reducing referral treatment and providing emergency care.
- Anti-retro viral therapy medicine needs to be made available. Anti-D medicine and Immunoglobulin supplies are also required.
- As per the guidelines, deliveries of SCs should be referred to the respective PHCs. However, most of the time some of the SCs are located far away from PHC and it is more convenient for them to take the patient to the nearest RH than the PHC. Because of the guidelines, it is difficult to refer a patient to another facility. Hence, it is recommended to add flexibility in guidelines and patients be referred to a nearby facilities.
- IEC needs to be improved pertaining to JSSK for its effective implementation. Awareness of JSSK scheme through Mahila Melava, folk media, Kalapathak, etc., be created. Political and well- known personalities may take initiative in the generation of awareness among people about the scheme.
- Coordination and communication between RHs and PHCs needs to be improved.

CHAPTER IX

SUMMARY AND CONCLUSION

Health and social care of mothers and babies provided through JSSK service need to be further strengthened. This chapter discusses the challenges and shortcomings that underpin the existing models of care provided through JSSK services. The priority should be to strengthen those entitlements provided under JSSK services and are working well as well as focus attention on addressing the weaknesses in existing entitlements provided to mothers and babies. In this chapter we discuss the summary of existing JSSK services in Maharashtra and areas to be strengthened that may hold potential for enhancing service quality and improving productivity.

BACKGROUND CHARACTERISTICS

Empowering women for fully using new information of health care is a key factor in enhancing the quality and outreach of health services. Substantial number of women in our survey were below the legal age of marriage and consequently their age at first delivery was low. Consequently, birth order increases as reflected in birth order of four and above primarily concentrated in tribal areas, among NT, Nanded district and low SLI households. The study indicates that an increase in delivery in government health facilities led to a decline of home delivery in tribal areas and decline of private deliveries in non-tribal areas and urban slums. This can be attributed to some extent the availability of JSSK services.

AWARENESS AND SOURCES OF INFORMATION OF JSSK SERVICES

Awareness regarding JSSK services is an important component in utilization and outreach of the services. Differential levels of awareness were observed between women in rural areas and urban slums with more women in rural areas being aware about JSSK as compared with women in urban slums. Inter-district comparison shows that women from Pune district were more aware about JSSK than women in Nanded district. Districts-specific communication plan for JSSK services can improve the outreach services. A majority of women reported awareness about JSSK entitlements to mothers and only a quarter of women respondents were aware about JSSK entitlement to neonates. Within entitlements very few women were aware of availability of free blood and referral transport if required facilities as compared with other entitlements. Women in urban slums were more aware of free drugs, diagnostics and diet as compared with other entitlements. This may be attributed due to the fact that women may have perceived of free availability of drugs and diagnostics in government health facilities and not specifically as an entitlement of JSSK services.

The main sources of information about JSSK in rural areas were ANM and ASHAs whereas in urban slums they were ANM and doctors. Very few women were aware of toll free number however, although most of them were aware of ANM/ASHA number. The study finds gaps in the awareness regarding entitlements of the scheme. The focus should be to identify community-wise target groups and reach them through relevant information on JSSK by involving the community. IEC should ensure that information is conveyed to the target group in a language and method they understand.

ANC CARE

Almost all the women received ANC services and near about 65 per cent of them received ANC check up four to six times. Awareness about pregnancy complications from health workers was found to be high among women in urban slums as compared with women in tribal and non-tribal areas. However, women registered for JSY was dismissal lower in urban slums contradicting the fact that most of the households with BPL and women belonging to SCs are in urban slums. Functioning of Anganwadi is also weak in urban slums and needs to be strengthened. Nearly two-thirds of women in tribal areas delivered babies in government health facility as compared with 55 per cent women in non-tribal areas and urban slums. Complication in pregnancy was the major reason quoted by women for delivering in private health facility. The average expenditure incurred for private deliveries was in the range of Rs 5,000 to Rs 25,000 in the case of about 60 per cent women.

JSSK ENTITLEMENTS

Regarding entitlements under JSSK, although awareness is high it is not reflected in the level of utilization and is very low in utilization of free referral transport and free blood, if required. Although the awareness of free pick up transport facility is high, it is not reflected in the number of women seeking it. Women paid for essential diagnostics such as blood and urine tests in public health facility even with awareness level of free diagnostic to 80 per cent of women. Few women paid for drugs and consumables and the highest expense incurred is higher than the expense incurred on drugs and consumables by women in private facilities. More than 60 per cent women reported that diet service was not available at health facility. Overall awareness and utilization of JSSK services needs to be strengthened in urban slums.

It is appreciable that nearly 90 per cent neonates received check up within the first hour of delivery. Near about 85 per cent of babies were exclusively breastfed for six months but still nearly 30 per cent of neonates were provided with other food apart from breast milk within the first three days of birth. Focus should be on exclusive breastfeeding and most importantly for mothers in non-tribal areas and urban slums.

The proportion of home deliveries was higher in tribal areas and the proportion of babies weighing less than 2.5 kg was also high in tribal areas. Provision of timely transport service and emergency care can bring down the home deliveries and provide essential post natal and neonatal care primarily in tribal areas.

KEY RECOMMENDATIONS

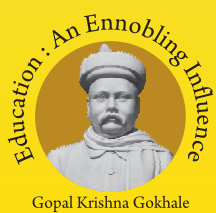
The study attempts evaluation and assessment of the availability, adequacy and utilization of JSSK services, the role played by health providers in creating awareness of health, nutrition among the mothers and to identify the constraints in the implementation of the JSSK services. Along with the role of health providers, utilization of JSSK services in studying entitlements like availability of transport services, planning and preparedness of health facilities and human resources, drugs and

diet availability, quality of care and diagnostic-services, and referral transport services were also evaluated.

Some key recommendations for effective management of the JSSK scheme have been given here. Based on these recommendations we hope to achieve its stated objectives. These recommendations are presented below:

- IEC is important for the effective utilization of health services. Beneficiaries' perception about the quality of healthcare which prompts them to utilize the JSSK services needs to be understood and communicated effectively through medium and language best suited. Knowledge is shared and communicated through community participation for example through VHSNC, SHG etc.
- The study indicates a huge increase in public institutional deliveries with a consequent decline in home deliveries in tribal areas and decline in private deliveries in non-tribal areas. This can be attributed to the popularity of the JSSK scheme. In order to reach the stated goal of institutional deliveries, more capacity needs to be created in public health institutions to cater to this JSSK-induced demand in future. Capacity building and care should be based on a continuing provider-beneficiaries relationship.
- Management of JSSK scheme needs strengthening. Plans should be developed using of utilization data. There has to be short and long-term planning using facility data. While past trends in service utilization are good pointers, there is need of some kind of **facility mapping** with volumes achieved in previous years. Planning based on such information will help in identifying under-served areas and the programme should take steps to set up facilities in these areas. Needs and limitations of the target groups needs to be anticipated.
- JSSK guidelines provide detailed information about the scheme at different levels. However, some issues are area and facility specific such as issues related to inadequate and untimely funds, delays or limitation in providing transport services, date and time of discharge, provision of cash benefits, etc., need to be addressed. JSSK entitlements need clarity and up gradation after interactions with service providers and beneficiaries receiving services.
- Districts/Blocks should be encouraged to have area specific IEC activity plan for JSSK. The plan should identify key target groups and relevant messages focused on JSSK and overall cleanliness.
- The study indicates important knowledge gaps in the scheme. Overall awareness about JSSK needs to be further strengthened by each and every entitlement to mothers and specifically to neonates. Entitlements to neonates are now extended to infants.
- Level of awareness is not reflected in the level of utilization. The role of ASHAs and resource persons needs to be understood. General availability of free health services and availability through JSSK need to be communicated.

- In case of non-availability or timely availability of funds in an emergency, the Medical Officer-in-charge of the facility should be in a position to use either RKS funds or untied funds available. Additional staff to handle administrative and payments matters, etc., especially at the high levels, demand facilities.
- Provision of essential diagnostics care and drugs and medicines at PHC level is required, thereby increasing the efficiency of JSSK services.
- Shortage of health specialists and supporting staffs needs to be addressed.
- Programme objectives for reduction of maternal and infant mortality and morbidity will be achieved when women coming to facilities receive quality ANC, delivery and post partum care services. Optimum engagement of ANM and Anganwadi needs to be strengthened.
- Limitations in providing JSSK services in tribal areas and difficult to reach areas are of major concern. The approach should be to reach out to the beneficiaries. Health providers need to be encouraged through rewards and incentives.
- JSSK entitlements of DIET can be extended to SC.
- Up gradation of salaries of drivers and work load needs to be prioritized.
- Grievance cell needs to be set up for both beneficiates and providers at block levels.



Gokhale Institute of Politics and Economics

(Deemed to be University)
Pune - 411 004

846, Shivajinagar, BMCC Road, Deccan Gymkhana, Pune 411 004.

Ph. No. : 020-25650287, 25675008, 25654288, 25654289, 25661369

Fax : 020-25652579

Website : www.gipe.ac.in