Chapter – 3

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3.1. Introduction

After Independence, India adopted the welfare state approach, which was dominant worldwide at that time. Health is one of the most important assets a human being has. It permits us to fully develop our capacities. If this asset erodes or it is not developed completely, it can cause physical and emotional weakening, causing obstacles in the lives of people. To understand the problem precisely and to focus on the rationale of the study, it becomes urgent to have an idea about the studies conducted so far related directly or indirectly with the problem. The present chapter reviews some available empirical studies regarding different aspects of health status in India and its respective states. The review of these studies provides a broad scenario of various dimensions of health status.

3.2. National Health Policies in India

The Health Ministry is the authorised agency for formulating and implementing health policy in India. Improvement in the health status of the population has been one of the major trust areas in social development programmes of India since independence. The Indian government has set up a number of committees to assess and improve health standards in India. Some of the major committees and their recommendations are follows:

(A) Bhore Committee (1946):

Bhore Committee (1946), known as the ‘Health Survey and Development Committee’, was appointed in 1943 with Sir Joseph Bhore as its Chairman. It laid emphasis on integration of curative and preventive medicine at all levels. It made comprehensive recommendations for remodeling of health services in India. It was strongly remarked in the committee report that:

"If it were possible to evaluate the loss, which this country annually suffers through the avoidable waste of valuable human material and the lowering of human efficiency through malnutrition and preventable morbidity, we feel that the result would be so startling that the whole country would be aroused and would not rest until a radical change had been brought about."
The Bhore Committee report, submitted in 1946, had some important recommendations like:

(1) The committee recommended that “No individual should fail to secure adequate medical care because of inability to pay for it”.

(2) The committee observed that:
   - Child Death Rate (CDR): 22.4/1000
   - Infant Mortality Rate (IMR): 162/1000 live births
   - Maternal Mortality Rate (MMR): 20/1000 live births
   - Life Expectancy at Birth: 27 years.

(3) The committee emphasized improvement in housing, communication, water supply, sanitation, nutrition, agriculture and industrial production and elimination of unemployment for improvement of health.

(4) The committee emphasized more on health care services for rural population and recommended that health services should be placed as close as possible to the people in order to ensure the maximum benefit to the communities to be served.

(5) It also recommended the integration of preventive and curative services.

(6) The committee recommended development of Primary Health Centers in two stages:

   - **Short-term Measures:** The committee recommended short-term plan to be implemented in 2-3 years time. One primary health centre as suggested for a population of 40,000. Each PHC was to be manned by 2 doctors, one nurse, four public health nurses, four midwives, four trained dais, two sanitary inspectors, two health assistants, one pharmacist and fifteen other class IV employees. Secondary health centre was also envisaged to provide support to PHC, and to coordinate and supervise their functioning.

   - **Long-term Measures:** A long-term programme recommended a 3-tier system:
     - **First Tier:** Primary health unit with 75 bedded hospital for each 10000-20000 population with a staff of 6 medical officers, 6 public health nurses, 2 sanitary inspectors, 2 health assistants and other supportive staff;
     - **Second Tier:** 650 bedded Regional Health Unit (RHU) to serve as a referral centre for 30-40 PHUs; and
     - **Third Tier:** District hospitals with 2,500 beds to serve the needs of about 3 million.
(7) Major changes in medical education which includes 3-month training in preventive and social medicine to prepare “social physicians”. Though most of the recommendations of the committee were not implemented at the time, the committee was a trigger to the reforms that followed. It was instrumental in bringing about the public health reforms related to peripheral health centres in India.

(B) Mudaliar Committee (1962):

Mudaliar Committee (1962) known as the ‘Health Survey and Planning Committee’, headed by Dr. A. L. Mudaliar, Vice-chancellor of the Madars University, was appointed in 1959 to assess the performance in health sector since the submission of Bshore Committee report. The committee recommended that:

1. The committee found the conditions in PHCs to be unsatisfactory and suggested that the PHC, already established should be strengthened before new ones are opened.
2. The committee also advised strengthening of sub-divisional and district hospitals. It was emphasised that a PHC should not be made to cater to more than 40,000 population and that the curative, preventive and promotive services should be provided at the PHC.
3. The Mudaliar Committee also recommended that an All India Health Service should be created to replace the erstwhile Indian Medical service. The concern of the Health Survey and Planning Committee (Mudaliar Committee 1962) was limited to the development of the health services infrastructure and the health care at the primary level. It felt the growth of infrastructure needed radical transformation and further investment.

(C) Chadda Committee (1963):

Chadda Committee (1963) was appointed under chairmanship of Dr. M. S. Chadha, the then Director General of Health Services, to advise about the necessary arrangements for the maintenance phase of National Malaria Eradication Programme (NMEP). The committee suggested that the vigilance activity in the NMEP should be carried out by basic health workers (one per 10,000 population), who would function as multipurpose workers and would perform, in addition to malaria work, the duties of family planning and vital statistics data collection under supervision of family planning health assistants. Basic health workers should visit house-to-house once in a month to implement malaria eradication activities. The scope of Chadda committee was restricted to malaria eradication.
(D) Mukherjee Committee (1965):

The recommendations of the Chadda Committee, when implemented, were found to be impracticable because the basic health workers, with their multiple functions could do justice neither to malaria work nor to family planning work. The Mukherjee Committee (1965) headed by the then Secretary of Health Shri Mukherjee, was appointed to review the performance in the area of family planning. The committee recommended separate staff for the family planning programme. The family planning assistants were to undertake family planning duties only. The basic health workers were to be utilised for purposes other than family planning. The committee also recommended to delink the malaria activities from family planning so that the latter would receive undivided attention of its staff.

(E) Mukherjee Committee (1966):

Multiple activities of the mass programmes like family planning, small pox, leprosy, trachoma, NMEP (maintenance phase), etc. were making it difficult for the states to undertake these effectively because of shortage of funds. A committee of state health secretaries, headed by the Union Health Secretary, Shri Mukherjee, was set up to look into this problem. The committee worked out the details of the Basic Health Service which should be provided at the Block level, and some consequential strengthening required at higher levels of administration. The Committee did not attempt to work out any details of the organisation that would be needed above the district level, i.e. at the Zonal, the State and the Central level. The Committee felt that the State Governments should work out the better methods for the functioning of the health organisations at the Zonal and State levels.

(F) Jungalwalla Committee (1967):

Jungalwalla Committee (1967), known as the “Committee on Integration of Health Services” was set up in 1964 under the chairmanship of Dr. N. Jungalwalla, the then Director of National Institute of Health Administration and Education (currently NIHFW). It was asked to look into various problems related to integration of health services, abolition of private practice by doctors in government services, and the service conditions of Doctors. The committee defined “integrated health services” as:
(1) A service with a unified approach for all problems instead of a segmented approach for different problems.

(2) Medical care and public health programmes should be put under charge of a single administrator at all levels of hierarchy.

Following steps were recommended for the integration at all levels of health organisation in the country:

(1) Unified Cadre.
(2) Common Seniority.
(3) Recognition of extra qualifications.
(4) Equal pay for equal work.
(5) Special pay for special work.
(6) Abolition of private practice by government doctors.
(7) Improvement in their service conditions.

(G) Kartar Singh Committee (1973):

Kartar Singh Committee (1973), headed by the Additional Secretary of Health and titled the "Committee on Multipurpose Workers under Health and Family Planning" was constituted to form a framework for integration of health and medical services at peripheral and supervisory levels. Its main recommendations were:

(1) Various categories of peripheral workers should be amalgamated into a single cadre of multipurpose workers (MPW - male and female). The erstwhile auxiliary nurse midwives were to be converted into MPW(F) and the basic health workers, malaria surveillance workers etc. were to be converted to MPW(M). The work of 3-4 male and female MPWs was to be supervised by one health supervisor (male or female respectively). The existing lady health visitors were to be converted into female health supervisor.

(2) One Primary Health Centre should cover a population of 50,000. It should be divided into 16 sub-centres (one for 3000 to 3500 population) each to be staffed by a male and a female health worker.
(H) Srivastav Committee (1975):

Srivastav Committee (1975) was set up in 1974 as ‘Group on Medical Education and Support Manpower’ to determine steps needed to:

1. Reorient medical education in accordance with national needs and priorities.
2. Develop a curriculum for health assistants who were to function as a link between medical officers and MPWs.

The Srivastav Committee recommended immediate action for:

1. Creation of bonds of paraprofessional and semi-professional health workers from within the community itself.
   - Creation of Village Health Guide (VHG) or community health volunteers from the community itself like teachers, post masters, gram sevaks who can provide comprehensive health services as paraprofessional.
   - Primary health care should be provided within the community itself through specially trained workers so that the health of the people is placed in the hands of people themselves.
2. Establishment of 3 cadres of health workers namely – multipurpose health workers and health assistants between the community level workers and doctors at Primary Health Centres (PHCs).
3. Development of a “Referral Services Complex” by the development of proper linkages between the PHC and higher level referral and service centres.
4. Establishment of a Medical and Health Education Commission for initiating the reforms needed in health and medical education on the lines of UGC. Acceptance of the recommendations of the Srivastav Committee led to the launching of the Rural Health Scheme in 1977-78.

The major steps initiated were:

1. Involvement of medical colleges in health care of selected with the objective of reorienting medical education according to rural population called Reorientation of Medical Education (ROME). It led to teaching and training of undergraduate students and interns at PHCs.
2. Training of Village Health Guides and utilising their services in the general health service system. With the widespread disillusionment with vertical programmes
worldwide and the need to provide universal health services came the Primary Health Care Declaration at Alma Ata in 1978, which India was a signatory to. Accordingly, a working group on “Health for All by 2000 AD” was constituted in 1981 under the chairmanship of Kripa Narain.


‘The Working group on health for all by 2000 AD’71 under the Chairmanship of Kripa Narain submitted its report in 1981 and based on its recommendations the following health strategy was worked out for the Sixth Plan Period:

(1) Emphasis would be shifted from development of city based curative services and super specialities to tackle rural health problems.

(2) The infrastructure for rural health would consist of primary health centres serving a population of 30000 each, sub-centres serving a population of 5000 each and a trained health volunteers for every 1000 people.

(3) Facilities for treatment in basic specialities would be provided at community health centres at the block level for a population of 1 lakh with a 30 bedded hospital attached and a system for referral cases from the community health centre to the district hospitals would be introduced.

(4) Various programmes under education, water supply and sanitation, control of communicable diseases, family planning, maternal and child health care, nutrition and school health implemented by different agencies would be properly coordinated for optimal results.

(5) Medical and para-medical manpower would be given adequate training for meeting the requirements of a programme of this order and all education and training programmes would be given suitable orientation towards rural health care and finally, the people would be involved and community participation in the health programme would be encouraged. They would be entitled to supervise and manage their own health programmes. The report submitted by the Committee was in fact a move towards articulating a national health policy that was thought of as an important step to realise the Alma Ata Declaration. It was realised that one had to redefine and rearticulate and get back into track an integrated and comprehensive health system that policy-makers had wavered from. It reiterated the need to integrate the development of the health system
with the overall plans of socioeconomic and political change. It recommended that the Government should formulate a comprehensive national health policy dealing with all dimensions—environmental, nutritional, educational, socioeconomic, preventive and curative.

**J) The National Health Policy, 1983:**

For the first time in the history of free India a very comprehensive health policy was approved by the Parliament in 1983. The National Health Policy, 1983, has clearly admitted the failures of the government in health sector in the past.

1. Firstly, the government felt that the then existing situation was largely caused by the almost wholesale adoption of health manpower development policies and the establishment of curative centres based on the Western models which were inappropriate and irrelevant to the real needs of the people and the socioeconomic conditions obtaining in the country.

2. Secondly, the establishment of medical services for urban poor through hospitals was undertaken at the cost of providing comprehensive primary health care services to the poor, especially in rural areas.

3. Thirdly, the existing approach, instead of improving awareness and building up self-reliance in the community, has tended to enhance the dependence of the community and weaken its capacity to cope up with the growing health problems.

**K) The National Health Policy, 2002:**

The Ministry of Health and Family Welfare, Govt. of India, evolved a National Health Policy in 1983 keeping in view the national commitment to attain the goal of Health for all by the year 2000. Since then there has been significant changes in the determinant factors relating to the health sector, necessitating revision of the policy, and a new National Health Policy-2002 was evolved.

The main objective of this policy was to achieve an acceptable standard of good health amongst the general population of the country. The approach would be to increase access to decentralized public health system by establishing new infrastructure in the existing institutions. Over-riding importance would be given to ensure a more equitable access to health services across the social and geographical expanse of the country. To translate the above objectives into reality, the Health Policy has laid down specific goals.
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to be achieved by year 2005, 2007, 2010 and 2015. These are as given in below table.
Steps are already under way to implement the policy.

Tab.3.1-Goals to be achieved by 2015

<table>
<thead>
<tr>
<th>No.</th>
<th>Goal</th>
<th>Year</th>
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<tbody>
<tr>
<td>1.</td>
<td>Eradicate Polio</td>
<td>2005</td>
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<tr>
<td>2.</td>
<td>Eliminate Leprosy</td>
<td>2005</td>
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<tr>
<td>3.</td>
<td>Achieve zero level growth of HIV/AIDS</td>
<td>2007</td>
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<td>4.</td>
<td>Eliminate Kala-Azar</td>
<td>2010</td>
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<td>5.</td>
<td>Reduce mortality by 50% on account of TB, Malaria and other vector and water-borne diseases.</td>
<td>2010</td>
</tr>
<tr>
<td>6.</td>
<td>Reduce prevalence of blindness to 0.5 %</td>
<td>2010</td>
</tr>
<tr>
<td>7.</td>
<td>Reduce IMR to 30/100 and MMR to 100/lakh</td>
<td>2010</td>
</tr>
<tr>
<td>8.</td>
<td>Increase utilization of public health facilities from current level to less than 20% to more than 75%.</td>
<td>2010</td>
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<tr>
<td>9.</td>
<td>Increase health expenditure by government as a percentage of GDP from the existing 0.9% to 2%.</td>
<td>2010</td>
</tr>
<tr>
<td>10.</td>
<td>Increase share of central grants to constitute at least 25% of total health spending.</td>
<td>2010</td>
</tr>
<tr>
<td>11.</td>
<td>Increase state share health spending from 5.5% to 7% of the budget</td>
<td>2015</td>
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Source: www.mohfw.nic.in

The highlights of the policy are:

(1) Increase health sector expenditure to 6 percent of GDP, with 2 percent of GDP being contributed as public health investment, by the year 2010. With the stepping up of the public health investment, the Central Government's contribution would rise to 25 percent from the existing 15 percent by 2010. An increased allocation of 55 percent of the total public health investment for the primary health sector. The secondary and tertiary health sectors being targeted for 35 percent and 10 percent respectively.

(2) The plan envisaged gradual convergence of all health programmes under a single field administration. Vertical programmes for control of major diseases like TB, Malaria, HIV/AIDS, as also the Reproductive and Child Health andm Universal Immunization Programmes, would need to be continued till moderate levels of prevalence are reached.

(3) It was proposed that the programme implementation be effected through autonomous bodies at State and district level.
Critical assessment of health policies:

Both the health policies of 1983 and 2002 highlight the importance of the role of decentralisation but do not state how this will be achieved. The National Health Policy (2002) includes all that is wanted from a progressive document and yet it glosses over the objective of NHP 1983 to protect and provide primary health care to all.

The Policy document talks of integration of vertical programmes, strengthening of the infrastructure, providing universal health services, decentralization of the health care delivery system through Panchayati Raj Institutions (PRIs) and other autonomous institutions, and regulation of private health care but fails to indicate how it achieves the goals. It encourages the private sector in the first referral and tertiary health services.

The overview of the plans and policy reports not only throws light on the gap between the rhetoric and reality but also the framework within which these policies and programmes have been formulated. There has been an excessive preoccupation with single-purpose driven programmes. Above all, the spirit of primary health care has been reduced to just primary level care. The health reports and plans mostly concentrated on building the health services infrastructure and even this lacked a sense of integration. Most of the policy reports miss out on the importance of a strong referral system. Instead, there has been more emphasis on building the primary level care and even that has lacked proper implementation. The Bhore committee report and later, the Primary Health Care Declaration discussed the operational aspects of integrating the other sectors of development related to health. The multi-sectoral approach that is much needed and the inter-sectoral linkages that are essential for a vibrant health system have not been well thought out, and there has been no plan drawn out for it later. The outline of plan documents and their implementation have been incremental rather than being holistic. It is important to question whether it is only the low investment in health that is the main reason for the present status of the health system or is it also to do with the framework, design and approach within which the policies have been planned.
3.3. Review of Literature

The aim of this chapter is to exemplify analytically the scholarly investigations, both theoretical and empirical, on the health and healthcare status


Health education is widely promoted in primary care, but there have been few rigorous evaluations of its impact, especially in developing countries. The efficacy of health education interventions that rely solely on giving people information to bring about a change in health behavior is unproved; interventions should be evaluated before being implemented on a large scale. Alternative strategies for health promotion in developing countries such as interactions within families, peer groups, or communities may be more effective but are costly and difficult to implement on a large scale.

According to Alma Ata declaration of 1978, the rational approach to health promotion, information given by health workers during clinic based or community based contacts will bring about a change in health behavior, is an integral part of primary healthcare strategies. In practice, opportunities for one to one health education are given low priority by busy health workers. Health education and information is critical for ensuring people’s participation in rural health service.

Cleland J.G. et al (1988) concluded through their study that during the past two decades a considerable amount of information has become available from developing countries showing that maternal education has a strong impact on infant and child mortality. On average each one-year increment in mother’s education corresponds with a 7-9% decline in under-5s’ mortality. Education exercises a stronger influence in early and later childhood than in infancy.

Paivi Rautava et al (1990) found in their study on women’s opinion on antenatal training courses that according to puerperal women the training courses increased their knowledge, helped them to cope up with pregnancy and delivery and helped in reducing anxiety but few felt that the information they received was out-of-date, inadequate and poorly presented. Women wanted more detailed information about both normal and abnormal delivery, as well as life at home after delivery.
**Rajna P.N. et al (1998)** shows through their study on the effect of maternal education on child mortality that education has direct as well as indirect effects through antenatal care and family formation patterns on neonatal mortality. Maternal education also has a substantial effect on later childhood mortality. While improving maternal education is a means of reducing childhood mortality, an immediate reduction in childhood mortality is feasible even under existing social conditions by enhancing accessibility to maternal and child health services and safe drinking water.

**Anne McDonald Culp et al (2007)** found out in their study that mothers who received early education home visits from child development specialists experienced positive health and safety outcomes. Further, authors have highly recommended that a program such as this be implemented as part of health delivery program with new mothers and infants.

**Britta et al (2007)** provide evidence through their study that educating pregnant women and their male partners yields a greater net impact on maternal health behaviors compared with educating women alone.

**Dongre A.R. (2008)** in their study found gap between mothers' knowledge and their health seeking behavior for sick newborn and explored their deep perceptions, constraints and various traditional treatments. Most of the mothers of sick newborns knew that sick child should be immediately taken to the doctor and only around 50% of such sick newborns got treatment either from government hospital or from private hospital and almost rest 50% of sick babies received no treatment. The reasons for not taking actions even in presence of danger signs/symptoms were ignorance of parents, lack of money, faith in supernatural causes, non availability of transport, home remedy, non availability of doctor and absence of responsible person at home. For almost all the danger signs/symptoms supernatural causes were suspected and remedy was sought from Traditional Faith Healer (Vaidu) followed by doctor of primary health centre and private doctor. Comprehensive intervention strategies are required to change behavior of caregiversalong with improvement in capacity of Government health care services and National Health Programs to ensure newborn survival in rural area.

**Jennings K. et al (2010)** demonstrated in their study that the messages provided to pregnant women significantly improved in birth preparedness, danger sign recognition
and new born care and authors concluded that a job aids-focused intervention can be integrated into routine antenatal care with positive outcomes on provider communication and maternal knowledge. Efforts are needed to address time constraints and other communication barriers, including introduction of on-going quality assessment for long-term sustainability.

Titaley C.R. et al (2010) found in their study that a comprehensive strategy to increase the availability, accessibility, and affordability of delivery care services should be considered and also, health education strategies are required to increase community awareness about the importance of health services along with the existing financing mechanisms for the poor communities. Public health strategies involving traditional birth attendants will be beneficial particularly in remote areas where their services are highly utilized.

Akhund S.A. et al (2011) found from their pretesting study that a majority of pregnant women have an understanding of the culturally relevant ANC handbook, as a part of health education during antenatal care. The handbook was found to be practical by healthcare paraprofessionals and community workers for use in different tiers of the health care system. The ANC handbook can be applied in the health service sector and can be adopted with relevant cultural modifications by countries with a similar context.
B). A Review of Maternal and Child health care services in India

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death. Most maternal deaths and pregnancy complications can be prevented by quality ante-natal, care during delivery period and post natal care. Antenatal care is the “care before birth” to promote the well-being of mother and fetus, and is essential to reduce maternal morbidity and mortality, low-weight births and peri natal mortality. However, the content and quality of antenatal care and the availability of effective referral and essential obstetric care are important for antenatal care to be effective.

Ante natal care is generally aimed at producing healthy mother and baby at the end of any pregnancy. It presents important opportunities for reaching pregnant women with a number of interventions that may be vital to their health and well being and that of their infants. The antenatal care period also provides a forum to supply information may positively influence maternal and child outcomes. Thus, it has been suggested that the antenatal care could play a role in reducing maternal mortality rate and that it could ensure that pregnant woman deliver with the assistance of a skilled attendant. Most maternal deaths and pregnancy complications can be prevented by quality antenatal, natal and post-natal care.

Stokoe U. (1991) concludes that maternal mortality is the culmination of a series of detrimental events in a woman's life, pregnancy being the last one. And found in their study that the underlying pathology is the lack of education, sanitation, accessible health care, as well as poor nutrition and poverty. These affect women during pregnancy and childbirth when they are more vulnerable.

Facuveau V. et al (1991) showed in their study that maternal survival can be improved by the posting of midwives at village level, if they are given proper training, means, supervision, and back-up. The inputs for such a programme to succeed and the constraints of its replication on a large scale should not be underestimated.

Sundari T.K. (1992) in their study put together evidence from maternal mortality studies in developing countries of how an inadequate health care systems characterized by misplaced priorities contributes to high maternal mortality rates. Inaccessibility of
essential health information to the women most affected, and the physical as well as economic and socio-cultural distance separating health services from the vast majority of women, are only part of the problem. Even when the woman reaches a health facility, there are a number of obstacles to her receiving adequate and appropriate care. These are a result of failures in the health services delivery system: the lack of minimal life-saving equipment at the first referral level; the lack of equipment, personnel, and know-how even in referral hospitals; and worst of all, faulty patient management. Prevention of maternal deaths requires fundamental changes not only in resource allocation, but in the very structures of health services delivery. Further, they concluded that most of the maternal mortality is due to “avoidable factors” either patient factors or structural factors.

Patient factors are defined as those actions by the patients that are faulty: delayed arrival or non arrival at a health facility, failure to seek legal abortion or interference with pregnancy, nonuse of prenatal care, and transportation problems. Structural factors are inaccessible health services and failures in the health services delivery system with shortage of trained personnel, lack of equipment and supplies, and poor patient management.

Pillai G. (1993) in their study found that the immediate causes of maternal mortality include pregnancy and delivery and the management of complications such as hemorrhage, toxic and bacterial infections (sepsis), eclampsia, and obstructed labor. The poor health, nutrition, and socioeconomic status of women are the underlying causes of maternal death. Gender bias in the allocation of meager food supplies results in the poor health and nutritional status of women, rendering a woman's pelvis too small, which causes obstructed labor and even death. Socioeconomic status is linked to access the family planning and health services which affect mortality and reproductive health.

Martey J.O. et al (1994) found in their study that prenatal care alone is not sufficient to prevent some deaths. The high mortality rate during delivery is a justification to improve the quality of care during delivery at all levels of the district health system. Causes of maternal death were postpartum hemorrhage (45.5%), jaundice in pregnancy (22.7%), obstructed labor (6.8%), eclampsia (6.8%), and fever (4.6%). 2.3% of deaths were attributed to ante partum hemorrhage, ectopic pregnancy, and septic abortion.
Kwast B.E. (1996) found in their study that access was improved through training of traditional birth attendants (TBAs) in timely recognition and referral of pregnancy/delivery/neonatal complications, while quality of care in health facilities was improved through modifying health professionals’ attitude towards TBAs and clients, and implementation of management protocols.

Bloom S.S. et al (1999) in their study of evidence to support that antenatal screening and interventions are effective in reducing maternal mortality found out through Logistic Regression that the women with relatively high level of care had an estimated odds of using trained assistance at delivery than that was almost four times higher than women with low level of care. And similar results were shown for the women delivering in health facility versus home. This strong positive association between level of care obtained during pregnancy and the use of safe delivery care may help explain why antenatal care could also be associated with reduced maternal mortality.

Fazili F. et al (1999) found their research that peri-natal mortality reflects the amount of pregnancy wastage due to fetal and neonatal deaths, and is considered a sensitive indicator of maternal and child health status in particular and community health status in general. Peri-Natal Mortality Rate (PNMR) was significantly higher among illiterate mothers, in extremes of age, among those living in joint families, and those having incomplete antenatal care. PNMR was low among the higher socioeconomic classes. Maternal weight had a significant effect upon peri natal loss.

Partha Abhay T.B. et al (1999) found in their study that home-based neonatal care, including management of sepsis, is acceptable, feasible, and reduced neonatal and infant mortality by nearly 50% among malnourished, illiterate, rural study population. This approach would reduce neonatal mortality substantially in developing countries.

De et al (2002) study’s results showed that children are more likely to receive immunization if their parents are a couple, with the father literate and the mother with at least a middle-school-education level who received antenatal care or delivered in an institutional environment.

Gokhale M.K. et al (2002) showed in their study that Illiteracy of females had a more detrimental impact on rural than on urban areas. In the event of high female illiteracy, male literacy was beneficial for improving the use of services for reducing infant
mortality rate. The micro-level study supported all major findings obtained for the national-level aggregate data. Programmes, like providing free education to girls, will yield long-term health benefits.

**Adam Wagstaff et al (2004)** evidently showed in their study that in most countries, rates of mortality and malnutrition among children continue to decline, but large inequalities between poor and better-off children exist, both between and within countries.

**Nirmala Murthy et al (2004)** was carried out a study to explore non-medical factors responsible for the persistently high maternal mortality in India showed that most deaths occurred at home and during the postnatal period. Most 'death cases' belonged to high-risk age groups, had high parity (3+), were socially disadvantaged, had not received prenatal care and advice to go to hospital as compared to women with complications. Consequently, they either had not gone to hospital or had gone too late. Delay in care was also because of lack of transport facilities, inappropriate referrals or poor emergency preparedness of referral facilities. Data suggested that about half the deaths could have been avoided if the health system had been alert and accessible. The critical determinants of avoidable death were families' awareness about complications, emergency transport and preparedness of referral facilities. The study highlighted the need for health workers to stress on health education, care during the third trimester and postnatal period, and referral to appropriate and accessible facilities, even bypassing the hierarchical referral system if necessary.

**Moran A.C. et al (2006)** highlight their findings from their study that how birth-preparedness and complication readiness may be useful in increasing the use of skilled providers at birth, especially for women with a plan for saving money during pregnancy. Controlling for education, parity, average distance to health facility, and the number of antenatal care visits, planning to save money was associated with giving birth with the assistance of a skilled provider.

**Hossain J. et all (2006)** found in their study of impact of interventions on use of obstetric services in government facilities that the best results are achieved through a combination of facility improvement, quality of care activities and targeted community mobilization activities.
Collin S.M. et al (2007) in their study through model-based analysis by adopting the effective interventions which have demonstrated potential to prevent maternal deaths showed that maternal mortality could be reduced by a combination of micronutrient supplementation and presumptive treatment of infection during pregnancy. Such an approach could be adopted in resource-poor settings where visits to antenatal clinics are infrequent and would complement existing Safe Motherhood activities.

Margaret E.K. (2007) found in their study that greater government participation in health financing and higher levels of health spending are associated with increased utilization of two maternal health services: skilled birth attendants and Caesarean section. While government financing is associated with better access to some essential maternal health services, greater absolute levels of health spending will be required if developing countries are to achieve the Millennium Development Goal on maternal mortality.

Susmita Bharati et al (2007) showed in their study that the status of literacy of mothers and standard of living of the family are of prime importance in improving the obstetric health care practices. The study indicates that the educated women with high standards of living have an emphasized role in the practice of more maternal health care. The study shows that rural antenatal care is still mostly based on Indian traditional system. It is the women who need to be educated and must be made aware about the importance of the health care for ensuring healthy pregnancy and safe delivery.

Kayode Osungbade et al (2008) in their study to assess the content of antenatal care and adequacy of maternal health care concluded that the antenatal care service has reasonable capacity for intervention against pre-eclampsia and some foetal problems and could contribute to delivery in a health facility and by a health worker and also health care centers are to be equipped with the capacity to detect anemia and proteinunia in order to improve the ante natal care service. Furthermore, iron and foliate supplements in pregnancy should be intensified.

Abdullah H.B. et al (2008) found in their study that NGO facilitation of government programmes is a feasible strategy to improve equity of maternal and neonatal health programmes. Improvements in equity were most pronounced for household practices, and inequities were still apparent in health care utilization. The equity of programme coverage and antenatal and newborn care practices improved from baseline to end line in
the intervention district while showing little change in the comparison district. Equity in health care utilization for mothers and newborns also showed some improvements in the intervention district, but notable socio-economic differentials remained, with the poor demonstrating less ability to access health services.

Manju Rani et al (2008) showed through their study on differentials in the quality of antenatal care that poor quality of antenatal care is likely to reduce its utilization. Policy and program interventions to improve the quality of care of antenatal care, especially for the poor and other disadvantaged population groups.

Anwar et al (2009) concluded in their research that the human-resource constraints are the major barrier for maternal health. Sanctioned posts for nurses are inadequate in rural areas of both the divisions; however, deployment and retention of trained human resources are more problematic in rural areas. To improve maternal healthcare, there is a need for a human-resource plan that increases the number of posts in rural areas and ensures availability. All categories of maternal healthcare providers also need training on evidence-based techniques. The authors recommend special strategies for improving the response in the low-performing areas is urgently warranted.

Chowdhury Mahbub Elahi et al (2009) showed through their study that access to and use of comprehensive Emergency Obstetric Care (EmOC) services possibly is the major contributor to the reduction in maternal mortality. Policies that bring expansion of female education, later childbearing, better financial access to the poor, and poverty alleviation are also essential to sustain the success achieved to date.

Mrisho M. et al (2009) found in their study that efforts to improve antenatal and postnatal care should focus on addressing geographical and economic access while striving to make services more culturally sensitive. Antenatal and postnatal care can offer important opportunities for linking the health system and the community by encouraging women to deliver with a skilled attendant. Addressing staff shortages through expanding training opportunities and incentives to health care providers and developing postnatal care guidelines are key steps to improve maternal and newborn health.

Lawn J.E. et al (2009) showed in their study that even in high-performance settings, there is scope to improve intra partum care and especially reduce impairment and disability. Addressing missed opportunities for births already occurring in facilities could
avert 36% of intra partum-related deaths. Improved quality of care through drills and audit are promising strategies. However, the majority of deaths occur in poorly performing health systems requiring urgent strategic planning and investment to scale up effective care at birth, neonatal resuscitation, and community mobilization as well as to develop, adapt, and introduce tools, technologies, and task shifting to reach the poorest.

**Sharad D. Iyengar et al (2009)** study's findings indicate that several factors had contributed to maternal mortality. Lack of skilled attendance and immediate postpartum care were major factors contributing to deaths. Improved access to emergency obstetric care facilities in rural areas and steps to eliminate costs at public hospitals would be crucial to prevent pregnancy-related deaths. Although the high prevalence of health conditions and diseases, including TB and anemia, are identifiable as direct or indirect causes of death, important societal and health systems factors constrain women from accessing quality health services. If reduction in maternal mortality is to become a reality, women in rural regions will require more efficient access to high-quality delivery and emergency services at an affordable cost.

Further they concluded that widespread irrational practices by a range of care providers in both homes and facilities can adversely affect women and newborns while inadequate observance of beneficial practices and high costs are likely to reduce the benefits of institutional delivery, especially for the poor. Government health agencies need to strengthen regulation of delivery care and, especially, monitor perinatal outcomes. Family preference for hastening delivery and early discharge also require educational efforts.

**Sharma M.P. et al (2009)** found in their study on assessment of institutional deliveries under Janani SurakshaYojana ((JSY) that the quality aspects of institutional deliveries are far from desired level mostly because of lack of resources, both manpower and materials; non achievement of Indian Public Health Standards etc. The Janani SurakshaYojana is perceived as an effective scheme by the beneficiaries but gaps in resources and lack of quality of services needs to be adequately dealt with. Also the quality of emergency obstetric care services (EmOC) was still poor due to the lack of blood storage units and anesthetists.
Dogba M. et al (2009) in their study concluded that (a) staff shortages are a major obstacle to providing good quality EmOC, (b) women are often dissatisfied with the care they receive during childbirth and (c) the technical quality of EmOC has not been adequately studied.

Sharad D. Iyengar et al (2009) concluded in their study that there is a lack of doctors in the PHCs, especially in tribal districts, and the availability of specialists at higher levels is even worse. Their review further shows that human-resource capacity, especially of specialists and skilled midwives, has been deficient, and referral arrangements continue to be weak. Non-residence on part of field staff, such as ANMs, whose personal mobility, security, and family needs have not been met, seriously impedes access to round-the-clock services. Efforts, such as raising salaries or contracting private practitioners, have failed to boost the availability of specialists adequately. The reasons for lack of staff are multiple. While anecdotal evidence points to the apparent perception of lack of safety, especially for female staff in some areas, there is little to attract specialists to government service. Several specialists posted at the CHCs manage to get themselves posted in peri-urban CHCs or „on-deputation” in district hospitals. Given the unwillingness of specialists to provide services at rural CHCs, the Government should train and empower much greater numbers of graduate doctors to provide EmOC services.

Amarit Singh et al (2009) showed that it is possible to develop large-scale partnerships with the private sector to provide skilled birth attendants and emergency obstetric care to poor women at a relatively small cost. Poor women will take up the benefit of skilled delivery care rapidly, if they do not have to pay for it.

Pena-Rosas J.P. et al (2009) found in their study that universal prenatal supplementation with iron or iron+folic acid provided either daily or weekly is effective to prevent anemia and iron deficiency at term. We found no evidence, however, of the significant reduction in substantive maternal and neonatal adverse clinical outcomes (low birth weight, delayed development, preterm birth, infection, postpartum hemorrhage). Associated side effects and particularly haemo concentration during pregnancy may suggest the need for revising iron doses and schemes of supplementation during pregnancy and adjust preventive iron supplementation recommendations.
Sadiquea et al (2009) in their study of finding the medical and socio economic causes of maternal deaths, found out that high risk groups are women with low socioeconomic status, illiteracy, low-earnings jobs, parity and bad obstetric history. The sixty-nine percent of deaths occurred in the postpartum period, 51% took place within 24 hours of delivery. Also study identified gaps in reporting of maternal deaths and profile of the dead women and causes of death.

Ravendra K. et al (2010) in their study demonstrates that utilization of maternal and child health services is very poor among the tribes of central India. Clinically acceptable maternal and newborn care practices for delivery, cord cutting and care, bathing of mother and newborn and skin massage are uncommon. Therefore, newborns remain at high risk of hypothermia, sepsis and other infections. Prelacteals, supplementary feeding practices and delay in breastfeeding are very common, although colostrum is less frequently discarded. Malnutrition is a severe problem among tribes and many tribal children and women are severely malnourished as well as anemic.

Bhatta Z.A. et al (2010) amply demonstrated in their review that opportunities for assessing outcomes for both mothers and newborns have been poorly realized and documented. Most of the interventions reviewed will require more greater-quality evidence before solid programmatic recommendations can be made.

However, on the basis of our review they conclude that, birth spacing, prevention of indoor air pollution, prevention of intimate partner violence before and during pregnancy, antenatal care during pregnancy, Doppler ultrasound monitoring during pregnancy, insecticide-treated mosquito nets, birth and newborn care preparedness via community-based intervention packages, emergency obstetrical care, elective induction for post term delivery, Cesarean delivery for breech presentation, and prophylactic corticosteroids in preterm labor reduce perinatal mortality; and early initiation of breastfeeding and birth and newborn care preparedness through community-based intervention packages reduce neonatal mortality.

Further their review demonstrates that Reproductive, Maternal and Newborn Health (RMNH) are inextricably linked, and that, therefore, health policies and programs should link them together. Such potential integration of strategies would not only help improve outcomes for millions of mothers and newborns but would also save scant resources.
would also allow for greater efficiency in training, monitoring, and supervision of health care workers and would also help families and communities to access and use services easily.

**Magoma M. et al (2010)** showed in their research that increasing coverage of skilled delivery care depends upon improved training and monitoring of health care providers and greater family participation in antenatal care visits.

**Amanda Harris et al (2010)** showed that utilization of maternal health care services is associated with a range of social, economic, cultural and geographic factors as well as the policies of the state and the delivery of services. Utilization is not necessarily increased through easy access to a health facility and also identified the potential for improving utilization through developing the role of village-based health care workers, expanding mobile antenatal care clinics and changing the way township hospital services are provided and funded.

**Sheela Saravanan (2010)** while assessing the contribution of Traditional Birth Attendants (TBAs) in providing maternal and infant health care service at different stages of pregnancy and after-delivery and birthing practices adopted in home births, found out that apart from TBAs, there are various other people in the community also involved in making decisions about the welfare and health of the birthing mother and new born baby. However, TBAs have changing, localised but nonetheless significant roles in delivery, postnatal and infant care in India. Certain traditional birthing practices such as bathing babies immediately after birth, not weighing babies after birth and not feeding with colostrum are adopted in home births as well as health institutions in India. There is therefore a thin precarious balance between the application of biomedical and traditional knowledge. Customary rituals and perceptions essentially affect practices in home and institutional births and hence training of TBAs need to be implemented in conjunction with community awareness programmes.

**Anita Raj et al (2010)** showed in their study that infant and child malnutrition is significantly more likely among the children born to mothers married as minors than in those born to women married as adults. Also study concludes that, association between the maternal child marriage and low infant birth weight as well as infant and child mortality seem to be a consequence of early motherhood, low maternal education, and
other indicators of poor maternal health and socioeconomic status factors all significantly linked to early marriage of girls.

In recent years developing countries, influenced heavily by findings in developed countries, have become increasingly interested in assessing the quality of their health care. Outcomes have received special emphasis as a measure of quality. Assessing outcomes has merit both as an indicator of the effectiveness of different interventions and as part of a monitoring system directed to improving quality of Care. Quality assessment studies usually measure one of three types of outcomes: medical outcomes, costs, and client satisfaction. For the last mentioned, clients are asked to assess not their own health status after receiving care but their satisfaction with the services delivered.

Most maternal deaths are avoidable, as the health-care solutions to prevent or manage complications are well known. All women need access to antenatal care in pregnancy, skilled care during childbirth, and care and support in the weeks after childbirth. It is particularly important that all births are attended by skilled health professionals, as timely management and treatment can make the difference between life and death.

**Ekabua J. et al (2011)** found through their study that Awareness of birth preparedness / complication readiness, by parturient, during antenatal care was very low. (21.5%). To reduce maternal deaths through antenatal care, it is critical to link antenatal care with detecting and treating causes of maternal mortality by a skilled attendant.

**Gross K. et al (2011)** found out in their study that efforts to improve antenatal care should address shortages of trained staff through expanding training opportunities, including health worker cadres with little pre-service training. Attention should be paid to the identification of informal practices resulting from individual coping strategies and "street-level bureaucracy" in order to tackle problems before they become part of the organizational culture.

**Nyamterna A.S. et al (2011)** study presents a list of evidenced-based packages of interventions for maternal health, their impacts and factors for change in resource limited countries. It indicates that no single magic bullet intervention exists for reduction of maternal mortality and that all interventional programs should be integrated in order to bring significant changes. State leaders and key actors in the health sectors in these
countries and the international community are proposed to translate the lessons learnt into actions and intensify efforts in order to achieve the goals set for maternal health. Programs integrating multiple interventions were more likely to have significant positive impacts on maternal outcomes. Training in emergency obstetric care (EmOC), placement of care providers, and refurbishment of existing health facility infrastructure and improved supply of drugs, consumables and equipment for obstetric care were the most frequent interventions integrated in reviewed programs. Statistically significant reduction of maternal mortality ratio and case fatality rate were reported in 55% and 40% of the programs respectively. Births in Emergency Obstetric Care facilities and caesarean section rates increased significantly in 71%-75% of programs using these indicators. Insufficient implementation of evidence-based interventions in resources limited countries was closely linked to a lack of national resources, leadership skills and end-users factors.

**Nyametema A.S. et al (2011)** study’s findings indicate that audit can be implemented in rural resource limited settings and suggest that the vast majority of maternal mortalities and severe morbidities can be averted even where resources are limited if strategic interventions are implemented. Improving responsiveness to obstetric emergencies, capacity building of the workforce for health care, referral system improvement and upgrading of health centers located in hard to reach areas to provide comprehensive emergency obstetric care (CEmOC) were proposed and implemented as a result of audit.

**Gabryschi S. et al (2011)** concluded from their review that there is ample evidence that higher maternal age, education and household wealth and lower parity increase use, as does urban residence. Facility use in the previous delivery and antenatal care use are also highly predictive of health facility use for the index delivery, though this may be due to confounding by service availability and other factors. Obstetric complications also increase use but are rarely studied. Quality of care is judged to be essential in qualitative studies but is not easily measured in surveys, or without linking facility records with women. Distance to health facilities decreases use, but is also difficult to determine. Further they conclude that studies of the determinants of skilled attendance concentrate on socio cultural and economic accessibility variables and neglect variables of perceived benefit/need and physical accessibility.
Upadhyay R.P. et al (2012) in their study of role of prevalent culturally driven beliefs and practices in influencing the home based new born care, found that significant portion of mothers have some beliefs/ practices with respect to care of the cord, taking the baby out of the house for the first time. Also around 11% of the mothers did not prefer their baby to be weighed at frequent intervals because according to them, doing so could lead to slowing of the growth of the baby. Further researchers concluded that Traditional knowledge and practices must be considered before developing neonatal health care intervention strategies.

Iron deficiency is the most prevalent nutrient deficiency during pregnancy. According to the literature, anemia, particularly severe anemia, is associated with increased risk of maternal mortality. It also puts mothers at risk of multiple perinatal complications. Numerous studies in the past have evaluated the impact of supplementation with iron-folic acid and multi nutrient supplements and effectiveness of these interventions on maternal anemia and maternal mortality. The studies have shown that these supplements improve anemia status and have other benefits for maternal and child nutritional status and birth outcomes.
C). A review of health care issues and potential in India

Thaddeus S. et al (1994) research on the factors that: (1) delay the decision to seek care; (2) delay arrival at a health facility; and (3) delay the provision of adequate care, findings from their study indicates that while distance and cost are major obstacles in the decision to seek care, the relationships are not simple. There is evidence that people often consider the quality of care more important than cost. These three factors--distance, cost and quality--alone do not give a full understanding of decision-making process. Their salience as obstacles is ultimately defined by illness-related factors, such as severity. Also they found in their study that shortages of qualified staff, essential drugs and supplies, coupled with administrative delays and clinical mismanagement, become documentable contributors to maternal deaths.

Khare R.S. (1996) in his study explicates "practiced medicine" as an operative cross-cultural analytic concept by locating it within previous major developments and directions of study within anthropological studies of medicine in India, and medical anthropology more generally. Practiced medicine in India, for example, allows us to see better how India manages not only multiple traditional and modern medical approaches, languages, therapeutic regimens, and material medica, but it also leads us to a sustained moral, social and material criticism from within. Author concludes that, as India today grapples with issues of availability, affordability, equity, and distributive justice in medical care, its practiced medicine raises issues of "critical consciousness" for modern (and traditional), state supported medicine.

McDonald J. et al (2002) discuss in their study how the present health funding models can place onerous pressures on rural health services. Staff may lack the time, resources, access to data, and the expertise needed to complete complex and lengthy funding submissions. This present study describes an innovative capacity-building approach to working with Victorian rural communities seeking to access health care funding through the Regional Health Services Program.

This approach used several strategies: engaging stakeholders in targeted rural communities, developing an information kit and running a workshop on preparing submissions to the Regional Health Services Program, facilitating community
consultations, and providing ongoing support with submissions. This capacity-building approach is both effective and replicable to other health funding opportunities.

Sheehan H.E.(2009) in his research on Indian health care described that the mal distribution of biomedical services creating a dilemma for Indian patients encountering a bewildering arrangements of medical services, ranging from qualified traditional medical practitioners to untrained, self taught purveyors of medicines and cures. The study revealed the ground reality of the consequences of limited choices for patients, characterized as “forced pluralism”, with no state of regulation of type of care, quality of care or credentials of practitioners.

World Health Organization (2009) in its study on increasing access to health workers in remote and rural health areas found that there is more a problem of geographical mal distribution rather than a lack of physicians. The movements of health workers in general, such as turnover rates, absenteeism, unemployment or dual employment has a correlation between the factors influencing the choices and decisions of health workers to practice in remote and rural areas and the categories of interventions that could respond to those factors. The deepest concerns of health workers when it comes to practicing in remote and rural areas are those related to the socio-economic environment, such as working and living conditions, access to education for children, availability of employment for spouses, insecurity, and work overload.

Christiana R.T. et al (2010) found in their study that strategies to increase the accessibility and availability of health care services are important particularly for communities in rural areas. Financial support that enables mothers from poor households to use health services will be beneficial. Health promotion programs targeting mothers with low education are vital to increase their awareness about the importance of antenatal services.
D). A review of disparities in health care sector in India

Drazanic A. (2001) in their study found that the bad socioeconomic background and a lack of organized antenatal and perinatal health care system are the reasons for high maternal and perinatal mortality. Authors concluded that the policy with respect to improvement of antenatal booking, the number of prenatal visits of pregnant women, their childbearing under professional assistance to be adopted to decrease maternal and perinatal mortality.

Majumdar A. et al (2004) found in their study that doctors are technically more resourceful than any other supporting, Paramedical personnel. However, in rural India the people are more dependent on the latter which play a dominant role. If we consider the elasticity coefficients as a measure of productivity then in the rural health care system Paramedical Staff are more productive than the Doctors. Geographical factors, social structure, family characteristics, and quality of care also work as the main determinants of the utilization of health care services. Education of the acceptors is also an important factor. Our study reveals that as education increases people are likely to avoid public health facilities for reproductive health related services. This may be due to poor quality of services provided at the health centers.

Hanan AL-Ahmadi et al (2005) found out from their study that the factors that are determining the high quality care are management & organizational factors, implementation of evidence-based practices, professional development, use of referrals to secondary care and organizational culture. The other factors that are required in order to improve quality are the knowledge and skills of staff.

Collin S.M. et al (2007) found in their study that the trend in professional attendance was entirely confounded by socioeconomic and demographic changes, but education of the woman and her husband remained important determinants of utilization of obstetric services. Despite commendable progress in improving uptake of antenatal care, and in equipping health facilities to provide emergency obstetric care, the very low utilization of these facilities, especially by poor women, is a major impediment to meeting MDG-5.
E). A review of urban health care in India

In much of the developing world, access to quality health care is limited, and people depend on providers who have limited training or supervision, often from the private sector. A number of studies have suggested that improving quality of services can increase utilization in low-income countries. In some contexts even in the face of higher user fees. But public providers often lack the resources and systems to encourage high quality services; while insufficient attention is paid to the preferences of the people, the interventions are intended to benefit. The poor may prefer private and unqualified providers because they may be more accessible, affordable, and responsive to their needs, even if the technical quality of care is questionable. The outcome is that many people’s health conditions are inappropriately treated. Various studies have been made in developed and developing country health delivery systems to try to assess whether health services meet acceptable levels of quality.

Avedis Donabedian (1988) developed a popular Donabedian model of Structure – Process - Outcome, which is widely validated and applied in implementing quality in health care services. In his work he advocated that before assessment can begin we must decide how quality is to be defined and that depends on whether one assesses only the performance of practitioners or also the contributions of patients and of the health care system; on how broadly health and responsibility for health are defined; on whether the maximally effective or optimally effective care is sought; and on whether individual or social preferences define the optimum. We also need detailed information about the causal linkages among the structural attributes of the settings in which care occurs, the processes of care, and the outcomes of care. Specifying the components or outcomes of care to be sampled, formulating the appropriate criteria and standards, and obtaining the necessary information are the steps that follow. Though we know much about assessing quality, much remains to be known.

Duggal R.(1994) in his study on the utilization of health care in India, revealed that India has a plurality of health care systems as well as different systems of medicine. The government and local administrations provide public health care in hospitals and clinics. Public health care in rural areas is concentrated on prevention and promotion services to the detriment of curative services. The rural primary health centers are woefully
underutilized because they fail to provide their clients with the desired amount of attention and medication and because they have inconvenient locations and long waiting times. Public hospitals provide 60% of all hospitalizations, while the private sector provides 75% of all routine care. The private sector is composed of an equal number of qualified doctors and unqualified practitioners, with a greater ratio of unqualified to qualified existing in less developed states. In rural areas, qualified doctors are clustered in areas where government services are available. With a population barely able to meet its nutritional needs, India needs universalization of health care provision to assure equity in health care access and availability instead of a large number of doctors who are profiting from the sicknesses of the poor.

Rohde J. et al (1994) in their research on the profile and practice of the private practitioners revealed that majority of India’s rural population is being provided by private practitioners. It was found that the private practitioners are almost always male, practice in or close to their birth place, and have attended school, of which only 25% of them graduates and almost 50% have no formal training. Regardless of training, nearly 90% practice allopathic. Medications, including antibiotics are given in small doses (a practice which is certainly harmful). The practitioners refer difficult cases to the government centers. Most of the practitioners however, practice alone with their only professional contact being the town chemist. Another important finding is that the patients were satisfied with the care they received because the private practitioners paid more attention to them than they were accustomed to receive from primary health care doctors. Further study also reveals that analysis of the cost of this health care shows that it accounts for a substantial portion of rural expenditure and constitutes a sizeable “hidden industry”. And authors have suggested that In order to respond to this situation, the government must ban the untrained rural private practitioner, promote the quality of care provided by the government network, or acknowledge the existence of the private practitioners and provide them with support and training.

Jorge H. et al (1999) in their study they found that the method of reviewing medical records has low specificity for the detection of the performance, but is recommended for the evaluation of quality in prescription of drugs. Study also found that exit interview of
the mother has a better specificity with respect to the performance of health workers than that of medical record review.

Raz Samandari et al (2001) conclude from their study that a specialized private health care institute, its funding, organization, delivery of care and measures to ensure quality of care. Further, the authors also claiming that privately funded quality health care could be a sustainable and equitable ‘model for the developing world’.

Gogtay N.J. et al (2002) concluded in their study on use and safety of non – allopathic Indian medicines that non-allopathic Indian medicines, Ayurveda, Siddha, Unani and Homeopathy, referred to elsewhere in the world as complementary and alternative medicine have gathered increasing recognition in recent years with regard to both treatment options and health hazards. The challenges in these non-allopathic systems relate to the patient, physician, regulatory authorities, the abuse/misuse of these medicines, quality and purity issues. Safety monitoring is mandated by a changing ecological environment, the use of insecticides, new manufacturing techniques, in yet unregulated pharmaceutical industry. The Indian traditional medicine industry has come a long way from the times when it was considered unnecessary to test these formulations prior to use, to the introduction of Good Manufacturing Practice guidelines for the industry. There is an urgent need for the practitioners of the allopathic and non-allopathic systems to work together to optimize the risk-benefit profile of these medicines.

Singh P. et al (2005) in their study on the usage and acceptability of indigenous systems of medicine to provide estimate of utilization of different indigenous systems of medicine in the country showed that very small proportion (around 14% ) of sick persons utilizing indigenous system of medicine. Also those who preferred Indian System of Medicine & Homeopathy, the reasons were mainly “no side effects” and low cost treatment. Slow progress and non availability of practitioners were the main reasons for not preferring the ISM &H treatment.

Laurant M. et al (2005) in their findings suggest that appropriately trained nurses can produce as high quality care as primary care doctors and achieve as good health outcomes for patients, process of care, resource utilization or cost. While doctor-nurse substitution has the potential to reduce doctors' workload and direct healthcare costs, achieving such reductions depends on the particular context of care. Doctors' workload may remain
unchanged either because nurses are deployed to meet previously unmet patient need or because nurses generate demand for care where previously there was none. Savings in cost depend on the magnitude of the salary differential between doctors and nurses, and may be offset by the lower productivity of nurses compared to doctors. However, this conclusion should be viewed with caution given that only one study was powered to assess equivalence of care, many studies had methodological limitations, and patient follow-up was generally 12 months or less.

**Peters D.H. et al (2006)** showed in their study that Decision Support Technologies (DST) have considerable potential to improve coverage and quality of health care for the poor and where there is no doctor, but the unreceptive attitude of public health workers would need to be overcome. Application of these technologies should take advantage of their popularity with patients and the opportunity to work through the private sector.

Various methods have been used in developed and developing country health delivery systems to try to assess whether health services meet acceptable levels of quality. These include record review or audit, interview with health care providers, written and oral examinations, interviews and focus groups with patient patients, direct observation of the delivery of the services.

**Syed S.A. et al (2007)** conclude from their study that improving medical care requires attention to service features that are regularly rated by patients. These features include doctors, nurses, tangibles, process features. However, additional organizational and extra organizational issues that play a vital role must also be addressed to improve the health care system.

**Yadav R.J. et al (2007)** found in their study on acceptability of Indian System of Medicine that very small proportion of sick persons actually availed ISM&H treatment. Majority availed Homeopathy followed by Ayurvedic medicines and use of Unani and Siddha is almost negligible. ISM&H are preferred only in case of minor ailments. In case of serious illness, like Jaundice, snake bite, dog bite and bone setting, sick persons sought treatment from traditional healers. Sizable proportion of seek persons used various “kitchen remedies” for conditions lie indigestion, fever, body ache, sprain, cough and cold.
De Costa A. et all (2007) empirically demonstrates the domain heterogeneous private health sector and the overall disparity in health care provision in rural and urban areas with 75.6% of the qualified doctors work in the private sector, 80% of these private physicians work in urban areas and 72.1% of all qualified paramedical staff work in the private sector mostly in rural areas. It argues for a new role for the public health sector, one of constructive oversight over the entire health sector (public and private) balanced with direct provision of services where necessary. It emphasizes the need to build strong public private partnerships to ensure equitable access to healthcare for all.

Tourigny A. et all (2010) found in their study to evaluate how a primary care reform, which aimed to promote interpersonal and inter organizational collaborative practices, affected patients” experiences of the core dimension of primary care that perceptions of relational and informational continuity increased significantly whereas organizational and first- contact accessibility and service responsiveness did not change significantly. Perception of physician-nurse coordination remained unchanged, but perception of primary care physician-specialist coordination decreased significantly. And also authors concluded in their study that the reorganization of primary care services resulted in considerable changes in care practices, which led to improvements in patients” experiences of the continuity of care but not improvements in their experiences of the accessibility of care.

F). A review of rural health care in India

Community based primary health care is the mainstay of health care delivery to persons in developing countries. In these countries, primary care must be accessible to the vast majority of the population as poor access to primary health care is associated with adverse pregnancy outcomes, infant mortality and decreased vaccination coverage. In accessibility of health care facilities may also affect adherence to treatment regime. Access to health services in the developing world is poor, but it gets significantly worse in the rural areas.

Nath L.M. (1994) study shows that in rural areas where the government centers are particularly desolate, the community has chosen to erect its own health care system of private practitioners of all sorts and qualifications. Even in rural areas where a comprehensive health service is provided, with each household visited regularly by health
workers, people depend upon practitioners of various types. Upon analysis, it was discovered that the reason for using this multiplicity of practitioners had nothing to do with the level of satisfaction with the government service or with the accessibility of the services. Rather, when ill, the people make a diagnosis and then go to the proper place for treatment. If, for instance, they believe their malady was caused by the evil eye, they consult a magico-religious practitioner. These various types of practitioners flourish in areas with the best primary health care because they fulfill a need not met by the primary health care staff.

Frank Tanser (2006) found out in their study that the population level increase in accessibility that would be achieved by the construction of the test clinic (location optimized by PHIT methodology) would be 3.6 times the increase in accessibility achieved by the construction of the newest clinic. The corresponding ratio for increasing clinic coverage (% of population within 60 minutes of care) would be 4.7 and also develop a model through Person Hours of Travel Time (PHIT) methodology for health planners to identify potential localities for establishing new health care facilities by using GIS technology to efficiently site new facilities to achieve the maximum population level increase in accessibility to primary health care.

Ager A. et al (2007) in their study examined the patterns of service utilization across the rural population of four districts of Orissa, with special reference to perceptions of the availability and quality of state services at the primary care level. Despite emphasis on strengthening local health care provision, concern remains regarding the rates of utilization of state provided services. Households reported utilizing a wide range of health care providers, although hospitals constituted the most frequently--and primary health care centers (PHCs) the least frequently--accessed services. Private practitioners (qualified and unqualified) represented a major sector of provision. This included high rates of access by scheduled tribes and castes (running at approximately twice the rate of access to both local and PHC provision). Key factors guiding patterns of utilization were reputation of the provider, cost and physical accessibility. Local health provision through assistant nurse midwives and male health workers was generally perceived of poor quality, with the lowest rates of resolution of health problems of all service providers. The location of a sub-centre base for assistant nurse midwives within a village had no
demonstrable impact on access to services. Acknowledging constraints on broader generalization, the implications of the findings for informing health policy and programming within Orissa are noted. This includes support for current efforts to strengthen the capacity of PHC and sub-centre level provision within the state, and acknowledgement of the potentially growing role of effectively regulated private provision in meeting the needs of the rural poor.

**Srivastava R.K. et al (2009)** study revealed that the utilization of RCH services in the government facilities was higher among the backward classes than the general category; and higher the level of education the lower was the utilization of the government services. Also the users were not satisfied with the services provided by the governmental health facilities especially with the behavior of medical officer and health workers and non-satisfaction was highest among SC category. Also authors concluded that all the health facilities need to be made functional according to the Indian Public Health Standards (IPHS) of National Rural Health Mission (NRHM).

**Kaveri Gill (2009)** in their study concluded that the National Rural Health Mission is on the right track of addressing the rural health care with the institutional changes it has brought within the health system. But there are problems in implementation, so that delivery is far from what it ought to be with respect to physical infrastructure, medicines and funding. Whereas with respect to human resources and to the extent these impact actual availability of services, structural issues of some complexity need careful resolving with a definite long term investment in the training and education of paramedical and medical staff.

**G). Recent developments in health care sector in India**

**Meenakshi Gautham et al (2011)** in their study found that most rural persons seek first level of curative healthcare close to home, and pay for a composite convenient service of consulting –cum-dispensing of medicines. Non Degree Allopathic Practitioners (NDAPs) fill a huge demand for primary curative care which the public system does not satisfy and are *de facto* first level access in most cases.

**Ray S.K. et al (2011)** found in their study that large no of patients did not avail any services when they fall sick especially in the tribal district where distance, poor knowledge about the availability of the services and non-availability of the medicine in
addition to the cost of treatment and transport. Utilization of government health facilities was around 38% followed by unqualified Practitioners and Private Practitioners. Referral was mostly by self or by close relatives / families. Also attention is required with respect to the cleanliness of the premises, safe drinking water, face-lift of PHCs and SCs, clean toilet with privacy. Also they concluded that an attempt should be made to improve utilization by cordial behavior, providing more time for patient care by the doctor, and staff, explain their prescription and report, reducing time for registration as well as waiting and finally cost of medicine they can afford.

Chakrabarti et al (2012) enlisted major findings of their study as follows. First, a woman with greater educational qualification and autonomy in terms of her power to take decisions on her own, control over household resources and complete freedom to move beyond the confines of her household exerts a significant influence on the probability of seeking care. In addition to this, formal care is more likely to be sought for children whose mothers are more exposed to the media. Programmes devised to enhance utilization of formal health care for children should be targeted to catering for the needs of the vulnerable group i.e. female child, predominantly, residing in households belonging to Scheduled Tribe. In addition to this, children belonging to Muslim households are at higher risk of contracting the diseases but there is no significant difference in their health seeking behavior as compared to other religious groups.

Lewando Hundt et al (2012) found in their study that there are issues of accessibility in terms of distance, and of acceptability in relation to the lack of local and female staff, lack of cultural competencies and poor communication. Also they found that provision of accessible acceptable health care in rural areas poses a challenge to health care providers and these providers of health care have a developing partnership that could potentially address the challenge of provision to this rural area.
3.4. Research Gap

In this chapter we have discussed about National Health Policies, healthcare issues and disparities, rural and urban healthcare system in India. The understanding of the rural healthcare system - the primary health centers - as it emerges from our review emphasizes the peculiar nature and position of these lowest health care delivery units within the larger frame work of the health delivery system of the country. The image of the primary health centers in rural areas is very poor. In fact primary health centers are regarded by the people as being synonymous with family planning centers. The doctors do run out - patient Department clinics at primary health centers but the supplies and services are so inadequate that the clientele is automatically restricted in numbers. Hence, it is not surprising that the National Sample Survey Organization (NSSO) in its 42nd Round Survey on health care utilization found that of all routine ailments treated in rural areas only 5 percent were treated in primary health centers. The remaining either went to public hospitals or to private practitioners.

Another feature of the rural healthcare system is that there are a number of health programmes imposed by the Centre (and gladly accepted by the States because of the money that come with it) without understanding the ground realities, especially the health care demands of the population. The organised sector has the ability and means to raise demands on the State to meet their social needs like health care, education and water supply. Also, the officials of the State are located in the urban areas and hence have a vested interest in giving primacy to its development. The rural areas lack this clout and are subject to programmes that may not necessarily meet their demands. In Maharashtra, the key institutions for the delivery of primary health care are Primary Health Centers. Very few studies have been done in Maharashtra on the extent of services and satisfaction of the people in relation to the health care delivery system.
3.5. Conclusion

Health facility statistics show that even after 45 years of planned development, rural areas have 31% of hospitals, 10% of beds and 25% of qualified allopathic doctors (40% all system doctors) to serve the 75% of population which resides in village. When the Community Development Programme was launched in the year 1952, Maharashtra state also started implementing the scheme by establishing a number of primary health centers and community development blocks throughout the State. But studies have shown that people are dissatisfied with the services they get from the primary health centre. Generally they link Primary Health Centre to a place from where family planning services are offered. People complain that they do not receive any needed medication in times of illness. In a study on status of healthcare in Pune district, information was collected through Household survey and Healthcare facility survey in rural area of Pune district. Health facility awareness and availing have been recorded. It is with the intention of taking a fresh look at the state of rural health care delivery system in this study entitled 'A socio economic study of health related schemes with special reference to rural area in Pune district.'