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PAYING FOR PERFORMANCE: THE JANANI SURAKSHA YOJANA PROGRAM IN INDIA

Vikas Dagur, Katherine Senauer, and Kimberly Switlick-Prose

Inside

The pay-for-performance (P4P) Janani Suraksha Yojana *(JSY) program in India consists of supply-side payments to individual community health workers and demand-side payments to women accessing a continuum of maternal and newborn health services at government or accredited private institutions. Its overall goal is to reduce maternal and infant mortality through increasing institutional deliveries, especially by poor women and members of scheduled caste/scheduled tribe communities. Key features of the JSY program include a graded scale for payments; payments are greater within rural communities and within the 10 states that have been classified as low performing based on established health and demographic indicators, including institutional birth rate. In addition, the program offers a demand-side payment to poor women even for home deliveries. The JSY program is being implemented in all states, but each state has the authority to adapt and modify the program to best fit its local context. This case study provides an example of a government-led, centrally funded, nation.*

HEALTH SYSTEMS 20/20

ABOUT THE P4P CASE STUDIES SERIES

Pay-for-performance (P4P) is a strategy that links payment to results. Health sector stakeholders, from international donors to government and health system policymakers, program managers, and health care providers increasingly see P4P as an important complement to investing in inputs such as buildings, drugs, and training when working to strengthen health systems and achieve the Millennium Development Goals (MDGs) and other targets that represent better health status for people. By providing financial incentives that encourage work toward agreed-upon results, P4P helps solve challenges such as increasing the quality of, as well as access to and use of health services.

Many developing countries are piloting or scaling up P4P programs to meet MDGs and other health indicators. Each country's experience with P4P is different, but by sharing approaches and lessons learned, all stakeholders will better understand the processes and challenges involved in P4P program design, implementation, evaluation, and scale-up.

This Health System 20/20 case study series, which profiles maternal and child health-oriented P4P programs in countries in Africa, Asia, and the Americas, is intended to help those countries and donors already engaged in P4P to fine-tune their programs and those that are contemplating P4P to adopt such a program as part of their efforts to strengthen their health system and improve health outcomes.

Annexed to each case study are tools that the country used in its P4P program. The annexes appear in the electronic versions (CD-ROM and Health Systems 20/20 web site) of the case study.

Rena Eichler, Ph.D.
Technical Advisor, Pay for Performance
Health Systems 20/20 Project

ACRONYMS

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BPL	Below Poverty Line
CS	Caesarean Section
GOI	Government of India
HPS	High-performing States
JSY	Janani Suraksha Yojana (Pregnant Women Safety Scheme)
IFA	Iron and Folic Acid
LPS	Low-performing States
MOHFW	Ministry of Health and Family Welfare
ND	Normal Delivery
NMBS	National Maternity Benefit Scheme
NRHM	National Rural Health Mission
P4P	Pay for Performance

INTRODUCTION

This brief case study describes how the Government of India (GOI) implemented and adapted a pay-for-performance (P4P) program to increase utilization of core maternal and newborn health services at government and accredited private facilities, with a primary focus on institutional deliveries targeted to poor women and members of scheduled caste/scheduled tribe communities.[1] The *Janani Suraksha Yojana* (JSY) program, which is both a demand- and supply-side P4P program, provides payments to individual community health workers and to women seeking a continuum of maternal and newborn health services. Payments are based on a graded scale determined primarily by geographic location. At the high end of the payment scale are beneficiaries residing in rural, low-performing states (LPS) that are selected based on a set of demographic and health indicators including institutional birth rate. At the lower end of the payment scale are beneficiaries in urban, high-performing states (HPS). JSY is not the first P4P program to be implemented by the GOI – its design took into consideration past lessons learned and recommendations. Continual GOI monitoring has resulted in modifications that have strengthened the JSY program and will ultimately improve maternal and infant health outcomes.

The JSY program, both a supply and demand side P4P program, is geared towards improving maternal and infant health in India.

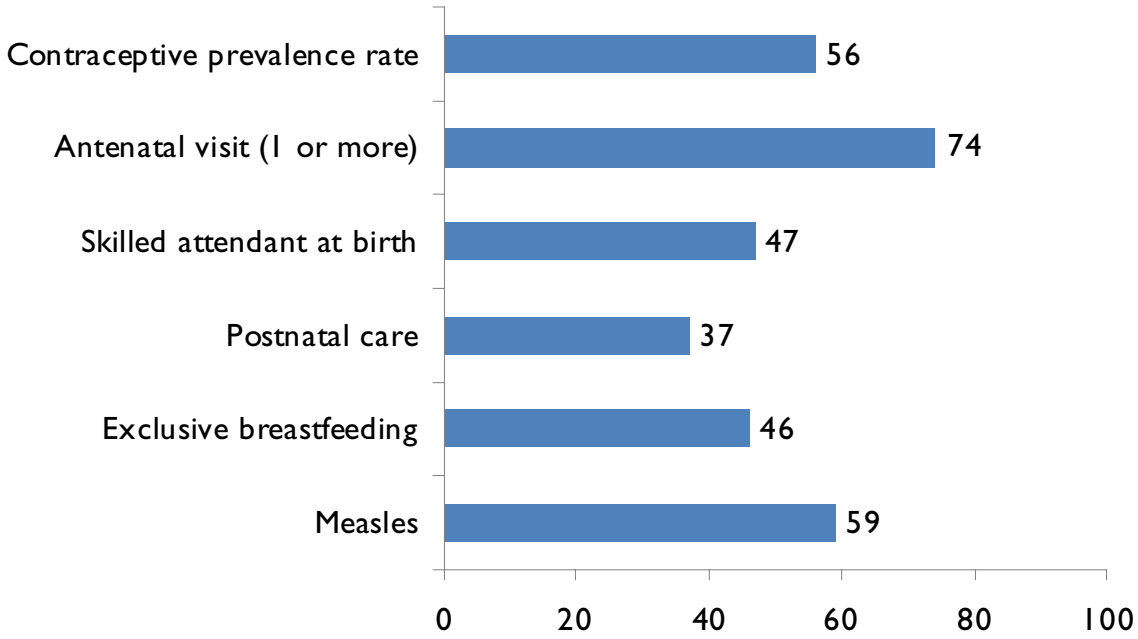
[1] Scheduled castes and scheduled tribes are population groupings recognized by the Constitution of India and are communities that have traditionally been underserved.

BACKGROUND

With its population of over 1.1 billion, India represents a large segment of the countries that are working toward global and regional targets for improved maternal and newborn health. India's maternal mortality rate was 450 per 100,000 live births in 2005, which accounts for about 20 percent of the global burden, and the neonatal mortality rate was 39 per 1,000 live births in 2004, which means about 25 percent of all neonatal deaths in the world occurred in India. These indicators show improvement over those of previous years, but improvement is not happening at a pace that puts India on track to meet its Millennium Development Goals (MDGs) for reduction of maternal and under-five mortality rates. In addition, while institutional deliveries have increased, approximately 60 percent of women continue to deliver at home. Many gaps still exist in access to and use of core health services, including family planning (see Figure 1).

Gaps in access to maternal and infant health services continue to be an obstacle in India's pursuit of achieving its MDGS for reduction of maternal and under-five mortality rates.

FIGURE 1. SELECTED INDICATORS OF REPRODUCTIVE HEALTH CARE IN INDIA*



Source: Bryce et al. (2008)

To help address these gaps, the GOI through the Ministry of Health and Family Welfare (MOHFW) formed the National Rural Health Mission (NRHM) in 2005. The NRHM's goal is to provide accessible, affordable, and effective health care to all citizens, with specific focus on vulnerable and poor populations. A core initiative of the NRHM is to provide improved access to health care at the community level through female village-level health workers known as Accredited Social Health Activists (ASHAs). ASHAs serve as liaisons between the community's health needs and the government health system and play a critical role in the JSY program.

Since 2005, the NRHM has managed several maternal and child health initiatives, including the *Janani Express Yojana* program, which offers transport when needed for pregnant women, and the *Janani Sahyogi Yojna* program, which accredits private and other non-governmental hospitals and provides set levels of payment to accredited facilities for the delivery of selected core maternal and child health services. Separate from the JSY program, the NRHM uses family planning funding to pay to medical staff at public facilities individual financial incentives for performing sterilization. The NHRM also promotes maternal health by funding administrative costs of maternal care improvements – maintenance etc. – in public facilities. The funding levels are fixed for state-, district-, and block-level facilities.

The MOHFW developed certain maternal and child health strengthening initiatives prior to the establishment of the NRHM. One of these initiatives was the National Maternity Benefit Scheme (NMBS) (2001–05) for nutritional support for pregnant women. It gave a one-time cash payment per pregnancy of Rs. 500 to below-poverty line (BPL) pregnant women, 19 years of age or older, for up to two pregnancies that resulted in live births. When designing the NRHM in 2005, the GOI and stakeholders took the opportunity to look at the existing efforts to improve health and explore how those programs could be strengthened. Based on stakeholder feedback, the GOI felt that nutrition-oriented NMBS was not addressing safe motherhood comprehensively. To broaden service delivery and utilization, it proposed the JSY program, an improved P4P scheme.

The JSY program was introduced in 2005 and the Supreme Court officially merged the NMBS into JSY. The goals of the JSY program are to reduce maternal and infant mortality through increasing institutional delivery and access to quality antenatal and postpartum health care especially by poor women. Therefore, the program provides a continuum of care package that includes antenatal care (ANC), institutional delivery, postpartum care, and family planning, coordinated by the ASHA

JSY PROGRAM DESIGN AND STRUCTURE

SCOPE AND SCALE OF THE JSY PROGRAM

The JSY program covers all 28 states in India. It is mandatory for states to implement the program, but they do have authority to modify the centrally created guidelines to better shape the program to their local context. As mentioned above, the GOI has divided the states into two categories; the categories are based on a set of health and demographic indicators that include the rate of institutional deliveries, infant mortality rate, maternal mortality rate, immunization rate, total fertility rate, family size, and per capita income. The 10 states that rank lowest based on these indicators are classified as LPS, while the remaining 18 states are HPS (see Box 1).

In theory, the JSY program was initiated simultaneously across the country; in practice, implementation was delayed in places, due to political and administrative challenges. For example, in Uttar Pradesh, program implementation was delayed by issues that included political instability, the large population, and the lack of infrastructure and staff in the field. Although there still are some implementation gaps, the establishment of program management units at the district and block levels have improved implementation of JSY and NRHM activities.

BOX 1. LOW- AND HIGH-PERFORMING STATES IN INDIA

LOW-PERFORMING STATES (LPS)

Assam, Bihar, Chattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh, Uttaranchal, and Jammu and Kashmir

HIGH-PERFORMING STATES (HPS)

Andhra Pradesh, Arunachal Pradesh, Goa, Gujarat, Haryana, Himachal Pradesh, Karnataka, Kerala, Maharashtra, Manipur, Meghalaya, Mizoram, Nagaland, Punjab, Sikkim, Tamil Nadu, Tripura, West Bengal

The MOHFW reported that the number of JSY beneficiaries has increased greatly, from approximately 700,000 in 2005/06 to nearly 8.4 million in 2008/09.[2] Many challenges have resulted from this rapid and large increase in coverage including:

- Information dissemination to communities about the JSY program;
- Classification of beneficiaries on the basis of urban/rural background and LPS/HPS status;
- Selection, training, and placement of ASHAs;
- Establishment of the financial distribution system down to the field level; and
- Report and record maintenance.

JSY PROGRAM DESIGN

As a program of the central-level GOI, the JSY provides overall guidelines for program development and implementation to all states. In the central GOI guidelines, the key features of the JSY program are:

- Early registration and identification of complicated cases;
- Referral and referral transport when necessary;
- Micro-birth plans (Annexes A and B, respectively, show GOI Guidelines for Micro-birth plans and an example of a plan from Assam State);
- Institutional birth; and
- ANC visits and postpartum visits.

Women enrolled in the JSY program benefit from receiving a package of maternal and newborn health services.

As noted earlier, each state can adapt the guidelines to their specific context and needs. Therefore, program specifics vary by state. (A later section of this case study discusses several state-specific differences, based on the states' implementation needs.)

P4P program payments go to two types of recipient: (1) women receive demand-side payment for accessing a continuum of maternal

[2] Opening Address at the 5th Asia Pacific Conference in Reproductive and Sexual Health and Rights. http://www.5apcrshr.org/en/detail.aspx?articleid=091211114040856636 Accessed January 7, 2010.

and newborn health services at government or accredited private institutions; (2) individual community health workers receive supply-side payment.

DEMAND-SIDE RECIPIENTS

Eligibility criteria differ in LPS and HPS. In LPS, all pregnant women of any caste, age, or income group who deliver in a government or accredited private health facility qualify for the JSY program and receive the financial incentive. In HPS, all pregnant women who are members of scheduled caste/scheduled tribe communities and pregnant women who are BPL and older than 19 years qualify for the program. It is the responsibility of health staff at the delivery institution to disburse the payments at discharge and to file and submit the appropriate documentation for reimbursement.

SUPPLY-SIDE RECIPIENTS

On the supply side, incentives are paid only in LPS, not in HPS. The primary supply-side beneficiaries targeted are ASHAs. Also eligible for payments are other "link workers," such as *Anganwadi* workers (AWW), who serve as links to the community. To qualify for JSY benefits they must fulfill the JSY responsibilities listed below.

Ultimately, each state determines the community-level health workers who are eligible to receive JSY benefits based on the specific needs and availability of workers in that state. For example, in Rajasthan, it was difficult to recruit ASHAs because of the lack of literate, motivated women at the village level. The state government therefore decided to give specific JSY responsibilities to another cadre of community health worker known as Sahyogini. *Sahyogini* support community mobilization efforts and in Rajasthan were given specific training to undertake ASHA functions, including JSY responsibilities. These workers are now known as ASHA-Sahyogini. Similarly in other states, link workers other than ASHA are responsible for implementing NRHM activities, including JSY responsibilities, and receive the appropriate incentives associated with these responsibilities. In most states, the State Health Resource Center is responsible for overseeing the identification, training, and performance of link workers. Each district has a list of link workers.

JSY program responsibilities of ASHAs or other link workers include:

- Identifying pregnant women as beneficiaries for the JSY scheme;
- Developing and following birth plans for enrolled women;

- Facilitating beneficiaries to receive at least three ANC visits, two tetanus toxoid immunizations, and iron and folic acid (IFA) tablets;
- Escorting the beneficiary to a qualified health facility for delivery and remaining with the beneficiary until she is discharged;
- Arranging the appropriate immunizations for the newborn;
- Registering the birth of the child;
- Conducting a postpartum visit within seven days of birth; and
- Providing counseling for appropriate breastfeeding and options for family planning.

Payment is made only if the ASHA or other link worker escorts the pregnant woman to the delivery facility and stays with her until the delivery is completed. Sometimes, conflicts arise when a link worker such as a trained birth attendant escorts the pregnant woman to the facility and the ASHA arrives later. In such cases, the qualifying link worker who escorted the pregnant woman to the institution receives the JSY payment.

The auxiliary nurse midwife (ANM) pays the appropriate link worker. ANMs themselves are not permitted to receive incentive payments, even if there is no other link worker and the ANM performs the JSY responsibilities. In fact, the ANM does not receive any payment under the JSY program. The funds for the payments are kept in the subcenter bank account and deposited into the account by the appropriate district authorities.

HOW WOMEN ARE IDENTIFIED AND REGISTERED

Because the ASHA is embedded within the community, it is expected that pregnant women will be identified and registered at the respective subcenter as soon as a pregnancy is confirmed, ideally within the first trimester. To register the woman, the ASHA or other link worker fills out a JSY card or form. (See Annexes C and D, GOI Guidelines for JSY: Model Format for JSY Card and a JSY Card.) To receive the JSY payment, the woman must present specific documentation, including the JSY card, at the time of delivery. Other documentation requirements vary by state. For example, some states require BPL certificates. (See section below for more information on differences across states.)

PAYMENT AMOUNTS

The amount of payment to beneficiaries depends on the category of state (LPS or HPS) as well as the district classification of rural or urban. The payment package guidelines provided by the GOI are summarized in Table 1.

TABLE 1. JSY PAYMENT PACKAGES RECOMMENDED BY THE GOI

	Rural		Urban	
	LPS	HPS	LPS	HPS
Mother's package for ND	Rs 1,400 (US$36)	Rs 700 (US$18)	Rs 1,000 (US$25)	Rs 600 (US$16)
ASHA or other link worker's package	Rs 600 (US$16)		200 R (US$5)	

Note: ND=normal delivery

Beneficiaries in rural districts receive a larger payment package than those in urban districts to compensate for greater transport costs to a qualified delivery facility. Women – whether in LPS or HPS – who must deliver by Caesarian section (CS) receive a payment of Rs. 1,500 to defray costs. If a poor woman delivers at home, she receives Rs. 500 to pay for assistance by a trained traditional birth attendant or skilled birth attendant to provide the delivery and post-delivery services.

DIFFERENCES IN JSY IMPLEMENTATION ACROSS STATES

As mentioned above, states have authority under the JSY program to modify the general GOI guidelines. Table 2 shows some of the variations – in eligibility criteria, documentation requirements, and amounts paid for NDs and CSs – between states (Devadasan et al. 2008).

TABLE 2. EXAMPLES OF DIFFERENCES ACROSS STATES UNDER THE JSY PROGRAM

	LPS		HPS	
	Chattisgarh	**Orissa**	**Karnataka**	**Maharashtra**
Eligibility criteria	• All women if they deliver at home or in public facilities. • In accredited private facilities, only poor women qualify.	All women who deliver at home or in public facilities.	Only poor women and only for the first two deliveries.	Poor women or women of scheduled caste/scheduled tribe communities.
	• None if the woman delivers in a government facility. A poor woman who delivers in a private hospital or at home must show a BPL card. She also has to produce a discharge summary if she delivers in a private institution	ANC and JSY form	• Income certificate • ANC card and JSY form • A photo of the parents and the baby	• BPL card • Proof of residence • ANC check-up details • Proof of age • Discharge summary • JSY form • All must be produced within seven days of delivery
Payments	• Rural area: ND Rs 700 CS Rs 1,400 • Urban area ND Rs 600 CS Rs 1,400	• ND Rs 1,400 • CS Rs 1,400	• ND Rs 1,400 • CS Rs 1,500 (Rs. 700 for the mother and Rs 800 for the attending doctor)	• ND Rs 700 • CS in government hospital Rs 1,500 (Rs 500 to the mother and Rs 1,000 for the attending doctor) • CS in private hospital Rs 1,500

Source: Devadasan et al. 2008

TIME OF PAYMENT

Registered pregnant women should receive payments in one installment at the time of discharge from the institution where the delivery took place. It is the responsibility of the ANM/ASHA to ensure disbursement. The GOI recommends that payments to ASHA and other link workers are made in two installments. The first installment (Rs 400 in rural districts and Rs 100 in urban districts) is given at the health facility and the second (Rs 200 in rural districts and Rs 100 in urban districts) is paid approximately one month after delivery, when the ASHA or other link worker has helped with postnatal care, the registration of the birth, and immunization of the newborn for BCG.

FORM OF PAYMENT

Initially all beneficiaries received payment in cash. However, it was found that this facilitated fraud, so the GOI now recommends that all beneficiaries be paid by check. Checks provide another written record of the disbursement and have indeed helped reduce fraud. Still, some states issue a mix of cash and checks to beneficiaries, while others continue paying exclusively in cash. If state policy requires payments in the form of checks, beneficiaries must have bank accounts, which is a challenge for some beneficiaries. However, in many cases, beneficiaries have appreciated the opportunity to create a bank account in order to receive their JSY check.

ACCREDITATION

Under the centrally developed JSY guidelines, the GOI recognizes the need for increased choice of delivery facility. For each block (a defined geographic region within each district), the district government may accredit two private institutions. The GOI provides general criteria as an example for accreditation criteria, but it is left to the discretion of the state and district authorities to specify the criteria. (See Annexes E and F, Rajasthan State Guidelines for Accrediting Private Facilities under JSY and Example of a Memorandum of Understanding with a Private Accredited Facility in Rajasthan.) Under the accreditation criteria, private institutions may charge up to a maximum of Rs 1,500 for delivery.

Many private institutions noticed a marked decrease in clients who sought services from accredited government facilities when the JSY program was initiated. Private institutions sought accreditation status in hopes of increasing their reputation for quality services, regaining clients, and exposing new clients to the services offered in hopes that they would seek additional services in the future.

START-UP

Each State Health Mission was responsible for forming a JSY Implementation Committee. The roles of the implementation committee include:

- Incorporating a specific plan for JSY into the overall State Action Plan, which includes the funding requirements per district for the estimated beneficiaries who are expected to participate in JSY for the relevant fiscal year;
- Reporting data and progress to the GOI;

- Ensuring dissemination of JSY information to communities;
- Making available JSY application forms/cards and official JSY Guidelines for Implementation;
- Overseeing monitoring of JSY including appropriate completion of procedures as outlined in the Guidelines for Implementation;
- Ensuring quality of services in government and accredited facilities through appointed Nodal officers; and
- Addressing grievances and legal settlements of JSY cases.

State implementation committees were provided the JSY Guidelines for Implementation describing the program and have been provided with updated guidelines as the GOI has made modifications. The State Institute of Health and Family Welfare organized training of state trainers. Subsequently, the state trainers trained district training units to then train ASHA in their respective districts. Various State Support Units also provide field level implementation support for JSY, such as ASHA resource centers and state health and resource centers.

Of the central funds provided to the states, about 7 percent is applied to cover administration costs including monitoring and demand-creation strategies such as health awareness events to disseminate information about JSY and the role of ASHA in JSY and engage communities in the program. At the district level, 1 percent of the funds can be used for administrative costs; at the facility level, 3 percent.

Overall cash assistance schemes are well received among communities in India. For the launch of the JSY program, states and districts disseminate information through large multi-media campaigns: print, radio, television, village group meetings, and one-on-one interactions. In some instances, it has been a challenge to provide timely service delivery to keep up with the demand.

STRENGTHENING THE JSY PROGRAM

Since initiation in 2005, several central-level and subsequent state-level changes have been made to the JSY program. Many of these changes were the result of studies of state-level JSY programs. National JSY Guidelines for Implementation were updated in November 2006 to expand beneficiaries to include all pregnant women, not just BPL. Home deliveries by BPL women in both rural and urban areas receive Rs 500. ASHAs initially received Rs 50 for a home delivery of a BPL woman, but under the revised guidelines, ASHAs now do not receive any cash assistance for a home delivery. Since 2005, the payments amounts have also increased slightly.

The JSY Program continues to evolve since it's inception in 2005 and now considers all pregnant women, not just BPLs, as eligible beneficiaries.

At the state level, the NRHM Executive Committee has authority to modify and add additional components to complement the JSY guidelines set by the GOI depending on the specific context of the state. For example, in Rajasthan state, five liters of butter is also provided to BPL women at the time of her first delivery.

Overall, changes recommended by the central government have strengthened the program, but disseminating information on the changes and implementation of the changes has been challenging at the state and district level. During a follow-on study in Rajasthan in 2007 (*Center for Operations Research & Training 2007*), one state officer provided the following feedback regarding the revised national guidelines:

> *"Improving the guidelines is good for the program but practically changing now and then creates confusion not only at the field level but even at program level. Dissemination of previous guidelines by the state followed a process. Districts were communicated through circulars and responsible authorities were asked to share the information with staff members during monthly meetings or similar interactions. Trainers of ASHAs were informed too and were asked to include in the training curricula. With the revision, we have repeated this process and have explained about the changes. However, during field visits, we often hear about different amounts being quoted. It will take some time for new guidelines to sink in."*

FINANCING THE JSY PROGRAM

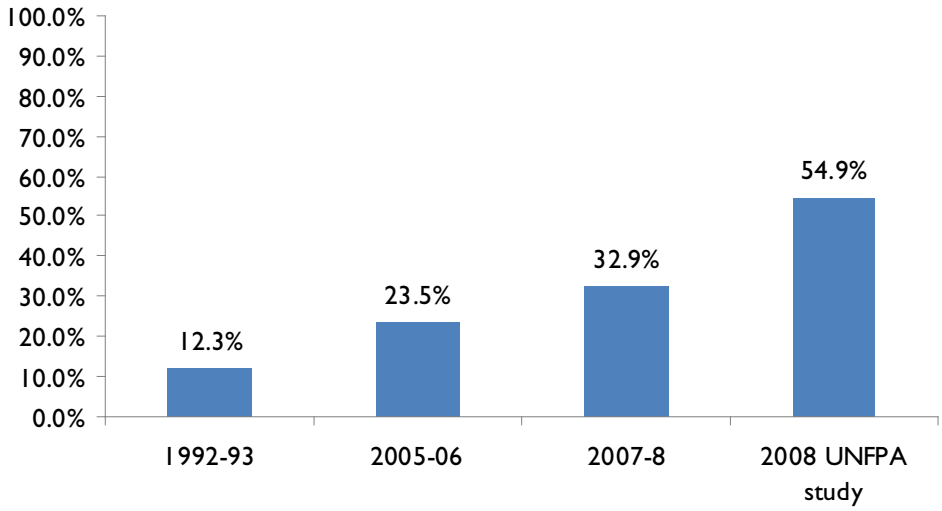
Districts provide financing requests to their state counterparts which are then channeled to the GOI for annual budget planning.

JSY is centrally funded by the government. Initially, the GOI provided funds to all states for the JSY program. To receive central funds now, states are required to incorporate an appropriate budget based on project coverage into their annual Project Implementation Plan for NRHM activities. The central level does not recommend a specific percentage to allocate for the JSY budget as part of their annual planning. Each state must decide on the appropriate JSY budget based on information including the previous year's JSY project expenses. States receive requests from districts and incorporate district requests into their annual Project Implementation Plan.

RESULTS

Institutional deliveries have increased in India over the past few years. Figure 2 shows data on the trend of institutional delivery over several years and includes data from a concurrent assessment of the JSY program in five states (Bihar, Madhya Pradesh, Orissa, Rajasthan, and Uttar Pradesh) conducted in 2008 and sponsored by UNFPA (Development and Research Services Ltd. May 2009).

FIGURE 2. TRENDS IN INSTITUTIONAL DELIVERY IN FIVE STATES (BIHAR, MADHYA PRADESH, ORISSA, RAJASTHAN AND UTTAR PRADESH)



Sources: Data for 1992/93 and 2005/06 are from National Family Health Surveys. Data for 2007/08 are from District Level Household Survey

Of course, many factors contributed to this increase, but it is likely that the JSY program played a role in increasing the number of institutional deliveries, as beneficiaries have reported that the payments received as part of the JSY program do help motivate them to deliver in health facilities.4

No national-level evaluation of the JSY program has been done. Although studies have been conducted of the JSY program in particular states and districts, the lack of quantitative data has been a challenge and many studies rely on qualitative data from beneficiaries and stakeholders. The fact that states are allowed to modify and adapt the JSY program makes comparisons across states more difficult. Some highlights from the larger studies are discussed below.

A study conducted in 2007 in Rajasthan state (a LPS) by the Center for Operations Research and Training (2007) on behalf of UNFPA compared the change in number of deliveries in public sector facilities before and after the JSY program began. The number of institutional deliveries in the public sector increased by 36 percent in the first year of the program. The same study asked mothers about their motivation for institutional delivery and more than half of the 173 mothers interviewed stated that the JSY incentive payment was a major factor in their decision to deliver in a facility (Table 2).

TABLE 2. MOTIVATION FOR INSTITUTIONAL DELIVERY AMONG JSY BENEFICIARIES WHO HAD INSTITUTIONAL DELIVERY, RAJASTHAN, 2007

Factor	Total (N=173)*
Money available under JSY	56.1%
Better access to institutional delivery services in area	43.9%
Support provided by ASHA	22.0%
Previous child was born in an institution	8.1%
Support provided by health personnel	7.5%
Safe delivery of child/safety of both mother and child	7.5%
Others/previous history of still birth/miscarriage	5.2%
Complicated delivery, had health problem	4.6%

* Multiple responses given

In 2007–08, the Population Research Center at Mohanlal Sukhadia University conducted a study sampling two districts in Rajasthan state (Sharma and Yojana 2008). Two hundred JSY beneficiaries were interviewed. Of the two districts sampled, one had a high performance record of institutional deliveries (Banswara district) and the other

had a low performance record (Barma district). The study found that overall the JSY program contributed to increased access to antenatal and postpartum care as well as to increased institutional deliveries. The majority of beneficiaries interviewed had access to a trained ASHA in their village and received the full package of JSY services including: three ANC visits, use of IFA tablets, delivery with the presence of an ASHA or other link worker, a postpartum visit, and an appropriate payment package.

TABLE 3. RESPONSES FROM WOMEN RECEIVING JSY BENEFITS IN RAJASTHAN STATE

Indicator	Banswara (N=100)	Barmer (N=100)	Total (N=200)
Trained ASHA available in village	93%	89%	91%
ASHA or link worker approached you for JSY registration	79%	77%	78%
Registration was done within three months of pregnancy	84%	86%	85%
Received three ANC visits	81%	83%	82%
Received postnatal check-up	77%	69%	73%
ASHA or other link worker was present at the time of delivery	70%	65%	68%

KEY CHALLENGES AND LESSONS LEARNED

Although overall the JSY program is well received by beneficiaries and stakeholders, there are several ongoing challenges. Table 4 highlights suggestions and challenges made by ASHA in Rajasthan state. A total of 173 ASHA were interviewed and 143 gave suggestions for improving the JSY program and commented on particular challenges.

TABLE 4. TOP SUGGESTIONS FOR JSY IMPROVEMENT AND CHALLENGES FACED BY ASHA IN RAJASTHAN STATE, 2007

	Total (N=124)
Suggestions made by ASHA for improving the JSY program	
Payments should be increased	35.5%
Should give more complete information during training for ASHA	30.6%
Should use posters, role play, drama for training ASHA	26.6%
Should get good/practical training for ASHA	20.2%
More dissemination/advertise on TV/newspaper/rallies	16.1%
Challenges faced by ASHA	
Other ASHA take away my cases	24.9%
Village people are not ready for institutional delivery	19.7%
Women do not listen regarding weighing baby/immunizing child	15.6%
My husband/family does not like my job	11.0%

In addition to the suggestions summarized in Table 4, key challenges identified in several state-specific studies are discussed below.

- *Limited capacity at health facilities.* Health facility staff are often overburdened and there are not enough health workers to offer 24/7 delivery services. In addition, public health facilities often do not have the appropriate infrastructure for providing a complete range of delivery services. Stakeholders specifically mentioned subcenters as needing improvements in infrastructure and staffing to provide adequate delivery services. Moving forward, it will be important to incorporate strategies to strengthen infrastructure and human resources at government health facilities. In addition, some stakeholders have proposed encouraging increased participation from the private sector to better leverage capacity in the private sector.

- *Insufficient mechanisms for timely and consistent payments to beneficiaries.* The current funding flow is complex, differing between states, and this often results in late payments to beneficiaries. For example, Table 5 summarizes the timing of payments to beneficiaries from a study in the state of Orissa (Malini et al. 2008). Creating consistent payment mechanisms for mothers and ASHAs that do not overburden health workers with document submission and reporting requirements is an important step in improving the flow of funds.

TABLE 5. TIME TAKEN IN RECEIPT OF JSY PAYMENT BY MOTHERS IN A SAMPLE OF THREE DISTRICTS (GANJAM, GAJAPATI, AND KANDHAMAL) IN ORISSA

Time Taken	Total (N=120)
< 7 days	33.3%
7 days to 1 month	37.6%
> 1 month	23.3%
Not received yet	5.8%

- *Regular monitoring of the program.* Improvements that have been made to the JSY program have been the result of studies conducted to monitor JSY implementation. It is important that findings from studies be shared across states. Strengthened systems for ongoing monitoring and evaluation will help ensure quality services and increase accountability. A national-level evaluation would be helpful in informing future JSY improvements.

ANNEX A. GOI GUIDELINES FOR JSY: MICRO-BIRTH PLAN

Step	Activity	Responsibility of	Proposed Timeline
1	Identification and registration of beneficiary	ANM/ASHA/AWW or any link worker	At least 20–24 weeks before the expected date of delivery
2	Filling out the maternal and child card and the JSY card	ANM/ASHA/AWW or any link worker	At time of registration
3	• Inform dates of three ANC & TT injections • Identify the health center for all referral • Identify place of delivery • Inform expected date of delivery	ANM/ASHA/AWW or any link worker	At time of registration
4	Collecting BPL or necessary proof/ certificates	ANM/ASHA/AWW or any link worker	Within 2–4 weeks after registration
5 • •	• Submission of completed JSY card to the health center for verification by the authorized medical officer • Take necessary steps toward arranging transport or making cash available to the beneficiary to come to the health center • Ensure availability of funds to ANM/ ASHA/AWW, etc.	Medical officer, PHC ANM/ASHA/AWW or any link worker ANM/MO/PHC	At least 2–4 weeks before the expected date of delivery
6	Payment of benefit to the mother and ASHA	ANM/MO/PHC	At the institution
7	Payment of last installment to ASHA and settlement of advance pay	ANM	At sub-center

Source: http://india.gov.in/allimpfrms/alldocs/2384.pdf

For complicated cases or those requiring Caesarean section:

Step	Activity	Responsibility of
1	Pre-determine a referral health	ANM/ASHA/AWW or any link worker
2	Familiarize the woman with the referral center, if necessary bring a letter of referral from the MO/PHC	ANM/ASHA/AWW or any link worker
3	Pre-organize the transport to the facility in consultation with family members/community leader	ANM/ASHA/community
4	Arrange for the medical experts if the same is not available in the referred health center	MO, PHC

ANNEX B: MICRO-BIRTH PLAN FOR ASSAM STATE

OFFICE OF THE MISSION DIRECTOR,
NATIONAL RURAL HEALTH MISSION
House No.16, Jana Path, opp. Kendriya Vidyalaya Khanapara, Guwahati-22

Guideline

Micro Birth planning for JSY and Mamoni Beneficiaries.

Micro Birth Planning for JSY and Mamoni Beneficiaries is the most important activities to be carried out in the different levels. If it is done properly the purpose of implementing JSY and Mamoni Scheme will be achieved. Micro Birth planning comprises of following steps.

Step 1: **Activity-** Identification of pregnant women and registration. The **Mamoni booklet** is to be given to the beneficiaries and counseling is to be carried out regarding what to do and what not to do during pregnancy period including taking of balance diet. **The Beneficiary will have to open a Bank Account in her name**. It is prerequisite that she has to register herself in the Subcenter/Health Institution of her hunsband's village/ place to get the benefit of Mamoni Scheme.
To be undertaken by- ANM (all ANM including Boat Clinic, MMU, working in other institutions and Subcenters) with the help of AWW/ ASHA/ Link Worker
Proposed timeline- As early as possible taking help of urine examination for pregnancy test by using "Nischay" Kits available with ASHA

Step 2: **Activity-** Filling of maternal and child card and JSY Card one each for mother, ASHA/ Link Worker and Block PHC. Filled up card is to submitted to Block PHC for verification and arrangement is to be made for issueing of 1st cheque during the 1st ANC.
To be undertaken by- ANM with the help of AWW/ ASHA/ Link Worker
Proposed timeline- Immediately on registration (On the same day of registration).

Step 3: **Activity-** Inform Dates of 1st ANC with TT injection and IFA tablet and pay an A/c payee cheque of Rs. 500.00 (1st installment) under Mamoni Scheme to the beneficiaries as per guidelines provided already.
To be undertaken by- ANM with the help of AWW/ ASHA/ Link Worker and Block Accounts Manager / PHC Accountant cum Asstt. BPM
Proposed timeline- during 5th months (20 Weeks) of pregnancy

Step 4: **Activity-** Inform Dates of 2nd ANC with TT injection and IFA tablet.
To be undertaken by- ANM with the help of AWW/ ASHA/ Link Worker
Proposed timeline- during 8th months (32 Weeks) of pregnancy

Step 5: **Activity-** Inform Dates of 3rd ANC with TT injection and IFA tablet
Identify the Health Center for all referral
Identify the place of delivery
Inform expected date of delivery
Payment of Rs. 500 in A/c payee cheque (2nd Installment of Mamoni Scheme)
To be undertaken by- ANM with the help of AWW/ ASHA/ Link Worker and Block Accounts Manager / PHC Accountant cum Asstt. BPM
Proposed timeline- during 9th months (36 Weeks) of pregnancy

N.B. *ASHA will motivate the beneficiaries for ANC at SC/ Village Health & Nutrition Day/ PHC and explain about the JSY benefits, Mamoni benefits and need of institutional delivery for safety of the mother and Newborn while performing the activities under step 1 to step 5.*

Step 6: **Activity-** Collecting BPL Certificates for home delivery.
To be undertaken by- ANM with the help of AWW/ ASHA/ Link Worker
Proposed timeline- Within 2-4 weeks from registration.

Step 7: **Activity-** Submission of the completed JSY Card in the health center for verification by authorized person/MO
To be undertaken by- MO , PHC
Proposed timeline- Atleast 2-4 weeks before the expected date of delivery.

Step 8: **Activity-** Payment of JSY Beneficiary by Account payee cheque.
To be undertaken by- Accounts Manager of the Institution where delivery is conducted.
Proposed timeline- Just after Institutional delivery.

Secretary to GoA,
Health & FW Deptt.
& Mission Director, NRHM, Assam

ANNEX C. GOI GUIDELINES FOR JSY: MODEL FORMAT FOR JSY CARD

(Note : To be filled by ANM/Health Worker on Identifying a beneficiary. Ensure that she is picked up in the Scheme at the earliest, preferable in the First Trimester of the pregnancy. Please note that the maternal card should be enclosed with JSY card for claiming the benefit the Scheme)

Please use Capital letters, one letter in each box and leave one box after each word

Date of filling the Application: ...../...../20.....

Part I – Identification	Identification No.	
A. Sub-Centre's Name		
B. Primary Health Centre		
1. Applicant 's Name: (Pregnant Women)		
2. Husband's Name:		
3. Applicant's Address		
4. Husband's Occupation	4.1 Daily wager/self employed/vagabond/Rag-picker/small vendors in village Haat/Bazar/**others** (Please use tick mark)	
	4.2 If others, please specify:	
5. Beneficiary of any these schemes? NMBS/NFBS/NOAPS/Targeted PDS /Antyodaya Anna Yojana/ Beneficiary of any other social assistance schemes of State or GOI for BPL families /**others** etc.		(Please specify and enclose document if available)
6. Possess a BPL card?	YES/NO (Please use tick mark)	If **Yes**, **BPL Card No.** (Enclose a copy)
6.1 If **NO**, any other certification required? (Keeping in view para 5 above)	**YES/NO** (Please use tick mark) (If **YES**, ANM/Dai/Health Worker/AWW to assist/complete the activity **within 2 weeks** of filling this application)	
7. Applicant's Place of living	**Rural/Urban/ slums** (Please use tick mark and cut others)	
8.Is she 19 years /and above?	**YES/NO** (Please use tick mark)	
9. Currently in which month/week of Pregnancy?		

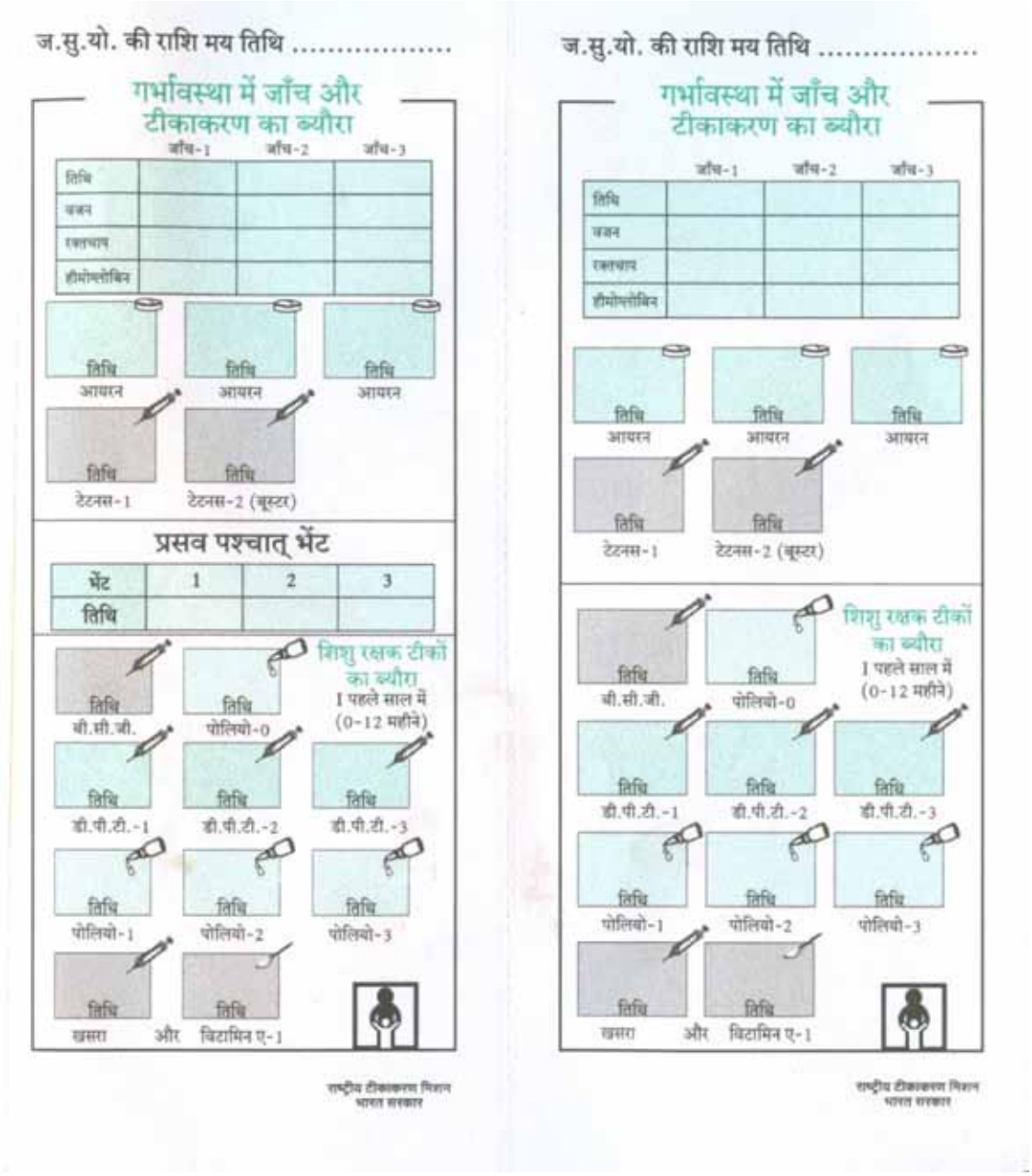
10. Ex. date of delivery	
11. Order of Present pregnancy?	1/2/3 (Please use tick mark)
12. Is this pregnant woman eligible under JSY?	Y/N (To be certified by ANM/SN/MO
13. Name of the identified place of Delivery? **Please record it in your daily dairy** for future monitoring)	(Explain the benefits of delivering at a Health Centre under JSY)
14. **Registered Trained Dai** (Linked to this case **if any** preferably from same village/urban slum)	**Name:** **Add:**
Verified by ANM/AWW/Dai/ASHA etc.	Signature/TI of the Applicant
PART II – DELIVERY	
15. Who accompanied the beneficiary to the Health Centre?	Name/Designation/Relationship: (Signature/TI of the accompanying person)
16. Was the above accredited worker present with the beneficiary during the entire period of her stay in Health Centre and provided support?	(To be certified by ANM/SN/MO)

17. Place of Delivery	**PHC/CHC/Private** (Please use tick mark and indicate name)
18. Date of Delivery	
19. Normal delivery /Caesarean?	**N/C** (If Caesarean, **Indicate where performed)**
20. Outcome	(Live/still Birth)
21. Chose to undergo voluntarily sterilization in the health facility immediately ?	YES/NO

22. If YES, have you received compensation in the health centre?	Y/N Signature/TI of the Applicant
23. Order of Present Birth (If live birth)	1/2/3
24. During the present pregnancy, ever referred to the Health Centre due to complication? **If Yes**, date and what complication.	To be verified by ANM/SN/other Health official
25. Who accompanied her to the health centre then?	Name/Relation/ASHA
26. Mode of travel by the applicant to Health Centre	Walking/hand cart/bullock cart/rickshaw/car/tempo/jeep etc.
27. Any money paid then to the applicant for transport?	If yes, Amount Paid Rs .
28. Who paid?	(Name/designation) Verified by the MO/Authorised Signatory
29. Two independent witnesses and their **signatures/Thumb impression**	1. 2.
30. Name of ANM/Dai/Health Worker who filled this application Signature/thumb impression with date	Verify that the above facts are correct Name: Signature/TI of the ANM/MO
PART III – SUMMARY (For sanctioning by the Medical officer/Authorized officer)	
1. Is she an eligible Beneficiary for JSY?	YES/NO (If NO, state Reasons and also inform the beneficiary)
2. Are the documents complete for considering disbursal of the benefit?	YES/NO
3. Type of delivery?	Normal/Complicated/ Caesarean, (State the complication if any and enclose a copy of the discharge slip)
4. If requiring Caesarean section, was any expert hired for coming to the Health Centre for deliver?	Y/N If Y, how much money paid to the expert? Rs.

5. Was the woman referred to any health centre for receving obs. Services with referral slip?	YES/NO	
6. How much cash paid to the pregnant woman? And when (Indicate date)	Rs. If delayed, reason ? Signature of ANM/ASHA	Date of payment .....
How much cash paid to the accredited worker? And when (Indicate date)	Rs. If delayed, reason ? Signature of ANM/ASHA	Date of payment .....
I have satisfied myself with the facts stated above and as per the norms of JSY, I recommened/approved/ authorized Smt./Ms.....ANM/Health worker to pay a sum of Rs. ..... to the beneficiary, Smt. ....and a sum of Rs..... to the Trained Registered Dai, Smt/Ms....., to be paid in two installment. I have checked the **maternal Card** (enclosed with this) of this women and found that she has received the desired ANCs and the regular immunization of the new born. (Name and Designation of the authorized/Medical officer)		

ANNEX D: JSY CARD



ज.सु.यो. की राशि मय तिथि .....

गर्भावस्था में जाँच और टीकाकरण का ब्यौरा

	जाँच-1	जाँच-2	जाँच-3
तिथि			
वजन			
रक्तचाप			
हीमोग्लोबिन			

तिथि आयरन | तिथि आयरन | तिथि आयरन

तिथि टेटनस-1 | तिथि टेटनस-2 (बूस्टर)

प्रसव पश्चात् भेंट

भेंट	1	2	3
तिथि			

शिशु रक्षक टीकों का ब्यौरा
I पहले साल में (0-12 महीने)

तिथि बी.सी.जी. | तिथि पोलियो-0

तिथि डी.पी.टी.-1 | तिथि डी.पी.टी.-2 | तिथि डी.पी.टी.-3

तिथि पोलियो-1 | तिथि पोलियो-2 | तिथि पोलियो-3

तिथि खसरा और तिथि विटामिन ए-1

राष्ट्रीय टीकाकरण दिवस
भारत सरकार

ज.सु.यो. की राशि मय तिथि .....

गर्भावस्था में जाँच और टीकाकरण का ब्यौरा

	जाँच-1	जाँच-2	जाँच-3
तिथि			
वजन			
रक्तचाप			
हीमोग्लोबिन			

तिथि आयरन | तिथि आयरन | तिथि आयरन

तिथि टेटनस-1 | तिथि टेटनस-2 (बूस्टर)

शिशु रक्षक टीकों का ब्यौरा
I पहले साल में (0-12 महीने)

तिथि बी.सी.जी. | तिथि पोलियो-0

तिथि डी.पी.टी.-1 | तिथि डी.पी.टी.-2 | तिथि डी.पी.टी.-3

तिथि पोलियो-1 | तिथि पोलियो-2 | तिथि पोलियो-3

तिथि खसरा और तिथि विटामिन ए-1

राष्ट्रीय टीकाकरण दिवस
भारत सरकार

कार्ड सं.....

APL/BPL/SC/ST/OBC/GEN.

II-V दूसरे से पाँचवें साल तक (12-60 महीने)

उचित टीकाकरण सूची	
गर्भवती महिलाओं को :	
गर्भावस्था में जितनी जल्दी हो सके	टेटनस-1 का टीका
टेटनस-1 के 1 माह बाद	टेटनस-2 या बूस्टर का टीका यदि गर्भ पिछले टी टी टीकाकरण के तीन वर्ष के भीतर दिया गया है।
बच्चे के लिए :	
1½ माह पर	बी.सी.जी. * व डी.पी.टी.-1 के टीके और पोलियो-1 की खुराक
2 ½ माह पर	डी.पी.टी.-2 का टीका और पोलियो-2 की खुराक
3½ माह पर	डी.पी.टी.-3 का टीका और पोलियो-3 की खुराक
9 माह पर	खसरे का टीका
18 से 24 माह के बीच में	डी.पी.टी. और पोलियो की बूस्टर टीका/खुराक

- यदि किसी टीके/खुराक के लिए आपको देरी हो जाए, तो भी आप इसे जरूर लगवाइये। इस विषय में आप अपने स्वास्थ्य कार्यकर्ता से सलाह लें।
- इस कार्ड को अपने पास सँभाल कर रखें।
- आप जब भी स्वास्थ्य केन्द्र आयें, इस कार्ड को अपने साथ जरूर लाएँ।
- टीकाकरण के बाद इस कार्ड में टीके/ खुराक लेने की तारीख जरूर दर्ज करवाएँ।
- यदि बच्चे का जन्म अस्पताल/ क्लिनिक में हुआ है, तो उसे जन्म के समय ही बी.सी.जी. का टीका व पोलियो की जीरो खुराक दिलवायें।
- कार्ड का यह भाग जच्चा/ बच्चे की माँ के पास रहेगा।

कार्ड सं.....

APL/BPL/SC/ST/OBC/GEN.

जच्चा–बच्चा रक्षा कार्ड

क्रम संख्या

जच्चा का नाम

पति का नाम

बी.पी.एल. क्रं. प्रमाणित निर्धन परिवार

घर नं. गांव/वार्ड

पी.एच.सी./नगर

उप-केन्द्र/क्लिनिक

शिशु होने की संभावित तिथि

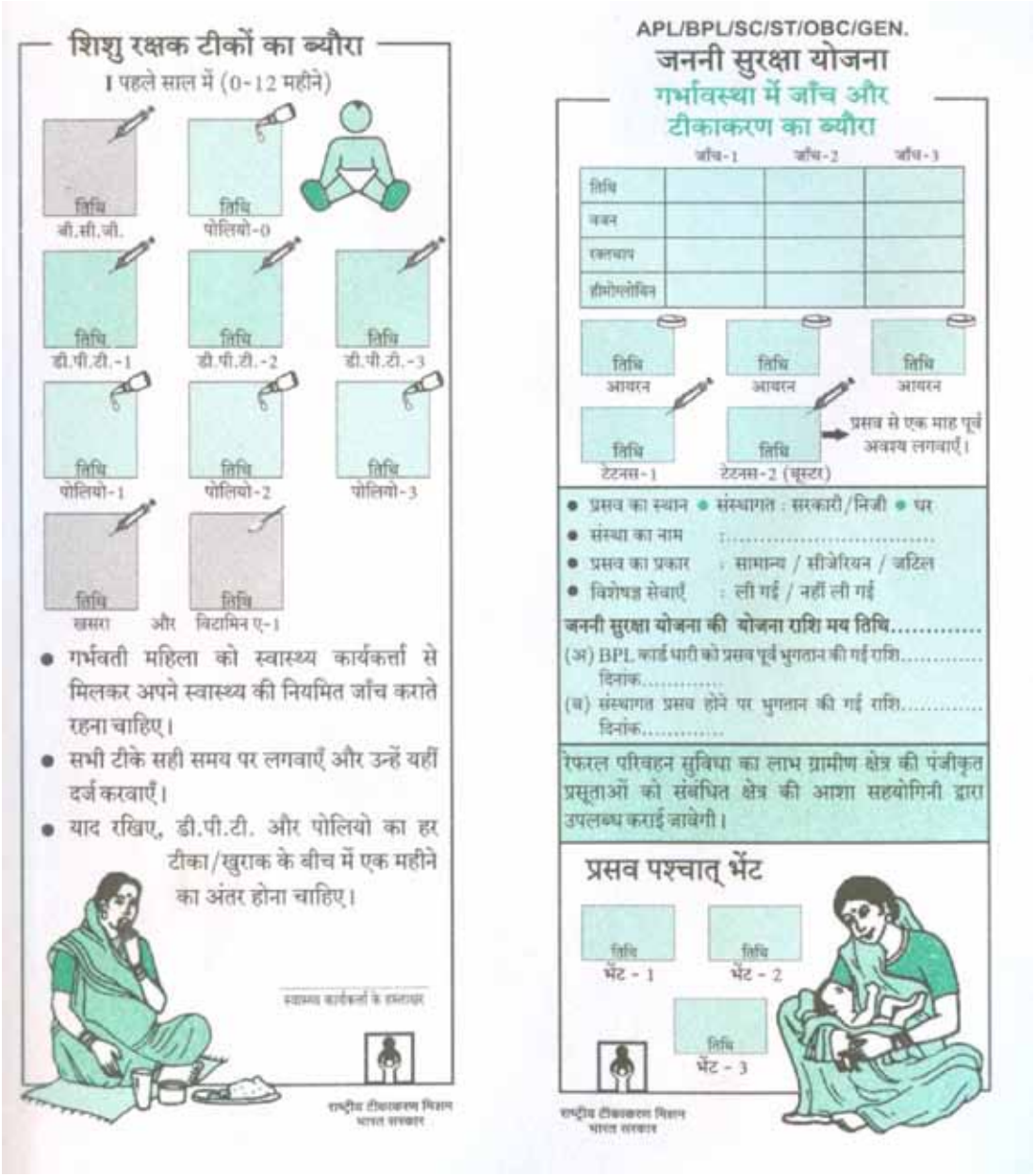
बच्चों की संख्या

लड़का/लड़की जन्मतिथि

शिशु का नाम

राष्ट्रीय टीकाकरण मिशन

भारत सरकार


शिशु रक्षक टीकों का ब्यौरा
I पहले साल में (0-12 महीने)
तिथि
बी.सी.जी.
तिथि
पोलियो-0
तिथि
डी.पी.टी.-1
तिथि
डी.पी.टी.-2
तिथि
डी.पी.टी.-3
तिथि
पोलियो-1
तिथि
पोलियो-2
तिथि
पोलियो-3
तिथि
खसरा
और
तिथि
विटामिन ए-1
• गर्भवती महिला को स्वास्थ्य कार्यकर्त्ता से मिलकर अपने स्वास्थ्य की नियमित जाँच कराते रहना चाहिए।
• सभी टीके सही समय पर लगवाएँ और उन्हें यहीं दर्ज करवाएँ।
• याद रखिए, डी.पी.टी. और पोलियो का हर टीका/खुराक के बीच में एक महीने का अंतर होना चाहिए।
स्वास्थ्य कार्यकर्त्ता के हस्ताक्षर
राष्ट्रीय टीकाकरण दिवस
भारत सरकार

APL/BPL/SC/ST/OBC/GEN.
जननी सुरक्षा योजना
गर्भावस्था में जाँच और
टीकाकरण का ब्यौरा
जाँच-1
जाँच-2
जाँच-3
तिथि
वजन
रक्तचाप
हीमोग्लोबिन
तिथि
आयरन
तिथि
आयरन
तिथि
आयरन
तिथि
टेटनस-1
तिथि
टेटनस-2 (बूस्टर)
प्रसव से एक माह पूर्व अवश्य लगवाएँ।
• प्रसव का स्थान • संस्थागत : सरकारी/निजी • घर
• संस्था का नाम :.....
• प्रसव का प्रकार : सामान्य / सीजेरियन / जटिल
• विशेषज्ञ सेवाएँ : ली गई / नहीं ली गई
जननी सुरक्षा योजना की योजना राशि मय तिथि.....
(अ) BPL कार्ड धारी को प्रसव पूर्व भुगतान की गई राशि.....
दिनांक.....
(ब) संस्थागत प्रसव होने पर भुगतान की गई राशि.....
दिनांक.....
रेफरल परिवहन सुविधा का लाभ ग्रामीण क्षेत्र की पंजीकृत प्रसूताओं को संबंधित क्षेत्र की आशा सहयोगिनी द्वारा उपलब्ध कराई जावेगी।
प्रसव पश्चात् भेंट
तिथि
भेंट - 1
तिथि
भेंट - 2
तिथि
भेंट - 3
राष्ट्रीय टीकाकरण दिवस
भारत सरकार

कार्ड सं._____

APL/BPL/SC/ST/OBC/GEN.

जच्चा - बच्चा रक्षा कार्ड

II-V दूसरे से पाँचवें साल तक (12-60 महीने)

तिथि डी.पी.टी.-बू.	तिथि पोलियो-बू.	तिथि विटामिन ए-2
तिथि विटामिन ए-3	तिथि विटामिन ए-4	तिथि विटामिन ए-5
तिथि विटामिन ए-6	तिथि विटामिन ए-7	तिथि विटामिन ए-8
तिथि विटामिन ए-9		

वर्ष :

तालिका 5 (ANC) की SDR की क्रम सं.

योग्य दम्पत्ति सं.

जच्चा का नाम

पति का नाम

बी.पी.एल. क्रं. प्रमाणित निर्धन परिवार

घर नं. गाँव/वार्ड

पी.एच.सी./नगर

उप केन्द्र /क्लिनिक

SDR की तालिका-6(टीकाकरण) की क्रम सं.

शिशु होने की सम्भावित तिथि

बच्चों की संख्या

लड़का/लड़की जन्मतिथि

जन्म रजिस्ट्रीकरण संख्या व दिनांक

शिशु का नाम

• कार्ड का यह भाग आंगनबाड़ी कार्यकर्त्ता के पास रहेगा।

आंगनबाड़ी कार्यकर्त्ता के हस्ताक्षर

स्वास्थ्य कार्यकर्त्ता के हस्ताक्षर

कार्ड सं._____

APL/BPL/SC/ST/OBC/GEN.

जच्चा - बच्चा रक्षा कार्ड

II-V दूसरे से पाँचवें साल तक (12-60 महीने)

तिथि डी.पी.टी.-बू.	तिथि पोलियो-बू.	तिथि विटामिन ए-2
तिथि विटामिन ए-3	तिथि विटामिन ए-4	तिथि विटामिन ए-5
तिथि विटामिन ए-6	तिथि विटामिन ए-7	तिथि विटामिन ए-8
तिथि विटामिन ए-9		

वर्ष :

तालिका 5 (ANC) की SDR की क्रम सं.

योग्य दम्पत्ति सं.

जच्चा का नाम

पति का नाम

बी.पी.एल. क्रं. प्रमाणित निर्धन परिवार

घर नं. गाँव/वार्ड

पी.एच.सी./नगर

उप केन्द्र /क्लिनिक

SDR की तालिका-6(टीकाकरण) की क्रम सं.

शिशु होने की सम्भावित तिथि

बच्चों की संख्या

लड़का/लड़की जन्मतिथि

जन्म रजिस्ट्रीकरण संख्या व दिनांक

शिशु का नाम

• कार्ड का यह भाग स्वास्थ्य कार्यकर्त्ता के पास रहेगा।

स्वास्थ्य कार्यकर्त्ता के हस्ताक्षर

ANNEX E. EXAMPLE: RAJASTHAN STATE GUIDELINES FOR ACCREDITING PRIVATE FACILITIES UNDER JSY

Under Janani Suraksha Yojana there is a provision of facility to avail services of private hospitals/ institutions through accreditation

1. Up to two willing private hospitals/institutions per block are to be accredited at Tehsil or block level.
2. Willing private hospitals/institutions should have casualty services round the clock with availability of:
    a. An obstetrician & surgeon
    b. Pediatrician & anesthetist (To be accessible either as full time employees or available on-call)
    c. Separate outdoor facility for examination of the patient (including PV examination), casualty room, labor room, operation theater, and at least a 4 bedded ward.
    d. Life-saving drugs, IV fluids & blood transfusion facility.
    e. Patient transport system within the hospitals/institutions.
    f. Power backup in case of electricity failure.
    g. Telephone connection with interconnectivity in OPD, causality, labor room, operation theater, ward and laboratory.
    h. Laboratory services for routine investigations.
3. Private hospitals/institutions willing for accreditation should have the following:
    a. Emergency obstetric procedures
        - Vacuum extraction
        - D&C
        - Forceps delivery
        - LSCS
        - Emergency hysterectomy
        - Laprotomy
    b. Emergency newborn care
        - Every delivery is to be attended by staff nurse trained in newborn resuscitation and pediatrician to be available on call round the clock for emergency interventions.
    c. Laboratory services

d. Hospital/institutions should have 24 hours laboratory investigations including:

- Blood grouping, typing, cross matching,
- All routine investigations such as HB, BT, CT, urine for Alb/sugar and blood sugar.

4. Accredited private hospital/institution will also be responsible for any postnatal complications arising out of the cases handled by them.
5. They should not deny their services to any referred targeted expectant mother.
6. Every month, accredited hospital/institution would prepare a statement of JSY – delivery/ANC/ obstetrics complication handled by them and send report to concerned block PHC along with JSY Jachha Bachha Raksha card.
7. Pregnant women choosing to deliver in an accredited private hospital/institution will have to produce the JSY Jachha Bachha Raksha card.
8. It should be made clear to the beneficiary that Government is not responsible for the cost of her delivery. She has to bear the cost while choosing to go to an accredited private hospital/ institution for delivery. She will only get her entitled cash of Rs. 1400/- belonging to rural area and Rs. 1000/- belonging to urban area.
9. While mother will receive her entitled cash, the scheme does not provide for ASHA package for such pregnant women choosing to deliver at an accredited hospital/institution
10. Cash assistance to the beneficiary should be distributed at hospital/institution itself.
11. Disbursement of cash to the mother should be done through ANM/MO– PHC/Block PHC/ CHC of the concerned area. CM&HO of the concerned area will be overall responsible for payments to the beneficiary.
12. Cash assistance to beneficiary for referral transport in accredited hospital/institution Rs. 300/- per delivery.
13. Disbursement of money to expectant mother going to her place of delivery should be done at the place of delivery. The entitlement of cash should be determined by her JSY Jachha Bachha Raksha card and her usual place of residence.
14. The accredited institution also needs to agree to charge up to a maximum amount of Rs. 1500/- per case from the patient irrespective of the nature of the delivery.
15. Institutions desirous of getting accreditation from the Government for running JSY will need to enter into MOU with the CM&HO which will lay down the above conditions.
16. The best performing institutions will be provided cash incentive on the basis of measurable performance indicators decided by the department.

ANNEX F. EXAMPLE OF A MEMORANDUM OF UNDERSTANDING FOR A PRIVATE ACCREDITED FACILITY IN RAJASTHAN

A MOU made this day, the _____ between Private Accredited Hospital/Institution _____address _____ (the first party) and _____ designation of hiring authority representing District Health Society, constituted by Government of Rajasthan, the Second Party.

Whereas the first party has agreed to provide delivery services to public at their institution under Janani Suraksha Yojana of National Rural Health Mission, a Program of India on the terms and conditions herein after contained.

NOW THESE PRESENT WITNESS AND BOTH THE PARTNERS HERE TO RESPECTIVELY AGREE AS FOLLOWS

1. The first party should have casualty services round the clock with availability of:
    a. An obstetrician & surgeon
    b. Pediatrician & anesthetist (To be accessible either as full-time employees or available on-call)
    c. Separate outdoor facility for examination of the patient (including PV examination), casualty room, labor room, operation theater, at least 4 bedded ward & sufficient trained staff.
    d. Life-saving drugs, IV fluids & blood transfusion facility.
    e. Patient transport system within the hospitals/institutions.
    f. Power backup in case of electricity failure.
    g. Telephone connection with interconnectivity in OPD, causality, labor room, operation theater, ward and laboratory.
    h. Laboratory services for routine investigations.
    i. Emergency obstetric procedures
        i. Vacuum extraction
        ii. D&C
        iii. Forceps delivery
        iv. LSCS

v. Emergency hysterectomy

vi. Laparoscopy

j. Emergency newborn care - every delivery is to be attended by staff nurse trained in newborn resuscitation and pediatrician to be available on call round the clock for emergency interventions.

k. Laboratory services

i. Hospital/institutions should have 24 hours laboratory investigations. Investigations facility including blood grouping, typing, cross matching

ii. All routine investigations such as HB, BT, CT, urine for Alb/sugar and blood sugar

2. First party will also be responsible for any postnatal complications arising out of the cases handled by them.

3. First party should not deny their services to any referred targeted expectant mother.

4. The first party is being accredited on the basis of availability of aforesaid facilities mentioned in point no. 1-3; if these services are found unavailable the MOU will be terminated by the second party.

5. Every month, first party would prepare a statement of JSY – deliver/ANC/obstetrics complication handled by them and send report to concerned Block Medical Officer District Office. The first party will maintain JSY delivery register and other records as required by the second party.

6. Cash assistance to the beneficiary should be distributed at hospital/institution itself as per guidelines issued by the second party from time to time.

7. Disbursement of case to the mother should be done through block, CMO of the concerned area. Block Chief Medical Officer will be overall responsible for payments to the beneficiary.

8. Disbursement of money to expectant mother going to her place of delivery should be done at the place of delivery. The entitlement of cash should be determined by her JSY Jachha Bachha Raksha card & her usual place of residence.

9. First party agrees to charge up to Rs. 500/- for normal delivery and Rs 1500/- other than normal delivery per case from patient and it will be displayed in front of its reception.

10. The institution agrees to display an information board detailing the services provided to the beneficiaries under JSY and will ensure that the beneficiaries will have to stay up to 24 hours after delivery.

11. The MOU is valid from the one year from the date of signing of MOU i.e. from _____ or the JSY scheme period whichever is earlier.

12. The second party may extent the MOU after completion of one year, based on evaluation of performance of the institution during the MOU period.

The first party will abide by spirit and letter of this MOU. In case there is breach of any terms and conditions of the MOU, the second party may at its discretion terminate the accreditation status of the first party without asserting any reason whatsoever.

REFERENCES

Bryce J., J. Requejo J, and the 2008 Countdown Working Group. 2008. Tracking progress in maternal, newborn, and child survival: the 2008 report. http://www.countdown2015mnch.org. Accessed May 2010.

Center for Operations Research and Training. April 2007. Assessment of ASHA and Janani Suraksha Yojana in Rajasthan.

Devadasan, Narayanan et al. 2008. A conditional cash assistance programme for promoting institutional deliveries among the poor in India: process evaluation results. Studies in HSO&P, 24.

Development and Research Services Ltd. May 2009. Concurrent Assessment of Janani Suraksha Yojana Scheme in Selected States of India, 2008. New Delhi: UNFPA, GfK MODE.

Malini, M. et al. 2008. "A rapid appraisal on functioning of Janani Suraksha Yogana in South Orissa." Health and Population: Perspectives and Issues 31(2), 126-131.

Ministry of Health and Family Welfare, Government of India. Janani Suraksha Yojana, Guidelines for Implementation. http://mohfw.nic.in/layout_09-06.pdf (accessed May, 2010)

Sharma, Ramakant and Janani Suraksha Yojana. 2008. A Study of the Implementation Status in Selected Districts of Rajasthan, 2007-08. Mohanlal Sukhadia University: Population Research Centre.

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For more information about Health Systems 20/20 please contact:
Health Systems 20/20 | www.healthsystems2020.org
Abt Associates Inc. | www.abtassociates.com
4550 Montgomery Lane
| Suite 800 North | Bethesda, MD 20814 | USA
E-mail: info@healthsystems2020.org