2.1 INTRODUCTION

The researcher reviewed the studies conducted between 1993 and 2012. A thorough examination of the available literature shows that NRHM has resulted in the betterment of funds related to health besides ameliorating the infrastructure associated with health delivery. It has improved health care delivery in many regions (Jacob, 2010). The studies show that most of the Accredited Social Health Activists (ASHA) has been able to fathom their part with respect to providing assistance to the expectant mothers by taking them to the medical institutions. They have also understood their duties pertaining to providing counseling to the communities in matters related to breastfeeding, Ante Natal Care (ANC)/Post Natal Care (PNC), immunization and the prevention of sexually transmitted diseases and also of reproductive tract infection.

It has been seen that monetary benefits give a significant push to ASHA and as a result, site based activities and delivery related activities are fast gaining the reputation of being an extremely pivotal domain to the same (Deoki, 2007). Studies also reveal that the Out Patient Department (OPD) visits have increased at all three levels. It is also notable that there was no significant increase in service delivery in the initial two years of NRHM (Kumar et al., 2009). This was due to the initial phase of the implementation where the entire system was not in place and the awareness about the scheme did not reach adequately to the masses.

The number of institutional deliveries has significantly increased after 2007 courtesy the initiatives taken by NRHM (Pardeshi et al., 2011). It has been found out that facilities provided by ASHA are more likely to be availed by literate women who have delivered in the recent past and who
hail from a relatively elevated socio-economic background. It has also been seen that Hindu women, women who are young and those whose status is comparatively lesser have greater probability of availing health services provided by ASHA regarding Ante Natal Care and Post Natal Care than the others. It was seen that females hailing from castes which are not regarded to be elevated have a higher probability to utilize antenatal care services and postnatal care services. It was also found that women from lower castes were more likely to avail antenatal and postnatal care (Manish et al., 2010). Some of the prominent attempts are as follows:

1. Providing benefits offered by Janani Suraksha Yojana in order to promote institutional deliveries
2. Rooting for the establishment of services in the domain of obstetrics
3. Building the capacities of nurses and nurse midwives for a period of 14-21 days in order for them to become capable birth attendants (Paul et al., 2011).

Steps are being taken to ensure the participation of NGOs in matters related to health delivery systems. There is an attempt to improve the infrastructure related to the training requirements of ASHA. Around 300 NGOs have been roped to assist with the training of ASHA. (Deoki, 2007)

2.2 MATERNAL MORTALITY, MATERNAL CARE DETERMINANTS AND UTILIZATION OF MATERNAL HEALTH CARE SERVICES

Jagdish Bhatia (1993) in his study titled ‘Levels and causes of maternal mortality in southern India’ discusses that majority of the researches centered on the mortality rates of pregnant women and also those women who have just delivered rely solely on facts and figures
taken from hospitals. The data provided by hospitals does not give the accurate picture concerning maternal mortality as it fails to include the number of deaths that take place during deliveries which are non institutional. In a country like India, a substantial number of deliveries still take place at the residence of the concerned person and hence, it becomes all the more important to include such instances as well while giving an account of maternal mortality.

It is also a fact that not much is known about the causes which influence maternal mortality particularly those related to demography and health patterns. Socio economic reasons influencing maternal mortality too are unknown for the most part. One of the studies conducted in South India in the year 1986 introduced a novel way to find out about the factors related to maternal mortality. The method fused data accumulated from various sources such as hospitals, field surveys, case control studies and health facility records. According to the study mentioned above, the rate of maternal deaths stood at 7.98 per 1,000 live births. Around 50% of the deaths had taken place either at the residence of the concerned person or while the person was being taken to a health institution. Maternal deaths were responsible for 36 percent of mortality for women of reproductive age. It has been seen that death in several cases could have been avoided. It has also been found out that there was sufficient variation as far as the causative factors such as demography, social conditions and behavioral changes were concerned.

Jagdish Bhatia C., and Cleland John (1995), in their research titled ‘Determinants of maternal care in a region of South India’ conducted a survey in 1993 which was cross sectional in nature. The survey targeted the cities and the villages of Karnataka. The respondents of the study were 3,595 women who were married at that point of time and had not attained 35 years of age. These women had a minimum of 1 child, below
the age of 5 years. Around 90% of the women in every 10 instances had a minimum of 1 antenatal session in the event of their last fertile pregnancy. Majority of such sessions involved the presence of doctors and the contributions of primary health care systems were negligible (with reference to paramedical services). It was seen that around 38% respondents had deliveries in hospitals. It was also observed that maximum institutional deliveries made use of private facilities. A little above one third of the births that happened in institutional settings made use of surgery. The number of women who received postnatal care was not even one fifths of the total. Factors such as the women’s educational qualifications, religion and economic status did play an important role in determining the extent to which maternal health services were availed. There was a correlation between the complications faced during the period of expectancy and the behaviors concerned with health conditions and they were studied in a thorough manner.

Navaneetham K., & Dharmalingam, A. (2000), in their study titled ‘Utilization of maternal health care services in south India’, explored maternal health and its related components in Tamil Nadu, Andhra Pradesh and Karnataka. The information was provided courtesy the National Family Health Survey (NFHS) that took place during 1992-93. It was conducted in most of the states in the country. The research’s concentration was on the last births that had taken place among all married women in the final 4 years before the commencement of the survey. The study has made use of the model pertaining to logistic regression in order to gauge the extent to which the maternal health services have been used by the covariates. Services such as antenatal care and the provision of tetanus toxoid vaccine were included among others. It is evident from the study that the factors determining maternal health care services vary from 1 state to the other. They also differ on the basis...
of varied indicators pertaining to maternal health care services. It was seen that there was not much variation in the utilization of maternal health care services among the literate people, though they were far less availed by the uneducated women. Tamil Nadu witnessed the maximum usage of maternal health care services while, Andhra Pradesh and Karnataka occupied the 2nd and 3rd positions respectively. One reason behind the patterns of usage varying across the southern states of the country was owing to variations in terms of accessibility as well as availability. It was found out that services related to maternal health care are not used very much in villages, especially for the purpose of institutional deliveries because there is a noteworthy gap in terms of the access to health oriented facilities between the cities and the villages. The above mentioned fact is very relevant with respect to 3 southern states of India i.e. Tamil Nadu, Andhra Pradesh and Karnataka. The study highlights the significant contributions made by health workers regarding the provision of antenatal care in villages. It was established that the usage of maternal health services depends, to a large extent, on the kind of health service and also on the state. Factors related to culture, reproduction etc. also play an instrumental role in the usage of maternal health care services.

The study conducted by Sunil, T.S., Rajaram, S., & Zotarelli, Lisa K. (2006) is titled ‘Do individual and program factors in the utilization of maternal care services in rural India? A theoretical approach’. Most of the studies about the usage of facilities concerning maternal health which are based in India only talk about individual causes. This study has adopted the theoretical model which was conceptualized by Andersen and Newman in 1973. It is known as ‘Societal and individual determinants of medical care utilization in the United States.’ Milbank Memorial Fund Quarterly, 51(1), 95-124] was entrusted with the responsibility to gain
knowledge about the ways in which maternal care facilities are used by the people living in the villages of India. The approach takes into consideration system factors (also known as factors related to individual and welfare programs) in order to understand the patterns related to the usage of health care. The study also makes use of the information provided by the National Family Health Survey-2. It was found out that Mahila Mandals and Anganwadis played an important role in highlighting the advantages of utilizing the maternal care facilities especially, in the rural regions. A point of paramount significance which got established was that the existence of private health care centers does not necessarily ameliorate the usage of the maternal care facilities. There was a considerable improvement with respect to the utilization of maternal care services whenever, the health workers used to spread awareness among the expectant mothers in the community. It would be better to include more data on individual and program characteristics from state based researches in order to bolster comprehension of the ways in which health care facilities are availed.

The study conducted by Asha George (2007) is titled ‘Persistence of high maternal mortality in Koppal district, Karnataka, India observed service delivery constraints’. It was found out that the number of deaths among women having obstetric difficulties in Koppal (Karnataka’s poorest district) was very high in spite of them contacting health service providers. This study sheds light on the factors that throw a spanner in the deliveries conducted in Koppal resulting in an increase of maternal mortality rate. The study furnishes facts provided by case studies based on the experiences of women going for services pertaining to obstetric care besides, consulting government health services which indulge in participant observation. There are many reasons responsible for the hitches caused in the smooth functioning of the services. The reasons
include poor systems of information, care being provided in bits and spurts, health workers not getting adequate backing, referral systems being patchy and the systems responsible for accountability being unreliable. It has also been noticed that the health workers are not too well versed with respect to the knowledge of vaccines. They also are not very well equipped to cure sepsis and anemia. People are unable to get proper care facilities despite spending considerable amounts of money and other resources. There have been several occasions where the low rung health workers and also the women have been held responsible for not being able to access the institutional services. It has also been found out that the responsibilities to be carried out by the politicians and the bureaucrats in matters related to health are ambiguous and unclear. The measures taken to keep a stable balance between the demand and the supply do not talk about the factors hindering effective delivery of services. These measures also do not cater in a productive way to the informal providers. It is important to bring reforms at the managerial level because in their absence, it will be pointless to have budgetary allocations which involve rescuing the lives of women.

Pathak et.al (2010) in their study ‘Economic Inequalities in maternal health care: Prenatal care and skilled birth attendance in India 1992-2006’ have made an attempt to understand the manner in which the prenatal care services are availed in the 1st trimester with a minimum of 4 antenatal care visits and skilled birth attendants with respect to mothers living in Tamil Nadu, Uttar Pradesh and Maharashtra. The research made use of information provided by the National Family Health Survey (comprised of 3 rounds) which was held between 1992 and 2006. The role of the health facilities (private as well as public) with respect to catering to the provision of Skilled Birth Attendants particularly, among the downtrodden mothers was scrutinized. The ways in which other
factors (cultural, socioeconomic, and demographic) contributed to the previously stated results were also noted. The 2 outcome variables were comprehended courtesy the implementation of concentration curve, concentration index, multinominal logistic regression models, bivariate analyses and logistic regression. It was found out that Prenatal Care and Skilled Birth Attendants were availed in an indolent manner in the country, especially in the states where the survey was conducted between 1992 and 2006. It was seen that the downtrodden sections of the society were unable to properly utilize Pre Natal Care and Skilled Birth Attendants. The fact that the services were not utilized equally by varied classes was confirmed by multivariate analysis. It was seen that both the services were not utilized optimally by the downtrodden sections of the society notwithstanding, the contribution of the other determinants such as the area of residence. The government mechanisms to promote delivery services among the weaker sections of the society proved to be futile as the latter were mostly dependent on private suppliers.

According to Kranti Suresh Vora (2012), rural women in India contribute in a lopsided manner to the nation's staggering maternal mortality ratio. In response to this problem, the Indian government introduced a conditional cash transfer scheme, "Janani Suraksha Yojana (JSY)," in 2005 to ameliorate the reach of maternal health care among the women belonging to weaker sections. The state of Tamil Nadu reorganized public health system resources and the state of Gujarat contracted with private providers to implement the scheme in rural areas. This study investigated the role of JSY/government assistance, and other health care sector and household factors in estimating the usage patterns with respect to maternal health facilities by the village women belonging to the economically backward sections of the society in the 2 states mentioned above. Health care sector factors included receipt of JSY
payment, provision of a primary health center with 24 hour facilities, and connection to a health institution by a durable road. Household factors included maternal education, paternal education, age at first birth and parity. The use of the following four maternal health care services was examined: adequate antenatal care, institutional delivery, private facility delivery and Cesarean section. State findings were compared and contextualized by examining health polices/practices and health infrastructure within each state.

The study employed secondary data analysis using District Level Household Survey (DLHS)-3 data, with a sample of 2,267 rural women from the lowest two wealth quintiles. Multivariate logistic regression analysis examined associations between identified factors and maternal health care utilization in the two target states. Overall, Tamil women had better access to maternal health care services than Gujarati women. JSY payment predicted use of private facility deliveries in Gujarat, which incentivized the use of private providers, but not institutional deliveries in Tamil Nadu where women also received cash regardless of the place of delivery. JSY payment did not predict adequate antenatal care, which was not incentivized. Access to an all-weather road predicted institutional deliveries in both states and adequate antenatal care by Tamil women. Maternal education was a significant predictor of maternal health services utilization in Tamil Nadu, while paternal education predicted such usage in Gujarat. Parity significantly predicted poor, rural women's use of all services. Implications of the findings for strengthening conditional cash transfer schemes and improving maternal health care services are discussed.

2.3 ANTENATAL CARE AND MORBIDITY

Matthews et.al (2001) in their study ‘Antenatal care, care-seeking and morbidity in rural Karnataka, India: Results of a prospective study’
describe the type of antenatal morbidities borne by women. The study also talked about the levels of suffering faced by women as a result of antenatal morbidities. The study aimed to list the determinants associated with antenatal services among the women living in villages of South India. The results were based on the answers provided to a spate of chronological questionnaires administered at the time of pregnancy and further. The respondents comprised of all the expectant women residing in the selected 11 hamlets of South India between August, 1996 and September, 1998. The responses were gathered during the period of lactation and hence, the scope for errors common to most cross sectional researches was negligible. A total of 282 ladies were asked the questions. The other salient participants of the research were the family members of the ladies, and also, the health care providers. 60% of the women in the study had home deliveries. The results show that cultural and social causes and restriction from elders play an important role in the utilization institutional services. There is a need of strong behavioral change along with the need for effective communication for eradicating misconceptions, superstitious beliefs and old practices in the respective community regarding antenatal care and delivery places.

Raju K.N. et.al (2004) in their study titled ‘Normative and actual provision of antenatal health care services in Karnataka’ tried to find out the extent to which facilities related to sound deliveries were utilized. The study was provided information from RCH in Karnataka. The utilization of the entire essential antenatal health services are found to be only 8.6 percent and 12% has not received any services. It was found out that more women residing in urban areas, coastal and malnad areas received antenatal health care services compared to the other regions. Health care services were received by more number of women who were educated. Institutional deliveries were more frequent in the above mentioned areas,
as the other areas had more number of home based deliveries since the women living in these regions were not as literate.

A study conducted by Rani et.al (2008) titled ‘Differentials in the Quality of Antenatal Care in India’ found out that the Northern states as well as the Southern ones have quality of antenatal care which is not as per the prescribed standards. However, South India fared relatively better than North India, especially with respect to women belonging to backward sections of the society. It was seen that North India had more pronounced differences in terms of the socio economic variables determining the quality of care compared to South India. However, the fact remains that both the regions showed considerable differences with respect to socio economic variables determining quality of care. A healthy relationship of paramount importance was seen with respect to the quality of the antenatal care and its usage in the rural regions as part of the multivariate analysis. A major reason behind the antenatal care services not being used optimally is the low quality of the same. It is essential to introduce more measures (policies, program based interventions etc.) in order to ameliorate the condition of maternal care in the country, especially, with respect to the people belonging to the poverty stricken sections of the society more so, in North India. It is important for the National Rural Health Mission, to stress more on ameliorating antenatal care in the country in order to elevate the condition of maternal health.

Sharma et. al (2012) have done a study on the impact of NRHM in its antenatal care mainly in urban and rural areas. The study was conducted in Lucknow at a Primary Health Center. The study was conducted among 682 women, hailing from both urban and rural areas varying in age, different social background and religion. The study shows
that 58.5% of women, of both urban and rural areas had utilized ANC services in their first trimester itself. The interesting finding is that both educated and uneducated women had received the ANC services, and hence, education was not an influencing factor. In rural areas, the service of ASHA and other health workers had motivated, encouraged and convinced the women to utilize the service of NRHM. 86.5% of urban women and 70.4% of rural women had their ANC visit more than three times. The study shows that the socioeconomic and religious factors are the only influential ones in the antenatal care services.

### 2.4 HOME DELIVERIES

Matthews et.al (2001) in their study ‘Antenatal care, care-seeking and morbidity in rural Karnataka, India: Results of a prospective study’ describe the type of antenatal morbidities borne by women. The study also talked about the levels of suffering faced by women as a result of antenatal morbidities. The study aimed to list the determinants associated with antenatal services among the women living in villages of South India. The results were based on the answers provided to a spate of chronological questionnaires administered at the time of pregnancy and further. The respondents comprised of all the expectant women residing in the selected 11 hamlets of South India between August, 1996 and September, 1998. The responses were gathered during the period of lactation and hence, the scope for errors common to most cross sectional researches was negligible. A total of 282 ladies were asked the questions. The other salient participants of the research were the family members of the ladies, and also, the health care providers. 60% of the women in the study had home deliveries. The results show that cultural and social causes and restriction from elders place important role in utilizing institutional services, in this services. There is a need of strong behavioral change along with the need of effective communication in order to
eradicate misconceptions, superstitious beliefs and old practices in the respective community regarding antenatal care and delivery places.

The study conducted by Muthharayappa, K., & Prabhuswamy, P. (2003) titled ‘Factors and consequences of home deliveries: A study in rural Karnataka’, speaks of the factors influencing the place of delivery, and why women prefer home based deliveries in rural areas though a large number of health institutions such as sub centers, primary health centers and community health centers exist. To highlight these dimensions, the study was conducted in three districts of Karnataka state. The respondents for the study were women who had at least one child during the last three years. The study finds that through primary health care services have expanded in recent years, deliveries conducted in health institutions or deliveries assisted by trained personnel are very few. Over half the deliveries are unsafe. Several factors have contributed to this phenomenon. The factors are as follows: time of delivery, illiteracy, economic conditions of women, customs of natal home, transportation and place of stay of health workers. Moreover, most health centers do not have women medical officers in position, and the lack of staff and inadequate facilities at sub centers and hospitals is an important factor as well. Nearly half the infants died due to maternal causes among women who had deliveries at home. The causes of infant death are premature delivery, infection in the umbilical cord, being accidentally hit on the head while delivery, breach presentation, severe anemia of mother, etc. These problems could be easily solved if women are provided with good antenatal services, adequate rest and nutrition during pregnancy and counseled to deliver at health institution. Therefore, one has to promote institutional deliveries to reduce prenatal and neonatal mortality rate. Also there is need to strengthen the dai training programme as a traditional dai would be easily accessible to women in rural areas.
2.5 HEALTH CARE SYSTEM IN INDIA

Sharma and Narang (2011) conducted a research on the perception of rural people with regard to health care services. Though majority of people in rural India are illiterate, they also have their own views on the quality of health care that is provided by the Government. The study focuses mainly on the rural people that are availing the health care services provided by the Government. This study was conducted in the 7 districts of Uttar Pradesh, where they randomly selected one Community Health Center and two Primary Health Centers. The results show that there are varied differences of opinion among the literate and the illiterate. For the majority of the literate people, the quality of health care depends upon the mode of delivery of health care, and availability of facilities. The illiterates, however did not have problem with physical access and financial aspects, as they are ready to travel great distance for treatment. For men, quality depends upon the method and style of treatment and the financial aspect. On the other hand, women look for concern, care and availability at the health center. In Community Health Centers, the unavailability of doctors, low grade facilities are the main shortcomings.

2.6 THE HEALTH CONDITIONS OF RURAL LOCALITIES OF MADHYA PRADESH

Bano and Wani (2012) conducted research on the life style and environment conditions of rural area and its impact on the health conditions of the rural people. The study was conducted among males and females from different families, age group and background. The study found that rural people do not have any significant diseases relating to their environment except for probably skin diseases. They have diabetes, lung and heart diseases like that of urban people. The findings say that diabetes is because of their shifting lifestyle and lung and heart diseases
are because of their habit of tobacco use. It is found that women have more urinary and genital infections than men. The study concludes that improvised programs such as anti tobacco programs need to be incorporated in rural areas.

Patralekha Charrerjee (2006) reported that India's Planning Commission agrees with the fact that the country’s systems of health care are replete with drawbacks and fundamental flaws. "Across states, 6% to 30% posts of doctors remain vacant and random checks showed that from 29% to 67% doctors were absent", observes an approach paper to the country's Eleventh Five Year Plan (2007-2012), currently being readied. There has been a recommendation to utilize medical professionals in a more efficient manner, especially those who have received training from the Indian Systems of Medicines. However, a major issue is that there is a major dearth of practitioners like gynecologists, pediatricians, surgeons etc.

It has been seen that socioeconomic status of people are at varied levels in different regions of the country i.e. in developed parts of the country, the socioeconomic status is very different from the not very developed parts. As a result, there is inconsistency with respect to the health outcomes. To cite an instance, only a meager 5% children have received complete immunization in Gaya (one of the poorest districts of the country, situated in Bihar), while over 90% children are completely immunized in Tumkur (situated in Karnataka). The data stated above, has been provided by the National Sample Survey Organization and UNICEF as per the results obtained from a survey conducted in 42 districts of 14 states of the country.

According to the National Family Health Survey (2005-2006), a comparatively prosperous state like Punjab, had around 28% children aged below 3 years whose height was not in sync with their age i.e. they
were much shorter than what their age warranted. Orissa, which is counted amongst the least prosperous states, had a population of 38% children (below the age of 3 years) whose growth was stunted.

The National Rural Health Mission makes an attempt to reduce the disparity quotient by incorporating indicators of good health like, sanitation, good quality drinking water and nutrition. The initiative targets the 18 states which have been found to have low quality infrastructure and poor indicators of health (however, the initiative is active throughout the country).

According to Geeta et.al (2011), there is an increase in the rate of child survival if deliveries take place in institutions. Another advantage of institutional deliveries is the decline in terms of maternal mortality. Several attempts have been made by the National Rural Health Mission (NRHM) to promote institutional deliveries. The research focuses on the ways in which the place of delivery is selected in the district of Nanded (as part of NRHM’s 1st phase). Several prominent people were asked questions in order to compile the report about the efforts of the Mission in Nanded. The method chosen to conduct the research was 1 stage cluster sampling (30 villages were selected courtesy the method) and the research was cross sectional (descriptive) in nature. In June 2009, the survey was conducted on a door-to-door basis. Every woman who had a delivery between January 2004 and May 2009 was interviewed and they were asked a series of open ended questions in a structured format. The motive was to find out about places where the deliveries took place and also to figure out the type of assistance provided during the deliveries. The outcomes were found out using chi-square test and the odds ratio. Based on the outcomes, several measures to ameliorate the quality of the health based facilities were installed in the region. The rate of institutional deliveries soared to 69% (2009) from a paltry 42% (2004).
More number of deliveries started taking place in institutions (private as well as government owned). More deliveries (institutional) started being conducted in the presence of health personnel courtesy the implementation of the National Rural Health Mission. The figures of deliveries that took place at home in the presence of health personnel were below 10% during the period of the research. It was seen that the villages chosen for the study demonstrated varied patterns in terms of locations at which the deliveries took place. It was suggested that some out of the box interventions should be thought of for the rural regions where the institutional deliveries were not popular.

2.7 UTILIZATION OF HEALTH SERVICES UNDER NRHM

Kumar et.al (2009) studied the implementation of NRHM and its utilization by the rural people in the state of Uttar Pradesh, India. The study was conducted in the district and block level (community health center and in primary health centers). The results showed that there is massive improvement in the infrastructure and the facilities provided at the district hospital, CHC and PHC. Although there are limited workforce and human resources at some periods of time, it has been increased at later stages. As per the study, the health services and the utilization of health services by the rural people has gone up during the implementation of NRHM. The use of OPD services by the rural people and the surgeries conducted reveal that the awareness among the rural people has been greatly increased by the NRHM programme over the years. In district hospitals, the patient flow into the OPD and IPD has increased after the NRHM programme by 86% and 82% respectively. In the Community Health Centers, the IPD patients has increased by 163% because of the major surgeries conducted while the OPD patients have increased by about 86%. At the PHC level, the OPD patients have increased more significantly than IPD patients in 2008. The main reason for the same
may be that if no surgeries are conducted in PHCs, then they will all be transferred to the CHC. The study shows that the major beneficiaries are the women, children and then the men.

2.8 WOMEN’S PERCEPTION OF QUALITY OF CARE

Praveen & Das (2004) conducted a study on the Reproductive and Child Health Program launched in 1998, its concept on the client oriented, demand driven, and high quality based services to the community. The women’s perception of quality of care and the provider’s access to quality of services are a far cry from each other. The results show that there is a big gap between the quality care provided by the scheme and the expectations of rural women. This study was conducted in Azamgarh, Uttar Pradesh in 2004. The study was conducted among rural women in two villages where there is a sub centre and a PHC. From the findings, it can be understood that women have their own expectations and perceptions on quality of care with respect to their different health conditions. The rural women are not satisfied with the Government health care centers mainly because of the unavailability and rude behavior of the personnel at the Government Health Care Centers.

2.9 EXPOSURE TO ELECTRONIC AND MASS MEDIA

The study conducted by Debarchana Ghosh (2006) is titled ‘Effect of mothers’ exposure to electronic mass media on knowledge and use of prenatal care services: A comparative analysis of Indian states’. The Government of the country thinks that an effective way to endorse safe motherhood and also to increase the rate of child survival is to adopt facilities based on pre natal care. There is a strong dependence on the different forms of electronic media to enlighten the women about pre natal care (many women are not educated). The study referred to the information provided by the National Family Health Survey (1998-1999) in order to gauge the extent to which electronic media was utilized by the
women to know about the pre natal care services. Multivariate logistic regressions were used to estimate the effects of media exposure by calculating odds ratios of each of the four response variables (complete prenatal care services, prenatal check-ups, tetanus toxoid injections, and iron prophylaxes) for exposure to mass media. It was seen that the various forms of electronic media were used by the women to gain knowledge about pre natal care services even though the other factors were restrained at their mean. It was also noted that the influence of electronic media on women was more in North India compared to South India.

2.10 ACCREDITED SOCIAL HEALTH ACTIVISTS (ASHA)

It was found out that majority of the ASHAs understood the duties entrusted to them which included taking the expectant women to medical institutions, providing counseling services to the community members regarding the salience of safe delivery, immunization, breast feeding, contraception, ANC/PNC etc. They were also supposed to contribute to the knowledge of the community about availing medical services at varied places, besides, inspiring the people to build infrastructure such as toilets in the houses. The ASHAs were supposed to inform the community about the various health determinants as well. Many ASHAs were unable to effectively carry out their duty pertaining to updating AWWs and ANMs regarding the number of births and deaths. There were also ASHAs who were not too successful in providing aid to VHSCs in constructing plans related to community health at the village level. The above mentioned facts become noteworthy considering the fact that ASHAs motivations in carrying out their duties are largely based on monetary profits. Therefore, ASHAs very often take up jobs which are site based and also delivery oriented. It was recommended that the ASHAs should be given exposure in areas such as the construction of
health plans at the village level and they should also be involved in
enabling registration of programs related to ANMs/AWWs (Deoki Nandan, 2007).

The study on “Factors influencing utilization of ASHA services under NRHM in relation to Maternal Health in Rural Lucknow” conducted by Singh et.al,2009 was an effort to understand the factors influencing utilization of ASHA services under NRHM Programme in relation to maternal health. The study was conducted at the Primary Health Centre (PHC) located in Sarojini Nagar, Lucknow and its rural field area. Sample for the study includes RDW (recently delivered women) i.e. those who delivered a live newborn at PHC Sarojini Nagar within a week of the conducted interview and belonged to villages within the confines of the PHC being served by ASHA. The samples were selected through simple random sampling method and a total of 350 RDWs were interviewed. The data was collected through a schedule which was prepared by the researchers in consultation with experts in the field.

The results of the study show that educated RDW, those belonging to higher socio-economic class, Hindus in reference to Muslims, Young RDW and those with low parity were more likely to utilize ASHA services for early registration, adequate ANC and postnatal checkup. It was also found that women from lower castes were more likely to avail antenatal and postnatal care. The reason for discordance is better approach of ASHA and her ability to connect and convince the women belonging to lower caste. Counseling on antenatal care was found to be lagging (only 34 out of 350 i.e. 9.7% of the RDW received adequate antenatal care. The authors recommended that extra efforts are needed to sensitize ASHA on these issues during training and by regular orientation programs. There is a need to enhance the knowledge and awareness of
ASHA on the importance of postnatal care. She should be provided hands on training on postnatal care components by specialists. This will reflect into proper utilization of ASHA services for postnatal care.

Sangeeta Kansal, Kumar, S., & Kumar, A. (2012) conducted a research which was cross-sectional in nature and its sample size consisted of 135 ASHAs who were stationed at various places of Chiraigaon Block, Varanasi, Uttar Pradesh. The participants were asked questions in order to determine the contribution of their educational level towards making them operate in an efficient manner. It was seen that one third of ASHA had schooling up to class eight, 36.6% high school and 22.2% intermediate, and 10.4% were graduates. The results confirmed that there was a noteworthy relationship between the educational qualifications of ASHAs and their work performed in the communities. It became apparent that the ASHAs who had studies only up to 8th standard did encounter hardships while completing the Village Health Index Registers. The study advocates for rigorous supervision and monitoring of the ASHAs from the remaining functionaries since it is tough to raise the minimum level of education with respect to their recruitment. There was also a suggestion to make the Village Health Index Registers easier to understand for the ASHAs in order to help them keeps records in an orderly fashion. The service delivery would surely get a huge shot in the arm if more qualified women would volunteer to render their services in the capacity of an ASHA.

A study team of NRHM in Cuttack, Orissa (2007) has done the research on the performance of ASHA in the community and to explore their roles and responsibilities and to recommend improvised plans and methods. The study was conducted in two districts of Orissa state. From the study, we can see that the duties of ASHAs are limited to just accompanying the pregnant women for delivery and giving counseling for proper
medications and nutrients. 71.3% of the ASHAs said that the main motivational factor for coming for this job is to earn some money for living. 33.8% said they would like to serve the community. Majority of the ASHAs are happy with their job as their social status has gone up and people are giving them respect. 93.8% ASHAs are not happy with their monetary compensation. Most of them have not got their incentive for more than 6 months. Regarding the training, most of them feel that it was very informative, but still they need regular training and need to update on most of the issues. The ASHAs have limited their role only to pregnant women, mainly because of the financial gain. They have forgotten their other major responsibilities like creating awareness in the community, health and hygiene classes.

2.11 JANANI SURAKSHA YOJANA/ CASH ASSISTANCE

The evaluation study conducted by Devadasan et.al (2008) titled ‘A Conditional Cash Assistance Program for promoting Institutional Deliveries among the Poor in India: Process Evaluation Results’ states that India’s share with respect to the global burden of maternal deaths cannot be overlooked. The figure of deaths taking place in India exceeds 20% of the total number of maternal deaths taking place in the world. An initiative named, ‘Janani Suraksha Yojana’ (conditional cash assistance scheme) was launched by the country’s Government in order to reduce the number of maternal deaths and also to endorse institutional deliveries. The scheme proposed to offer cash benefits to women belonging to the downtrodden sections of the society provided they have had 3 antenatal checkups along with delivering at an institution. The scheme was decided to be implemented in 4 states in order to see if the aim of getting significant number of institutional deliveries is being achieved. Despite getting indications confirming an upward trend pertaining to the number of institutional deliveries, the findings cannot be credited to the scheme
yet as there was no bankable evidence which established a connection between the 2 variables. The reason for the above stated fact is the dearth of reliable information at both levels (state and district). The scheme has met with an enthusiastic response from the expectant women and also from the employees of the institutions. Yet, the fact cannot be denied that there were certain flaws in the manner in which the scheme was implemented. One such flaw relates to the inconsistency with respect to the way in which the cash benefit was dispensed. While on one hand, there were women who got the promised amount, there were also some women who only got a part of the stated amount (due to corrupt staff). A major loophole regarding the implementation of the scheme was the shift in terms of the rules i.e. cash benefits were given to all women who delivered and not only to those who delivered in institutions. This fact was a diversion from the originally stated objective (cash benefits would only be provided to women who deliver at an institution).

Jain A.K. (2010) wrote an evaluation oriented article titled the ‘Janani Suraksha- A Yojana and Maternal Mortality Ratio’. Many surveys have come up with the result that the number of deliveries taking place in institutions has shown an upward trend courtesy the implementation of Janani Suraksha Yojana. There is a possibility of the cash benefit attracting women in hordes to deliver in institutions and because of such a trend, expectant mothers who do not suffer from any type of complications may not get adequate medical care. In order to assess the scheme, the need of the hour is to get samples from states having high maternal mortality ratio of 2 kinds i.e. institutions having facilities for emergency obstetric services and those which do not have such facilities.

‘India’s Janani Suraksha Yojana, a conditional cash transfer programme to increase birth in the health facilities: an impact of
evaluation’. In 2007-2008, the extent of Janani Suraksha Yojana’s reach across the state was not uniform. In some states, around 44% women used to get the benefits of the scheme whereas, there were many states where less than 5% of the women got benefits of the scheme. The chances of getting the benefits of the scheme were not always dependent on the socioeconomic status and the literacy level of the women. Antenatal care and in facility births were positively impacted courtesy Janani Suraksha Scheme. In the matching analysis, JSY payment was associated with a reduction of 3-7 95% CI 2-2-5-2) prenatal deaths per 1000 pregnancies and 2-3 (0.9-3.7) neonatal deaths per 1000 live births. In the with – verses-without comparison, the reductions were 4.1 (2.5-5.7) prenatal deaths per 1000 pregnancies and 2.4(0.7-4.1) neonatal deaths per 1000 live births. The observations made by such an analysis show an improvement as a consequence of Janani Suraksha Scheme, however, there still is room for improvement as the most downtrodden women ought to be focused upon and also, obstetric care needs to be bettered in the institutional centers. It is very essential to incessantly monitor and evaluate the impact made by Janani Suraksha Scheme in an autonomous manner so that the monetary and political resources invested in the same can be justified and altered.

**Assessment of Janani Suraksha Yojana (JSY)**

Gupta et al. (2011) conducted a study on the beneficiaries of Janani Suraksha Yojana -their social background, awareness and their use of JSY scheme. JSY scheme is targeted towards the below poverty line rural women to improvise institutional deliveries thereby reducing maternal mortality rate and infant mortality rate. The results shows that majority of the population use this scheme for monetary purposes. This study was conducted in Jabalpur among 300 beneficiaries at N.S.C.B Medical College. From the study, it is seen that 55% of the women had their first
pregnancy below the age of 20 years. Majority (95%) of them have registered their pregnancy before coming to the hospital. 34.3% of them came along with ASHAs and ANMs. For getting JSY services 64.33% had to arrange vehicle on their own and had to travel more than 2 hrs. 33.7% says that monitory factor is the main motivation in availing JSY scheme. 87% of the beneficiaries knew about the scheme but most of them do not know about the name of the scheme.

Access and Utilization of Cash Incentive Programs under NRHM

Balasubramaniam and Shanthi G. (2011) have done the study on the Cash Incentive Programs of NRHM (JSY & PA) in the Forest Based Tribal Women (FBTW) of Karnataka. The study was conducted in H.D. Kote of Mysore District. 61 FBTW were selected for the study and medical officers, ANM, ASHA etc. were also involved. The study throws light upon the work of ASHA and ANM in tribal areas and also on the awareness level of tribal women about cash incentive program of NRHM. The study shows that the awareness is low among FBTW and even the ASHAs and ANMs are not very clear about the criteria of CI programs.

2.12 OUT PATIENT DEPARTMENT VISITS

The Out Patient Department (OPD) visits have increased at all three levels, though with variation. The maximum improvement is found at the PHC (129%) level followed by almost similar increase (86%) at the district and CHC level. As there was severe shortage of infrastructure and human resource at PHC before NRHM, this sharp increase of 129% indicates filling of pre-existing vacuum of service delivery at PHC. It is also notable that there was no significant increase in service delivery in the initial two years of NRHM. This might have happened because either the benefits of NRHM could have not percolated in the initial years to the
CHC and PHC level or service providers were not oriented about NRHM in a systematic and comprehensive manner or the scheme was operational in the state for a very short period resulting in the dismal performance (Kumar et.al 2009).

2.13 SERVICE DELIVERY UNDER THE NATIONAL RURAL HEALTH MISSION (NRHM)

Gill (2009) has done a research paper for the Planning Commission of India to study the quantity and quality of service delivery of NRHM in Rural India. It was conducted in four states of North India namely Andhra Pradesh, Uttar Pradesh, Bihar and Rajasthan. The study focuses on the overall impact of NRHM in these states particularly measuring the concrete aspects (availability of staff, quality of medicine, attendance, funding, availability and utilization of services) and indefinable (satisfaction of patients) aspects through random visits and exit interviews. This study also throws light upon the ranking of different states and the condition of each state in terms of these parameters. The results show that there are inconsistencies in all areas especially in the infrastructure, medicines and funding but these can be sorted out easily within a given time frame. The major problem lies in the availability, commitment of staff and the utilization of services.

The NRHM has been described as one of the largest and most ambitious programs to revive health care and has many achievements to its credit. It has reiterated the focus on health and re-prioritized rural health and health care. It has increased health finance, and improved infrastructure for health delivery. It has established standards and trained health care staff. It has also set benchmarks for health institutions and improved and streamlined health care delivery structures. It has coordinated technical support from health resource institutions and non-governmental organizations. It has improved health care delivery in many
regions. It has facilitated financial management, assisted in computerization of health data, suggested centralized procurement of drugs, hospital equipment and supplies, and mandated the formation of village health and hospital committees and community monitoring of services. It has revived and revitalized a neglected public health care delivery system (Jacob, 2010).

The National Rural Health Mission deserves credit for ensuring that the number of institutional deliveries multiplies by leaps and bounds. The efforts made by the ASHAs are commendable in ensuring that women from several reputed communities step forward to deliver in institutions especially, at the elementary level (the number of beneficiaries under JSY had increased from 7 lakhs in 2005–2006 to over 86 lakhs in 2008–2009). Efforts have to be made to ensure that the facilities have ample supplies, in order for the women and their children to be healthy. The many pros as a consequence of the NRHM being implemented include the decline of maternal mortality rate to 254 and the decrease in infant mortality rate to 53. The total fertility rate has now become 2.7. (Deoki Nandan, 2010)

According to Paul V. et.al. (2011), India faces multiple hurdles in the sector of health as the country’s population exceeds 1 billion. Hence, a lot of ground needs to be covered in order to ameliorate the standards pertaining to the population’s nutrition and general well being. There has been a gradual fall in terms of the mortality rates (maternal, child and infant) and also the fertility rates. However, the pace of such developments has not been rapid enough to keep pace with the deadlines mentioned in the Millennium Development Goals and also various other national programs. The apparent reasons for the expectations not being met are the inequalities of the social kind, gaps in the health provisions of varied states and the problems stemming due to the growth of urban
areas. Though the National Rural Health Mission is a noble attempt, the problem lies in the reach of the primary mechanisms being inadequate. Another issue which plagues the country is the fact that the interventions which are available at present are not satisfactory in terms of their content and quality. There are many issues as a result of unsafe sexual practices, like teenage pregnancies and also the lack of sufficient number of places for safe abortions. The supply of contraceptive methods does not fulfill the demand for the same. It has been found that though the number of institutional deliveries is on the rise, the efficiency and effectiveness with respect to neonatal care and intra partum care has stagnated. The quality of health care is below the mark especially, in the domain of pediatrics. Over the years, treatment pertaining to illnesses like diarrhea and pneumonia to name a few has not covered much ground. The nutrition programs too have failed to make much headway as their penetration with respect to the communities is limited. The administration concerning health systems is quite feeble and the lack of proper financing, infrastructure, planning, human resources, monitoring etc. bears testimony to this fact.

There are certain steps which can be taken in order to ensure the metamorphosis of the health systems for the better. Such steps include, decision making powers getting transferred to the state government, the manpower associated with providing services being impactful, adoption of a practical approach to ensure proper utilization of monetary resources in matters pertaining to health care. The communities can also be enlightened about the desirable behaviors related to nutrition and health via the conduction of programs. It would also be advisable to bring changes to the programs revolving around nutrition (especially nutrition of children). It is very important to give priority to such a plan
of action so that the issue comes to the forefront. The mobilization of people is an absolute must while dealing with such an issue.

Several measures have been attempted by the country’s government to ameliorate maternal health as part of the National Rural Health Mission. The prominent steps taken by the Government as per the Janani Suraksha Scheme are the promotion of institutional deliveries, the patronage provided to formulate services concerning emergency obstetric care and the training imparted to nurses and nurse midwives for a period of around 14 to 21 days in order to develop skills in the capacity of birth attendants (Paul et.al 2011).

2.14 RESEARCH GAP

The literature reviews presented show that majority of the studies are focused on certain components of NRHM i.e. health finance, infrastructural improvements, Accredited Social Health Activists, Out Patient Department (OPD) visits, institutional deliveries, Janani Suraksha Yojana etc. There are few studies conducted on the Impact of NRHM in Antenatal Care, Utilization of Health Services under NRHM, Women’s Perception of Quality of Care on the basis of RCH Programme, Quality of Healthcare Services in Rural India, the health conditions of rural localities of Madhya Pradesh with reference to life style and environment conditions, all are focusing on different localities of the country and on specific themes. A comprehensive analysis of the view points of women who are the major beneficiaries of NRHM in terms of their knowledge, availability and accessibility, benefits and challenges are seldom conducted or available. Review of the literature has further shown that most of the studies conducted on NRHM was restricted to an administrative perspective or focused on a particular component of NRHM which has guided the researcher to undertake this study.