RESULTS-BASED FINANCING AT THE WORLD BANK

India

RESULTS-BASED FINANCING AT THE WORLD BANK PREPARED BY KATHRYN BOATENG AND CLEARED BY: VIKRAM RAJAN

PROJECT NAME: The Janani Suraksha Yojana (JSY)-Safe Motherhood Scheme

PROJECT ID: P075060-The World Bank supports the Reproductive and Child Health Program II (RCH II) of the Government of India, of which JSY is a key feature.

UNIT: SASHD

TIME PERIOD: 2006 - 2012

TTL: Vikram Rajan

AMOUNT (USD): $360 million

LENDING INSTRUMENT: IDA Credit

RBF COMPONENT OR PROJECT: With other pooling partners, the IDA credit supports the RCH II program.

PILOT (Y/N): No

Characteristic	Description
CONTEXT AND RATIONALE	In 2005, the Government of India's Ministry of Health and Family Welfare (MOHFW) launched the National Rural Health Mission (NRHM) with a strong commitment to reduce maternal and infant mortality, provide universal access to public health services, prevent and control communicable and non communicable diseases, ensure population stabilization, maintain gender balance and revitalize local health traditions. A core feature of the NRHM is Janani Suraksha Yojana (JSY), a program which provides financial assistance to poor pregnant women for institutional delivery and post delivery care. Another important component of the NRHM is to provide improved access to health care at the community level through female village health workers known as Accredited Social Health Activists (ASHAs). JSY was a product that replaced then existing centrally financed maternal health and nutritional support initiatives which provided cash payments to poor pregnant women. Together with considerable financing from other donors (DFID and UNFPA), the World Bank, supports the RCH II through an IDA credit. The RCH II program is the key vehicle under the umbrella of the flagship NRHM to address maternal and child health challenges in India. One of the key interventions under the RCH II program is the JSY, along with other evidence-based interventions on the demand and supply-side to address maternal and child mortality.
OBJECTIVE OF PROGRAM	JSY aims to reduce maternal and infant mortality through increasing institutional deliveries, especially for poor women living below the poverty line (BPL) and members of the scheduled caste and tribal communities.
BENEFICIARIES	The priority target group is poor pregnant women, particularly those living in the 10 Low Performing States (LPS), as determined by health and demographic indicators and reported institutional birth rates. Women in High Performing States (HPS) living below the poverty line (BPL) are also eligible. So far the JSY has been implemented in all 28 states, but each state has the ability to modify the program to best fit its local needs. The program started with 700,000 beneficiaries in 2005, and today reaches ten million women every year with cash payments.
TYPE OF RBF INTERVENTION	JSY is a demand and supply-side ('mixed') pay for performance (P4P) program that provides payments to individual community health workers and to women seeking a continuum of maternal and newborn health services. On the demand side, conditional cash payments are made out to pregnant women for institutional delivery in both government and private accredited hospitals. On the supply side, vouchers are given to community-level health workers on the condition that they identify eligible pregnant women and assist them to reach a health facility. Additionally, health workers must provide postnatal care visits, ensure that children receive a BCG vaccination, and provide mothers with family planning and counseling advice.

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TYPE AND AMOUNT OF INCENTIVE PROVIDED	The amount of the incentives varies by region and falls between Rs 600-1,400 (US $13-31). Specifically, after delivery in government or accredited private health facility, eligible women living in rural areas within LPS receive Rs 1,400 and those in urban areas receive Rs 1000; in HPS women receive Rs 700 in rural areas and Rs 600 in urban areas. JSY also provides Rs 500 (US$11) for home births by pregnant women living below the poverty line, for the first two births. Pregnant women can also receive cash assistance for transport to the nearest government facility for delivery - the minimum is set at Rs 250 (US$5). ASHAs in LPS also receive payments of Rs 200 (US$4.4) in urban areas and Rs 600 (US $13.3) in rural areas per in-facility delivery assisted by them in LPS. In addition, the ASHA receives a voucher from the auxiliary nurse midwife (ANM), to cover transportation costs of the pregnant woman to the hospital and the ASHA can receive a transactional cost payment (to cover costs of board and lodging if she stays with the pregnant woman in the delivery center). In both LPS and HPS, a subsidy for emergency Caesarean section, on referral, is also available. If emergency obstetric care is not available at the government health facility, the facility can provide up to Rs 1500 to subsidize fees of a specialist from the private sector.
PAYMENT RULES AND MECHANISM	Pregnant women receive payments in one installment at the time of discharge following delivery. It is the responsibility of the Auxiliary Nurse Midwife/ASHA to ensure disbursement. On the supply side, the payment of the ASHA utilizes a voucher system disbursed in two installments. Payment is made only if the ASHA escorts the pregnant woman to the delivery facility and stays with her until the delivery is completed. The ANM pays the appropriate community health worker. ANMs are not eligible to receive incentive payments.
INDICATORS AND TARGETS FOR RECEIVING PAYMENT	According to JSY guidelines, the indicators for measuring the performance of ASHAs or other health workers associated with the scheme are: 1. Identify the pregnant woman as a beneficiary of the scheme and facilitate registration for ANC. 2. Assist the pregnant woman with obtaining necessary certifications wherever necessary. 3. Ensure pregnant women receive at least three ANC visits, including Tetanus Toxoid (TT) injections and iron-folate (IFA) tablets. 4. Identify a functioning government health center or an accredited private health institution for referral and delivery. 5. Provide counseling to promote institutional delivery. 6. Escort the beneficiary to the predetermined health center and remain by her side until the woman is discharged. 7. Arrange for immunization of the newborn from birth until 10 weeks. 8. Inform ANM about the birth or death of the child or mother when necessary. 9. Arrange a post natal visit within 7 days of delivery and track the mother's health. 10. Provide counseling for initiation of breastfeeding within one hour of delivery and its continuance until 3-6 months, and promote family planning.
MONITORING AND VERIFICATION PROCESS	ANMs set monthly goals for institutional delivery for the village and design a work schedule for ASHAs to meet those goals. On the seventh day of each month, the ANM submits a progress report to the Medical Officer of the primary or community health clinic. Block officers consolidate the reports and submit them to the district nodal officer. District composite reports, along with other financial reports, are submitted bi-annually to the nodal division of the government.
INSTITUTIONAL ARRANGEMENTS AND ROLES	Each state's health mission is responsible for forming a JSY Implementation Committee (IC), whose role includes: reporting data and progress to the Government of India (GOI); overseeing monitoring of JSY including appropriate completion of procedures as outlined in the guidelines for implementation document; ensuring quality of services in government and accredited facilities through appointed nodal officers, and addressing grievances and legal settlement of JSY cases. Also, the GOI provides general guidance on the accreditation of private health facilities but leaves it up to the discretion of the state and district authorities to specify the criteria.

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EVALUATION STRATEGY AND RESULTS	No national level evaluation of the JSY program has been conducted, but state and district-level evidence of the program's impact is emerging. A UNFPA funded study conducted in 2007 in Rajasthan state (a LPS) compared the change in number of deliveries in public sector facilities before and after the JSY program began, and found an increase of 36 percent in institutional deliveries compared to the first year of the program. The same study asked mothers about their motivation for institutional delivery, and more than half of those in the sample indicated that the JSY incentive payment was a major factor in their decision. More recent coverage evaluation surveys (UNICEF, 2009) in the LPS also showed similar dramatic improvements in institutional deliveries. In 2010, an independent evaluation funded by the Bill & Melinda Gates Foundation assessed the impact of JSY on intervention coverage. Using data from the most recent nationwide district-level household surveys, the study found that JSY had a significant effect on increasing antenatal care and in-facility births. It also highlighted the need for improved targeting of the poorest women and paying attention to the quality of obstetric care provided in health facilities.
STATUS REPORT	In January 2011, the Bank released its Implementation Status Report on India's RCH II program. It indicated that the program has seen some positive outcomes in terms of increased access to deliveries by skilled birth attendants, children fully immunized, increased access to family planning and a moderate increase in breast feeding. Concerns remain, however, about the quality of care in delivery of services and the near stagnant rates for the use of oral rehydration solution in the management of diarrhea.

LINKS TO REFERENCES AND OTHER WEB RESOURCES

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