

Visiting Madhya Pradesh

A Report on the implementation of The National Maternity Benefit Scheme & JSY In Four districts of Madhya Pradesh

Nick Robinson**

Yale Fox Fellow at Jawaharlal Nehru University
(in association with *Vikas Samvad*^{††}, Bhopal)

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** nickrobinson5@gmail.com

†† vikassamvad@gmail.com

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Introduction

This report investigates the implementation of the National Maternity Benefit Scheme and the schemes that have purported to replace it in Madhya Pradesh. The report is based off interviews conducted in four districts in the state – Bhopal, Seoni, Barwani, and Sheopur – during the last three weeks of March, 2007.

The report finds that despite the Supreme Court’s orders to the contrary the government is no longer implementing the National Maternity Benefit Scheme (NMBS). Instead, NMBS has been replaced with Janani Suraksha Yojana (JSY) – a scheme that gives cash incentives for pregnant women to seek an institutional birth. Although JSY was created to pursue a worthy goal – the safe delivery of babies – it does not address the nutritional needs of women during pregnancy like NMBS was designed to do. Further, although JSY does give money to women who have home deliveries this aspect of the program is rarely implemented in practice. Finally, JSY is encouraging women to give birth in public institutions that are often incapable of giving competent and safe care.

Madhya Pradesh is also implementing a scheme rarely known but commonly referred to as the pre-birth benefit program. Under this scheme pregnant woman over 19 who hold a yellow card receive 500 Rs several weeks before delivery for their first two births (actually it has been restricted to a particular class at the ground level). This scheme is similar to NMBS except under NMBS all pregnant women holding a Below Poverty Line (BPL) card would receive 500 Rs, not just yellow card holders (which are given only to the poorest of the poor). Additionally, the pre-birth benefit program suffers from widespread under-implementation with many potential beneficiaries remaining unaware of the program.

The principal findings of this report are:

- ⊕ Neither Janani Suraksha Yojana (JSY) nor the pre-birth benefit program is a comparable replacement to the National Maternity Benefit Scheme. JSY provides no nutritional support to women before delivery. The pre-birth benefit program, unlike NMBS, is limited to yellow card holders. Further, it is massively under-implemented. Finally, many women who should benefit from the pre-birth benefit program have difficult proving their eligibility. NMBS should, therefore, be universalized to all women
- ⊕ The multitude of schemes available to pregnant women and the failure of the government to communicate them clearly has caused intense confusion surrounding these schemes and resulted in widespread underutilization. Women do not know the eligibility criteria, benefits, and implementing agency for the scheme. This confusion has helped foster a climate of unaccountability in their implementation
- ⊕ Although JSY encourages women to have their delivery in public health institutions, these institutions are rarely capable of providing safe and competent care.

Report Methodology

This report investigated the implementation of the National Maternity Benefit Scheme, Janani Suraksha Yojana, and the pre-birth benefit scheme in four districts in Madhya Pradesh. Its findings are based on the

relevant literature, individual interviews, group discussion, and observation. The focus of the interviews and other research in these districts was on poor and marginalized populations – slum dweller, tribal, and other backward caste communities – where pregnant women would likely benefit most from these maternity schemes, but where implementation problems were also likely.

District	Type of District	Focus of Interviews	Location in Madhya Pradesh	Location in District interviews done
Bhopal	Urban	Slum Dwellers	Center - Capital	Urban slum and resettled village
Seoni	Rural/Tribal	Tribal Communities	South-east	South of Seoni
Barwani	Rural/Tribal	Tribal Communities	South-west	Around Sendhwa
Sheopur	Rural/Backward Tribal	Tribal and OBC Communities	North	Around Karahal

Background on Nutrition in Madhya Pradesh

Despite India’s remarkable economic growth rate in the last decade the nutritional health of many of its citizens has decreased. Madhya Pradesh is symptomatic of this broader national trend. According to the National Family Health Survey the number of wasted children under three in Madhya Pradesh increased from 20.2% to 33.3% between 1998-1999 and 2005-06. The number of underweight children under three increased from 53.5% to 60.3% during this same period. The number of women with a body mass index below normal increased from 35.2% to 40.1%.³ These indicators have a real impact on health. UNICEF estimates that malnutrition is the underlying cause in half of the 21 lakh under-5 deaths in India each year. Further, malnutrition in pregnant women is one of the chief causes of low birth-weight babies, which in turn is a significant contributor to infant mortality.⁴

Anemia rates also increased for both women and children between 1998-1999 and 2005-06. The number of anemic children 6-35 months went from 71.3% to 82.6%. For pregnant women it increased from 49.9% to 57.9%.⁵ Anemia is a significant contributor to maternal and infant mortality. Further, anemia often impacts energy-levels which effects educational development, work productivity, and general well-being.

There is some limited positive news under the latest National Family Health Survey for Madhya Pradesh. Stunted children under age 3 in Madhya Pradesh decreased from 49% to 40% from 1998-1999 to 2005-06. Further, the NFHS recorded a decline in infant mortality from 88 per 1000 births to 70 per 1000 births.⁶ However, the Sample Registration System (SRS) of the Indian Census still finds that Madhya Pradesh has

³ Fact Sheet: Madhya Pradesh (Provisional Data) 2005-2006 National Family Health Survey (NFHS-3) www.nfhsindia.org/pdf/MP.pdf

⁴ UNICEF webpage. Under-nutrition – Challenge for India. www.unicef.org/india/nutrition_1556.htm

⁵ Fact Sheet: Madhya Pradesh (Provisional Data) 2005-2006 National Family Health Survey (NFHS-3) www.nfhsindia.org/pdf/MP.pdf

⁶ Id.

the highest infant mortality rate of any state in the country. SRS also records the infant mortality as 76 deaths per 1000 births as of 2005, which is somewhat higher than the NFHS-III numbers.⁷ If Madhya Pradesh were a country it would rank amongst nations with some of the highest infant mortality rates in the world. Its infant mortality rate is about fifteen to twenty times as high as most developed nations.⁸

In such situation, the Government of India has released figures related to maternal mortality for the first time since 1998, which claims that the Maternal Mortality Rate (MMR) has gone down from 498 (per lakh childbirth) to 379 during the period⁹ which still ranks it amongst the highest in the country.¹⁰ In fact, 10% of the country's maternal deaths take place in Madhya Pradesh. As per the report of GoI, *about two-thirds of maternal deaths occur in a handful of the states - Bihar and Jharkand, Orissa, Madhya Pradesh and Chhattisgarh, Rajasthan, Uttar Pradesh and Uttaranchal (the Empowered Action Group or EAG states) and in Assam*¹¹.

The National Maternity Benefit Scheme

The National Maternity Benefit Scheme (NMBS) came into effect in August 1995 as part of the National Social Assistance Program (NSAP).¹² NMBS provides 500 Rs in cash assistance to pregnant women living below the poverty line for her first two births provided she is 19 years or older.¹³ The benefit is to be given several weeks before delivery and used for nutrition and other needs.

In reality though, the intended beneficiaries of the scheme rarely have received the funds. The target for the scheme in the budget of 1995-96 was about 58 lakh pregnant women. By 2002-03 only 10 or 11 lakhs were receiving the benefit according to government figures. Further, studies revealed that women rarely received the benefit during the last few months of pregnancy as the scheme intended.¹⁴

As part of the right to food case, the Supreme Court ordered on November 11, 2001 that the state governments fully implement the National Maternity Benefit Scheme. The Court directed that the beneficiaries should receive the program's 500 Rs cash assistance eight to twelve weeks prior to delivery.¹⁵ In 2004, the Court heard complaints that schemes under NSAP were being discontinued by the states. The Court issued an interim order in April 2004 saying that none of the NSAP schemes, including NMBS, should be discontinued.¹⁶

⁷ Sample Registration System. Table 1: Estimated Birth rate, Death rate, Natural growth rate and Infant mortality rate, 2005. Vol. 41 No. 1 Oct. 2006. www.censusindia.net/vs/srs/bulletins/SRS_Bulletin_-_October_2006.pdf.

⁸ The 76 per 1000 infant mortality rate ranks Madhya Pradesh slightly worse than Haiti, which had an infant mortality rate of 74 per 1000 births in 2006. Most of the remaining countries with a worse infant mortality rate than Madhya Pradesh are in Africa and have experienced civil strife in recent years. See www.who.int/whosis/whostat2006_mortality.xls.

⁹ Govt. Of India, Registrar General, India in collaboration with Centre for Global Health Research University of Toronto, Canada. October 2006, Maternal Mortality in India: Trends, causes and risk factors - 1997-2003

¹⁰ SRS Data, April 2006

¹¹ Govt. Of India, Registrar General, India in collaboration with Centre for Global Health Research University of Toronto, Canada. October 2006, Maternal Mortality in India: Trends, causes and risk factors - 1997-2003

¹² Dept. of Rural Development, "National Social Assistance Programme" <http://rural.nic.in/nsap.htm>

¹³ Second Report of the Commissioner in the Right to Food Case, par. 2.5.

¹⁴ Second Report of the Commissioner, par. 2.5.5

¹⁵ S. Ct. Order Right to Food Case, Nov. 28, 2001

¹⁶ S. Ct. Order Right to Food Case, April 27, 2004

In May 2005, the government asked whether it could replace the National Maternity Benefit Scheme with Janani Suraksha Yojana (JSY). The Court requested the government provide more information about this proposal. It ordered though that, “[m]eanwhile, the existing National Maternity Benefit Scheme will continue.”¹⁷

However, in seeming contempt of the Court’s previous directions the scheme had already been replaced by the government by May 2005. According to the government, on April 12th, 2005, the National Maternity Benefit Scheme (NMBS) was replaced with Janani Suraksha Yojana (JSY).¹⁸ No one interviewed for this study reported participating in a scheme with the name of National Maternity Benefit Scheme or its requirements in the last year. Although NMBS is still listed on the Ministry of Rural Development’s website,¹⁹ the government’s own admission and the situation on the ground in Madhya Pradesh confirms that NMBS is no longer being implemented. This is in direct conflict with the Supreme Court’s orders in the right to food case and must be remedied immediately. Results clearly proves that now NO scheme to fulfill the specific nutritional requirements of the pregnant women is being implemented by the Government, now they have converted the previous NMBS scheme, which used to provide support to address nutritional needs of pregnant women, in to a technical medical support scheme – JSY. As far as Madhya Pradesh is concerned, nutritional component is the crucial one. In this context results of the latest National Family Health Survey (III) makes the picture clear, the percentage of anemia among ever married women age 15-49Yrs., has increased from 49.3% to 57.6% and anemia in Pregnant women age 15-49 Yrs, has increased from 49.9 to 57.9% in last 8 years.

Relevant Supreme Court Orders in Right to Food case concerning NMBS:

“We direct the State Govts./Union Territories to implement the National Maternity Benefit Scheme (NMBS) by paying all BPL pregnant women Rs.500/- through the sarpanch, 8-12 weeks prior to delivery for each of the first two births.” (Nov. 28, 2001 order)

“By IA 37, permission is sought to modify the National Maternity Benefit Scheme (NMBC) and to introduce a new scheme namely Janani Suraksha Yojana (JSY). . . . We have requested learned Additional Solicitor General to place on record further material in the form of affidavit to effectively implement the new Scheme sought to be introduced. . . . Meanwhile, the existing National Maternity Benefit Scheme will continue.”

(May 9, 2005 order)

“The intentions of the [JSY and NMBS] schemes appear to be providing nutritional assistance to the expecting mothers. It is apparent from the report of the Commissioner that in the rural areas the non performance is more acute. It is brought to our notice that there have been some modifications in the JSY scheme which do not appear to have been made known to the beneficiaries.

It would be appropriate if the Union of India and the State Governments take steps to make the beneficiaries aware of the benefits of the schemes and the entitlements flowing therefrom.” (Feb. 1, 2007 order)

Janani Suraksha Yojana

¹⁷ S. Ct. Order Right to Food Case, May 9, 2005

¹⁸ Ministry of Health and Family Welfare, *Janani Suraksha Yojana: Features & Frequently Asked Questions and Answers*. Oct. 2006, Frequently Asked Question 1. [hereinafter Oct. 2006 JSY Guidelines]

¹⁹ Ministry of Rural Development Website, Page describing National Social Assistance Program, rural.nic.in/nsap.htm

Under Janani Suraksha Yojana (JSY) the government provides a cash incentive for pregnant mothers to have institutional births as well as pre- and ante-natal care. According to the October 2006 JSY guidelines, all women in Low Performing States (LPS), like Madhya Pradesh, receive cash assistance if they have their baby in a government health centre or accredited private institution. In rural areas they receive 1400 Rs and in urban areas 1000 Rs. The money is to be dispersed at the time of delivery in the institution. Importantly, unlike NMBS which provided cash assistance 8-12 weeks before delivery to help with nutrition and other expenses the government states that “the cash assistance to the mother [under JSY] is mainly to meet the cost of delivery.”²⁰

Under JSY, below poverty line pregnant women older than 19 also receive 500 Rs cash assistance for their first two births if these deliveries are at home. The cash is to be given at birth or around 7 days before for “care during delivery or to meet incidental expenses of delivery.”²¹

In the JSY guidelines from October 2006 the government asks under frequently asked questions: “If the focus of the scheme is to promote institutional delivery, why should there be a provision for home delivery?” In reply to its own question the government agrees that it wants to discourage home delivery, but that under the Supreme Court’s decision in the right to food case it is mandatory to provide money for home delivery.²²

This misses the point. NMBS and the Supreme Court orders were not intended to give a benefit for home delivery, but to provide financial support for below poverty line women *before* the birth of their child, whether that birth was at home or in an institution. The focus in NMBS was on supplying money during pregnancy that mothers could use to supplement their nutrition during these critical months. JSY entirely abandons this goal by giving money only at or near the time of delivery.

Additionally, below poverty line women rarely receive the money for home delivery actually envisioned under JSY. In Sendhwa block in Barwani district there reportedly had been only one applicant by a BPL woman for a home birth for the first two and a half months of 2007.²³ Many Anganwadi workers (AWWs) and nurses reported never hearing about the money available for a home delivery under JSY.²⁴ Others report they are discouraged to give this money. The AWW in Dargada village, Seoni, says that her supervisor told her to give money out for home delivery only if the delivery was performed by a trained mid-wife and it was an emergency.²⁵ In turn, most communities reported not receiving this money or even being aware it was available.²⁶

The state’s own numbers support these field observations concerning the massive under-utilization of the home delivery benefit of JSY. According to the government, during 2006-2007 only 1687 women in Madhya Pradesh who had a home delivery received a benefit from JSY. In some districts, such as Barwani and Bhopal, there were no reports of this benefit being given last year. In Seoni district the government claims 56 women who had a home delivery in 2006-2007 benefited from JSY. In Sheopur 23 women

²⁰ Oct. 2006 JSY Guidelines, para. 4.7

²¹ Oct. 2006 JSY Guidelines, para. 4.13

²² Oct. 2006 JSY Guidelines, Frequently Asked Question 8.

²³ Interview #24

²⁴ Interview #20

²⁵ Interview #7

²⁶ Interview #30, Interview #36

reportedly received the benefit.²⁷ When even the state's own optimistic numbers claim only a bit over half of the state's births are in institutions,²⁸ these figures show a massive under-implementation of the home delivery benefit available under JSY. This is especially troubling since women who have a home birth are more likely to be poor and malnourished.

None of these criticisms about JSY are directed against the goals of JSY. Instead, the criticism is that JSY does not have the same goals as NMBS so it cannot possibly replace NMBS. Ante- and post-natal care is vital to the health of the child and mother. Institutional delivery can save lives. However, women also need greater nutritional support before the birth of their child. JSY does not address this need in its current form. NMBS attempted to do so.

The Pre-Birth Benefit Program

The government of Madhya Pradesh is administering a program, popularly known as the pre-birth benefit program, which does have some similarity to the National Maternity Benefit Scheme.

Under the pre-birth benefit program pregnant yellow card holders over 19 receive 500 Rs for their first two births if there are three years between the two births. Further, the birth should take place in an institution, although this aspect of the program cannot be enforced because the money is given out before delivery. The money is reportedly given out about a month after the beneficiary applies.²⁹

The pre-birth benefit program fails to meet NMBS's purpose in two ways. First, the pre-birth benefit program is only open to yellow card (as it is found in the filed that the home delivery benefit is only being provided to the Yellow card holders) holders while NMBS was open to all BPL women. The program, therefore, reaches out to a significantly smaller part of the pregnant population. This reduction in beneficiaries is compounded by the fact that many people do not have yellow cards although they were entitled to one. For example, a group of AWWs in Seoni district said that for every village in their district of 1000 persons there are 5 to 10 women who should have a yellow card that do not.³⁰ Of the 150 Scheduled Tribe families in Ranipura, in Sheopur, only 6 have a yellow card although all are entitled to them.³¹

Second, many yellow card holders have never heard of or received the pre-birth benefit.³² For example, in the tribal community in New Parond village not a single woman has ever received money under the program although all have yellow cards.³³

There is also confusion and bureaucratic hurdles surrounding the program. For example, an Anganwadi worker in Dhawli village, Barwani, claimed the benefit was only given if the baby was a girl.³⁴ In Kapoora,

²⁷ Reply Submitted on the State of Madhya Pradesh to the Supreme Court on March 1, 2007 in People's Union for Civil Liberties v. Union of India & Others.

²⁸ Interview #54

²⁹ Interview #11

³⁰ Interview #4

³¹ Interview #48

³² Interview #30

³³ Interview #47

³⁴ Interview #28

in Sheopur, the husband of the local Anganwadi worker tried to apply for the program when his wife became pregnant only to be told by the area Anganwadi worker that there were no forms.³⁵ (see boxed text on the situation in Kapoora)

For a comparison of JSY (home and institutional birth benefits), the pre-birth benefit program, and NMBS see table below:

Program	Benefit	When Receive Benefit	Ration Card Requirement	Age/amount requirements	Implementation
JSY – Institutional Delivery	1400 Rs (rural) 1000 Rs (urban)	At institution or shortly after	None (in low performing states like MP)	None	Widespread
JSY – Home Delivery ³⁶	500 Rs	At delivery or after the delivery	BPL Card	+19/first two births	Sporadic
Pre-Birth Benefit Program	500 Rs	2-3 months before delivery	Yellow Card (poorest of the poor)	+19/first two births	Sporadic
National Maternity Benefit Scheme	500 Rs	2-3 months before delivery	BPL Card	+19/first two births	None

After the Joint Commission of Enquiry’s Visit: Gothra-Kapoora Village

On October 5, 2006 the Joint Commission of Enquiry appointed under the Special commissioner to the Supreme Court in the Right to Food case visited Gothra-Kapoora village after malnutrition related deaths had been reported in the area. There the Commission found several children in poor health due to malnutrition. They heard complaints of women having to pay fees for delivery at the hospital in Karahal.³⁷ The district collector made assurances the situation would be remedied.

As of March 31st 2007, things have changed little for those living in Kapoora. After the Supreme Court visit they now get the 35 kg of wheat they are required to under PDS instead of the 30 kg they were being given. They also received some more food at the local Anganwadi Center. Fifteen packets of soya biscuits were given to help treat three children who had been identified as malnourished in the village. Upon inspecting the biscuits while visiting Kapoora for this report, it was discovered that they were four months past their expiry date. They had been given by block officials just the month before. Visits in other villages uncovered that expired biscuits had been given out throughout the block to treat children for malnutrition. This is this potentially dangerous to the children’s health. It is also symptomatic of the entrenched neglect and indifference of government officials towards these communities.

³⁵ Interview #50

³⁶ But still it is not mentioned in the Government document. See - http://www.health.mp.gov.in/janani_suraksha.pdf

³⁷ *Report of the Joint Commission of Enquiry: Incidence of Repeated Deaths Due to Malnutrition, Sheopur District, Madhya Pradesh.* Nov. 2006.

The school in Kapoora, which has 108 children enrolled, still effectively does not function, nor its mid-day meal. Gajraj Singh has been the teacher in the village for the last seven years. He lives 40 km away and has never come regularly. After two years of his appointment he was suspended for a year after villagers complained about his attendance. No replacement was given though and he was reinstated after his suspension.

Now Gajraj Singh comes two or three times a month according to community members. The mid-day meal is only served when he comes. The villagers claim they have seen him selling the grain for the MDMS in the open market and that he keeps the money given under the program. After the Commission of Enquiry visited Mr. Singh's records were seized, but no further action was taken as far as they could tell. Villagers think he is politically well-connected.

In the District Collector's response to the Joint Commission of Enquiry's Report, the District Collector denied that Mamta [Radhabai] had to pay any fees to hospital staff for her delivery as the JCE report had claimed.³⁸ Upon questioning her again she confirmed that she had to pay additional fees when going to the hospital in Karahal for her delivery.

Additionally, such fees continue to be demanded from the local hospital from villagers in Kapoora. On March 29th, 2007, the local Anganwadi worker in Kapoora gave birth at the Karahal hospital. She paid 100 Rs to the nurse and 50 Rs to the sweeper, as well as money for transportation to the hospital and back home. These fees are lower than others reported in the area, but perhaps she received a discount because she is an Anganwadi worker. The Anganwadi worker's husband also asked the Anganwadi's supervisor for a ****pre-birth benefit scheme form****, but the supervisor said she did not have any so they did not receive any money.

The District Collector's Response to the Joint Commission of Enquiry's Report also claims that the National Rural Employment Guarantee Act is functioning for villagers with several ongoing projects in the area. However, the villagers say they worked for two weeks about two months ago, but there has been no work before or since.³⁹

Navigating the Maternity Benefit Programs

One of the largest problems facing the implementation of JSY, the pre-birth benefit program, or NMBS is the confusion surrounding what programs exist and what their requirements and benefits are. For example, Janani Express Yojani provides ambulances in 11 blocks for pregnant women. Under Deen Dayal Antyodaya Upchar Yojana a health card is given to a family for one year for medical treatment in a hospital of up to 20,000 Rs. Surakshit Prasav Hetu Pariwahan Evam Upchaar Sahayata Yojana provides transportation costs for above poverty line, scheduled caste or scheduled tribe pregnant women to go to the hospital for delivery⁴⁰. This Scheme provides support to those women, who are not entitled to receive any benefit from JSY. Dhanvantri Vikaskhand Yojana (implemented in only 50 blocks out of total 313 blocks of Madhya Pradesh) provides a benefit for a BPL pregnant woman to seek ante and post-natal care. Vijaya

³⁸ District Collector's Response to the Joint Commission of Enquiry's Report, para. 6.2.5.

³⁹ Interview #50

⁴⁰ <http://www.health.mp.gov.in/prasav.pdf>

Raje Janani Bima Kalyan Yojana gives pregnant women 1000 Rs as support for medicine, if they have their birth in an institution. If she dies in the institution her family receives the insurance benefit of Rs. 50,000.

Some of these programs are state-sponsored and some are nationally sponsored. These schemes span two departments – health and women and child development. The websites of neither of these departments are kept up-to-date. There is no booklet explaining all the programs a pregnant woman is entitled to in a clear and simple way. No one interviewed for this report – including many government officials, Anganwadi workers, nurses, and doctors – could correctly identify and explain all the maternity benefit schemes available to a pregnant woman.

A woman should not be expected to have to know each of these programs and then go ask for them. Instead, the government should facilitate their access so that if she has made contact with any government health worker like an Anganwadi worker or nurse she will be given all the information she needs about each of the programs in an easily understandable manner.

Further, the confusion surrounding these programs makes it more difficult to hold anyone accountable for their non-implementation. It is difficult to fault a nurse or Anganwadi worker for sometimes confusing these numerous programs in good faith.

Receiving the Money

While both the pre-birth benefit program and the home-delivery aspect of JSY were massively under-implemented in the state, JSY benefits are widely received for institutional births. However, there was confusion about the amount of money that was being received under JSY. Reports varied from 700 Rs to 1400 Rs being received under JSY⁴¹. The correct amount (1000 Rs urban areas, 1400 Rs rural) was more commonly cited in areas where the benefit was given out by check. It is unclear when those being interviewed simply did not remember how much was given or when this was a sign of greater corruption. However, it is clear many beneficiaries are not receiving the correct amount under JSY.

In Karahal block in Shoepur it was commonly reported that although the mother received their benefit under JSY she then had to pay a fee to the nurse or sweeper, or for vaccination injections. In the OBC community in New Parondd village it was reported by two women that they had to pay fees of 200 Rs to the nurse and 100 Rs to the sweeper.⁴² In Ranipura village a woman said she had to pay 300 Rs to the doctor, 100 Rs to the nurse, and 80 Rs for the sweeper.⁴³ In Rahorn village a woman reportedly had to pay 250 Rs to the nurse, 70 Rs to the sweeper, and 110 Rs for injections.⁴⁴ The nurse at the block hospital claimed that there were no such fees being charged.⁴⁵ In the Tribal community in New Parondd women reported only receiving 700 Rs or 800 Rs from JSY. They also had to transport the women to the hospital on the back of a bicycle.⁴⁶

⁴¹ Interview #47

⁴² Interview #45

⁴³ Interview #48

⁴⁴ Interviews #52

⁴⁵ Interview #53

⁴⁶ Interview #47

Women also sometimes reported inconvenience in getting money related to JSY. As one woman who lives in Sabji farm slum in Bhopal says, “We know you can get compensation at the hospital for a birth, but you have to go four or five times before you get the money. We are told that they don’t know about it or to see someone else. You have to push for it to get it. Maybe the workers take it? I don’t know, but they torture you before you can get it.”⁴⁷

Using the money

It was widely reported that many of the women who received money under JSY or the pre-birth benefit program used it for food and medicine. However, there were also reports of misuse of the money. Dr. Sanjay Barbar, the block medical officer for Sendhwa in Barwani district, reported that drunk husbands had come back asking for more money after it had been given to their wives.⁴⁸ The nurse in the Karahal block health center in Sheopur thought that the money was misused perhaps 10% of the time by husbands for drinking and inappropriate uses.⁴⁹

While creating this report it was observed that it was husbands, brothers, or fathers who often made most of the important medical decisions for pregnant women. They decided to take the woman for ante-natal care or not. They decided whether to have the birth at an institution or at home. They took the money received under JSY or NMBS and decided what to use it for. It was not that women always had no voice in these decisions, but this voice was often filtered through, or could be easily vetoed by, men.

In such a male-dominated society it is important to take continuous steps towards empowering women. If women do not have control over their bodies or the ability to access health services or government benefits on their own, their health and the health of their baby is more likely to be put in jeopardy. Further, men must be educated about the needs of women during and after pregnancy so that if they make health decisions for pregnant women they make the correct ones.

Not enough money

The amount of money given, especially in the pre-birth benefit program, was frequently cited as being too low to adequately meet the nutritional and other needs of pregnant women. Hira Choihan, an Anganwadi worker in Dhawli village says that the pre-birth benefit plan “should give 5000 Rs not 500 Rs.”⁵⁰

This observation is in line with a 2000 study from Bihar by the Mathura Krishna Foundation for Economic and Social Opportunity and Human Resource Management that found beneficiaries of the old National Maternity Benefit Scheme found the amount given was too low to meet their needs. Those that participated in that survey thought on average 4500 Rs should be given.⁵¹

Failure of ICDS

⁴⁷ Interview #35

⁴⁸ Interview #24

⁴⁹ Interview #53

⁵⁰ Interview #28

⁵¹ Mathura Krishna Foundation for Economic and Social Opportunity and Human Resource Management, “An Empirical Study of Poverty Alleviation Programmes in Bihar” (2000)

The Integrated Child Development Service (ICDS), operated through local Anganwadi Centers, is a critical component of the government's strategy to combat malnutrition in pregnant women and children by providing grain to pregnant and lactating women and children under five. However, several villages in the state reported that ICDS was not properly reaching pregnant women.

In Khappa village, Seoni, the local Anganwadi worker does not receive enough grain to meet the combined needs of the children and pregnant and lactating women enrolled at the center. Local officials have told the Anganwadi worker if there is not enough food for the month to prioritize the children first. This means that for one or two weeks every month the Anganwadi worker gives no food to the pregnant and lactating mothers.⁵² This situation is repeated in Sukhdongri village in Seoni.⁵³ This breakdown of the ICDS system is particularly troubling given the implementation problems surrounding the pre-birth benefit program and the home delivery benefit of JSY. If the ICDS cannot give pregnant women grain and the pre-birth benefit program or home delivery benefit of JSY is not implemented, she may be left with no nutritional safety net during the critical months of pregnancy or while she is breastfeeding.

A lack of legal recognition of certain communities also plagues the effectiveness of Anganwadi centers and the social programs that are implemented through them, like the pre-birth benefit program. There are four slums that surround Sabji Farm slum in Bhopal. There is only one Anganwadi center for the over 5,000 people who live here as only three of these five slums are recognized by the government. The Anganwadi center is too far away for many children and women to go regularly. Further, according to local residents the Anganwadi worker has only been sanctioned to provide nutrition for a limited number of children, pregnant women, and lactating mothers. The rest are turned away. Community members conducted a small survey and found that of 23 pregnant women in their slum only 5 were registered at the Anganwadi. The rest got no benefits from any Anganwadi related scheme.⁵⁴

The Costs of Slum Relocation

In 2004, the government moved about 350 households from an unregistered slum in B-Cabin Double Fatark in Bhopal to near Sukhisevaniya village about 20 km outside the city. The relocation site is rocky and bleak, located under towering electrical towers. Shacks made out of sticks, cardboard, and canvas ramble up against each other. During school hours young children run through this new state-sponsored slum. When sitting together they pick fleas off each other

When the slum-dwellers were moved to this site the government promised that they would be given title to this new land. Of the 80 families that have remained in these horrible conditions, only about 30% have gained such title 3 years later. They were given no compensation when they were moved. They were given free transportation for their few belongings, dropped off, and given one day's worth of food rations.

They requested a water tanker for the site, which the government promised it would provide. The tanker remained the first five days and then left. They have been asking to get it back ever since. The villagers in Sukhisevaniyya across the main road have spurned the slum dwellers as they are rag pickers and considered untouchable. As a result, they are not allowed to use the water pump in the village. An electrical pump was provided to the slum by the government, but there has never been electricity to run it. To survive, the slum

⁵² Interview #15

⁵³ Interview #20

⁵⁴ Interview #35

dwellers must walk three kilometers every day to the nearest hand-pump for water. Because of this distance from a water source, they often do not bath for weeks at a time.

Many of the children in this slum do not attend the local school. They and their parents continue to be rag pickers in Bhopal. Now though they must travel 20 km by train spending up to a week at a time in the city making it impossible for the children to attend school regularly. Additionally, some of the children say they are treated badly by the village school children. Others claim the teacher is too strict. Regardless, growing up as rag pickers in Bhopal they never had to go to school and so the transition would be difficult even under the best of circumstances.

The nutritional deficiencies of the slum are apparent. Four of the children have been identified by the local Anganwadi worker as having third grade malnutrition. Slum dwellers try as much as possible to avoid the nearby village. This is where the closest Anganwadi center is located so they rarely go. Currently, the helper to the village Anganwadi worker comes once a week to deliver soya biscuits to the children.

Even if they did have an Anganwadi center most of the residents of this relocation site do not have valid ration cards. They had ration cards in Bhopal and applied for them to be transferred to this new slum. Few have gotten them and so cannot avail of many state benefits, like subsidized grain. One woman laments, “What does it matter though? Even if we had the cards the PDS shop is never open.”

Of five women who recently gave birth in the slum only one had the baby in an institution. She received 600 Rs under JSY as the local hospital has been giving out a reduced amount if the woman cannot show identification. The others received nothing as they had their baby at home and had no ration card.⁵⁵

Problems with Institutional Birth under JSY

Difficult to reach public health facility

Primary Health Centers are still too difficult to reach from many villages making them effectively useless to these villagers. In Dawda village, in Barwani, is symptomatic of this problem. The village has no four-wheel motorized vehicle. It takes two and a half hours by bullock cart over very rocky terrain for a woman to reach the nearest health center. There have been many instances of pregnant women giving birth on the way. Several of the women in the community seemed to think that giving birth in the hospital is better than at home, but since it is such a difficult journey they said most women in the village just have their baby at home.⁵⁶

Low Quality of Care

Dr. Sanjay Barbar, the block medical officer in Sendhwa, points out “the problem [with JSY] is that although we are calling on our women to have institutional deliveries our institutions are not up to the task.”

⁵⁵ Interview #36, Interview #39

⁵⁶ Interview #30

First, the infrastructure in much of the state is old and outdated. Motioning towards the dilapidated walls of the primary health center in which he works Dr. Barbar says, “This building is over 100 years old. Most of the infrastructure in my block is from British times. You can re-plaster the walls for a while, but the only answer in the end is new buildings.”⁵⁷

Additionally, many hospitals, even district hospitals, lack even the most basic equipment. There are 48 districts in Madhya Pradesh, but not 48 blood banks. Fear over spreading HIV/AIDS has rightly increased quality-control measures for blood supplies. This has made it more difficult to have blood banks in remote areas. However, problems like this can be overcome with creative thinking like bringing in pre-screened blood from elsewhere in the state so the only requirements on site would be a refrigerator and technician trained in using the blood.⁵⁸

Second, there is a frightening scarcity of trained medical personnel throughout the public health system. This shortage is particularly acute for highly trained medical staff. For example, in Seoni district of the ten sanctioned spots for Class I medical officers, which includes the chief medical health officer, district health officers, and specialists, only two were filled. Of the nine post-graduate medical officers sanctioned only three spots were filled.

These highly trained personnel form the core expertise and leadership for a medical system. They provide guidance and training for other staff. They also provide critical knowledge and skill that can save lives. The Chief Medical Officer in Seoni District laments that “many mothers and babies needlessly die because we do not have enough post-graduate doctors.” He remarks that “Often the paramedical staff cannot identify early enough the cases where pregnant women will need a caesarean and these women die.”⁵⁹

Additionally there is a severe shortage of women doctors. In the entire district of Seoni there are only eight to ten women doctors with three or four of them in the district hospital. Sendhwa block in Barwani district has 250,000 people. There are only six institutions that give delivery services for the 140 villages scattered throughout the block. Incredibly there is only one woman doctor for the entire block. She is not a post-graduate. There is no facility for caesarians for obstructed labors. There is no gynecologist in the block, but instead all pregnancy cases the female doctor cannot figure out or does not have the facilities to deal with are referred to the district hospital two hours away. This is on top of the time that it took for the woman to make it from the village to Sendhwa. The government does not pay for transport to the district hospital so the ambulance to and from the district hospital will cost the woman 900 Rs.⁶⁰

In Karahal block health center in Sheopur two nurses and five doctors (a block medical officer, a female doctor, and three general doctors) are sanctioned. However, currently only two of those positions are filled: one nurse and one doctor, who is not a post-graduate. The district hospital in Sheopur is two hours away. This can have deadly and traumatizing consequences. Sua, from New Parondd village, went to Karahal block health center to have her baby in February 2007. During the delivery the doctor realized there were going to be complications with her delivery and sent her to the district hospital in Sheopur. While on her way to Sheopur the child was born dead.⁶¹

⁵⁷ Interview #24

⁵⁸ Interview #54

⁵⁹ Interview #13

⁶⁰ Interview #24

⁶¹ Interview #45

Finally, many women report being badly treated by public health officials and prefer to go to private doctors who are more responsive to their concerns. There are also a number of stories of botched surgeries that have caused death or serious injury to women. (see boxed text on Kamla's story) These have made many afraid to seek out public health care.

The public health center seems like a towering bureaucracy that is very difficult to navigate. As one woman in a Bhopal slum said, "Women are afraid of the public hospital. They don't know anyone there. They don't know who to approach. They prefer to go to private hospitals even if they know the public [hospital] is free."⁶²

If the state does not have up-to-date public health facilities staffed by quality medical personnel, JSY will never reduce infant and maternal mortality in the dramatic way that is necessary.

Failed Operations: Kamla's Story

Women cite several reasons for not going to a public health center for an institutional delivery or other care. These include the long distance to the facility, mediocre treatment and rude behavior by staff. Importantly, women also express an outright fear of going because of the numerous stories of failed operations in public health facilities. Sadly, Kamla's death, which is detailed below, has now become one of these stories.

Kamla was thirty years old and had four children when she decided to go to a camp organized for family planning operations in Karahal on December 25th, 2006. A retired doctor had been hired by the Sheopur government to conduct this camp, as Karahal has no doctor who can perform such an operation.

During the operation the doctor cut a blood vessel in Kamla's stomach that caused severe bleeding. Realizing that the situation was serious and he would be blamed, he fled the camp leaving the local staff to try to stop the bleeding. They failed and she died. Not knowing what to do they called the Chief Medical Health Officer at Sheopur who directed them to put an intravenous drip into her now dead body and tell the family she was in serious condition, had to be transferred to Shevpori, and they should follow. When she arrived in Shevpori the doctor there said she had already been dead for two or three hours.

The Sheopur CMHO then traveled to Shevpori. A local social worker with the Right to Food campaign was now in contact with Kamla's family. The social worker feared that the Sheopur CMHO might try to influence the autopsy and so asked for it to be video recorded and conducted by court appointed doctors. When the medical officers turned down this request, the family had the body transferred to Gwailor where an autopsy was conducted.

Presumably because the case involves important medical officials in the area, the Karahal police have refused to let Kamla's family file a First Information Report (F.I.R.) in the case. Further, the Gwailor hospital says that they will not release the autopsy results directly to the family, but only to the Karahal police who will then give them to the family. The Karahal police though claim they have never received the autopsy report.

⁶² Interview #35

The family has now hired a lawyer and filed a complaint in court. In February, the police called the family and unofficially offered to settle the case for one lakh. They refused. It is rare to find a family who has the commitment and wherewithal to fight for justice in what will likely be a long and uncertain litigation process. No matter the result of the court proceedings though Kamla's children will now be raised without their mother. Additionally, the people's trust in the public health system will be further eroded as yet another story of criminally incompetent care in the public health system spreads through the region.⁶³

⁶³ Interview #46

Recommendations

National Maternity Benefit Scheme

- Immediately implement the National Maternity Benefit Scheme in Madhya Pradesh in compliance with the Supreme Court's orders in the right to food case. The Ministry of Health must make clear to all state health ministries and Rural Development Ministries that the program must be fully implemented without any delay.

Administrative confusion:

- Clearly communicate the current maternal benefit schemes to potential beneficiaries. Simple pictorial posters or calendars should be created to publicly display what the benefits, requirements, and purpose of each scheme is. Additionally a booklet should be created detailing the schemes. All relevant schemes should be explained together even if they are run under different government departments.
- Consider bringing all the current maternal benefit schemes under one scheme. This would make it easier for beneficiaries to understand the schemes and their entitlements. It would also enable better coordination of the schemes.

Corruption:

- Monitor the maternity benefit schemes for corruption and punish those responsible. The government should create a district level vigilance committee that would receive complaints about JSY and other maternity benefit schemes, including the charging of fees. The committee would have to resolve these complaints within one month.

Developing public health care infrastructure:

- Ensure that pregnant women can easily access health care institutions. This means providing more health care centers in rural parts of the state and providing ambulances that can reach those unable to quickly access a health center on their own.
- Invest heavily in hiring trained health care personnel and updating the public health care infrastructure. Without these fundamentals in place women and babies will continue to needlessly die as women will resist seeking out medical treatment from public health facilities and those that do will find them unable to deliver adequate care.
- Give additional emphasis to educating women and their husbands about how to reduce the risk of infant and maternal mortality. This includes education about eating correctly during pregnancy, separating births by an adequate amount of time, and not having babies until the woman reaches maturity.

Appendix One

Status of JSY Benefit and field reality

Sr. No.	District/State	Total deliveries (April 06-Feb 07)	Institutional deliveries (April 06-Feb 07)	JSY Benefit (April 06-Dec-06)	Benefited women after Home deliveries up to Dec 06	Actual needy pregnant women (who had delivery at Home but not getting benefit)	Women not benefiting under the scheme (data from Jan and Feb 07 not included)
1	Seoni	26245	12204	4912	56	14041	21333
2	Sheopur	13263	5642	2068	23	7621	11195
3	Badwani	27808	11502	5308	00	16306	22500
4	Bhopal	26314	20641	8132	00	5673	18182
	TOTAL	93630	49989	20420	79	43641	73210
	State level	1587505	819202	235350	1687	768303	

Appendix Two

Statistical scenario of Madhya Pradesh – Year 2006-07

1. Total deliveries in Madhya Pradesh⁶⁴	1587505
2. Institutional deliveries⁶⁵	819202
3. Benefited under JSY⁶⁶	333013
4. Women not benefited at all after institutional delivery⁶⁷	486189
5. %age of women not received JSY benefits after Inst. Delivery⁶⁸	59.3%
6. Non-benefited under JSY⁶⁹	1254492
7. Benefited women, after Home delivery⁷⁰	1687
8. Total Deliveries at Home	768303
9. %age of women benefited who had delivery at home⁷¹	0.2195%

⁶⁴ <http://www.health.mp.gov.in/fp.xls>

⁶⁵ <http://www.health.mp.gov.in/fp.xls>

⁶⁶ http://www.health.mp.gov.in/janani_suraksha.pdf

⁶⁷ Point 2 - Point 3 = Point 4

⁶⁸ (Point 4/ Point 2)* 100 = Point 5

⁶⁹ Point 1 – Point 3 = Point 6

⁷⁰ Reply submitted by Government of Madhya Pradesh in the Supreme Court on 1st March 2007

⁷¹ (Point 7/ Point 8) * 100

Appendix Three

Health institutions and Hopes for safe institutional Deliveries in Madhya Pradesh (as on 12th April 2007)

Sr. No	District / State	Total Health institutions	Available beds ⁷²	No. of Deliveries (Year 2005-06)	Blood Banks	Pathology Lab
1	Seoni	322 (SHC-284)	487	30090	1	45
2	Badwani	278 (SHC-240)	502	29324	1	42
3	Sheopur	100 (SHC-89)	166	16105	1	7
4	Bhopal	78 (SHC – 63)	407	25683	9	34
5	All MP	10355 (SHC - 8834)	21009 ⁷³ DH-8945 Civil H – 2775 Rural - 11720	1716355	107 ⁷⁴	1319

⁷² Sub Health Centers (SHCs) are without bed facility. Source - <http://www.health.mp.gov.in/health-institutions.pdf>

⁷³ Urban centers (48 District hospitals and 54 Civil Hospitals) are facilitated with 11720 bed and rural centers (CHC & PHC) are facilitated with only 9289 beds.

⁷⁴ Total Blood Banks in MP – 108, out of which 58 are run by non-government private institutions. These private institutions are mostly operating Blood banks in urban centers – 20 in Indore, 6 in Gwalior, 7 in Bhopal and 4 in Jabalpur. The government is still strengthening the Sheopur blood bank.