

# Implementation of Janani Suraksha Yojana

## Mapping evidence-based policy recommendations from implementation narratives of ASHAs

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*This paper reports an exploratory study that presents the implementation experiences of CHWs ASHAs from India in the flagship maternal health programme, the Janani Suraksha Yojana (JSY). It attempts to infer evidence based policy recommendations. The study has a purposive sample of 100 ASHAs from Maharashtra, a high performing state (high rate of institutional deliveries). Mixed methods were applied with a participatory approach. A process analysis of the ASHA's' experiences lead to evidence based policy recommendations. The paper reports on the findings and discusses their import to policy.*

Keywords : Community health workers, maternal health, ASHAs, Janani Suraksha Yojana

There is a plethora of literature available on the performance of Community Health Workers (CHWs), but very little is known about the CHWs' perspectives of the health programme that they implement. Frontline workers are the agents that transform policy into practice. It is important to have their unique insights owing to their hands-on experience with the health programme. Their proximity to the other stakeholders makes it possible for them to reflect unknown realities. Their perspectives can, therefore, form the basis for authentic and impactful evidence-based policy changes.

Maternal health is a core function of all public health services. Recent case studies (USAID 2013, Perry et.al 2017) of global large-scale CHW programmes show that CHWs in several countries are the frontline providers of maternal health care. In countries like India, Rwanda and Zambia, CHWs also facilitate safe deliveries.

India's flagship national maternal health programme is called the Janani Suraksha Yojana (JSY). It began in 2006. At the outset, ten states were classified as Low Performing States with a low rate of institutional deliveries, and the rest were classified as High Performing States. JSY integrates cash incentives to pregnant women and CHWs, with antenatal care, institutional delivery in a public/recognized facility and post-natal services. Incentive payments are conditional to eligibility and institutional delivery (MoHFW,2006). It is implemented in every village, by a CHW, supported by a subcentre at 1000 population level, a Primary Health Centre at 30,000 and a Community Health Centre at 100,000 level. It is now extended to slums supported by maternity hospitals, district hospitals and state hospitals in the urban areas.

A large scale CHW programme called the Accredited Social Health Activist (ASHA) programme implements JSY, and other health programmes, at the community level. Starting from 2005, every village (now extending to every slum) in the country has a woman CHW called ASHA, selected,

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trained and supervised by the public health services system and paid task-based incentives (NHM Guidelines, 2006). ASHAs are the primary workers that implement the JSY in the community, but there is little evidence of their implementation experiences.

A literature search was carried out in PubMed Central and Google scholar. The search term used was 'Asha AND Janani Suraksha Yojana'. The start and end dates were January 2012 and July 2017. Studies with no mention of ASHAs were eliminated. Studies from Indian journals were included through Google. Weekly reference lists given in 2017 by the Biomed Updater were included under the search term 'Community Health Workers, large scale programmes'. The start date and end dates were August 2014 and July 2017. Only studies on 'CHWs IN maternal health' were included.

This search showed that the earlier studies largely reported the impact of JSY on the beneficiaries and not the ASHAs. The focus of the recommendations too was on increasing the uptake of JSY services, not on the ASHAs. For example, the poor behaviour of hospital staff towards the beneficiaries was identified as a gap, but their behaviour towards the ASHAs is not reported.

A few findings that were relevant to this study were as follows. In India, 301 maternal deaths per 100,000 live births during 2001-03 have reduced to 167 during 2011-13. Infant Mortality Rate (IMR) has declined from 58 deaths per 1000 live births in 2005 to 37 in 2015 (SRS Bulletin 2015). In 2005–06, only 39 per cent of Indian women delivered in a health facility. JSY helped raise institutional delivery to 74 per cent in the first eight years since its implementation. (Sidney et.al., 2017).

On the other hand, in areas where there was underutilization of public facilities for deliveries, the main factor has been the poor quality of care in the facilities. (Sidney et.al.2017, Vellakal et.al., 2017, Silan et.al., 2017). The motivation and support services by ASHAs are a major enabling factor for the pregnant women to avail of JSY services and to increase the uptake of institutional delivery in public health facilities. The cash incentive given to pregnant women has played a lesser role (Chaturvedi et. al., 2017, Mondal et.al., 2017).

There was a paucity of evidence collected directly from the frontline implementers, namely, the ASHAs. This study attempts to address this gap, towards developing a stronger JSY. Brownson (2017) proposes three key domains of evidence-based policy. These are process, content, and outcomes. This study is placed within the domain of process. To the best of the researcher's knowledge there is no earlier study that has conducted such an enquiry.

## **The Study**

This study was conducted on ASHAs in a High Performing State, namely, Maharashtra. The underlying assumption was that the experiences of ASHAs are similar across states, regardless of the uptake of JSY services.

Each ASHA works in her own village. She only meets other ASHAs from her own area at the monthly meetings of the local Primary Health Centre (PHC) or at training sessions. There are no official meetings of ASHAs across districts in the same state. Therefore, the sample was drawn from an unofficial meeting of ASHAs from several districts of Maharashtra, for wider diversity in the sample.

### *Sampling and Methods*

The ASHAs were accessed at one single state level trade union meeting held in Kolhapur city (the name of the trade union and the date is withheld for anonymity). A total of 230 ASHAs who also held

honorary positions as district and block level trade union leaders were present at the meeting. These women were leaders but were practicing ASHAs as well.

All ASHAs go through the same processes while implementing a programme. They all face challenges. Their responses to the challenges might differ depending upon the personality and leadership qualities but their leadership abilities do not exempt them from any challenge in the field. This study is about the ASHA challenges in JSY and the emergent recommendations. Therefore the experiences of these ASHAs, even though they were trade union leaders, were considered as being representative of any ASHA.

The aims of the study and the methodology were explained to all the 230 ASHAs and their informed consent was sought for participation. Of the 230, only a 100 ASHAs consented to participate in the study. Thus this study had a purposive sample of a 100 ASHAs, who were based in a 100 villages of 78 blocks of 14 districts in Maharashtra state.

The study used mixed methods with a participatory approach. It was entirely conducted in the local language Marathi. Since time was limited, the tool of enquiry was a self-answered questionnaire in Marathi. It had multiple choice questions, open questions and scales. All the 100 ASHAs were given the questionnaire simultaneously and thus a sample size of 100 was covered in a single all-day meeting. Unstructured individual and group interviews were also conducted but their purpose was only to iterate the findings from the self-answered questionnaire and not to add to the findings.

The findings that are reported in this study are drawn only from the answers given in the self-answered questionnaire.

#### *Data analysis and findings*

The responses of the ASHAs in the self-answered questionnaire, were analyzed both qualitatively and quantitatively.

1. Basic Profile: The basic profile of the ASHAs was established by multiple choice questions and reported numerically.
2. Challenges during implementation: Open questions, designed to explore their experiences of JSY, yielded over 350 responses. Almost all the responses were about the challenges faced during implementation. They formed the basis for a large part of the findings. Six Challenges were identified in the following manner:
  - 2.1 All the responses were listed, and read repeatedly, yielding 10 themes.
  - 2.2 A detailed matrix including representative quotes was prepared. This matrix underwent data consolidation and reduction.
  - 2.3 Repeated reading of the detailed matrix and thematic analysis and the continuous process of inference revealed six major challenges faced by ASHAs during implementation of JSY.
  - 2.4 Finally, a matrix of the challenges faced by ASHAs, was prepared for discussion. In this matrix, the six major JSY challenges faced by ASHAs were presented. The matrix also presented recommendations for the six challenges for implementation and policy reforms.
3. ASHAs' perceptions of key JSY processes: Earlier studies and field observations indicated that there are some key processes undertaken during implementation of JSY, Therefore the

ASHAs' perceptions of these key processes were explored by way of three point scales. The emergent data was converted to a single frequency table for discussion.

4. ASHAs' perceptions of safety: Safety emerged as one of the six challenges identified by ASHAs. Apart from this, perceptions of safety were explored both qualitatively and quantitatively. The themes and numbers findings were triangulated in the analysis. Safety perceptions were reported in a table and figures.

Thus the findings include percentages, numerical and text tables, matrices, figures, and quotes. These are reported in a seamless manner in the findings.

#### *Profile of the respondents*

*Age:* The ages of the ASHAs in the sample ranged from 23 years to 50 years.

*Place of work:* About 84 of the 100 ASHAs reported that they lived and worked in rural areas, while 14 were from tribal areas and 2 did not respond.

*Work Experience:* More than half the women that are 52 had worked for 5-6 years while 22 had worked for 4-5 years. The rest of the ASHAs (26) had less than 4 years of experience except one who had worked for 8 years.

*Psycho-social profile:* This was an active and articulate group with leadership qualities and experience, making them very eligible for process documentation. Yet more than half of the ASHAs present, did not participate in an investigation about their own experiences (refer sampling). The ASHAs in the sample were asked why the others did not participate. Their responses revealed uncertainty and insecurity about their post.

“It is okay to speak in a group...if the news goes back then what will happen...it is not a job” (ASHA Worker-Leader)

## **II**

### **Challenges During the Implementation and Perceptions of Key Processes**

ASHAs are given defined tasks in JSY (MoHFW, 2017). However, JSY was seen by the ASHAs as a challenging process of nine months with each pregnant woman. Six major challenges defined by the ASHAs through open questions. These JSY Asha challenges are presented below in the form of themes. The same challenges were reflected in their perceptions of key processes as well, when measured numerically by scales. This numerical data is also presented below as it supports and illustrates the qualitative themes.

#### **JSY Asha Challenge 1: Documentation**

Maharashtra is a High Performing state. Incentives are given only to pregnant women who are eligible (Below Poverty Line (BPL)/ Scheduled Caste) and only after documents are submitted. Although the policy guidelines specify that the ASHAs need submit only the pregnant woman's BPL card, in practice, there were many papers.

JSY incentive eligible mothers needed a caste certificate to prove they met the caste eligibility of being from a Scheduled Tribe; an identification card called the Aadhar Card was mandatory for all cash transfers from the government and lastly, proof of a bank account was needed. Address proof in the form of a Ration Card was necessary if the pregnant woman was registered in her marital home but delivered at her natal home.

## Matrix 1: Challenges of implementing a maternal health care program for CHWs and the emergent policy recommendations: Ashas in Janani Suraksha Yojana

Challenges	Emergent recommendations	Challenges	Emergent recommendations
<b>Theme one: Documentation</b> 1.1 Too many documents demanded 1.2 Frequent, unpaid travel 1.2 Lack of co-operation from families, officials, ANM (Auxiliary Nurse Midwife). 1.3 Confusions over documents required.	<b>Changes in guidelines</b> 1.1 Single window-single paper policy 1.2 Local full time staff handles documentation, not Ashas 1.3 Link Asha identity letter and registration of birth to incentives, not signatures	<b>Theme four: Decision making</b> 4.1 The choice of facility for delivery is decided by Ashas, a responsibility she feels is beyond her training and position.	<b>Changes in guidelines</b> 4.1 Ashas get the solo power for issuing a referral note to a health facility for delivery.
<b>Theme two: Coverage Pressure</b> 2.1 Difficult to persuade community for delivery in public health facility. 2.2 Out of pocket travel and uncounted efforts for pregnant women who are above JSY criteria. 2.3 Exploitative ANMs	<b>Changes in guidelines</b> 2.1 Quality and monitoring systems at PHC/CHC levels. 2.2 Eliminate the role of ANMs for payments to Ashas. 2.3 Create parity for JSY incentives.	<b>Theme five: Loss of face</b> Loss of face in the community due to: 5.1 Onward referrals, absence of ambulance, doctors and kits. 5.2 Rude and dismissive behaviour by full time staff.	<b>Changes in guidelines and implementation</b> 5.1 A redressal system by toll free line to the CM's office. 5.2 A complain should attract an inquiry of the concerned MO. 5.3 Sensitivity classes for all staff and the community.
<b>Theme three: Transportation</b> 3.1 Ambulance does not turn up 3.2 Arranging alternative transportation stressful 3.3 Out of pocket expenses for travel.	<b>Changes in implementation</b> 3.1 Make non arrival of ambulance a punitive action for ambulance driver. 3.2 An advance travel allowance for Ashas.	<b>Theme six: Safety concerns</b> 6.1 Unsafe people 6.2 Unsafe behaviors	<b>Changes in guidelines and implementation</b> 6.1 Vishakha Act. 6.2 Eliminate the clause of Asha escort for delivery at night.

ASHAs were expected to collect these and other documents from the family, or help them acquire the papers from the concerned officials. In addition, the signature of the Auxiliary Nurse Midwife (ANM) had to be acquired by ASHAs after the delivery in a public facility in order to be eligible for their own cash incentive. They felt pressurized because the documentation required repeated visits, at their own expense. The families and officials did not always co-operate in the process, enhancing their difficulties.

### JSY Asha Challenge 2: Coverage Pressure

The Asha is expected to facilitate maternal health and institutional delivery for every single pregnant woman in the village. The ASHAs said they were pressurized for the coverage of women by Auxilliary Nurse Midwives (ANMs). Other forms of exploitation by the ANMs that were reported were the refusal of travel expenses compensations, and usurping of the credit and incentives for Family Planning coverage after the delivery. These trends were seen in an earlier study as well. (Bhatia, 2014)

There is pressure for the total coverage of JSY on one hand and at times, resistance from the families on the other. However, ASHAs are paid only if the mother too is eligible for an incentive. For all the pregnant women outside the incentive criteria, the ASHAs said they not only completed all the tasks, but also facilitated deliveries without any compensation. In addition there was out of pocket expense for travel if the ambulance did not turn up, a finding seen earlier (Bhatia, 2014) as well.

There was a blasé attitude towards this exploitative practice among the health functionaries. A senior official confirmed

“ASHAs of 24 states (High Performing States) do JSY under the free services department”

The ASHAs were aware but resigned.

“We are from open area, we get nothing” (ASHA Worker)

### **JSY Asha Challenge 3: Transportation**

The ASHA has to reach the PHC with the pregnant woman in time for the institutional delivery. Arranging for transportation is also the responsibility of ASHAs.

There is a helpline to call for an ambulance, but it can be unreliable. Table 1 shows that about half the ASHAs did not get an ambulance always. ASHAs regularly undertook the nerve-racking exercise of looking for alternative transportation, with the woman inching towards delivery time. This could be a three-wheeler, a share-a-seat open jeep, a private vehicle, or a makeshift cot until the nearest vehicle is reached. This happened at odd hours, in distant areas, and in adverse weather, as during the monsoons. The ASHAs also payed out of their pocket for alternative transportation because advance travel allowance was not given.

### **JSY Asha Challenge four: Decision-making**

The JSY guidelines indicate that ASHAs and ANM should identify the health facility for delivery. In practice, most of the ASHAs decided the health facility where the pregnant woman should deliver, alone (Table 1). Frequent upward referrals and the absence of staff (Matrix 1 and Table 1) often nullified their efforts to bring the pregnant woman to the Primary Health Centre (PHC). At other times, they had to opt for a private facility due to the preferences of the family. At all times, the Asha was alone.

ASHAs felt undervalued and unsupported by the full time staff during the decision-making. This heightened their resentment for the perceived non-participation of the ANM. As pointed out by an Asha.

“The decision should be taken by the ANM, and not by us.”

ANMs on the other hand, cited their own work pressures to the ASHAs, thus underlining the fact that a clear cut line of authority for referrals was missing in JSY.

### **JSY Asha Challenge Five: Loss of face**

The ASHA lost face in the community when there were delays in replenishing kits, leading to delays to give supplements to pregnant women. Delays or non- appearance of the ambulance; absence of staff and frequent upward referrals led to community dissatisfaction. ASHAs also reported that they were treated dismissively by the full time staff. As shared by many ASHAs, their sense of pride over facilitating the entire JSY process disappeared with such incidents.

**Table 1: Ashas' rating of key JSY processes and the emergent policy recommendations**

Process	Most of the time No./ (%)	Sometimes No. /(%)	Never/no re- sponse No. /(%)	Total responses No./(%)	Emergent policy recommendations
Instructed to aim for universal JSY coverage at official meetings?	90 (90 %)	8 (8%)	2 (2%)	100 (100%)	Make JSY a universal program with universal Asha incentive coverage
Find it difficult to convince community for institutional delivery?	75 (75%)	2(2%)	23(23%)	100 (100%)	Improve quality control and monitoring of facilities
Took the decision of the choice of health facility for delivery alone?	85 (85%)	11(11%)	4 (4%)	100 (100%)	Give Ashas the solo power to issue a referral letter for delivery in any health facility
Referred to hospital for delivery after bringing the expectant woman to the PHC?	47 (47%)	38 (38%)	11(11%) / 4 (4%)	100 (100%)	Create redressal channels for community/ Ashas
Availability of ambulance service for delivery?	49 (49%)	43 (43%)	6 (6%) / 2 (2%)	100 (100%)	Create redressal channels for community/ Ashas Pay Ashas advance travel allowance

“There is no value for Asha in the hospital... even PHC staff do not treat properly.” (ASHA Worker)

### **JSY Asha Challenge six: Safety during the JSY implementation process**

Overcoming shame, reticence and fear due to the privacy of written responses, ASHAs shared safety concerns in the JSY implementation process during the qualitative exploration. However, the major findings emerged in the quantitative exploration.

Only 30 per cent of the total multiple responses of ASHAs reported a feeling of being safe while implementing institutional deliveries (Figure 1.)

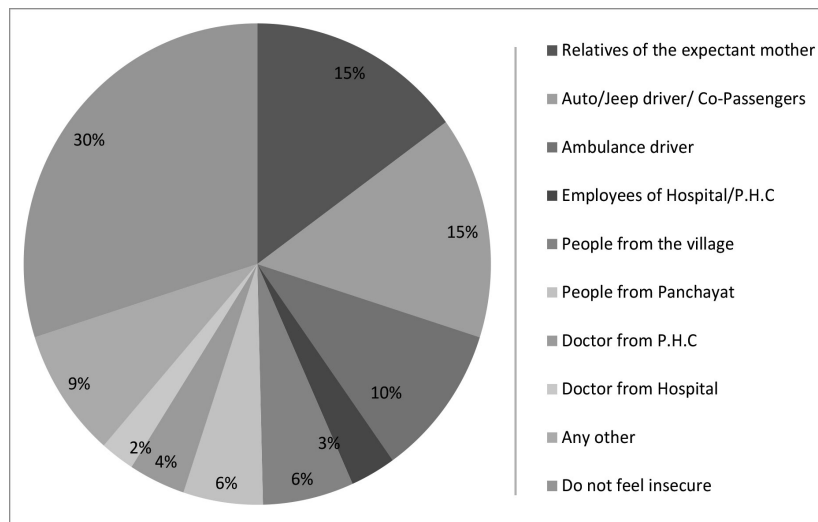
“We don't face any difficulties as the patients belong to our own village and due to this we are getting all the support and cooperation from their family members, auto drivers, ambulance drivers.” (ASHA Worker)

In a tragic indictment of the JSY process, 70 per cent of the total multiple responses have collectively identified virtually every male figure that they could have possibly encountered as unsafe. These

included relatives of the pregnant woman, drivers, officials, villagers and doctors. (Figure 1). There are other ASHAs who have not been named, indicated by the fact that as many as 9 per cent selected the option tagged as ‘others’.

*The behaviour that made the ASHAs feel unsafe during JSY implementation*

**Figure 1: People that make Ashas feel unsafe while facilitating institutional deliveries under Janani Suraksha Yojana**



**ASHAs’ perceptions of safety during implementation of JSY**

*The people that made ASHAs feel unsafe while facilitating institutional delivery*

Physical safety is the first concept that springs to the mind during travel. However, the threat of physical safety was not the only source of insecurity. A thematic analysis of the ASHAs’ narrations (Figure two) indicated much more.

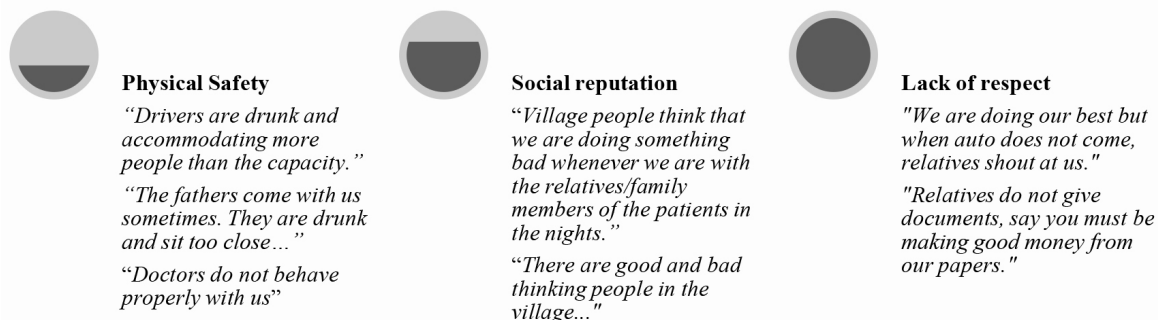
Threats to physical safety: There were responses that described the fears during the travel with the pregnant women for delivery. Other responses directly described the persons with whom the ASHAs felt physically unsafe. Ambulance drivers and drivers of private share seat jeeps and three wheelers felt problematic and unsafe. The relatives of the pregnant women were mentioned very often (Figure 1), and the narratives indicated safety threats from within the community (Figure 2).

There is one published case study of sexual harassment of ASHAs by a PHC doctor (Bhatia 2017). And one published case study of the rape of an Asha by community members (Dasgupta et.al. 2017). Both were not in the JSY context. This is the first study that documents safety in JSY, to the author’s best knowledge.

Threats to the social reputation: Living in a social milieu that restricts the free movement of women, there were threats to their reputation due to the kind of travel required from the ASHAs. Some ASHAs even established communication with the community, solely on this subject, in order to stem this threat (Figure 2).



**Figure 2: Threats to safety experienced by Ashas while facilitating institutional delivery under Janani Suraksha Yojana**



Threats to self-respect due to lack of respect from the community: Forms of disrespectful behavior from the family members and humiliation by officials, were seen as a safety issue, an interesting dimension to the ASHAs’ perceptions of safety.

The findings are contextualized within a gendered, hierarchical and structured health systems services and society. However, things can be different within the same context as seen by the handful of good experiences, when ASHAs were given their due respect and co-operation by all the stakeholders (Text table 1).

Available studies largely mention the ASHAs in the context of the impact of JSY on the community. There is very little evidence of the ASHAs’ views and their first hand experiences during service provision. There are a few documented examples of the Asha earning the respect of the community due to her JSY services, including in this study. Difficulties with transportation and expenses have been studied and are well known. Overall there was scant material therefore it was not possible to discuss the findings with reference to earlier studies.

**Matrix 2: Good Experiences of Ashas while implementing Janani Suraksha Yojana**

Theme one: support from the health system	Theme two: Support from the community	Theme three: satisfaction of providing a service
“We are getting good support when we take the patients.”	“Getting lots of respect and trust from the community but all the same it’s a very responsible job.”	“As I am Asha worker I am enjoying my work and very happy that I helping poor in spite of not getting payment on time.”
“I am taking patients to the sub district hospitals but I am getting payment on time due to strong support from my PHC.”	“Many people appreciating family planning treatment done by us by giving some gifts and due respects.”	“It’s giving inner satisfaction that we are doing good work with lots of hard work.”
“Good experience is that the vehicle is available whenever we call.”	“Many times people are appreciating Asha for helping pregnant women in her delivery in safely manner.”	“I did one safe delivery due to delay in availability of ANM on time, am very satisfied.”
	“We are getting money and the case in our name but the same time patients getting 700 rupees and giving blessing.”	

### III

#### Conclusions

Changes are needed both in the implementation of JSY and in the guidelines.

##### *1. Changes in JSY Implementation*

Some unimplemented mandates in JSY guidelines need to be operationalized:

- a. The JSY guidelines stipulate a grievance redressal mechanism but it was not activated. If this clause is operationalized it will ensure community control over the implementation lapses, like delays, absence and frequent upward referrals. A toll free telephone line to the Chief Minister's Office and an enquiry mechanism are recommended.
- b. The sexual harassment of women at workplace (prevention, prohibition and redressal) act, 2013 mandates an enquiry committee for sexual harassment at the work place but is not implemented. It should be implemented to give a legal recourse to ASHAs. This has been suggested earlier. (Bhatia, 2017, Dasgupta et.al., 2017).
- c. Advance travel allowance and compensation for travel money, is mandated in the guidelines and should always be provided.

##### **1. Changes in the JSY Guidelines**

- a. Confirming Doke's findings in Maharashtra (Doke et. al., 2015), it is recommended that simplification of the JSY documentation could save ASHAs from immense stress and encourage better usage of public health facilities. The responsibility of documentation could be handed to the local full time workers, namely the Auxiliary Nurse Midwife (ANM) or the male Multi-Purpose Worker (MPW), who have an advantage over the Asha in terms of proximity to the offices, education and paid working hours. The CHW Asha will thus be able to better redirect her energies to the programme elements.
- b. The ASHAs hold a major responsibility of reaching pregnant women to the health facility for delivery. This should be recognized as a stellar contribution. ASHAs should be given the solo authority for issuing the referral slip for any facility for delivery. This would give them an official sanction and better response from the community besides being a confidence boosting measure.
- c. ASHAs travel in unsafe conditions for facilitating institutional deliveries. They should only arrange for transportation and be exempted from escorting pregnant women at night. Provision of mobile phones should be mandated to ease co-ordination and reporting.
- d. Relevant upgradation of the training will support the ASHAs in decision-making.
- e. The insistence on total coverage is a rights violation, as it makes volunteers like ASHAs accountable to the state. Service improvement, quality control and monitoring of public health facilities are needed to encourage total coverage.
- f. CHWs like ASHAs subsidize the state's health budget when they are not compensated. Out of pocket expenses by ASHAs have been mentioned in this study and also recently endorsed in other states (Sarin, 2016). In JSY the out-of-pocket expenses happen due to the gaps in the policy guidelines and the tacit collective agreement among all the stakeholders. It is just

and appropriate to give the same incentive to ASHAs for services given to every pregnant woman irrespective of any criterion. This is applicable in Maharashtra as well as in other High Performing States. Asha payments including travel, should also be freed from the control of the ANMs to avoid power struggles.

- g. The loss of face experienced by ASHAs must be addressed with the gravity it deserves. Training sessions on gender sensitivity and the role of CHWs in health care, must be made mandatory for the full time health staff and the community. This has also been suggested earlier.

### In sum

The health services system's insistence on the total coverage of JSY on the one hand, and the community's demand for quality services on the other, presents several challenges for the ASHAs. These can be addressed by some practicable changes like Quality control and upgraded public services, simplified documentation, revised Asha incentives, advance travel allowances, implementation of the legal provisions against sexual harassment, and gender and CHW sensitivity training for the staff and the community are recommended. A quantum improvement can happen by ensuring that the full time staff like ANMs work interactively and responsibly, not authoritatively. It is important to listen more closely to the ASHAs for valuable insights into the relevance of JSY and the maternal health policies of the country. Indeed such an attempt would yield rich insights even for other programmes.

Methodological innovations are needed to listen to frontline workers. Process analysis of the first hand experiences of frontline workers can yield rich data and direct changes towards evidence-based policy. The study attempts to present a replicable methodology to do this. Further areas of research could explore the six challenges presented here, and the particularly the safety issues, in greater detail than has been attempted in this study.

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## **Annexure 1: The tasks of ASHAs under Janani Suraksha Yojana**

Identify the pregnant woman and whether from BPL family; Assist the woman to obtain BPL certification if BPL card is not available; Facilitate registration; 4 ANC check-ups and 2 TT injections; Counsel for institutional delivery; Escort the women to the health facility and stay with her till the delivery is complete and woman is discharged; Arrange to immunize the newborn till the age of 10 weeks; Register birth or death of the child or mother; Post-natal visits within 7 days of pregnancy and track mother's health; and Counsel for initiation of breastfeeding within one-hour of delivery and its continuance till 3-6 months. Source: JSY Guidelines.