CHAPTER 1
INTRODUCTION

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India has a rich century old heritage of medical and health sciences. The philosophy of Ayurveda and the surgical skills enunciated by Charak and Shusharuta way back during 2000 century B.C. to our ancient tradition in the scientific health care of our people. The approach of our ancient medical system was a holistic nature which took into account all aspects of human health and disease. Over the centuries, with the infusion of foreign influences and mingling of cultures, various systems of medicine evolved and have continued to be practiced widely. However, the allopathic system of medicine has in a relatively short period of tune, made a major impact on the entire approach to health care and pattern of development of the health services infrastructure in the country.  

The Constitution of India envisages the establishment of new social order based on equality, freedom, justice and the dignity of the individual. It aims at elimination of poverty, ignorance and ill-health and directs the State with regard to raising the level of nutrition and the standard of living of the people, securing the health and strength of workers, men and women, and especially ensuring that health and strength of workers, men and women and especially ensuring that children given opportunities to develop in a healthy manner. Constitutionally while public health, sanitation, hospitals and dispensaries are the responsibilities of the States, population control and family planning, and maternity services are concurrent subject in the Seventh Schedule of the Constitution.
Health: Concepts and Significance

It is a recognized fact from the times immemorial that good health is a prerequisite to human productivity and the development process. It is essential to economic and technological development. A healthy community is the infrastructure upon which to build an economically viable society. The progress of society greatly depends on the utility of its people. Unhealthy people can hardly be expected to make any valid contribution towards developmental programmes. Health is man's greatest possession, for it laid a solid foundation for his happiness. Charaka, the renowned Ayurvedic physician is known to have said: "Health is vital for ethical, material and spiritual development of man".  

The Planning Commission has stressed the vital importance of public health in the enrichment of community life. It has been stated, "Health is fundamental to the national progress in any sphere. In terms of resources for economic development, nothing can be considered of higher importance than the health of the people which is a measure of their energy and capacity as well as of the potential man-hours for productive work in relation to the total number of persons maintained by the nation. For the efficiency of industry and of agriculture, the health of the worker is an essential consideration."  

There can be no two opinions that health is basic to national progress. As such good health must be a primary objective of national development programmes. It is precursor to improving the quality of life for a major portion of mankind.

Health is viewed differently by different people all over the world. The World Health Organization defined health as "a state
of complete physical, mental and social well-being and not merely an absence of disease or infirmity.\(^5\)

Thus, good health is a synthesis of physical, mental and social well-being. As stated in the First Five Year Plan, “Health is a positive state of well-being in which harmonious development of mental and physical capacities of the individuals lead to the enjoyment of rich and full life. It implies adjustment of the individual to his total environment—physical and social.”\(^6\)

Some people even define it as a condition under which an individual is able to mobilize all his resources—intellectual, emotional and physical for optimum living. Thus health is not static; on the contrary, it fluctuates on a scale which ranges between optimum health as defined by WHO to complete lack of health.

**Health Profile of Haryana State**

Haryana State was carved out of the erstwhile state of Punjab on 1st November, 1966. Haryana is one of the smallest states of union of India in area. Haryana state has made rapid progress and is placed second among the states in agriculture; the state is exporting food grains to other States. It has also made rapid progress in all other field like agriculture, irrigation, electricity production and distribution, roads and transport, industrial production, education, health etc. Major infectious disease such as poliomyelitis, leprosy and blindness are steadily being defeated. The 21st century offers a bright vision of better health for all. It holds the prospect not merely of longer life, but superior quality of life with less disability and disease. The war against ill-health in the 21st century will have to be fought simultaneously on two main fronts: infectious diseases and
chronic non-communicable disease. The State comes under greater attack from both as heart disease, cancer and diabetes and other lifestyle conditions become more prevalent, while infectious illnesses remain undefeated. Of this latter group, HIV/AIDS continue to be the deadliest menace.\(^7\)

Today, girls and women are still denied the same rights and privileges as their brothers, at home, at work, in the classroom or the clinic. They suffer more from poverty, low social status and the many hazards associated with their reproductive role. As a result, they bear an unfair burden of disadvantage and suffering, often throughout their lives. The health of the parents, particularly the mother before and during pregnancy and the services available to her throughout of the health status of their children, Infants, whose health status is compromised at birth are more vulnerable to various health problems later in life as an integral part of the Community Development Programmer on October 2, 1952. Each Primary Health Centre Complex consisted the main center with 6 beds located at the Block Head quarters, and 4 sub-centers. The staff consisted of 1 Medical Officer, 1 Sanitary Inspector, 4 midwives (ANMs) and 2 Ancillary personnel. The Centre was to be supported by district organization for referral consultation, laboratory, medical, surgical, nursing and administrative services.\(^8\)

Subsequently, over the past forty-five years, the health services organization and infrastructure have undergone extensive changes and extension in stages following review by a number of Expert Committees, namely the Mudaliar Committee (1962), Chadha Committee (1963), Mukherjee Committee (1961), Jungawala Committee (1967), Kartar Singh Committee (1973),
and Srivastava Committee (1975). Progressive changes have been introduced into the programme over the sixth and seventh five year plan. The emphasis is mainly on consolidation of the existing health infrastructure rather than expansion. The thrust is given to qualitative improvement in the health services through strengthening of physical facilities like provision of essential equipment, supply of essential drugs and consumables, construction of building and staff quarters, filling up of vacant posts of medical and paramedical staff and in-service training of staff. However, all these committees and commission brought some changes in the health institutions but could not improve the health services in Haryana.\textsuperscript{9}

Therefore, giving impetus on the health front, the National Rural Health Mission (NRHM) was launched on 12th April 2005 to provide accessible, affordable and accountable quality health services even to the poorest households in the remotest rural regions by year 2012. The difficult areas with unsatisfactory health indicators were classified as special focus states to ensure greatest attention where needed. The thrust of the mission was on establishing a fully functional, community-owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health like water, sanitation, education, nutrition, social and gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes, measured against Indian public health standards for all health facilities. From narrowly defined schemes, the NRHM was shifting the focus to a functional health system at all levels, from
the village to the district. The NRHM being a comprehensive step encompasses within it various schemes having different objectives within universal objective of improving mass health. Its important schemes include Reproductive & Child Health Programme-II, National Malaria Programme, National Vector Borne Disease Control Programme (NVBDCP), National Filaria Control Programme, National Leprosy Eradication Programme, Revised National TB Control Programme, National Programme for Control of Blindness, National Iodine Deficiency Disorders Control Programme, National Kala-Azar Programme. These programmes would operate as sub components of the NRHM, retaining the independent sub budget lines wherever felt required.

**Objectives of the Eleventh Five Year Plan through NRHM**

The Eleventh Five Year Plan had set time bound measurable goals and some process objectives. The Measurable Outcomes specified were:

- Reducing MMR to 1 per 1000 live births (100 per 100,000 live births).
- Reducing IMR to 30 per 1000 live births.
- Reducing TFR to 2.1.
- Providing clean drinking water for all by 2009.
- Reducing malnutrition among children of age group 0 to 3 to half of its present level.
- Reducing anemia among women and girls by 50 per cent.
- Raising the sex ratio for age group 0 to 6 to 935 by 2011-12 and 950 by 2016-17.
NRHM: Strengthening Health System

Reproductive, Maternal, Newborn, Child Health and Adolescent (RMNCH+A) Services All schemes and programmes that constituted RCH-II would be absorbed into the NHM. The NHM provides an opportunity to build on past work and renew the emphasis on strategies for improving maternal and child health through a continuum of care and the life cycle approach. The inextricable linkages between adolescent health, family planning, maternal health and child survival have been recognized. There is additional focus on adolescence as a distinct life stage and the strategy is to increase knowledge and access to reproductive health services and information for adolescents and to address nutritional anaemia. Another dimension of the continuum of care which will receive attention is the linking of community and facility-based care and strengthening referrals between various levels of health care system to create a continuous care pathway. All these aspects are embodied in the ‘Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in India. The main strategies for RMNCH+A include services for mothers, newborns, children, adolescents and women and men in the reproductive age group.

Maternal Health: Key strategies include improved access to skilled obstetric care through facility development, increased coverage and quality of ante-natal and post natal care, increased access to skilled birth attendance, institutional delivery; basic and comprehensive emergency obstetric care through strengthening of carefully prioritized health care facilities. This will be done through mapping and identifying health facilities as ‘delivery points’ and strengthening them for delivery of
comprehensive package of RMNCH+A services. The purpose is to ensure universal access to all populations in a district. Wherever is required, private providers would also be contracted to supplement services through public health facilities. Multi-skilling medical officers with specialist skills will be needed to provide emergency obstetric care. The Janani Suraksha Yojana (JSY) which enables institutional delivery will be modified in the NHM period to synergize with the new Food Security legislation. Another key goal is to move towards UHC through an expanding comprehensive package of free and cashless services currently covering all pregnant women, and sick infants up to the age of one year, in government health institutions through Janani Shishu Suraksha Karyakram (JSSK), thereby reducing financial barriers to care and improving access to health services by eliminating OOP expenditure in all government facilities. In addition strengthened emergency response and patient transport systems for improving access to institutional care, including assured availability of referral and transport services with respect to inter facility transfers and out referrals will be supported. Improved monitoring of care in pregnancy will be enabled by mother and child name based information systems, and facility and community based MDRs will be emphasized. Comprehensive women’s health including pregnancy related morbidity, care for non-communicable diseases among women including screening and treatment of women for common cancers such as cervix and breast would be emphasized.

**Access to safe abortion services:** The focus would be to improve access to comprehensive abortion care, including post abortion contraceptive counseling and services, by expanding the
network of facilities providing MTP services. MTP services would be provided at least in every 24*7 facility in every block and in every facility upgraded for FRU services (also Level 3 services). Multi-skilling of providers will include use of Manual Vacuum Aspiration (MVA) and medical abortion.

**Prevention and Management of Reproductive Tract Infections (RTI) and Sexually Transmitted Infections (STI):** Key strategies include: prevention of RTI/STI to be included in BCC interventions for community health education and as part of adolescent health education, provision of diagnosis and treatment services at health facilities, syndromic management at 24*7 and lower levels, and laboratory and diagnostic based services at Level 3 facilities. Special focus would be given on linking up with Integrated Counseling and Treatment Centers (ICTCs) and establishing appropriate referrals for HIV testing and RTI/STI management.

**Gender Based Violence:** The consequences of gender based violence against women include physical injuries, reproductive health problems, and mental health. Because women are most often seen for the provision of reproductive and child health services, this is a starting point to identify women who are at risk for or who are subject to domestic violence. The steps towards enabling a system wide response to gender based violence (GBV) include: sensitize and train frontline workers and clinical service providers to identify and manage GBV, train ASHAs to identify and refer/counsel cases of GBV in the community, develop effective referral mechanisms from primary care to secondary and tertiary centers, with assured services, build functional referral linkages and create follow up mechanisms with government
departments and NGOs providing legal and social welfare services and women’s support groups in the district.

**Newborn and Child Health:** This will be through a continuum of care from the community to facility level and include the provision of home based newborn and child care through ASHAs and ANMs, supplemented by AWW, and community level care for acute respiratory infections, diarrhea, and fevers, including home remedies, first contact curative care, or referral as appropriate. Essential newborn care and resuscitation at all delivery points through establishment of Newborn Care Corners and skilled personnel will be ensured. Facility Based Care for sick newborns will be provided through the establishment of Newborn Stabilization Units and Special Newborn Care Units. This includes strengthening public health facilities and accrediting private providers to manage referrals. Institutional care for sick children and provision for management of children with Severe Acute Malnourished (SAM) at Nutrition Rehabilitation Centers (NRC) will be linked to community based care for SAM. Infant and Young Child Feeding (IYCF) and nutrition counseling to support early and exclusive breastfeeding, complementary feeding, micronutrient supplementation and convergent action will be also encouraged through platforms like VHSNC, VHNDs etc. Reporting and reviewing of child deaths (under five years) is another area of attention.

**Universal Immunization:** Sustaining Pulse polio campaigns and achieving over 80 per cent routine immunization in all districts will be emphasized. Introduction of new and underutilized vaccines will be considered on the basis of recommendations of the National Technical Advisory Group on
Immunization (NTAGI). Improved cold chain management would be ensured with adequate densities of Ice Lined Refrigerators (ILRs) and deep freezers. Adequate number of vaccination sessions and sites, and logistics arrangements to reach all such sites especially in remote areas will be a key area of intervention. Surveillance of vaccine preventable diseases would be integrated with IDSP and name based monitoring of children done through the MCTS system.

**Child Health Screening and Early Intervention Services:**
The purpose is to improve the overall quality of life of children 0-18 years through early detection of birth defects, diseases, deficiencies, development delays including disability and provide comprehensive care at appropriate levels of health facilities. These services are delivered through the Rashtriya Bal Swasthya Karyakram (RBSK). RBSK covers at least 30 identified health conditions for early detection, free treatment and management through dedicated mobile health teams placed in every block in the country. District Early Intervention Centers (DEIC) has been set up to provide further screening and management support to children detected with health conditions and make appropriate referrals. The mechanism to reach all the target groups of children for health screening would be through enabling facility based newborn screening at public health facilities, by existing health manpower, and community based newborn screening at home through ASHAs during home visits. Children six weeks to six years would be screened periodically by dedicated Mobile Health Teams at the Anganwadi Center. Further, in Government and Government aided schools children six years to 18 years would be screened. This intervention would not only halt
deterioration of the condition but also reduce the OOP expenditure among the poor and the marginalized. Additionally, the Child Health Screening and Early Intervention Services also provide country-wide epidemiological data on the 4 Ds (i.e., Defects at birth, Diseases, Deficiencies, Developmental Delays and Disabilities). This is important to inform planning in the future, for area specific services. Public health institutions, private sector partnerships and partnerships with NGOs have been encouraged to provide specialized diagnostics/tests and services and to fill gaps in services. Such institutions would be reimbursed for services as per agreed costs of tests or treatment. In addition to the direct provision of such services, the state would enable convergence with ongoing schemes of other relevant ministries. Patient transport network supported under NHM is used to transport sick children to higher facilities.

**Adolescent Health:** Adolescent Health programmes include the following priority interventions: Iron and Folic Acid (IFA) supplementation, facility-based adolescent health services, community-based health promotion activities, information and counseling on sexual and reproductive health (including menstrual hygiene), substance abuse, mental health, non-communicable diseases, injuries and violence including domestic violence. These interventions have been operationalized through various platforms including Adolescent Friendly Health Clinics (AFHC), VHNDs, Schools, Anganwadi Centers and Nehru Yuva Kendra Sangathan (NYKS), Teen Clubs and a dedicated Adolescent Health Day. Outreach activities aimed at information provision and health promotion would be through Peer educators and mentors. Provision of nutrition counseling, treatment for
RTIs/STIs, appropriate referrals and commodities such as IFA tablets, condoms, Oral Contraceptive Pills (OCPs) and pregnancy kits for all adolescent girls and boys at the AFHCs. Information and counseling would be provided by dedicated and trained counselors. There would be enhanced focus on vulnerable and marginalized sub-groups. Menstrual hygiene practices would be promoted in rural areas through use of sanitary napkins. This is to be combined with building adequate knowledge and information about the product through ASHAs. Provision of Weekly Iron and Folic acid Supplementation (WIFS) for addressing nutritional anemia among adolescent boys and girls in rural and urban areas would be part of the National Iron Plus Initiative. The scheme also includes nutrition and health education sessions, screening of target groups for moderate/severe anaemia and referring these cases to an appropriate health facility. There would be provision for biannual de-worming (Albendazole 400mg), six months apart, for control of helminth infestation, information and counseling for improving dietary intake and preventing intestinal worm infestation.

**Family Planning:** Meeting unmet needs for contraception through provisioning of a range of family planning methods has been prioritized. A differential approach between the high fertility states and the rest has been followed. In high fertility states the aim is to reduce fertility to replacement levels and states which have achieved replacement levels will sustain it. Family planning services has been utilized as a key strategy to reduce maternal and child morbidities and mortalities in addition to stabilizing population. Post-partum and post abortion
contraception would be a priority. All states have been encouraged to focus on promotion of spacing methods, especially Intra-Uterine Contraceptive Devices (IUCDs). Postpartum IUCD has been emphasized as a key spacing method to leverage the increase in institutional deliveries while ensuring appropriate counseling and quality of services. In addition to existing providers, AYUSH doctors have been trained for IUCD services. Male involvement including male sterilization would be promoted. Distribution of contraceptives at the doorstep through ASHAs and other channels has been actively promoted. Improved family planning service delivery including access, availability and quality of services; counseling services through dedicated counselors; improved technical competence of the providers and increased awareness among the beneficiaries would be ensured. Month-long national campaigns on the eve of World Population Day would be continued every year in all states/ districts across the country. The compensation scheme for sterilization acceptors to cover loss of wages to the beneficiary and also to the service provider (and team) for conducting sterilizations would be continued. The clients have been insured in the eventuality of deaths, complications and failures following sterilization and the providers/ accredited institutions would be indemnified against litigations in those eventualities under the National Family Planning Indemnity Scheme (NFPIS). The State Quality Assurance Cell would be responsible for management of claims under the NFPIS scheme. Additional strategies to be adopted in the high fertility states are: the promotion of healthy spacing after marriage and between the births by engaging ASHAs as the motivator and counselor for the community; intensification of
skill building strategies for family planning providers; involvement of private providers as appropriate to increase the use of spacing and limiting methods; substantial expansion in facilities and providers offering the full range of contraceptive services; and BCC activities that focuses on improving access and reducing unmet need.

**Addressing the Declining Sex Ratio** : Improving the adverse child sex ratio has been crucial and strategies that lie within the domain of health include: Stricter enforcement of the PCPNDT Act, improved monitoring and sensitization of the medical community, and a greater role for civil society action in addressing son preference, addressing neglect of the girl child in illness care, observing sex ratios in hospital admissions for illness in children, and providing proactive support for girl children through the ASHA and Anganwadi system.11

**NUHM (National Urban Health Mission)**

The Union Cabinet vide its decision dated 1st May 2013 has approved the launch of National Urban Health Mission (NUHM) as a Sub-mission of an over-arching National Health Mission (NHM), with National Rural Health Mission (NRHM) being the other Sub-mission of National Health Mission. Outcomes for NHM in the 12th Plan are:

1. Reduce MMR to 1/1000 live births.
2. Reduce IMR to 25/1000 live births.
3. Reduce TFR to 2.1.
4. Prevention and reduction of anaemia in women aged 15–49 years.
5. Prevent and reduce mortality & morbidity from communicable, noncommunicable; injuries and emerging diseases.

6. Reduce household out-of-pocket expenditure on total health care expenditure.

7. Reduce annual incidence and mortality from Tuberculosis by half.

8. Reduce prevalence of Leprosy.

To eradicate these problems, NHM has six financing components: (i) NRHM-RCH Flexipool, (ii) NUHM Flexipool, (iii) Flexible pool for Communicable disease, (iv) Flexible pool for Non communicable disease including Injury and Trauma, (v) Infrastructure Maintenance and (vi) Family Welfare Central Sector component.12

National Urban Health Mission (NUHM): NUHM seeks to improve the health status of the urban population particularly slum dwellers and other vulnerable sections by facilitating their access to quality primary health care. NUHM has covered all state capitals, district headquarters and other cities/towns with a population of 50,000 and above (as per census 2011) in a phased manner. Cities and towns with population below 50,000 has been covered under NRHM.13

The existing health care service delivery mechanism is mostly focused on reproductive and child health services, while the recent outbreaks of Dengue and Chikungunya in urban areas and the poor health status of urban poor clearly articulate the need for a broad based public health programme focused on the urban poor. It stresses upon the need to effectively infuse public health focus along with curative services. The urban health
programmes in Surat and Ahmedabad have been able to effectively integrate the two aspects. There is also need to integrate the implementation of the national programmes like National Vector Borne Disease Control Programme (NVBDCP), Revised National Tuberculosis Control Programme (RNTCP), Integrated Disease Surveillance Project (IDSP), National Leprosy Elimination Programme (NLEP), National Mental Health Programme (NMHP), National Deafness Control Programme (NDCP), National Tobacco Control Programme (NTCP) and other Communicable and Non communicable diseases for providing an effective urban health platform for the urban poor. The urban poor suffer an equally high burden of ‘life style” associated diseases due to high intake of tobacco (both smoking and chewing) and alcohol. The limited income coupled with very high out-of-pocket expenditure on substance abuse creates a vicious cycle of poverty and disease. There is also the added burden of domestic violence and stress. Studies also indicate the need for early detection of hypertension in the urban poor, as it is a common cause of stroke and other cardio- neurological disorders.¹⁴

Hence, the National Health Mission (NHM) encompassing two Sub-Missions, National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM), it is both flexible and dynamic and is intended to guide States towards ensuring the achievement of universal access to health care through strengthening of health systems, institutions and capabilities in accordance with the vision of the NHM “Attainment of Universal Access to Equitable, Affordable and Quality health care services, accountable and responsive to people’s needs, with effective
inter-sectoral convergent action to address the wider social determinants of health.” It brought the new hope among rural, BPL and urban slum people of the country. As far as women and neo natal is concerned, NRHM has been providing them quality of life through Janani Surkasha Yojana, Janani Sisu Suraksha Yojana and Janani Suvidha Yojana.15

**Concept of Janani Suvidha Yojana**

Government of India has a policy commitment to ensure that every pregnant woman gets delivery by a skilled birth attendant. In order to achieve this target, JSY was launched to promote demand of institutional delivery. We have been able to bring about 72 percent of the women into the institutional fold. However, still about 28 percent of pregnant women are delivering at home and those who deliver at the institutions are not willing to stay for more than 48 hrs. This is because of various reasons including high expenses incurred by pregnant women and their families for normal or cesarean section delivery. This becomes a deterrent for the family particularly the poor of urban slums and BPL in accessing and coming to health facilities, depriving them from the essential and emergency care during pregnancy and child birth and also in the post partum period.16 Before elaborating and analyzing more about JSY, it is necessary to discuss about institutional delivery. Institutional delivery is meant to avoid home births or delivery through ‘Dai’, in other words, it means giving birth to a child in a medical institution under the overall supervision of trained and competent health personnel where there are more amenities available to handle the situation and save the life of the mother and the child.17

In fact, Janani Suvidha Yojna aims at making quality Antenatal, Natal and postnatal services easily accessible to poor
in the urban slums of Haryana with its definite objectives of making to improve quality of health of mother and child, to provide good quality contraceptives, vaccines and other supplies to the urban poor, to provide good quality and low cost diagnostic services to the pregnant mothers in urban slums, to optimally utilize the existing resources in health and improving the technical quality of maternal and child health services. For the attainment of these objectives of JSY, institutional arrangement has been provided.\textsuperscript{18}

**Significance of Janani Suvidha Yojana in Urban Slum**

Rapid urbanization is an accepted phenomenon and Haryana is also witnessing the same. Not only are people migrating from rural areas of the state to urban areas within the state but people from other states are also settling in the urban areas of the State in growing numbers. Many of these new residents settle in urban slums resulting in their mushrooming growth. It is understood that the health status of urban poor is worse than that of those living in rural areas. The urban poor have poor health seeking practices and resort to medical treatment only when faced with loss of wages due to illness. The concepts of preventive and primitive healthcare are weak in their minds. Furthermore, the opportunity cost and loss of wages associated with long waiting times at government run hospitals, dissuades them from proactively seeking medical care. Many urban poor land up at the doorsteps of quacks and pay out of pocket for poor quality medical care resulting most often in further complications which then land in government hospitals for treatment. This is very well reflected in the socio-demographic data especially MMR. As per NFHS II data, the MMR for Haryana is 540. The institutional
delivery rate of Haryana is only 23 which are even lower than the all India figures (33) and our neighboring State of Punjab (37). In order to reduce MMR and IMR, Government of Haryana has already initiated the following schemes for rural and BPL families namely, Provision of Free of Cost Institutional Deliveries; Establishment of Delivery Huts; Janani Suraksha Yojana and Vikalap.

However, all the above schemes cater to the needs of rural poor, leaving aside a large portion of urban poor especially the slum dwellers. The available Public Health infrastructure also provides both primary and secondary health services mostly to the rural people. For urban population, the Health Department has medical services available at the District Hospitals only. These district hospitals often are not able to offer adequate outreach services [post partum centers attached with hospitals and the MCH centers], and are meant mainly for secondary level medical care. On the other hand, there is considerable presence of Private Health care Providers (PHPs) in the urban areas of the State.

The state of Haryana has 17.5 lakh people living in the urban slums, which amounts to almost 30 per cent of the urban population. In light of this ground reality, the State Government does not plan to set-up a new infrastructure for RCH services in urban areas but would harness the available private infrastructure through Janani Suvidha Yojna involving the existing private health providers with the objective of improving the accessibility of good quality Antenatal, Natal and Postnatal services to pregnant mothers of urban slums. The scheme has been started in eight districts namely Panchkula, Yamunanagar, Kurukshestra,
Sonepat, Gurgaon, Rewari, Mahendergarh (Narnaul) and Bhiwani of the State.

**Janani Suvidha Yojana (JSY) and Non Government Organizations**

JSY has introduced in urban slum of Haryana. It covers eight district of the state i.e., Panchkula, Kurukshetra, Yamunanager, Sonepat, Bhiwani, Gurgaon, Mahendergarh and Rewari. It is committed to provide Pre-Natal, Ante-Natal and Post-Natal care to the registered women under JSY. The implementation agency for this scheme is the District NGOs working in the respective districts. The Department of Health, Haryana is already working with NGOs for various RCH II and AIDS activities. The State NGO Coordinator ensures the capacities of NGOs in implementing the scheme. The roles and responsibilities of various Stakeholders proposed in the scheme.\(^{21}\)

**Participation of NGOs and Civil Society in Health**

The private sector has immense potential to contribute to the achievement of public health goals, and has a significant source of additional capacity for a range of functions where there are critical gaps, through clearly articulated deliverables and well designed monitoring mechanisms. IPHS norms have been adhered to while contracting for services with the private not for profit or for profit sector. NHM has encouraged the public sector to contract-in or outsource those services which improve efficiency and quality of care in the public hospital. These services include the provision of diet, of emergency transport services, of housekeeping services, and diagnostic services. In cases where the skill sets required are non-clinical but specialized, and high quality cannot be assured because the public health workforce is
largely clinical; outsourcing has significant advantages. There are also instances where specialized clinical services can be outsourced. For example, common blood tests may be provided locally at the public health institutions but biopsies or more technically demanding blood tests can be best done where there is specific expertise and specialization. Similarly, the provision of ambulance services based on a call center which meet standards of immediacy and quality are a specialized skill, and could be outsourced. Purchase of specific secondary or tertiary care services should be limited to such services which are part of the “assured services” for that level of care, and ought to be available in the district / public health facility, but are not for a range of reasons. This decision to purchase care can be taken based on local needs by the RKS/DHS. Thus for example, a district hospital that is unable to provide C-section services may refer the patients to a nearby non-governmental or private sector institution and undertake to pay for those services on a pre fixed rate. The government institution will monitor the service to ensure quality. The private sector engagement is clearly supplemental to the public sector, and can be from within and outside the district. The cost of transport would be included, provided that the said service was included on the assured services list. Purchase of those services which are needed in large numbers and where the demand exceeds public provider capacity could also be considered. For example, cataract surgery, or sterilization services in a district could be purchased. It could also apply where the load of a particular service is high and where quality cannot be assured beyond a certain number of cases, viz: the load exceeds the quantity ceiling required for
quality care e.g. where number of C-sections exceeds the capacity of a single gynecologist in a district hospital. Where services are contracted in, these will be governed by well designed contracts, which should include a set of measurable outcomes, quality control measures, careful monitoring, and appropriate budgets. Preference would be given to competent not for profit agencies. Contracting out of services which require specialists or medical doctors would be considered in case they are not available or adequate within the public health system. Contracting in of a private care facility in case there is no public health facility, can also be considered. For e.g., in urban agglomerations with large low income populations seeking publicly financed care. Contracting out of those tasks where internal capacity is already saturated, or which are not prioritized, such as training of VHSNC/MAS members or even ASHAs, to NGOs could be considered. A key function of NGO support would not only be to involve them as additional technical capacity to supplement government efforts in capacity building and support for community processes – mainly for the VHSNC/MAS and the ASHA programme, but also to encourage public participation in Rogi Kalyan Samiti and district/city planning. NGOs would be supported to mobilize additional technical capacity from a national canvas, where intra-district management capacity and training capacity is overwhelmed by existing requirements in districts with limited capacity. Community based monitoring would be continued into the Twelfth Plan and scaled up. However, this must be closely linked to local health planning and facilitation of service delivery and efforts must be made to bring community and service providers
closer to develop mutual trust and support. Community monitoring could be further expanded into areas such as improving data quality in HMIS and MCTS, measuring availability of drugs, monitoring support to JSSK and RBSK, and cashless Public-Private Partnership (PPP) arrangements. NGO involvement in NHM will be through the states, with the center playing a facilitatory role through a resource cell at the national level in NHSRC. NGO involvement would inter alia include areas such as community monitoring, the monitoring of Pre-Conception Prenatal Diagnostic Techniques (PCPNDT) Act implementation, assessing health impact of development programmes, monitoring of Food and Drug adulteration (consumer education and assistance to inspection roles), ensuring implementation of the Infant Milk Substitutes Act, Promotion of Rational Drug Use, amongst the public and professionals, where they have the necessary expertise.22

Non Government organizations

NGOs are the life blood of democracy. Their programme covers a wide range of factions of human welfare. The programmes of voluntary organization includes project to improve nutrition, food production and child and development.

Non Government Organization has a long history of active involvement in the promotion of human welfare and well being. Our literature is replete with examples, where the tendency to help a poor, weak, sick, disabled, helpless, hungry and thirsty from ancient times. This tendency of helping others or doing good to others by an individual or a group of benevolent people has been considered a service to the God and a path to moksha. Religion and charity always co-existed in our set up. NGOs came
in existence spontaneously, voluntarily and without any compulsion or control to fulfill the particular needs of some groups of people. These agencies are flexible and possess the virtues of human service with dedication. Voluntary action is the soul of democracy as their medium secures the active involvement of the people from policy making to implementation of social service.\textsuperscript{23}

NGOs are voluntary organizations (VOs). These are popularly known as NGOs because they are free from governmental control in their functioning. They are democratic and open to all those wishing to become member of the organization voluntarily and serve the society. NGO may be defined as “An organization that is administered by an autonomous board which handle meeting collects funds for its support, chiefly from private source, and express money, whether with or without paid workers, in conducting a programme.”\textsuperscript{24}

The number of NGOs in the United States of America has been estimated at 1.5 million. Russia has 277,000 NGOs and India is estimated to have around 2 million NGOs. It means India has one NGO per 600 people. India has a long history of civil society based on the concepts of \textit{daana} (giving) and \textit{seva} (service). They originated in the form of Voluntary organizations. Voluntary organizations are those organizations, which voluntary in spirit and without profit-making works, they active in cultural promotion, education, health, and natural disaster relief as early as the medieval era. They proliferated during British rule, working to improve social welfare and literacy and pursuing relief projects.\textsuperscript{25} During the second half of the 19th century, nationalist consciousness spread across India and self-help
emerged as the primary focus of sociopolitical movements. Numerous organizations were established during this period, including the Friend-in-Need Society (1858), Prathana Samaj (1864), Satya Shodhak Samaj (1873), Arya Samaj (1875), the National Council for Women in India (1875), and the Indian National Conference (1887). The Societies Registration Act (SRA) was approved in 1860 to confirm the legal status of the growing body of Non-Government Organizations (NGOs). The SRA continues to be relevant legislation for NGOs in India, although most state governments have enacted amendments to the original version. Christian missionaries active in India at this time directed their efforts toward reducing poverty and constructing hospitals, schools, roads, and other infrastructure. Meanwhile, NGOs focused their efforts on education, health, relief, and social welfare. A firm foundation for secular voluntary action in India was not laid until the Servant of India, a secular NGO, was established in 1905.\textsuperscript{26}

Mahatma Gandhi’s return to India in 1916 shifted the focus of development activities to economic self-sufficiency. His Swadeshi Movement, which advocated economic self-sufficiency through small-scale local production, swept through the country. Gandhi identified the root of India’s problem as the poverty of the rural masses and held that the only way to bring the nation to prosperity was to develop the villages’ self-reliance based on locally available resources. He also believed that voluntary action, decentralized to \textit{gram panchayats} (village councils), was the ideal way to stimulate India’s development. Gandhi reinvigorated civil society in India by stressing that political freedom must be accompanied by social responsibility.\textsuperscript{27}
After independence, the Government of India increased its presence in social welfare and development but recognized the potential for civil society to supplement and complement its efforts. The first Five-Year Plan stated, “Any plan for social and economic regeneration should take into account the services rendered by these agencies and the state should give them maximum cooperation in strengthening their efforts.”

The Central Social Welfare Board was established in 1953 to promote social welfare activities and support people’s participation programs through NGOs. This additional funding and recognition led to a growing body of professional NGOs. The Government of India decentralized development activities throughout the 1950s. The establishment of the National Community Development Program and the National Extension Service were early steps in this direction. Further decentralization was achieved with the introduction of the three-tier Panchayati Raj system in 1958. Many farmers unions and agricultural cooperatives were founded around this time, and networking became more commonplace in civil society. In 1958, the Association for Voluntary Agencies for Rural Development (AVARD) was founded as a consortium of major voluntary agencies.

International NGOs entered India in significant numbers to provide drought relief during two consecutive agricultural seasons, 1965–1966 and 1966–1967. Many of them established permanent local operations thereafter. Moreover, foreign funds began flowing to domestic NGOs in India, changing the character of civil society once more.

During the 1970s, the government pursued a “Minimum Needs” program, focusing on the basic impediments to improving
the quality of life for the rural poor, such as education, electrical power, and health. Several governmental development agencies were established around this time, such as the People’s Action for Development of India. Foreign-trained Indians entered civil society in greater numbers, leading to a professionalization of the sector. India witnessed a rapid increase in and diversification of the NGO sector as a response to the national political scenario and increasing concern about poverty and marginalization. Both welfare and empowerment oriented organizations emerged during this period, and development, civil liberties, education, environment, health, and livelihood all became the focus of attention. With community participation as a defined component in a number of social sector projects during the 1970s and 1980s, NGOs began to be formally recognized as development partners of the state. Their work was increasingly characterized by grassroots interventions, advocacy at various levels, and mobilization of the marginalized to protect their rights. The process of structural adjustment begun in the early 1990s and the more recent approach of bilateral and international donors channeling funds directly through the government, NGO networks, and large corporate NGOs have somewhat pushed peoples’ organizations into the background. Small, spontaneous initiatives at the community level, as a response to social and economic exploitations at the community level, are no longer the hallmark of the NGO sector.28

NGOs Today

Today, about 1.5 million NGOs work in India (i.e., nonprofit, voluntary citizens’ groups organized on a local, national, or international level). This includes temples, churches,
mosques, gurudwaras (Sikh place of workshop), sports associations, hospitals, educational institutions, and ganeshotsav mandals (temporary structures set up to house Ganesh festival celebrations). Most NGOs in India are small and dependent on volunteers. According to a survey conducted by Society for Participatory Research in Asia (PRIA), 73.4 per cent of NGOs have one or no paid staff, although across the country, more than 19 million persons work as volunteers or paid staff at an NGO.

The PRI A survey also reveals that 26.5 per cent of NGOs are engaged in religious activities, while 21.3 per cent work in the area of community and/or social service. About one in five NGOs works in education, while 17.9 per cent are active in the fields of sports and culture, Only 6.6 per cent work in the health sector. The Indian Centre for Philanthropy, the Center for Advancement of Philanthropy, Charities Aid Foundation (India), National Foundation for India, and the Society for Service to Voluntary Organizations are among the nonprofit organizations that provide information resources, services, and networking opportunities to NGOs.

The Credibility Alliance is an initiative by a group of NGOs committed to enhancing accountability and transparency in the voluntary sector through good governance. Credibility Alliance was registered in May 2004 as an independent, not-for-profit organization after 2 years of extensive consultation with thousands of NGOs in India. Credibility Alliance operates as a standards-setting body, and aims to build trust among all the stakeholders. Its members include nearly 600 organizations.
Methods of NGOs

NGOs work for a wide variety of causes that aims to bring about the change in the life of the people for a greater cause and to protect their rights. As there are various types of NGOs, therefore their way of working also differs from each other. Some NGOs simply act as lobbyists, while others mainly conduct programs and activities. For example, an NGO like Oxfam works to alleviate poverty by offering the help to the needy people in form of equipments and skills for getting access to food and clean drinking water. On other hand, an NGO like the FFDA carries out investigation and documentation of human rights violations. It helps by offering legal assistance to the victims of human rights abuses. Some other NGOs like Afghanistan Information Management Services, helps by providing specialized technical products and services for supporting development activities which are implemented by other organizations on the ground.

NGO types by orientation:

- **Charitable Orientation** often involves a top-down paternalistic effort with little participation by the "beneficiaries". It includes NGOs with activities directed toward meeting the needs of the poor -distribution of food, clothing or medicine; provision of housing, transport, schools etc. Such NGOs may also undertake relief activities during a natural or man-made disaster.

- **Service Orientation** includes NGOs with activities such as the provision of health, family planning or education services in which the programme is designed by the NGO and
people are expected to participate in its implementation and in receiving the service.

- **Participatory Orientation** is characterized by self-help projects where local people are involved particularly in the implementation of a project by contributing cash, tools, land, materials, labour etc. In the classical community development project, participation begins with the need definition and continues into the planning and implementation stages. Cooperatives often have a participatory orientation.

- **Empowering Orientation** is where the aim is to help poor people develop a clearer understanding of the social, political and economic factors affecting their lives, and to strengthen their awareness of their own potential power to control their lives. Sometimes, these groups develop spontaneously around a problem or an issue, at other times outside workers from NGOs plays a facilitating role in their development. In any case, there is maximum involvement of the people with NGOs acting as facilitators.

**NGO Types by level of operation:**

- **Community-based Organizations (CBOs)** arise out of people's own initiatives. These can include sports clubs, women's organizations, and neighborhood organizations, religious or educational organizations. There are a large variety of these, some supported by NGOs, national or international NGOs, or bilateral or international agencies, and others independent of outside help. Some are devoted to raising the consciousness of the urban poor or helping them
to understand their rights in gaining access to needed services while others are involved in providing such services.

- **Citywide Organizations** include organizations such as the Rotary or lion's Club, chambers of commerce and industry, coalitions of business, ethnic or educational groups and associations of community organizations. Some exist for other purposes, and become involved in helping the poor as one of many activities, while others are created for the specific purpose of helping the poor.

- **National NGOs** include organizations such as the Red Cross, YMCAs/YWCAs, professional organizations etc. Some of these have state and U.T branches and assist local NGOs.

- **International NGOs** range from secular agencies such as Redda Barna and Save the Children organization, OXFAM, CARE, Ford and Rockefeller Foundations to religiously motivated groups. Their activities vary from mainly funding local NGOs, institutions and projects, to implementing the projects themselves.\(^\text{30}\)

**Significance of the study**

According to Census 2001, 28.6 crore people live in urban areas. The urban population has increased to 37.7 crore in 2011. Urban growth has led to rapid increase in number of urban poor population, many of whom live in slums and other scattered settlements. As per Census 2001, 4.26 crore people lived in slums spread over 640 towns/cities having population of fifty thousand or above. In the cities with population one lakh and above, the 3.73 crore slum population (in 2001) was expected to reach 7.66
crore by 2011, thus putting greater strain on the urban infrastructure which is already overstretched. As per the United Nations projections, if urbanization continues at the present rate, then 46 per cent of the total population will be in urban regions of India by 2030. While the Jawaharlal Nehru Urban Renewal Mission is beginning to tackle the urban infrastructure issues, urban health issues need immediate attention, especially in the context of the urban poor. It also needs attention from a public health perspective. As per Census 2011, population of India has crossed 121 crores with the urban population at 37.7 cores which is 31.16 per cent of the total population. Despite the supposed proximity of the urban poor to urban health facilities their access to them is severely restricted. This is on account of their being “crowded out” because of the inadequacy of the urban public health delivery system. Ineffective outreach and weak referral system also limits the access of urban poor to health care services. Social exclusion and lack of information and assistance at the secondary and tertiary hospitals makes them unfamiliar to the modern environment of hospitals, thus restricting their access. The lack of economic resources inhibits restricts their access to the available private facilities. Further, the lack of standards and norms for the urban health delivery system when contrasted with the rural network makes the urban poor more vulnerable and worse off than their rural counterpart. The urban poor suffer from poor health status. As per NFHS III (2005-06) data under 5 Mortality Rate (U5MR) among the urban poor at 72.7, is significantly higher than the urban average of 51.9. More than 46 per cent of urban poor children are underweight and almost 60 per cent of urban poor children miss total
immunization before completing one year.

As far as urban slum women are concerned, they live in a very unhygienic condition. They are not well aware of ante-natal care and immunization. During pregnancy, they don’t get adequate nutritious food, vitamins and minerals. They foster much superstitious beliefs. Deliveries are normally conducted by untrained Dais or elderly women of the family due to that many women die every year because of unsafe abortions, infections and other health consequences.  

In the recent era, the role of government has changed from doer to facilitator. The concept of Public-Private Partnership empowered the Voluntary Organizations or NGOs to provide the services to marginalized section of the societies and urban slum is not an exception. The NGO sector has been given increased importance by the government in every Five-Year plan. The involvement of NGOs increased from service provision to training, planning, consultancy and technical guidance. ‘SAHAJ’ is a non-government organization with more than 20 years of experience in understanding and promoting holistic health and women centered health care through research and innovation intervention. SAHAJ provides managerial inputs and also channels the funds for the project. In the same manner Haryana Nav Yuvak Kala Sangam, Utthan Institute of Development & Studies, SWACH (Survival for Women and Children Foundation), SOSVA (Service for Society to Voluntary Agencies) and SNS (Sant Nishchal Singhjii) has committed to provide the health facilities in urban slum area of Haryana. They are implementing agency in Janani Suvidha Yojana.
Therefore, this study is selected for research because Janani Suvidha Yojna aims at making quality Antenatal, Natal and Postnatal services easily accessible to poor in the urban slums of Haryana with its definite objectives of making quality mother and child health services accessible to the neediest, to provide good quality contraceptives, vaccines and other supplies to the urban poor and to provide good quality and low cost diagnostic services to the pregnant mothers in urban slums. The implementation agency for this scheme is the District NGOs working in the respective districts. The Department of Health, Haryana is already working with NGOs for various RCH II and AIDS activities. Various studies have been done on these issues in order to ascertain the efficiency and success of such healthcare programmes by government organizations as well as private think tanks. A brief review of the literature related to the above mentioned issues and policies has been discussed henceforth.

**Review of Literature**

*Nair and Panda, (2011)*[^1] in his article “Quality of maternal healthcare in India: Has the National Rural Health Mission made a difference?” examine the scenario of quality of care in maternal health over the last decade and the impact of NRHM initiatives on the same. While NRHM has made efforts to address lacunae associated with quality of maternal care in the public health system, there is much scope for improvement. Community based organizations and consumer groups will need to advocate for quality of care in maternal services by forging collaborations and sharing resources amongst all stakeholders involved in advocating for quality of care in maternal health services. This could be initiated by a pan national organization which would be

[^1]: Nair and Panda, (2011)
able to bring together national and international organizations like the White Ribbon Alliance, UNICEF, WHO, UNFPA and other international donors on a common platform. State Governments will need to establish task forces for enforcing Indian Public Health Standards (IPHS) guidelines at all levels and these should be monitored by an independent body at the centre. State Governments should also set up mechanisms for efficient procurement, management and monitoring of supply chain systems [on the lines of Tamil Nadu Medical Supplies Corporation (TNMSC)] for equipment and drugs for essential maternal health services. Standard treatment guidelines created in consultation with senior medical officials also need to be implemented and monitored. Hospitals need to be certified as women and baby friendly. Multi pronged strategies should also be worked out to improve the quality and efficiency of services being delivered by ASHAs as these will have a major impact on the success of NRHM in general and improvement of maternal health indicators in particular.

Kumar, (2005) in his article “Challenges of maternal mortality reduction and opportunities under National Rural Health Mission--a critical appraisal” argues that Maternal Mortality Ratio (MMR) continues to remain high in our country without showing any declining trend over a period of two decades. The proportions of maternal deaths contributed by direct obstetric causes have also remained more or less the same in rural areas. There is a strong need to improve coverage of antenatal care, promote institutional deliveries and provide emergency obstetric care. Delays occur in seeking care for obstetric complications and levels of 'met obstetric need'
continue to be low in many parts of the country. Most of the First Referral Units (FRUs) and CHCs are function at sub-optimal level in the country. National Rural Health Mission (NRHM) offers institutional mechanism and strategic options to reduce high MMR. 'Janani Suraksha Yojna', strengthening of CHCs (as per Indian Public Health Standards) to offer 24 hours quality services including that of anesthetists and Accredited Social Health Activist (ASHA) are important proposals in this regard. District Health Mission can play an important role in monitoring maternal deaths occurring in hospitals or in community and thus create a social momentum to prevent and reduce maternal deaths. NRHM, however, depends largely on Panchayati Raj Institutions for effective implementation of proposed interventions and utilization of resources. In most parts of our country, State Governments have not empowered PRIs with real devolution of power. Therefore, much needs to be done locally to build the capacity of PRIs and develop state-specific guidelines in operational terms to implement interventions under NRHM for reducing maternal mortality ratio.

Singh, Kaur, Gupta and Kumar, (2012)\(^{35}\) in his article “Impact of national rural health mission on prenatal mortality in rural India” are of the viewpoint that Innovations under National Rural Health Mission have paved the way for increased utilization of hospitals for childbirth. The association of increase in hospital deliveries with decline in the prenatal mortality rate in rural India after the launch of NRHM in 2005 was assessed using the Sample Registration System reports. Relative increase in hospital deliveries was 57 per cent from year 2005 to 2008 but relative decline in the PNMR was only 2.5 per cent; in the rural
areas of Indian states (r=0.2; 95 per cent; confidence interval -0.2-0.6; P=0.3). Hence, quality of care at the time of childbirth needs to be assessed.

**Parsad, Chakraborty, Yadav and Bhatia,** 36 in his article “Addressing the social determinants of health through health system strengthening and inter-sectoral convergence: the case of the Indian National Rural Health Mission” elucidate that under the NRHM, Rs. 666 billion (US$12.1 billion) was invested in rural areas from April 2005 to March 2012. There was also a substantially higher allocation for 18 high-focus states and 264 high-focus districts, identified on the basis of poor health and demographic indicators. Other determinants of health, especially nutrition and decentralized action, were addressed through mechanisms like State/District Health Missions, Village Health, Sanitation and Nutrition Committees, and Village Health and Nutrition Days. Consequently, in bigger high-focus states, rural IMR fell by 15.6 points between 2004 and 2011, as compared to 9 points in urban areas. Similarly, the maternal mortality rate in high-focus states declined by 17.9 per cent between 2004-2006 and 2007-2009 compared to 14.6 per cent in other states. The article, on the basis of the above approaches employed under NRHM, proposes the NRHM model to 'reduce health inequities and initiate action on SDH'.

**Singh and Paul, (1997)** 37 in his article” Maternal and child health services in India with special focus on pre-natal services.” argue that India has an excellent infrastructural layout for the delivery of MCH services in the community through a network of sub-centers, primary health centers, community health centers, district hospitals, state medical college hospitals, and other
hospitals in the public and private sectors. However, the health pyramid does not function effectively because of limited resources, communication delays, a lack of commitment on the part of health professionals, and, above all, a lack of managerial skills, supervision, and political will. The allocation of financial resources for the delivery of health care continues to be meager. Nevertheless, in spite of obvious constraints, the country has made laudable progress in reducing post-neonatal mortality in recent years. Under the CSSM program, a massive expansion of MCH services has occurred at the sub-district and the district levels. The RCH program, to be launched shortly, aims at effective utilization of these facilities to ensure delivery of integrated services of assured quality through decentralized planning. Simultaneously, as a result of the ongoing economic liberalization, the MCH care in the private sector will also expand rapidly. Indeed, India is on the threshold of an extraordinary improvement in the status of its neonatal-prenatal health.

Lahariya and Khandekar, (2007)\(^{38}\) in his article “How the findings of national family health survey-3 can act as a trigger for improving the status of anemic mothers and undernourished children in India: a review” point out that the national family health survey-3 (NFHS-3) reports of declining fertility rate while increasing prevalence of anemia in women and children, since NFHS-2 in 1998-99. The proportion of anemic, stunted and wasted children has also increased since the previous two rounds. NFHS trends show that the status of mother's and child's health indicators is continuing to deteriorate in spite of the many government-run targeted programs, e.g. integrated child
development scheme (ICDS), Midday meal program. The only good sign in the findings is the favorable trend in fertility indicators and infant mortality rate. A review of the findings of NFHS surveys, the current government policies and programs targeted upon the improving of health status of women and children in India and of the published scientific literature was conducted. The aim of the review was to understand the health situation of women and children in India and to suggest measures to bring about positive changes in the health status of this population. The analysis suggests that the findings of these successive surveys are not being utilized for the necessary corrective measures. The authors argue that although the NFHS is a useful exercise, in the wake of decentralized planning, the country needs more detailed data focusing on the districts. Synchronization of the ICDS and national rural health mission (NRHM), along with entrusting the responsibility of conducting NFHS to the planning commission, is the other possible solution to tackle the problems of rising anemia and malnutrition in the country.

Planning Commission, (2011)\textsuperscript{39} in his article “Evaluation Study of National Rural Health Mission (NRHM) in 7 States” emphasizes that the study attempts evaluation and assessment of the availability, adequacy and utilization of health services in the rural areas, the role played by ASHAs, AYUSH in creating awareness of health, nutrition among the rural population and to identify the constraints and catalysts in the implementation of the NRHM programmes. Along with role of ASHA and mainstreaming of AYUSH the utilization aspects of health services necessitates studying other crucial factors like
availability, planning and preparedness of health facilities and human resources, drugs availability, quality of MCH care and diagnostic-services, referral services, process of accreditation, effective decentralization, effective utilization of funds, etc. Simultaneous attention on programs impacting nutrition, capacity building, communitization, empowerment, etc. are equally important for effective utilization of the health services. Apart from accessibility and affordability it is also client’s perception about the quality of healthcare which prompts them to utilize the healthcare facilities, whether private or public. The study reveals that secular decline in neonatal component of infant mortality during last five years was witnessed only in Tamil Nadu. However, secular decline in infant mortality rate was observed in all the seven states under the purview of the study. Further, we find that the Maternal Mortality Ratio (MMR) of 254 as per SRS in 2004-06 for India ranges from 111 in Tamil Nadu to 440 in Uttar Pradesh amongst the seven states. Secular declines in MMR have also been observed in all the seven states excepting J&K.

James, (2014) in his article “Recent Sift in Infant Mortality in India: An Exploration” opines that the pace of decline in infant mortality in India has quickened in recent years after the introduction of the National Rural Health Mission. However, the post-neonatal deaths have declined faster than the neonatal deaths despite the emphasis on preventing the latter in the health mission. Apart from a number of reasons, this is linked to the poor quality of the public health services in general, and the undernourishment and anaemia levels of pregnant women in particular.
Dongre and Kapur, (2013) in his article “How Janani Surksa Yojana Performing in Backward India” opined that with a view to reduce high levels of maternal and neonatal mortality, the National Rural Health Mission launched the Janani Suraksha Yojana in 2005. This is an innovative conditional cash transfer programme to provide monetary incentives to women to deliver in medical facilities. This study evaluates its functioning by using a unique data set covering eight districts spread across seven "low performing states" in the country. It shows that JSY is working reasonably well, judging by the proportion of women receiving incentives after delivering in a government facility, location of receiving incentives, mode of payments and payment of bribes. But the accredited social health activists, an important component of JSY, play a limited role in facilitating delivery in a medical facility. Importantly, even though the proportion of women delivering in a medical facility has improved considerably, a significant fraction of women continues to deliver at home. These women are more disadvantaged than those who deliver in government facilities.

Jackson, (2013) in his article “An Assessment of the Quality of Primary Health Care in India” analyzed that there is limited evidence on the quality of primary health care provision in India. Using data on the availability of inputs from a nationally representative survey of primary health centers, a composite measure of structural quality of care for primary health centers was developed with a view to examine its geographical variation, associations with mortality and healthcare utilization, and the determinants of better quality, giving particular attention to the role of management. The mean quality
score was 52 per cent, with large differences across regions, states and districts. Quality of care was the worst and the variation greatest in states designated by the government as low performing. Good management practices in a facility were highly correlated with better quality of care. The majority of primary health facilities in India fall far short of government minimum standards, in part explaining why most people in rural areas use private providers for outpatient care. Future research should explore the causal relationship between management practices, quality of care and patient outcomes.

Patra, (2008)\textsuperscript{43} in his article “Exploring the Determinants of Childhood Immunization” attempts to analyse the effects of some selected demographic and socio-economic predictor variables on the likelihood of immunisation of a child for six vaccine-preventable diseases covered under the Universal Immunisation Programme. It focuses on immunisation coverage (a) at the all India level, (b) in rural and urban areas, (c) in Bihar, Tamil Nadu and West Bengal, and (d) for three groups of states, the empowered action group, north-eastern and other states. The study applies a logistic regression model to National Family Health Survey-2 (1998-99) data. The likelihood of immunisation increases with urban residence, mother's education level, mother's exposure to mass media, mother's awareness about immunisation, antenatal care during pregnancy and other such variables. Further research with both demand- and supply-side issues and current data is critical to help policymakers make the immunisation programme universal.

Bhandari, Berman and Ahuja, (2010)\textsuperscript{44} in his article “The impoverishing Effect of Health Payment in India: New
Methodology and Finding” opined that high private healthcare spending as well as high out of pocket spending in India is placing a considerable financial burden on households. The 60th national morbidity and healthcare survey of the National Sample Survey Organization provides an opportunity to examine the impoverishing effect of healthcare spending in India. This paper presents an analysis of the NSSO survey data with some new approaches to correcting some of the biases in previous assessments of the "impoverishing" effect of health spending. Despite these corrections, the results suggest that the extent of impoverishment due to healthcare payments is higher than previously reported. Furthermore, outpatient care is more impoverishing than inpatient care in urban and rural areas alike. The analysis of the extent of impoverishment across states, regions (urban and rural areas), income quintile groups, and between outpatient care and inpatient care yields some interesting results. The present study pertains to health administration in Haryana but the review of literature reveals that there are very few studies in this area in the state of Haryana.

Husser, Carlotla and Stafford, Hartment, (1992) have made a critical assessment on the topic “Analysis of the Administrative and Medical Management authority structure in Hospitals: Dimensions of Culture, Leadership style and Conflict coping Strategies” elaborated that contemporary hospital managers, administrators and medical professionals were being asked to control costs, improve services, enhance alternative payments and delivery systems, which put the limits on risk and remain competitive without compromising on quality. All these have given rise to the environment conducive to mistrust and
conflict too difficult to develop productive relationship among the management groups, administrative and medical professionals in hospitals.

Agarwal and Sangar, (2005)\textsuperscript{46} in their article “Need for Dedicated focus on Urban Health within Rural Health Mission” feel that NRHM represent an important public health initiative to address essential health needs of the country's underserved population. For the Mission to achieve goals, urban population needs to be included in its scope. Urban poor population constitutes nearly a third of India's population and is growing at three times the national population growth rate. Health status and access of reproductive and child health services of slum dwellers are poor and comparable with the rural population. Efforts to improve the conditions of urban poor necessitate strengthening national policy and fiscal mandate, augmenting and involving private sector, strengthening municipal functioning and building community capacities. NRHM should be broadened to National Public Health Mission.

Panda, (2005)\textsuperscript{47} in his article “Health of Tribal Women: Issues in Focus”, feels that inadequate facilities are the principal reason for dismal health conditions of the tribal women but it is not sufficient to explain the phenomenon. Other significant determinants are the socio-cultural factors, surrounding of their habitat, hygiene awareness, accessibility to available health care facilities and articulation of the issue at proper places. The author focuses on the issue on a selected cluster of tribal women of Orissa with similar economic condition. Basing on the observation of their health condition, interaction with health officials, elected leaders, NSS volunteers and influential from the
community, among various other findings the researcher lays importance to the patriarchal community culture, unhygienic living conditions, inadequate and imbalanced food habits, pervasive malnutrition, early marriage, high fertility, widespread misconceptions and ignorance of physical and mental health are linked to morbidity and illness.

**Taneja, D.K, (2005)** is of the opinion that NRHM is strategic framework to implement the National Health Policy, 2002. The scheme of Accredited Social Health Activist (ASHA) is an improvement over the earlier Community Health Guide Scheme. Integration of various health and family welfare programmes will result in economy and allocation of resources as per needs of the districts. Decentralized planning with the involvement of PRIs is likely to make with health planning is a logical step. The proposal to strengthen institutions of primary health care and CHCs as .functional Rural Hospitals along with introduction of Indian Public Health Standards and accountability of public health institutions to the public is likely to revolutionize the status of health care in rural India.

**Rao, (2005)** is of the opinion that the government has recognized the importance of health in the process of country's socio-economic development and improving the quality of life of its people. In this process the government has launched the NHRM in April 2005. He stresses the main purpose of the mission is to carry out necessary architectural correction in the basic health delivery-system. He also feels that the health care system has expanded considerably over the years. However, the quality of services is not uniform due to various reasons like non-availability of manpower, problem of access, acceptability and lack of community involvement.
Rajalakshmi, (2005)\textsuperscript{50} while commenting upon the NRHM, feels that while the Mission appears to be based on a lofty concept note, women's organizations and health workers are concerned that it is a disguised attempt at population control. The author is of the opinion that the continuing preoccupation of the government with population stabilization - it is lamentable that nowhere do the guidelines of NHRM mention about the adverse child sex ratio - is a worrying trend, especially as the two-child norm continues to be implemented in several states.

Nandan, Deoki, (2005)\textsuperscript{51} feels that NRHM launched by the Government of India holds great hopes and promises to serve the deprived and underserved communities of the rural areas. The backbone of the programme is ASHA, which will play major role in the implementation of the programme. The invariable existence of socio-cultural clusters in the community has always been a major challenge to the health care efforts made by the government. Though ASHA is a novel concept to melt the ice in the culture of silence among the various cluster community groups, it is important to emphasize that inter cluster communication may still pose a problem, which ASHA may be unable to address. Considering the constraints of ASHA and success of cluster community approach in UNICEF supported community bases Maternal Child Health and Nutrition (MCHN) Project, it is quite reasonable to state that inclusion of community mobilizes (Bal Parivar Mitra) from within the cluster community group might well be an asset to the programme, who may actually bring about the task of spreading the spirit of NRHM. These set of functionaries may work in coordination to bring about the desired behaviour changes and decrease the social
delays responsible for maternal and childhood mortality. It will also bring about the feeling of community participation and ownership. The programme is in its initial phase but has years ahead of it to bring visible changes at community level to make it a reality.

Kessler, (1994)\textsuperscript{52} in his article, “Family planning and the role of WHO” in world Health, viewed that the success of family planning programmes has led to a considerable decrease in average family size in developing countries, yet actual numbers continue to increase. It poses enormous challenges in terms of proving food, water, energy and services, let alone improving the quality of life. Far more emphasis must be placed on the importance of family planning services.

Kasyap, Rajan (2000)\textsuperscript{53} in his article “Danger from Medical Wastage-Need for multi-Disciplinary approach” stated that even as hospital provide solace and relief from disease, the dangerous waste generated by them have become a serious hazard which threatens public health. Indiscriminate disposal of hospital wastes is indeed a major source of pollution and infection. Biomedical wastes from hospital, nursing homes and clinic include hypodermic needles, scalpel blades, surgical gloves, cotton, bandages, clothes, medicine and body blood fluid, human tissue and organ, body parts, radio-active substances and chemicals. Some of these contain harmful organisms. Reuse of discarded syringes can transmit lethal disease like AIDS and hepatitis. Similarly, indiscriminate recycling of used cotton, clothes and medicines poses a host of health hazards. For a solution, it is necessary to appraise both visible and invisible factor. A multi disciplinary approach would have to be adopted for the management of biomedical wastages.
Siwach, (2003)\textsuperscript{54} in his article, “Perspective Role of NGOs in Tenth Plan” argues that the NGO have a zig-zag path to tread towards their destination. The common masses and bureaucracy, however, still perceive them as crooked and dishonest. Their credibility, owing to numerous inexplicable reasons, is at stake. The government, as well as, NGO people should take a keen and genuine interest to promote voluntarism with devotion. The NGO sector should take a keen and genuine interest to promote voluntarism with devotion. The NGO sector should ex-communicate those fraudulent organizations who have been giving a bad name to the fraternity and, the government, on the other hand should stick to ‘carrot and stick’ approach to encourage committed and honest organisations.

The Hindu, (2006)\textsuperscript{55} in article “Slum Women to get better Health Care” explained that it would be a new era for urban slum women of Haryana. On Tuesday government announced an innovative scheme - "Janani Suvidha Yojana" – it would be launched to enable women living in urban slums to avail of services like ante-natal care, free delivery services and immunization of children from selected qualified doctors or nursing homes within their own residential areas through pre-paid vouchers. The scheme has been started in eight districts namely Panchkula, Yamunanagar, Kurukshetra, Sonepat, Gurgaon, Rewari, Mahendergarh (Narnaul) and Bhiwani of the State. The implementation agency for this scheme will be the District NGOs working in the respective districts. The Department of Health, Haryana is already working with NGOs for various RCH II and AIDS activities. The State NGO Coordinator will ensure the capacities of NGOs in implementing the scheme.
The Tribune, (2006)\textsuperscript{56} in his article “Safe Delivery” praises Haryana Government for setting up Prasuti Greha (delivery huts) all over the state to increase the institutional delivery rate, and helped in bringing down the maternal mortality rate (MMR) and the infant mortality rate (IMR). Till the launch of the Prasuti Greha scheme, Haryana had a poor institutional delivery rate. Only 23 per cent of the deliveries were being done in health institutions, while a whopping 77 per cent of the deliveries were being done by unskilled midwives. With an aim to reduce the MMR and the IMR, the Health Department, Haryana, decided to set up 300 Prasuti Greha all over the state. We propose to reduce the MMR from the present over 300 per 100,000 to 100 per 100,000 live births, and decrease the IMR from 58 to 30 per 1000 live births.

Husain, (2011)\textsuperscript{57} in his articles “Health of the National Rural Health Mission” opines that National Rural Health Mission was introduced as a flagship scheme of the United Progressive Alliance government in 2005-06 to address the needs of the rural population through an architectural correction of the health system. With the completion period drawing to a close in 2012, this paper critically evaluates the success of the intervention strategies under this scheme. Based on rapid appraisal surveys in selected districts, three common review missions by the Ministry of Health and Family Welfare, and data reported on the NRHM website, this paper attempts a desk review of the progress of the mission with respect to its core strategies – provisioning of health services to households through accredited social health activists, strengthening rural public health facilities, enhancing capacity of panchayats to control and manage provisioning of
health services and positioning of an effective health management information system.

Dhar, (2012) in his article “Women and Child Health” viewed that there can be no improvement in maternal health without eradicating extreme poverty and hunger to which women, in general, and pregnant mothers, in particular, are most vulnerable. Improved maternal health will, on its own, bring about a visible improvement in child survival and child health also. To curb these issues government has been taking some steps. The Ministry of Health and Family Welfare has issued operational guidelines for Home Based Newborn Care. To be implemented by Accredited Social Health Activists (ASHAs), HBNC will go a long way in ensure the safety of young mothers and infants who cannot access health facility for various reasons. Pentavalent vaccine which consists of vaccines against five diseases (Diphtheria, Pertussis Tetanus, Hepatitis Band Haemophilus influenzae B) has also been introduced in some States. Vaccine against Hib disease (Haemophilus influenza B) is a new addition to the immunization programme. Pentavalent vaccine is administered to children at 6, 10 and 14 weeks of age and will replace the existing DPT and Hepatitis B vaccine primary dose of which is given at the same age. Under the Family Planning programme, eligible couples are now being counseled to delay their first child and then better space their children for which contraceptives like condoms are provided by ASHAs at the doorsteps. The ASHA charges a nominal amount from beneficiaries for her effort to deliver contraceptives at doorstep. However, government is taking steps in this regard but there can be no improvement in maternal health, unless women are
enlightened through education at least till the primary level and we cannot imagine improved maternal health in any society that does not promote gender equality or in one which does not empower its women; or in one which does not reduce child mortality rates.

**Bhushan, (2012)**\(^59\) in his article “Janani-Shishu Suraksha Karyakram” stated that Government of India has launched Janani Shishu Suraksha Karyakaram (JSSK) on 1st June, 2011. The initiative has been rolled out in all States and Union Territories under the overall umbrella of National Rural Health Mission (NRHM). The scheme is estimated to benefit more than 12 million pregnant women who access Government health facilities for their delivery. Moreover it will motivate those who still choose to deliver at their homes to opt for institutional deliveries.

**Sadgopal, (2009)**\(^60\) in his article “Can Maternity Services Open Up to the Indigenous Traditions of Midwifery” thrust on the Ayurveda, Yoga, Unani, Siddha and Homeopathy systems. These systems can bring deep changes in maternity care. Big changes there are, but in the wrong direction. Aiming to reduce maternal and neonatal mortality, the National Rural Health Mission’s Janani Suraksha Yojana scheme presses expectant mothers to go for “institutional delivery” and avoid home births. The NRHM document also speaks of revitalizing local health traditions. This means that the dais, which has been part of the local health traditions should be incorporated into the government structure at the lowest end as has always been the case. This paper raises various questions related to maternity care governance for the benefit of local communities and looks at the
possibilities of strengthening the services with serious inputs from dais. It acknowledges the dimensions of class, caste, gender, power and ideology that would be implicated in the acceptance of the “dai tradition” within the healthcare services system.

Duggal, (2004) in his article “The Slums of Panchkula” described that four slum colonies in the satellite township of Panchkula, on the periphery of Chandigarh, are profiled. In some of the colonies, hardly one fourth of the children were attending school. Health Services were poor and water was scarce. Lack of sewerage facilities, due to which slum dwellers had to defecate in the open, added to the squalor. In contrast to this dismal picture, in Azad Colony, most of the children were encouraged to go to school; and in one of the slum settlements-Indira Colony, due to the efforts of the pradhan, groups of children were being educated in the juggis itself. Residents of Azad colony had also collected money and harnessed skilled and unskilled labour available locally to provide better drainage and sanitation.

Mathai, (2004) in his article “Urban Slum-Specific Issues in Neonatal Survival” articulates that urbanization is rapidly spreading throughout the developing world. An urban slum poses special health problems due to poverty, overcrowding, unhygienic surroundings and lack of an organized health infrastructure measures to reduce neonatal mortality in urban slums should focus on health education, improvement of antenatal practices, institutional deliveries, and ensuring quality pre-natal care and also need inclusion of all key players, provision of health infrastructure, forming an effective system of referral and developing programs with active, democratic participation of the community.
Agarwal and Sangar, (2005)\textsuperscript{63} in his paper entitled “Need for Dedicated Focus on Urban Health within National Rural Health Mission” claims that National Rural Health Mission represents an important public health initiative to address essential health needs of the country’s underserved population. For the Mission to achieve its goals, urban population needs to be included in its scope. Urban poor population constitutes nearly a third of India’s urban population and is growing at three times the national population growth rate. Health status and access of reproductive and child health services of slum dwellers are poor and comparable to the rural population. Efforts to improve the conditions of urban poor necessitate strengthening national policy and fiscal mandate, augmenting and strengthening the urban health delivery system, coordinating among multiple stakeholders, involving private sector, strengthening municipal functioning and building community capacities. National Rural Health Mission should be broadened to National Public Health Mission. This paper discusses issues pertaining to health conditions of the urban poor, present status of services, challenges and suggests options for NRHM to bridge the large gap.

Mondal and et.al, (2015)\textsuperscript{64} in his article entitled “Does Janani Shishu Suraksha Karyakram Ensure Cost-Free Institutional Delivery? A Cross-Sectional Study in Rural Bankura of West Bengal, India” has come up with the following findings. Background: Janani Shishu Suraksha Karyakram (JSSK) was launched in India to ensure cost-free institutional delivery. Objectives: 1) To assess the awareness of recently delivered women regarding JSSK 2) To estimate the cost of institutional
delivery and its differentials. Materials and Methods: A community-based, cross-sectional study was conducted in a rural community in Bankura, West Bengal, India in 2013, among 210 women who delivered babies in the last 12 months. Information regarding socio demographic and health service-related variables as well as item-wise costs incurred for institutional delivery was collected. Costs were expressed in Indian National Rupee (INR). A nonparametric, bivariate analysis was performed to examine the difference in median cost. Results: All components of JSSK were known to 12.9 per cent women; the highest (77.1 per cent) for admission and lowest (29.0 per cent) for blood transfusion. The median (±IQR) costs of delivery in the Block level Primary Health Center (PHC), medical college, and private facilities were INR 205.0 (±825.0), 900.0 (±1013.0), and 6600.0 (±16195.0), respectively. Median cost of normal delivery in a private facility (INR 2750.0) was 3.6 times of that in a government facility (INR 765.0). Median direct cost of caesarian section (CS) in a government facility (INR 1100.0) was nearly one-fifteenth of that in a private facility (INR 16,350.0). Cash incentives under Janani Suraksha Yojana for poor and socially marginalized women could not cover the cost of CS delivery in a government facility. Conclusion: Gaps existed in the awareness of beneficiaries regarding entitlement under JSSK. Drugs and transport were two major causes of out-of-pocket (OOP) expenditure in public health facilities.

Ray, (2005) in his study “National Rural Health Mission-Opportunity for Public Health Mission” argues that manpower requirements of the Community Health Centre (CHC) should be rationally determined on the basis of work and patient load.
of the CHC. Importance should be given on availability of simple & life saving equipment, female staff when male staff is not available. Safe drinking water, an adequate sanitation and excreta disposal facility through Panchayet Raj Institution (PRI) or privatization was proposed. Accredited Social Health Activist (ASHA) has been accepted more streamlining based on the community was suggested. Capacity building or training should be CHC based for grass-root level functionaries with incentive to Medical officer (MO). IPHA proposes to extend support in capacity building, development of manual for ASHA & other categories of health professional as well as Program Implementation Plan (PIP).

Munjial et al, (2009) in his study “A Comparative Analysis of Institutional and Non-Institutional Deliveries in a Village of Punjab” attempts to make a comparative analysis of various characteristics pertaining to institutional and non-institutional deliveries. The study revealed that in spite of the efforts in this direction, two out of every five deliveries were taking place at home. This was the situation in a village located in the periphery of a state capital that had easy access to all the health facilities. Scheduled caste, landless, daily-wagers and higher order pregnancy couples preferred non-institutional deliveries to institutional deliveries. Families with higher income level went more for childbirth at a health facility. The main reason of delivering at a health facility or home was delivery being easy and convenient (74 per cent) or cultural factors (68 per cent). The most common fist feed given to a newborn child was breast milk/colostrums (53 per cent) in a health facility and cow/buffalo milk (31 per cent) at home. In case of non-institutional deliveries, umbilical stump was applied antiseptic to
only 12 per cent of the cases.

**Singh and Tamulee, (2012)** in his study “Janani Surasksha Yojana: Impact on Socio-Economic Conditions among Beneficiary Families” attempts to find out the socio-economic role of the program in terms of awareness, implementation and changes in the beneficiary families. The study has been conducted in the two districts, Nawada and Araria of Bihar selected on the basis of their contrasting health outputs. With response rate of 94.67 per cent, the total sample under study was 142 women registered as beneficiaries with the local health service providers. The results of the study reflected a high level of awareness among women accessing and community at large. Involvement of ASHA worker in program is considered to be a philanthropic work (66.2 per cent). It is also to be considered that this awareness level about the program is among the women who have availed the services of JSY. However with regards to cash incentives, only 68 per cent of the participants have received incentive of which only 69 per cent have collected it themselves. Only 67.7 per cent is registered for antenatal check-up. Reflecting upon the changing social status, 61 per cent have provided a positive response of upward movement in the community describing the facilitative nature in building the educational and livelihood standard of the family. Undoubtedly the program is a beneficial inclusive initiative of the government helping families move up the social ladder. The two regions in spite on contradictory health outcomes had similar responses about JSY. However red-tape incidents were also reported
reflecting the need of amendments in the process of implementation.

Sharma et al, (2011) in his paper entitled “A Comparative study of utilization of Janani Suraksha Yojana (Maternity Benefit Scheme) in rural areas and urban slums” attempts to study JSY. Background: Janani Suraksha Yojana (JSY) was launched on 12th April 2005, under the umbrella of National Rural Health Mission (NRHM) with the main objective of reducing maternal, neo-natal mortality and promoting institutional delivery. It was implemented in all states and UTs with special focus on 10 low performing states (LPS). Uttarakhand is one of the LPS and JSY was implemented here in Sept.2005. Objective: To find out the difference in utilization of Janani Suraksha Yojana in rural areas and urban slums. Material and Methods: A cross-sectional study was conducted under Rural Health Training Centre and Urban Health Training Centre of the field practice area of department of Community Medicine. A total of 227 married women in reproductive age (15-49 years), who delivered in government hospital were considered for the study out of which 88 women belonged to rural areas and 139 women were from urban slums. Results: Out of the total number of married women who delivered at govt. hospital i.e. 227, majority (78.42 per cent) were registered with some health personnel. Out of these, 74.15 per cent women were registered with ASHA and maximum number (83.64 per cent) of these women belonged to urban slums. Only 29.21 per cent women went for three or more ANC visits and the proportion was higher (33.64 per cent) in urban slums. Only 48.31 per cent women consumed hundred IFA tablets and the proportion was high (79.41 per cent) in rural women. All the women received complete TT immunization. Conclusion: The JSY utilization was found to be low in rural
areas i.e. 38.7 per cent. Thus, IEC activities should be strengthened and ASHA’s work should be properly monitored.

Pachauri, (1996) in his study “NGO Efforts to Prevent Maternal and Infant Mortality in India” argues that NGOs have been successful in reaching the poor and reducing mortality and fertility. As innovators and experimenters, NGOs have the potential to help operationalize the reproductive amid child health (RCH) Programme. The author discusses strategies for reducing material and infant mortality drawing from past NGO experience. Issues related to the safe motherhood programme are raised. Attention is drawn to the problem of stagnating maternal mortality. Issues related to adolescent sexuality and fertility and sexually transmitted diseases in women and children are discussed. The author urges the government to form new partnerships with NGOs. NGOs should also develop new coalitions and allies to address emerging challenges.

Bhat, (2007) in his paper “Contracting-out of Reproductive and Child Health (RCH) Services through Mother NGO Scheme in India: Experiences and Implications” puts the case study of three states presented in this paper suggests that this challenge emanates several factors. Inter alia, these include delay and uncertainty of funding and contract renewal, lack of partnership orientation in the scheme, lack of trust among the key stakeholders, capacity constrain in the district and state health system, weak monitoring system, procedural delays and multiple points of authority and reporting relationships. It is also observed that the capacity of field NGOs to deliver in the programme is constrained due to non-availability of financial and human resources. The scheme demands a strong leadership at local
levels and ownership from the state health system. This can be achieved through effective decentralization, flexibility in decision-making and creating adequate accountability systems. Regional Resource Centers has to play an important role in coordination between state/district RCH society and the NGOs and strengthening their capacities. The central government instead of focusing on micro-management of the scheme at state level should focus on developing and strengthening the enabling environment and capacity of various stakeholders to implement the scheme. Also, they need to address various systemic issues including development of accountable and performance oriented system, ensuring financial autonomy and decentralisation, delegation of authority, building trust and accountability in the system, effective integration, continuity of the scheme and fostering true sense of partnership between the state and non-state sector.

Begam, (2014) in his paper entitled “A Study on Effectiveness of Janani Suraksha Yojana for Promoting Institutional Delivery Services in Karimganj District of Assam” is of the opinion that Janani Suraksha Yojana (JSY) is getting popular day by day and especially rural poor women are significantly benefited by the scheme. And ASHAs are aware of their roles and responsibilities in JSY regarding antenatal services, complications during pregnancy and child-birth and thereafter, micro planning, referral care, arranging for transport, accompanying women for deliveries to institutions and ensuring child immunization services. There are evidences that institutional deliveries are increasing at PHCs and sub-centres because ASHA is actively working for promoting institutional
deliveries. ASHAs are performing satisfactory performance in their villages and they are actively organizing VHND session and helping the pregnant women to avail the JSY services. As a result Maternal Health status among rural women is improving by this scheme.

Srinivas et al, (2011)\textsuperscript{72} in their article “Family Welfare Programme in India: Expenditure vs. Performance” analyzed that since the launch of the reproductive and child health policy regime in 1998-99, there has been a massive rise in government expenditure on family welfare programmes in India. This paper makes a systematic effort to assess the performance of the family welfare programmes vis-à-vis the trends in expenditure. The trends in key performance indicators for India and selected states reveal that progress has been slow and limited in the post-rch policy regime. Child immunisation coverage has decelerated, and the increase in the contraceptive prevalence rate and institutional delivery coverage has stalled. Consequently, the pace of reduction in the total fertility rate and infant mortality rate has slowed. Overall, the progress in key programme indicators is found to be incommensurate with rising expenditure.

Agrawal et al, (2013)\textsuperscript{73} In this study “Pregnancies, Abortion and Women’s Health in Rural Haryana, India” examined that women’s perceived health status and self-reported health problems has been examined according to the number of pregnancies, gestational stage of abortion, and number of abortions among the rural women of Haryana, India by analyzing data from an in-depth interview of 329 ever-married women conducted in five villages of Haryana state of India during the year 2003. From our study, it emerged that women who had
undergone an abortion were 1.7 times (OR: 1.68; 95% CI: 0.95-2.98; p=0.076) more likely to perceive their health status as worse with reference to women who had not experienced any abortion. Self-reported health problems such as pain in lower abdomen and body weakness were found to be significantly (p<0.0001) higher among women who had experienced abortion. As the gestational stage of abortion increases (late abortion), the health problem among women is also found to be more as compared to women who had an early abortion i.e., abortion in the first trimester. Further, repeated pregnancies greatly worsen the health of women and also deteriorate the already prevailing morbidity conditions. Surprisingly, the number of pregnancies has not come out as a significant factor for the different health problems among women while it is believed that more number of pregnancies worsens women’s health condition.

The above mentioned review of literature on the selected problems eventually guides to draw the objectives of the present study.

**OBJECTIVES OF THE STUDY**

The main objectives of the study are:

1. To find out the institutional arrangement made for Janani Suvidha Yojana in Haryana.
2. To study the efficacy of various benefits provided under the JSY.
3. To evaluate the role of NGOs in maternity benefit schemes in general and Janani Suvidha Yojana in particular.
4. To examine the inadequacies and problems in state administration and NGOs causing hindrance in achieving desired goals.
5. To critically assess various interlink ages between governmental and non-governmental setup.

6. To suggest policy measures for better integration of governmental and non-governmental initiatives.

HYPOTHESES OF THE STUDY

1. It is assumed that there are institutional inadequacies in the working of Janani Suvidha Yojna.

2. It is assumed that the condition of maternity benefit services among urban poors is more deplorable than rural areas.

3. It is assumed that the NGOs are not performing up to the desired and potential level to realize the desired ends.

4. It is assumed that there is lack of proper coordination between governmental and non-governmental efforts.

5. It is assumed that the financial irregularities are responsible for ineffective performance of NGOs.

RESEARCH METHODOLOGY

Janani Suvidha Yojana has been implemented in eight districts of Haryana state. The present study has been conducted in purposively selected four districts, namely Sonepat, Bhiwani, Gurgaon and Yamunanagar having maximum urban slum population. Both primary and secondary sources of data have been utilized. Primary data has been collected through structured interview schedule from the officials of state health department, the selected NGOs under Janani Suvidha Yojana and its beneficiaries. Beneficiaries have been selected on the basis of purposive random sampling. The total sample comprises 100 officials and 400 beneficiaries equally distributed among the selected four districts. The secondary data has been collected
from various books, journals, government reports, annual appraisal reports of NGOs etc.

**Chapterization**

Chapter I: **Introduction**: It is an introductory chapter, which spells out the concepts relating to healthcare, health profile of the state of Haryana, NRHM and its objectives, significance of the study, research methodology as well as the review of the relevant literature.

Chapter II: **Janani Suvidha Yojana and Non-Government Organisations**: deals with maternal and child health scenario in India, role of NGOs in NRHM, JSY, its objectives and features; and role of NGOs in JSY.

Chapter III: **Organisational Set up of Janani Suvidha Yojana**: This chapter discusses the Organisational setup of Janani Suvidha Yojana at the state level.

Chapter IV: **Perception of Respondents**: This chapter comprises of the analytical study of the various aspects of Janani Suvidha Yojana and its working.

Chapter V: **Conclusion and Suggestions**: The last chapter pertains to the findings of the study along with the suggestions for the better implementation of Janani Suvidha Yojana in the state.
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