PERFORMANCE OF NRHM IN A SELECTED AREA IN COIMBATORE

SUBMITTED BY

NASEEMA BEGAM, M

(12PEC008)

A DISSERTATION SUBMITTED TO THE
AVINASHILINGAM INSTITUTE FOR HOME SCIENCE AND
HIGHER EDUCATION FOR WOMEN, UNIVERSITY
COIMBATORE-641 043

IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE
DEGREE OF MASTER OFARTS IN ECONOMICS

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CERTIFIED AS BONAFIDE RESEARCH WORK

P. Ambica Devi 27.3.14.

SIGNATURE OF THE
HEAD OF THE DEPARTMENT

27.3.14

SIGNATURE OF THE
SUPERVISOR

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CHAPTER I

INTRODUCTION

For any country, especially for a developing country, human capital formation is necessary, because to run the wheel of economic development, both physical capital as well as human capital have immense importance. Human capital formation is the process of acquiring education, skills, experience and physical ability for doing work which is crucial for the socio-economic and political development.

India, being home to one sixth of the world's population; the state of the health of the Indians has a significant bearing on the state of the world's health. Here too, approximately 40 percent of the people cited health as their main concern before other issues, such as financial problems, housing or crime (WHO, 2008).

HEALTH OVER THE YEAR

Before independence, socio-political and economic degenerations in India had reached a level where hunger and malnutrition were rampant. British India was ranked low among the nations because of high mortality and morbidity (GOI, 1946). The life expectancy at birth was as low as 26.9 years for males and 26.5 years for females. Nearly half the children used to die before the age of 5 years. Proportion of death among children less than ten years was accounting approximately 50 percent of the total deaths (average for the year 1935-39). Infant Mortality Rate (IMR) was as high as 162 infant deaths per 1000 live births, so was Maternal Mortality Ratio; 20 per 1000 live births (GOI, 1946).

The first generation reform started with the recommendations and guidance provided by Health Survey and Development Committee which is popularly known as Bhore Committee (1943). The reform primarily focused on Primary Health Care approach.

It was the recommendations of Bhore committee that, India's first formal national economic planning exercise i.e. First Five Year Plan (1951-55) laid emphasis on rural health service and infrastructure development. It was during this period that programs related to malaria, leprosy control, family planning, population control, water supplies and sanitation were

started. The major landmark in the development of health system post-independence was the establishment of the Public Health Centres (PHCs). These were established as part of a broader strategy for rural development, called Community Development Program.

In October 1952, the first PHC was established to serve population of 1, 00,000 with a staff of a physician, and a nurse. By 1956, there were 725 PHCs, though not fully staffed but serving 18 percent of India's 4, 00,000,000 populations.

The major contribution of Second Five Year Plan (1956-61) was in the form of strategic initiatives in the expansion of primary health care for rural population. The emphasis was on the construction and staffing of the facilities including training of the nurses and mid-wives, particularly from the tribal population. By 1961, the number of primary health centers increased to 2800 theoretically covering 63 percent of India's 440,000,000 populations. While the facilities were still short of the (then) existing norms (one PHC/1,00,000 Population), it was realized that even the existing facilities were underutilized. Extremely meagre transportation facilities were thought to be the key constraint in reaching the facility.

Over the plan period, major changes took place in the expansion of infrastructure and in ensuring utilisation of health services. The formulation of India's first National Health Policy in 1983 initiated second generation reforms in India. The policy reflected the commitment of India to attain the goals by 2000 AD through universalization of comprehensive 'Primary Health Care' services to achieve 'Health for all'.

Considerable achievements have been made over the past six decades in our efforts to improve health standards. Despite impressive economic growth in recent years, health sector do not enjoy such status and the health gain is not very pronouncing in India. Malnutrition affects a large proportion of children. An unacceptably high proportion of the population continues to suffer and die from various types of diseases. The rising cost of health care is a great threat both to the rich and poor. Further there is a striking disparity in the health care facilities that are made available to the people. There is a persistent gap in the infrastructure facilities in urban and rural area. According to David Morley: "Three quarters of our population are rural, yet three quarters of our medical resources are spent in towns where three quarters of our doctors live. Three

quarters of the people die from diseases which could be prevented at low cost and yet three quarter of medical budget is spent on curative services"

A large proportion of the people living in rural areas are not being provided with rudimentary health care. The 11th plan draft comments that universal health care no longer exists in India. There have been sharp decline in people's access to health facilities and service in recent years. And disparities in accessing health care services are becoming more pronounced between different states.

Differential access to health care between states is a big problem. For instance the closest healthcare unit was 1 km away for 82 percent household of urban in Andhra Pradesh. Only 61 percent of rural residence enjoyed such proximity. Similarly the availability of number of beds per 1000 population varied from 0.8 in rural area to 1.4 in urban areas. The poor and downtrodden frequently seek care from private provider. Poor service in rural and remote areas is often scarce or plagued by understaffing, supply shortages and low quality care. They therefore often turn to private providers for health care they need. Private provider engagement can still be pro-poor if there are mechanisms to exempt the poor or subsidize user fees (Preker, Harding & Girishankar, 2001) and purchasing arrangements include coverage for the poor.

RURAL HEALTH

Health has been declared a fundamental human right. Health care is a public right and it is the responsibility of the government to provide this care to all people in equal measure. These principles have been recognized by nearly all government of the world and enshrined in their respective constitutions. In India, health care is completely or largely a government function.

At the individual level it cannot be said that health occupies an important place as it is usually subjugated to other needs defined as more important. It is often taken for granted, and its value is not fully understood until it is lost. Health cannot be given or distributed, it has to be acquired actively and sustained by an individual. Health may be described as a potentiality or the ability of an individual or a social group to modify him or itself continually, in the face of

changing conditions of life not only, in order to function better in the present but also to prepare for the future.

World Health Organisation (WHO) defines Health as a state of complete physical, mental and social wellbeing and not merely an absence of disease or infirmity**.** In recent years, this statement has been amplified to include the ability to lead a *socially and economically productive life.* The meaning of health can be understood better by considering health as a state of equilibrium or harmony between man and his physical, chemical, biological, emotional and social environment, compatible with full functional activity of the problem.

Health dimension is one of the important dimensions which are almost neglected, especially in the rural part of our country. This excluded part should be included in our economic growth because there is an interrelationship between health and economic development. On the one side, improved health provides sufficient manpower that helps in enhancing economic development and, on the other side, economic development eliminates poverty, malnutrition and promotes health of working force, thereby helping in enhancing further the development process.

Residents of metropolitan cities are generally through to have easy access to the relatively concentrated health services of the central areas. However, most of the districts are so large that they contain small towns and isolated from these central clusters and their corresponding health services by physical barriers. While healthcare as an industry is being termed as a sunrise sector, public health is still a neglected area particularly rural area. According to the Medical Council of India the allopathic doctor – population ratio at present stands at 1:1,722. Taking into consideration other stream of Indian medicine systems as well as the practice of homeopathy in India, the doctor-population ratio comes to 128 doctors per lakhs of population. At the WHO recommendation of 1 per 300 populations, India needs 3.7 million doctors.

Rural Health care is one of biggest challenges facing the Health Ministry of India. With more than 70 percent population living in rural areas and low level of health facilities, mortality rates due to diseases are on a high level. Healthcare is the right of every individual but lack of quality infrastructure, dearth of qualified medical functionaries, and non- access to basic medicines and medical facilities thwarts its reach to 60% of population in India. Considering the

picture of depressing facts there is a terrible need of new practices and procedures to ensure that quality and timely healthcare reaches the deprived corners of the Indian villages. Though a lot of policies and programs are being run by the Government, the success and effectiveness of these programs is questionable due to gaps in the implementation.

WOMEN'S HEALTH

India is one of the few countries in the world where women and men have nearly the same life expectancy at birth. The fact that the typical female advantage in life expectancy is not seen in India suggests there are systematic problems with women's health. Indian women have high mortality rates, particularly during childhood and in their reproductive years. The health of Indian women is intrinsically linked to their status in society. Many of the health problems of Indian women are related to or exacerbated by high levels of fertility.

Women are major consumers of health care services, negotiating not only their own complex health care but often managing care for their family members as well. Their reproductive health needs as well as their greater rates of health problems and longer life spans compared with men are complex. Women are also more likely to be low-income and often face the added challenge of balancing work with family health and care giving responsibilities. For one in five women who are uninsured, access to high quality, comprehensive care is even more difficult.

Women have a vested interest in the scope and type of services offered by the health care system, as well as in the mechanisms that fund their health care services. Because their access to care is influenced by a broad range of factors, analysis of women's health policy cuts across many sectors of the health care financing and delivery system, including reproductive health policy, reforms to publicly-financed health programs, as well as private sector efforts to contain costs and improve health. Women comprise the majority of beneficiaries in publicly-funded programs such as Medicaid, Medicare, and welfare, making them key stakeholders in public policy debates about the impact of reforms to these programs. Because of their lower incomes, affordability and cost of care are critical issues for women.

Women's reproductive, combined with their lower socio-economic status, result in women bearing the greater burden from unsafe sex-which includes both infections and

complications of unwanted pregnancy. For example, among young adult women in Sub-Saharan Africa, unsafe sex accounts for one-third of their total disease burden.

Maternal conditions are one of the leading causes of death and disability among women in the reproductive ages. Haemorrhage, hypertensive disorders, obstructed labor, and unsafe abortion can have devastating consequences. An estimated 5,36,000 women die of pregnancy-related cause each year, and about 10 million women suffer complications related to pregnancy or childbirth, many with life-long consequences, including obstetric fistula. Complications may be physical, psychological, social or Economic. In addition to the impact on women, maternal chronic ill-health can affect the health and quality of life of the surviving children, as they depend on her for food and support. Children whose mothers die are three to 10 times more likely to die (World Health Organization, 2005).

Women from infant stage to their old age get an unfair deal in the matter of health. Their health concerns receive a low priority resulting in women bearing pain and discomfort in silence for long periods of time without seeking relief. The sex ratio in India speaks volumes about the neglect. It is not just the poor who for want of resources and with the inherent preference for a boy are guilty of bias. Even in well-to-do families parents tend to spend more on the health-care of boys than on girls.

The three most important features of the Indian health care system are:

1. ***Low levels of public spending*:** Between 1996-97 and 2005-06, total government spending on health was stagnant at about 1 percent of GDP, and the public expenditure elasticity with respect to GDP was at 0.94, lower than the average for low-income countries (1.16) for the same period (tendon and cashin, 2010). Despite efforts to increase public spending after 2005-06 including the adoption of NRHM, the expenditure increased only marginally to 1.2 percent of GDP in 2009-2010.
2. A resulting ***poor quality of preventative care and poor health status*** of the population.
3. The inadequate level of public health provision has forced the population to seek private health providers resulting in ***high OOP spending.*** OOP spending in India is over four times higher than the public spending on health care.

Thus, reform in the health sector will have to address the issue of increasing the allocation to health care, focusing on preventative care, ensuring greater access to health care by the poor and significantly improving the productivity of public spending (India MoHFW, 2005a, 2005b, 2005c).

Interventions of the Government:

The Government has undertaken specific measures in this regard, the designing and implementation of specific Health Programmes being a major contributing factor. The various programmes presently operational in the country are listed below,

Major Health Programmes in India:

- National Rural Health Mission (NRHM): incorporating AYUSH, IPHS and PRI
- National Urban Health Mission (NUHM)
- Reproductive and Child Health Programme (RCH)
- National Vector Borne Disease Control Programme (NVBDCP)
- National AIDS Control Programme (NACP)
- Revised National Tuberculosis Control Programme (RNTCP)
- National Leprosy Eradication Programme (NLEP)
- Integrated Disease Surveillance Project (IDSP)
- Integrated Child Development Services (ICDS)
- National Water Supply and Sanitation Programme
- National Cancer Control Programme
- National Programme for Control of Diabetes, Stroke and Cardiovascular Diseases
- National Mental Health Programme
- National Programme for Control of Blindness (NPCB)
- National Iodine Deficiency Disease Disorder Control Programme.

Acknowledging the gaps in health infrastructure and deficiencies in the health care system in rural areas the government conceptualized the National Rural Health Mission (NRHM) which is considered a milestone in the national health policy.

NATIONAL RURAL HEALTH MISSION

Recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has launched the National Rural Health Mission in 2005 to carry out necessary architectural correction on the basic health care delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health, viz. Segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care. The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalizing community health centres into functional hospitals meeting Indian Public Health Standards in each Block of the country. The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

The core strategies include training and enhancing the capacity of Panchayat Raj Institutions (PRIs) to own, control and manage public health services, promote access to improved healthcare at household level through the female health activist (ASHA), health Plan for each village through Village Health Committee of the Panchayat, strengthening existing sub-centre, PHCs and CHCs for improved curative care to a normative standard (Indian Public Health Standards defining personnel, equipment and management standards).

An important premise of the NRHM is the involvement of the Community. Starting from the need assessment, decentralized participatory planning, institutional arrangements, fund management, selection and training of Accredited Social Health Activist (ASHA), monitoring of the NRHM, the Panchayat Raj Representatives, NGOs, etc. have been involved in the health mission. This idea has been taken from moderate success of the education programmes like the Sarva Shiksha Abhiyan where the involvement of the community has resulted in some success in the respective developmental programmes.

The Mission aims to provide universal access to equitable, affordable and quality health care which is accountable and at the same time responsive to the needs of the people. The Mission is expected to achieve the goals set under the National Health Policy and the Millennium Development Goals.

To achieve these goals, NRHM facilitates increased access and utilization of quality health services by all, forge a partnership between the Central, State and the local governments, set up a platform for involving the PRIs and the community in the management of primary health programmes and infrastructure and provides an opportunity for promoting equity and social justice. The NRHM established a mechanism to provide flexibility to the States and the community to promote local initiatives and develop framework for promoting inter-sectoral convergence for primitive and preventive health care. The Mission has also defined core and supplementary strategies.

Low public expenditure allocation and its skewed interstate distribution were the major reasons for the central government‘s launching in 2005 a major program, the National Rural Health Mission (NRHM). The program covers the entire country but has a greater focus on 18 lagging states behind the spending on health care is expected to increase to 2-3 percent of GDP (from about 1 percent of GDP in 2005).

The important components of NRHM include the initiation of an Accredited Social Health Activist Program—a voluntary female community health program aimed at improving immunization rates, institutionalized deliveries, reproductive health care, and nutrition. NRHM also mandates improvements in health infrastructure, human resources for health, and availability of drugs. It is a flexible, decentralized program comprising

i. A mission flexible pool.
ii. A reproductive-health flexible pool.
iii. Infrastructure maintenance, and
iv. A national disease control program.

For allocating funds in the first two schemes, the states are divided into high-focus states and non-focus states. The states with poor health status are categorized into focus states. The funds for these schemes are allocated according to population, with focus states getting 30

percent higher weight. The program was supposed to contribute an additional minimum of 15 percent of the central government 'allocation for NRHM (by 30 percent for the first two years and thereafter by 40 percent) until 2012, and the states were required to contribute an additional minimum of 15 percent of the central government's allocations or an increase of 10 percent in their health budgets every year over the period 2007 to 2012. In order to ensure that the funds would be transferred to the implementing agencies without delay, the transfers were made directly to the state-level societies, by passing the budgets.

Improving women's health requires a strong commitment on the part of the government and it is with the basic idea to help rural women to have access to health care government designed NRHM. Against this backdrop the current study made an attempt to study the performance of NRHM in a selected rural area.

The objective of the study

- To identify the strategies of NRHM.
- To examine the working of NRHM in the selected area.
- To assess the impact of NRHM on rural women.
- To address the gaps in the provision of health care to women.

REVIEW OF LITERATURE

CHAPTER II

REVIEW OF LITERATURE

Health is a fundamental right. Health and economic developments are inter-related. There is abundant evidence that a health indicator is associated with many different dimensions of economic prosperity. The central problem today is associated with health and economic growth. Health is a positive state of well-being in which harmonious development of mental and physical capacities of the individuals leads to the enjoyment of rich, full and productive life based on cultural values that prevail in various states of our country.

The studies pertaining to the current study on "Performance of NRHM in a selected area in Coimbatore" is discussed under the following heads:

2.1 Inequality in Health Care Services,

2.2 Health status of rural women,

2.3 Maternal Health,

2.4 Need for National Rural Health Mission (NRHM),

2.5 Related studies.

2.1 Inequality in Health Care Service

Kumar and Devi (2010) observed that females in Kerala were better off in all conventional health indicators and that the problems related to women's health in Kerala are different from those addressed at the national level. Therefore, priorities, approaches and strategies set at the national level may not be appropriate for Kerala. The state needs to work out strategies specific to particular groups of people who are vulnerable in terms of health and issues such as problems of old age of women and widows, over mediatisation, increasing cost of healthcare and occupational health of women.

Prasad and Cyril (2010) observe that over 80 per cent of the world population depends on traditional systems of medicine, largely plant based to meet their primary health needs. In India, there are 3203 hospitals in traditional medical care systems with 61561 beds and 21351 dispensaries in 2007. State-wise analysis shows that Uttar Pradesh has the dominance in Ayurveda and Unani with 1771 and 209 hospitals respectively, while Tamil Nadu has the dominance over Siddha medicine with 275 hospitals. Several states have the upper hand over homeopathy medicine but Maharashtra gains the top spot with 44 hospitals in 2007. However, in India there are only 8 hospitals to provide medical care under yoga system and under naturopathy 18 hospitals provide medical care. They held the view that traditional systems of medicine are undoubtedly emerging as very close substitutes to other medicines.

Health care is provided by many institutions such as private sector hospitals, public sector hospitals and hospitals run by voluntary associations like religious bodies.

Prashanth (2011) commends that Primary Health Centres (PHCs) run by Non-Governmental Organizations (NGOs) in Karnataka have greater impact on health conditions of the people. There is a good record of institutional deliveries at the PHC in Gumballi with 81 per cent while the state has recorded only 65 per cent of institutional deliveries in 2006. At the same time, in the state only 60 per cent of women received three post-natal checkups but the NGO run Gumball PHC recorded 100 per cent. He reports that in 2004, the infant mortality rate decreased to 24 from 75 per 1000 live births in 1997. It is achieved only with the help of NGO run PHC, but, the state recorded only 48.70 per 1000 live births. Likewise Gumball PHC has earned better record in pre-natal care, birth rate and death rate in comparison with the state record.

In Karnataka there is high efficiency variation in the performance of health system. Purohit (2010) carried out his study in two stages by using stochastic frontier technique. He states that being a middle income state it has a per capital income of Rs.13141 which is higher than that of the all-India average. Likewise, life expectancy and literacy rates are also slightly above the country's average, but there are disparities across districts in the per capital availability as well as in the utilization of hospitals, beds and manpower inputs, which have an adverse impact on improving life expectancy in the state. He concludes that in Karnataka, the efficiency

variation at sub-state level in the health care system indicates that there is low efficiency of public health delivery system.

Acharya and Kent (2005) clarify that health indicators in India may have seen substantial improvements in recent decades but quality and affordable health care services continue to elude the poor. Government provided health services meet partially the needs of the rural and the urban poor in the informal sector and making equitable and affordable medical care accessible to this segment remains a challenge.

To study the health problems of women engaged in Visual Display Terminal (VDT) at their workplace and to develop intervention strategies for health maintenance for women engaged in VDT, Kaila (2000) made a study on sample the age group of 23-57 years of female non-computer users (113) and other computer users (37) drawn from the same organization. The entire sample was drawn through a random sampling method. The main problem was that they become tired in a very short period of time, trouble in breathing, trouble with pain or a feeling of congestion in chest. High blood pressure trouble with feeling nervous fidgety or tense etc. based on the above interventions were suggested to maintain improved health of women computer users. They should be allowed to take rest-pause or interval for 10 minutes and it is necessary to introduce medical examinations of women working on computer most of times during the day at work. The periodicity of the cheek-up may be six months (or) one year.

Several jobs are inherently dangerous to both men and women workers, but some jobs are more dangerous for women because they have less physical strength and their special needs during maternity put them at risk (Rethi,2003). Women work in industries like tanning, textiles, garments etc. In all industries, they toil long hours at low paid wages and in unskilled jobs. The health problems like T.B, allergies, abortions bronchial disorders, anaemia, toxicity etc. are common phenomenon. Women in the last decade become exposed to new kinds of health hazards. The solution to combating the health risks of women at work is to prohibit women from working in potentially hazardous jobs.

The utilisation of any social services, including health services, has never been equitably distributed throughout society. People with access to the facilities are generally found to make greater use of them than people who have neither knowledge nor access to the facilities. Ray et.al

(2014) identified that it is the structure through which medical services are dispensed that alienates lower-class patients. However, as observed in the study RCH services including Family Planning as well as immunization services (preventive services) were utilized much better while there was a strong need of improvement of Post Natal Care, otherwise, Neonatal and Maternal mortality and morbidity will continue to be high.

Gerntholtz (2009) asserts that in India and South Africa, the number of pregnancy-related death is alarmingly high. In South Africa, the number of pregnancy-related deaths increased by 20 per cent between 2005 and 2007 and nearly 40 per cent of these deaths are avoidable. Emergency obstetric is one of the most important factors in reducing maternal deaths. Uttar Pradesh has fewer than half of the 1097 community health centres. One in 20 referral units has caesarean section and one in hundred has blood storage facility. Moreover, he says that the government of Uttar Pradesh has not collected sufficient information about the outcomes of deliveries or pregnancy related deaths. Further, the author admits that inability to pay for transportation to a hospital costs life of many women.

Bell (2005) indicates that disparities between poor and non-poor vary enormously across countries. On an average, the chance a child born in lowest income quintile household is likely to die before reaching the age of five is twice higher than a child born in the highest income quintile household. The health system is farther away from achieving the objectives of equity and quality.

Recognising that improving performance of ASHAs is critical to achieving the outcomes of NRHM, Panwar et.al (2010) planned to identify, the gaps between the desired and actual performance of ASHAs, key factors affecting ASHA performance, and on-the-job support, capacity building and mentoring needs of ASHAs. They found that there is not much support or mentoring after the training programme to improve their competence.

Chatterjee (2009) throws light on the sharp health inequalities existing in India. Health outcomes across regions and income group remain poor and the scenario is deteriorating. Poor people concentrated in backward and remote areas have very weak infrastructure, degraded environment, poor sanitation, and lack of access to safe drinking water. Investment in the above said areas must be enhanced to improve the health status and living conditions of the poor.

Kelleher (2001) has explored as to why primary health care offers a more comprehensive approach for tackling health inequities than primary care. The study attempted to focus more intently on how to deal with alarming measures of health disadvantage and inequities, a reformist gaze seems to have settled on the primary care sector. Simultaneously, in the study about this area, whether intended or not, primary health care and primary care are terms that are increasingly interchanged.

Singh (2013), examined factors associated with maternal healthcare utilization in nine high focus states in India, which shares more than half of the total maternal deaths in the country. Multilevel analyses were applied to three maternity outcomes, namely, four or more antenatal care visits, skilled birth attendance and post-natal care after birth. Results show that along with individual-/household-level factors, community and district-level factors influence the pattern of utilization of maternal healthcare services significantly. At the community level, the odds of maternal healthcare utilization were lower in rural areas and in communities with a high concentration of poor and illiterate women. The study also found a strong association between the extent of previous use of maternal healthcare and its effect on subsequent usage patterns.

Patra (2013) assessed of the impact of NRHM on the health infrastructure and the health development of Odisha. The main Objectives of the Study were analyzing the impact of NRHM in terms of health infrastructure in Odisha and trends in the health indicators in Odisha after the implementation of NRHM. The study was based on the secondary data. The study showed that the health status of study area is very poor and is gradually increasing as a result of the implementation of NRHM and the staple reasons for this tendency are: low income, illiteracy, shortage of doctors, unwillingness doctors to go to remote areas and lack of health care facilities and lack of production of laboratory technicians and radiographers.

Ramani and Mavalankar (2005) explained the status of the health system of India from a different view. Their study found that non-availability of staff, poor service delivery, financial shortfalls, a weak referral system and lack of qualitative health care as the main problems in the Indian health care system.

2.2 Health status of rural women

Patil et.al (2002), opines that the problem of rural health is to be addressed both at macro (national and state) and micro (district and regional) levels. This is to be done in a holistic way, with a genuine effort to bring the poorest of the population to the centre of the fiscal policies. A paradigm shift from the current 'biomedical model' to a 'socio-cultural model', which should bridge the gaps and improve quality of rural life, is the current need.

Sharma and Dhawan (1986) found the prevalence of a number of health problems among rural women and a need was felt for their education on health aspects. The existence of a government hospital in village had no association of significant level with the health problems of rural women. Majority of the respondents perceived the treatment given in government hospital to be not effective and several other constraints in availing of the treatment facilities.

The aim of the study was to analyze the rural health care systems in China and India, through comparing differences and similarities and putting forward recommendations for each country. In this study the method applied is Bereday's classical comparative pedagogy including four steps – description, interpretation, juxtaposition and comparison. Wang (2011) found that both have similar three-level health centres under the rural health system. The majority of the public health care costs are paid by the governments, with a much smaller proportion paid by rural individuals; even most of the costs are free in rural India. However, while under the rural health system in China, a social insurance as the financing mechanism is running well through pooling the risks and contributions, a formal comprehensive mechanism is lacking in India, where the government just provides most of the health care services for free.

The health of Indian women is basically linked to their status in society. Research into Indian women's status by Saha and Saha (2010) found that their family contributions are often overlooked and they are likely to be regarded as an economic burden, especially in rural areas. This attitude has a negative impact on their health status. Poor health has repercussions not only for women, but also for their children and other family members. As women rise in economic status, they will gain greater social standing in the household and the village, and will have a greater voice.

Rural women with breast cancer were found to be more likely to get chemotherapy and mastectomies and less likely than urban women to have had radiation therapy and lumpectomies for breast cancer treatment Bettencourt et.al (2007) found that travelling to distant treatment facilities disrupted family life, employment, contributed to feelings of isolation, and displacement.

In rural India, early onset of sexual activity and the pressure on young married women to prove their fertility as soon after marriage as possible results in high rates of adolescent fertility. Considering the expected lower autonomy that younger women experience, the results are surprising. No differences in measures of care such as prescription of iron supplements and receipt of Tetanus Toxoid injections were observed by age, although a significantly lower percentage of women aged 19 and under received advice on contraception. An understanding of health seeking behaviour among pregnant youth will also be useful to better inform local education efforts. (Kilaru et.al 2002)

Among the 1013 women, whose health data were analyzed only 23 were in good health, while the rest had some health problems. It follows that women rarely go for preventive health checkups and often "live" with their health problems, without seeking medical help. The lack of awareness as well as indifference contributes to their myriad problem (Sinha, 1993).

Prasad (2000) made a study on the health related problems of the rural poor in Gujarat. His study suggest that most of the rural poor are facing problem in accessing healthcare services because the government fails to detect the social spaces or gaps in health care policies.

Rao et.al (2012) examined the healthcare delivery facility and community involvement role to the beneficiaries of rural healthcare in India. It provides an overview of the basic features and recent developments in rural healthcare infrastructure, services delivery to the beneficiary and accountability mechanisms. It examines the quality of healthcare services delivery by healthcare centres and community participation role. It then addresses recent policy proposals on the rural healthcare management and infrastructure improvement. The study makes constructive suggestions for innovative practices to improve the rural healthcare delivery services and the community involvement.

2.3 Maternal Health

Basu and Sidh (2008) identified that though both work status and socio-economic factors influence health status, the latter are more important; most of the gross effect of work status is due to socio-economic conditions rather than work participation. Srinivasan and Ilango (2013) explained that migrant women workers were not having any basic facilities. They are deprived of their basic rights and are exploited by the contractors. So there is an urgent need for the protection of migrant women workers to overcome these problems.

Women in developing countries particularly poor working women are suffering badly from all ills. Poverty induces them to work. Exposure to poor working conditions and poor health due to lack of money has serious repercussions on their pregnancies. The rise of miscarriages, premature deliveries and spontaneous abortions get increased. Riaz et.al (2012) found that heath of working women is strictly affected negatively by number of births, number of live children and hours of economic activity, while the provision of sanitation facilities, household income and family planning methods are positively affecting women's health.

A study was undertaken to assess the nutritional status, dietary intake and morbidity patterns among 100 non-pregnant non-lactating rural women of reproductive age group (18-40 years) in the village Bashahpur, Gurgaon. It was found efforts were needed to improve diet quality and education for rural women so that they rise in economic status and are better nourished. (Mittal 2013)

The World Health Organization (WHO) has divided maternal deaths in two main groups: Direct obstetric deaths resulting from pregnancy complications occurring before, during or after delivery, due to inadequate or improper care. Evidence shows that the direct causes account for the majority of the maternal deaths in developing countries. But it is very difficult to determine the exact cause of death, especially when the woman dies at home.

Pandey et.al (2012) support that utilization of health services reduces maternal mortality. Findings showed that three of the five indicators of empowerment women's age at birth of their first child, their education and knowledge about sexually transmitted diseases significantly increased utilization of health services, especially antenatal and delivery services.

Freeman et.al (2012) stated that While India has made significant progress in reducing maternal mortality; attaining further declines will require increased skilled birth attendance and institutional delivery among marginalized. Mothers belonging to general castes were almost twice as likely to have an institutional birth as compared to scheduled castes and tribes. Mothers belonging to other backward caste or general castes had 1.8 times higher odds of having an institutional delivery as compared to scheduled castes and tribes.

The health conditions of pregnant women, neonatal and infants in most of the states in India are woefully poor and need urgent attention from a number of fronts. Rajasthan has great physical, geographical, demographical and socio-economical diversity. Most of tribes of the state are inhabited on hillocks and to its bottom. Physical terrain and living style of tribal, create their health hazards, because of modern means of health and medical services is very difficult to reach to grass root level (Nagda, 2006)

To Khanna et.al (2013), large proportion the total expenditure on service provision for RH is spent through the government system, which includes donor support channelled through the government system under pooled funding. The donor expenditure on population assistance in Bangladesh showed fluctuations in the past, but is showing increasing trend for last three to four years. Out of pocket spending constitutes a significant proportion (around 65 percent) of the total spending on reproductive health.

Health system constraints often have the greatest impact on disadvantaged populations, resulting in poor access to quality health services among vulnerable groups. Reports Kraft et.al (2013).The Investment Case framework combines the basic setup of strategic problem solving with a decision-support model. They can lead to important maternal mortality reductions at relatively low costs.

The portal ‘Repository on Maternal Child Health’ was developed using an open source content management system and standardized processes were followed for collection, selection, categorization and presentation of resource materials. Agarwal (2013) discussed in relation to improving quality and access to health information. The overall bounce rate was 27.6%. There

was a high degree of agreement between the two experts regarding quality assessment carried out under the three domains of knowledge access, knowledge creation and knowledge transfer.

The emergence of maternal health as a political priority in Madhya Pradesh was the result of convergence in the developments in different streams. Currently, there is a supportive policy environment in the state for maternal health backed by greater political will and increased resources. However, malnutrition and population stabilization are the competing priorities which may push maternal health off the agenda. Hurtig et.al (2013)

To Costan et.al (2012) high maternal mortality in India is a serious public health challenge. Two programs, Janani Suraksha Yojana (JSY) and Chiranjeevi Yojana (CY), were designed and implemented to reduce financial access barriers that preclude women from obtaining emergency obstetric care. JSY, a conditional cash transfer, awards money directly to a woman who delivers in a public health facility. The implementation of the protocol will also generate evidence to facilitate decision making among policy makers and program managers who currently work with or are planning similar programs in different contexts.

Maternal Health Services are one of the basic health services to be provided by any government health system as pregnant women are one of the most vulnerable victims of dysfunctional health system. The maternal mortality in India varies across the states. Geographical vastness and socio-cultural diversity make implementation of health sector reforms a difficult task. It also identifies the reasons for limited success in maternal health and suggests measures to improve the current maternal health situation. Sharma et.al (2008) recommends improvement in maternal death reporting, evidence based, focused, long term strategy along with effective monitoring of implementation for improving Maternal Health situation. It also stresses the need for regulation of private sector and proper Public Private Partnership (PPP) policy together with a strong political will for improving Maternal Health

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The current maternal mortality rate (MMR) in Maharashtra is 104/100000 live births, ranking 3rd in India. There is scope for reducing it as majority of the causes of MMR are preventable and curable. 1/3rd of the women were illiterate, half of the women belonged to urban slum areas and of lower socio-economic class.1/3rd of the deaths occurred in primigravida,

within 24 hrs. From admission, 58.73% of the patients were referred from outside. Out of that86.49% of women were sent from private hospital and died in postpartum period, having poor prenatal outcome. (Surve et.al 2013)

Since the beginning of the Safe Motherhood Initiative, India has accounted for at least a quarter of maternal deaths reported globally. Sharma et.al (2009) identifies the causes for limited success in improving maternal health and suggests measures to rectify them. The author stresses the need for regulation of the private sector and encourages further public-private partnerships and policies, along with a strong political will and improved management capacity for improving maternal health.

Kamal (2012) aimed to investigate the effect of maternal education on neonatal mortality in Bangladesh. Programmes should be undertaken to improve female education in Bangladesh for a better chance of satisfying important factors that can improve infant survival, such as the quality of infant feeding, household sanitation and adequate use of preventive and curative health services.

Editorial, EPW (2011) has lamented the delivery related deaths of women and death of children in Jodhpur. With the central and state government's initiating measures to reduce the MMR, was 570 per 100000 live births in 1990, come down to 230 in 2008,but still the highest in the world. In Jodhpur's government hospitals 18 women lost their lives after child birth and three infants also died between 13th February and 15th March 2011. It is nothing but the neglect of maternal health, especially of poor women. Lack of expert care during complicated deliveries at home also lead to a large number of maternal and neonatal deaths every year.

Prasad and Cyril (2011) observed that maternal mortality has declined significantly in India. It declined from 519 in 1991, to 301 in 2003 and to 212 per 1,00,000 live births in 2009, but by citing the MDG target of 109 per 100000 live births by 2015 they say that we are far away from the target and still 1,36,000 maternal deaths are reported from India. Moreover, India is well behind the Asian countries like Malaysia (30), China (37), Sri Lanka (44), and Philippines (162 per 100000 live births).

Global Monitoring Report (2010) reveals that maternal deaths in 181 countries found a significant decline around the globe. It decreased by over 35 per cent from 5,26,300 in 1980 to 3,42,900 in 2008. The Report clearly says that more than half of all maternal deaths were concentrated in six countries – India, Nigeria, Pakistan, Afghanistan, Ethiopia and the Democratic Republic of Congo, while, the Arab Republic of Egypt, China, Ecuador and Bolivia have been achieving rapid gains. Southern and Western Regions showed deterioration because of the significant number of pregnant women who died from HIV infection but at the same time Sub-Saharan Africa, Central and Eastern Regions showed some improvement. In Southern Africa, the maternal mortality rate increased from 171 in 1990 to 381 per 100000 live births in 2008. Analysis found that only 23 countries so far are on the track of MDG5.

Vujicicet, et.al (2009) points out that maternal mortality rate in Rwanda, Zambia and Kenya is much higher than the global average. Maternal mortality in Rwanda is 1300 per 100000 live births; Zambia has 830 deaths per 100000 live births against the global average of 304 deaths per 100000 live births in 2005. Kenya with 506 maternal deaths per 100000 live births did better than the Sub-Saharan regional average.

Kannan (2009) believes that verbal autopsies have reduced maternal mortality rate considerably. In Tamil Nadu, verbal autopsies achieve significant success in bringing down maternal mortality rate to 91 against 301 at the national level. He added that by improving female literacy, better access to quality public health services can be achieved.

Pandey, et.al (2004) correlated the utilisation of antenatal care services and assistance received during delivery in three recently formed Indian states namely Chhattisgarh, Jharkhand and Uttaranchal. Which are characterized with distinct geographical and topographical features? The study focuses on the particular features of the three states. The study concludes that, it is necessary for the reproductive and child health programme to visualize a dynamic strategy giving due consideration to the geographical and socio-economic factors.

2.4 Need for National Rural Health Mission (NRHM)

According to Andrea et.al (2012) greater proportion of pregnant women and grandmothers were uneducated and below poverty than the new mothers and husbands. While some indicated that hospital delivery is becoming more favoured among the younger generation, others described many factors that dissuaded them from institutional delivery. However, some preferred practices that were available at home births were not available at either hospital type. Finally, though some received the benefits of incentive schemes or aid from Accredited Social Health Activists (ASHA), many others did not.

The adoption of the NRHM has brought about improvements in the number of health institutions available and it has also made healthcare facilities accessible to villagers in far flung remote areas. The government needs to play a more proactive role in delivering better health services to the people. Efforts should be made to reach the goals set forth under the Millennium Development Goals. (Nongkynrih, 2013)

Sujatha and Kumari (2009) stated that the prestigious mission of Government of India in the health care has great challenges. The mission of NRHM is a revolutionary reform and a boon for the rural health sector. The main aim of NRHM is to provide accessible, affordable, accountable, effective and reliable primary health care, especially to poor and vulnerable sections of the population. It also aims at bridging the gap in Rural Health care through creation of a cadre of Accredited Social Health Activists (ASHA) and improves hospital care, decentralization of programme to district level to improve intra and inter- sectoral convergence and effective utilization of resources.

Mukhopadhyay (2012) attempted to draw linkages between system strengthening and fund absorption capacity to argue that only consistent investment can make health systems stronger. This in turn would allow the system to absorb more funds. Since the introduction of NRHM, there has been some growth in the funds disbursed to the states. But, the increase in spending at the state, district and block levels was not adequate, leaving huge unspent balances. However, utilisation had been more in activities in the form of entitlements like cash incentives for promoting family planning, safe motherhood programme or activities that run on a vertical mode like the Pulse Polio Immunisation.

Utilisation of untied fund at the village level by VHSCs has remained low. Bhanot et.al (2010) observed that late release of fund and lack of clarity on decision-making processes as well as operational guidelines in regard to utilisation of flexi-fund was barriers to effective utilisation of flexi-fund. Other issues included poorly defined auditing as well as supervision/ monitoring systems and lack of orientation to fund managers.

The NRHM has put rural public health care firmly on the agenda, and is on the right track with the institutional changes it has wrought within the health system. On physical infrastructure, medicines and funding, procession problems might be more easily scaled with time, whereas on 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, especially women, and close monitoring of attendance. (Gill 2009)

Gupta et.al (2011) opines that Innovations under National Rural Health Mission have paved the way for increased utilization of hospitals for childbirth. The association of increase in hospital deliveries with decline in the prenatal mortality rate in rural India after the launch of NRHM was noticed. Relative increase in hospital deliveries was 57% from year 2005 to 2008 but relative decline in the PNMR was only 2.5% in the rural areas of Indian states.

Uttar Pradesh has been identified as one of the low performing state, both in terms of health system indicators and health outcome parameters. From the analysis it is evident that service delivery capacity of the public health system has increased at each level. Baijal et.al (2009) found that Outdoor Patient 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. The main beneficiaries of indoor services at each level were invariably women followed by children and men respectively.

The problem of evaluating ASHA is compounded by multiple and contesting narratives of what constitutes the legitimate role of an ASHA. The discourse on the ASHA's role centres around three typologies: ASHA as an activist, ASHA as a link worker or facilitator, and ASHA as a community level health care provider. Another problem for evaluation is that the ASHA programme is implemented concurrently with a number of other components of the NRHM such

as the Janani Suraksha Yojana (JSY) and the emergency transport (108) programme and it is impossible to isolate or attribute outcomes as being due to the ASHA programme alone. Raju and Mony (2012) observed that ASHA programme was found to be operational in the villages of Karnataka. They also found that there is inadequate coverage of marginalized households within villages and hamlets in rural and urban Karnataka.

ASHA is looked upon themselves as another cadre of state healthcare services accountable to the medical supervisor in the primary health centre rather than the Panchayat and the community. This certainly hampered the primary role of the ASHAs. Mishra (2010) found that different ASHAs understood their work profile differently. They observed that the cash incentives have certainly increased the number of institutional deliveries as the ASHAs make all possible efforts to take the pregnant woman to the healthcare institutions for delivery.

Bajpai and Dholakia (2011) believed that under the given circumstances it is not only prudent but also most practical and meaningful to concentrate on improving the performance of ASHAs. The success of the ASHA programme is highly dependent on the individual ASHAs who are chosen to advocate for and provide knowledge about the importance of healthy practices.

To Swain (2008), the NRHM has envisaged capacity-building of the ASHA through training and motivating them through a performance-based compensation. The analysis and interpretations of data from different stakeholders have been summarized into many areas of strength and weakness, which are extremely useful to bring about improvement in the functioning of the ASHAs.

Nandan (2008) stated that the role of the ASHAs in institutional deliveries was appreciable. More than three-fourth of the beneficiaries were found satisfied with the ASHAs. The PRI members too were appreciative of ASHAs' presence in the village indicating acceptance of the ASHAs in the community. Non-availability of funds at district-level was not found to be a problem. Funds were being transferred to sub-district levels through e-banking. Almost all the BNOs had complete knowledge of the provisions of compensation money for the ASHAs. The majority of ASHAs and ANMs had incomplete knowledge about the compensation provisions made available under the scheme.

Costa et.al (2012) found reasons for participation/ non participation, factors associated with non-uptake of the program, and the role played by a program volunteer, accredited social health activist (ASHA), among mothers in Ujjain district in Madhya Pradesh, India. The major finding of the study was majority of deliveries (318/418; 76%) took place within the JSY program. Ninety percent of the women had prior knowledge of the program. The ASHA's influence on the mother's decision on where to deliver appeared limited.

Dileep et al (2004) in their study explored the primary healthcare system in India. Primary healthcare system in India is very large and covers almost all the parts of the country. It has more than 20,000 PHC's and 140,000 sub-centres spread in more than 400 districts. This system consumes large amount of resources and is the system which provides the services for primary care including preventive programs. The system is mainly managed by doctors, some of whom have brief public health training. It is imperative that the doctors who are put in charge of the PHC system receive reasonable skills and training in management so that the resources spent on the PHC system can be utilized well - in an efficient and effective manner.

The study conducted by Haines et.al. (2007) reveals that the vision of PHC in the Alma ata declaration and highlights some of the management concept between this and the selective approach to PHC, which promotes a few cost-effective interventions. The study explain that despite movements towards selective packages of health care and health-care reforms the idea of PHC as described in the alma at a declaration is attracting renewed interest. There are several reasons for the shortage of health workers, especially in developing country. The States have renewed interest in the role of community-health workers; the study also highlights the growing research evidence about the cost-effectiveness of some components of PHC, such as the role of community participation in improving neonatal and maternal mortality in India.

A study was carried out by Kumar (2009) by using multistage purposive random sampling method from Out Patient and Inpatient Registers maintained at each level of health facility i.e. District hospital, Community Health Centre (CHC) and Primary Health Centre (PHC) in the state of Uttar Pradesh. From the analysis it was evident that service delivery capacity of the public health system has increased at each level. It was also found that Outdoor Patient visits have increased at all three levels, though with variation. The main beneficiaries of indoor services at each level were invariably women followed by children and men respectively

however; the changes are not uniform especially where peripheral facilities are showing less improvement in comparison to the district hospital. There is still much to be done to call all health facilities 'fully functional' as per the Indian Public Health Standards (IPHS) guidelines.

Nair and Panda (2011), aimed to examine the scenario of quality of care in maternal health over the last decade and the impact of NRHM initiatives on the same. While NRHM has made efforts to address lacunae associated with quality of maternal care in the public health system, there is much scope for improvement. The report also recommends that improving the quality of care and comfort of stay for the in-patients in the public hospitals especially at the secondary level, through clean toilets, fresh linen, and a friendly environment are steps towards a system of ensuring quality improvement in all public health facilities. One of the major road blocks towards fostering a movement in enforcing quality of care in maternal health services has been the absence of independent advocates for promoting quality of care in this realm within the civil society.

Maternal Mortality Ratio (MMR) continues to remain high in our country without showing any declining trend over a period of two decades. There is a strong need to improve coverage of antenatal care, promote institutional deliveries and provide emergency obstetric care. Delays occur in seeking care for obstetric complications and levels of 'met obstetric need' continue to be low in many parts of the country. Most of the First Referral Units (FRUs) and CHCs function at sub-optimal level in the country. National Rural Health Mission (NRHM) offers institutional mechanism and strategic options to reduce high MMR. 'Janani Suraksha Yojana', strengthening of CHCs (as per Indian Public Health standards) to offer 24 hours quality services including that of anaesthetists and Accredited Social Health Activist (ASHA) are important proposals in this regard. District Health Mission can play an important role in monitoring maternal deaths occurring in hospitals or in community and thus create a social momentum to prevent and reduce maternal deaths. NRHM, however, depends largely on Panchayat Raj Institutions for effective implementation of proposed interventions and utilization of resources. (Kumar 2005)

Bhatt(2012), in his study planned for ascertaining how efficient the ASHAs are to play their defined roles effectively, what are the problems they are facing and to further suggest measure for optimization of their working. A cross-sectional, descriptive study was undertaken

in Bageshwar and Nainital districts of Uttarakhand. In -depth interviews were conducted with the accredited social health activists (ASHAs), the members of the Panchayat Raj institutions (PRIs), and the auxiliary nurse midwife (ANMs), anganwadi workers (AWWs), and the members of the community. It was found that at many of the places the ASHAs had to cater a population more than the norm of 1000, compensation for ASHAs should be suitably increased. The irregularity in the area of supply of medicine kits should be investigated. Also capacity building training should be imparted to the ASHAs as they are unable to conduct meeting in the community.

2.5 Related studies

Sharma and Dhawan (1986) in their study indicated the prevalence of a number of health problems among rural women and a need was felt for their education on health aspects. The existence of a government hospital in village had no association of significant level with the health problems of rural women.

Krishnan et.al (2010) conducted a study to evaluate the effectiveness of a computerized Health Management Information System in rural health system in India. They found that there had been no major hardware problems in use of computerized HMIS. More than 95% of data was found to be accurate. Health workers acknowledge the usefulness of Health Management Information System (HMIS) in service delivery, data storage, generation of work plans and reports. For program managers, it provides a better tool for monitoring and supervision and data management.

Another study found that rural women with chronic illness benefited from obtaining health education specific to their disease through use of the internet in a support group format (Winters & Sullivan, 2010). Rural women in communities with limited health care resources, and an absence of women with similar chronic illnesses in the same rural community reported a decreased sense of emotional isolation while participating in the program.

Cudney et.al (2005) reported that rural women with varying chronic illnesses participated in a computer based education and support group that eliminated the emotional isolation often experienced by rural women, and helped to empower women to advocate for themselves.

Folta et al. (2009) studied a community-based program to reduce cardiovascular (CVD) risk in rural sedentary, overweight, and obese women. They point out that nutrition counselling, dietary changes, and exercise were found to be effective for improving self-efficacy, and decreasing waist circumference and body weight.

Another study found improvements in facilitating dietary changes to reduce CVD risk in rural women through the use of a computer-based, interactive nutrition education program (Tessaro, et.al, 2007).

A woman's health literacy is an important element in her ability to engage in health promotion and prevention activities both for herself and her children. Without an adequate understanding of health care information, it is difficult if not impossible for a woman to make informed decisions that will lead to satisfactory health care outcomes for herself and her family (Shieh and Halstead, 2009).

Jain (1981) studied the level and differentials of infant and child mortality in India and the demographic impact. He studied the factors affecting the levels and differentials of infant and child mortality. He stressed the importance of socio-economic factors, nutrition and control of communicable diseases for infant and child mortality.

Duggal (2009) strongly argued that persons, who provide health care and understand the reality at the grass root level, should essentially participate while planning. According to him, if the planners have no idea about the ground realities, then, increase in expenditure on public health through NRHM will be fruitless. Thus, he suggests that those who have direct links with the public health system should be given full autonomy while allocating budgets.

Baru et al (2000) throw light on the efficiency of the private sector in providing health services to the people. The private sector is more efficient and provides better quality care. At the same time, private hospitals are having many loopholes. Profit motive of private hospitals leads them to increase the medical costs, which has direct bearing on the patients. Then for quick turnover, they follow all fraudulent practices.

Yazbeck (2009) points out that health inequality is rampant among 56 low and middle income countries, representing 2.8 billion people. The author compares the well-off 20 per cent

of the population with the poorest 20 per cent and finds that an infant from the poorest is more than twice likely to die than that of the rich before reaching the age of one. A child belonging to the poorest family has a chance to suffer three times more than a child belonging to the richest family by severe stunting. In case of pregnant women, a poor pregnant woman is three times likely to deliver a baby at home instead of at a health centre than rich pregnant women. He observes that the poorest 20 per cent of the population captured only about 10 per cent of the total net public subsidy, but the wealthiest quintile benefited three times more than the poorest. There is wide disparity in immunization coverage also. Only 20.2 per cent of the poorest quintile children receive all routine vaccinations whereas the wealthiest quintile receives 59.8 per cent.

Perker (2005) asserts that the incidence of spending on public services is often pro-rich and outcomes for the poor are much worse, though in principle public financing favours an efficient and equitable spending on health care. Governments and households spend substantial resources on health care, but they fail to prevent the occurrence of even common diseases. The public funded programmes fail to ensure access to quality health services. They also fail to prevent people from falling into poverty when they seek health care. Eighty per cent of the total health expenditure is due to high user charges in both public and private health sector. There are also countless incidence of poor staff treatment of patients in government funded hospitals and clinics.

A study of the female labour force in Thailand by Archevanitkul (1998), reported that most of the female labourers belonged to the age group of 20-40 years. They were poor and they had only elementary education. About 20 percent of these women had been exposed to pesticides due to poor practice in self-protection. The health problem reported included headache, nausea, vomiting and skin rash. The study also found that young children were exposed to pesticide residues on their mother's clothes. The women workers were usually unaware of any minor symptoms and unlikely to seek treatment or change their behaviour.

UN Report (1998) indicated that because of multiple tasks and responsibilities, women workers did not have time for health care. Above 63 per cent of the private plantation labourers suffered from lack of time for cleaning their house and rearing domestic animals, around 57 percent of the Government labourers also reported on a similar live. Almost 50-60 % of the

women labourers in private and Government plantation found no time for recreational activities regardless of the type of plantation.

Kumar (2000) in a study in Haryana revealed that average number of working hours for women was between 15 and 16 both in home and fields. In one family the workload of 3 women and one 12-year-old girl totalled 58 hours per day of these 12hours were spent in doing household work. In other family, 75 year old women were putting in 10 hours work per day. We know that its women who do 2/3rdof world's work, they produce 50 percent of its food and yet the world pays them only 1/10thof its income and allows them to own one hundredth of its property. Women who work are recognized by their income. The work is unpaid and unrecognized and facilities are minimum to the workforce.

Jakab and Krishnan (2001) examined on healthcare community financing. The community financing is, to assess the performance of community involvement in health financing in terms of the level of mobilized resources, social inclusion, and financial protection; and establish the determinants of reported performance results, including technical design characteristics, management, organizational, and institutional characteristics.

METHODOLOGY

CHAPTER III

METHODOLOGY

For a systematic understanding of any research work, a well and organized plan of work is essential. The methodology that a researcher adopts in this carries much weightage. This chapter gives the methodology adopted by the researcher for her work on "Performance of NRHM in a selected area in Coimbatore". It is discussed under the following heads.

3.1 Selection of the study,

3.2 Selection of the Location,

3.3 Selection of the sample,

3.4 Source of data,

3.5 Data Analysis,

3.6 Limitation of the study.

3.1 Selection of the study:

Every year, India adds more people than any other nation in the world, and in fact the individual population of some of its states is equal to the total population of many countries. Tamil Nadu is situated on the south eastern side of the Indian peninsula. Tamil Nadu is one of the most developed states of India with 44% of its population living in urban areas and the remaining in rural area.

Tamil Nadu is one of the best performing states in the provision of quality health care. It is reported that in recent years certain health indicators show a positive sign in relation to some

other states such as Kerala, which showed a good results for a very long period. In comparison with the national average, Tamil Nadu's performance in IMR, MMR, and CDR, CBR, LEB and immunization, working of public health centres and insurance coverage is good.

3.2 Selection of the location:

Population of Tamil Nadu is growing at a rapid rate. In the last 10 years, the state population has witnessed a growth of 15.6% to its total population. Population of Tamil Nadu has doubled in the last 60 years; from a small figure of 30 million in 1951, it currently stands at 74 million in 2013. Comparing it with other states of India, Growth of Population in Tamil Nadu is not disturbing but decent. Every year, Tamil Nadu adds 1 million more people to its population.

Healthcare Services in Coimbatore

The size of the Coimbatore health care industry has been estimated as ₹1500 Crore (150 million) in 2010. There are nearly 750 hospitals in and around Coimbatore with a capacity of 5000 beds. The first health care centre in the city was started in 1909. In 1969, it was upgraded to Coimbatore Medical College Hospital (CMCH). It is a government run hospital with bed strength of 1020 and provides free health care. Including the CMCH, corporation maintains 16 dispensaries and 2 maternity homes. The city also has many large multi-facility private hospitals like the PSG Hospitals, Kovai Medical Center and Hospital (KMCH), KG Hospital, Coimbatore Kidney Centre, G. Kuppuswamy Naidu Memorial Hospital(GKNM), Sri Ramakrishna Hospital, Sheela Hospital, Kongunadu Hospital, Gem Hospital, Ganga Hospital, Aravind Eye Hospital, SankaraNetralaya,Sankara Eye Centre, Lotus Eye Hospital, Ashwin hospital, Vikram ENT hospital, SheelaHospital,Coimbatore Cancer Foundation, G. P. Hospital, Diabetes Care and Research Centre. The city is also a major centre for medical tourism. The city remains the preferred healthcare destination for people from nearby districts and also from the neighbouring state of Kerala.

The Health Care Industry in Coimbatore has witnessed a tremendous growth in the last decade. Coimbatore is well-known for its exclusive super-speciality hospitals. The Lakshmi

group started the Kuppusamy Naidu Hospital. It is one of the five centres in the country for the detection of cancer and education on cancer. The PSG Hospitals with highly scientific clinical services; The KG Hospital with the state-of-the-art facilities; The Kovai Medical Centre and Hospital (KMCH) with specialised procedures such as stenting, fallopian tube recanalisation, chemoembolisation and laparoscopic and thoracoscopic; Ganga Hospital for trauma, orthopaedic and micro-vascular surgery; Gem Hospital for laparoscopy; Rao Hospital for assisted reproduction and endoscopy; The Eye Foundation and Sankara Eye Clinic for ophthalmology - which offer world-class treatment at affordable rates; Vikram Hospital for ENT and so on.

Thudiyalur is a part of Coimbatore city. It is about 12 km from the city centre in the north direction. It is located 15 Kilo meters from Coimbatore Junction. Thudiyalur is located on the stretch of Mettupalayam road, one of the arterial roads of Coimbatore. The total population of the Panchayat is 88,366, of which of male population is 45,945 and female population is 42,421. The main area covered in this study is Vadamadurai, Goundenpalayam, Housing unit, Jangamanayakan palayam (J.N.palayam) and Thudiyalur.

3.3 Selection of the sample

Health is a state of complete physical, mental and social well-being and not merely the absence or infirmity. Women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology. However, health and well-being get away from the majority of women**.**

The NRHM scheme was launched in the year 2005. Under this scheme, for women they have introduced Accredited Social Health Activists (ASHA). and Janani Suraksha Yojana (JSY) which is for pregnant women. By this scheme 80.68 women benefited in the year 2012-13. To analyse the impact of these schemes on women, selected samples were chosen through convenience sampling. The woman who had access to a PHC where NRHM is functioning in full swing was chosen. Women who had benefitted from this scheme were selected as sample. The size of the sample was 110. All these women had benefitted from NRHM scheme. They continue to enjoy benefits from NRHM. With the help of a questionnaire the details were collected.

3.4 Source of data

The study made use of both primary and secondary sources. Women's health in India is generally much worse compared to other countries, despite two decades of very rapid growth in India. The health of women and girls can be considered as the basic indicators for the health of a society. Precisely because of gender discrimination, the health conditions of females generally tend to lag behind those of males, and therefore absolute improvement in these conditions is a reasonable indicator that the overall health conditions of that society are also getting better.

Data for the study was collected by administrating interview schedule to the 110 respondents personally by the investigator. (Appendix I).The interview schedule consisted of questions on the General profile, Pregnancy details and Awareness of NRHM scheme. The data collection was done during month of January 2014.For secondary sources, all the publication from government offices, health units and journals were used.

3.5 Data Analysis

The collected data were analysed using percentage, frequency method, and Factor analysis.

Tools used:

A. Garrett's Rating Scale

To find out the strength of factors ranked by the selected sample groups in relation to the reasons for selecting Garrett's rating scale technique was used. From the ranks given for each factor, percent positions were calculated by using the formula.

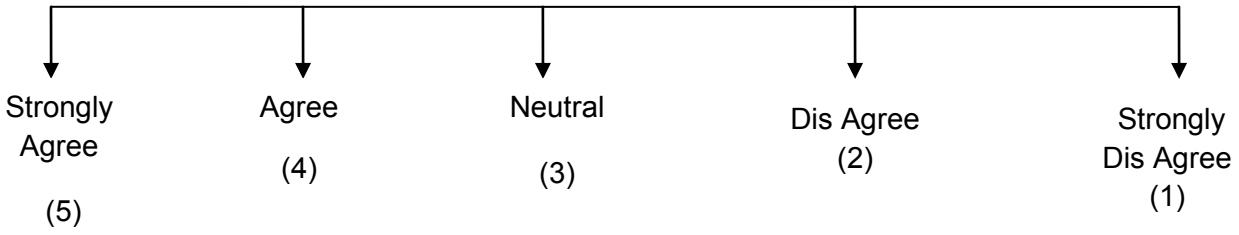
$$\text{Percent position} = 100 * (R-0.5)/N$$

Where R is the rank assigned and N is the number of items ranked. The percent position was then converted into scores using Garrett's scores table (Garrett H, 2005).

Garret ranking scale technique was used in ranking the various reasons for identifying the effectiveness of the scheme NRHM. This was in terms of satisfaction realized by the beneficiaries.

B. Likert's Summated Scale

The Likert summated scaling technique was used to scale the facilities provided by NRHM. Its access and benefits to technology. In the Likert scale, the respondents were asked to respond to each of the statements in terms of five degrees of agreement or disagreement.



Each point on the scale carries a score. Response indicating the least favourable degree of satisfaction is given the least score (say 1) and the most favourable is given the highest score (say 5). These score values are normally not printed on the instrument but are shown here just to indicate the scoring pattern.

The Likert scaling technique, thus, assigns a scale value to each of the five responses. The same procedure is repeated for each and every statement in the instrument. This way the instrument yields a total score for each respondent, which would then measure the respondent's favourableness toward the given point of view.

Factor Analysis

Factor analysis is a generic name given to a class of multivariate technique whose primary purpose is to define the underlying structure in a data matrix. Broadly speaking, it addresses the problem of analyzing the structure of the interrelationships (correlations) among a large number of variables by defining a set of common underlying dimensions, known as factors.

With factor analysis, the researcher can first identify the separate dimensions of the structure and then determine the extent to which each variable is explained by each dimension.

Once these dimensions and the explanation of each variable are determined, the two primary uses for factor analysis, namely summarization and data reduction can be achieved. In summarizing the data, factor analysis derives underlying dimensions that, when interpreted and understood, describe the data in a much smaller number of concepts than the original individual variables.

Factor analysis was used in the present study to identify the underlying pattern of facilities provided by NRHM, scheme available to pregnant women, scheme effectiveness, hygienic conditions, availability of drugs, infrastructure and transport facilities.

3.6 Limitation of the study

- Different schemes had been in operation with regard to health, by government but NRHM alone is taken up for study.
- The study is restricted only to a selected rural area and only pregnant women were selected.
- Since the study is conducted through primary data, there are many facts which are not given exactly.

RESULTS AND DISCUSSION

CHAPTER IV

RESULTS AND DISCUSSION

The findings of the current study on "**Performance of NRHM in a selected area in Coimbatore"** were discussed in this chapter under the following headings

4.1 General profile of the pregnant women,

4.2 Knowledge on the working of NRHM,

4.3 Health problem,

4.4 Details of first delivery,

4.5 Help received during pregnancy,

4.6 Health check-up carried out,

4.7 Health care facilities,

4.8 Transport charges,

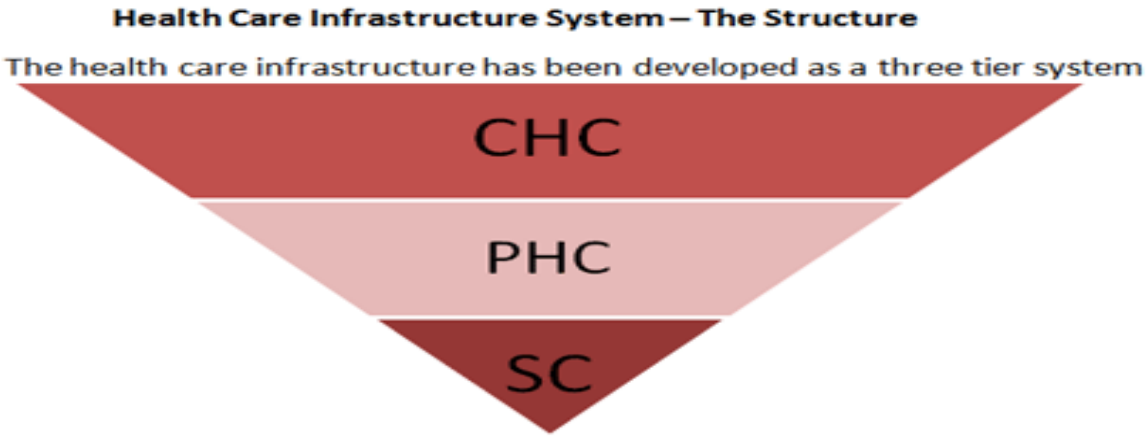
4.9 Benefits of scheme,

4.10 Response of pregnant women

4.11 Suggestions.

Health care infrastructure

The entire family welfare programme is being implemented though Primary Health Care system. The Primary Health Care infrastructure has been developed as a three tier system with Sub Centre, Primary Health Centre (PHC) and Community Health Centre (CHC) being the three pillars of Primary Health Care system. Progress of Sub Centres, which is the most peripheral contact point between the Primary Health Care system and the community, is a prerequisite for the overall progress of the entire system



Community Health Centres (CHCs)

CHCs are being established and maintained by the State Government under Minimum Needs Programme (MNP) / Basic Minimum Services Programme (BMS). As per minimum norms, a CHC is required to be manned by four medical specialists i.e. Surgeon, Physician, Gynaecologist and Paediatrician supported by 21 paramedical and other staff. It has 30 in-door beds with one OT, X-ray, Labour Room and Laboratory facilities. It serves as a referral centre for 4 PHCs and also provides facilities for obstetric care and specialist consultations.

Primary Health Centres (PHCs)

PHC is the first contact point between village community and the Medical Officer. The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and primitive aspects of health care. The PHCs are established and maintained by the State Governments under the Minimum Needs Programme (MNP)/ Basic Minimum Services Programme (BMS). As per minimum requirement, a PHC is to be manned by a Medical Officer supported by 14 paramedical and other staff. It acts as a referral unit for 6 Sub Centres. It has 4 - 6 beds for patients. The activities of PHC involve curative, preventive, promotive and Family Welfare Services.

Sub-Centres (SCs)

The sub-centre is the most peripheral and first contact point between the primary health care system and the community. Each Sub-Centre is required to be manned by at least one Auxiliary Nurse Midwife (ANM) / Female Health Worker and one Male Health Worker One Lady Health Visitor (LHV) is entrusted with the task of supervision of six sub-centres. Sub-Centres are assigned tasks relating to interpersonal communication in order to bring about behavioural change and provide services in relation to maternal and child health, family welfare, nutrition, immunization, diarrhoea control and control of communicable diseases programmes. The Sub-Centres are provided with basic drugs for minor ailments needed for taking care of essential health needs of men, women and children. The Ministry of Health and Family welfare is providing 100 percent Central assistance to all the sub-centres in the country since April 2002

in the form of salary of ANMs and LHVs, rent at the rate of Rs.3000/- per annum and contingency at the rate of Rs. 3200/- per annum, in addition to drugs and equipment kits. The salary of the Male Worker is borne by the state Governments.

Private hospitals

A private hospital is a hospital owned by a profit company or a non-profit organisation and privately funded through payment for medical services by patients themselves, by insurers, Governments through national health insurance schemes, or by foreign embassies. This practice is very common in the United States, Chile, France, Germany, and Australia. In the United Kingdom, private hospitals are distinguished from the far more prevalent National Health Service institutions.

Public hospital

A public hospital or government hospital is a hospital which is owned by a government and receives government funding. This type of hospital provides medical care free of charge, the cost of which is covered by the funding the hospital receives.

National Rural Health Mission (NRHM)

NRHM was launched on April 12, 2005, to provide accessible, affordable and accountable quality health services to the poorest households in the remotest rural regions. The thrust of the Mission was on establishing a fully functional, community owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health like water, sanitation, education, nutrition, social and gender equality. Under the NRHM, the focus was on a functional health system at all levels, from the village to the district.

The Mission aims to provide universal access to equitable, affordable and quality health care which is accountable and at the same time responsive to the needs of the people. The Mission is expected to achieve the goals set under the National Health Policy and the Millennium Development Goals.

To achieve these goals, NRHM facilitates increased access and utilization of quality health services by all, forge a partnership between the Central, State and the local governments, set up a platform for involving the PRIs and the community in the management of primary health programmes and infrastructure and provides an opportunity for promoting equity and social justice. The NRHM established a mechanism to provide flexibility to the States and the community to promote local initiatives and develop framework for promoting inter-sectoral convergence for primitive and preventive health care. The Mission has also defined core and supplementary strategies.

Strategies of NRHM:

A. Core Strategies:

- Train and enhance capacity of Panchayat Raj Institutions (PRIs) to supervise and manage public health services.
- Promote access to improved health care at household level through the female health activist (ASHA).
- Health Plan for each village through Village Health Committee of the Panchayat.
- Strengthen sub-centre through an untied fund to enable local planning and action and more Multi Purpose Workers (MPWs).
- Strengthen existing PHCs and CHCs and provision of 30-50 bedded CHC per Lakh population for improved curative care to a normative standard (Indian Public Health Service Standards defining personnel, equipment and management standards).
- Prepare and implement an inter-sectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation, hygiene and nutrition.
- Integrate vertical health and family welfare programmes at National, State and District levels.
- Technical Support to National, State and District Health Missions for Public Health Management.
- Strengthen capacities for date collection, assessment and review for evidence-based planning, monitoring and supervision.
- Formulate transparent policies for deployment and career development of Human Resources for health.

- Develop capacities for preventive health care at all levels for promoting healthy life styles, reduction in consumption of tobacco and alcohol, etc.
- Promote non-profit sector particularly in underserved areas.

B. Supplementary Strategies:

- Regulation of Private Sector including the informal rural practitioners to ensure availability of quality service to citizens at reasonable cost.
- Promotion of Public Private Partnership (PPP) for achieving public health goals.
- Reorienting medical education to support health issues including regulation of Medical Care and Medical Ethics.
- Effective and viable risk-pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality health care.

Five planks of the National Rural Health Mission

- The mission is expected to address the gaps in the provision of effective health care to rural population with special focus on 18 states, which have weak public health indicator and/or weak infrastructure.
- The mission is a shift away from the vertical health and family welfare programmes to a new architecture of all inclusive health development in which societies under different programmes will be merged and resources pooled at the district level.
- The mission aims at effective integration of health concerns with determinants of health like safe drinking water, sanitation and nutrition through integrated District Plans for Health. There is a provision for flexible funds so that the state can utilise them in the areas they feel are important.
- The mission provides for appointment of Accredited Social Health Activist (ASHA) in each village and strengthening public health infrastructure, including outreach through mobile clinics. It emphasizes involvement of the non-profit sector, especially in the underserved areas. It also aims at flexibility at the local level by providing for united funds.
- The mission in its supplementary strategies, aims at fostering public-private partnership; improving equity and reducing out of pocket expenses; introducing effective risk-pooling mechanisms and social health insurance; and taking advantage of local health traditions.

FIVE MAIN APPROACHES UNDER NRHM

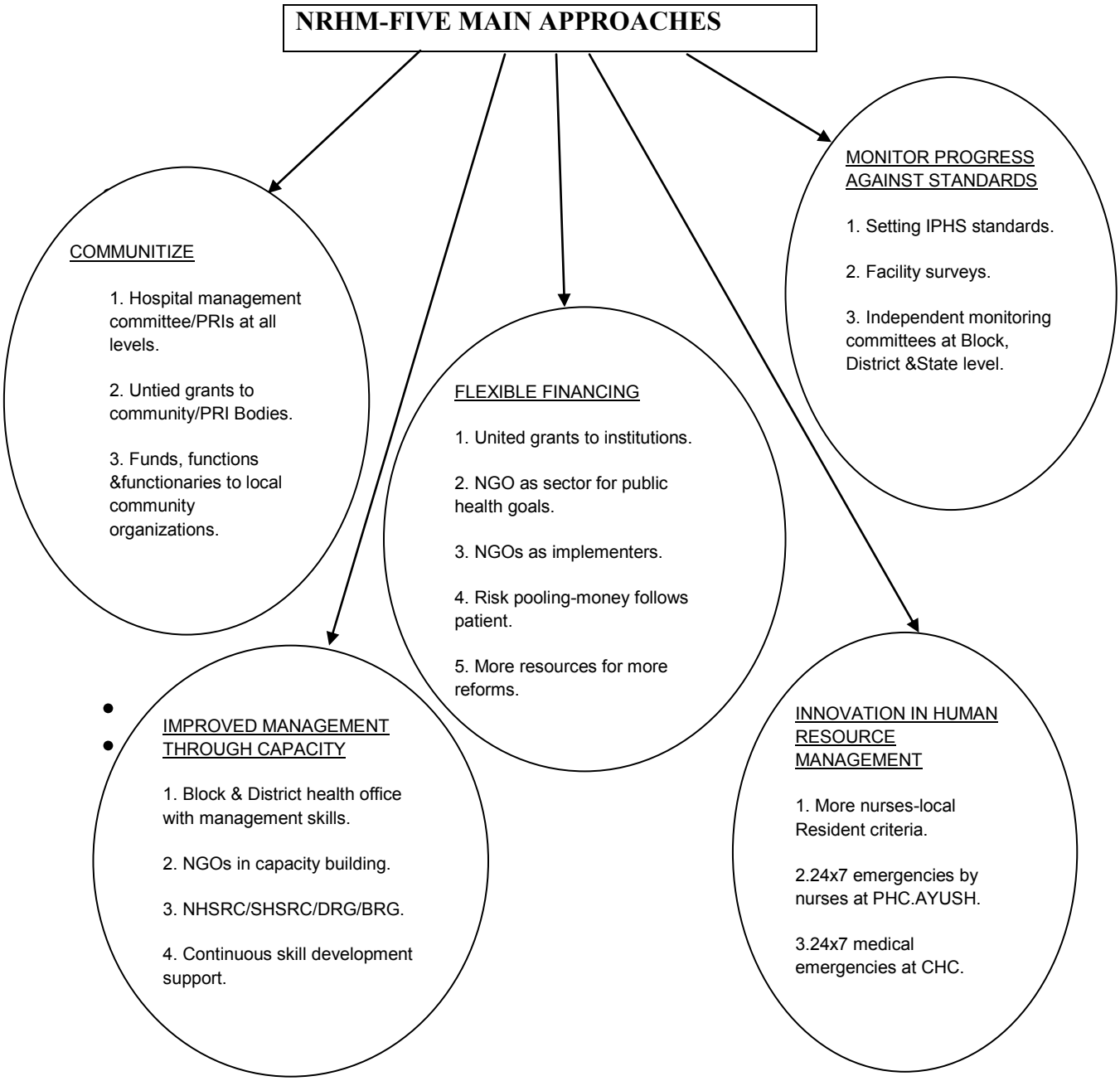


Figure 1

This mission was launched with the following major objectives:

- Decrease the infant mortality rate and maternal mortality rate
- Provide access to public health services for every citizen
- Prevent and control communicable and non-communicable diseases
- Control population as well as ensure gender and demographic balance
- Encourage a healthy lifestyle
- Encourage alternative systems of medicine through Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy (AYUSH)

Accredited Social Health Activists (ASHA)

The NRHM covers all the vages through village-based **"Accredited Social Health Activists" (ASHA)** who would act as a link between the health centres and the villagers. One ASHA will be raised from every village or cluster of villages. The ASHA would be trained to advise villagers about Sanitation, Hygiene, Contraception, and Immunization to provide Primary Medical Care for Diarrhea, Minor Injuries, and Fevers; and to escort patients to Medical Centres. They would also deliver Directly Observed Treatment Short (DOTS) course for tuberculosis and oral rehydration; distribute folic acid tablets and chloroquine to patients and alert authorities to unusual outbreaks.

Although these ASHAs would be honorary volunteers, there is a provision to provide them with performance-based compensation for undertaking specific health or other social sector programmes with measurable outputs, thus promoting employment for these volunteers. If rural women want counselling on important issues such as birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child, they may contact the concerned ASHA who shall be happy to provide them with all relevant guidance and assistance. The general norm as decided under the Programme is ‘One ASHA per 1000 population’. In tribal, hilly, desert areas the norm could be relaxed to one ASHA per habitation, dependant on workload etc.

Criteria for selection as ASHA

- ASHA must be primarily a woman resident of the village - 'Married/Widow/Divorced' and preferably in the age group of 25 to 45 yrs.
- ASHA should have effective communication skills, leadership qualities and be able to reach out to the community. She should be a literate woman with formal education up to Eighth Class. This may be relaxed only if no suitable person with this qualification is available.

The selection of ASHAs is being done by the District Health Society envisaged under NRHM. Over 3, 51,000 ASHAs have already been selected from various States, out of which, more than 2, 26,000 have been trained in the first module.

Janani Suraksha Yojana (JSY)

Janani Surakha Yojana is another important component under NRHM. JSY is a centrally sponsored scheme to benefit pregnant women and certified poor families. The Government has introduced the Janani Suraksha Yojana to provide comprehensive medical care during pregnancy, child birth and postnatal care and thereby endeavour to improve the level of institutional deliveries in low performing states to reduce maternal mortality.

General profile:

The status of women in India has been subject to many great changes over the past few millennia. From equal status with men in ancient times through the low points of the medieval period, to the promotion of equal rights by many reformers, the history of women in India has been eventful. In modern India, women have held high offices including that of the President, Prime Minister, Speaker of the LokSabha and Leader of the Opposition.

Women and Health

Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being. But their ability to participate in all areas of public and private life is limited among many sections of the society. In terms of health also many women are subject to lack of treatment and vulnerable conditions. The

reproductive health of any women plays a crucial role in the life cycle of women. The general family background of the respondents selected in given in Table 1.

TABLE 1

GENERAL PROFILE

Characteristics		Frequency	Percent
Age(in years)	Less Than 25	76	69.1
	26-30	28	25.5
	Above 31	6	5.5
Education	Primary	3	2.7
	Secondary	23	20.9
	Higher Secondary	17	15.5
	Degree	29	26.4
Income(in Rs)	Below 5,000	20	18.2
	5,000-10,000	56	50.9
	10,000-20,000	21	19.1
	Above 20,000	13	11.8
Religion	Hindu	95	86.4
	Christian	8	7.3
	Muslim	7	6.4
Caste	BC	54	49.1
	SC/ST	24	21.8
	MBC	29	26.4
	FC	3	2.7
Total		110	100

Source: Field Survey, 2014.

Age

Age is an important demographic variable which not only determines an individual physical and mental maturity but also depicts her life experiences. The above table explains that 69 percent of respondents were less than 25 years of age, 25.5 percent of respondents are in the age group of 26-30 years, and 5.5 percent of respondents were above 31 years of age.

Educational status

Education is an important component which determines the human development index. It is one factor which moulds the person. It helps an individual to be a better and fruitful citizen and an asset to the economy. Education not only creates knowledge and understanding but also generates attitude and behaviour patterns and thereby plays an important role in all kinds of decisions.

The table also shows that 2.7 percent respondents had primary level education, 20.9 percent studied up to secondary level, 15.5 percent respondent completed higher secondary level education and 26.6 percent respondents were graduates and the rest were illiterate.

Income

The level of income plays a significant role is many arenas of an individual. It helps one to enjoy a better standard of living. Income decides the way of life, his education and socio-economic status. The most significant and vital factor which has its bearing on the economic status of the family is its income.

The survey found that 18 percent were getting income below Rs. 5,000, 51 percent were getting income between Rs. 5,000-10,000, and around 12 percent were getting income above 20,000. This shows that most of them were below the average level and their living conditions are very poor.

Religion and caste

Caste has been a peculiar feature of Indian society determining the status of its members on the basis of birth as also prescribing the corresponding roles. Data pertaining to religion and caste of the surveyed respondents unravel that 86.4 percent were Hindus, followed by Christian

(7.3 percent) and Muslim 6.4 percent. Pertaining to caste, the largest single group was backward caste (49.1 percent), followed by most backward Community (26.4 percent) and scheduled caste/scheduled tribe (21.8 percent). The remaining 2.7 percent were forward community. Thus the respondents were mostly from Hindu Community predominantly belonging to backward caste.

The mission envisages achieving its objective by strengthening Panchayat Raj Institutions and promoting access to improved healthcare through the Accredited Female Health Activist (ASHA). It also plans on strengthening existing Primary Health Centres, Community Health Centres and District Health Missions, in addition to making maximum use of Non Governmental and Civil Society Organizations. Though many programmes are introduced, it does not reach the people due to lack of awareness. Therefore the investigator wanted to find out whether the women knew about this programme. Regarding the knowledge of NRHM, the details are given in Table 2.

TABLE 2

KNOWLEDGE ON THE WORKING OF NRHM

Particulars		Frequency	Percent
Awareness of NRHM	Yes	80	72.7
	No	30	27.3
Source	Television	30	27.3
	Newspaper	12	10.9
	Radio	16	14.5
	Pamphlets	6	5.5
Total		110	100

Source: Field Survey, 2014.

With respect to the knowledge on NRHM, 72.7 percent knew about it and 27.3 percent never knew about it. The women got awareness from Television (27.3 percent); from Newspaper (10.9 percent); from Radio (14.5 percent); and through pamphlets (5.5 percent).

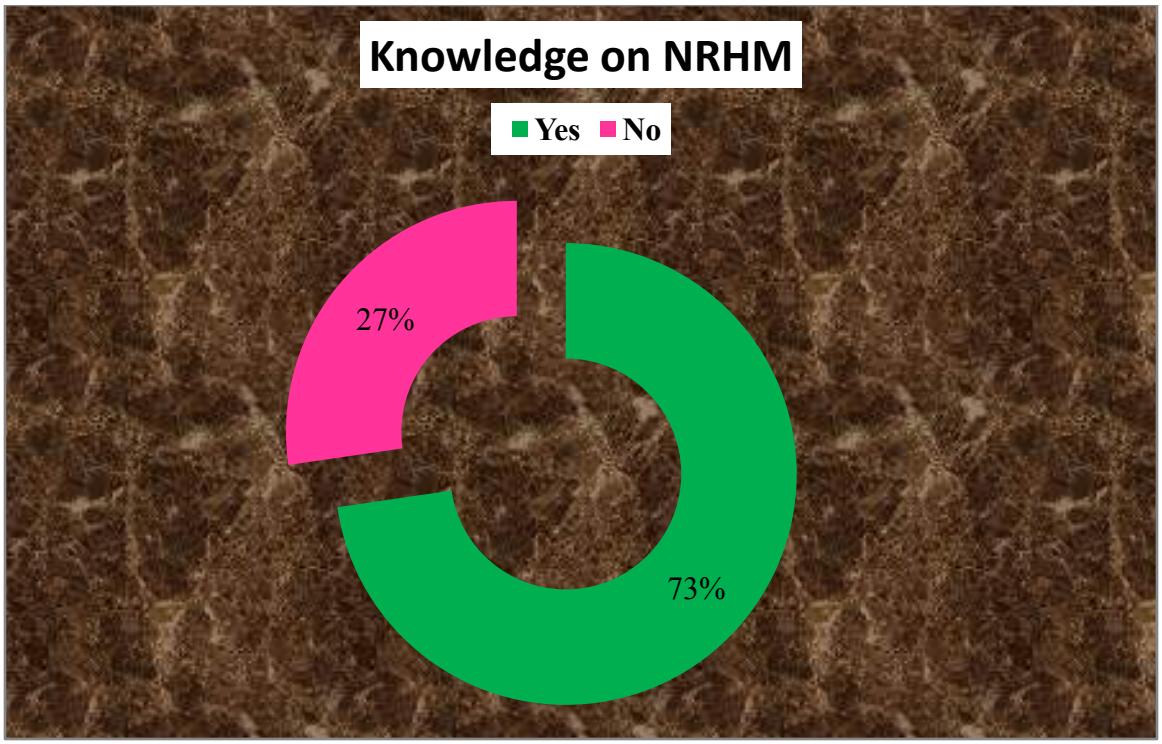


Figure 2

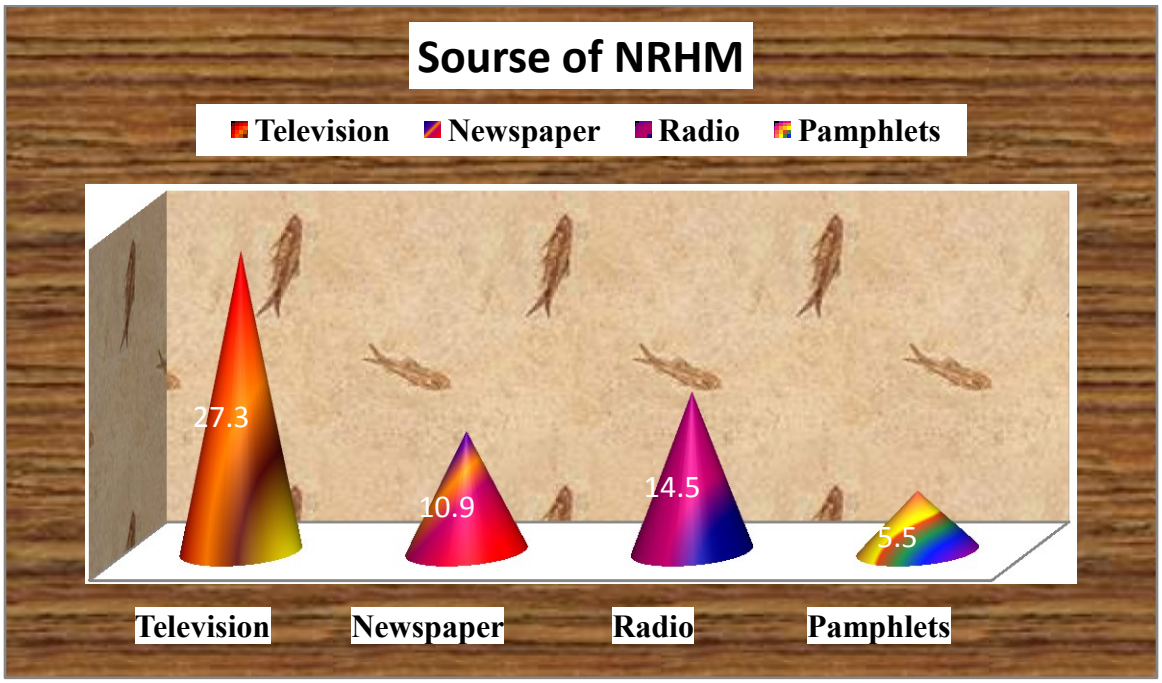


Figure 3

Women's health:

The health of women and girls can be considered as the basic indicators for the health of a society. Precisely because of gender discrimination, the health conditions of females generally tend to lag behind those of males, and therefore absolute improvement in these conditions is a reasonable indicator that the overall health conditions of that society are also getting better.

Women in India belong to various socio-economic backgrounds and are sometimes marginalised or neglected when it comes to basic healthcare. Women however are the backbone of our society and if one needs a healthy society, then it is essential to have healthy women.

Health problem

Many estimates points out that 50% of the population are women and a good proportion came in the poor group. The poor cannot offer for nutrition food and therefore most of them suffer from various kinds of illness. When women are worked up they do multiple tasks and health is poor for those who take up many jobs. Some of the common ailments reported by the selected respondents are given in table 3.

TABLE 3

HEALTH PROBLEM

Indicators	Frequency	Percent
Fever	16	14.5
Head Ache	14	12.7
Stomach Ache	6	5.5
Joint Pain	3	2.7
Breathing Trouble	1	0.9
Back Pain	7	6.4
Total	110	100

Source: Field Survey, 2014.

Some of the common health problem that affects the women are fever, head ache, stomach ache, joint pain, breathing problem, and back pain. There is every likelihood that these tend to be more or the incidence of such sickness will be greater for the poor, weak and over worked women. The common health problem of the respondent is disclosed in the above table. The table shows that 14.5 percent respondents were getting fever frequently, 12.7 percent respondent had head ache,5.5 percent use to get stomach ache,2.7 percent were having joint pain, and only 0.9 percent had breathing trouble.

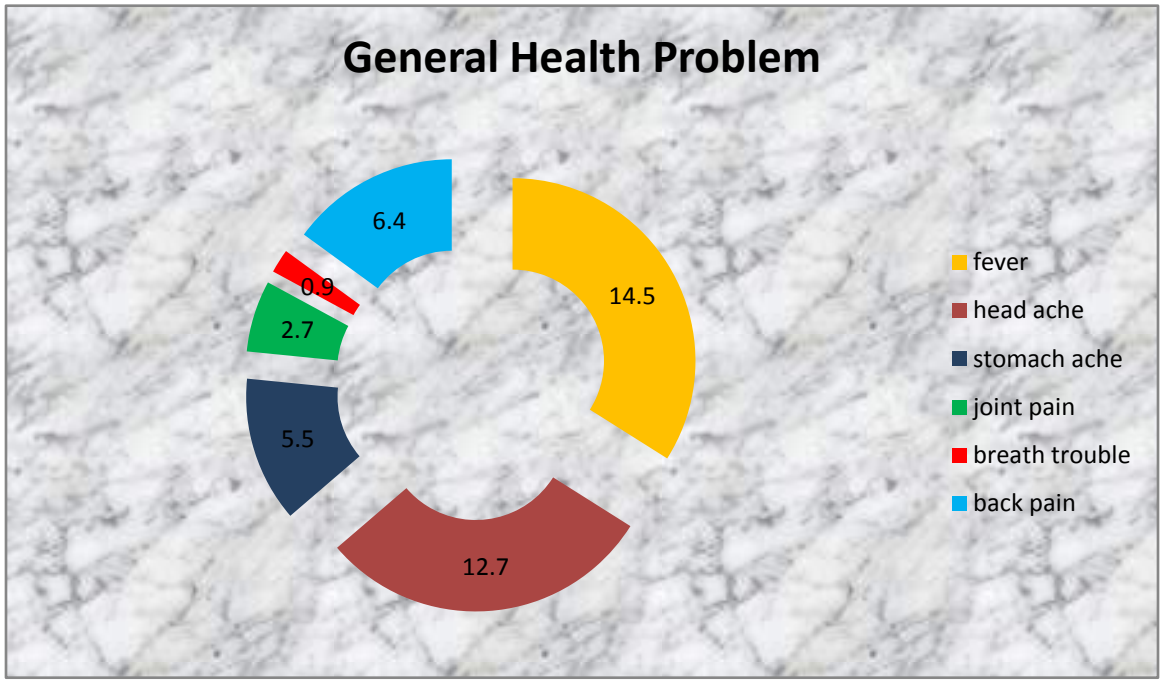


Figure 4

Status of women's health in India:

India is one of the few countries in the world where women and men have nearly the same life expectancy at birth. The fact that the typical female advantage in life expectancy is not seen in India suggests there are systematic problems with women's health. Indian women have high mortality rates, particularly during childhood and in their reproductive years.

The health of Indian women is basically linked to their status in society. Research on women's status has found that the contributions Indian women make to families often are overlooked, and instead they are viewed as economic burdens. There is a strong son preference in India, as sons

are expected to care for parents as they age. This son preference, along with high dowry costs for daughters, sometimes results in the mistreatment of daughters. Further, Indian women have low levels of both education and formal labour force participation. They typically have little autonomy, living under the control of first their fathers, then their husbands.

Poor health has repercussions not only for women but also their families. Women in poor health are more likely to give birth to low- weight infants. They also are less likely to be able to provide food and adequate care for their children. Finally, a woman's health affects the household economic well-being, as a woman in poor health will create more mortality during their reproductive period. The average female life expectancy today in India is low compared to many other countries, but it has shown gradual improvement over the years. In many families, especially rural ones, girls and women face nutritional discrimination within the family, and are anaemic and malnourished.

Before the introduction of NRHM, the women took help from government hospital and private clinics. Most of them resort to medical help from these health units for their first delivery. The details on these are given in table4.

TABLE 4

DETAILS OF FIRST DELIVERY

Details On Children	Delivery at			Method		Expenses(in Rs)		Benefits(in Rs)	
	GH	PHC	Pvt	Normal	cessarion	Above 10,000	Above 20,000	6,500	12,700
First child	18	13	25	43	6	15	10	18	13
Second child	-	-	6	4	2	4	2	-	-

Source: Field Survey, 2014.

In the above table, 18 women had their delivery of the first child in government hospital and 25 women had their delivery in private hospital. The number of women who availed PHC service was 13. The normal delivery of the first child was for 17 women in government hospital and 13 women in PHC. PHC do not take up cessarion cases and therefore these women who had

to undergo cessarion will go to private hospital. There were six women who had to have cessarion for the first child and only two women for second child.

The expenses for delivery were above Rs. 10, 000 and Rs.20, 000 for 19 and 12 women respectively. They had to incur this expenditure if they were in private hospital. In PHC and government hospital it was free. Further there were cash benefits given for the delivery in government hospital and PHC. Around five women received cash amount of Rs. 700 for first baby and seven women received a sum of Rs.12, 000. These were given under Dr. Muthulakshmi Reddy delivery scheme. This is divided into three terms. The first instalment was given during the pre-natal check-up, second instalment was given after the delivery. The third instalment was given when the baby is vaccinated.

NRHM concentrated on reproductive health to a great extent. Pregnant and lactating mother's health occupied a special position in NRHM. The current study therefore probed into certain issues relating to pregnant women and their health status and to what measure or degree the NRHM programme was of help to these women. Some of the facilities availed by the respondents are listed in table 5.

TABLE 5

HELP RECEIVED DURING PREGNANCY

Details	Frequency	Percent
Antenatal Check-Up	110	100.0
Sonogram/Ultrasound	100	90.0
Visit Of Health Worker	92	83.6
IFA Tablets	109	99.1
Tetanus Injection	100	90.9
Diet	1	0.9
Normal Delivery	42	38.2
Instrument	7	6.4
ANM Visit After Delivery	21	19.1
Total	110	100

Source: Field Survey, 2014.

The entire sample had done ante-natal check up. This is a pre-requisite for smooth and proper delivery. This was followed by administration of Iron Folic Acid (IFA) tablets (99 percent) and sonogram and tetanus injection by 90 percent of the respondents. Around 84 percent of the sample reported regular visit of health worker. Health worker has a great responsibility of introducing new medicines, creating awareness on government programmes and also availability of benefits and the needed information during and after pregnancy.

Health check-up

Being pregnant and giving birth are physically demanding. Having a reasonable level of fitness will help one manage ones changing body shape as well as the demands of pregnancy, birth and early parenting.

A reasonable level of fitness will prepare one both physically and emotionally. Fitness refers to stamina, strength and flexibility. The best way to get fit is through regular physical activity at an intensity that pushes one to work at a moderate pace, but not to the point of being out of breath.

Human height is the distance from the bottom of the feet to the top of the head in a human body, standing erect. It is usually measured in centimetres when using the metric system, and feet and inches when using the imperial system. Human height has varied from under 60 centimetres (2 ft 0 in) to over 260 centimetres (8 ft 6 in). On average, males are taller than females.

When populations share genetic background and environmental factors, average height is frequently characteristic within the group. Exceptional height variation (around 20% deviations from average) within such a population is sometimes due to gigantism or dwarfism, which are medical conditions caused by specific genes or endocrine abnormalities.

In regions of poverty or warfare, environmental factors like chronic malnutrition during childhood or adolescence may account for delayed growth and/or marked reductions in adult stature even without the presence of any of these medical conditions.

It is a good idea to check your cholesterol levels and blood triglycerides from time to time. High levels may indicate an increased risk of various health problems including heart disease. If one is over 45, she should have these blood tests once every two years and more frequently as one get older. If one is at high risk of cardiovascular disease, one should be tested every year.

A pregnancy test attempts to determine whether a woman is pregnant. Markers that indicate pregnancy are found in urine and blood, and pregnancy tests require sampling one of these substances. The first of these markers to be discovered, human chorionic gonadotropin (HCG), was discovered in 1930 to be produced by the trophoblast cells of the fertilised ova (eggs). While HCG is a reliable marker of pregnancy, it cannot be detected until after implantation. This results in false negatives if the test is performed during the very early stages of pregnancy. Apart from this, regular health check up was carried out as reported in the following table 6.

TABLE 6
HEALTH CHECK-UP CARRIED OUT

Details	Frequency	Percent
Weight	110	100
Height	110	100
Blood Pressure	110	100
Blood Test	110	100
Urine Test	110	100
Breast Test	15	13.6
Scan	21	19.1
Total	110	100

Source: Field Survey, 2014.

All the pregnant ladies had carried out Weight, Height, Blood Pressure, Blood Test and Urine test during their pregnancy time. Of course these are requirements and PHC has really helped them to do this check up. Based on this counselling can be given to women.

In PHC the health worker will give some pregnancy advice to the pregnant women. They give diet advice to pregnant women and only 5 women had taken it up; Breast feeding advice was given to 10 women; the PHC has also given delivery care, and family planning counselling. Knowledge on giving colostrums is limited among poor and illiterate women. The ANM workers take it up and educate them on this. Further to breast feed the baby, they should be made aware of the importance of breast milk and need to be insisted to give breast milk.

The first delivery of the selected pregnant women took place in sub-centre (22 women); in private hospital (16 women); and in PHCs is (32 women). The delivery conducted by doctor was for 66 women and by nurse it was for 17 women.

During the delivery period the women had some health problem like high fever (11 women); excessive bleeding (18 women); and low abdomen pain (15 women). The treatment was taken in sub-centre by 10 women; in private hospital by 5 women and from PHC by 20 women and women who took medicine in pharmacy was nine.

In Thydiyalur Panchayat the PHC serves the people with all health care benefits. It has SC, PHC, and Private Hospitals. The government hospital is situated 12-15 Kms away from Thydiyalur and the time and transport cost makes people hesitant to go to government hospital. But still there are a few who avails health care from government hospital. The selected samples made use of all the available health units, as reported in Table 7.

TABLE 7

HEALTH CARE FACILITIES

Units	Series				
	Tablets	**Delivery**	**General consult**	**Pre-natal**	**Post-natal**
Sub centre	20	18	18	20	12
PHC	78	29	28	35	28
Private	15	20	11	17	4
Government	12	22	16	26	16
Total	110	110	110	110	110

Source: Field Survey, 2014.

The above table shows that the respondents used the availability of the hospital units. The respondent who buys the tablets from sub centre is 20, from PHC 78, Private Hospital 15, and from government hospital it is 12. The delivery of the women in these units was 18, 29, 20, and 22 respectively. For general consultation the respondents who preferred sub centre was 18, PHC was 28, private hospital was 11, and public hospital was 16. Those who sought general consultation from private clinics were the least. This is mainly because of the high cost charged by private clinics.

The women who took ante-natal check-up were 20 in sub centre, 35 in PHC, 17 in private hospital, and 26 in government hospitals. The post-natal check-up was done by 12 in sub centre, 28 in PHC, four in private hospital and 16 in public hospital. An overview of the health facilities point out that it was PHC from where maximum benefit is availed by the respondents. PHC's in the present day are working well and this makes people to approach PHC without any hesitation. The government of Tamil Nadu is giving lots of inputs to make PHC's work on a sound footing so as to help the poor and marginalised to get health care.

Transport

Transport charge is an indirect out-of-pocket expenditure met by the respondent. The following table gives details on this.

TABLE 8

TRANSPORT CHARGES

Amount (In Rs.)	Frequency	Percent
Less than 35	57	51.8
36-65	37	33.6
Above 65	16	14.5
Total	110	100

Source: Field Survey, 2014.

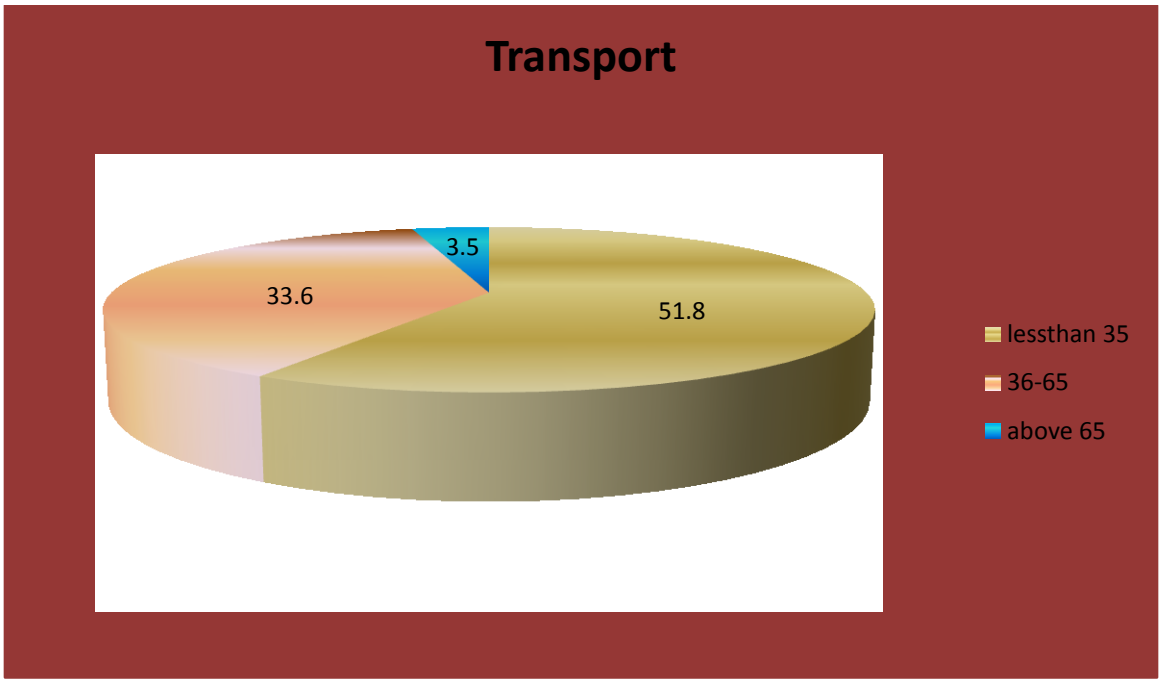


Figure 5

The transport cost to the people for coming to the PHC was found to be less than Rs.35 for 51 percent. It was Rs.36 to 65 for 34 percent and and above Rs.65 for 15 percent of the respondents.

Benefits

The scheme aims to provide various types of medical or health benefits to the poor and marginalised. Some of the benefits are given in table 9.

TABLE 9

BENEFITS OF SCHEME

Indicator		Frequency	Percent
Benefits	Doctor	43	39.1
	Medicine	26	23.6
	Regular service	10	9.1
	Hygienic	14	12.7
	Infrastructure	17	15.5
Total		110	100

Source: Field Survey, 2014.

The benefit of NRHM in the form of availability of Doctors was to the tune of 39 percent followed by getting medicine 23.6 percent. Around 15.5 percent opined of good infrastructure and 12.7 stated that the hygienic condition were good.

An analysis was carried out in the study to assess the performance of National Rural Health Mission in the selected area. The respondents were asked to state their opinion towards NRHM scheme and its benefits for women as either ‘strongly agree’, or ‘agree’ or ‘neutral’ or ‘disagree’ or ‘strongly disagree’. Using Likert’s Summated Rating Scale Technique, the scores were assigned as 5, 4, 3, 2, and 1 respectively. Factor analysis was used to identify the underlying pattern of relationship between various dimensions of NRHM scheme and its benefit for women was grouped in terms of composite variables.

KMO statistics and Bartlett's test measure was used to determine the appropriateness of applying factor analysis. The KMO statistics varies between 0 and 1. A value close to one indicates the pattern of correlations as relatively compact and hence factor analysis should yield distinct and reliable factors. KMO statistics for NRHM scheme was 0.607 signifying higher than acceptable adequacy of sampling. The Bartlett test of sphericity was significant at one percent level showing the presence of relationship between variables to apply factor analysis.

KMO and Bartlett's Test		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		**.607**
Bartlett's Test of Sphericity	Approx. Chi-Square	**141.355**
	D f	**45**
	Sig.	**.000**

The communalities for each variable were assessed to determine the amount of variance accounted for by the variable to be included in the factor rotations. All the variables had a value greater than 0.5 signifying substantial portion of the variance in the variables were accounted by the factor.

Table 10 enlists the Eigen value and their relative explanatory for 6 linear components identified within the data set. The result reveals for the first two factors on opinion of the respondents towards NRHM scheme. Eigen value was greater than one indicating that these factors alone were appropriate for inclusion in the analysis. The Kaiser rotated component matrix presented in table-5 shows that factor 1 had significant loading for four dimensions namely, (Availability of Drugs, Good treatment, and 24x7 service and transport vehicles). Factor 2 had significant loading for two dimensions namely, (On time service and Good caretaking). Factor 3 had significant loading for three dimensions namely (Good infrastructure, Hygienic service and regular check-up).Factor 4 had significant loading for only one dimension namely (Good Doctors).

TABLE 10

RESPONSE OF PREGNANT WOMEN

OPINIONS	I.	II.	III.	IV.
Availability of drugs	.692			
Good treatment	.645			
Good infrastructure			.503	
Hygienic service			.654	
24x7 service	.754			
Good doctor				.900
On time service		.858		
Regular check-up			.705	
Good caretaking		.849		
Transport vehicles	.723			

Source: Field Survey, 2014.

Extraction Method: Principal Component Analysis

Rotation Method: Varimax with Kaiser Normalization Rotation converged in 6 iterations.

NRHM for Women

Rural Health Care forms an integral part of the National Health Care System. Provision of Primary Health Care is the foundation of all rural health care Programmes. For developing vast public health infrastructure and human resources of the country, accelerating the socio-economic development and attaining improved quality of life, the Primary health care is accepted as one of the main instruments of action. Thus, recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has launched this programme to carry out necessary architectural correction in the basic health care delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe

drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care.

The NRHM provides broad operational framework for the Health Sector. Suggestive guidelines have been issued on key interventions like institutional deliveries, immunization, preparation of District Action Plan as well as schemes including ASHA, JSY etc. The States have the flexibility to project operational modalities in their State Action Plans.

It is envisaged that National Rural Health Mission shall be able to effectively improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children. It is doing enormous work and the comments of the respondents would mark or prove to make it more beneficial. Some of the suggestion given by the sample is given in Table 11.

TABLE 11

SUGGESTIONS

Impressions	Frequency	Percent
Good and Convient	62	56.4
Better and improved	28	25.5
Scan facility	7	6.4
Water facility	7	6.4
Transport facility	6	5.5
Total	110	100

Source: Field Survey, 2014.

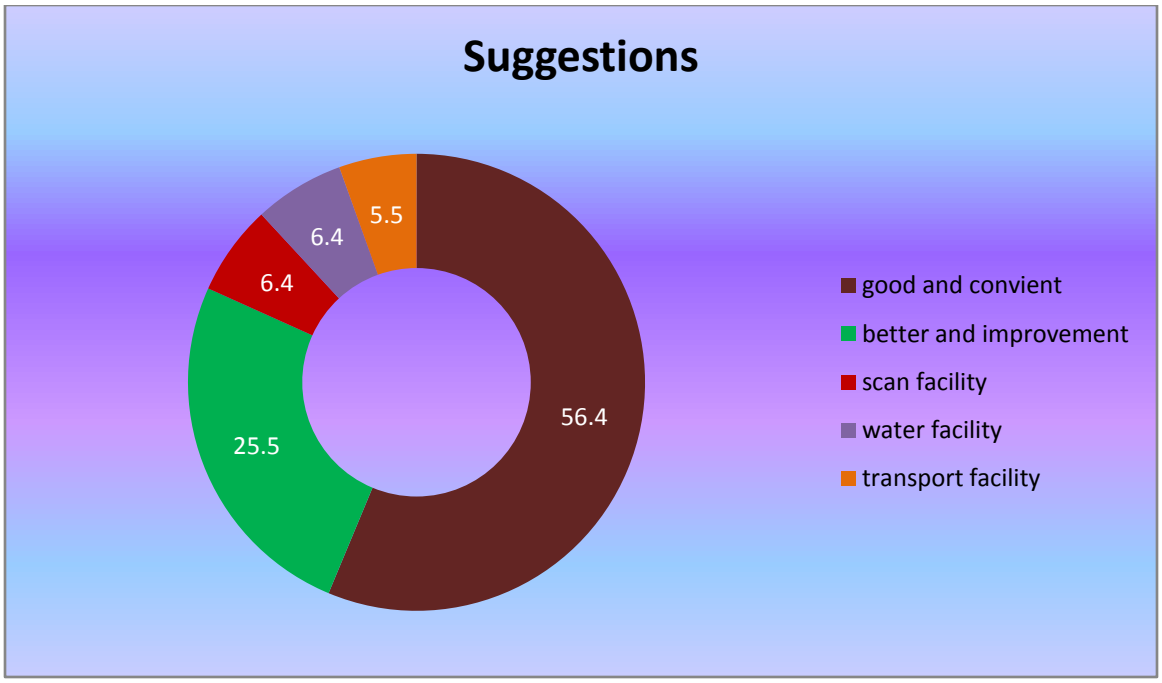


Figure.6

Around 56 percent felt that it was convenient. Some of the facilities which need attention are scan, water and transport facilities. However 25 percent felt that it needs to be improved so as to make it fruitful for the betterment of the women.

SUMMARY AND CONCLUSION

CHAPTER V

SUMMARY AND CONCLUSION

Health has been declared a fundamental human right. Health care is a public right and it is the responsibility of the government to provide this care to all people in equal measure. These principles have been recognized by nearly all government of the world and enshrined in their respective constitutions. In India, health care is completely or largely a government function.

Rural Health care is one of biggest challenges facing the Health Ministry of India. With more than 70 percent population living in rural areas and low level of health facilities, mortality rates due to diseases are on a high level. Healthcare is the right of every individual but lack of quality infrastructure, dearth of qualified medical functionaries, and non- access to basic medicines and medical facilities thwarts its reach to 60% of population in India. Considering the picture of depressing facts there is a terrible need of new practices and procedures to ensure that quality and timely healthcare reaches the deprived corners of the Indian villages. Though a lot of policies and programs are being run by the Government, the success and effectiveness of these programs is questionable due to gaps in the implementation.

Women from infant stage to their old age get an unfair deal in the matter of health. Their health concerns receive a low priority resulting in women bearing pain and discomfort in silence for long periods of time without seeking relief. Acknowledging the gaps in health infrastructure and deficiencies in the health care system in rural areas the government conceptualized the National Rural Health Mission (NRHM) which is considered a milestone in the national health policy.

The important components of NRHM include the initiation of an Accredited Social Health Activist Program—a voluntary female community health program aimed at improving immunization rates, institutionalized deliveries, reproductive health care, and nutrition. NRHM also mandates improvements in health infrastructure, human resources for health, and availability of drugs.

The objective of the study

- To identify the strategies of NRHM.
- To examine the working of NRHM in the selected area.
- To assess the impact of NRHM on rural women.
- To address the gaps in the provision of health care to women.

The Health Care Industry in Coimbatore has witnessed a tremendous growth in the last decade. Coimbatore is well-known for its exclusive super-speciality hospitals. Thudiyalur is a part of Coimbatore city. It is about 12 km from the city centre in the north direction. It is located 15 Kilo meters from Coimbatore Junction.

The woman who had access to a PHC where NRHM is functioning in full swing was chosen. Women who had benefitted from this scheme were selected as sample. The size of the sample was 110. All these women had benefitted from NRHM scheme. They continue to enjoy benefits from NRHM. With the help of a questionnaire the details were collected. The study made use of both primary and secondary sources.

The interview schedule consisted of questions on the General profile, Pregnancy details and Awareness of NRHM scheme. The data collection done during month of January 2014.For secondary sources, all the publication from government offices, health units and journals were used. The collected data were analysed using percentage, frequency method, and Factor analysis.

This mission was launched with the following major objectives:

- Decrease the infant mortality rate and maternal mortality rate
- Provide access to public health services for every citizen
- Prevent and control communicable and non-communicable diseases
- Control population as well as ensure gender and demographic balance
- Encourage a healthy lifestyle
- Encourage alternative systems of medicine through Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy (AYUSH)

The study showed that 2.7 percent respondents had primary level education, 20.9 percent studied up to secondary level, 15.5 percent respondent completed higher secondary level education and 26.6 percent respondents were graduates and the rest were illiterate.

The survey found that 18 percent were getting income below Rs. 5,000, 51 percent were getting income between Rs. 5,000-10,000, and around 12 percent were getting income above 20,000.

With respect to the knowledge on NRHM, 72.7 percent knew about it and 27.3 percent never knew about it. The women got awareness from Television (27.3 percent); from Newspaper (10.9 percent); from Radio (14.5 percent); and through pamphlets (5.5 percent).

The study showed that 14.5 percent respondents were getting fever frequently, 12.7 percent respondent had head ache,5.5 percent use to get stomach ache,2.7 percent were having joint pain, and only 0.9 percent had breathing trouble.

NRHM concentrated on reproductive health to a great extent. Pregnant and lactating mother's health occupied a special position in NRHM. The current study therefore probed into certain issues relating to pregnant women and their health status and to what measure or degree the NRHM programme was of help to these women.

The entire sample had done ante-natal check up. This is a pre-requisite for smooth and proper delivery. This was followed by administration of Iron Folic Acid (IFA) tablets (99 percent) and sonogram and tetanus injection by 90 percent of the respondents. Around 84 percent of the sample reported regular visit of health worker.

All the pregnant ladies had carried out Weight, Height, Blood Pressure, Blood Test and Urine test during their pregnancy time. The first delivery of the selected pregnant women took place in sub-centre (22 women); in private hospital (16 women); and in PHCs is (32 women). The delivery conducted by doctor was for 66 women and by nurse it was for 17 women.

The above table shows that the respondents used the availability of the hospital units. The respondent who buys the tablets from sub centre is 20, from PHC 78, Private Hospital 15, and from government hospital it is 12. The delivery of the women in these units was 18, 29, 20, and 22 respectively. For general consultation the respondents who preferred sub centre was 18, PHC

was 28, private hospital was 11, and public hospital was 16. Those who sought general consultation from private clinics were the least. This is mainly because of the high cost charged by private clinics.

The benefit of NRHM in the form of availability of Doctors was to the tune of 39 percent followed by getting medicine 23.6 percent. Around 15.5 percent opined of good infrastructure and 12.7 stated that the hygienic condition were good.

Around 56 percent felt that it was convenient. Some of the facilities which need attention are scan, water and transport facilities. However 25 percent felt that it needs to be improved so as to make it fruitful for the betterment of the women.

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APPENDIX

APPENDIX

QUESTIONNAIRE

TO ELICIT INFORMATION ON NRHM IN A SELECTED AREA.

SCHEDULE NO:

I GENERAL PROFILE:

i. Name:

ii. Address:

iii. Religion:

iv. Caste:

II FAMILY BACKGROUND:

S.No	Name	Relation to the head of the family	Sex	Age	Education		Occuption	Income
					studied upto	studing in		
1								
2								
3								
4								

III AWARENESS ON NRHM

a. Do you know about NRHM?

☐ Yes ☐ No

b. How do you know about NRHM?

☐ Television
☐ Radio
☐ Newspaper
☐ Pamphlets

IV INCIDENCE OF SICKNESS:

S.No	Common	Frequency	Treatment		Specific treatment under NRHM
			Place	Cost	
1	Fever				
2	Head ache				
3	Stomach ache				
4	Joint pains				
5	Breathing trouble				
6	Back pain				

V DETAILS ON FIRST DELIVERY:

Particulars No. of Children's	Age	M/F	Delivery at			Normal / Cessarion	Expenses	Benefits received Amount or any other	Source
			GH	Pvt Clinic	PHC				
1									
2									
3									
4									

VI PREGNANCY DETAILS:

A.

S.No	Particular	YES	NO
A	Did you go for antenatal check-up?		
B	Did you go for sonography or amniocentesis (SCAN)?		
C	Did any health worker visit you at home for an antenatal check up?		
D	Were you given Iron and Folic Acid (IFA) tablets/syrup during pregnancy?		
E	Were you given an injection in the arm during pregnancy to prevent Tetanus?		
F	Did you follow any diet during pregnancy time?		
G	Was delivery normal?		
H	Was the delivery Cesarian?		
I	Was the delivery Instrument or Assisted?		
J	Did ANM (Auxiliary Nurse Midwife**)** visit you within 2 weeks of delivery?		

B.

S. No	Particular	No. of time	Do not remember	Not visited
I	During entire pregnancy period how many times did you visit PHC for antenatal checkups?			
II	How many times did she (health worker) visit you for antenatal check-ups during this pregnancy?			
III	How many times did you take Tetanus injection?			
IV	How many times did ANM (Auxiliary Nurse Midwife) visit you within six weeks of delivery?			
V	How many tablets of IFA (Iron and Folic Acid)/tablespoons of syrup in a day were taken regularly?			

VII

A. PRE-NATAL TREATMENT:

a. Whom did you consult for treatment?

☐ Doctor
☐ Nurse
☐ Health Professional
☐ Other specify_____

b. Did you have any health problem in pregnancy time? YES / NO
If yes, where did you go for consultation for treatment?

☐ Sub centre
☐ PHC
☐ Private Hospital
☐ Pharmacy

c. Did you have the following performed during pregnancy period? YES/NO

☐ Weight
☐ Height
☐ Blood Pressure
☐ Blood Test
☐ Urine Test
☐ Breast Test
☐ X-Ray
☐ Sonogram/Ultrasound
☐ Abdoment Test
☐ Other Specify_____

d. Did you receive advice on any of the following at least once during your this pregnancy?

☐ Diet
☐ Delivery care
☐ Breast feeding
☐ Family planning

e. Where did you get IFA Tablets?

- ☐ Sub centre
- ☐ PHC
- ☐ Private Hospital
- ☐ Pharmacy

f. Where did the delivery take place?

- ☐ Sub centre
- ☐ PHC
- ☐ Private Hospital
- ☐ Home(Health worker)

B. POST-NATAL TREATMENT:

a. Who conducted the delivery?

- ☐ Doctor
- ☐ Nurse
- ☐ Relative / Friends
- ☐ None

b. During the first six weeks after delivery did you experience any of the following health Problem?

- ☐ High Fever
- ☐ Lower abdominal pain
- ☐ Excessive Bleeding
- ☐ Other specify_____

c. Where did you go for consultation for treatment?

- ☐ Subcentre
- ☐ PHC
- ☐ Private Hospital
- ☐ Pharmacy

VIII MEDICAL EXPENSES:

Transport cost:

- ☐ Lessthan Rs.10
- ☐ Rs.51-100
- ☐ Rs.11-50
- ☐ Above 100.

IX IMPACT OF NRHM:

a. Benefits (Ranking):

S.No	Particulars	Rating
1	Good Treatment	
2	Availability of Medicine	
3	Regular check up	
4	On time Service	
5	Good Doctors	

b. Indicate your response to the following points:

S.No:	Particulars	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
a	Scheme is Effective					
b	Quality of Medicine					
c	Best Service rendered					
d	24 X 7 Service					
e	Keen response					
f	Medical Service					
g	Reasonable cost					
h	Providing Safety Treatment					

c. Any Suggestions: