

# Gaps in NRHM Do Tribal Women Matter?



**“A Study on Access and Utilization of Cash Incentive Programs under NRHM for the Forest Based Tribal women of Heggadadevanakote Taluk in Mysore District of Karnataka”**

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# Contents

## 1. Introduction

- 1.1 National Rural Health Mission
- 1.2 Cash Incentive Programmes under NRHM
- 1.3 Rationale for the study
- 1.4 Objectives of the study

## 2. Study details

- 2.1 Review of literature
- 2.2 Research Setting
- 2.3 Study Design
- 2.4 Survey Tools and Protocols

## 3. Background characteristics

- 3.1 Respondents
- 3.2 Health Infrastructure
- 3.3 Awareness about NRHM and cash incentive programs
  - 3.3.1 Awareness among the Forest Based Tribal Women
  - 3.3.2 Awareness among the health functionaries and ASHAs:
- 3.4 Access, availability and utilization
  - 3.4.1 Maternal Health Services
  - 3.4.2 Cash Incentives
  - 3.4.3 Difficulties faced in availing CIs
  - 3.4.4 Utilization of cash incentives by beneficiaries

## 4. Findings and Recommendations

- 4.1 Key findings
- 4.2 Recommendations

# 1. Introduction

## 1.1 National Rural Health Mission (NRHM)

The government of India recognizes the role of health in the socio-economic development and improving quality of life of citizens of India. NRHM, a flagship program of Govt. of India, was introduced in April 2005 with a goal to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children. One of the important goals for improvement of health under NRHM is to reduce neonatal mortality and maternal mortality rates thereby help India reach the Millennium Development goals for improvement in maternal and child health.

## 1.2 Cash incentive (CI) programs under NRHM

In order to promote institutional deliveries, the government of India introduced Janani Suraksha Yojana (JSY) as a 100 percent centrally sponsored CI program. The scheme focuses on poor pregnant women and proposes to integrate the cash assistance to them with quality care in a health centre during pregnancy, delivery and immediate post-partum period by establishing a system of coordinated care by field level health workers (ANMs and ASHAs).

The vision of JSY is to reduce overall maternal mortality ratio (MMR) and infant mortality rate (IMR) and to increase institutional deliveries in BPL families. The target group for JSY is all pregnant women who are 19 years of age or above, belonging to the below poverty line (BPL) households. Karnataka is classified as a low-priority, large State under NRHM. In Karnataka, the pregnant women delivering in a government /private hospital recognized under JSY scheme are entitled for cash incentive of Rs.700 for normal delivery and Rs.1500 for Caesarean section. Women delivering at home are entitled to receive Rs.500. The benefit is limited to the first two live births.

In addition to JSY, Karnataka introduced a special program called Prasuti Aarika (PA) for pregnant women, under NRHM. The highlight of this scheme is CI for women belonging to BPL, SC and ST families during the antenatal period to encourage rest, nutrition and medical care. The beneficiaries get Rs.1000 during the second trimester and another Rs. 1000 during the third trimester. Subsequently PA was altered to give beneficiaries Rs.1000 in the third trimester and Rs.1000 after delivering in a government hospital. The benefit is limited to the first two live births.

### **1.3 Rationale for the study**

Significant progress has been made in terms of life expectancy, IMR and MMR. But there are inequities based on rural urban divides, gender imbalances and caste patterns. Studies indicate poor health status among STs compared to national/rural figures (ICMR bulletin 2003; NHFS3 fact Sheets). It is important to take note of the fact that even among the deprived sections there are multiple layers of deprivations. It is a matter of concern that poverty and social hierarchy prevents some sections of the population from reaping the fruits of development. There is a paucity of data disaggregated for the tribal populations across India which makes it difficult to document their health status in comparison to other groups (SVYM, 2009). This makes planning and executing health interventions for these marginalized people more difficult.

Karnataka is one of the better placed states with respect to IMR & MMR. The institutional delivery rate was 65.1% (DLHS 3 -2007/08) and MMR was 178 per 100,000 live births (SRS 2007-09). The goal of the RCH program in Karnataka for 2011-12 is to increase institutional deliveries to 99% as per Karnataka NRHM PIP 2009-10.

The official records of Karnataka indicate a steep increase in institutional deliveries and drastic reductions in number of home deliveries. In spite of the fact that health services have improved, there is a large rural- urban difference in health indicators. For example, the IMR for urban areas was 33 compared to 52 in rural areas (SRS 2007); the institutional delivery in urban areas was 79.8% compared to 59.7% in rural areas (DLHS 3, 2007-08).

NRHM identifies women belonging to STs as one of the most vulnerable sections and hence special target groups to deliver health services. The present study has been envisaged and undertaken to map access to, availability and utilization of cash incentive programs under NRHM with reference to women belonging to Jenukuruba (JK), Kadukuruba (KK), Soliga and Yerava communities who shall be hence forth identified as forest based tribes (FBT) for the purpose of this study.

### **1.4 Objectives of the study**

The study focuses on access, availability and utilization of cash incentive programs under NRHM for women belonging to FBTs of Heggadadevanakote (H.D.Kote) Taluk of Mysore district in Karnataka. The objectives of the study are as follows:

1. To understand the awareness levels of forest based tribal women about the Janani Suraksha Yojana and Prasooti Araike cash incentive programs under NRHM.

2. To identify the gaps if any, in accessibility and availability of the cash incentives for the forest based tribal women and the reasons for these gaps.
3. To document the purposes for which the cash incentives were utilized by the tribal women.

## 2. Study Details

### 2.1 Review of literature

*A Rapid Appraisal on Functioning of Janani Suraksha Yojana in South Orissa* undertaken by Nandan Deoki, et. al, 2008. The study reviewed the operational mechanism and usage status of JSY scheme, reasons for non -usage, perception and awareness of beneficiary and non -beneficiary mothers and the involvement of ASHAs, ANMs along with district and block officers in the implementation of the Janani Suraksha Yojana.

The study found higher number of ANC visits and institutional deliveries among JSY beneficiaries compared to non beneficiaries. The study highlighted the lack of orientation of the health staff other than ASHAs on JSY and recommended training the health staff on the scheme so that the services to expectant mothers would be more user-friendly. The study found low levels of awareness even among beneficiaries about various aspects of the JSY scheme including cash assistance. Though majority of stake holders perceived monetary assistance as a big advantage for mothers, the study identifies non availability of 24x7 health centers and lack of staff as one of the major deterrents for prospective mothers in accessing the JSY services.

The study titled “*Assessment of ASHA and Janani Suraksha Yojana in Rajasthan*” was undertaken by Center for Operations research and Training (CORT) 2007. The study found a significant shift in the number of women opting for institutional deliveries after introduction of JSY. One of the important findings of the study is that women with no formal education or primary education and those belonging to SC/ST go for home deliveries. The study found that nearly 85% of beneficiaries received payment but that the payment was delayed.

### 2.2 Research setting

The study was conducted in H. D. Kote Taluk of Mysore district in the state of Karnataka from September 2010 to June 2011. According to Census 2001, Mysore district has a population of 2,641,207. The district stands at 7<sup>th</sup> position out of the 29 districts in terms of income, but is 14<sup>th</sup> in the HDI (District Health Development Report, 2009). Some of the health indicators of Mysore district are: an institutional delivery rate of 93%, IMR of 18 and MMR of 13 in 2008 (Karnataka NRHM PIP 2009-10). 85% of women in Mysore district registered in their first trimester of pregnancy and 92% of the women had at least 3 antenatal care visits during their last pregnancy; the figures for rural areas were 82% and 93% respectively; the institutional delivery rate was 80% for the district and 72% for rural areas(DLHS 3)..

Geographically, the H.D.Kote Taluk is the largest of the 7 Taluks of Mysore district and has a total population of 235,155 (Source: [www.rdpr.kar.nic.in](http://www.rdpr.kar.nic.in) ). FBT population in H.D. Kote Taluk lives along the fringes of the Bandipur and Rajiv Gandhi National Park areas. As stated earlier, the FBTs belong to Jenu Kuruba, Kadu Kuruba, Soliga and Yerava tribes. Out of these, the Jenu Kuruba tribe is notified as one of the fifteen “particularly vulnerable” groups in India by the Government and comprises 60-70% of the total FBT population in the Taluk. Together, the FBTs account for around 6% of population of H.D. Kote Taluk and hence are a numerical minority.

### **2.3 Study design**

The study is descriptive in nature, employing a mix of both qualitative and quantitative methods. The total population of forest based tribal communities is 14,530 (6.17% of population of the Taluk, ITDP, GoK). FBT communities live in small colonies called Haadis, separate from the non tribal villages. There are in all 109 Haadis in the Taluk. The FBTs residing in these 109 Haadis formed the universe for the sample. 30 Haadis out of the total 109 Haadis in the Taluk were selected by cluster sampling method using probability proportional to size (PPS) technique of sampling.

A base line survey was conducted in the chosen 30 Haadis to identify FBT women who were eligible to be included in the study. The data for the study was collected from FBT women (FBTW) living in the chosen 30 Haadis, who had delivered between 1<sup>st</sup> Oct 2009 to 30<sup>th</sup> September 2010 and who were entitled for JSY and PA schemes. The second category of informants were Medical Officers (MOs), Auxiliary Mid-wife and Nurse (ANM), Accredited Social Health Activist (ASHA) within whose jurisdiction the chosen FBT Haadis fall.

### **2.4 Survey Tools and protocols**

Data was elicited from the chosen universe by employing Interview schedule after taking into account due ethical considerations. Interview schedules (IS) for different categories of respondents were prepared by the Principal investigators (PI) in English. This was translated into Kannada, the local language. The IS had questions to capture both qualitative and quantitative types of data. Field testing of all the IS for different categories of respondents was undertaken. Based on the feedback received, interview schedules were reworked and finalized. One field researcher was employed and was trained to conduct and document individual interviews. The interviews of the FBTW women, ANMs, ASHAs were done by the field researcher. The MOs were interviewed by the PIs.

In all 61 FBTW who were eligible for JSY and PA and falling within the study period were identified and interviewed after getting written informed consent. A total of 7 medical officers

under whose jurisdiction the 30 Haadis fall were interviewed after getting written informed consent. A total of 8 ANMs out the 10 ANMs who were willing to be part of the study were interviewed. A total of 11 ASHAs out of the 13 working in the Haadis were interviewed.



### **3. Background characteristics**

#### **3.1 Respondents**

The age of the FBTW respondents varied from 18 years to 28 years. The mean age was around 22 years. Around 8 % of them were less than 19 yrs of age. Almost 74% of the women had some schooling and 30% of them had attended school till class 8 or more.

The mean age at marriage of the women was 17.5 yrs. Almost 60% of the women said that they were married when they were less than 18 years of age and 38% among these women said they were married by the age of 16 yrs. Thus, early marriage is the prevalent practice among FBTs.

70% of the respondents belonged to the JK category of FBTs. Rest 30% included tribes of KK, Soliga and Yerava. Majority of tribal women worked as daily wage laborers in the agriculture sector. Almost 70% of the women belonged to families living on less than Rs.1500 per month and the average reported annual income of the families was less than Rs.17000. Around 40% of the families did not possess any ration card. 56% of the women lived in Haadis which were difficult to access based on a set of objectively measurable criteria designed by the researchers. Majority of JK women (90%) lived in Haadis categorized as difficult to access.

#### **3.2 Health Infrastructure**

The 7 PHCs under the study had 92 Haadis under their jurisdiction with an average of 13 Haadis per PHC. There were 42 sub centers (SCs) under these PHCs. Of them 8 were exclusive tribal SCs, 10 SCs had some tribal population and rest of the SCs catered to non tribal population. Each SC had one sanctioned ANM position. Each ANM covered anywhere from 2 to 19 haadis with an average of around 8 Haadis. Though the populations of these Haadis were less, the ANM had to cover wide geographical areas, many a times by foot in remote areas with no or poor transportation facilities.

#### **3.3 Awareness about NRHM and cash incentive programs**

##### **3.3.1 Awareness among the FBT women**

Almost none of the FBTW recognized the nomenclature “NRHM”, while 46 % of the study respondents had heard about CI programs. Though 43% could name JSY, only 10% could name PA. Only 38% of the women knew how much money they were entitled to. Awareness was

higher among women with longer years in school and younger women. More than 90% of the women living in difficult to access haadis, not having a fulltime ANM had not heard about CIs. The major sources of information about CIs were the ANMs, while some mentioned ASHAs, NGOs and family members as their information sources.

Though most of the MOs said that the tribal status of the women was an eligibility criterion for cash incentives, this information did not seem to have percolated down to ANMs and ASHAs. Only one of the ASHAs mentioned this as a criterion.

### **3.3.2 Awareness among the health functionaries and ASHAs**

All the health personnel on probing say that there is an age factor for the women to be eligible for CI schemes. But they have not taken this as a reason to reject the benefits. In fact all the MOs and ANMs contacted for the study noted that the need for extra care and nutritious food is higher for the under-aged mothers.

50% of the ANMs also said that the woman should have had institutional delivery to be eligible. Though under NRHM women who had home deliveries are also entitle for CIs, the fact that ANMs did not know about this would make access for these women difficult. Responses indicate that there is confusion among ANMs and ASHAs about documentary evidences required and eligibility criteria for receiving CIs. Due to this, in the absence of documentary evidence like a ration card, immunization card or photos, it would be difficult for the FBTW to get the incentives.

## **3.4 Access, availability and utilization**

### **3.4.1 Maternal health services**

**Presence of health functionaries:** 24% of the SCs had ANM positions vacant. The vacancies at the exclusive tribal SCs stand highest at 37% (3 out of 8). Because of this, more than I/3 rd (>38%) of the Haadis did not have a full time ANM. In our study sample, of the 61 beneficiaries, 72% of women lived in Haadis with a full time ANM.

32 (53%) women reported having an ASHA in the Haadi. Among those who said there was no ASHA, only 7 per cent lived in easy to access Haadis compared to 93 percent living in difficult to access Haadis. Absence of ASHAs was strongly associated with remoteness of the Haadis.

**ANC registration:** 58 (95%) FBTW had registered for antenatal care, irrespective of remoteness of the Haadi. 74% of women had registered with ANM. Since registering with ANM is very important if they were to receive cash incentive, the women who did not do so might lose their entitlements. Even in Haadis in which a full time ANM was present, 11(25%) out of 44 women did not register with her. Among women living in Haadis having ASHA, 84% women had registered with ANM compared to 62% of women living in Haadis without an ASHA.

The most common reason for not registering with ANM was “ANM not regular”. Other reasons quoted included, “not aware should register with ANM” and “ANM did not give card for one visit”.

34(56%) women had registered in their first trimester. 66% of women living in Haadis with a full time ANM registered in the 1<sup>st</sup> trimester compared to 30% of those living in Haadis not having a full time ANM. 67% of women from easy to access Haadis registered in 1<sup>st</sup> trimester compared to 50% those from difficult to access Haadis.

Thus accessibility of the Haadi and availability of ANMs were factors influencing early ANC registration.

**ANC visits:** Almost 75% of women reported at least 3 visits and 46% of women reported 5 or more visits during the antenatal period. From among the difficult to access Haadis 35 % of women had 5 or more visits compared to 67% of women from easy to access Haadis. More number of women from difficult to access Haadis had no ANC or only 1 or 2 visits compared to those from easy to access Haadis (30% vs. 19%). Thus remoteness hinders women from accessing regular ANCs.

Less than 6% of women who had registered in the 1<sup>st</sup> trimester had less than 3 visits. Similarly, of the 79% of women who had 5 or more ANC checkups had registered in the 1<sup>st</sup> trimester. This was true even for remote Haadis. Thus early registration and frequent ANCs seem to go hand in hand.

**Institutional deliveries:** 59% of the FBTW delivered in an institution and 41% delivered at home. 85% of women who registered in the first trimester delivered in an institution. Even among women living in remote Haadis 89% who had early ANC registration and 3 or more visits delivered in an institution. Thus encouraging early and regular ANCs would go a long way in ensuring institutional deliveries. Among the 25 women who delivered at home, 16 (64%) had registered with ANM. Thus an opportunity to convert these ANC registrations into institutional deliveries seems to have been lost by the system.

In difficult to access Haadis, where both ASHA and ANM were absent, institutional delivery was 26%, when one of them was present it was 58% and when both were present it was 84% as shown in table 1. Thus, presence of ASHA/ANM in these Haadis increased the rate of institutional deliveries.

**Table 1: Place of delivery of FBTW living in difficult to access of Haadis with presence or absence of health functionaries**

Place of delivery	Presence of ASHA and ANM			Total
	Both present	One present	Both absent	
Institutional deliveries	11	7	4	22
Home	2	5	11	18
<b>Total</b>	<b>13</b>	<b>12</b>	<b>15</b>	

**Influence of NGO on maternal health services:** 52% of FBTW registered with hospital run by local NGO. Of those women who delivered in an institution, 56% delivered in the NGO hospital. Thus presence of NGO has had a positive impact both on ANC and institutional deliveries. The NGO hospital is recognized under JSY & PA.

As per the information given by MOs, the home delivery rate stands at 12% for FBTW. The same was 7.4% according to the ANMs interviewed. Our study had a home delivery rate of 41%. This needs to be further investigated.

### 3.4.2 Cash incentives

All women who registered with ANM are considered registered under JSY. They are expected to give documentary proof of eligibility for cash incentives. Out of the 45 women who were registered for care with ANM, 32 provided documentary proofs that were required. An additional 7 women who had not registered with ANM also applied for CI by giving documentary proof. Thus, a total of 39 women applied for CIs. Only 28% of women who had delivered at home applied for CIs compared to 89% of those who had institutional deliveries.

All women were eligible for CIs and 74% had registered with ANM; only 44% of them got cash incentive as shown in table 2. Even among those who said they had received card of JSY/PA, only 25 (56%) out of the 45 women got cash incentives. Only 10 % of the women received either full or partial (Rs.1000) money under the state government scheme of PA. Out of these 4 received full amount and 2 received partial under PA.

**Table 2: Number of FBTW who received cash incentives**

Received JSY	Frequency	Percentage
Yes	27	44.3
No	34	55.7
Total	61	100.0
Received PA		
Yes	6	9.8%
No	55	90.2%
<b>Total</b>	<b>61</b>	<b>100</b>

As shown in table 3, 66.7% of women who delivered in an institution received JSY compared to 12% of those who delivered at home. 62.5% who had delivered in a government hospital and 70% of those who delivered in NGO hospital received JSY. Among those who had given documentary evidence and delivered in an institution, 25% of the women did not receive CI.

Out of the 39 who actually applied, 43% said they received help for applying from ANM or ASHA and another 12% said they received help from NGO. Receiving help from ANM or NGO had the highest rate of conversion in terms of actually receiving CI (19 out of 21).

All the women who received cash had received Rs.700 under the JSY. One woman who had undergone Caesarean section also got Rs.700.

**Table 3: Place of Delivery and FBTW Who Received CI**

Place of delivery	Received CI or Not		Total
	Received CI	Did not Receive CI	
<b>Govt. Hospital</b>	10 (37.0%)	6 (17.6%)	16 (26.2%)
<b>NGO</b>	14 (51.9%)	6 (17.6%)	20 (32.8%)
<b>Home</b>	3 (11.1%)	22 (64.7%)	25 (41.0%)
Total	27 100.0%	34 100.0%	61 100.0%

### 3.4.3 Difficulties faced in availing CIs

**Difficulties in applying:** The time of application for CIs ranged from 3 months before to 4 months after delivery, majority being after delivery. According to NRHM, the women are deemed to have registered for JSY the moment ANM identifies and registers them. 45 women

had registered with ANM and 34 had their registration in their first trimester itself. Thus, though registration with ANM was done, it took the women many days and multiple visits to the SC/PHC to furnish the documents. 29% (13) of women who had registered with ANM did not apply for CIs.

In our study of the 61 respondents all eligible for availing CIs, only 39 had applied and 22 had not. 31 (51%) women expressed difficulties in applying for cash incentives. 50 % of these women quoted 'ANM not available' and 'procuring documentary evidences' as the reasons for difficulty. The ANMs and ASHAs are expected to help them procure documentary evidences if the women are not in a position to do so. In a community socially and economically as marginalized as the forest based tribes, with their low levels of awareness on most issues, this responsibility would be expected to be higher. In practice, the burden of establishing proof rests on the women, especially in absence of ASHA/ANM.

**Timeliness of disbursement:** In our study, of the 27 women who have received JSY only one person has indicated that she got CI immediately after delivery where as 16 (62 %) women got JSY funds between 1 to 3 months. 9 (35%) of women had to wait between 4 to 13 months before they got JSY. 6 women who got PA got it between 5 to 13 months after delivery and not before delivery when it is most required. The delay in turn would decrease the motivation of women to access JSY benefits. Reduction in time gap in applying and receiving funds would be very important in realizing the vision of NRHM.

**Reasons for not getting CIs:** 34 women did not get any cash incentives. Majority of the women who did not receive said it as either due to lack of funds or because they delivered at home. Other reasons quoted were lack of documents or because they delivered a hospital outside the state. Since H.D. Kote is a border Taluk, people living in the border, near the remote forest terrain find it much easier to go to Kerala, the neighboring state.

Only 3 out of 25 women who delivered at home received CIs. 11 who delivered at home also did not have any ration card indicating the practical problems in procuring documentary evidence. This problem intensifies with remoteness of the Haadis. The women who had a home delivery would be practically invisible to the system in the absence of ASHAs and full time ANMs for these remote Haadis.

Reasons quoted by the FBTW women for not getting CIs include funds not available, home delivery and difficulty in procuring documents.

The ASHAs, ANMs and MOs quoted delay in fund release, lack of funds (for PA), lack of awareness among FBTW and difficulty in procuring documental evidences as the problem for FBTW not getting CIs. Most of the medical officers agreed that they could certify the tribal status if the women lack documents. The JSY and PA fund related data collected from PHCs indicate a mismatch in time when funds were required and funds received. For PA, there was a large gap between the time and amount of funds required and received. This becomes a very important point having policy implications as providing adequate and timely funds are crucial for the success of the program.

#### **3.4.4 Utilization of cash incentives by beneficiaries**

47 % of women said they spent major part of fund on procuring ration for the household. 9% of women said they used it to travel to the hospital to treat the sick baby, buy nutrition supplements. Women who got the money late said they spent the money to buy jewels, household utensils. Only one woman said her husband took away the money.

Majority of the MOs felt the money was not being spent by the FBTW for the purpose it was meant for. Though ANMs felt that money was being spent for buying nutritious food or hospital expenses, they too said that due to delay in fund disbursement, money was being used for purposes like buying jewelry. Most of the health functionaries also were of the opinion that the funds were being spent on alcohol by the men in the family.

## 4. Findings & Recommendations

### 4.1 Key findings

1. Awareness about cash entitlements under NRHM is low among FBTW. This is more so among women who live in remote Haadis and who are less educated.
2. There is lack of clarity among ASHAs and ANMs about the eligibility criteria for CIs under NRHM. This would make access to CIs difficult for FBTW.
3. There is higher number of vacancies of ANMs and ASHAs in tribal areas, especially in remote Haadis, thus impacting delivery of maternal health services.
4. The FBT population in our study had 95% ANC registration, 56% early ANC registration and 75% women with 3 or more visits. All the ANC indicators were higher than the national average as per NFHS 3.
5. 26% of women did not register with ANM, even in Haadis with full time ANM in place.
6. Registration with ANM in Haadis with ASHAs was higher than those without ASHA.
7. The institutional delivery rate was 59%. Presence of NGO has had a positive influence on ANC indicators and institutional deliveries.
8. Remoteness of the Haadis hindered early registration, regular antenatal visits and institutional deliveries. In remote Haadis, institutional deliveries were highest when both ASHA and ANM were present and least when both were absent.
9. 44 % of women received cash under JSY and 10% of women received cash under PA. 67% of women who delivered in an institution and 12% of women who delivered at home received JSY.
10. The mean time after delivery for receipt for money was 3.8months for JSY and 9.8 months for PA. Most of the women utilized the CIs for purposes other than for what it was meant since the CIs were not received at appropriate time.

### 4.2 Recommendations

1. In the absence of mechanisms to check early marriage, keeping age as criteria for JSY benefits might discourage a significant number of women from accessing regular maternal health services, thus, increasing the chances of maternal mortality. We recommend that all tribal pregnant women be made eligible to receive CIs.
2. Idea of introducing CI is to bring all women under the umbrella of safe delivery. A mother who has a still birth requires as much medical attention as the mother giving birth to a live child. Probably the level of vulnerability is much more since these mothers may also



experience complications and psycho-social trauma. We recommend that all mothers who have delivered irrespective of the status of the child at birth be eligible for CIs

3. Training for ANMs and ASHAs should focus on sensitizing them to the needs of the community they work with. There is also a need to reorient them at regular intervals depending on ground realities.
4. Funds for CIs should be released in advance to the PHCs; there should be a mechanism to monitor the disbursement of the CIs including the timeliness. All vacancies of ANM to be filled on a war footing. We suggest that ANMs in remote areas be covered under soft-loan schemes to help procure vehicle for easy mobility.
5. We recommend that there should be a separate “Tribal ASHA scheme” with higher incentive money for ASHAs. This would encourage tribal women in remote areas to work as ASHAs and ensure institutional deliveries.