Summer Training at
National Health Systems Resource Centre, Munirka, Delhi
(April 3 to June 2, 2017)

Exploring the Socio-Economic Linkages Associated with Reproductive Rights of the Beneficiaries of JSY in an Urban Slum

By
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MBA Hospital & Health Management
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Institute of Health Management Research
The IIHMR University, Jaipur
2017

INSTITUTE OF HEALTH
MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

TO WHOMSOEVER IT MAY CONCERN

This is to certify that Mr. Mukesh Pant, student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone summer training in National Health System Resource Centre, Delhi from 3rd April to 2nd June, 2017.

The Candidate has successfully carried out the study designated to him during training and his approach to the study has been sincere, scientific and analytical.

The Summer Internship is in fulfillment of the course requirements.

I wish him success in all his future endeavors.

Col. (Dr.) Ashok Kaushik
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National Health Systems Resource Centre
Technical Support Institution with National Health Mission
Ministry of Health & Family Welfare Government of India

F. No. NHSRC/09-10/Rectt /02-Placement II
Date: June 16, 2017

TO WHOMSOEVER IT MAY CONCERN

This is to certify that Mr. Mukesh Pant has completed his Internship in Public Health Planning Division in National Health Systems Resource Centre (NHSRC) from 3rd April 1017 to 2nd June 2017.

We wish him all success in his future endeavors.

Dr. Uddipan Dutta
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I see as this open door as a major point of reference in my profession improvement. I will endeavour to utilize picked up abilities and learning in the most ideal way.

Sincerely,

Mr. Mukesh Pant

Dr. Satish Kumar — Prof. Gautam Sadu

Advisor (National Health System Resource Centre) — (Dean Rural)

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National Health System Resource Centre

Place: Munirka ,Delhi

Exploring the Socio economic linkages associated with Reproductive Rights of the Beneficiaries of JSY in an urban slum.

TABLE OF CONTENT

AIM: - The aim of this study is to determine the impact of various socio economic factors affecting decision making power of women in JSY.

Objectives:-

- To assess the socio economic linkages and the level of reproductive rights in beneficiaries of JSY.
- To assess the linkages of service utilization with various socio economic variables. (Education vs Utilization), (Job vs Utilization).
- To identify major stakeholders affecting decision making power of a women in society.
- To determine and recommend further changes on to utilization of services and way to empower women decision making.

Introduction:-

A. Janani Suraksha Yojana (JSY)

Janani Suraksha Yojana (JSY) is a sheltered parenthood intercession under the National Health Mission (NHM) being actualized with the goal of decreasing maternal and neo-natal mortality by advancing institutional conveyance among the poor pregnant ladies. The Yojana, propelled on twelfth April 2005, by the Hon'ble Prime Minister, is being executed in all states and UTs with exceptional concentrate on low performing states.

JSY is a 100 % halfway supported plan and it coordinates money help with delivery and post-delivery care. The achievement of the plan would be controlled by the expansion in institutional delivery among the poor families

The Yojana has recognized ASHA, the licensed social wellbeing lobbyist as a viable connection between the Legislature and the poor pregnant ladies in l0 low performing states, to be specific the 8 EAG states and Assam and J&K and the rest of the NE States. In other qualified states and UTs, wherever, AWW and TBAs or

ASHA like lobbyist has been occupied with this reason, she can be related with this Yojana for giving the services.

Eligibility for Cash Assistance:

LPS States :- All pregnant ladies conveying in Government wellbeing centres like Sub-centre, PHC/CHC/FRU/general wards of District and state Hospitals or licensed private foundations.

HPS States:- BPL pregnant ladies, matured 19 years or more

LPS and HPS: - All SC and ST ladies conveying in an govt health centres like Sub-centre, PHC/CHC/FRU/general ward of District and state Hospitals or certify private establishments

C.4 Scale of Cash Assistance for Institutional Delivery:

Category	Rural Area		Total	Urban Area		Total
	Mother's Package	Asha's Package	RS.	Mother's Package	Asha's Package	RS
LPS	1400	600	2000	1000	200	1200
HPS	700	200	900	600	200	800

India accounted for 19% of the globally estimated 287,000 maternal deaths in 2010.Maternal mortality ratio of India has declined from 212/100,000 live births in 2007–2009 to 178/100,000 live births in 2010–2012. Most of the neonatal deaths in developing countries occur at home, unattended by skilled health professionals.

A. Reproductive Rights:-

- Rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children.
- All couples and individuals have right to information and means to do so
- Right to highest standard of reproductive health
- Right to make decisions concerning reproduction free of discrimination, coercion, violence.

Reproductive Rights In India:-

- Reproductive wellbeing and rights were examined in the International Conference on Population and Development (ICPD) in 1994 at Cairo. India took after its Program of Action changed its populace strategy and renamed as Reproductive and Child Health (RCH) approach in October 1997. The RCH approach included basic segments like educated decision of value contraception, fundamentally implied for sheltered and fulfilling sexual coexistence, treatment of barrenness, pre-birth, natal and post-natal tend to mother, juvenile training implied for mentally get ready youths through data, instruction and correspondence for sexual and regenerative vocation, administration and treatment of HIV/AIDS, conceptive tract contaminations (RTIs), sexually transmitted sicknesses (STDs), and so on. These significant outlook changes in India's populace approaches were reflected in the National Population Policy record discharged in 2000 (MoHFW, 2000).

- The approach by and large embraced in huge scale wellbeing studies picks up data from respondents on their statistic, financial and social attributes which affect their conceptive conduct and issues, dreariness and general medical issues and furthermore their medicinal services looking for conduct. On socio-mental ground, absence of information on restorative and medical problems, disgraceful finding, absence of clinical testing, varieties in study outline and strategies are in charge of highlighting the connection among free market activity side elements impacting urgent RCH and general wellbeing conditions over space and time. Still the benefits of the group based studies for evoking self-detailed announced medical issues is by all accounts engaging on down to earth grounds like minimal effort, high attainability and speculations (Bhatia, 2000).(http://planningcommission.nic.in/reports" Evaluation Study of National Rural Health Mission (NRHM) in 7 States").

Women Empowerment

It alludes to expanding the otherworldly, political, social, instructive, sexual orientation, or Financial quality of people and groups of ladies. Ladies'

strengthening in India is vigorously reliant on a wide range of factors that incorporate geological area (urban/provincial), instructive status, economic wellbeing (standing and class), and age

NEED FOR WOMEN EMPOWERMNENT :-

The Major prerequisite of ladies strengthening it to build Decision Making Power, Freedom of Movement, Access to Education ,Access to Employment Exposure to Media, Domestic Violence.

DECISION MAKING POWER :-

Women Decision Making:-

Although much has been composed about the requirement for mainstreaming gender and to improve basic leadership, and on the best way to go about it, the hole amongst expectation and practice is tremendous. National wellbeing approaches and programs that have sexual orientation fundamentally included into their destinations and exercises are uncommon , however National Health Policy 2017 discusses Gender Mainstreaming and Gender based savagery , it needs clearness how it is to be actualized and accomplished. The satisfy all record gloats about expanding ladies' entrance to medicinal services should be reinforce by making open healing centers more ladies neighborly and guaranteeing that the staff have introduction to sexual orientation touchy issues. This approach notes with concern the genuine and far reaching results of sexual orientation imbalance and prescribes that the human services to the ladies and survivors/casualties of sex based brutality should be furnished free and with respect out in the open and private sector.

Wellbeing examination to create sexual orientation and sex-particular information, andintegrating sex inhealthprovider preparing, has gotten rare consideration. Mainstreaming sexual orientation inside organizations has stayed shallow, contributing more on shape than on content. The clear absence of advance in mainstreaming sexual orientation in wellbeing might be credited to: depoliticization and delinking of sex mainstreaming from social change and social equity plans; reception of top-down ways to deal with mainstreaming; developing antagonistic vibe inside the worldwide strategy condition to equity and value

concerns; and expanding privatization and withdrawal of the state's part in wellbeing.

Background of Reproductive Rights:-

WHO On Reproductive Rights:-

"Gender and Reproductive Rights(GRR) aims to promote and protect human rights and gender equality as they relate to sexual and reproductive health by developing strategies and mechanisms for promoting gender equality and human rights in the Departments global and national activities, as well as within the functioning and priority – setting of the Department itself"

Savagery against ladies damages ladies' rights to life, physical and mental uprightness, to the most astounding feasible standard of wellbeing, to opportunity from torment and it abuses their sexual and conceptive rights.

A. International (Global Landmarks) on Reproductive Rights:-

International conference on Population and Development (IPCD) 1994:-

Women have the right to:

1. Decide freely and responsibly the number, spacing, and timing of their children
2. To have the information and means to decide freely and responsibly the number, spacing, and timing of their children
3. Attain the highest standard of sexual and reproductive health which mean to be physically , mentally , and socially healthy with access to medical, mental and social facilities, services and supports to exercise their sexual and reproductive rights.

4. Settle on decisions about their era free of isolation, terrorizing and violence.

Bejing Platform for Action 1995

1. The promotion of reproductive rights should be the fundamental basis for government and community sponsored policies and programmes
2. The government must consider women's rights as a fundamental part of the laws it enacts, the policies it puts in place and the programmes it creates.
3. Right to EQUALITY in Reproductive Decisions:-
    A. Choose whether and when to wed and begin a family, marriage ought to be with the full free, and educated assent of both the people.
    B. Decide freely and responsibly the number and spacing of her children.
    C. Women's have the right to make reproductive decisions when it comes to their body, health and their family.

4. Right to Sexual and Reproductive Security:-
    A. To live a life free of gender – based violence which includes sexual violence , and rape based on the fact that she's a female.
    B. Protection of physical and mental integrity.
5. Right to Reproductive and Sexual Health Services
    A. It includes safe and affordable methods of family planning (delivery of children in a safe environment with medical care assistance, access to family planning services in a safe and hygienic environment).
    B. Management of gynecological problems, infertility, prevention.
    C. Treatment and prevention of sexually transmitted diseases ,sexually transmitted infections, and HIV/AIDS.
6. Right to Access to Information and Education
    A. Access to information regarding sexual and reproductive issues so as to make informed decisions.
    B. Information must be provided in a clear, complete and sensitive manner.

B. National landmarks On Reproductive Rights:-

Constitution of India: National Law

- Article 21: The Right to life
  1. "No person shall be deprived of his of her life or personal liberty except according to procedure established by Law". The Supreme Court of India issued that Article 21 includes:-
     A. The right to health;
        Major violation to this is high maternal death in India.
     B. The right to be free from torture and inhuman treatment;
        Major violation to this is high rate of forced abortions in India
     C. The right to dignity;
        Major violation to this is coercive female sterilization
     D. The right to shelter;
        Major violation to this is homeless pregnant and lactating women.
- Article 14: The Right to Equal Access to the law
  1. "equality before the law or the equal protection of the laws within the territory of India"
  2. Every person has equal right to access the law and protections

CHARM vs. State of Bihar and Ors.(2011)

1. Denial of maternal health care in Bihar.
   Violations:
   A. Collection of fees by doctors and nurses for referral and registration of pregnancy.
   B. Dilapidated and unsanitary health facilities without electricity, toilets, running water , and blood supplies
   C. Lack of transport services for pregnant women
   D. Lack of safe abortion services.
   E. Lack of grievance redressal system for violations suffered
   F. Resulting in maternal deaths

Argument: Bihar government has obligation to ensure access to maternal health services under the Constitution of India and international human rights law.

Dunabai vs. State of MP and Ors.

PIL

A. Fact finding in tribal area where an adavasi women had no choice but to give birth outside a hospital and after repeated denial of medical treatment.
B. Govt. health facilities functioned without blood, emergency obstetric facilities, basic medicines, adequate staff.
C. The High Court ordered state institutions to make immediate and specific changes regarding staff, medicines, equipments and facilities that would bring them up to the prescribed standards. The court also ordered that the semi- government monitoring committee that had initially found violations investigate to ensure that the Court orders were compiled with.

PRIYA KALE VS. NCT OF DELHI & ORS (2013)

A. In January 2013 the Times of India published an article about Priya Kale , a homeless women who lost her baby to exposure after she delivered on the balcony of the homeless shelter where she lives.
B. A fact finding was conducted at the shelter, families , including pregnant women live in absolute squalor and struggle to provide food to their families.
C. A petition was filed in asking court to issue immediate interim orders in the case for

   1. maternal health care; 2. heaters 3. Hot water heaters for bathing 4. Three meals a day for all residents.

LITERATURE REVIEW:-

This record has a goal to fill in as an asset for accomplishing sex fairness in social insurance framework which will incorporate having a solid sex arrangement, giving staff preparing in examination of sexual orientation, coordinating sex affectability into HR procedures, for example, sex delicate occupation enrollment, presenting strategies that are family neighborly and supporting equivalent pay for approach work.

The process that makes up the Gender Audit, including assessing social readiness, surveying beneficiaries to understand perceptions of decision making , using interviews to explore what a gender-sensitive social set up would look like, creating a detailed action plan for integrating gender, and finally, monitoring on-going activities that influence the achievement of gender equality in national programmes like jsy.

The investigation broadens existing examination on India's wellbeing financing plans by including elements like socio-statistic and obstetric calculates foreseeing utilization of maternity wellbeing administrations. Lion's share of ladies' utilization of JSY to take care of the expense of their institutional births and an abnormal state of maternal training was the main noteworthy indicator of satisfactory ANC in Gujarat**. {Kranti Suresh Vora, Sally A. Koblinsky, and Marge A. Koblinsky[3] "Predictors of maternal health services utilization by poor, rural women: a comparative study in Indian States of Gujarat and Tamil Nadu"}**

Study demonstrates that accessibility of safe fetus removal mind is constrained particularly in country ranges. More accentuation on giving safe premature birth administrations, especially at essential care level, is critical to more decrease maternal mortality in India,{ .Chaturvedi S, Ali S, Randive B, Sabde Y, Diwan V, De Costa" Availability and distribution of safe abortion services in rural areas: a facility assessment study }

The investigation indicates focusing on troublesome ranges with unique measures and empowering more antenatal visits were fundamental, essentials to enhance the effect of JSY.{Vikram K, Sharma AK, Kannan AT "Beneficiary level factors

influencing Janani Suraksha Yojana utilization in urban slum population of trans-Yamuna area of Delhi"}

Study indicates disparity in access to institutional conveyance and money motivation program and high MMR in ghetto zone propose that the money motivator alone is not adequate to accomplish value in maternal wellbeing results. Or maybe, the money motivation program should be upheld by the arrangement of value medicinal services administrations**. (Randive, San Sebastian De Costa, Lindholm L Inequalities in institutional delivery uptake and maternal mortality reduction in the context of cash incentive program, Janani Suraksha Yojana: results from nine states in India.)**

Methodology:-

Study Design

Quantitative study on effect of various socio economic factors on decision making related to pregnancy.

Study tools

Interview schedule was used as a study tool in this study. The schedule comprised of following sections.

Section A: Socio demographic variables of beneficiaries

Section B: Awareness about the JSY scheme among beneficiaries

Section C: Utilization pattern of the JSY scheme among beneficiaries.

Section D: stakeholders in decision making.

A total of 24 questions was used to study the effects of various socio-economic factors on decision making during pregnancy in JSY.

SAMPLING:-

The present cross-sectional study was conducted among the beneficiaries of the JSY scheme residing in the East Delhi area where maximum institutional deliveries are conducted by Guru Teg Bahadu Hospital and General Hospital. A purposive sampling was undertaken of beneficiaries visiting PUHC Amar Colony who availed delivery services in last 1 year (in either a government or private health

centres). Further, those beneficiaries who are currently pregnant were also included. Total sample size was of 61. Data was collected over a period of 1 week during the OPD hours. A interview schedule was used to collect the information. Interactions were also undertaken with service providers- ASHAs (12) and ANMs (1)- to understand providers perspective about JSY.

Results:-

The data was analyzed on the basis of 4 factors.

1. Literacy Status vs Decision Making:-
   A. Out of the total no. of respondents(61),9 were found to be illiterate and the major decision maker in that sample was found to be husband(HUS) (56%) ,followed by mother in law(MIL) who contributes to 33% of decision making.

FOR N=9(15% ILLLITERATE)		
MIL	3	33%
FIL	0	0%
HUS	5	56%
OTHERS	0	0%
MYSELF	1	11%
TOTAL	9	

   B. 4(7%) were found to be others(upto5th standard),in which major decision maker is mother in law which contributes to 50% of decision making, followed by husband and self which contributes equally (25% each) to decision making.

FOR N=4(7% OTHERS)		
HUS	1	25%
MIL	2	50%
MYSELF	1	25%
TOTAL	4	

C. 30(49%) were found to be matriculate (above 5^{th} upto $10^{th)}$ and the major decision maker in that sample was found to be husband (40%) followed by mother in law (30%) and self (23%).

FOR N=30(49% MATRICULATE)		
MYSELF	7	23%
MIL	9	30%
HUS	12	40%
OTHERS	2	7%
TOTAL	30	

D. 12(20%) were found to be educated up to higher secondary level. Among the sample decision making was evenly split between Mother in law, husband and self.

FOR N=12(20% HIGHER SECONDARY)		
MYSELF	4	33%
MIL	4	33%
HUS	4	33%
TOTAL	12	

E. 6(10%) were found to be graduates, in which major decision maker was self (33%) followed by husband (33%).

FOR N=6(10% GRADUATES)			
OTHERS	1	17%	
MYSELF	2	33%	
HUS	2	33%	
MIL	1	17%	
TOTAL	6		

2. Occupation vs Decision making

A. Out of the total sample, 52(85%) were found to be housewives, in which husband (40%) is the major decision maker followed by mother in law (33%).

FOR N= 52(85% OF THE HOUSEWIFE)		
MIL	17	33%
FIL	0	0%
HUS	21	40%
OTHERS	3	6%
MYSELF	11	21%
TOTAL	52	

B. Only 1(2%) responded to be working in government job, in which she herself was the decision maker.

FOR N=1(2% OF GOVT JOB)		
MYSELF(4)	1	100%
TOTAL	1	

C. 3(5%) of the respondents were found to be working in a private job ,in which she herself was able to take her decisions contributing to 67% followed by mother in law(33%).

FOR N=3(5% OF PVT JOB)		
MYSELF(4)	2	67%
MIL(0)	1	33%
TOTAL	3	

D. 4(7%) of the respondents were found to be having own business in which husband (75%) was found to be the major decision maker, followed by self (25%) of decision making.

FOR N=4(7% OF OWN BUSINESS)		
HUSBAND(2)	3	75%
MYSELF(2)	1	25%
TOTAL	4	

E. Only 1(2%) was involved in other kind of work (assignment based jobs),in which self is the major decision maker contributing 100% of total responses.

FOR N=1(2% OF OTHERS)		
MYSELF(4)	1	100%

TOTAL	1	

3. Type of Family vs Decision Making
   A. Out of the total no. of respondents(61), 45(74%) were found to be living in a joint family, in which mother in law(40%) was found to be the major decision maker, followed by husband(31%).

   B. 16(26%) were found to be living in a nuclear family ,in which husband (63%) was found to be major decision maker, followed by self(31%)

FOR N=45(74% OF JOINT FAMILY)		
MIL(0)	18	40%
HUS(2)	14	31%
OTHERS(3)	3	7%
MYSELF(4)	10	22%
TOTAL	45	

FOR N= 16(26% OF THE NUCLEAR FAMILY)			
MYUSELF(4)	5	31%	
HUSBAND(2)	10	63%	
MIL(0)	1	6%	
TOTAL	16		

4. Education status vs Institutional delivery (pvt and govt combined).
   A. Out of the total no of respondents(61), 9(15%) were found to be illiterate, in which majority of them had a delivery in public health facility(PHF) 56% , followed by delivery in private setup 22%.

FOR N=9(15% of illiterate)		
PHF(1)	5	56%
PVT(2)	2	22%
HOME(3)	1	11%
YET/NA(4)	1	11%

TOTAL	9	

B. 4(7%) were found to be others (up to 10th) ,in which most of them had a delivery in public health facility(75%) , followed by home delivery(25%)

FOR N=4(7% OF OTHERS(0-5))

PHF	3	75%
HOME	1	25%
TOTAL	4	

C. 30(49%) were found to be matriculate,in which most of them had a delivery in public health facility (60%),followed by home deliveries(20%).

FORN=30(49% MATRICULATE)		
PHF(1)	18	60%
PVT(2)	3	10%
HOME(3)	6	20%
YET/NA(4)	3	10%
TOTAL	30	

D. 12(20%) were had higher education , in which 33% of them had a delivery in public health facility, followed by delivery in pvt set up(33%).

FOR N=12(20%OF HIGHER EDUCATION)		
PHF	4	33%
PVT	4	33%
HOME	2	17%
YET/NA	2	17%
TOTAL	12	

E. 6 (10%) were found to be graduates, in which 66% of them had a delivery in public health facility , followed by 33% of deliveries in private set up.

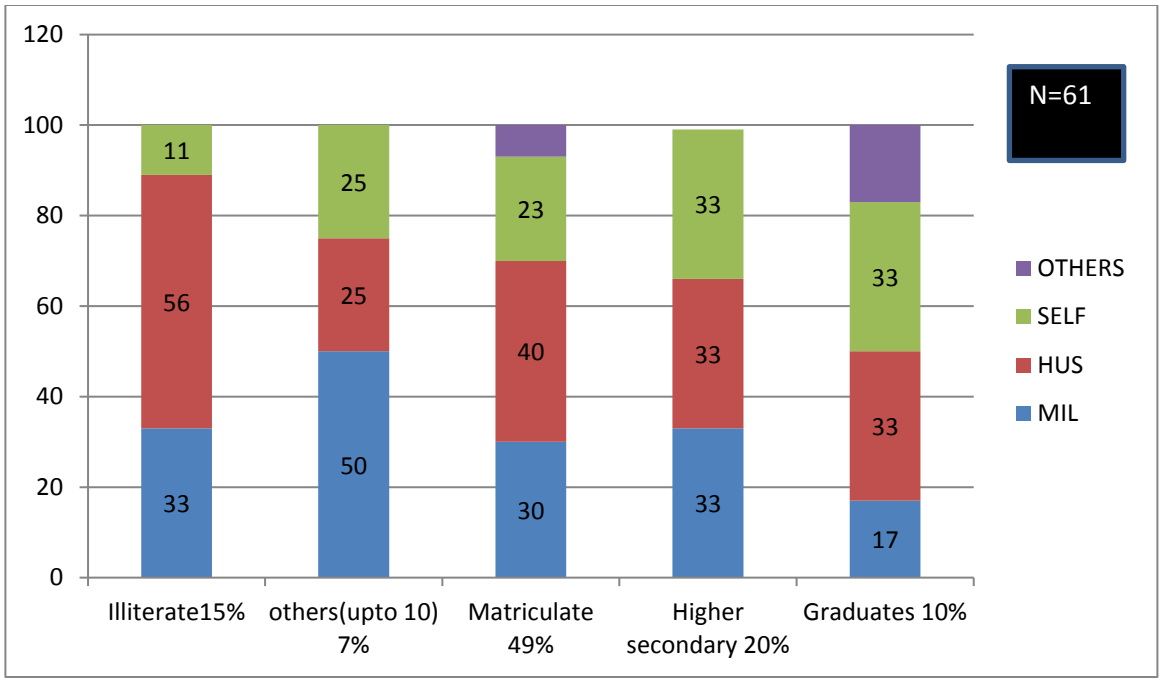
FOR N=6(10% OF GRADUATES)		
PHF(1)	4	66%
PVT(2)	2	33%
TOTAL	6	

DISCUSSION AND CONCLUSION:-

The study reveals the impact of various socio economic factors on independent decision making of women related to reproductive rights. The impacts of the various factors are:-

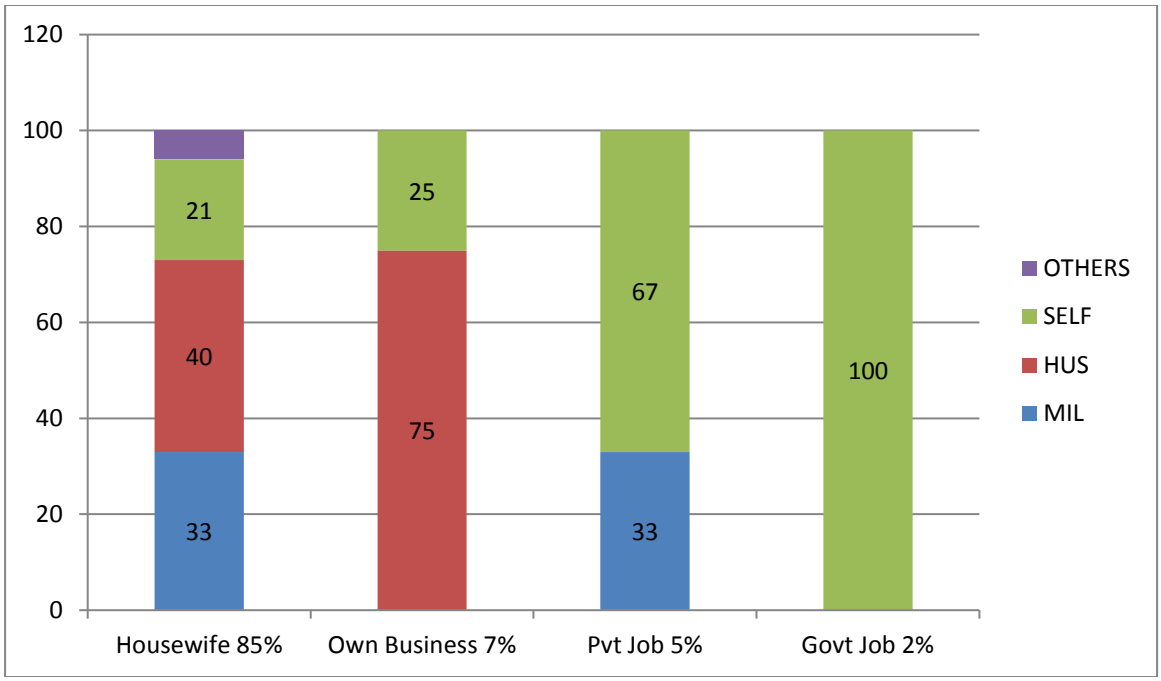
1 .literacy status vs decision making

- In literacy status a gradual increase in independent decision making could be seen as the education of pregnant woman increased, however it is seen that this increase stagnates after the education level reaches higher secondary level.
- The targets of reproductive rights say that decision making must be confined to either husband & wife or self. It can be seen here that this is true in the case to graduates. Hence there is a strong linkage between literacy levels & decision making.



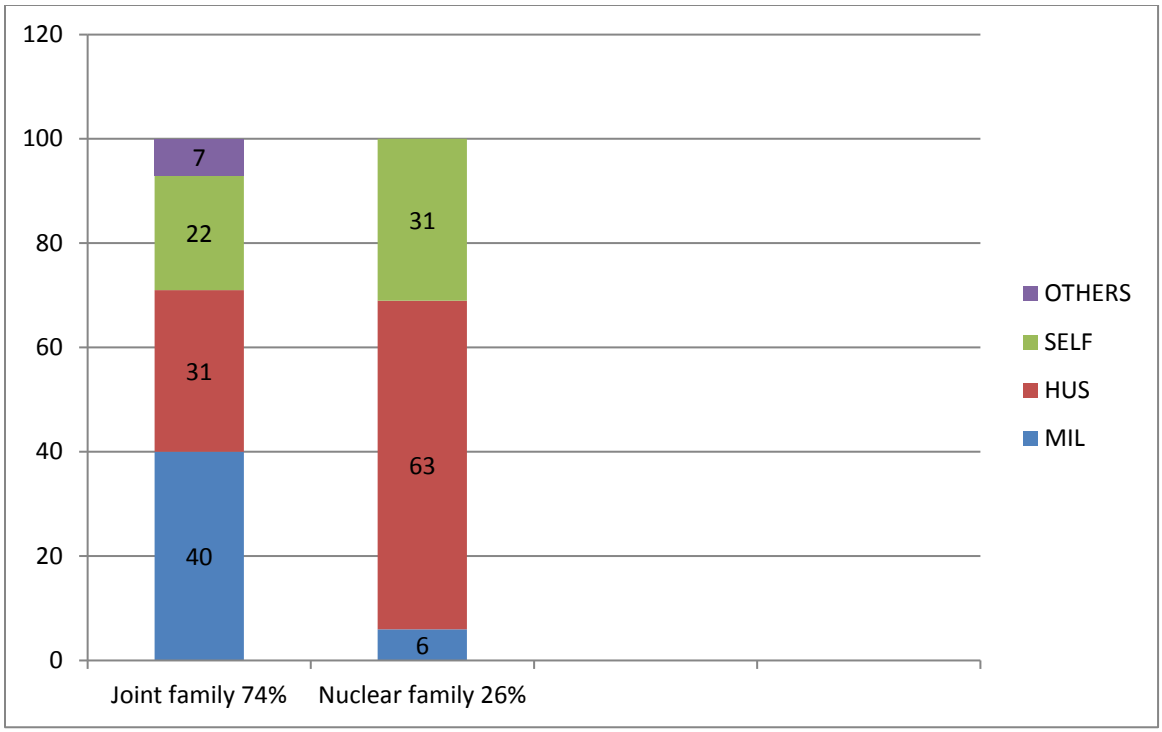
2. Occupation vs decision making

- It is seen that independent decision making is higher among financially independent wom
  However of the total sample only 14% were financially independent ,hence this may not
  Represent the overall picture. Among the women who were housewives ,the major decisi
  Continued to be husband/mother in law. This will require further research.



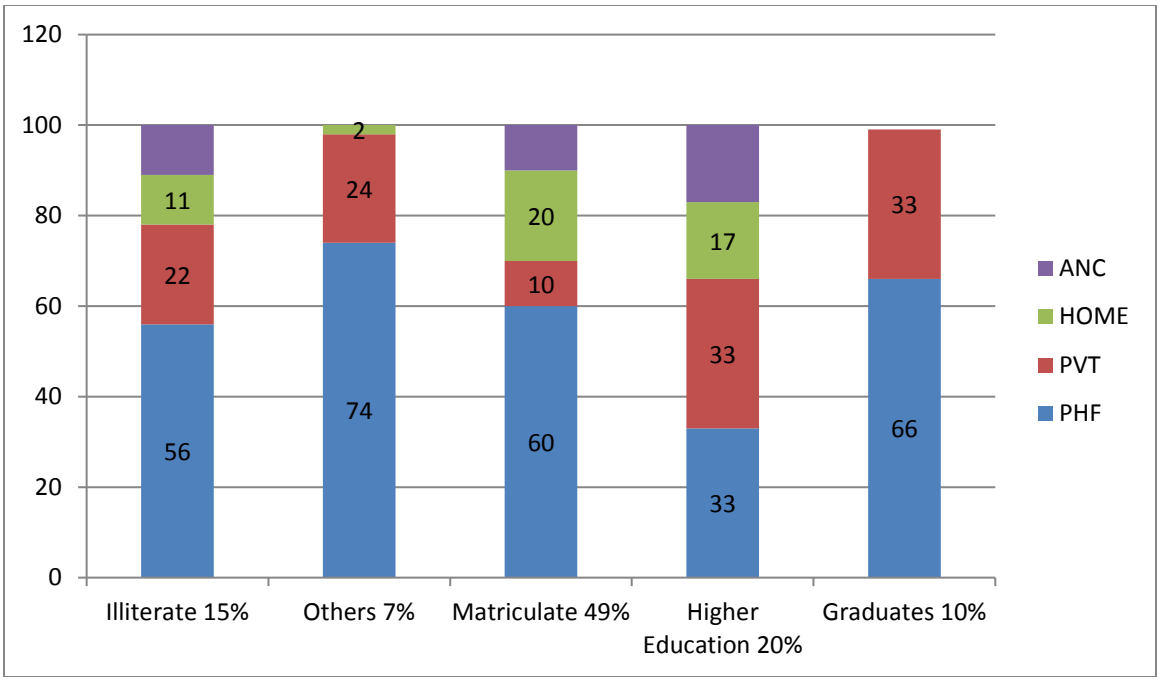
3. Type of family vs decision making

- The pregnant lady living in a joint family set up seems to be less free in decision making and contributes to only 22% of total decision making and mother in law and husband remains the major decision maker.
- In case of nuclear family set up, independent decision making has improved a little bit but husband remains the major decision maker in the nuclear family set up also, but nuclear family contributes only to the 26% of the total respondents.



4 .Education status vs Institutional delivery (pvt and govt combined)

- It is seen that matriculate (from 5th up to 10th) seem to be utilizing the public health facility more but at the same time home delivery percentage is high in this population.
- The highest amount of institutional deliveries at public institutions is among the graduates(66%) and Others(1 to 5th) .However it can also be seen that home deliveries are the highest among matriculate & higher secondary educated .Institutional deliveries in private set up are the highest in higher secondary and graduates.
- It can be seen that the only category with no home deliveries are the graduates. Hence it can be said that while education has a role in improving institutional delivery, it cannot be concluded that is has an impact considering the size of sample of graduates. However it can be said education does not seem to have an impact on choice of facility (Pvt or PHF).



Though not part of study from interaction with service providers(ASHA's and ANM) to understand provider's perspective about JSY it was found that beneficiaries of this area utilizing the services are very low and the amount provided to them is also not enough to meet the expenses of delivery and post delivery expenditures.

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ANNEXURE-1

. QUESTIONNAIRE FOR BENEFIICIARY

Name of Mother…… Age…….

Adress…… Number of children……

1. Literacy status :-
   a) Illiterate b) Matriculate c) Higher secondary d) Graduate e) other
2. Occupation:-
   a) Housewife b) Govt job c) Pvt. Job d) Own Business e) Others
3. Type of family:-
   a) Joint family b) Nuclear family c) others
4. Are you aware about the janani Suraksha Yojna ? Yes/No
   a) If yes, from where / whom did you get the information regarding the scheme
      …….

b) Please describe what does scheme includes……
……

5. When did you know abt JSY scheme?
   a) Before the pregnancy b) During the pregnancy c) After the pregnancy
6. A re you familiar with the ASHA in your area .YES /NO
7. DO you know the role of ASHA? Yes / No
8. If yes, please describe in brief the servives provided by ASHA.
   ……
   ……
   ……
9. Did you receive 3 antenatal checkups and TT injections during pregnancy? Yes/No
10. Where had you delivered your baby (for previous Pregnancy)? Public Health Facility/ Private/Home?

……

11. What is the sex of your child?.....
12. Do you have JSY And MCH card? Yes / No
13. Do you get any incentives for undergoing delivery at the health centre? Yes/NO
14. When did you get incetives ? Immediately at the time of registration/ At time of discharge/ within one week of discharge/ within one month of discharge/ others
    ……
15. What was the mode of payment of incentive ? Cash/ Cheque/DBT
    ……..
16. Do you own a bank account on your name? Yes/No
17. Whether the amount was paid to you or your relative/ Husband?

    ……h

18. Has any community leader ever tried to influence your health seeking behavior? Yes/no? …….
19. If yes Did you change your health behavior under the influence of community leader? Yes / No…..
20. What motivated you to avail the benefits of the scheme?
    ……
    ……

21. Major Stakeholder in decision Making?
    a) Mother in law b) Father in law c) Husband d) Others
22. Will you motivate other women to take benefit of scheme? If yes, why?
23. Are you allowed to freely take decisions related to child birth in your home? Yes/ NO……
24. Who takes decision for number of kids to be born in the house?.....