CHAPTER 2

JANANI SUVIDHA YOJANA AND NON-GOVERNMENT ORGANISATIONS

The Alma-Ata Declaration in 1978 called on all governments to “formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system”. In India, however, health has traditionally received low priority in the central and state budgets. Expenditure on the health sector comprised, for instance, less than 1 per cent of the gross domestic product (GDP) in 1999 – one of the lowest in the world. Further, there was a considerable urban bias characterizing health policies and investment strategies – about 75 per cent of the resources and infrastructure were concentrated in urban India (Patil et al 2002). The resultant increase in the incidence of both communicable and non-communicable diseases, coupled with poor health facilities in rural areas resulted in high infant, child and maternal mortality rates. While the United Progressive Alliance government integrated public health as a critical component into its common minimum programme, this objective could not be attained without providing efficient and affordable healthcare services to the rural population, which constitutes three-fourths of India’s population. However, the sheer enormity involved in servicing a population of over 74 crore calls for integrated macroeconomic and grassroots level efforts to improve the rural health infrastructure, ensuring adequate presence of healthcare manpower and addressing local needs and concerns. The need for a concerted
targeting of rural India led the government to introduce the National Rural Health Mission (NRHM) as its health flagship scheme in 2005.1

**National Rural Health Mission**

The National Rural Health Mission (NRHM) was launched by the Honorable Prime Minister on 12th April 2005. The Mission seeks to provide accessible, affordable and quality health care to rural populations, especially vulnerable and underserved population groups in the Country. The Mission aims to achieve infant mortality rate (IMR) of 30 per 1000 live births, maternal mortality 100 per 100 thousand live births and total fertility rate of 2.1 by the year 2012. The Mission attempts to achieve these goals through a set of core strategies including enhancement in Budgetary Outlays for Public Health, decentralized village and district level health planning and management, appointment of Accredited Social Health Activist (ASHA) to facilitate access to health services, strengthening the public health service delivery infrastructure, particularly at village, primary and secondary levels, improved management capacity to organize health systems and services in public health, promoting the non-profit sector to increase social participation, and community empowerment, inter-sectoral convergence, upgradation of the public health facilities to Indian Public Health Standards (IPHS), reduction of infant and maternal mortality through Janani Suraksha Yojana (JSY), etc. The Mission aims at operationalising existing health facilities to meet Indian Public Health Standards in each Block of the Country. Mainstreaming of AYUSH is needed to facilitate comprehensive and integrated health care to rural population, especially underserved groups in India.2
The World Health Organization (WHO) estimates that, of 536,000 maternal deaths occurring globally each year, 136,000 take place in India. Estimates of the global burden of disease for 1990 also showed that India contributed 25 per cent to disability-adjusted life-years lost due to maternal conditions alone.\textsuperscript{3} Unfortunately there is little evidence that maternity has become significantly safer in India over the last 20 years despite the safe motherhood policies and programmatic initiatives at the national level.

India, with a population of over a billion and decadal growth of 21 per cent estimated its maternal mortality ratio (MMR) at 301 (maternal deaths per 100,000 live births) in 2003. The MMRs vary across the states, with the large North Indian states contributing a disproportionately-large proportion of deaths. Uttar Pradesh and Rajasthan, for example, have high rates of fertility and maternal mortality while Kerala and Tamil Nadu have rates comparable with middle-income countries. Geographical vastness and socio cultural diversity across India contribute to this variation. The status of women is generally low in India, except in the southern and eastern states. Female literacy is only 54 per cent, and women lack the empowerment to take decisions, including decision to use reproductive health services. As health services are governed at the state level, much also depends on state leadership and management skills.\textsuperscript{4}

**Maternal Health Scenario in India**

Globally, about 8 million women suffer from pregnancy-related complications and more than half a million die from those complications. In developing countries especially, in India about 28 million pregnancies take place every year. Out of them 24
million women delivered babies and 15 per cent of these are likely to develop complications. Although, it is not possible to predicate the complications and these pregnancies also lead to 67,000 avoidable maternal deaths per year. The causes of maternal death are related to maternal care utilization during pregnancy, childbirth and postnatal periods. Maternal mortality is one of the major health challenges in our developing economy. The scenario remains very grim for our mothers, with pregnancy related complications claiming the lives of an estimated 0.5 million women worldwide every year, and one woman every minute. Most of deliveries in India occurs at home and without any assistance from skilled health professionals and hence majority of the maternal deaths contributed by the mother who had a home delivery. Therefore, in this regard government of Haryana introduced JSY; it is reducing Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) by encouraging institutional deliveries, and to provide referral transport, escort and improved hospital care at subsidized rate for institutional deliveries particularly among women of urban slums. At present in India MMR are 254 per 100,000 on live births. It is varies from (Kerala) 95 to 440 (Uttar Pradesh /Uttarakhand).National Rural Health Mission has targeted 100 per 100,000 live-births, institutional delivery 80 percent and 100 percent safe delivery up to 2015.

**Child Health Scenario in India**

About 9.7 million deaths take place globally under the age of five years. Out of them 2.1 million are alone in India alone. Approx 25 million births occur every year in India out of which approx 1.57 million children die before one year of age and
approx 1 million newborns die within one month of age. 52 percent of under five deaths continue to occur in the first month of life. 75 per cent of neonatal deaths occur in first week of life, which means that the proportion of U5 deaths by neonatal causes is disproportionately high. 37 per cent of all infant deaths in India are concentrated in two states: Uttar Pradesh and Bihar. 70 per cent of all infant deaths in India are concentrated in eight states: Bihar, UP, Madhya Pradesh, Orissa, Rajasthan, Andhra Pradesh, Maharashtra and Gujarat. The primary causes of neonatal deaths are sepsis, low birth weight and Asphyxia and he primary causes of child deaths are Pneumonia, Diarrhea and in some states Malaria, meningitis and measles. 7

Components of Child Healthcare include

- Essential newborn care;
- Immunization;
- Infant and young child feeding;
- Vitamin A supplementation and Iron and Folic Acid supplementation;
- Early detection and appropriate management of Acute Respiratory Infections, Diarrhea and other infections;
- Integrated management of neonatal and childhood Illnesses (IMNCI) and Pre- Service IMNCI;
- Facility Based New Born Care;
- Home Based Newborn Care.

Child Health Strategies

Essential Newborn Care: As the majority of births in India still occur at home and 66 per cent of all deaths occur in the first
month of life, it is essential to ensure that skilled health care is provided to babies at birth. Further appropriate referral health care must be made available and accessible at health facilities.

**Infant and young child feeding:** Promotion of early initiation of breast feeding (within one hour of delivery) and exclusive breast feeding till 6 months and timely complementary feeding with continued breast feeding is emphasized under infant and young child feeding.

**Vitamin – A supplementation**

The policy was recently revised with the objective of decreasing the prevalence of Vitamin A deficiency to levels below 0.5 per cent, the strategy being implemented is:

- 1,00,000 IU dose of Vitamin A is being given at nine months
- Vitamin A dose of 2,00,000 IU (after 9 months) at six monthly intervals up to five years of age
- All cases of severe malnutrition to be given one additional dose of Vitamin A.

**Iron and Folic Acid supplementation**

To manage the widespread prevalence of anemia in the country, the policy has recently been revised.

Infants from the age of 6 months onwards up to the age of five years shall receive iron supplements in liquid formulation in doses of 20mg elemental iron and 100mcg folic acid per day per child for 100 days in a year.

- Children 6-10 years of age shall receive iron in the dosage of 30 mg elemental iron and 250mcg folic acid for 100 days in a year.
• Children above the age of ten years and adolescents are also to be included in the iron supplementation programme. They shall be supplemented at the dose rates for adults.

Management of Diarrhea

The Government of India in order to control diarrheal diseases has adopted the WHO guidelines on Diarrhea management.

• India was the first country in the world to introduce the low osmolarity Oral Rehydration Solution (ORS), as recommended by WHOM for the management of diarrhea.

• Zinc has been approved as an adjunct to ORS for the management of diarrhea. Addition of

• Zinc is likely to result in reduction of the number and severity of episodes of diarrhea as well as in the duration of each episode.

• New Guidelines on Management of Diarrhea has recently been modified.

Integrated Management of Neonatal and Childhood Illness: Integrated Management of Neonatal and Childhood Illness (IMNCI) strategy is one of the main interventions under the RCH. The strategy encompasses a range of interventions to prevent and manage the commonest major childhood illnesses which cause death i.e. neonatal illnesses, Acute Respiratory Infections, Diarrhea, Measles, Malaria and Malnutrition. It focuses on preventive, primitive and curative aspects, i.e. it gives a holistic outlook to the programme. The Child survival strategy of IMNCI has been introduced in 219 districts of the country and 90401 health persons have been trained.
**Pre Service IMNCI:** Pre Service IMNCI has been accepted has an important strategy to scale up IMNCI by GOI and has been included in the curriculum of 79 Medical colleges of the country. 4000 students have been trained. This will help in providing the much required trained (IMNCI) manpower in the public and the private sector.

**Facility Based New Born Care (FBNC):** As more and more sick children are screened and detected at the peripheries through IMNCI and referred to the health facilities, care of sick newborn and child at health facilities (CHCs FRUs, District Hospitals and Medical College Hospitals) assumes priority. Building up the capacity of the Medical Officer at these facilities to handle such cases thus becomes important. 146 SNBCU have been set up to address sick new born care at facilities.

**Home Based New Born Care:** The Government of India has approved the implementation of Home Based Newborn Care (HBNC). In the five high focus states to be covered under the Indo Norway Initiative (NIPI), the HBNC shall be implemented. It has been incorporated into the ASHA training and duties. As home based care of the newborn is a skill based task, material to enhance the skills of the ASHAs is being done by the NIPI secretariat. In addition, a course module recently developed by WHO headquarters has been field tested in UP, found useful and shall be adapted to suit Indian conditions and the material shared with the states.

**Management of malnutrition:** To effectively tackle the huge burden of malnourished children in the country, nutrition rehabilitation centres have been set up. Malnourished children (grades III and IV) are admitted at these centres, nurtured back to
normalcy through the provision of hot cooked high calorie dense foods using locally available food materials. 582 Nutritional Rehabilitation Centres have been established to address malnutrition among children. Community based guidelines for management of malnutrition shall be developed to supplement the facility based guidelines.8

Role of NGO in NRHM

NGOs have played a significant role in shaping the design of NRHM and in championing its implementation. They have consistently expressed eagerness to participate in strengthening public health systems, instead of becoming parallel to it. There is now sufficient experience across the country to show that NGOs can take on a variety of roles beyond awareness generation and community mobilization or undertaking service delivery in special situations. There are NGOs that can work to leverage and support the health department in terms of human resources, developments of skills and provision of technical assistance. Though some States have made considerable use of NGO capacity, this has neither been consistent and widespread enough, nor is it focused in the districts where it is needed the most.9

A large number of models of partnership between Government and Nongovernmental sector has emerged in the course of implementing health programmes. Accreditation of non-governmental hospitals would be required to extend health care services in remote areas. Given the NRHM commitments regarding maternal and child health, partnerships with the nongovernmental sector to increase institutional deliveries and to facilitate improvement of standards in the Government and non-governmental system would be attempted.10
Janani Suraksha Yojana (JSY) is a flagship programme of the Government of India to promote institutional deliveries among poor pregnant women. A 100 per cent centrally sponsored scheme, JSY integrates cash assistance with delivery and post-delivery care. Other demand-side financing options, as in the use of vouchers, also appear to be popular with both the private and public sectors being involved. Chiranjeevi Yojana in Gujarat is the frontrunner in adapting the JSY model for involving the private sector in providing safe delivery services. Several other States have adopted the JSY/Chiranjeevi model to further provide services in areas not covered by JSY or to boost the gains from JSY, including Saubhagyawati Scheme (Uttar Pradesh), Janani Suvidha Yojana (Haryana), Janani Sahyogi Yojana (Madhya Pradesh), Ayushmati Scheme (West Bengal), Chiranjeevi Yojana (Assam) and Mamta Friendly Hospital Scheme (Delhi). In some States, additional facilities for institutional delivery have been created so as to enhance geographic access, for example, Delivery Huts in Haryana, and Maternity Waiting Homes in Andhra Pradesh, Uttarakhand and Manipur.11

As far as Haryana is concerned it is a region called heaven on earth- Vikrami Samvat (1385). Haryana the land where 3000 years ago, Lord Krishna preached the Bhagvad-Gita and admonished Arjuna, your right is to do your duty and not bother about the fruits; the land which formed the battleground in the famous epic Mahabharata. It was here that Ved Vyas wrote Mahabharata. In this epic, this land was referred to a Bahudhhanyaka land of plentiful grains and Bahudhana land of immense riches. Haryana is a small State with 253 Lakhs Population. For administrative purposes, the State has been
divided into 21 Districts, 111 Blocks spread over 6764 Villages. There are 53 Hospitals, 111 CHCs, 330 PHCs, and 263 Sections from where health services are provided to the Community.  

But after this marvelous historical achievement women’s health in Haryana is very low. According to census 2001 it shows that the number of women is million (495, 738, 169) 48.27 per cent of the total population of India. Women literacy ratio in 2001 was 39.42 per cent compared to men is 63.66 per cent and 52.11 per cent for the whole nation. Also the male-female ratio is 1072: 1000. But the status of women is inferior to men in social economic and political sphere. The position of women in Haryana is no better than their counterparts in rest of the country. No doubt within a short span of its existence, Haryana has assumed an important place in the economic scenario of the country, but unfortunately this material prosperity could not go along with its moral commitment to enhance the status of its women. The brief survey of various schemes for economic development of women in Haryana shows that position of women has been steadily improving but a lot remains to be done. In Haryana women as a class have been rated as healthy, sturdy and hard working. In villages a woman normally puts in about 10-12 hours of work. She does household work; she supports services in dairy farming. To raise the status of women and for the welfare of women numerous schemes, policies and programmes are implemented by the Government of Haryana. Janani Suvidha Yojana is one of them. Which is run for improve the health status of women in urban slum of Haryana.

**Janani Suvidha Yojana**

Janani Suvidha Yojana (JSY) under the umbrella of National Rural Health Mission (NRHM) aims to replace the
existing traditional ‘Dai’ system with efficient and effective ‘Institutional delivery’ system, to ensure child birth in a medical institution under the overall supervision of trained and competent health personnel where there are more amenities available to handle the situation and save the life of the mother and child. If the child is born at home, then chances of getting infected from unhygienic environment are more and it is very tough and sometimes impossible to handle childbirth complications. In India, it is a prevalent practice to deliver the child at home instead of taking the pregnant women to some health facility. This is more common in urban slum areas as compared to urban areas. Therefore, to provide better health status in urban slum areas, the concept of institutional delivery has introduced. Many programmes in India like the Child Survival and Safe Motherhood (CSSM) and the Reproductive and Child Health (RCH) programme are focused on this aspect.

**Important Features of Janani Suvidha Yojana:**

The scheme focuses on the pregnant as well as lactating woman of urban slums of Haryana. The JSY has some features:

- **Registration of the women**: All the pregnant women residing in the urban slums are eligible to get services under Janani Suvidha Yojana. Pregnant women are registered with the help of Sakhi, AWW and ANMs.

- **Provide them Voucher**: Vouchers are provided by the FNGOs to the pregnant or lactating mother to give it to the private health provider or doctors in the form of money or fee. In fact, Vouchers are extensively used in the delivery of safe motherhood services across the globe and most of these
schemes cover a well defined set of goods and services
including: a) Ante Natal Checkups (ANCs) with diagnostic
tests; b) Iron and folic acid tablets and Tetanus Toxoid
injection; c) Delivery services (normal, caesarian and
complicated); d) Essential new born care with immunization;
e) Post Natal Checkups (PNCs) which can include pills, breast
feeding and family planning counseling; and, f) Transport
expenditure. Therefore some provision has made in Janani
Suvidha Yojana to empower pregnant women.

- Provides opportunity to cover the out of reach that are
  most in need
- Utilization of existing infra-structure
- Ensures the utilization of underutilized services
- Empowers the consumers to make choices and hence
  improves the quality of services
- Increases clients satisfaction

- **Provide them Referral Facilities**: Referral cards are
  provided to the high risk pregnant mothers. Instructions are
given to all the Civil Surgeons to provide services to such
clients on priority basis. No user charges are taken from
clients having referral cards. The referral cards are used for,
Additional Antenatal Checkups (more than 3) for High Risk
Pregnancies, Delivery of referred cases from the Private
Health Providers, Care of sick newborns

- **Government as a facilitator**: In the JSY all facilities are
  provided by the government i.e., vouchers, service package,
budget and remaining required facilities for the
implementation of the scheme.
• **MNGO and FNGO as a Doer**: They implement this scheme through Sakhi and Private Health Provider or doctor.

• **Service Package**: It means everything included in the bag which is providing to the pregnant women under registered Janani Suvidha Yojana. In this bag facilities are described in the section of before and after delivery. **Before delivery** i.e., Antenatal registration; Pre-natal check up; 2 TT injections; IFA (Iron and Folic Acid) Tablets **after Delivery** i.e., 2 Post-natal free checkup; Essential Newborn care; IUD insertion/sterilization; complication within 42 days and Immunization of child. A brief description is as follows:

  **Antenatal registration**: Antenatal care is the care you receive from healthcare professionals during your pregnancy. You'll be offered a series of appointments with a midwife, or sometimes with a doctor who specializes in pregnancy and birth (an obstetrician). They will check that you and your baby are well, give you useful information to help you have a healthy pregnancy (including healthy eating and exercise advice) and answer any questions you may have.

  **Antenatal Checkups**: after registered the women under JSY, to provide them free antenatal checkup

  **2 TT injections**: The Tetanus Toxoid (TT) vaccine is given during your pregnancy to prevent the risk of tetanus to you as well as your unborn baby. Tetanus is a life-threatening bacterial disease that is caused by the toxin of a bacterium called *Clostridium tetani*. Tetanus bacteria enter the body through an open wound. Although the tetanus infection is more common when there is a deep puncture wound such as a bite, cut,
burn or an ulcer, it may well be caused by a tiny prick or scratch on the skin.

Tetanus affects a person's nervous system and can be fatal if left untreated. It is preventable through immunization. Antibodies formed in your body, after the vaccination, are passed on to your baby and protect her as well for a few months after birth.

**IFA (Iron and Folic Acid) Tablets;**

It is estimated that more than 40% of pregnant women worldwide are anaemic. At least half of this anaemia burden is assumed to be due to iron deficiency. Pregnant women require additional iron and folic acid to meet their own nutritional needs as well as those of the developing fetus. Deficiencies in iron and folic acid during pregnancy can potentially negatively impact the health of the mother, her pregnancy, as well as fetal development. Evidence has shown that the use of iron and folic acid supplements is associated with a reduced risk of iron deficiency and anemia in pregnant women. Thus, it is way through which 1st phase of JSY is completed.

2 **Post natal checkups:** It means you should have your postnatal check about six weeks after your baby's birth to make sure that you feel well and are recovering properly.

**Essential Newborn care:** It means newborn receives essential care right from the time of birth and first 48 hours at the health facility and then at home during the first 42 days of life. Newborns identified as sick or preterm /low birth weight soon after birth or during home visit are referred to special newborn care facilities for further management and long term follow up after discharge.
Post delivery IUD insertion/sterilization (if the client wishes so) An IUD, or intrauterine device, is a small contraceptive device made of flexible plastic. It's inserted into the uterus, where it provides safe, highly effective long-term contraception. An IUD is a good option for women who want a highly effective, long-term, easily reversible method of contraception. It can be an appropriate choice for women who can't use certain hormonal methods like birth control pills or who aren't good pill takers. Keep in mind that, like the Pill, an IUD won't protect you from sexually transmitted infections (STIs).

Any pregnancy related complication within 42 days of delivery; if any problem occurs to the mother or baby then she is covered or cured under JSY.14

Immunization of child: About 67,0000 women in india die every year due to pregnancy related complications. Similarly, every year approximately 13 lakhs infant die within one year of birth. Out of the 9 lakh newborns who die within four weeks of birth (2/3rd of the infant deaths), about 7 lakh i.e., 75 percent within the first week (a majority of these in the first two days after birth). The first 28 days of infancy period are therefore very important and critical to save children. Both maternal and infant deaths could be reduced by ensuring timely access to quality services or called through immunization programme. The explanation of immunization defined below:

At the time of Birth: The baby is due to get BCG Dose 1 (Tuberculosis vaccine), OPV (Oral Polio Vaccine) Dose 1, Hepatitis B (Hepatitis B vaccine) Dose 1.

During 6-8 weeks after Birth: The baby is due for DTaP/DTwP (Diphtheria, Tetanus and Pertussis) Dose1, Hib
(Haemophilus Influenzae type B Vaccine) Dose 1, Rotavirus Dose 1; it helps in protecting against rotavirus the leading cause of diarrhoea. The WHO recommends this vaccine because the rotavirus is a major cause of dehydration in babies. IPV (Injectable Polio Vaccine) Dose 1, Hepatitis B (Hepatitis B Vaccine) Dose 2. **Optional vaccine:** PCV (Pneumococcal Conjugate Vaccine) Dose 1, which prevents Pneumonia and Meningitis (brain fever). It is quite a costly vaccine and is given as an injection in three doses.

**During 10-16 weeks after Birth:** The baby is due for DTaP/DTwP (Diphtheria, Tetanus and Pertussis) Dose 2, Hib (Haemophilus Influenzae type B Vaccine) Dose 2, Rotavirus Dose 2 IPV (Injectable Polio Vaccine) Dose 2. **Optional vaccine:** PCV (Pneumococcal Conjugate Vaccine) Dose 2.

**During 14-24 weeks after Birth:** The baby is due for DTaP/DTwP (Diphtheria, Tetanus and Tertussis) Dose 3, Hib (Haemophilus Influenzae type B Vaccine) Dose 3, Rotavirus Dose 3, IPV (Injectable Polio Vaccine) Dose 3. **Optional vaccine:** PCV (Pneumococcal Conjugate Vaccine) Dose 3

**After 6 months of Birth:** OPV (Oral Polio Vaccine) Dose 1, Hepatitis B (Hepatitis B Vaccine) Dose 3. **Optional vaccine:** Influenza vaccine Dose 1. This prevents common flu to a large extent. It is administered as an injection any time after 6 months age. First timers are given 2 shots with a gap of 4 to 6 weeks. After the priming doses, one shot is given every year between October and December. This vaccine is unique, as it is specially manufactured for that particular year only, depending on the flu virus prevalent.
During 7-8 months after Birth: Optional vaccine: Influenza vaccine Dose 2. This prevents common flu to a large extent. It is administered as an injection any time after 6 months age. First timers are given 2 shots with a gap of 4 to 6 weeks. After the priming doses, one shot is given every year between October and December. This vaccine is unique as it is specially manufactured for that particular year only, depending on the flu virus prevalent.

After 9 months of Birth: The baby is due for OPV (Oral Polio Vaccine) Dose 2, Measles Dose 1, MMR (Measles, Mumps and Rubella vaccine) Dose 1.

During 9-12 months of Birth: The baby is due for Typhoid CV (Typhoid Conjugate Vaccine) Dose 1. The vaccine protects baby against Typhoid. Typhoid is a bacterial disease which spreads through contaminated food and water. JE (Japanese Encephalitis vaccine) in endemic areas only Dose 1.

After 12 months of Birth: The baby is due for Hepatitis A (Hepatitis A vaccine) Dose 1

After 15 months of Birth: The baby is due for PCV (Pneumococcal Conjugate Vaccine) Booster, MMR (Measles, Mumps and Rubella vaccine) Dose 2. Optional vaccine: Chickenpox Dose 1. The chickenpox vaccine provides lifelong protection from the chickenpox virus.

During 16-18 months of Birth: The baby is due for IPV (Injectable Polio Vaccine) Booster, Hib (Haemophilus Influenzae type B vaccine) Booster, DTaP/DTwP (Diphtheria, Tetanus and Prtussis) Booster.
After 18 months of Birth: The baby is due for Hep A (Hepatitis A vaccine) Dose 2, JE (Japanese encephalitis vaccine) in endemic areas only Dose 2.

After attaining the age of 2 years: The baby is due for Typhoid Booster. Optional vaccine: Meningococcal Meningitis: This also prevents Meningitis (brain fever). It is given at 2 years as an injection and is valid for 2 years.

During 4-6 years of Birth: The baby is due for OPV (Oral Polio Vaccine) Dose 3, Typhoid Booster, TaP/DTwP (Diphtheria, Tetanus and Pertussis) Booster. Optional vaccine: Chickenpox Dose 2.¹⁵

Measure Goals of JSY

Janani Suvidha Yojna scheme proved an exemplary scheme in the area of Public Health which has contributed significantly in improving the access to Institutional deliveries for marginalized section of the society in urban slum by reducing the maternal deaths. Under the scheme, the government would enter into a contract with the private provider to cater to institutional services for both normal and complicated delivery including Caesarian-Sections operation and blood transfusion to targeted group and to make quality antenatal, natal and postnatal services easily accessible to poor in the urban slums of Haryana.¹⁶

Various Objectives of JSY

As far as the sphere of health is concerned, maternal and child health issues still continue to be at forefront of national and global health policies. One of the major concerns of the state Reproductive and Child Health (RCH) Programme phase II is the extremely low percentage of institutional deliveries. Among
women living Below Poverty Line (BPL) in urban slum and in remote villages the number of institutional deliveries is almost negligible\textsuperscript{17}. Saving mothers’ lives is not only a moral imperative, but a sound investment that benefits their children, their families, their communities and their countries. “Indeed, there is a clear connection between maternal health and other Millennium Development Goals, such as eradicating extreme poverty, reducing child mortality and combating HIV and AIDS and other diseases”.\textsuperscript{18} In these circumstances Janani Suvidha Yojana is one of the sound efforts to address these issues.

There is an urgent need to empower communities to take control of their health by strengthening their participation in identifying their own maternal and child health needs and identifying measures to address them.\textsuperscript{19} Therefore, to achieve these desired ends some objectives are defined, which are given below.

- To make quality mother and child health services accessible to the neediest.
- To provide good quality contraceptives, vaccines and other supplies to the urban poor.
- To provide good quality and low cost diagnostic services to the pregnant mothers in urban slums.
- To optimally utilize the existing resources in health.
- Improving the technical quality of Maternal and Child health services.

**Vision of the JSY**

The scheme is estimated to benefit more than 250 pregnant women per month who access government health facilities for
their delivery. Moreover it is motivated those who still choose to
deliver at their homes to opt for institutional deliveries. . It is an
initiative with a hope that states would come forward and ensure
that benefits under JSY would reach every needy pregnant woman
coming to government institutional facility. The State of Haryana
has initiated implementation of the scheme. The JSY has been
implemented in the State with view to encourage all pregnant
women to deliver in public health faculties and full fill the
commitment of achieving cent percent institutional deliveries .It
will also help to reduce the MMR and IMR of the State. Though
this the procedure of the JSY through which it deals with
registered women and empowered them.

Hence, under umbrella of NRHM, Janani Suraksha Yojana
provides the institutional delivery system to the poor pregnant
women of rural as well as urban area. In the same manner Janani
Suvidha Yojana was introduced for urban slum in Haryana.
Although Janani Suraksha Yojana focuses on the poor pregnant
woman with special dispensation for states having low
institutional delivery rates namely the states of Uttar Pradesh,
Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh,
Assam, Rajasthan, Orissa and Jammu and Kashmir but Janani
Suvidha Yojana is covered only state of Haryana. This scheme is
committed to make quality Antenatal, Natal and Postnatal
services easily accessible to poor in the urban slums of Haryana.
This scheme is implemented through NGOs i.e., SWACH,
Haryana Nav Yuvak Kala Sangam, SOSVA, SNS and Utthan
Institute of Development Studies. In fact, they are MNGOs which
are working through various Field NGOs in the selected eight
districts. Before describing the selected MNGOs and FNGO, it becomes necessary to discuss about the concept MNGO and FNGO.

About Mother NGO and Field NGO

**Mother NGO (MNGO):** Mother NGO scheme is one of the largest initiatives in India to involve NGOs in delivering RCH services among the un-served and under-served areas. The scheme involves large number of contracts between government and the NGO sector. As of April 2006, 215 Mother NGOs are working in 324 districts of the country. In the ninth Five-Year Plan (1997-2002), Department of Health and Family Welfare introduced the Mother NGO scheme, under the Reproductive and Child Health Programme. Under this scheme, Department of Health and Family Welfare is identifying and sanctioning grants to the selected NGOs, called Mother NGOs, in allotted districts. These MNGOs, in turn, issue grants to smaller NGOs, called Field NGOs (FNGOs), in the allocated district/s. MNGOs are registered under the Societies Registration Act with substantial presence and experience for at least three years in health and social sector in the state or district where they propose to work.

**Field NGO (FNGO):** Field NGOs are smaller NGOs with field presence of at least two years in the geographical area for which it is seeking a grant. These NGOs implement small projects, for a population of two sub-centres (10-15 thousand population); in specific aspects of RCH service delivery. FNGO is supported by MNGO for meeting their skill requirement either directly or through linkages with district hospitals, private
The concerned districts, list of MNGOs and number of FNGOs are given below.

Table: 2.1

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<th>S.No</th>
<th>Name of Districts</th>
<th>Name of MNGO</th>
<th>Number of FNGO</th>
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<tr>
<td>4.</td>
<td>Rewari</td>
<td>SNS</td>
<td>3</td>
</tr>
<tr>
<td>5.</td>
<td>Narnaul</td>
<td>-Do-</td>
<td>3</td>
</tr>
<tr>
<td>6.</td>
<td>Sonepat</td>
<td>SOSVA</td>
<td>10</td>
</tr>
<tr>
<td>7.</td>
<td>Gurgaon</td>
<td>-Do-</td>
<td>5</td>
</tr>
<tr>
<td>8.</td>
<td>Kurukshetra</td>
<td>Utthan Institute of Development &amp; Studies</td>
<td>7</td>
</tr>
</tbody>
</table>

Hence, these MNGOs are implementing the Janani Suvidha Yojana with the help of Field NGOs. The MNGOs related to JSY have been defined below:

Haryana Nav Yuvak Kala Sangam, Utthan Institute of Development & Studies, SWACH (Survival for Women and Children Foundation), SOSVA (Service for Society to Voluntary Agencies) and SNS (Sant Nishchal Singhji), Theses foundations implemented “Janani Suvidha Yojana Scheme” (JSY) in February 2007, within the framework of Ministry of Health & Family Welfare Government of Haryana. The Foundations are Partners
(Mother NGO) with the Government in operating this program in Rewari, Mehandargarh, and Gurgaon etc in districts of Haryana. The Foundations are instrumental in providing pregnant women complete anti-natal check-ups, safe delivery and posts natal services through selected community mobilizes and private nursing homes. The selected community mobilizer is called “Sakhi”. They are in turn engaged by the project to identify & mobilize pregnant women to go for health check-ups and later opt for institutional deliveries. SNSF covers approximately a population of 684183 people living in urban slums in these districts. In the first year of the project, SNS Foundation has been able to conduct 700 antenatal checkups, and has ensured 330 institutional deliveries.

Thus, MNGOs of various districts are committed to provide the institutional delivery system in urban slum. As far as their further functioning is concerned, field NGOs work through private doctors and Sakhi. Sakhi plays a pivotal role in this scheme. She acts as a link between Clients & Private Health Providers. She is selected by FNGOs/SHGs. She is responsible for facilitating the clients for availing Antenatal Checkups, institutional delivery, referral transport and immunization of the newborn from the designated Private Provider. Sakhi gives undertaking to District NGO and get performance based honorarium after completion of a set of activities. The Sakhis is provided imprest money of Rs.200 as the revolving fund for referral transport of pregnant mothers for delivery purposes, referral of high risk pregnancies and sick newborns. Sakhi is
selected on the basis of population. She is selected on the basis of resident woman from the urban slum and per 1000 population. The number of Sakhis and respective urban slum population where scheme is implemented are given below:

Table: 2.2

<table>
<thead>
<tr>
<th>S. No</th>
<th>Name of Districts</th>
<th>Total Slum Population</th>
<th>Number Of Sakhis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Panchkula</td>
<td>44753</td>
<td>30</td>
</tr>
<tr>
<td>2.</td>
<td>Kurukshetra</td>
<td>70389</td>
<td>65</td>
</tr>
<tr>
<td>3.</td>
<td>Sonepat</td>
<td>1,62264</td>
<td>123</td>
</tr>
<tr>
<td>4.</td>
<td>Yamunanagar</td>
<td>113191</td>
<td>96</td>
</tr>
<tr>
<td>5.</td>
<td>Bhiwani</td>
<td>1,25,223</td>
<td>127</td>
</tr>
<tr>
<td>6.</td>
<td>Gurgaon</td>
<td>1,14840</td>
<td>97</td>
</tr>
<tr>
<td>7.</td>
<td>Rewari</td>
<td>31437</td>
<td>28</td>
</tr>
<tr>
<td>8.</td>
<td>Narnaul</td>
<td>22086</td>
<td>28</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>684183</td>
<td>594</td>
</tr>
</tbody>
</table>

Hence, in eight districts, slum population of 684183 is covered under JSY. To cater this huge population, 594 Sakhis are performing their duties.

This scheme has been implemented in eight districts as we discussed already but our area of study is only four districts. Further we will discuss about selected four districts, i.e., Sonepat, Bhiwani, Gurgaon and Yamunanagar.
Table 2.3

District wise distribution of slum population and name of MNGO, FNGO & Sakhis

<table>
<thead>
<tr>
<th>S. No</th>
<th>Districts</th>
<th>Total Slum Population</th>
<th>Name of MNGO</th>
<th>Number of FNGO</th>
<th>Number Of Sakhis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sonepat</td>
<td>1,62264</td>
<td>SOSVA</td>
<td>10</td>
<td>123</td>
</tr>
<tr>
<td>2</td>
<td>Bhiwani</td>
<td>1,25,223</td>
<td>Haryana Nav Yuvak Kala Sangam</td>
<td>14</td>
<td>127</td>
</tr>
<tr>
<td>3</td>
<td>Gurgaon</td>
<td>1,14840</td>
<td>SOSVA</td>
<td>5</td>
<td>97</td>
</tr>
<tr>
<td>4</td>
<td>Yamunanagar</td>
<td>113191</td>
<td>SWACH</td>
<td>10</td>
<td>96</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>Four</td>
<td>Three</td>
<td>39</td>
<td>443</td>
</tr>
</tbody>
</table>

Hence, in these four districts, three MNGOs and thirty nine FNGOs have been working. The FNGOs work under MNGOs. The MNGOs facilitate FNGOs and then they further deliver the services. They perform the following function to implement the JSY in urban slum areas.

**Providing Health Checkup to the registered women under JSY**

FNGOs provide the timely health check up to the pregnant women and after delivery they provide them two post natal checkups as well. During this check up doctor take the weight of the pregnant women and their infant, checks Hemoglobin, Amniotic Fluid, and Blood pressure etc. She also advises to the pregnant women about healthy diet, quality of life for the healthy mother and her baby. After delivery of the baby, FNGOs provide the lactating mother two free post natal checkups. In this checkup doctor check the health of baby and mother. She tells them about
importance of vaccination and gives them first Polio drop and BCG injection.

Providing Counseling to registered women

FNGOs counsels registered women regarding instilling overall hygienic habits in their life, to motivate them about institutional delivery, to take the guidance of Sakhi if any problem occurs at any time. They advise them about healthy food habits. They ask them about behavior of doctor towards them and they also motivate Sakhi’ for performing her duties diligently.

Distribution of Medicine among registered women

They distribute the folic acid, iron and calcium tablets. They also tell them about importance of vaccination i.e., Chickenpox, Diphtheria, Hepatitis A, Measles, and Rotavirus etc.
FNGOs advise to lactating women about breast feeding because it is necessary for immune system of new born.

Meeting of DSO with Sakhi

DSO and Sakhi are line agency in this scheme. They treat people directly. DSO meets people through Sakhi and asks about their grievances and redresses them. DSO and Sakhi discusses about various aspect of JSY. While meeting, they advise registered women about how to take care during pregnancy and after delivery. They tell them about the coverage of designated area under them and give their suggestions for necessary requirements.

Meeting with CMO

Every month FNGO submits their progress report to MNGO and MNGO meets CMO. MNGO put the various related issue before CMO and CMO tries to resolve them. CMO also discuss
with them status of empanelled doctors, status of normal and cesarean deliveries. They focus on normal delivery in place of cesarean because it is beneficial for health of mother. CMO motivate them for effective implementation of the scheme.

**Motivation and Training Programme**

FNGO and MNGO assemble all Sakhi and motivate them to perform in her defined area. As we have defined that a resident woman from the urban slum area is selected as a Sakhi on per 1000 population basis. She acts as a link between clients & private health providers. She is selected by FNGOs. She is responsible for facilitating the clients for availing antenatal checkups, institutional delivery, referral transport and immunization of the newborn from the designated Private Provider. FNGO provide the training to Sakhi regarding handling of pregnancy. At times, they invite the gynecologist to prepare them about how to provide care during pregnancy, iron, folic acid tablets, healthy diet, avoiding smoking and drinking and regular basic exercise etc.

**Coordination with Government**

For the effective implementation of this scheme MNGO and FNGO coordinates with the government. In the field, DSO is the representative of government and FNGO cooperate with DSO in their functioning. They provide them required data for his/her report submission. They also help him/her to survey the scheme. While giving the training to Sakhi, they invite them for his/her suggestions. MNGOs report to Chief medical Officer also by submitting monthly report or demanding any information. Sometimes nodal officers and scheme director also visit the
functioning areas. At that time they provide them required attention and assistance. Hence, at every stage MNGO/FNGO cooperates and coordinates with government for effective implementation of the JSY.

**Distribute vouchers to the pregnant mothers**

FNGO distribute the vouchers among pregnant women. On the basis of the issued vouchers doctor checks the pregnant women. Doctors get the 100 rupees per voucher and on the basis of voucher, Sakhi also get the financial benefits. Hence, vouchers are medium of fee for doctor and remuneration for Sakhi.

**Selection of Private Health Providers in consultation with District authorities**

MNGO selects the qualified and experienced gynecologist or doctor with the help of Chief Medical Officer. While selecting them, they also consider the availability of basic infrastructure i.e., her own hospital - preferably minimum of 15 beds, labor room and operating room, able to access blood in emergency situation, able to arrange for anesthetists and do emergency surgery etc.

**Provide the Referral System**

In order to facilitate maximum and effective utilization of health services in urban areas, it is necessary to set up a definite system of referral. For the high risk pregnancies and safe delivery practices, FNGO provides the referral system to the pregnant women with help of district administration. Referral cards are provided to the high risk pregnant mothers. Instructions are given to all the Civil Surgeons to provide services to such clients on priority basis. For these services, charges are taken from clients having referral cards. The referral cards are used for
additional antenatal checkups (more than 3) for high risk pregnancies and delivery of referred cases from the private health providers. They also provide them new born care facilities. The sick children are screened and detected at the peripheries through IMNCI and referred to the health facilities, care of sick newborn and child at health facilities assumes priority.\textsuperscript{22}

**Supervising and Monitoring**

FNGO supervise and monitor the functioning of JSY and services of the Sakhi. They meet with pregnant women and ask about timely checkup, timely meeting of Sakhi, response of doctor while checkup, status of voucher and strength of pregnant women provided by Sakhi etc. Thus, FNGOs evaluate the all over functioning provided by them directly or indirectly.

**Appraisal:** Janani Suvidha Yojana has been introduced in Haryana for providing the quality of healthcare to the urban slums of eight districts. Its goals and objectives cover the infants and mothers for providing them institutional delivery system and post natal care. In this chapter concept, features, goals and objective of JSY have been given. The relation between NGOs and JSY has also been defined. Under the JSY, 05 MNGOs and 56 FNGOs have been working. The Mother NGOs are Haryana Nav Yuvak Kala Sangam, Utthan Institute of Development & Studies, SWACH (Survival for Women And Children Foundation), SOSVA (Service for Society to Voluntary Agencies) and SNS (Sant Nishchal Singhji). In each district one MNGO has been working. In district Panchkula and Yamunanager, SWACH and fourteen Field NGOs have been working. In Bhiwani district, Haryana Nav Yuvak Kala Sangam and 14 Field NGOs have been
working. Rewari and Mahendergarh are covered by SNS and six Field NGOs. Sonipat and Gurgaon have also been covered by one Mother NGO i.e., SOSVA and 15 Field NGOs. In Kurukshetra district, Utthan Institute of Development and Studies has been working for JSY and seven other Field NGOs are involved.

In the JSY, functions and objectives of the Mother NGOs and Field NGOs are well defined and elaborated. In fact, NGOs are key agencies in the scheme. In one district, one Mother NGO works and a number of Field NGOs work on the basis of area. Sonipat has the maximum urban slum population in the state. Its population is 1,62264, followed by Bhiwani (1,25,223), Yamunanager (113191), Gurgaon (1,14840) with Rewari having the least population in the state. The above mentioned four districts are having maximum urban slum population among the eight JSY districts, therefore most favourable for our research. Moreover, maximum number of Sakhis are also working in these selected districts. In the Bhiwani district, maximum of 127 Sakhis are working, followed by Sonipat (123), Gurgaon (97) and Yamunanager (96). Sakhi is the key figure in the JSY because she is the one who contact and motivate families for registration of pregnant women. She also gets support from ANM and AWW while registering the women under the scheme. They all work under the supervision of Field NGOs.

The Mother NGOs are responsible for implementation of the JSY in the district. Field NGOs assist Mother NGOs to fulfill their responsibilities efficiently. They provide them counseling i.e., hygiene, food habits, vitamins and minerals, avoiding alcohol consumption and timely health checkup etc. As far as Janani Suvidha Yojana is concerned, it has been performing
efficiently and its various components are cooperating with each other in fulfilling their duties and responsibilities. Mother NGOs and Field NGOs are performing their duties as expected despite the fact that they are involved in implementation of multiple projects provided to them by the government. The government reviews the working of these programme and the grants are disbursed only after meeting requisite norms and performance.
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