4.12 Case 4: Decoding Public Health Ethics and Inequity in India: A Conditional Cash Incentive Scheme—Janani Suraksha Yojana

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4.12.1 Background

The domestic sphere of home and family defines the lives of most women in India, where they assume the role of caregiver, either as wife or mother. Overall, age and sex govern the household's hierarchy of authority, older over younger, men over women. Women, especially those living in northern India, experience decreased autonomy and increased inequalities in all areas of life (Iyengar et al. 2009; Bloom et al. 2001). Limited autonomy harms women's maternal health outcomes, restricting their ability to choose safe childbirth options. In India, most births still occur in the home; less than 41 % occur in an institutional setting (International Institute for Population Sciences 2007).

Worldwide, more than half a million women die each year from complications during pregnancy and childbirth (UNICEF 2009). About 99 % of these deaths occur in developing countries. Based on maternal mortality trends from 1990 to 2008, developing countries, especially India, contribute about 18 % of the global burden of maternal deaths (Dikid et al. 2013). Data during 2007 through 2009 indicated that India's maternal mortality ratio (MMR) was 212 per 100,000 live births (Registrar General of India 2011). Regional differences in MMR are found in India; during 2007 through 2009 the MMR in northern states was 308/100,000 compared with 207/100,000 in the southern states.

India has had a long history of redistributive poverty-reduction programs, but few programs provide direct cash assistance to the needy (Mehrotra 2010). Cash incentive programs started in the 1990s predominantly in Latin America where their success led to adoption in other parts of the world (Powell-Jackson et al. 2009b). These programs vary in size and scope; examples include programs that address vaccinations, education, health care, safe childbirth, sterilization, and poverty. An example from an Asian country is the Safe Delivery Incentives Programme (SDIP), which was started in

2005 in Nepal with funds from the U.K. Department of International Development and the Nepalese government (Powell-Jackson et al. 2009a; Karki 2012). The program provided cash incentives to women who gave birth in health facilities and to health providers for each attended delivery (either in the woman's home or in a facility). The program implementers or administrators expected that the cash incentive would reduce transportation barriers and delays in maternal care seeking (Bhandari and Dangal 2012). The program was most effective in changing health care-seeking behavior wherever women's groups highlighted the importance of effective communication of the policy to the public (Powell-Jackson et al. 2008). Women exposed to the program were 24 % more likely to deliver in government health institutions, 5 % less likely to deliver at home, and 13 % more likely to have their delivery attended by a skilled health worker. Deliveries in government health institutions went from 34 % in the first year (2005/2006) to 59 % in the third year (2007/2008). Overall, the program was well received, however certain aspects of the policy were not accepted, including a condition that limited receipt of the cash incentive to women who had no more than two living children (Powell-Jackson et al. 2008).

India's conditional cash transfer program, Janani Suraksha Yojana (JSY), is one of the largest programs of its kind in the world (Lim et al. 2010). JSY is funded through the central government, provides welfare to women living in indigent families, and includes efforts to empower women to choose institutional childbirth rather than home delivery.

JSY represents a novel and useful way to ensure the social welfare of women by integrating cash assistance with childbirth delivery and post delivery care. The program focuses on poor pregnant woman, especially those living in states with high MMRs and low institutional delivery rates. These low-performing states include Uttar Pradesh, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa, and Jammu and Kashmir (Tiwari 2013). An important component of this program is its focus on monitoring, evaluating, and providing, health care for the mother and her baby (Lim et al. 2010). District-level household surveys have documented a decline in the proportion of home deliveries, which dropped from 59 % in the 2002–2004 survey (International Institute for Population Sciences 2006) to 52 % in the 2007–2008 survey (International Institute for Population Sciences 2010).

Despite indicators of success, the JSY program has raised a number of concerns. One of the aims of JSY is equity in addition to coverage; the JSY program does not include private health care providers. The increased deliveries (from 35 % to 65 %) in public health care facilities may raise issues in the quality and standards of health care (MacDonald 2011). Another concern is that the lack of comprehensive emergency obstetric care at many institutions compromises the safety of institutional deliveries (International Institute for Population Sciences 2010). A final concern is that socioeconomic status, caste, and education create large inequities in access to the program's cash incentives, while women who do gain access lack financial control over the cash incentives (Gopichandran and Chetlapalli 2012).

4.12.2 Case Description

A 19-year-old woman from a poor area in India is pregnant for the first time and only weeks from her delivery date. Wearing a long pardah to cover the lower half of her face and traditional maang tikka jewelry on her forehead to indicate married status, her attire reflects the traditional values embedded in her culture. She wants to deliver her baby in her home village, which is an overnight's journey away. But her husband and in-laws have other ideas. They have just learned of a government program that provides a cash payment of 1000 rupees to women who opt for institutional delivery over home delivery. Her mother-in-law insists that the delivery take place in their district institution. The woman's parents, believing the in-laws to be driven purely by greed, support their daughter. With encouragement from her parents, the woman disobeys her husband and in-laws to travel to her parent's home, but goes into labor on the road and loses her child due to complications in the delivery. The young woman not only is disconsolate over the loss of her child, she must now face the wrath of her husband and in-laws.

This is a poignant case, but only one in a dossier full of similar cases that you, as the state director for the maternal cash incentive program, have read that involve clashes between traditional ways and the incentive program. As a result, you have decided to convene an expert panel to consider recommendations to smooth not only the cultural friction the program is causing, but also the program's impact on the quality and safety of care, as well as access to it.

4.12.3 Discussion Questions

1. Who are the main stakeholders in the case of the 19-year-old woman and what values and cultural perspectives does each stakeholder bring to this situation?
2. How should you consider the issues about this and similar cases when deciding whether to revise the cash incentive program?
3. What are the pros and cons of cash incentive programs from a public health perspective?
4. What role should government play in improving the public's health?
5. In the context of inequities based on socioeconomic status, caste, and education, to what extent should you attempt to ensure that a woman's autonomy is not violated? Should the same notion of autonomy be applied in India or other unique contexts as prevails in European and North American countries?
6. Due to a financial downturn, the state government is thinking about eliminating the maternal cash benefit program. How can an ethical analysis assist in making this decision? What factors should be considered as part of this ethical analysis?

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