DATA ANALYSIS AND INTERPRETATION

INTRODUCTION

The study focused on the Women Beneficiaries of National Rural Health Mission with special emphasis on Barwani District of Madhya Pradesh. The literature shows that women are one of the major beneficiaries of NRHM in the country. It focuses on providing health services to rural women at an affordable price, and in an accessible and effective manner. Since the rural women face many health challenges, this scheme seems to be a significant step. The awareness level and accessibility of NRHM services are also a major focus of this research. The research was focused on the state of knowledge, access and availability, benefits and challenges of the programme on rural women beneficiaries.

The data analysis and interpretation part is divided in to the following six items:

1. Socio demographic profile of the participants
2. Knowledge of women beneficiaries of Barwani District of Madhya Pradesh on National Rural Health Mission services
3. Extent of availability and accessibility of National Rural Health Mission services to women beneficiaries of Barwani District of Madhya Pradesh.
4. Challenges faced by women beneficiaries of Barwani District of Madhya Pradesh to access National Rural Health Mission services
5. Benefits received by women beneficiaries of Barwani District of Madhya Pradesh from National Rural Health Mission
6. Association of socio demographic variables on accessing National Rural Health Mission services

4.1. SOCIO DEMOGRAPHIC PROFILE OF THE PARTICIPANTS

Table 4.1.1. Age of the Participants

		Frequency	Percent
Age of the participants	18-25	66	23.7
	26-33	119	42.8
	34-41	48	17.3
	42-49	27	9.7
	50-60	18	6.5
	Total	**278**	**100.0**

Most of the participants of the study fall under the age group of 26 – 33 years (42.8%). During the study, it was found that the women under the age group of 26-33 years were more interested to participate in the research. They have shown keen interest in answering the questions in comparison to participants belonging to other age groups.

Table 4.1.2. Religion of the Participants

		Frequency	Percent
Religion of the participants	Hindu	278	100.0
	Total	**278**	**100.0**

All the participants follow Hinduism. Hindu religion has prominence among all the village Panchayats which were included in the study.

Table 4.1.3. Caste of the Participants

		Frequency	Percent
Caste of the Participants	Scheduled Caste	50	18.0
	Scheduled Tribe	228	82.0
	Total	**278**	**100.0**

Scheduled Tribe population forms a major part in the sampled village Panchayats. Barela and Bhilala are two prominent tribes in these villages. As per the Census (2011) data, there are 842 women from Scheduled Tribes in Nawalpura Village Panchayat whereas, 32 women are from Scheduled Castes. In a similar way, Mehatgaon Village Panchayat has 281 women belonging to Scheduled Tribes and 76 women from Scheduled Castes. Julwania village Panchayat has the highest number of women belonging to Scheduled Tribes (897) among these three village Panchayats. There are only 15 women who belong to Scheduled Castes in Julwania village Panchayat. The three village Panchayats have no other caste other than Scheduled Castes and Scheduled Tribes.

Table 4.1.4. Availability of Below Poverty Line (BPL) Cards

		Frequency	Percent
Availability of Below Poverty Line (BPL) Cards	Yes	200	71.9
	No	78	28.1
	Total	**278**	**100.0**

It was found during the study that majority of the participants (71.9%) have a below poverty line card for their family. These cards help them to avail food grains, sugar and kerosene at a subsidized rate from public distribution system.

Table 4.1.5. Family Status of the Participants

		Frequency	Percent
Family Status of the Participants	Nuclear	236	84.9
	Joint	42	15.1
	Total	**278**	**100.0**

Majority of the participants of the study belong to nuclear families (84.9%).

Table 4.1.6. Marital Status of the Participants

		Frequency	Percent
Marital Status of the Participants	Married	272	97.8
	Widow	6	2.2
	Total	**278**	**100.0**

Out of 278 participants, 272 (97.8%) are married and 6 (2.2%) are widows.

Table 4.1.7. Age of Participants at the time of Marriage

		Frequency	Percent
Age at Marriage	18 years and above	225	80.9
	Below 18 years	53	19.1
	Total	**278**	**100.0**

The data reveals that majority of the participants (80.9%) got married only after they became of marriageable age. While conducting the study, majority of the participants affirmed about knowing the minimum age for validating a marriage.

Table 4.1.8. Educational Status of the Participants

		Frequency	Percent
Educational Status of the Participants	Illiterate	261	93.9
	Can Read and Write	5	1.8
	1-5 standard	2	0.7
	6-10 Standard	10	3.6
	Total	**278**	**100.0**

According to the data, majority (93.9%) of the participants are illiterate. 3.6% participants had received education between 6^{th} to 10^{th} standard. Remaining 1.8% participants can read and write and 0.7% had education from 1^{st} to 5^{th} standard.

Table 4.1.8.1. Education, Age and Caste Cross Tabulation

Caste		Age					
		18-25	26-33	34-41	42-49	50-60	Total
Scheduled Caste							
Illiterate	Frq	11	10	9	7	6	43
	%	(26%)	(23%)	(21%)	(16%)	(14%)	(100%)
6-10 Standard	Frq	01	01	02	01	02	07
	%	(14%)	(14%)	(29%)	(14%)	(29%)	(100%)
Total	Frq	12	11	11	08	08	50
	%	(24%)	(22%)	(22%)	(16%)	(16%)	(100%)
Scheduled Tribe							
Illiterate	Frq	50	107	34	18	09	218
	%	(23%)	(49%)	(16%)	(8%)	(4%)	(100%)
Can Read and Write	Frq	2	0	2	0	1	5
	%	(40%)	(0%)	(40%)	(0%)	(20%)	(100%)
1-5 Standard	Frq	0	1	0	1	0	2
	%	(0%)	(50%)	(0%)	(50%)	(0%)	(100%)
6-10 Standard	Frq	2	0	1	0	0	3
	%	(67%)	(0%)	(33%)	(0%)	(0%)	(100%)
Total	Frq	54	108	37	19	10	228
	%	(24%)	(48%)	(16%)	(8%)	(4%)	(100%)

The results of the study show that in both Scheduled Caste and Scheduled Tribe categories, majority of participants are illiterate. Majority of the earlier studies have stated that education plays a vital role on determining the accessibility of any services. Since NRHM is meant especially for rural population the literacy rates of people matters a lot. That will lead them to avail the services specified in the programme.

Table 4.1.9. Occupation, Ownership of Land and Annual Income of the Participants

		Frequency	**Percent**
Occupation of the Participants	Unemployed	35	12.6
	Agriculture Labour	236	84.9
	Daily Wage Earner	7	2.5
	Total	**278**	**100.0**
Ownership of land	No Land	252	90.6
	Less than 2 acres	14	5.0
	2-5 acres	12	4.3
	Total	**278**	**100.0**
Annual Income of the Participants	Rs. 10000 and below	45	16.2
	Rs. 10000 - 20000	218	78.4
	Rs. 20000-30000	9	3.2
	Rs. 30000 and above	6	2.2
	Total	**278**	**100.0**

The results show that majority of the participants (84.9%) are Agriculture Laborers. Agriculture plays a prominent place in the life of the participants. The major field crops cultivated in this area are cotton, sorghum, maize, soybean, groundnut, sugar cane, wheat and gram (Economical survey of Madhya Pradesh, 2007-08).

Out of 278 participants, 252 do not have any land. These families depend majorly on agricultural labor and daily wage work. It was found during the study that a few families own Cattle, Buffaloes, Goat or Sheep for their survival. The financial status of the participants is below average.

Majority of the participants' (78.4%) annual income falls in the bracket of Rs. 10000-20000. It is supported with the fact that majority (71.9%) own a below poverty line card for their family.

Table 4.1.10. Housing, Electricity and Toilets Availability to the Participants

		Frequency	**Percent**
Housing	*Pakka* (Cemented)	18	6.5
	Kacha (Mud House)	260	93.5
	Total	**278**	**100.0**
Electricity at Home	Yes	199	71.6
	No	79	28.4
	Total	**278**	**100.0**
Toilets availability	Yes	5	1.8
	No	273	98.2
	Total	**278**	**100.0**

According to the study, it was found that majority of the participants (93.5%) have mud houses and only a few (6.5%) have cemented houses. The mud houses in this area are congested and require frequent maintenance.

They are constructed with walls using wooden particles with mud and cow dung. The roofs of these houses are constructed with locally available tiles. A few mud houses have their walls constructed with local bricks joined with mud in place of cement. Such houses are good for summer since the structure of such houses help them to neutralize the effect of the soaring temperatures. These houses are also low heighted.

The study shows that majority of the participants have electricity connectivity at home. During the period of data collection, the participants shared that the long hours of power cuts lead to loads of problems especially during the nights. It was also found out during the study that majority of the people in these villages possess television, mobile phones and radios.

When asked about the availability of toilets at their home, majority (98.2%) answered in the negative. A significant finding of the study is that unavailability of toilets at home leads to several psycho social and health issues. During the focus group discussions, the researcher could identify the issues associated to non availability of toilets at home.

Unavailability of toilets in rural areas leads to increase of water-borne diseases and mostly affects women and children. Women and girls defecate in public harming their health and also inviting molestation and unwanted attention from men. The non availability of toilets results in women visiting fields or nearby open spaces for defecation. The weather plays an important role in determining their access to open fields. Insects and dogs are a major cause of trouble, and during the monsoon the

ground becomes marshy. In summers, the drying up of trees and plants results in insufficient cover. This makes the women more vulnerable.

Table 4.1.11.Availability of own Well, Drinking Water, Grocery and Vegetable Shops

		Frequency	Percent
Own well	Yes	9	3.2
	No	269	96.8
	Total	**278**	**100.0**
Access to drinking water from Panchayat	Yes	244	87.8
	No	34	12.2
	Total	**278**	**100.0**
Access of water from Community well	Yes	25	8.99
	No	253	91.01
	Total	**278**	**100.0**
Availability of Grocery and Vegetable shops within one KM of the Village	Yes	63	22.7
	No	215	77.3
	Total	**278**	**100.0**

The study findings show that participants use different sources to access drinking water. 9 (3.2%) participants have their own well.

Majority (87.8%) of the participants use hand pumps provided by Panchayat to avail drinking water.

25 participants (8.99%) avail drinking water from community wells. The hand pumps provided by the Panchayats are unable to cater to all the needs of the villagers. The average ground water level of these villages is 600 to 800 feet. That is why the women in the village face issues in pumping the water. During the summer season, the availability of water is very less and the families struggle to fulfill their basic needs. This in turn, affects their health and hygiene. Carrying water from faraway places is a common trend in these villages. Women and girl children are engaged in this work that affects their health and education.

Majority of participants (77.3%) have no access to grocery and vegetable shop near (within 1 kilometer) their homes. The average distance of these three village Panchayats from the town is 8 kilometers and the villages don't have any public transport system to commute. The villagers normally use their own vehicles (mainly 2 wheelers) and bullock carts to go to town. Many of the villagers walk to the town which is again a big challenge. The roads to these villages are mostly mud road. A lot of trouble is caused to the people during the rainy season.

4.2. KNOWLEDGE OF WOMEN BENEFICIARIES OF BARWANI DISTRICT OF MADHYA PRADESH ON NATIONAL RURAL HEALTH MISSION SERVICES.

Table 4.2.1. Knowledge about NRHM Scheme

		Frequency	Percent
Heard about NRHM	Yes	233	83.8
	No	45	16.2
	Total	**278**	**100.0**
NRHM Started in 2005	Yes	49	17.6
	No	229	82.4
	Total	**278**	**100.0**
Zilla Panchayat started this Scheme	Yes	3	1.1
	No	275	98.9
	Total	**278**	**100.0**

The above table shows that out of 278 participants, 83.8% (233) of participants have heard about National Rural Health Mission. 17.6% of participants don't know the year of commencement of the programme as 2005. 275 participants (98.9%) disagreed that Zilla Panchayat started this programme. Participants were asked about their understanding on who started this programme and majority of them said that the State Government had introduced NRHM.

Table 4.2.1.1. Cross Tabulation of Age, Caste and Knowledge of NRHM

Caste		Age					
		18-25	26-33	34-41	42-49	50-60	Total
Scheduled Caste							
Heard about NRHM	Frq	10	08	08	05	05	36
Yes	%	(28%)	(22%)	(22%)	(14%)	(14%)	(100%)
	Frq	02	03	03	03	03	14
No	%	(14%)	(21.5%)	(21.5%)	(21.5%)	(21.5%)	(100%)
	Frq	12	11	11	08	08	50
Total	%	(24%)	(22%)	(22%)	(16%)	(16%)	(100%)
Scheduled Tribe							
Heard about NRHM	Frq	46	97	31	16	07	197
Yes	%	(23%)	(49%)	(16%)	(8%)	(4%)	(100%)
	Frq	8	11	6	3	3	31
No	%	(26%)	(35%)	(19%)	(10%)	(10%)	(100%)
	Frq	54	108	37	19	10	228
Total	%	(24%)	(47%)	(17%)	(8%)	(4%)	(100%)

The findings of the study show that out of 50 Scheduled Caste participants who have heard about NRHM, majority (10) of them fall under the age group of 18-25 years. In the Scheduled Tribe category, 97

out of 228 participants who have heard about NRHM, belong to the age group of 26-33 years. When discussed about the medium of knowledge, the participants said that the television programmes about NRHM gave them information about this scheme. Having electricity at home is an advantage for many of the participants for getting information about such schemes.

Table 4.2.2. Knowledge about the Objectives of NRHM

		Frequency	Percent
Aim of NRHM to improve Health	Yes	182	65.5
	No	96	34.5
	Total	**278**	**100.0**
NRHM is for rural women	Yes	102	36.7
	No	176	63.3
	Total	**278**	**100.0**

65.5% of the participants opined that the aim of NRHM is to improve health whereas, 34.5% participants responded in the negative. As per the NRHM document published by Ministry of Health and Family Welfare, the primary aim of National Rural Health Mission is to improve health of rural population especially, that of rural women. The findings of the study show that only 36.7% of participants don't know the coverage of the programme. 176 (63.3%) participants were aware that this programme is for the entire rural population.

Table 4.2.3. Knowledge about the Components of NRHM

		Frequency	Percent
Awareness programme on NRHM by ASHA worker is useful	Yes	136	48.9
	No	142	51.1
	Total	**278**	**100.0**
Aware about village health plan	Yes	228	82.0
	No	50	18.0
	Total	**278**	**100.0**
Aware about the Village Health and Sanitation committee at their village	Yes	99	35.6
	No	179	64.4
	Total	**278**	**100.0**
Aware about the role and functions of ASHA worker	Yes	151	54.3
	No	127	45.7
	Total	**278**	**100.0**
Aware about the health day at Anganawadi in every month for immunization	Yes	186	66.9
	No	92	33.1
	Total	**278**	**100.0**
Aware that Generic medicines are available for common sickness at sub centre	Yes	117	42.1
	No	161	57.9
	Total	**278**	**100.0**

The study found that 51.1% (142) of participants disagreed to the usefulness of the awareness programme on NRHM by ASHAs. ASHA is the connecting link between the village population and the rural health systems. 136 (48.9%) participants had the view that ASHA's awareness programme is usefulness to them. The ASHA appointed at these villages are educated up to 8th standard. A study conducted by Sangeeta Kansal, Kumar, S., & Kumar, A. (2012) on ASHA found that there was a noteworthy relationship between the educational qualifications of ASHAs and their work performed in the communities.

The study further shows that the ASHAs who had studied only up to 8th standard did encounter hardships while completing the Village Health Index Registers. Another study conducted by a study team of NRHM in Cuttack, Orissa (2007) on the performance of ASHA in the community found that responsibilities of ASHA is limited to just accompanying the pregnant women for delivery and giving counseling for proper medications and nutrients. The other major responsibilities like creating awareness in the community, health and hygiene classes are not well taken by many ASHAs.

82% of the women beneficiaries know about the village health plan. Under the NRHM guidelines, a village health plan needs to be developed by the Panchayat taking in to account, the health needs of the community. The village health plan will serve as a road map for the Panchayat and the health system to deliver services. The result shows that the Panchayat has implemented the guidelines of the NRHM and the awareness about the same is provided to the villagers.

The study further shows that 64.4% participants are not aware about the Village Health and Sanitation *Samiti* (Committee) at their village. According to National Rural Health Mission guidelines, there should be one Village Health and Sanitation Committee (VHSC) in every

village. VHSC's role is to plan and monitor the activities under NRHM at the village level. VHSCs are prime contributors for the success of NRHM. The VHSCs focus on the functioning and activity centric domain to ensure service delivery of Auxiliary Nursing Midwifes (ANM). The VHSCs ensure stipulated duties of the ANM related to maternal health on Fixed Health Days & service delivery. The results of the study show that the awareness on Village Health and Sanitation Committee is not reached to the entire village population.

There are only 54.3 % (151) of participants who are aware about the role and functions of ASHAs. This may be due to lack of training received by the ASHA to do effective intervention in the community. A study conducted by Deoki (2007) suggested improving the infrastructure related to the training requirements of ASHA.

66.9% (186) of participants are aware about the monthly Health Day at the *Anganwadi* for immunization. According to Sunil, T.S., Rajaram, S., & Zotarelli, Lisa K. (2006) *Anganwadis* played an important role in highlighting the advantages of utilizing the maternal care facilities especially, in the rural regions.

The study results show that 57.9% (161) of participants are not aware that generic medicines are available for common sickness at sub centre. According to NRHM guidelines, the sub centers are required to provide generic medicines to people in need. Many of the participants are not aware about this.

Table 4.2.4. Knowledge about the schemes of Government of Madhya Pradesh under NRHM

		Frequency	Percent
Knowledge about schemes of health promotion under NRHM by Government of Madhya Pradesh	Yes	123	44.2
	No	155	55.8
	Total	**278**	**100.0**
Knowledge about *Vijaya Raje Janani Kalyan Beema Yojana*	Yes	141	50.7
	No	137	49.3
	Total	**278**	**100.0**
Knowledge about *Janani* Express *Yojana*	Yes	158	56.8
	No	120	43.2
	Total	**278**	**100.0**
Knowledge about *Janani Sahyogi Yojana*	Yes	187	67.3
	No	91	32.7
	Total	**278**	**100.0**
Knowledge about *Prasav hetu Parivahan evam Upchar Yojana*	Yes	115	41.4
	No	163	58.6
	Total	**278**	**100.0**
Knowledge about *Bal Shakti Yojana*	Yes	130	46.8
	No	148	53.2
	Total	**278**	**100.0**
Knowledge about *Deendayal* Mobile Hospital Scheme	Yes	70	25.2
	No	208	74.8
	Total	**278**	**100.0**
Knowledge about *Deendayal Anthyodaya Upchar Yojana*	Yes	199	71.6
	No	79	28.4
	Total	**278**	**100.0**
Knowledge about *Janani Suraksha Yojana*	Yes	185	66.5
	No	93	33.5
	Total	**278**	**100.0**

As stated in the table above, the Government of Madhya Pradesh has introduced many innovative programmes under NRHM in the state. The researcher intended to know the level of awareness of women beneficiaries of NRHM in the sampled villages. The results show that only 44.2% (123) are aware about these schemes in general. However, when asked specifically, 50.7% (141) participants said that they know about *Vijaya Raje Janani Kalyan Beema Yojana*. 56.8% (158) participants know about *Janani Express Yojana* and 67.3% (187) participants know about *Janani Sahyogi Yojana.* Less than half (41.4%) of the participants know about *Prasav hetu Parivahan evam Upchar Yojana and* about *Bal Shakti Yojana (*46.8%). A few participants (25.2%) know about *Deen Dayal mobile hospital scheme.* Majority of the participants (71.6%) know about *Deendayal Anthyodaya Upachar Yojana* and 66.5% participants know about *Janani Suraksha Yojana*.

As per the findings of the study, it can be understood that people in these villages do not know all the schemes of the Government under health promotion. Varied opinions were given about different schemes by the participants. It can be seen that comprehensive knowledge about the schemes is not provided to the participants or their families by the Panchayat, ASHA or the other concerned Government departments. There are no academic courses available which focus on these components. Since these schemes have high relevance to the rural population, it is expected from the concerned departments to spread the awareness to the rural population. It was also found during the focus group discussions that even though there are awareness programmes from the health departments and other organizations, people do not show much interest to participate in them. The literacy level of the women again prevents them from accessing many of the information.

4.3. EXTENT OF AVAILABILITY AND ACCESSIBILITY OF NATIONAL RURAL HEALTH MISSION SERVICES TO WOMEN BENEFICIARIES OF BARWANI DISTRICT.

Table 4.3.1. Accessibility of Health Systems and Health Personnel

		Frequency	Percent
Sub Centre is accessible	Yes	136	48.9
	No	142	51.1
	Total	**278**	**100.0**
PHC is reachable from Home	Yes	170	61.2
	No	108	38.8
	Total	**278**	**100.0**
ASHA is from the same Village	Yes	128	46.0
	No	150	54.0
	Total	**278**	**100.0**
Service of Doctor available at PHC	Yes	218	78.4
	No	60	21.6
	Total	**278**	**100.0**
Service of Specialist Doctor	Yes	218	78.4
available at Community Health	No	60	21.6
Centre	**Total**	**278**	**100.0**

The location of the sub centre and primary health centre determines the accessibility and availability of NRHM services. The results of the study show that the response from the participants is mixed in terms of accessibility of Sub centre and Primary health centre. Sub centre is considered as the first meeting point for all the health related needs of the community.

It was found during the study that there are buildings constructed by the Government for sub centre but the same has not opened for

service. No appointments of Auxiliary Nurse and Midwife (ANM) have been made so far. That is the reason why people are depending on other forms of health care in these villages. The condition is different in some villages where they have a sub centre.

The Primary Health Centre (PHC) is the second layer in the three tier system and is accessible to 61.2% of population. The participants said that they were unable to access the services of the PHC as a result of transport and road issues. According to the NRHM guidelines, there should be an ASHA appointed for every 1000 people, who preferably hails from the same village. It was also found that due to less population in some villages, ASHA is appointed for more than one village which becomes a challenge for her in providing prompt services. Majority of the people agreed to the availability of doctors at Primary Health Centre (PHC) and Community Health Centre (CHC).

Table 4.3.2. Visits of ASHA and ANM

		Frequency	**Percent**
ASHA frequently visits homes	Yes	196	70.5
	No	82	29.5
	Total	**278**	**100.0**
ANM is available in the sub centre	Yes	175	62.9
	No	103	37.1
	Total	**278**	**100.0**
ANM frequently visits the village	Yes	110	39.6
	No	168	60.4
	Total	**278**	**100.0**

The results show that ASHA workers' visit to the households is frequent as per majority (70.5%) of participants. Majority (62.9%) opined that the ANM is available in the sub centre. The study also reveals that 60.4% (168) of participants disagreed to the frequent visit of ANM to their villages. When discussed with ANM about this component, she expressed her inability to cover all the villages allotted to her due to distance and lack of transportation facilities. It was also understood that the ANM is not completely aware about the NRHM components.

Table 4.3.3. Perception of women beneficiaries about the availability of care for common and critical illness

		Frequency	**Percent**
Availability of care for common illness like fever, diabetes and hypertension from PHC	Yes	40	14.4
	No	238	85.6
	Total	**278**	**100.0**
Availability of care for critical illness like cancer, epilepsy and mental illness from PHC	Yes	94	33.8
	No	184	66.2
	Total	**278**	**100.0**

When studied about care for common and other critical illness, it was found that majority (85.6%) of participants have disagreed to the care for common illness like fever, diabetes and hypertension from PHC whereas, 66.2% had issues with the medical care provided for Cancer, epilepsy and mental illness from PHC. It was found during the focus group discussions that the population of these villages is not satisfied with the services provided by PHCs. People generally approach the private clinics and hospitals for the care pertaining to critical illness. There are a few private health practitioners in the community which is

accessible to the entire population. People in these villages generally approach these doctors for their health needs.

Table 4.3.4. Perception of women beneficiaries of NRHM about the availability of Laboratory facility, Vaccination, and surgical interventions

		Frequency	Percent
Availability of Laboratory facility at PHC	Yes	164	59.0
	No	114	41.0
	Total	**278**	**100.0**
Availability of Vaccination facility at Sub Centre	Yes	146	52.5
	No	132	47.5
	Total	**278**	**100.0**
Availability of Vaccination facility at PHC	Yes	150	54.0
	No	128	46.0
	Total	**278**	**100.0**
Availability of Vaccination facility at CHC	Yes	138	49.6
	No	140	50.4
	Total	**278**	**100.0**
Vaccination is Free	Yes	132	47.5
	No	146	52.5
	Total	**278**	**100.0**

The study found a mixed response in terms of availability of laboratory facilities and vaccination facilities at various levels. 59% (164) of participants agreed having laboratory facility at PHC. Regarding the availability of vaccination facilities, 52.5% (146) opined that it is available at the Sub Centre where as 54% (150) responded positively to the availability of vaccination facility at PHC and 49.6% (138) at CHC.

The results show a decline in the level of awareness of the participants regarding the availability of vaccination at various levels. This could be due to less exposure to the higher level of health systems by the participants. 52.5% participants disagreed to the free vaccination facilities available. Under NRHM, a clear demarcation is established between the roles and responsibilities of Sub centre, Primary Health centre and Community Health centre. Higher the centre, higher the facilities and services is the norm established by the health standards of the country.

Table 4.3.5. Perception of women beneficiaries of NRHM about the Visit of mobile units, availability of medicines and transportation

		Frequency	Percent
Frequent visit of mobile unit to the village	Agree	114	41.0
	Disagree	164	59.0
	Total	**278**	**100.0**
Accessibility of Ambulance Service	Agree	163	58.6
	Disagree	115	41.4
	Total	**278**	**100.0**
Availability of free medicines from Sub Centre	Agree	143	51.4
	Disagree	135	48.6
	Total	**278**	**100.0**
Availability of free medicines from PHC	Agree	59	21.2
	Disagree	219	78.8
	Total	**278**	**100.0**
Availability of transportation facility from Village to PHC	Agree	92	33.1
	Disagree	186	66.9
	Total	**278**	**100.0**

The above table shows that majority of the participants (59%) had disagreement with the frequent visit of mobile unit to the village. 51.4% agreed that they get free medicines from sub-centre when required. 78.8% participants had disagreement in terms of getting free medicines from PHC. Accessibility to ambulance service was another area where 58.6% participants had agreed upon. 66.9% participants expressed that they have no accessibility of transportation facilities from their village to PHC. The participants opined that they have to depend on the private vehicles and traditional modes of transportation like bullock carts and cycles to reach the PHCs. Few of the villagers walk to the PHCs to fulfill their health needs. Public transport system does not exist in any of the sampled villages.

Table 4.3.6. Perception of women beneficiaries of NRHM about the Health education and preparedness

		Frequency	**Percent**
Receive health education at doorstep	Agree	182	65.5
	Disagree	96	34.5
	Total	**278**	**100.0**
Health education received is useful	Agree	138	49.6
	Disagree	140	50.4
	Total	**278**	**100.0**
Preparedness against communicable illness	Agree	115	41.4
	Disagree	163	58.6
	Total	**278**	**100.0**

The above table describes the perception of women beneficiaries about the health education they receive through the health personnel and their preparedness against communicable diseases. 58.6% (163) of participants have no preparedness against communicable illness in the sampled villages.

Majority of the participants (65.5%) agreed that they are availing health education at their doorstep. Half of them (50.4%) found the health education as useful. NRHM has been introduced with the aim of providing health care services to rural population especially rural women.

The study shows that many of the components mentioned in the NRHM guidelines do not get fulfilled for majority of the participants. The role of ASHA is considered as significant in this regard. When discussed with the ASHA, it was understood that the training she received is not sufficient to undertake all the activities suggested in the NRHM Policy.

The capacity building of ASHA could not be achieved fully. The ASHA workers are expected to be equipped with knowledge of a certain kind and they are also supposed to be assured about their competencies in order to carry out their duties with flourish. The ASHA workers are evaluated on the basis of their work and are given certain incentives if they are successful in conveying the importance of universal immunization and the services related to Reproductive and Child Health (RCH) and other health related topics (NRHM Mission Document). A study conducted by a study team of NRHM in Cuttack, Orissa (2007) regarding the training of ASHA reveals that most of the health workers feel that it was very informative, but still they required regular training and also needed to get updated on most of the issues.

Table 4.3.7. Perception of women beneficiaries of NRHM about the support they receive during delivery

		Frequency	Percent
PHC Provide support to women during delivery	Agree	137	49.3
	Disagree	141	50.7
	Total	**278**	**100.0**
Delivery Facility is available for 24 hours at PHC	Agree	102	36.7
	Disagree	176	63.3
	Total	**278**	**100.0**
Financial Assistance is available for delivered women in Hospitals	Agree	113	40.6
	Disagree	165	59.4
	Total	**278**	**100.0**
ASHA assist in institutional delivery	Agree	154	55.4
	Disagree	124	44.6
	Total	**278**	**100.0**
Pregnant and lactating women receives nutritious food from Anganwadi	Agree	198	71.2
	Disagree	80	28.8
	Total	**278**	**100.0**

From the above table, it is evident that only 49.3% participants agreed that they receive support during delivery. According to 63.3% of participants, delivery facilities are not available throughout the day at PHCs. Majority of the participants (59.4%) disagreed on availing financial assistance for institutional deliveries. 55.4% participants agreed

upon the assistance of ASHA for institutional deliveries. A good number of participants (71.2%) agree having nutritious food at Anganwadi for pregnant and lactating women.

The women during the interview mentioned that they face lot of challenges in availing the cash incentives after delivery. The women in those villages also prefer home deliveries. There has been an increase in the awareness levels of women regarding the institutional delivery mechanisms adopted by the Government. This could be due to the intervention of ASHA in these areas.

4.4. CHALLENGES FACED BY WOMEN BENEFICIARIES OF BARWANI DISTRICT OF MADHYA PRADESH TO ACCESS NATIONAL RURAL HEALTH MISSION SERVICES

Table 4.4.1. Challenges in terms of availability of ASHA and ANM

		Frequency	Percent
ASHA is not approachable	Agree	153	55.0
	Disagree	125	45.0
	Total	**278**	**100.0**
ASHA is not available at Emergencies	Agree	157	56.5
	Disagree	121	43.5
	Total	**278**	**100.0**
ANM is available at Sub Centre	Agree	110	39.6
	Disagree	168	60.4
	Total	**278**	**100.0**

The study findings show that 55% of women face challenges in approaching ASHA. 56.5% (157) of women opinioned that ASHA is not

available during emergencies. Services of ASHA are considered as a 24x7 facility where they are supposed to be available to the health needs of the people. Majority of the participants (60.4%) responded that ANM is not available in the sub centers. The services of the ANM are mainly focused on sub centers and primary health centers. They are also supposed to assist the ASHA in providing awareness to people about the health related aspects. They are also trained health staff who can deal with health needs of people in the emergency. Availing the services of ANM is also found as a challenge for the participants.

Table 4.4.2. Challenges in terms of transportation and roads

		Frequency	**Percent**
Roads are not good which delay to reach PHC and CHC	Agree	213	76.6
	Disagree	65	23.4
	Total	**278**	**100.0**

Lack of proper road facilities is another major challenge shared by 76.6% (213) participants. The lack of proper all whether roads is a hindrance for women to avail NRHM services in an efficient manner. During the rainy season, people face many difficulties to commute. Most of the village roads are constructed of mud and cause hardship for people to travel from one place to another.

Table 4.4.3. Challenges in terms of awareness programmes on health issues

		Frequency	**Percent**
No awareness programme on health issues	Agree	191	68.7
	Disagree	87	31.3
	Total	**278**	**100.0**

Majority of the participants (68.7%) said that there are no programmes for them on health issues. As per the NRHM guidelines, the health personnel along with the local self government are supposed to provide awareness to village people about the health related areas. However, during the study it was found as a major challenge for the participants.

Table 4.4.4. Challenges in terms of family and community support to avail health services

		Frequency	Percent
Family supports to go to hospital for treatment	Agree	195	70.1
	Disagree	83	29.9
	Total	**278**	**100.0**
Community does not allow for hospital deliveries	Agree	180	64.7
	Disagree	98	35.3
	Total	**278**	**100.0**

195 (70.1%) participants had the opinion that their family does not support them to go to hospital for treatment. When asked about the support of community for hospital deliveries, majority (64.7%) responded in the negative. This is clear from the above findings that the family and community customs prevent them from availing health care services.

The participants discussed that the superstitious belief in the community related to treatment and other rituals are followed religiously by the community. In this context, they depend more on religious rituals and natural treatment practices in their community.

Table 4.4.5. Challenges in availing health services

		Frequency	Percent
Government hospitals do not provide good services	Agree	153	55.0
	Disagree	125	45.0
	Total	**278**	**100.0**
Availability of doctors at PHC and CHC	Agree	237	85.3
	Disagree	41	14.7
	Total	**278**	**100.0**
Sufficient medicines are not available at Sub Centre, PHC and CHC	Agree	240	86.3
	Disagree	38	13.7
	Total	**278**	**100.0**
Bribe to the hospital staff for their services	Agree	216	77.7
	Disagree	62	22.3
	Total	**278**	**100.0**

55% of (153) women opined that the Government hospitals do not provide good services. They revealed that the availability of doctors and other staff members, availability of space and beds are few challenges faced by them. 181 participants (65.1%) responded that sufficient beds are not provided in the PHC for patients. The findings of the study also show that there is lack of sufficient medicines in all the three tiers of health systems. 77.7% participants responded that they have to bribe the hospital staff to avail health services.

Table 4.4.6. Perception of Women about the Panchayats initiatives in NRHM

		Frequency	Percent
Panchayat takes initiatives in the improvement of health	Agree	92	33.1
	Disagree	186	66.9
	Total	**278**	**100.0**

Majority of the participants (66.9%) disagreed about the Panchayats taking initiatives in improving health facilities. It is mandatory for Panchayats to form village health plan and village health and sanitation committee in every village Panchayat (NRHM Document). However, the women beneficiaries of 3 village Panchayats feel that the initiatives of the Panchayat in this regard are not sufficient. There are 66.9% participants who expressed no interest in receiving NRHM benefits.

4.5. BENEFITS RECEIVED BY WOMEN BENEFICIARIES OF BARWANI DISTRICT OF MADHYA PRADESH FROM NATIONAL RURAL HEALTH MISSION

Table 4.5.1. Response of Women beneficiaries of NRHM about the incentives received under Janani Suraksha Yojana, assistance by ASHA and Sub Centre Facilities

		Frequency	Percent
Received incentives under Janani Suraksha Yojana	Yes	104	37.4
	No	174	62.6
	Total	**278**	**100.0**
ASHA always assist in need	Yes	169	60.8
	No	109	39.2
	Total	**278**	**100.0**
Sub Centre facilities have been improved after NRHM	Yes	107	38.5
	No	171	61.5
	Total	**278**	**100.0**
Pregnant women in the village are healthy after the intervention by ASHA	Yes	185	66.5
	No	93	33.5
	Total	**278**	**100.0**

The study results show that only 37.4% (104) out 278 participants received the cash incentives under Janani Suraksha Yojana. It is evident that 37.4% participants had their delivery at hospitals. Out of 50 scheduled caste women, 8 who received the incentives falls under the age group of 18-25 years. There were 6 women in the Scheduled Caste

category who belong to the age group of 26-33 years and received the JSY incentives. In the Scheduled Tribe category, 228 women belong to the age group of 26-33 years and 35 of them received benefits. 18 women belonging to the same category received the same benefits which were availed by those who fall under the age group of 18-25 years.

There is no significant association between the age group and caste of people who avail the benefits of this scheme. Majority (60.8 %) of the participants opined about the assistance they received from ASHA. The intervention by ASHA for pregnant women was found to be significant. According to 38.5% of participants, there is no major improvement in the condition of sub centers after NRHM. A study conducted by Kumar et.al (2009) on implementation of NRHM and its utilization by the rural people in the state of Uttar Pradesh, India shows that there is massive improvement in the infrastructure and the facilities provided at the district hospital, CHC and PHC. As per the study, the health services and the utilization of health services by the rural people has gone up during the implementation of NRHM.

Table 4.5.2. Response of Women beneficiaries of NRHM about the health care services received

		Frequency	Percent
Receive free Medication	Yes	104	37.4
	No	174	62.6
	Total	**278**	**100.0**
There is improvements in the existing health services in the last 5 years	Yes	163	58.6
	No	115	41.4
	Total	**278**	**100.0**
Receive Surgical intervention under NRHM	Yes	109	39.2
	No	169	60.8
	Total	**278**	**100.0**
Receive free diagnostic services	Yes	92	33.1
	No	186	66.9
	Total	**278**	**100**
Receive 24x7 health care facilities from NRHM	Yes	76	27.3
	No	202	72.7
	Total	**278**	**100.0**
Children get free immunization at sub centre	Yes	140	50.4
	No	138	49.6
	Total	**278**	**100.0**

The results of the study produced mixed responses from the participants on the above mentioned items. 58.6% (163) participants said that the health facilities did improve in the last five years. It was found that the women beneficiaries had difficulty in availing the benefits of the scheme. Many of the services under NRHM have not been utilized by the women. Huge discrepancy was found while analyzing the data in terms of

the responses given by women regarding certain components of NRHM. That shows lack of adequate understanding of the scheme and its benefits.

Studies conducted in other parts of the country found that there is progress in the service utilization of NRHM facilities by rural women. Kumar et.al (2009) in their study found that the use of OPD services by the rural people increased and the surgeries conducted revealed that the awareness among the rural people has also increased courtesy the NRHM programmes over the years.

Table 4.5.3. Response of Women beneficiaries of NRHM about the benefits received through Anganwadis

		Frequency	**Percent**
Children receive	Yes	183	65.8
nutritious food from	No	95	34.2
Anganwadi	**Total**	**278**	**100.0**

The study found that the services of Anganwadis are effective in the sampled villages. Majority of them responded that their children receive nutritious food from Anganwadis. Anganwadi services are provided to children falling in the age group up to 0-6 years. Women in these villages expressed their willingness to send their children to Anganwadis.

Table 4.5.4. Response of Women beneficiaries about the benefits received through different schemes under NRHM

		Frequency	Percent
Availability of Family Health Card under *Deendayal Antyoday Upachar Yojana*	Yes	75	27.0
	No	203	73.0
	Total	**278**	**100.0**
Covered under *Deendayal* Mobile Hospital Scheme	Yes	129	46.4
	No	149	53.6
	Total	**278**	**100.0**
Membership in *Rogi Kalyan Samiti*	Yes	59	21.2
	No	219	78.8
	Total	**278**	**100.0**
Village has a Health Plan through village Health Committee	Yes	139	50.0
	No	139	50.0
	Total	**278**	**100.0**
Constructed a toilet at home after the intervention of ASHA	Yes	5	1.8
	No	273	98.2
	Total	**278**	**100.0**
ASHA educates regarding the impact of smoking and chewing tobacco	Yes	184	66.2
	No	94	33.8
	Total	**278**	**100.0**

Only 27% participants have family health cards under Deendayal Antyoday Upachar Yojana. This is a major gap identified as 203 (73%) participants have not availed this facility. This scheme was initiated by Government of Madhya Pradesh to render health care services to the people belonging to the Scheduled Castes, the Scheduled Tribes and also to those who live below the poverty line. The scheme provides all the families living below the poverty line with free of charge health services up to the maximum limit of Rs. 20000/- in a financial year in government health institutions. Every BPL family is given a family health card. The card comprises of the household head's photograph along with the information of all the family members. The card can be used to register for medical checkup details as well as for the purpose of hospitalization.

As per the study results, 46.4% participants are covered under Deendayal Mobile Hospital Scheme. The state government initiated the Deendayal Mobile Hospital Scheme featuring mobile health clinics to render health services in the difficult to access tribal regions of Madhya Pradesh. This scheme is introduced to provide the people with free of charge facilities related to medical examination, consultation, treatment and the required medications. Every mobile health unit comprises of a doctor, a nurse and a compounder. The study results shows that majority of the participants (53.6%) are yet to receive the benefits under this scheme.

According to the study results, 21.2% (59) participants are members of Rogi Kalyan Samiti. Under the NRHM, community involvement is given as prime where the local self governing bodies and community members take part in the monitoring of health care programmes. It comprises of representatives of civil society, indigenous

Panchayati Raj Institutions, legislative body among others. This is a positive move in terms of the implementation of NRHM.

Half of the participants agreed that their village has a health plan courtesy the Village Health Committee. Health plan is one of the major components of NRHM where health, nutrition, water, sanitation and hygiene activities are monitored and regulated. Awareness about the village health plan is lacking among many participants.

Only 5 (1.8%) of the participants responded that they constructed a toilet at their home after getting awareness from ASHA. One of the major responsibilities of ASHA is to make people aware about the need to have toilets at their homes. Her intervention in this regard is found to be limited. According to the study team of NRHM in Cuttack, Orissa (2007) the ASHAs have limited their role only to pregnant women, mainly because of the financial gains. They have forgotten their other major responsibilities like creating awareness in the community, health and hygiene classes.

Majority of the participants (66.2%) agreed that ASHAs educate them about the consequences of smoking and chewing tobacco. This finding is really significant in the context of rural areas where majority of them are addicted to tobacco. A study conducted by Bano and Wani (2012) on the life style and environment conditions of rural area and its impact on the health conditions of the rural people found that rural people do not have any significant diseases relating to their environment except may be for skin diseases. They have diabetes, lung and heart diseases like that of urban people. The findings say that diabetes is because of their shifting lifestyle and lung and heart diseases is because of their habit of tobacco use. The study concludes that improvised programmes need to be incorporated in rural areas such as anti tobacco programmes.

4.6. ASSOCIATION OF SOCIO DEMOGRAPHIC VARIABLES ON ACCESSING NATIONAL RURAL HEALTH MISSION SERVICES

Table 4.6.1

Chi-square Table showing association of socio demographic variables and knowledge of NRHM

Variables		Heard about NRHM			
		No (N=45)	Yes (N=233)	χ^2-Value	P-Value
		NO (%)			
Caste	ST	31(69)	197 (85)		
	SC	14(31)	36 (15)	6.27	0.014*
Electricity at Home	No	23(51)	56(24)		
	Yes	22(49)	177(76)	13.59	0.001*
BPL Card	No	8(18)	70(30)		
	Yes	37(82)	163(70)	2.81	0.094 (NS)
Age	18-25	10(22)	56(24)		
	26-33	14(31)	105(45)		
	34-41	9(20)	39(17)	6.65	0.157
	42-49	6(14)	21(9)		(NS)
	50-60	6(13)	12(5)		

χ^2 Test indicated significant association between caste and electricity at home and knowledge about NRHM. Majority of those who have heard about NRHM were Scheduled Tribe (85%) while only 69% of those who have not heard of the Mission were Scheduled Tribe. 31% of those who have not heard of the Mission were SCs. Majority of the people who had heard about NRHM have electricity at home (76%) while more than half of those who have not heard about NRHM do not have electricity (51%) at home. Many of the participants had Below Poverty Line Cards, irrespective of whether they have heard about NRHM or not (70% and 82% respectively). There is no significant association between age, type of family, marital status and knowledge about NRHM.

Table 4.6.2

Mann-Whitney Table showing the difference between the study variables

Variables		Heard about NRHM		P-Value
		No (N=45)	Yes (N=233)	
		Mean ± SD		
Knowledge	No	10.20	3.15	0.006
	Yes	10.02	4.54	
Availability and accessibility	No	20.33	3.90	0.000
	Yes	14.02	5.72	
Challenges	No	12.57	9.38	0.001
	Yes	2.25	2.82	
Benefits	No	11.31	7.89	0.001
	Yes	1.53	3.34	

The mean scores of ‘Knowledge’ of 45 participants who reported that they did not ‘know about NRHM’ were 10.2 (± 3.15). The mean of 233 participants who reported that they ‘know about NRHM’ was 10.02 (± 4.54). The mean difference between the two groups was analyzed by using Mann -Whitney test because the model was imbalanced model. The means on ‘knowledge’, between ‘No’ and ‘Yes’ group was significantly different (Mann-Whitney U=3899.0, P=.006).

The mean scores of ‘Availability and Accessibility’ of 45 participants who reported that they did not ‘know about NRHM’ was 20.33 (± 3.90). The mean of 233 participants who reported that they ‘know about NRHM’ was 14.02((± 5.72). The mean difference between the two groups was analyzed by using Mann -Whitney test. The means on ‘Availability and accessibility’, between ‘No’ and ‘Yes’ group was significantly different (Mann-Whitney U=1696.0, P=>.001).

Similar test was applied to analyze the difference between two groups in terms of ‘Challenges’ and ‘Benefits’. The means on ‘Challenges’, between ‘No’ and ‘Yes’ group was significantly different (Mann-Whitney U=2032.0, P=.001) and the means on ‘Benefits’, between ‘No’ and ‘Yes’ group was significantly different (Mann-Whitney U=1908.5, P=.001).

Table 4.6.3

Table showing correlation between total scores of the variables used in the study:

		Knowledge Total Score	Challenges Total Score	Benefits Total Score	Availability Accessibility Total Score
Knowledge Total Score	Pearson Correlation	1	.246**	.705**	.735**
	Sig. (2-tailed)		.000	.000	.000
	N	278	278	278	278
Challenges Total score	Pearson Correlation	.246**	1	.494**	.386**
	Sig. (2-tailed)	.000		.000	.000
	N	278	278	278	278
Benefits Total Score	Pearson Correlation	.705**	.494**	1	.874**
	Sig. (2-tailed)	.000	.000		.000
	N	278	278	278	278
Availability Accessibility Total Score	Pearson Correlation	.735**	.386**	.874**	1
	Sig. (2-tailed)	.000	.000	.000	
	N	278	278	278	278

**. Correlation is significant at the 0.01 level (2-tailed).

The Correlation between the knowledge scores and challenges scores was significant (r = .246, P>.001). However the magnitude of Pearson r is .246 which implies only 6% ($r^2 = 0.06$) of variation of scores

in ‘Knowledge’ can be explained by scores of challenges. Although the correlation between these variables was significant, it is advisable to be cautious while interpreting the result since the magnitude of ‘r’ is relatively low.

The Correlation between the knowledge scores and benefits scores was significant (r = .705, P>.001). The magnitude of Pearson r is .705 which implies 49% ($r^2 = 0.49$) of variation of scores in ‘Knowledge’ can be explained by scores of benefits. The correlation between these variables was significant since the magnitude of ‘r’ is relatively high.

The Correlation between the knowledge scores and availability and accessibility scores was significant (r = .735, P>.001). The magnitude of Pearson r is .735 which implies 54% ($r^2 = 0.54$) of variation of scores in ‘Knowledge’ can be explained by scores of availability and accessibility. The correlation between these variables was significant since the magnitude of ‘r’ is relatively high.

4.7 FOCUS GROUP DISCUSSIONS

Majority of the women participated in the FGD agreed that there is no proper monitoring mechanisms to ensure effective implementation of the programme at Village level. Lack of awareness regarding the components of NRHM is felt as a challenge for women. Limited knowledge of ASHA results in to her focus only on Institutional Deliveries which gives her some cash incentives. Women agreed having improvements in the conditions of health after the implementation of NRHM. Role of Panchayats in the monitoring of Health Care systems was not satisfactory for many women. They have not experienced any such intervention from Panchayats. The women also discussed their preference to go to the local clinics rather Government Hospital due to the issue of transportation and negligence of Government Hospital Staff. Since they are agricultural

labourers the time spend on travel may prevent them from their earnings. Women were not really keen on constructing toilets at their home. Their awareness regarding the significance of Toilets was found very minimum. According to them water is the main issue in maintaining the Toilets. Anganwadi services are appreciated by women. But the learning happens at the Anganwadi was not aware to many of them. For them Anganwadi provides their children mid day meal and they are happy about that.