An important aspect of any research is review of literature related to one’s area of research. It saves time and effort by eliminating repetition through knowledge of what has already been done.

Review of literature is the backbone of the whole research work. It creates background for selection of procedure, helps the investigator in adoption of tools and provides comparative data on the basis of which, one can evaluate and interpret the significance of data. Keeping this in mind the related literature which directly or indirectly influences has been reviewed.

Conferences on women held under the auspices of the United Nations Organization in Cairo, Egypt in September 1994 and Beijing, China in September 1995 established the relevance of gender equality in ensuring the reproductive health of women. In pursuance of the objective of establishing gender equality in India the government brought about several reforms in its family welfare programmes. However, as is often the case in India, most of these changes have remained only on paper and the reproductive health of women continues to cause concern. Various studies have corroborated this fact.

In order to make the presentation systematic, the researcher has divided all the studied material into the following four categories in thematical order:

a) Reproductive and child health status

b) Factors affecting mother and child health

c) Mortality cause of mother and child

d) Reproductive and child health care services
2.1. REPRODUCTIVE AND CHILD HEALTH STATUS

Basu, S.K. (1993)\textsuperscript{26} says that the tribal women of India fare poorly as compared to Indian women in general as far as their age at time of marriage, fertility, mortality, life expectancy, maternal and child health facilities, sexually transmitted diseases, and genetic disorders are concerned. He has also identified the gaps in knowledge among tribal women leading to poor health and has also suggested a plan of action to overcome the problems.

Karkal, Maline (1998)\textsuperscript{27} has referred to male domination in most Asian societies. It is the man who decides matters of sexual behavior including use or non-use of the contraceptive method, and it is the man who controls the resources and decides what a woman does with her time or mobility. Practice of safe sex too depends on males.

Seth, Meera (2000)\textsuperscript{28} in her study reveals that Indian women have, regardless of their health, always try to bear children and even now 28 million women conceive every year out of which 25 million are live births.

Sood, A.K. and Nagla, B.K. in a study in (2000)\textsuperscript{29} have, through interviews and discussions with the local workers and women in the Rohtak district of Haryana, tried to find out the level of knowledge of the womenfolk in the villages regarding maternal and child health care, their faith in family planning methods, and their cultural practices. Their research made it evident that child health depends to a very vast scope on the level of education of both females as well as males, as also on their exposure to media.

Gulati, S. C. and Sharma, Suresh (2001)\textsuperscript{30} conducted a survey to analyze the reproductive and child health status (RCH) in 504 districts of the country. These districts were covered by the Rural Health Statistics (RHS-RCH) Project sponsored by the Government of India (MOHFW). The survey was based on RCH indicators and twelve
socioeconomic and demographic variables. It was found that at the district level factors like education of women and their employment, infrastructural facilities like easy availability ANMs (Auxiliary Nurse Midwives), and good road network linking villages, urbanization and economic development determined to a great extent reproductive and child health status. Areas dominated by Muslims had a significantly negative impact on the RCH status.

Kamalam, K. Jyothi and Rajalakshmi, B. (2005)\textsuperscript{31}; Ram, F. (2011)\textsuperscript{32} stated that the reproductive rights of women have always remained neglected. These advocates of the reproductive health approach believe that it is unavoidably linked to women’s economic status and education. Women and children are often denied right to health because of ignorance on the part of women about their rights.

Mathu, Anuradha and Pandya, Rameshwari (2006)\textsuperscript{33} mention that women’s health has become an issue which is almost like lost wealth. They feel their personal problems are of least priority and importance in comparison to men. To get better women’s health status there is no doubt that the common health services need to respond to women’s specific problems.

Ramanathan, Mala (2009)\textsuperscript{34} in her study indicates that Kerala has an inspiring citations in the part of maternal and child health as put side by side to other states of India.

Jhansi, S.C. (2010)\textsuperscript{35} finds that global estimates reveal that 5 to 15 percent of the burden of disease is associated with the failure to take care of the reproductive health requirements of women in an appropriate way. This affects women most severely and that in the prime of life.

Chaturvedi, Shivani (2011)\textsuperscript{36} reveals in her study that India is a nation, which has an astounding maternal death rate of 450 per 100000 live births. These deaths of women in the younger age group
who are often malnourished and anaemic, are preventable. Fertility rates in South Asia range from 71 to 119 births per 1000 women in the age group 15–19. Thirty percent of all induced abortions in India are performed on women who are under 20 years of age. Teenage pregnancy rate in India remains high because early marriages abound and there is lack of family planning know-how.

Mehrotra, Santosh (2006)\(^{37}\) in his study has put forward the thesis that in the South Asian countries of India, Pakistan and Bangladesh child malnutrition is more endemic than it is in countries to the south of Sahara in Africa and it is the direct offshoot of discrimination against women. The main focus, therefore, has to be on improving the health of women in the region.

Pandey, Manoj K. (2009)\(^{38}\) says that child mortality is not only the leading indicator of child health but also way the public health performance of a country. For the very survival of human race reduction in child mortality is a must. It is one of the primary concerns of the United Nations and they have therefore made it one the MDGs. According to the National Family Health Survey, Indian children are among the most malnourished in the world. Between 1990 and 2015 United Nations seeks to decrease child death by two-thirds. Despite all the efforts, however, the death of children under-five years of age remains unacceptably high with 21 children dying every minute. With all the progress India has made in the last fifteen years infant and child mortality remains as high as 57 and 74 respectively. In 2012, 1.5 million under-five child deaths were reported in India.

Ramani, K.V et. al. (2010)\(^{39}\) says that throughout the world a shocking more than ten million children in the under-5 age group die every year. Most of these deaths are preventable. The maximum number of child deaths occurs in India. In the year 2000, eight countries in the world reported for sixty percent of all child mortality. While 42 countries accounted for ninety percent of the child
mortality, forty percent of the child mortality happened in the four Asian countries, namely India, China, Pakistan, and Bangladesh.

Behl, Ajay S. (2012)\textsuperscript{40} concludes that in spite of significant reduction in the rate of child mortality in India between 1992 and 2005, there remains a significant rural-urban and inter and intra state divide.

2.2. FACTORS AFFECTING MOTHER AND CHILD HEALTH

Sood, A.K. and Nagla, B.K (1994)\textsuperscript{41} have revealed that those in the low-income group living in remote areas with poor housing facilities without bathrooms preferred home treatment in the initial stages of sickness. Those inclined to visit hospitals, especially government hospitals, had a mature head of the family, but had a lower level of education. They preferred Public Health Centres and Hospitals for prolonged illness or illness of a serious nature. Those who sought quick relief for their ailment were economically better off and belonged to the higher income group. They had better houses with separate bathrooms and with electricity, higher level of education, and had higher social participation. On the contrary, poorer people with lower incomes, lived in poor conditions and had a lower sense of hygiene. Such people usually preferred ‘free treatment’.

Data also revealed that people who were more educated and belonged to higher income group had smaller family size and preferred to go to a hospital for delivery. Hindus who were poor and did not socialize much preferred the local midwife (\textit{dai}) for delivery. Use of family planning methods was determined, among other things, by religion, size of the household and social participation, with those who had a larger household size and greater social participation showing greater inclination to accept family planning methods.

Jejeebhoy, Shireen J. and Rao, Saumya Rama (1995)\textsuperscript{42} show that several pregnancies one after another not only have a
detrimental effect on the mother’s health and nutritional status but also have a negative effect on the outcome of the pregnancy.

Shobha, I. (2003)\textsuperscript{43}; Das, Amrita (2009)\textsuperscript{44} in their respective studies have stated that the nutritional status of most expectant women was found to be very low and there were lots of superstitious restrictions and prescriptions about different dietary intake during pregnancy. Thus, child and maternal care practices are largely neglected in such areas.

Ram, F and Singh, Abhishek (2004)\textsuperscript{45} have in their study Safe Motherhood and Millennium Development Goals in India show that due to ignorance many women do not seek professional and proper medical advice for serious complications of pregnancy and childbirth which are life threatening. Even when they are aware that the problem is serious they remain indecisive.

Kanitkar, Tara and Radkar, Anjali (2004)\textsuperscript{46} found that very frequently delivery at home led to Reproductive Tract Infection (RTI) where delivery in a private hospital reduced the risk to the minimum. The prevalence of RTI was the greatest for women marrying at the age of 15 and lowest for those marrying at 19 or more.

Goel, Aruna (2004)\textsuperscript{47} in her study has shown that social approach also influence the condition and use of preventive and remedial health care, including maternal care.

demographic, genetic and socioeconomic variables influence reproductive and child health to a large extent.

Agnihotri, Satish B. (2001)\textsuperscript{59}; Kalita, D.K. (2001)\textsuperscript{60}; Bhatia, Vikas et al. (2004)\textsuperscript{61}; and Lyngdoh, Bremley A.B. (2004)\textsuperscript{62} conducted their respective studies to create a quick evaluation of the vaccination status of children in West Bengal, Union Territory of Chandigarh, and in the slums of New Delhi, Girwa (Rajasthan) and Kotra (Jalaun, Uttar Pradesh) Blocks respectively. Some of the most important causes for insufficient immunization of children were found to be lack of observing, weak health infrastructure in slums, immigration from low coverage states, lack of IEC, etc.

Bang, Abhay T. et al. (2001, 2005)\textsuperscript{63, 64}; Bang, Bhay et al. (2002)\textsuperscript{65} have in their studies reckoned the incidence of different types of sicknesses in newly born babies in villages and have calculated how many of them die due to lack of proper medical care and how many of them were saved by professional medical care. According to these studies nearly fifty percent of the newly born babies in villages got infected with serious diseases but did not receive medical care in a hospital and received treatment at home. The researchers assert that there is a desperate need to develop an infrastructure of expert and professional home-based care for newborn babies in order to bring down neonate mortality rate.

Gupta, Swagata and Roy, Rama Deb (2003)\textsuperscript{66} have revealed that only half of the Santal mothers take antenatal care and one-fifth of them opt for institutional delivery. Postnatal care remains highly neglected. Here lies the role of health workers in fighting social prejudices and custom. Economic uplift of the poorer families, however, remains the basic condition for permanent solution of the problem.

According to the findings of Sines, Erin et. al.(2006)\textsuperscript{67}; K., Kannika Parameswari et.al. (2009)\textsuperscript{68} for children to get a healthy start in life and to ensure good health for women it is essential that the
mother receives proper medical care during pregnancy, at the time of delivery, and in the early postnatal phase. Similarly, the newborn baby too should get adequate care. Proper care and good nutrition in these vital phases will go a long way to ensure that stillbirths and newborn deaths are averted. Usually health policies and programmes focus on one aspect alone – prenatal, labour or postnatal – ignoring important linkages. If such policies and programmes were to take a comprehensive view and include all the phases and incorporate them into integrated programmes millions of lives could be saved at much lower cost. It will also lead to overall improvement in health conditions.

**Mathur, Kanchan (2008)**

Mathur, Kanchan (2008) examines the socio-cultural factors determining the health of women in Rajasthan. She focuses the effect of the NFHS-3 as well as of the current policies and programmes on the health of women.

**Mavalankar, Dilip V. et al. (2009)**

Mavalankar, Dilip V. et al. (2009) in their study claim lack of proper management; shortage of doctors, nurses and paramedics; shortage of blood-banks in villages, together with other infrastructural and supply bottlenecks, pose the biggest challenge before the country in reducing maternal mortality ratio.

**Roy, J. et al. (2010)**

Roy, J. et al. (2010) have in their study found that maternal and child health care services in the tribal region of Khairwars of Sidhi district of Madhya Pradesh remained largely unsuccessful due to their prevailing beliefs, and their practices of modern health systems. They have their own perception regarding different components of antenatal and postnatal care.


Amirtha Gowri, R. and Welhelmina Lalsiemthar, S. (2010) found that every year about three million young girls enter into the reproductive stage with poor knowledge and understanding about reproductive health aspect. The best long term remedy is education of women. Hence education of women influences their reproductive health
through a variety of channels, including child bearing attitudes, health-seeking behavior and learning opportunities.

**Ravi, Ragi and Nair, Sajini B. (2011)** found that rural women and those from low socio-economic status groups were found to be more likely to have STI/RTI symptoms, in all the state. Use of contraceptives, pregnancy complications and increased number of pregnancies emerge as significant predictors of STI/RTI symptoms.

**Ramaswamy, Lalitha and R.D., Sathya Suba (2011); Ghosh, Saswata (2011)** stated that the nutritional status of teenage pregnant girls was lower than adult pregnant women, thus effective the birth weight of infants born to them. The determinants of prevalence of anaemia among pregnant women have to be taken in light of demographic, socio-economic and culture background in India. Nutritional counselling helps to improve their nutritional knowledge which will eventually have a positive impact not only on their nutritional status but also on their infants.

**C.S. Metgud, V.A. Naik and M.D. Mallapur (2012)** have asserted that the biggest problem women face during pregnancy is nutritional. Most current nutritional supplements available in the market are too expensive and beyond the reach of the poor sections of society. Such nutritional programmes therefore offer hardly any solution to the problem of malnutrition among pregnant women.

**Gupta, Sanjay K. and Nandeshwar, Sunil in their study (2012)** have concluded that Asian women not only face great difficulty in accessing health services but are also unable to express reproductive health needs. Most women in the antenatal phase availed medical care through cheap or free government hospitals, whereas care in the postnatal phase was grossly inadequate in cities slum as well as village areas.
Gazali, W. A. Gazali, Falmata Muktar, and Mahamoud Mohammed Gana in their study (2012)\textsuperscript{78} have stated that access to maternal health care facility has a great positive impact on the survival and wellbeing of both the mother as well as her child during labour. Not only this, it also influences the overall maternal and child mortality rate. Unfortunately in most poor countries of the world there are several factors that avoid pregnant women from accessing reproductive health facilities during labour.

Gupta, Sanjay K and Nandeshwar, Sunil (2012)\textsuperscript{79} have found that nutritional anaemia was a common problem among under-five children and their mothers in Bhopal urban slum areas. Nearly 35.44\% children suffered from anaemia. The main reason was lack of postnatal care, especially in government hospitals accessible to the poor.

2.3. MORTALITY CAUSE OF MOTHER AND CHILD

According to P. Mohapatra et al. (1990)\textsuperscript{80} a fairly high percentage of pregnant women suffered from malnutrition and anaemia.

Desai, Sonalde (1994)\textsuperscript{81}, IIPS (1995)\textsuperscript{82} state that discrimination against the girl child has an extremely pernicious influence on women’s health resulting in higher female mortality. In households where boys are given preferential treatment the girl child is not only overworked but also fed poorly.

According to a World Bank study conduct in (1996)\textsuperscript{83} the percentage of women suffering from anaemia in India is anywhere between 50 to 90 percent. Almost 20 percent of all maternal deaths in India are the result of severe anaemia.

The Institute for Research in Medical Statistics (IRMS)\textsuperscript{84} conducted a pilot study in Delhi, Karnataka, Maharashtra, Uttar Pradesh and Uttarakhand in 2003. One district was selected from each of the above named state. The study makes it amply clear that the major causes of death and disability among women in the reproductive age-
group are complications in the prenatal and labour stages. Poor nutrition, poverty, lack of education, lack of family planning leading to frequent births, and infection due to poor personal and civic hygiene are some causes that combine together to give birth to numerous health problems in mothers and newborn babies. They become the cause of several maternal and child mortality.

Pandey, A.K. (2003)\(^{85}\) comes to the conclusion that malnutrition among women leads to poor health especially in the reproductive phase. Other areas of concern are sexually transmitted diseases and illnesses caused by maternity.

Ramarao, Saroja et al. (2004)\(^{86}\) have in their study mentioned that inequity against a girl child is evident from the reality that female practice high rate of death in younger age groups as compared to boys.

Buckshee, K. (1997)\(^{87}\); Sudha, S. et al. (2003)\(^{88}\); Srivastava, Harish and Das, Arindam (2005)\(^{89}\); P.M., Rani Sandhya (2005)\(^{90}\); Raj, Papia (2005)\(^{91}\) in their respective studies have found that in developing countries and in the age group 15-49 years pregnancy-related problems are among the foremost causes of death and disability for women. The studies reveal that some of the factors governing maternal health utilization were education of women, education of husband, standard of living, and pregnancy and delivery related complications.

Smart, David, Henderson, J. et al. (2007)\(^{92}\) have, in their studies, discovered that in South East Asia pregnancy and childbirth are a major cause of diseases in women. This high maternal, infant and child mortality rate is a direct result of poor economic condition, poor levels of education, unemployment, low socio-economic status, lack use of contraceptive method and not use to health services. The difference in maternal and child mortality rates is a great distinguishing feature separating the developed and developing world.
Amirtha Gowri, R. and Welhelmina Lalsiemthar, S. (2009) has in this study found that malnutrition-induced anaemia, together with excessive bleeding, causes as many as forty-seven percent of maternal deaths in the villages of India. Every year nearly 78,000 women – pregnant or new mothers – in India, die from such preventable causes as internal bleeding (shock or haemorrhage) and anaemia. This works out to one death every seven minutes.

Chandraker, Richa et al. (2009) found that women's reproductive health in UP is poorer than in most other states in India. Social and cultural norms lead to early marriage and childbearing, low use of modern contraceptives, dismal maternal health and high stages of maternal deaths. The majority of deliveries in UP (88%) are conducted at home and more than two-thirds of these home deliveries are attended by untrained health professionals.

Raymond, Susan U. et.al. (2005) in their respective studies examined that among women in the age group between 15 and 34 years while more than 20 percent of deaths occurred due to chronic diseases, HIV and other reproductive diseases caused around 10% deaths. In the fourth world countries the most important cause of female deaths in their reproductive years and of women with young families was some chronic disease or the other. The above finding was true in seven out of the nine countries in which they carried out their research.

Medical research by Registrar General, India (IRG, 1996) shows that pregnancy at an early age, and frequent and many pregnancies have an adverse impact on the health of a woman. Although birth rate has declined in India, several areas of the country continue to have high levels of fertility. According to this report five states in 1993 had a fertility rate of more than four children per woman. Over all high fertility rates lead to high maternal mortality.

Munshi, Rakesh and Lee, Sang-Hyop (2000); Singh, Padam and Yadav, R.J. (2000, 2001) have worked out the effect of
demography and socio-economic conditions on vaccination of children and the result it has on child death.

Maitra, Pushkar and Ray, Ranjan (2004)\textsuperscript{100}; Ghosh, Shanti (2004)\textsuperscript{101} have found that good health and nutrition has a positive effect on learning, labour productivity, and on child survival. Data from the developing countries of Asia and Africa prove consistently that poor nutrition in children increases the risk of death. Children who are underweight contribute between 25 and 50 percent to childhood mortality. According to a study by David Pelletier in 1991, as the nutritional status worsens, child mortality goes up. There is widespread malnutrition among children in developing countries.

According to a year 2005\textsuperscript{102} report of the Department of Planning, Uttar Pradesh, Lucknow, there is a deep connection between premature death and disability, on the one hand, and poor nutrition and communicable diseases, on the other, especially among the poorer sections of society. Nearly 92 percent of the cases referred for hospitalization in the villages of Uttar Pradesh fell in the infectious category – diarrhoea and gastroenteritis to be more specific.

Sreekumaran, N. et al. (2000)\textsuperscript{103}; Kapoor, S.K. et al. (2001)\textsuperscript{104}; Sharma, Ravendra K. (2007)\textsuperscript{105} carried out research in the villages of Udupi Taluk in Karnataka and of Haryana to assess the extent of low birth weight (LBW). It was found that one important reason behind high infant mortality rate in poor countries is low weight at the time of birth.

Save the Children, Westport, USA (2008)\textsuperscript{106}, an NGO with headquarters in USA, found in a study that diseases like pneumonia, diarrhoea, malaria and complications arising because of them are the greatest killers of children throughout the world. The study also revealed that sixty-one percent of such deaths among children are those of girls leaving a survival gap of 39 percent between boys and girls.
Rohini Ghosh in a study conducted in 2012\textsuperscript{107} has touched upon two reasons for the slow decline in child mortality rates in India. One, she says, is economic disparity. Working through a network of traditional and cultural beliefs it has an indirect effect on people’s care seeking behaviour and making proper use of health care resulting in slow decline of child mortality. Two, cultural practices prevailing in India result in high death rate of newborns.

2.4. REPRODUCTIVE AND CHILD HEALTH CARE SERVICES

Majumdar, Prasanta K.; Tiwari, Ramji; Ram, Basant and Bhattacharya, B.N. (1994)\textsuperscript{108} revealed that nearness to a health centre played a positive role in spreading awareness about and utilisation of maternity and child health services. Similarly, high level of education and high per capita income were found to be positively associated with knowledge, type of services available and the extent of utilisation of maternal and child health services. An incidence rate for various kinds of immunisations to children (0-3) years was very high.

Bhatia, Jagdish C. and Cleland, John (1995)\textsuperscript{109} have shown that the incidence of caesarean section is much higher in private hospitals and nurshing homes than in hospitals run by government. In more than one-third degrees private hospitals performed surgery. Evidently, the motive is financial.

Gangopadhyay, Bhaswati and Das, D.N. (1997)\textsuperscript{110} have asserted that in order to spread awareness of the benefit of spacing deliveries among women belonging to the low income group the programmes of IEC (Information, Education & Communication) need to be redesigned. Health service providers must treat their patients humanely and give them complete information about all possible methods of delivery in order to enable them to make an intelligent choice. This however assumes a high level of education among women.
Barua, Alka et.al. (2003) reveal that the child health services given by the Family Welfare Programme is not only meagre but is also marked by weaknesses such as unscientific work schedules, poor availability of functioning equipment, and erratic supply of contraceptives and drugs. Not only this. Many villages are without health centres and villagers cannot access health services easily. Health workers are unskilled and poor in knowledge.

According to I. Shobha (2003), the national policy recognises the fact that childhood years are the important period for the development of physical and mental abilities. Childhood years are therefore crucial for later development of an individual and that makes the services provided in early childhood most important for the development of the child. Since mother is central to the life of a child it is equally important that due care is taken to ensure supply of proper nutrition not only to the mother but also to the child. Nutrition, health and education are thus equally important for the child as well the mother and these services must be provided simultaneously to both. Integrated Child Development Scheme (ICDS) had a positive impact on beneficiaries and has the potential of enhancing the child survival rate. Definite improvement has been reported on major indicators of health and nutrition like IMR, nutritional status, morbidity pattern, vaccination reporting and use of health services.

Goel, S.L. (2005) says that prevailing ill-health among women is a major concern. These are being addressed through several programmes, such as nutrition, Reproductive Health, Maternal and Child Health.

Kulkarni, M.S. et. al. (2005) highlights that antenatal services, in particular, and maternal and child health services, generally, participate a very significant role in the encouragement of small family norms and the acceptance of family planning methods. In their study the researchers emphasize on laying greater stress on antenatal services for
a perceptible effect on reducing fertility and increasing use of contraceptives in order to achieve our national goals and objectives for population stabilization at the earliest.

Kumar, Meenal and Kumar, R. (2006)\textsuperscript{115} claim in their study that discrimination in the area of health care during antenatal period and after childbirth is well known, especially among the poor and uneducated communities. They advocate greater research for effective intervention during crucial periods for bringing about improvement in the health of the mother by providing access to quality health care.

According to the 2006 report of the Department of Public Health and Family Welfare, Madhya Pradesh\textsuperscript{116}, the aim of the Reproductive and Child Health Programme (RCH II) in Madhya Pradesh is to bring about a change for the better in the health of women and children, especially of the poorest sections of society. This is sought to be done through better quality and access reproductive and child health services.

Garg, Suneela and Nath, Anita (2007)\textsuperscript{117} report state that several programmes for improving the health of the people living in villages have been initiated at the national level. The NRHM aims to provide across the board access to quality health care at affordable prices in the villages of India. The special focus of the mission will be on women and children and the underprivileged sections of the society.

Mahto, Ram Narayan (2007)\textsuperscript{118} has concluded that there are facilities of health check-ups available but due to lack of money and lack of knowledge women go to Dhami/Jhakri at the time of illness in the nearby village. Therefore, to reduce the high maternal and child mortality better primary health care services should be conducted.

Srinivasan, K.; Shekhar, Chander and Arokiasamy, P. (2007)\textsuperscript{119} have found that Reproductive and Child Health (RCH) services are significantly more effective at the state than at the district level. In
several areas of RCH – child-immunisation being one – the rate of progress since 1998 has actually gone down despite the expenditure being doubled due to corruption and wasteful expenditure. This goes to prove that decentralisation is not always effective unless the schemes are monitored and coordinated centrally. It is of paramount importance that healthcare services are backed by skilled medical and paramedical workers on a full time basis at the point of delivery.

**Goel, S. (2008)**\(^{120}\) says that although health services have seen considerable expansion in the last few decades but the quality of services leaves much to be desired. With a view to ensure a certain minimum standard of health services IPHS was introduced in 2007.

**Gupta, Madhu et.al. (2008)**\(^{121}\) have shown that there is great disparity in RCH services in different population groups. In order to achieve the United Nations MDGs it is imperative that special interventions are undertaken on a priority basis to restore parity among all sections of society.

**James, Ayangunna (2008)**\(^{122}\) examines the relationship between social wellbeing practitioner’s demographic variables and prerequisite of reproductive health information to adolescents in the town of Oye, in the state of Ekiti, Nigeria. According to the findings of the study, reproductive health information to adolescents can be provided both by married or single social welfare practitioners. Single marital status has no negative bearing on the dissemination of reproductive health information among adolescents when done by social wellbeing practitioners.

**Gaur, Parul (2008)**\(^{123}\) analyzes that maternal and child health is an essential aspect of community health. Maternal and Child Health mission aims at improving the availability of good preventive and primary health care for all women and children, irrespective of their economic condition.
**Hazarika, Indrajit (2009)** has concentrated on the continuous efforts directed towards creating awareness about the use of reproductive services in communities living in slums. The National Urban Health Mission as a sub-mission of National Health Mission (NHM) was approved by the Union Cabinet on 1st May 2013. NUHM aims to provide health care needs to the urban residents, particularly to the urban poor. It seeks to decrease out of pocket expenses of the poor for treatment. It is hoped that NUHM will provide an impetus to the use of reproductive services in urban slums.

**Chauhan, Anjali et. al. (2010)** claims that the health of women suffer due to avoidable inequalities to which they are subjected right from the time of birth. Special attention therefore has to be paid to the needs of women at every stage of life so that they may avail of an all round quality health care at reasonable cost.

**An international NGO called International Institute for Population Sciences (IIPS) (2010)** lays down an elaborate plan to ensure maternal health care. According to this plan services for antenatal care should consist of a minimum of three antenatal care check-ups, administering iron folic acid tablets for expected and lactating women, at least one dose of TT injection, prevention of anaemia, and management and referral of high risk pregnancies. It envisages safe delivery followed up by good postnatal care. In villages, the government has a network of reproductive health and other health services consisting of SCs, PHCs, and CHCs.

**Lalmalsawmzauva, K.C. and Nayak, D.K. (2010)** have in their study demonstrated the positive relationship between utilization of antenatal care and socioeconomic background of mothers in terms of literacy status and urbanization. At the same time, accessibility emerged as an important aspect of maternal health services.
According to a research carried out by K. Mallikharjuna Rao, N. Balakrishna, N. Arlappa, and others, in 2010\textsuperscript{128} insufficient intake of food leading to hidden hunger during the period of pregnancy and breastfeeding has a detrimental effect on the health of both mother and the children. Their study emphasizes the importance of community participation in developmental programmes for alleviation of poverty and speeding up literacy among women. Awareness about health and nutrition can be created with the help of the Department of Health and Integrated Child Health Services. Such awareness will bring about a definite improvement in the health of the mother and the child.

Varma, Deepthi S. et.al.(2010)\textsuperscript{129}; Thilagavathy, Ganapathy (2012)\textsuperscript{130} reveals that for women who do not want to deliver in an institution, it is important to convince them about the benefits of availing the services of a Skilled birth attendants (SBA) have an important responsibility to promote comfort during labour and birth conduct at home. Delivery preparedness is an important component that needs to be emphasized by the ASHA.

Deshpande, R.V. (2011)\textsuperscript{131} says that the female activists working under the ASHA scheme must make greater efforts in order to encourage women to go for delivery in a hospital. Those who are managing the programme and those operating at the field level must take the scheme seriously in order to eliminate, as far as possible, all those medical complications that endanger life before, during and after delivery, especially among women belonging to SCs and STs and those living under the poverty line. Only then the goal of reduced maternal and infant mortality will be realized.

Sharma, J.K. and Narang, Ritu (2011)\textsuperscript{132} have shown by employing the Haddad scale that they could see that people’s opinion differed according to the community they belonged to and the place where they lived, and accordingly there also was a difference in the quality of health care centres located at different places. The Haddad scale could
therefore prove to be useful in evaluating the difference in perception regarding healthcare quality in the villages and cities of India, and to assess the perception of the people of different places towards private healthcare centres. They therefore urge the government and policy-makers to take into account the view of the patients while formulating policy. This will bring about qualitative difference in the quality of healthcare services which in turn will increase utilisation.

Kumar, Anurag and others in their study (2012)\textsuperscript{133} have evaluated the quantum and quality of health services delivered in the villages of Uttar Pradesh under the auspices of the NRHM. The parameters of assessment were the condition of static and dynamic infrastructure; strength of the paramedical, technical and medical staff in employment; their attendance and gender ratio; quality, range and availability of drugs; availability and utilisation of funds at health centres; and the number of laboratories for diagnostic purposes.

Taneja, D.K. et.al. (2012)\textsuperscript{134} say that Delhi, the National Capital faces the challenges of very high population growth, mainly due to immigration from other states. Slums accommodate about one third of its population and are characterized by poor MCH service coverage. The cover of health services must extend to the entire population, not just a few. Health services have to be people-oriented. Abortion and delivery services must be comprehensive extending not only to the rich but also to the poorest sections. Special schemes have to be devised for slums.

\textbf{2.5 CONCLUSION}

On the basis of review, the following conclusion can be drawn: the high maternal and child mortality in the world, specially in developing countries including India is due to a number of preventable reasons. Factors related to sexual and reproductive health are socio-economic conditions, demographic aspects like menarche and marriage-related issues, nutrition, anthropometry, prenatal, natal and postnatal care, and various customs prevailing in the community. Customs and
general attitudes of society, along with biological and physiological problems, affect the health of women.