

# **A Study on Identifying Causes for Non Institutional Deliveries among Beneficiaries of National Rural Health Mission**

*Submitted in partial fulfillment of the requirements for the degree of*  
**Master of Philosophy in Social Work**

By

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## DECLARATION

I, Karthik B, hereby declare that the dissertation, titled “A Study on Identifying Causes for Non Institutional Deliveries among beneficiaries of National Rural Health Mission”, is a record of original research work undertaken by me for the award of the degree of Master of Philosophy in Social work. I have completed under the supervision of Dr. Hemalatha K, Associate Professor, Department of Social Work.

I also declare that this dissertation has not been submitted for the award of any degree, diploma, associate ship, fellowship or other title. It has not been sent for any publication or presentation purpose.

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## CERTIFICATE

This is to certify that the dissertation submitted by Karthik B Reg.No MLSW 1034703 “A Study on Identifying Causes for Non Institutional Deliveries among beneficiaries of National Rural Health Mission” is a record of research work during the period 2010-2012 under my supervision in partial fulfillment for the award of Master of Philosophy in Social Work.

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## ACKNOWLEDGEMENT

In the tenure of this study several people have directly or indirectly contributed for the successful completion of this study.

At the outset, I wish to express my gratitude and heartfelt thanks to my respected guide, Dr. Hemalatha K, Associate Professor of Social Work, Christ University, for her most valuable guidance, suggestions, encouragement and constant motivation rendered to me throughout this work and special interest towards this topic.

I extend my thanks to the women participants of Bellary District for their time, sincere answers and co-operation despite their routine work.

My sincere thanks to Bellary District Health Officials and field staff for their co-operation and inputs in completion of my work.

I would also like to extend my heartfelt gratitude to the experts from the field especially Dr. S.M. Sridhar, Deputy Director (O.D), Karnataka Health System Development and Reforms Project and Mr. S.L.N. Gurumurthy, Communication Expert, IEC wing, Dept. of Health & Family Welfare for their most valuable inputs, guidance, motivation and encouragement to take up this topic and completion of my work.

I would also like to extend my heartfelt thanks to Mr. S. Selvakumar, Mission Director, National Rural Health Mission and Mr. S. Chandrashekar, Joint Director (IEC & QA), Karnataka Health System Development and Reforms Project for their permission and co-operation in completion of my work and Dr. Mariyama Philip for her help in analysis of the data.

My thanks to my parents and most importantly Mr. Sumanth for his valuable assistance.

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## ABSTRACT

With the aim of “Health for all and Health everywhere”, several health programs have been launched in the country and worldwide. National Rural Health Mission has been started in the country as well as Karnataka in order to improve our health care delivery system with a strong focus on improving health outcomes especially among women, children and vulnerable population. Bringing healthcare to the door steps of the poor rural population is one of the criticisms under National Rural Health Mission. The main goal of National Rural Health Mission is to bring down maternal mortality and infant mortality by promoting 100% institutional deliveries, this is also above goals of millennium development goal 2015. To reach this goals holistic approach is necessary. In Karnataka under National Rural Health Mission, many programs implemented in order to improve the health status of women and children. The programmes are Janani Suraksha Yojana, Prasuthi Arike, Thayibagya, 108 ambulance services, asha workers for every 1000 population and 24/7 Primary Health Centers have been initiated to promote institutional deliveries and to reduce maternal and infant mortality. Apart from the above programmes mother and child tracking system has been introduced in National Rural Health Mission in order to ensure 100% registration of pregnant women and status to ensure institutional deliveries of pregnant. Taking this as a background the study on “Identifying Causes for Non-Institutional Deliveries”, was taken of by the researcher for identifying the researcher for identifying the reasons for Non-utilization of benefits provided by Government. There is increase of health services in terms of infrastructure, man power, drugs and equipment increase of health institution and other resources. Even though all health facilities are provided, the community is yet to encash the same due to several socio-cultural factors. This study encompass on religious, cultural, economical, infrastructural, medical causes/reasons for non-acceptance of Institutional deliveries which is critical for safe motherhood and child survival.

Keywords: Non-institutional delivery, National Rural Health Mission, Pregnancy.

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## Contents

Chapter	Subject	Page No.
Chapter 1	Introduction	1 to 15
Chapter 2	Review of Literature	16 to 33
Chapter 3	Methodology	34 to 40
Chapter 4	Analysis and Interpretation	41 to 106
Chapter 5	Findings, suggestions and implications of the study	107 to 115
References		116 to 121
Appendix		122 to 135



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## List of Tables

<b>Table No</b>	<b>Description</b>	<b>Page No.</b>
4.1	Showing the Distribution of Taluks to which participants belong	42
4.2	Showing distribution of participants by Age and the Age of Marriage	43
4.3	Showing the details of Religion, Community and type of Family of the participants	45
4.4	Showing the details of Education and Occupation status of participants	47
4.5	Showing the details of Education and Occupation of Spouses of the participants	49
4.6	Showing the details of annual income of the family	50
4.7	Showing the details of consanguineous marriage & marriage within the village	51
4.8	Showing the awareness about NRHM	52
4.9	Showing the type of benefit received from NRHM	54
4.10	Showing the detail number of participants benefiting from Janani Suraksha Yojana, Madilu kit and Prasuthi Arike.	56
4.11	Showing utilization of cash benefits	58
4.12	Showing the visit of Auxiliary Nurse Midwife at home of participants.	59
4.13	Showing the details of participants visit to Primary Health Centre for antenatal checkup.	61

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<b>Table No</b>	<b>Description</b>	<b>Page No.</b>
4.14	Showing the details of medication and medical examination received during the pregnancy	63
4.15	Showing the history of deliveries.	66
4.16	Showing the details of Antenatal care.	67
4.17	Showing the details of place of delivery:	69
4.18	Showing the sex of Child	70
4.19	Location with the home where delivery has taken place.	71
4.20	Showing the information about who conducted delivery at home.	73
4.21	Showing payment made to Traditional Birth Attendant	75
4.22	Showing the decision made prior to delivery:	77
4.23	Showing the reasons for non-institutional delivery	78
4.24	Showing the details of Cultural reasons	80
4.25	Showing the details of Economic reasons	82
4.26	Showing the details of Psychological reasons	84
4.27	Showing the details of Infrastructural causes	85
4.28	Showing the details of medical causes:	86
4.29	showing the details of other causes	88
4.30	Distance from place of delivery to Healthcare facilities	89
4.31	Showing whether delivery has taken place at hygienic place.	91
4.32	Showing Medical complications during home delivery	92
4.33	Showing the branding of babies after their birth.	94

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<b>Table No</b>	<b>Description</b>	<b>Page No.</b>
4.34	Showing the feeding of Infant immediately after birth and time of breast feeding.	95
4.35	Showing the health status of infant	97
4.36	Showing the information whether health staff visited participants house after delivery	99
4.37	Showing the details of post delivery visits to hospital.	101
4.38	Deliveries at Home are Safe	102
4.39	Showing the National Rural Health Mission benefited in providing good Maternal and Pregnancy care	103
4.40	Showing the plan for next delivery	104
4.41	Showing the details of association between cultural and non-cultural causes of Non Institution deliveries with community, educational status, annual income, consanguineous marriages, type of family and occupation of the participants.	105

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## List of Graphs

Graph No	Description	Page No.
4.1	Showing the Distribution of Taluks to which participants belong	42
4.2	Showing distribution of participants by Age and the Age of Marriage	43
4.3	Showing the details of Community of the participants	45
4.4	Showing the details of Education status of participants	47
4.5	Showing the details of annual income of the family	50
4.6	Showing the details of consanguineous marriage	51
4.7	Showing the awareness about NRHM	52
4.8	Showing the type of benefit received from NRHM	54
4.9	Showing the detail number of participants benefiting from Janani Suraksha Yojana.	56
4.10	Showing utilization of cash benefits	58
4.11	Showing the visit of Auxiliary Nurse Midwife at home of participants.	59
4.12	Showing the details of participants visit to Primary Health Centre for antenatal checkup.	61
4.13	Showing the details of T.T received during the pregnancy	63
4.14	Showing the details of Iron Folic Acid tablets received during the pregnancy	64
4.15	Showing the details of place of delivery:	69
4.16	Showing the sex of Child	70

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<b>Graph No</b>	<b>Description</b>	<b>Page No.</b>
4.17	Location with the home where delivery has taken place.	71
4.18	Showing the information about who conducted delivery at home.	73
4.19	Showing payment made to Traditional Birth Attendant	75
4.20	Showing the decision made prior to delivery:	77
4.21	Showing the reasons for non-institutional delivery	78
4.22	Showing the details of Cultural reasons	80
4.23	Showing the details of Economic reasons	82
4.24	Showing the details of Psychological reasons	84
4.25	Showing the details of Infrastructural causes	85
4.26	Showing the details of medical causes:	86
4.27	showing the details of other causes	88
4.28	Distance from place of delivery to Healthcare facilities	89
4.29	Showing whether delivery has taken place at hygienic place.	91
4.30	Showing Medical complications during home delivery	92
4.31	Showing the branding of babies after their birth.	94
4.32	Showing the health status of infant	97
4.33	Showing the information whether health staff visited participants house after delivery	99
4.34	Showing the details of post delivery visits to hospital.	101
4.35	Deliveries at Home are Safe	102

Use it for fair purpose. Give credit to the author by citing properly, if your are using it.

<b>Graph No</b>	<b>Description</b>	<b>Page No.</b>
4.36	Showing the National Rural Health Mission benefited in providing good Maternal and Pregnancy care	103
4.37	Showing the plan for next delivery	104



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## **Chapter 1: Introduction**

Pregnancy and childbirth are special events in women's lives, and, indeed, in the lives of their families. This can be a time of great hope and joyful anticipation. The primary aim of antenatal care is to achieve, at the end of pregnancy, a healthy mother and a healthy baby. The quality of care is more important than the quantity. Pregnancy requires specialized care, generally agreed to be a preventive activity. Where antenatal visits do occur, they appear to occur infrequently, late in the pregnancy and their content is unclear. Moreover, it appears that antenatal services are likely to be sought by women who experience difficulty or signals of a complicated delivery than other women. Poor utilization of services reflects cultural and socio-economic constraints as well as perceptions regarding accessibility of facilities and quality of care. Nearly 64% of women who did not utilize antenatal services consider it unnecessary, reflecting the traditional notion that child bearing is not an event worthy of medical attention (World Health Organization, Report on maternal health in developing countries).

Overall development of a country is incomplete without women who constitute nearly half of the human resource potential available. A woman requires special attention during 15-44 years of her life since she gets matured sexually and socially, gets married, conceives and gives birth to children during this phase. If proper care is not taken during this child bearing process, then it affects the overall health especially the reproductive health of the women as well as the health and well-being of the new born child. In real sense the place of delivery is an important aspect of reproductive health care provided to the mother and the quality of care received by the mother and the new born baby depends up on the place of delivery (UNICEF report).

Institutional delivery means giving birth to a child in a medical institution under the overall supervision of trained and competent health personnel where there are more amenities available to handle situation and save the life of the mother and child.

If the child is born at home, then chances of getting infected from an unhygienic environment are more and it is very tough and sometimes impossible to handle prenatal and postnatal child birth complications. In India it is a prevalent practice to deliver the child at

home instead of taking the pregnant women to some health facility. This is more common in rural areas.

Institutional births results in reduced infant and maternal mortality and increased overall health status of the mother and child.

Of the approximately four million global neonatal deaths that occur annually, 98% occur in developing countries, where most newborns die at home while they are cared for by mothers, relatives, and traditional birth attendants. During the past two decades, infant mortality rate has declined very slowly. This is as a result of a very slow declining neonatal mortality rate. There has been relatively little change in neonatal mortality despite proven cost-effective solutions to reduce neonatal mortality, such as promoting tetanus toxoid immunization, skilled attendance during delivery, immediate and exclusive breastfeeding, and clean cord care.

The World Health Organization (WHO) guidelines for essential newborn care include the following: hygiene during delivery, keeping the newborn warm, early initiation of breastfeeding, care of the eyes, care during illness, immunization, and care of low-birth-weight newborns.

Therefore it is necessary for the mother and her family to understand these aspects of childbirth and newborn care and be prepared to react to the potential danger signs. Newborn care practices may change over time and may be different in areas.

Studies from low socioeconomic settlements of Karachi, Pakistan, Bangladesh and Delhi, India have reported that traditional newborn care practices were of high risk and emphasized the need for community-based interventions to promote proper newborn care practices in rural areas.

Implementation of an effective program for promotion of childbirth and newborn care practices requires understanding of the community and household traditional newborn care practices. Such information will enable the development of programs to promote culturally sensitive and acceptable change in practices. Information about the reasons for delivering at home is also necessary for health care planners to design appropriate maternity services.

The present study on identifying causes for non-institutional deliveries among beneficiaries of National Rural Health Mission aims to find the reasons associated with these deliveries, the study was carried out in Bellary district.

## **Pregnancy**

Pregnancy is the carrying of one or more offspring, known as a fetus or embryo, inside the womb of a female. In a pregnancy, there can be multiple gestations, as in the case of twins or triplets. Human pregnancy is the most studied of all mammalian pregnancies. Childbirth usually occurs about 38 weeks after conception; in women who have a menstrual cycle length of four weeks, this is approximately 40 weeks from the last normal menstrual period (LNMP). The World Health Organization defines normal term for delivery as between 37 weeks and 42 weeks.

In many societies' medical or legal definitions, human pregnancy is somewhat arbitrarily divided into three trimester periods, as a means to simplify reference to the different stages of prenatal development. The first trimester carries the highest risk of miscarriage (natural death of embryo or fetus). During the second trimester, the development of the fetus can be more easily monitored and diagnosed. The beginning of the third trimester often approximates the point of viability, or the ability of the fetus to survive, with or without medical help, outside of the uterus.

The third semester is important one auxiliary nurse midwives has to monitor the pregnant women at community level and has to follow up the expected delivery date, arrangements has to made for transportation to health institutions for delivery or has to attend the delivery at community in case of home delivery in order to ensure safe delivery

## **Duration**

The expected date of delivery (EDD) is 40 weeks counting from the first day of the last menstrual period (LMP), and birth usually occurs between 37 and 42 weeks. Though pregnancy begins at implantation, it is more convenient to date from the first day of a woman's last menstrual period, or from the date of conception if known.



There is a standard deviation of 8-9 days surrounding due dates calculated with even the most accurate methods. This means that fewer than 5% of births occur at exactly 40 weeks; 50% of births are within a week of this duration, and about 80% are within 2 weeks. It is much more useful and accurate, therefore, to consider a range of due dates, rather than one specific day, with some online due date calculators providing this information. During the labour many complications may occur it is necessary for a pregnant women to delivery at institutions (PHC, CHC) where trained persons will provide safe deliveries in case of emergencies and also they can prevent maternal mortality, but still in our country the backward communities are not aware about the medical complications during delivery and their also not bother about maternal mortalities. The ignorance of the community is the result of non-institutional deliveries.

### **Delivery of the baby:**

Delivery is the moment when the fetus, followed by the placenta, exits the mother's body. In preparation of the delivery, a woman may be moved into a birthing room or delivery room, or she may remain in the same room for both labor and delivery. Fathers or partners are encouraged to be actively involved in the process of childbirth by helping with relaxation techniques and breathing exercises. Although serious complications are rare during labor, some problems can develop during this time.

During the delivery if proper care is not taken it ends with maternal mortality and infant mortality. For delivery a clean and hygienic place and trained people are necessary to conduct the delivery. Delivery under medical supervision is better because infant mortality rate and maternal mortality rate can be prevented.

In India the IMR was around 60 per 1,000 live births and maternal mortality was around 350 per lakh before launching of National Rural Health Mission.

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## **Childbirth**

Childbirth is the process whereby an infant is born. It is considered to be the beginning of the infant's life, and age is defined relative to this event in most cultures.

A woman is considered to be in labour when she begins experiencing regular uterine contractions, accompanied by changes of her cervix — primarily effacement and dilation. While childbirth is widely experienced as painful, some women do report painless labours, while others find that concentrating on the birth helps to quicken labour and lessen the sensations. Most births are successful vaginal births, but sometimes complications arise and a woman may undergo a cesarean section.

During the time immediately after birth, both the mother and the baby are hormonally cued to bond, the mother through the release of oxytocin, a hormone also released during breastfeeding.

After the childbirth, it is necessary to keep the child in clean and hygienic environment. The blood stains has to be removed by clean clothes, it is necessary that, it has to be observe that the child is normal like crying and normal breathings it has to be observed. In the non-institutional delivery this things are not observed by traditional birth attendants. In institutional delivery this things will be observed and proper care will be taken and can prevent infant mortality. The World Health Organisation states that half of the maternal mortality and infant mortalities can we prevent it, if 100% institutional deliveries occurs.

## **National Rural Health Mission (NRHM)**

The Government of India launched the National Rural Health Mission (NRHM) on the 12th of April 2005. The vision of the mission is to undertake architectural correction of the health system and to improve access to rural people, especially poor women and children to equitable, affordable, accountable and effective primary health care throughout the country, which have weak public health indicators and/or weak

infrastructure.

NRHM is a 7 years programme ending in the year 2012. It has time bound goals and its progress will be reported publicly by the government.

**Some of the goals of the Mission:**

- Reduction in child and maternal mortality
- Promote and increase institutional deliveries.
- Universal access to public health care services along with public services for food and nutrition, sanitation and hygiene
- Prevention and control of communicable and non- communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary health care.

**Some of the Core Strategies through which the mission seeks to achieve its goals:**

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services
- Promote access to improved healthcare at household level through ASHA
- Health Plan for each village through Village Health Committee
- Strengthening existing sub-centre, PHC and CHC
- Preparation and Implementation of an inter- sectoral District Health Plan
- Integrating vertical Health and Family Welfare programmes at National, State, Block, and District levels

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## **Service Guarantees and Important Schemes and NRHM focusing of women and child care.**

### **Accredited Social Health Activist (ASHA)**

With the launch of NRHM, the Government of India proposed Accredited Social Health Activist (ASHA) to act as the interface between the community and the public health system.

Since Sub centers were serving much larger population than they were expected to and ANMs were heavily overworked, one of the core strategies of NRHM is to promote access to improved healthcare at household level through ASHA.

ASHA is a Health Activist in the community, every village will have 1 ASHA for every 1000 persons and she will be selected in a meeting of the Gram Sabha.

She will be chosen from women (married/widowed/ divorced between 25-45 years) residing in the village with minimum education up to VIIIth class.

- ASHA is accountable to the Panchayat
- ASHA will work from the Anganwadi Centre
- ASHA is honorary volunteer and she is entitled to receive performance based compensation. Her services to the community are Free of cost
- ASHA will receive trainings on care during pregnancy, delivery, post-partum period, New born care, sanitation and hygiene

### **Roles and Responsibilities**

- ASHA is responsible for creating Awareness on Health including providing information to the community on nutrition, hygiene and sanitation
- Providing information on existing health services and mobilizing and helping the community in accessing health related services available at

Health Centers

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- Registering pregnant women and helping poor women to get BPL certification
- Counseling women on birth preparedness, safe delivery, breast feeding, contraception and care of young child
- Arranging escort/accompany pregnant women and children requiring treatment/admission to the nearest health center.
- Promoting universal immunization to the childrens.
- Organizing Health Day once/twice a month at the anganwadi with the Anganwadi worker and Auxilary nurse midwives.

### **Janani Suraksha Yojana (JSY)**

JSY is meant to reduce maternal mortality and neo-natal mortality by promoting deliveries at health institutions by skilled personnel like doctors and nurses.

JSY is a 100% centrally sponsored scheme. It integrates cash assistance to women from poor families for enabling them to deliver in health institutions along with anti natal and post natal care.

### **A Promise of Better Healthcare Services For The Poor**

The scheme applies differently to Low Performing States and High Performing States. While states having low institutional delivery rates have been named as Low Performing States (LPS), the remaining states have been named as High Performing States (HPS). LPS states include the states of Uttar Pradesh, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa and HPS states include Maharashtra and Tamilnada, Karnataka comes under High performance state.

### **Eligibility or Cash Assistance:**

- All pregnant women delivering in Government health centres like Sub-centre, Primary Health Centre/Community Health Centre/First Referral Unit/general wards of District and state Hospitals or accredited private institutions.

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- Pregnant women, aged 19 years and above
- All Scheduled Caste and Scheduled Tribe women delivering in a government health centre like Sub- centre, general ward of Primary Health Centre/Community Health Centre/First Referral Unit/Taluk Hospital/District Hospital and state Hospitals or accredited private institutions. No age constraint
- Upto 2 live births.

### **Assistance for Home Delivery**

BPL pregnant women, aged 19 years and above, preferring to deliver at home is entitled to cash assistance of Rs. 500/- per delivery. Such cash assistance would be available only upto 2 live births and the disbursement would be done at the time of delivery or around 7 days before the delivery by ANM/ASHA/any other link worker. The rationale is that beneficiary would be able to use the cash assistance for her care during delivery or to meet incidental expenses of delivery.

### **Role of ASHA or other link health worker associated with JSY**

Along with fulfilling their usual duties of providing anti natal and post natal care to woman, ASHA/other health workers would be responsible for Identifying pregnant woman as a beneficiary of the scheme. Assisting the pregnant woman to obtain necessary certifications. Identifying a functional Government health centre or an accredited private health institution for referral and delivery. Escorting the beneficiary women to the health center and stay with her till the woman is discharged.

### **Services Guarantees from Primary Health Centre (PHC)**

(All services provided at Primary Health Center are free of cost for Below Poverty Level families)

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Every PHC has to provide Out Patient Department services, Inpatient Service, referral service and 24 hours emergency service for all cases needing routine and emergency treatment including treatment of local diseases. All services provided by Sub centers are also provided by PHC. Some additional services provided in a PHC are as follows:

### **Maternal Health**

- 24-hour delivery services both normal and assisted
- Appropriate and prompt referral for cases needing specialist care
- Pre-referral management (Obstetric first-aid)
- Facilities under Janani Suraksha Yojana

### **Treatment of RTI/ STIs Basic laboratory services and referral services**

Appropriate and prompt referral of cases needing specialist care including: Stabilization of patient. Appropriate support for patient during transport and providing transport facilities

A Charter of Citizen's Health Rights should be prominently displayed outside all PHCs.

The Primary Health Centre (not at the block level) will be responsible to the elected representative of the Gram Panchayat where it is located.

The Block level PHC will have involvement of Panchayati Raj elected leaders in its management even though Rogi Kalyan Samiti would also be formed for day-to-day management of the affairs of the hospital.

The Mission seeks to provide minimum three Staff Nurses to ensure round the clock services in every PHC.

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## **Service Guarantees from Community Health Centers (CHC)**

Care of routine and emergency cases in surgery and medicine. 24-hour delivery services including normal and assisted deliveries. Essential and Emergency Obstetric Care including surgical interventions

### **Full range of family planning services**

- Safe Abortion Services
- Newborn Care and Routine and Emergency Care of sick children
- Diagnostic services through the microscopy centers
- Blood Storage Facility
- Essential Laboratory Services
- Referral Transport Services

All National Health Programmes should be delivered through the CHCs. e.g. HIV/AIDS Control Programme, National Leprosy Eradication Programme, National Programme for Control of Blindness Over the Mission period, the Mission aims at bringing all the CHCs on a par with the IPHS to provide round the clock hospital-like services. According to IPHS, it is mandatory to display Charter of Citizen's Health Rights outside all CHCs.

#### **a) Madilu – schemes of the Karnataka Government.**

The Madilu scheme under the National Rural Health Mission (NRHM), was launched on October 1, 2007. Under the programme, a post-natal care kit containing 19 items is provided for the benefit of the mother and her child belonging to the weaker sections of society. This unique programme has been launched for the first time in the country in Karnataka, which has been pioneering health services for the people. This initiative, which has generated tremendous response, has been well-appreciated by the Government of India. Following the introduction of this programme, the rate of institutional deliveries, especially in government hospitals, has gone up significantly source.

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Objectives of the Madilu Scheme:

- To reduce infant and maternal deaths.
- To reduce the number of home deliveries & promote institutional delivery.

Eligibility Criteria:

- For BPL woman for first two deliveries only in government institutions.
- Thai Card (ANC Card) to be produced for availing the benefit.

#### **b) Prasuthi Arike**

Prasuthi Arike scheme was initiated in the year 2008-2009, with a view to enhance nutrition of pregnant women and lactating mother. Under this scheme, Rs. 1,000/- during the second trimester of pregnancy and Rs. 1,000/- within 48 hrs of delivery in Government Institutions, is given to the beneficiary in all the districts.

Objectives:

- To reduce MMR (Maternal Mortality Rate) and IMR (Infant Mortality Rate).
- To promote institutional deliveries.
- To reduce the incidence of birth of under weight babies.
- To enhance nutrition status of pregnant women and lactating mothers.
- Acts as wage loss compensation for pregnant women and lactating mothers belonging to SC/ST & BPL families.

#### **c) Thai Bhagya**

This scheme is based on the “Chiranjivi” model of Gujarat. The scheme is introduced by Karnataka Government to overcome the shortage of specialists in rural area for conducting deliveries by outcoming them to private providers.

This scheme is introduced in the 7'C' Category districts (i.e. Gulbarga, Bidar, Bijapur, Bagalkote, Koppal, Raichur, Bellary and Chamarajanagar district through Public Private

Partnership made to provide totally cash less obstetric care services to women belonging to BPL, SC & St families in recognized 62 Private hospitals and 27 Government hospitals.

Objectives:

- To improve the institutional Deliveries by providing specialists services through Public Private Partnership.
- To reduce MMR (Maternal Mortality Rate) and IMR (Infant Morality Rate)

Conditionalities

- Delivery services free of cost.
- Accredited private or government hospitals.
- Benefit is limited to first two live births.
- The scheme for BPL, SC/ST women of more than 19 years of age who have regular Antenatal checkups.
- Private hospital will provide transportation charges of Rs. 250/- & 75/- to mother and one attendant (ASHA).

**Mode of payment.**

- Recognised Private Hospitals will be paid Rs. 3.00 lakhs for every 100 deliveries.
- Recognised Government Hospital will be paid for Rs. 1.5 lakhs for every 100 deliveries.

**Thayi Bhagya Plus**

The new scheme “Thayi Bhagya Plus” was introduced by the Government of Karnataka as announced to reduce the MMR from 213 to 100 and to improve the institutional deliveries to 100% by 2010-11. Under the scheme, rural BPL women who deliver in Private hospitals will receive Rs. 1000/- as special cash incentive”.

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## **Highlights**

- The beneficiary should be a resident of rural area.
- The beneficiary who delivers in private hospital should possess BPL card.
- The beneficiary should have completed 19 years.
- Benefit is applicable to the first two live births.

## **Identifying the beneficiaries.**

- Thai Card system, which has been successfully implemented across the State, helps in not only identifying the beneficiary but also documenting their data.
- At the time of pregnancy registration, the junior lady health assistant of rural area should educate the beneficiary about the delivery facility which is availability not only in government hospitals but also in private hospitals.
- The nearest Private registered hospitals' information should be given while examining the pregnant women.
- The women covered by this scheme should be informed that they must compulsorily carry the Thai Card when they go for delivery in Private hospitals.
- Bring the delivery documentation proof with doctor's seal, signature that she was admitted in the hospital in the hospital for 48 hours after the delivery to the concerned PHC.

## **About Bellary District**

Bellary District is considered to be one among the 7 backward districts in Karnataka. The total population of the Bellary District is the 25,27,182 as on April 2011. The Bellary district consists of 7 Taluks namely Bellary, Hospet, Sandur, Siruguppa, Kudligi, Hagaribomanahalli & Huvinahadagali taluks. The institutional deliveries at Bellary District before implementing

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NRHM was 65%, now at present March 2011 is 94%. The Infant Mortality Rate is 41 per 1000 live births and Maternal Mortality Rate is 190 per 1 lakh live births. The overall institutional deliveries rates in Karnataka at present is 96% but Bellary is low compared to State average. Among 7 taluks of Bellary District Sandur & Hospet taluks are major contributors of home deliveries. It is for these reasons, that this district was chosen to conduct the study.



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## Chapter 2 - Review of Literature

**A literature review** is a body of text that aims to review the critical points of current knowledge including substantive findings as well as theoretical and methodological contributions to a particular topic. Literature reviews are secondary sources, and as such, do not report any new or original experimental work.

Simai Haji Mati was quoted saying that literature review should be referred to as reviewing and analyzing the work of literature in relation to the specified topic in research.

Most often associated with academic-oriented literature, such as a thesis, a literature review usually precedes a research proposal and results section. Its ultimate goal is to bring the reader up to date with current literature on a topic and forms the basis for another goal, such as future research that may be needed in the area.

A well-structured literature review is characterized by a logical flow of ideas; current and relevant references with consistent, appropriate referencing style; proper use of terminology; and an unbiased and comprehensive view of the previous research on the topic.

Hence review of literature on this topic becomes important to understand the various factors and reasons associated with non institutional deliveries on various dimensions around the globe. The following paragraph portray the studies conducted by various medical personnels, sociologists, economics and other social scientists.

The review of literature for the study as categorized as follows:

1. Studies related to Non institutional delivery.
2. Studies related to Maternal care services.
3. Studies related to Causes for maternal mortality.
4. Studies related to Evaluation studies related to National Rural Health Mission.
5. Studies related to International studies.

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## **Time frame**

The studies were conducted between 1993 to 2011.

## **Studies on Non Institutional Delivery**

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

One of the studies conducted by Kilaru, Asha, Matthews, Zoe, Ramakrishna, Jayashree, Mahendra, Shanti & Ganapathy, Saraswathy (2004) on 'She has a tender body: Postpartum morbidity and care during bananthana in rural south India'. The neglect of 'M' in 'MCH' (Maternal and Child Health), which was first given international

prominence by Rosen field and Maine (1985), has now been partly redressed by recent increased interest in maternal well-being. However, very little research has focused on the postpartum period, despite the estimated 50% or more of maternal deaths occurring after delivery (Liet al., 1996). Although it is recognized that there is a need for improved services and more resources to improve maternal outcomes, there is little evidence available that helps us to understand morbidity and health- seeking behaviours during this culturally defined periods. The 'bananthana' period (the three months after delivery) is characterized in rural south India by many cultural prescribed practices, including severe restrictions of diet. The study presents the results of 366 women followed through pregnancy, delivery and traditional postpartum 11 villages in Karnataka, in southern India. Data were collected via questionnaires administrated to women during pregnancy, immediately after delivery and three months postpartum as well as qualitative interviews. By virtue of its prospective design, the study gives a unique insight into intentions for postpartum care, as well as postpartum morbidity and subsequent care-seeking behaviours reported soon after the vents. Only 10% of the women in the sample had intentions to seek routine postnatal care, due to a widespread belief that the mother only need care if a problem occurs. However, the occurrence of problems was not rare: 37% reported some morbidity and 5% reported moderate to severe morbidity within 42 days of delivery; mainly heavy bleeding and fever (excluding anemia, non-obstetric problems and fever that lasted less than three days). Extending the analysis to 3 months postpartum increases the number of women who reported morbidity to almost 30%. A majority of the sample did report a postnatal contact with services, but rather than routine care these contacts consisted mainly of tubectomy advice, immunization advice for newborns, and those who actually sought care because of a problem. This study suggests than both the planning of routine postnatal contact and actual care seeking in influenced by traditional restrictions on morbidity, beliefs about the origins of postpartum health problems, perceived severity of morbidity, difficulties in access to services, lack of resources, lack of resources, lack of support from other household members. Other factors such as education, parity, age, sex of child, and perceived quality of services are also important.

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In contrast to the above findings, Matthews, Zoe, Ramakrishna, Jayashree, Mahendra, Shanti, Kilaru, Asha & Ganapathy, Saraswathy (2005) on their study 'Born rights and

rituals in rural south India: Care seeking in the intrapartum period'. Maternal morbidity and mortality are high in the Indian context, but the mortality of maternal deaths could be avoided by prompt and effective access to intrapartum care (WHO, 1999). Understanding the care seeking responses to intrapartum morbidities is crucial if maternal health is to be effectively improved, and maternal mortality reduced. This paper presents the results of a prospective study of 388 women followed through delivery and traditional postpartum in rural Karnataka in southern India. In this setting, few women use the existing health facilities and most deliveries occur at home. The analysis uses quantitative data, collected via questionnaires administered to women both during pregnancy and immediately after delivery. By virtue of its prospective design, the study gives a unique insight into intentions for intrapartum care during pregnancy as well as events following morbidities during labour. Routine care in the intrapartum period, both within institutions and at home, and impediments to appropriate care are also examined. The study was designed to collect information about health seeking decisions made by women and their families as pregnancies unfolded, rather than trying to capture women's experience from a retrospective instrument. The data set is therefore a rich source of quantitative information, which incorporates details of event sequences and health service utilization not previously collected in a Safe Motherhood study. Additional qualitative information was also available from concurrent in-depth interviews with pregnant women, their families, health care providers and other key informants in the area. The level of unplanned institutional care seeking during the intrapartum period within study area was very high, increasing from 11 percent; planning delivering at a facility to an eventual 35 percent actually delivering in hospitals. In addition there was significant move away from planned deliveries with the auxiliary nurse midwives (ANM), to bring with a lay attendant or dai. The proportion of women who planned was less than half of this proportion. Perceived quality of care was found to be an important factor in health seeking behavior, as was wealth, caste education and experience of previous problems in pregnancy. Actual care given by a range of practitioners was found to contain both beneficial and undesirable elements. As a response to serious morbidities experienced within the study period, many women were able to seek care although sometimes after a

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long delay. Those women who experienced inadequate progression of labour pains were most likely to proceed unexpectedly to a hospital delivery.

### **Studies on Maternal Care Services**

Bhatia, Jagdish C., and Cleland, John (1995), in their research titled 'Determinants of maternal care in a region of South India'. conducted a cross-sectional survey during 1993 in urban and rural areas of Karnataka. The survey included 3595 currently married women aged under 35, who had at least one child under five. Nine out of ten women had at least one antenatal consultation during their most recent fertile pregnancies. Most consultants were with doctors and there was minimal use of the services provided by paramedical staff of the primary health care system. Of all participants, 38 per cent (57% urban and 29% rural) delivered in a hospital, and a majority of Institutional deliveries were in private hospitals. Surgical interventions were made in more than one-third of hospital deliveries. There was a marked imbalance between antenatal and postnatal care as fewer than one-fifth of the mothers had a postnatal checkup. The educational level, economic status and religion of the mother are significant predictors of use of maternal health services. The relationship of problems during pregnancy and delivery with subsequent health-related behavior is also examined.

Navaneetham K., & Dharmalingam, A. (2000) their study titled 'Utilization of maternal health care services in south India'. Trivandrum, Centre for Development Studies. In the study the researchers examined the patterns and determinants of maternal health care use across different social setting in south India: in the states of Andhra Pradesh, Karnataka and Tamil Nadu. The researchers use data from the National Family Health Survey (NFHS) carried out during 1992-93 across most states in India. The study focuses on most recent births to ever married women that took place during the four years prior to the date of the survey. Researcher have used logistic regression models to estimate the effect of covariates on the utilization of maternal health services viz., antenatal care, tetanus toxoid vaccine, place of delivery and assistance during delivery. The study indicates the determinants of maternal health care services are not same across states and

for different maternal health care indicators. Although illiterate women were less likely to use maternal health care services; there was no difference among the educated. The level of utilization of maternal health care services was found to be highest to Tamil Nadu, followed by Andhra Pradesh and Karnataka. Part of the interstate differences in utilization is likely to be due to differences in availability and accessibility among the three south Indian states. It is argued that the differential in access to health care facilities between rural-urban areas is an important factor for lower utilization of maternal health care services, particularly for institutional delivery and delivery assistance by health personal in the rural areas of the three states. Results from this study indicate that health workers might play a pivotal role in providing antenatal care in the rural areas.

This study examines the patterns and determinants of maternal health care utilization across different social setting in south India: In the states of Andhra Pradesh, Karnataka, Kerala and Tamil Nadu. Data from the National Family Health Survey (NFHS) carried out during 1992-93 across most states in India are used. Results show that utilization of maternal health care services is not only associated with a range of reproductive, socio-economic, cultural and program factors but also with state and type of health service. The interstate differences in utilization could be partly due to variations in the implementation of maternal health care program as well as differences in availability and accessibility between the states. In the case of antenatal care, there was no significant rural urban gap, thanks to the role played by the multipurpose health workers posted in the rural areas to provide maternal health care services. The findings of the study provide insights for planning and implementing appropriate maternal health service delivery programs in order to improve the health and well-being of both mother and child.

Raju, K.N. M., Rayappa, P.H. Rao, K.V., & Sivakami, M. (2004) their study titled 'Normative and actual provision of antenatal health care services in Karnataka'. An attempt has been made in the study, using RCH data in Karnataka, to know the level of utilization of all the services that are considered essential for safe delivery. The utilization of the entire essential antenatal health services are found to be only 8.6 percent 12% have not received any services. The percentage of women receiving all essential antenatal health care services is higher among those living in urban areas, Coastal and Malnad

regions, the literacy rate among the women is high and institutional deliveries are more in this areas, other than the urban areas and costal urban and malnadu regions home deliveries are more. In this area womens are more illiterate.

In the study work 'Economic Inequalities in maternal health care: Prenatal care and skilled birth attendance in India 1992-2006'. Using data from three rounds of National Family Health Survey (NFHS) conducted during 1992-2006. The study analyzed the trends and patterns in utilization of prenatal care (PNC) in first trimester with four or more antenatal care visits and skilled birth attendants (SBA) among poor and nonpoor mothers, disaggregated by area of residence in India and three contrasting provinces, namely, Uttar Pradesh, Maharashtra and Tamil Nadu. In addition, researcher has investigated the relative contribution of public and private health facilities in meeting the demand for SBA, especially among poor mothers, also examine the role of salient socioeconomic, demographic and cultural factors in influencing aforementioned outcomes. Bivariate analyses, concentration curve and concentration index, logistic regression and multinomial logistic regression models used to understand the trends, patterns and predictors of the two outcome variables. Results indicate sluggish progress in utilization of Prenatal Care and killed Skilled Birth Attendants in India and selected provinces during 1992-2006. Enormous inequalities in utilization of PNC & SBA were observed largely to the disadvantages of the poor. Multivariate analysis suggests growing inequalities in utilization of the two outcomes across different economic groups.

The use of PNC & SBA remains disproportionately lower among poor mothers in India irrespective of area of residence and province. Despite several governmental efforts to increase access and coverage of delivery services to poor, it is clear that the poor (a) do not use SBA and (b) even if they had SBA, they were more likely to use the private providers.

In the study 'Differentials in the quality of antenatal care in India". International Journal for Quality Health care'. Lower than desired quality of antenatal care was observed in both north and south Indian states, though the quality was significantly better in south India compared with north India, especially among the disadvantaged women. Significant

socio-economic differentials in the quality of care were evident in both north and south India, but were more glaring in north India. A significantly positive relationship was observed between the quality and utilization of antenatal care in the rural areas from village level multivariate analysis.

Poor quality of antenatal care is likely to reduce its utilization. Policy and program interventions to improve the quality of care of antenatal care, especially for the poor and other disadvantaged population groups, more so in north India, are essential to improve maternal health outcomes. India's National Rural Health Mission (NRHM), launched in 2005, should lay greater emphasis on improving the quality of antenatal care, among other things, to increase utilization of antenatal care and achieve better maternal health outcomes.

The study conducted by Kumar, Dinesh, Goel, N.K. Kalla, Meenu, Swami, H.M., & Singh, Ruchi (2008) on 'Gap between awareness and practices regarding maternal and child health among women'. Low levels of awareness and practice of TT immunization (74.2% awareness 58.1% practice), five – cleans (31.9% awareness and 14.4% practice) in home deliveries, trained birth attendant (69.6% awareness 39.1% practice) in home deliveries, and post-natal care (75.4% awareness and 51.0% practice) among lactating mothers. Knowledge regarding optimal infant and young child feeding practices was very poor: initiation of breast-feeding within six hours (17.4%), colostrum feeding (34.8%), exclusive breastfeeding (5.8%) and significant gaps between knowledge and practice were observed. Highly significant difference ( $P < 0.001$ ) between proportions of women aware of ICDS (59.4%) and of beneficiaries (21.7%). High levels of awareness regarding reproductive health parameters expect for contraception: desire for two children (81.6%), legal ages at marriages for girls (84.5%), desired birth interval of three or more years (71.7%).

George, Asha, Lyer, Aditi, & Sen, Gita (2005). In their study 'Gendered health systems based against maternal survival: Preliminary findings from Koppal, Karnataka, India'. In this study outline the context of pregnant women's live and the plural health systems they encounter in Koppal, the most deprived district in the state of Karnataka, south India.

Combined preliminary survey findings with qualitative work to illustrate the dynamics involved in seeking and receiving supporting primary health care in the region, women with obstetric complications do access a range of health providers. Yet they still die. Although addressing the technical and managerial capacity constraints to ensuring equitable access to emergency obstetric care is essential, They argue maternal well-being and survival cannot be effectively ensured without confronting the gender biases that also constrain health systems from supporting women's health and saving women's lives. Analyze these bases as failures in acknowledgement and accountability for pregnant women's needs and conclude with strategic steps to effectively respond to the situation that encompass technical, managerial and political action.

Matthews, Zoe, Mahendra, Shanti, Kilaru, Asha & Ganapathy, Sarswathy (2001) in their prospective study 'Antenatal care, care-seeking and morbidity in rural Karnataka, India: Results of a prospective study'. The objective of this prospective study was to identify the socioeconomic determinants of antenatal care-seeking among rural women in a South Indian setting. The extent and nature of the antenatal morbidities suffered by these women are also described. The results give their responses to sequential questionnaires administered during pregnancy and beyond. All those who became pregnant in 11 South Indian villages within a 25-month period from August 1996 to September 1998 were followed as part of the study. Responses were collected during lactating period itself, thereby reducing the recall error inherent in many cross-sectional studies. This article presents survey results for 282 women interviewed two or more and their families, as well as with health-care providers and other key informants. 60% of the women in the study had home deliveries. The results show that cultural and social causes and restriction from elders play an important role in utilizing institutional services, in these services. There is a need of strong behavioural change communication in eradicating misconceptions, superstitious beliefs and old practices in the respective community regarding antenatal care and delivery places.

The study of Deshpande, R.V (2008) titled 'Utilization of government health facilities for Reproductive and Child Health Services in Karnataka – An analysis based on DLHS -2 data. PRC working paper No. 56 Dharwad, Karnataka, Population Research Centre'.

Where do women seek medical help for reproductive and child health care aspects, for what type of reproductive health services they prefer government health facility and what are the socio-economic and demographic characteristics of people choosing government health care providers are important factors to further improve the utilization of government health facilities. These aspects have been studied in this paper with the help of responses from 7597 currently married women on the type of health facility visited for antenatal, natal, postnatal and child immunization services interviewed in the DLHSs conducted during 2002-04 in Karnataka.

The analysis revealed that women prefer government health facilities only for the limited number of reproductive and child health care services namely for immunization of their children and for family planning services especially for undergoing sterilization. However, for antenatal care, postnatal care, for treatment of diarrhea, pneumonia and for IUD insertion women prefer private health care facilities in spite of the existence of government health facility in the village. On the other hand, for delivery, women neither prefer government health centres nor private health center but prefer home. However, the good news is that one in five women who have availed ANC in private health facility had switched over to government health centres for the delivery may be because of lack of proper facilities in those centres. It is also found from the analysis that Indian Systems of Medicine comprising Ayurvedic, Yoga, Unani, Sidha, and Homeopathy (AYUSH) were preferred by a negligible proportion of women. It is also clear from the analysis that infrastructural facilities in the government health centres are poor and those centres also lack adequate trained staff. However, all the health centres have adequate stock of supplies and equipment. It is suggested that if the infrastructural facilities in the government health centres in the state are improved, the utilization of reproductive and child health services would certainly go up.

A study taken by Metgud, C.S., Katti, S.M. Mallapur, M.D., & Wantamutte, A.S. on 'Utilization patterns of antenatal services among pregnant women: A longitudinal study in rural area of north Karnataka'. Most of the pregnant women (92.31%) were registered for antenatal care, but only 30.00% of them were registered in the 1<sup>st</sup> trimester of pregnancy. As regards to TT immunization, 70.775 of the pregnant had received 2 doses

or 1 booster dose. Iron and Folic Acid supplementation was taken by 59.68% of the pregnant women. Nearly 39.52% of pregnant women were provided with full antenatal care. The main antenatal care provider for pregnant women was doctor (64.52%). The provision of full antenatal care package was found to be significantly higher among the pregnant belonging to social classes I and II and in those who have studied above SSLC.

The study shows early and wide spread use of antenatal care, but it also reveals that the antenatal visits occur late in the pregnancy. The literacy of women has significant bearing on utilization of antenatal care by the pregnant women.

In contrast to the above findings Sagir, Afrin, Varma, Aditi Vian, Samarsinghe, Charmaine Minoli, John, Sworooop Thomes (2009) in their study 'Maternal and child health services utilization in costal Karnataka'. India across for nearly 20% of maternal and child health services in the globe. This could be related to several factors such as non-utilization or underutilization of maternal and child health (MCH services) services. For proper programme implementation, understanding community knowledge and practices regarding maternal care during pregnancy, delivery, and postnatal period is required. To assess the utilization of MCH services, a cross sectional community based study was conducted in a sub-center area of the Udupi District. A pre-tested questionnaire was administered to 185 recently delivered mothers and the data analyzed using SPSS. 90% of the women had at least 3 antenatal visits and 96% of them had institutional deliveries. The literacy rate are more around 95% of the women are literates. 89% of the women were aware of the different contraceptive methods available. Around 37% of the under-fives were malnourished. Despite the findings, improving community awareness on maternal and child health (MCH) services is still required.

The study conducted by Desai, Sonalde, and Wu, Lijuan (2010). 'Structured Inequalities – Factors associated with spatial disparities in maternity care in India' on Research on India documents considerable heterogeneity in health and health care across states. However, while regional differences are well established, factors underlying these differences have received little attention. This paper seeks to explain disparities in delivery care across districts by focusing on three factors: (1) marriage and kinship

patterns; (2) district wealth; (3) governance and quality of services. Using data from the nationally representative India Human Development Survey 2005 (IHDS) it examines the probability that the 11,905 women who had a child between 2000 and 2005 delivered in a hospital or received care from a doctors or a nurse while delivering at home. Although compositional differences in education and household wealth explain some of the variation between districts, marriage and kinship patterns, district wealth and governance each has a significant impact on shaping between – district variation in maternity care.

Sivakami, M. (2008), in her research work ‘Determinants of maternal health care service use: A regional analysis in Karnataka’. This paper aims to examine the levels and determinants of maternal health care service across different regions in Karnataka. The data are drawn from the District Level Household Survey (DLHS-RCH), 2002-2004 that collected information on maternal health care services from currently married women whose last pregnancy resulted as stillbirth or live birth during three years preceding the survey. The analysis has been done separately for specific regions in Karnataka. The districts of Karnataka are grouped into four health divisions/regions; Gulbarga Division, Belgaum Division, Mysore Division and Bangalore Division. The key indicators of maternal health care considered in this paper are; antenatal checkup, tetanus toxoid vaccine, consumption of iron and folic acid tablets, place of delivery, and assistance delivery. In order to identify determinants of maternal health care service, legit regression approach has been adopted. The study indicates that determinants of maternal health care services are not same across regions/divisions and for different maternal health care indicators. The level of utilization of maternal health care services was found to be highest in Mysore division, followed by Bangalore division, Belgaum division and Gulbarga division. Education of the women and economic status of the household seems to be an important in enhancing the utilization of maternal health care in case of Gulbarga and Belgaum divisions. These variables seems to be important in the other two divisions namely Mysore & Bangalore divisions but only in the case of place of delivery and professional care at delivery (not in case of other three indicators which care considered for the analysis). Women who belongs to Scheduled caste and Scheduled Tribes continue to be at disadvantage position but only in case of certain specific indicators and specific divisions.



## **Studies on Maternal Mortality**

Bhatia, Jagdish (1993), in their study 'Levels and causes of maternal mortality in southern India'. Most studies of maternal mortality are hospital based. However, in developing countries, where many such deaths take place in the home, hospital statistics do not reflect the true extent of maternal mortality. Furthermore, the socioeconomic and demographic factors and health behavior affecting maternal mortality are rarely known. A study conducted in 1986 in South India demonstrates a new approach to investigating maternal mortality that combines the collection of information from hospital and health facility records, field surveys, and case-control studies. The findings from this study indicate that there were 7.98 maternal deaths per 1,000 live births. Approximately one-half of the deaths occurred in the home or on the way to the hospital. Maternal deaths accounted for 36 percent of mortality for women of reproductive age. Analysis reveals that many of these deaths were preventable and that sufficient differentials existed with regard to demographic, social, and behavioral factors between the cases of maternal deaths and the controls.

The study conducted by Sunil, T.S., Rajaram, S., & Zotarelli, Lisa K. (2006) on 'Do individual and program factors in the utilization of maternal care services in rural India? A theoretical approach'. Current studies on the utilization of maternal care services in India focus on Individual factors. In the present study, they use the theoretical model developed by Andersen and Newman [1973. Societal and individual determinants of medical care utilization in the United States. *Milbank Memorial Fund Quarterly*, 51(1), 95-124] to understand the utilization of maternal care services in rural areas of India. This theoretical model uses individual and welfare program—or system factors—to study health care utilization. Data collected through the National Family Health Survey-2 are used in the present study. The results suggest that in addition to individual characteristics, program factors, particularly educational activities promoting the benefits of maternal care services carried out through mahila mandal and anganwadi centers, are important in increasing the use of maternal care services in rural areas. Additionally, the results indicate that the mere presence of a private health care facility need not necessarily improve utilization. Increase in utilization is observed among households if the health

worker visited these households during pregnancy. More state-specific studies incorporating both program and individual characteristics are recommended to further strengthen understanding of the utilization of health care services in general and maternal care services specifically.

The study conducted by George, Asha (2007) on 'Persistence of high maternal mortality in Koppal district, Karnataka, India observed service delivery constraints'. Rural women with obstetric complications access many health providers in Koppal, the poorest district in the state of Karnataka, south India. Yet they die. Based on insights derived from case studies of women seeking emergency obstetric care and participant-observation of government health services, this article highlights service delivery constraints that underlie the persistence of high levels of maternal mortality in Koppal. Weak information systems, discontinuity in care, unsupported health workers, haphazard referral systems and distorted accountability mechanisms are identified as critical service delivery are not linked to postpartum or emergency obstetric care, and health workers use inappropriate injections but don't treat anemia or sepsis. Families waste valuable time and resources accessing many providers but fail to get effective care, and blame is laid on lower-level health workers and women for not accessing institutional delivery. Lastly, the role of administrators and politicians in ensuring functioning health services is obscured. While important supply and demand-side reforms are being implemented, these do not constructively engage with informal providers nor address systemic service delivery constraints. Critical managerial change is required, without which new budgetary allocations will be squandered with little impact on saving women's lives.

Wide gaps exist between awareness and practices related with MCH due to non-adoption of knowledge into actual practice, except some selected components lacking in both knowledge as well as practice. Need for bridging the existing gaps avoiding socio-cultural barriers and misconceptions prevailing in the community and by prompting and protecting healthy MCH care practices.

The study conducted by Ghosh, Debarchana (2006) on 'Effect of mothers' exposure to electronic mass media on knowledge and use of prenatal care services: A comparative

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analysis of Indian states'. The Government of India considers prenatal care programs as a priority activity for promoting safe motherhood and child survival. It relies heavily on electronic mass media, including radio, television, and cinema to educate mothers – two thirds of whom are illiterate – about prenatal check-ups and timing, iron prophylaxis, and tetanus toxoid injections. This study evaluated the effect of mothers' exposure to electronic mass media on knowledge and use of prenatal care services, using data from India's 1998-1999 National Family Health Survey. Multivariate logistic regressions were used to estimate the effects of media exposure by calculating odds ratios of each of the four response variables (complete prenatal care services, prenatal check-ups, tetanus toxoid injections, and iron prophylaxes) for exposure to mass media. The results indicated that exposure to mass media is related to the use of prenatal care services even when other likely causes of the relationships are statistically controlled at their mean. The effect also showed a north-south divide among the Indian States, being stronger in northern states as compared with southern states. Key Words: health geography, India, mass media, prenatal care service.

### **Studies related to Evaluation of National Rural Health Mission**

The evaluation conducted by Devadasan, Narayanan, Elias, Maya A., John, Denny, Grahacharya, Shishir, & Ralte, Lalnuntlangi (2008) on 'A conditional cash assistance programme for promoting institutional deliveries among the poor in India: process evaluation results'. India contributes significantly to the global burden of maternal deaths. More than 20% of all maternal deaths occur in India. To tackle this and especially to promote institutional deliveries, the government of India has introduced a conditional cash assistance programme called the Janani Suraksha Yojana (JSY). Under this programme, poor women who have had three antenatal checkups and who deliver in a health facility would get money soon after delivery to take care of their direct from four Indian states, to determine how the JSY is functioning in the field and whether it is meeting its original objective of increasing institutional deliveries. While there is some evidence to suggest that there has been an increase in institutional deliveries, we were able to neither to quantify it nor attribute it to the JSY. This is because of the paucity of

good quality data at the state and district levels. Both the staff as well as the pregnant women were happy with the scheme and felt that it met an important need. However, there were some important gaps in the implementation of the scheme. Some of the poor women getting the cash benefit. Some women also mentioned that they received only partial amounts – the rest being pocketed by the health staff. The most significant issue was that the scheme has been changed to permit the cash benefit to go to all women who deliver, irrespective of the site of delivery. This has resulted in the scheme actually promoting home deliveries, a perversion of the original objective.

Jain A.K. (2010) in their evaluation 'Janani Suraksha A Yojana and Maternal Mortality Ratio'. Surveys indicate that the Janani Suraksha Yojana, which offers cash assistance to pregnant women opting for institutional deliveries, has increased the number of such births in hospitals. Can this increase be used as an indicator of a decrease in the maternal mortality ratio? It is likely that the cash incentive may disproportionately attract pregnant women without complications not getting proper treatment. To evaluate the programme adequately, studies in states with a high maternal mortality ratio based on a representative sample of institutions with and without emergency obstetric services are needed.

'India's Janani Suraksha Yojana, a conditional cash transfer programme to increase birth in the health facilities: an impact of evaluation'. Implementation of JSY in 2007-08 was highly variable by state – from less than 5% to 44% of women giving birth receiving cash payments from JSY. The poorest and least educated women did not always have the highest odds of receiving JSY payments. JSY had a significant effect on increasing antenatal care and in-facility births. In the matching analysis, JSY payment was associated with a reduction of 3-7 (95% CI 2-2-5-2) perinatal deaths per 1000 pregnancies and 2-3 (0.9-3.7) neonatal deaths per 1000 livebirths. In the with –verses–without comparison, the reductions were 4.1 (2.5-5.7) perinatal deaths per 1000 pregnancies and 2.4(0.7-4.1) neonatal deaths per 1000 live births.

Interpretation: The findings of this assessment are encouraging, but they also emphasize the need for improved targeting of the poorest women and attention to quality of obstetric care in health facilities. Continued independent monitoring and evaluations are important

to measure the effect of JSY as financial and political commitment to the programme intensifies.

Deshpande, R.V. Katarki, P.A., & Pundappanavar, B.I (20) in their study 'Rapid appraisal of National Rural Health Mission (NRHM): Implementation in Koppal District, Karnataka, Dharwad, Karnataka, Population Research Centre'. In the light of National Rural Health Mission's existence in the country since four years, the Ministry of Health and Family Welfare, Government of India, intended to take a stock of the current status of NRHM implementation and its progress in the country on sample basis through Population Research Centres (PRCs). As per the directions of the MOHFW, the Population Research Centers (PRC), Dharwad, undertook a Rapid Appraisal of NRHM implementation in Koppal district of Karnataka state. Given the wide scope of the mission and diverse nature of its activities, as per the guidelines of Mohawk, the rapid appraisal was undertaken on selected four core interventions of the mission that directly address the health and family welfare needs of the people namely; 1. Facility up gradation 2. Janani Suraksha Yojana (JSY) 3. Utilization of untied funds at Subcentres (SCs), Primary health Centers (PHCs) and Community Health Centers (CHCs) and District Hospital 4. Assessment of health and family welfare situation at the village level. In the findings with respect to the above mentioned four interventions of NRHM are summarized.

### **Concurrent evaluation of national rural health mission 2009 national fact sheet**

In this fact sheet it found that currently married women with a recent health and being JSY ranged from 29 percent Scheduled Castes to 18 percent among others. The institution delivery increased around 48% and 60% of all delivers safe deliveries nearly one-third of the JSY beneficiaries had registered themselves within first semesters. Almost half of the JSY beneficiaries stayed for 1-3 days in the facility after delivery on the other hand those stayed more than 3 days in the health facility was 33 percent. Two fifths of the JSY beneficiaries received the cash incentive at the time of delivery or within a week after delivery.

## **International Studies on Non Institutional Delivery**

A Survey of Home Delivery and Newborn Care Practices among Women in a Suburban Area of Western Nigeria, Lamina Mustafa Adelaja, Department of Obstetrics and Gynaecology, Olabisi Onabanjo University Teaching Hospital, P.M.B. 2001, Sagamu 12001NG, Ogun State , Nigeria Department of Obstetrics and Gynaecology, Gizan General Hospital, Gizan, Jasan Region, Saudi Arabia.

In the study, 200 (66.7%) out of 300 home deliveries were planned, and, in 153 (76.5%) of these planned home deliveries, the reasons cited by the mothers were “I prefer home delivery,” “home delivery is easy and convenient,” and “all my previous deliveries were at home.” In our study, 100 (33.3%) home deliveries were unplanned. The common reasons cited for unplanned home deliveries were “precipitate labor” (57.0%), “lack of transportation” (21.0%), and “lack of escort during labor” (5.0%). “Worries about cost of care in the hospital” and “financial problems at home” (13.7%), “distance of the hospital” (2.7%), family members preference for home delivery (1.7%), and “before the expected date” (0.7%) were also mentioned as the reasons for delivering at home.

Home Delivery and Newborn Care Practices among Urban Women in Western Nepal: A Questionnaire Survey Reasons for delivering at home. In the study, 140 out of 240 home deliveries (58.3%) were planned and in 91 (65.0%) of these planned home deliveries the reasons cited by the mothers were 'I prefer home delivery', 'home delivery is easy and convenient' and 'all my previous deliveries were at home'. In the study, 100 (41.7%) home deliveries were unplanned. The common reasons cited for unplanned home deliveries were 'precipitate labor' (51.0%), 'lack of transportation' (18.0%) and 'lack of escort' during labor (11.0%). Financial problems at home' and 'worries about cost of care in the hospital (11.3%), distance of the hospital' (6.7%), 'fear about hospital' (2.5%) and 'family members' preference for home delivery' (2.5%) were also mentioned as the reasons for delivering at home.

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## CHAPTER 3 - METHODOLOGY

Research is defined as a systemized effort to gain new knowledge. It aims at researching more relevant facts from the existing facts. It is actually movement from the known to the unknown. It involves the systematic methods consisting of enunciating the problem formulating as a hypothesis, collecting facts and reaching certain conclusions either in the form of solutions towards the concerned problems or in central, generation for the same theoretical formulations.

Methodology is defined as the analysis of the principles of methods rules and postulates employed by a discipline or the “development of methods to be applied within a discipline.

Research methodology is a way of systematically solving the research problem. Research methodology refers to various sequential steps adopted by a researcher is studying the problem with certain objectives in mind.

In this study the researched has used various scientific methods, structure, strategy, plan, tools to conduct the study. This chapter deals with the methodology selected by the investigator in order to study the research problem.

### **Statement of problem**

A study on Identifying Causes for Non-Institutional Deliveries among Beneficiaries of National Rural Health Mission in Bellary District Karnataka State. The National Rural Health Mission was designed to address several of the health needs of Rural people. This study covers pregnant women who in spite of receiving benefits available under National Rural Health Mission and do not undergo delivery procedure in Medical hospital or Primary Health Centers. This study looks at this problem.

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## **Operational definition**

Non Institutional Delivery:

The process of giving birth to baby by pregnant women at a place other than health institution is known as non-institution delivery

National Rural Health Mission (NRHM)

It is a government mission which has an overall objective of architectural correction of the health system and to improve access to rural people, especially poor women and children to equitable, affordable, accountable and effective primary health care throughout the country, which have weak public health indicators and/or weak infrastructure.

## **Beneficiary**

A beneficiary is one who receives services or gets benefit from the National Rural Health Mission may be individual or community.

## **Monetary Benefits**

Who receives financial incentives along with the free medical services

## **Non-monetary benefits**

Who receives only free medical services.

## **Aim of the study**

The Study aims to find out the various social, economic and cultural factors associated with the non-institutional deliveries and reasons for non utilization of National Rural Health Mission benefits. The study included women who delivered at home during the April and May months of 2011.

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### **Objectives of the study**

- To find the Socio- Economic, education, occupation profile of participants.
- To find out the financial and non-financial benefits received under National Rural Health Mission.
- To find out the reasons why the beneficiaries of National Rural Health Mission undergo non-institutional deliveries and also to find out the factors which prevented in the utilization of Government services.
- To find out the social, cultural, economical and other factors related to non-institutional delivery.
- To find out whether the women who have undergone non institutional deliveries have received the prenatal and postnatal care and whether the deliveries which took place at home was attended by skilled medical personnel.
- To find out whether non institutional deliveries caused any medical complications to mother & child.
- To find out the indigenous practices related to pregnancy, antenatal, postnatal care among participants of non-institutional deliveries.

### **Scope of the study**

This study will find out the reasons for not utilizing the Government facilities like free institutional deliveries and delivery related services and reasons associated with non-institutional deliveries.

The study will enable the researcher to provide suitable suggestions to improve the activities in order to create demand generation among the community by filling gaps noted during the study.

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## **Research design**

Research design is a systematic plan prepared for directing a research study. A research design is the program that guides the researcher in the process of collecting, analyzing and interpreting the findings of the study.

The researchers has adopted the descriptive research design for this study. Descriptive is the exploration of the existing phenomena. Descriptive research also known as a statistical research, describes data and the characteristics about the population or phenomenon being studied.

The researcher used this design because it enables to describe the socio/cultural barriers associated with non-institutional/hospital deliveries and it is also helps in understanding indigenous/traditional practices related to deliveries, prenatal, postnatal care in their communities.

It is an effective design to understand the socio-demographic profile of the participants and family members. It is quantitative study; the researcher has used scientific tools to collect data as well as measures the variables and used statistics to compile the data.

## **Sampling size and method**

The researcher collected the data in Bellary district of Karnataka State. It was decided to collect the data from the women, who delivered at home during the months of April & May 2011 in Bellary District. As per the data obtained from the District, Health & Family Welfare Office, Bellary, i.e., secondary source. There were 486 home deliveries during that period. The total delivery including home delivery in the district are 4,126 i.e., 12% of home deliveries occurred in the district. The average home deliveries of Karnataka is 6%. The home deliveries in Bellary District is more than average State home deliveries.

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In order to have a sample size of 20% of the home deliveries in the District, it was limited to 100 home deliveries while collecting data. The researcher gathered 102 participants during the time of survey.

Bellary District has 7 taluks. The home deliveries were maximum in Sandur (201 deliveries) and Hospet taluk(84 deliveries) respectively and least in Kudligi & Bellary Taluks. Only these 4 taluks were taken up for the purpose of collection data for the study.

In view of difficulties of locating the participants due to the non availability of exact address/location it was decided to have Snow ball method (non-probability sampling) was used.

### **Exclusion and inclusion criteria**

The data has been collected from the participants, who have delivered at other than health institutions. They were all beneficiaries of National Rural Health Mission and belonged to Bellary District. The deliveries must have occurred two months prior to the date collection.

The people who are delivered at the Hospital, those who not beneficiary of the National Rural Health Mission due to several conditions and not a resident of Bellary District has been excluded from the study.

### **Sources of data**

One of the important stages in the research process is data collection. The researcher used both primary and secondary methods of data collection. Primary method was used to collect data from the participants. For primary data structured schedule was used and interview method was adopted to elicit the answers.

Secondary source of data have been collected from the articles from Government evaluation report, journals and review of articles from research data bank.

## **Tool**

In order to frame the schedule the researcher discussed the problem of the study with various technical persons in the Department of Health and Family Welfare, Research scholars working in the Department of Public Policy in Indian Institute of Management, Bangalore and the field staff concerned with the problem. After framing the schedule, it was revised on the instructions and the guidelines of the guide.

The schedule was pre-tested and finalized after making necessary modification. The schedule contains three parts. The first part contains questions related to the background characteristics of the participants including age, her age at marriage, religion, caste, tribe, education and her work. In the second part, detailed information is sought on the awareness and benefits received from National Rural Health Mission. In the third part, main reasons for the non-institutional deliveries, survival status of children and the information related to antenatal care, postnatal care such feeding practices was sought.

## **Data analysis**

Statistical method SPSS version 15, MS Excel, word has been used for analysis and interpretation of data, to know the details and causes by using numerical values. The chi-square test was also used.

## **Ethical considerations**

- The researcher obtained consent from the participants and their family.
- Confidentiality was maintained with respect to the identity of the participant.

- Participation was voluntary.
- The researcher has given credit to the authors, whenever their contributions was used for the study.

### **Chapterization**

The study consists of the following chapters.

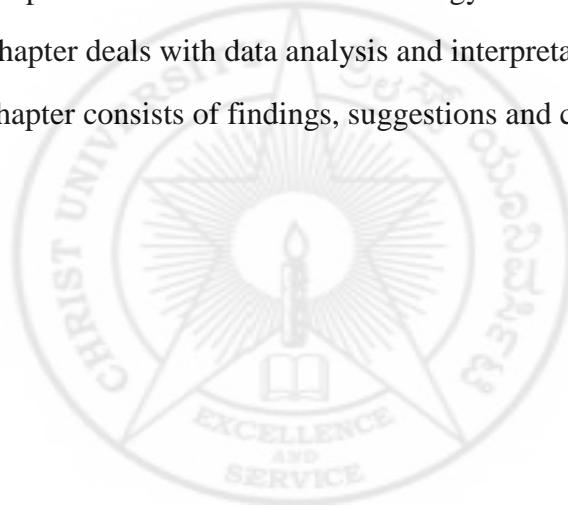
Chapter I: Introduction to the study about non institutional delivery, reasons and introduction, purpose of National Rural Health Mission.

Chapter II: This chapter details with review of literature.

Chapter III: This chapter includes research methodology.

Chapter IV: This chapter deals with data analysis and interpretation.

Chapter V: This chapter consists of findings, suggestions and conclusions.



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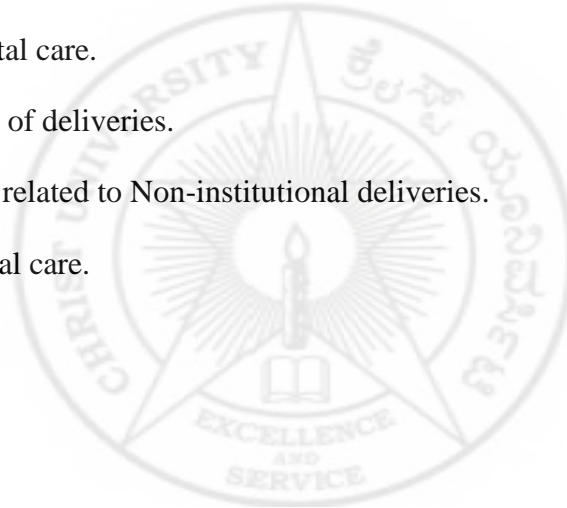
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## Chapter 4: Analysis and interpretation

Analysis of data is a process of inspecting, transforming, and modeling data with the goal of highlighting useful information, suggesting conclusions, and supporting decision making. Data analysis has multiple facets and approaches, encompassing diverse techniques under a variety of names, in different business, science, and social science domains.

In this chapter the tables and interpretations are arranged as per the objectives of the studies and the order is follows:

1. Personal profile of participants.
2. Awareness and benefits related to National Rural Health Mission.
3. Antenatal care.
4. History of deliveries.
5. Details related to Non-institutional deliveries.
6. Postnatal care.



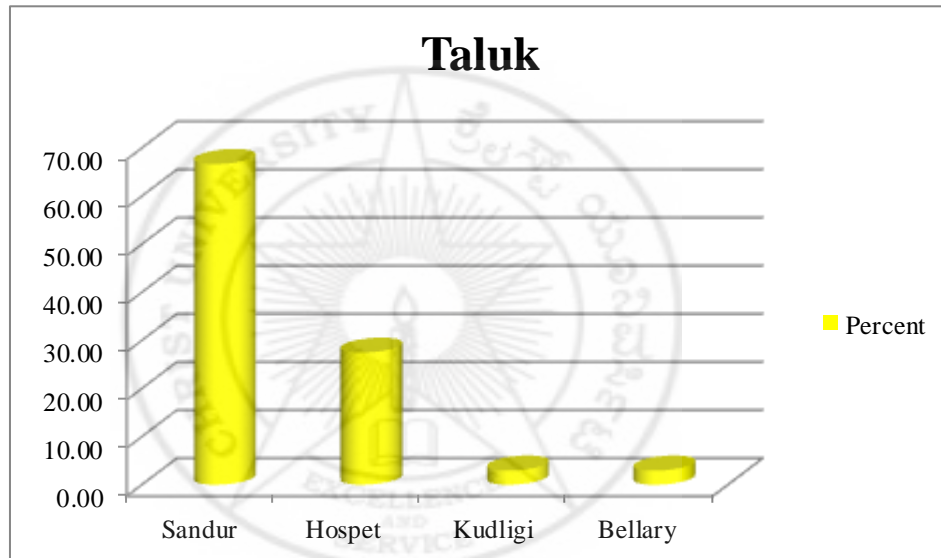
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## Personal profile

**Table 4.1: Showing the Distribution of Taluks to which the participants belong**

Taluk	Frequency	Percent
Sandur	68	66.67
Hospet	28	27.45
Kudligi	3	2.94
Bellary	3	2.94
<b>Total</b>	<b>102</b>	<b>100.00</b>



**Graph: 4.1**

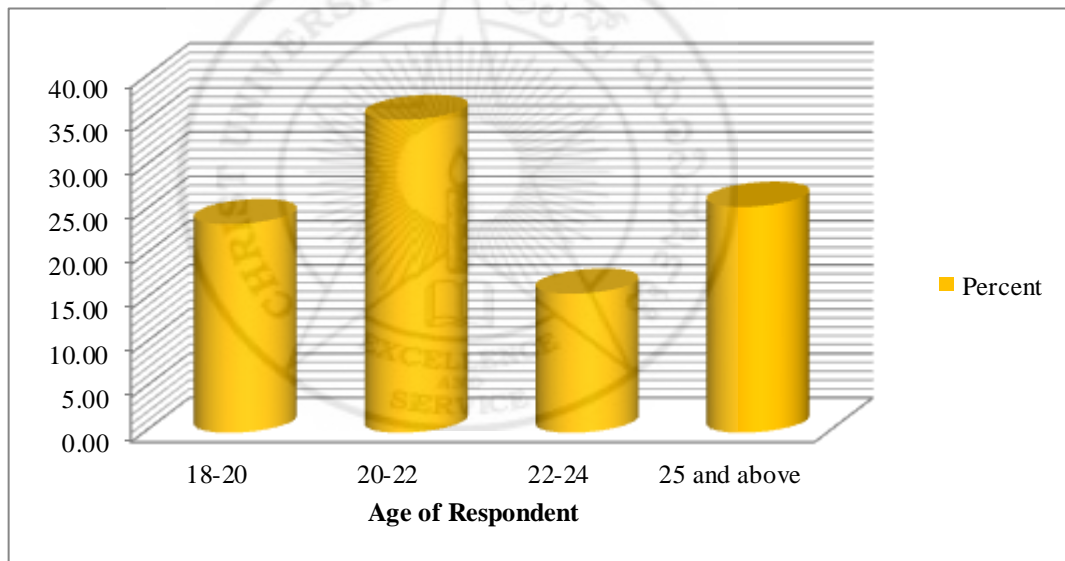
The table 4.1 indicates participants belonging to different taluks of Bellary District. 6% participants belong to bellary and kudligi taluks respectively. The Hospet Taluk represents 28% of the participants and Sandur represents 67% of the participants of the study. In Bellary District, Sandur taluk is the poorest performer of National Rural Health Mission programme and this taluk records 70% of total home delivery in the District. The Kudligi and Bellary Taluk are the best performers of National Rural Health Mission in Bellary District.

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**Table 4.2: Showing distribution of participants by Age and the Age of Marriage**

Sl. No	Personal detail	Years	Frequency N=102	Percentage	Average Age
4.2 (1)	Age	18-20	24	23.53	22.18 years
		20-22	36	35.29	
		22-24	16	15.69	
		25 and above	26	25.49	
4.2 (2)	Age of marriage	Below 18	84	82.35	17.12 years
		Above 18	18	17.65	



**Graph: 4.2**

The first segment of the table 4.2 (1) shows that 36% of participants belong to age group in the range of 20-22 years followed by 26% of participants belonging to the age group of 25 years and above, 23% of participants belong to age group in the range of 18-20 years and only 15% participants belong to age group in the range of 22-24 years. The average age is 22(21.78) years.

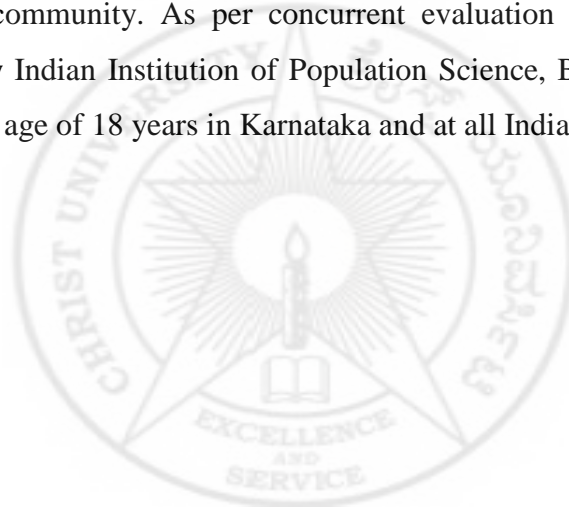
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Table reveals that 60% of the participants belong to age group in the range of 18-22. The age between 18 to 22 is the most fertile reproductive age as indicated by Navaneetham K & Rajan S, (2005) in their study 'Maternal Mortality in India'.

The second segment of the table 4.2 (2) reveals the age at which participants were married. It reveals 82% of the participants were below 18 years of age when they got married. only 18% of the participants married after attaining 18 years of age The average age of marriage is 17.12 years.

As per the Hindu Marriage act, the age at marriage for girl, is 18 years. The data shows most of the women who delivered at home were married below 18 years of age. Some of the participants were married at the age of 15 years. The socio-cultural factors of the participants community have a greater impact on these families, as early marriage is a custom in these community. As per concurrent evaluation of National Rural Health Mission (2010) by Indian Institution of Population Science, Bombay, 65.3% of women married before the age of 18 years in Karnataka and at all India level it a 43.2%.

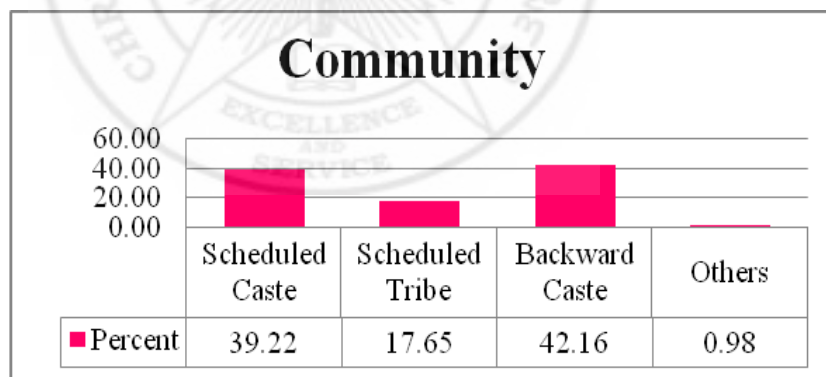


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**Table 4.3: Showing the details of Religion, Community and type of Family of the participants.**

Sl. No	Socio-demographic details	Category	Frequency N=102	Percentage
4.3 (1)	Religion	Hindu	90	88.24
		Muslim	12	11.76
4.3 (2)	Community	Scheduled Caste	40	39.22
		Scheduled Tribe	18	17.65
		Backward Caste	43	42.16
		Others	1	0.98
4.3 (3)	Family	Nuclear	44	43.14
		Joint	58	56.86



**Graph: 4.3**

The first segment of the table 4.3 (1) shows that majority of the participants belongs to Hindu religion and only 12% of the participants belong to Muslim community. Bellary district is constituted of 90% Hindu population and only 10% of the population consists of minorities. This is represented in the samples of the study.

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The second segment of the table 4.3 (2) reveals that 39% of the participants belong to Scheduled caste, 18% belongs to Scheduled Tribe and 42% of the participants represent Backward caste and only 1% of the participant belong to forward community.

The highest number of non institutional deliveries occur in backward community. The data shows that most of the home deliveries occurs in Scheduled Caste and Tribes, Backward communities and only 1% of the participant belong to forward communities.

Pathfinder International (2007) in their study on improving access to safe maternal care and services in northern Karnataka, states that 70% of the people belonging to Backward community, Scheduled Caste and Tribes are not utilizing the Government services for Maternal and Child care.

Muthurayappa R, Yoganand C, & Prabhuswamy P (2001) in their study Maternal health care conducted in Koppal, Gadag and Raichur Districts, reveal that among the total deliveries that occur at home, 90% of these deliveries occur among the Schedule Caste, Schedule Tribe, and Backward communities.

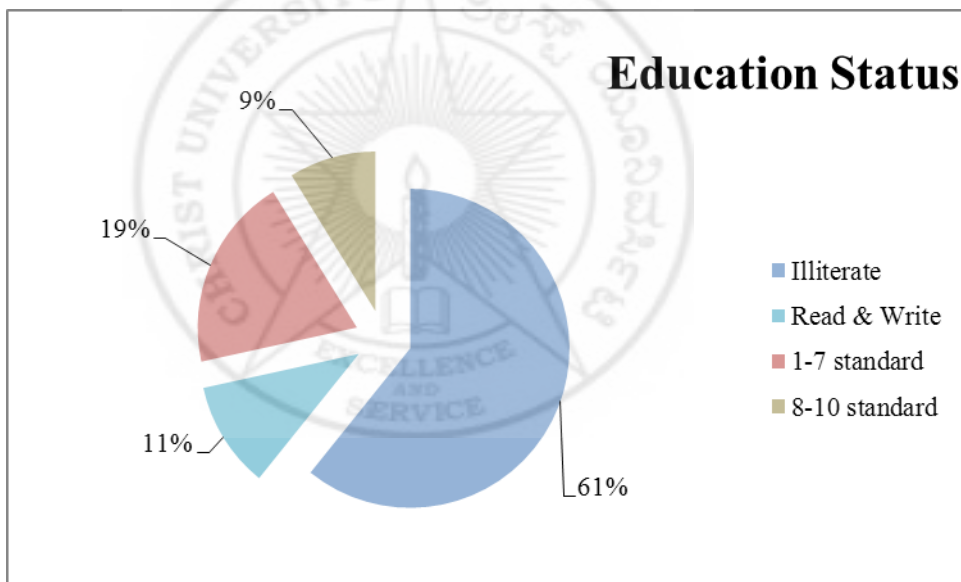
The third segment of the table 4.3 (3) shows that 57% of the participants belong to Joint Family and only 43% of the participants belong to Nuclear Family. From the data it may be seen home deliveries occurring in Joint Families, could be because decision making authorities in the Joint families will be with elders. Slightly larger percentage of home deliveries is seen in joint families, surprisingly even in nuclear families where there is no family support, women prefer to deliver at home.

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**Table 4.4: Showing the details of Education and Occupation status of the Participants**

Sl. No	Socio-demographic details	Category	Frequency N=102	Percentage
4.4 (1)	Education	Illiterate	62	60.78
		Read and Write	11	10.78
		1-7 standard	20	19.61
		8-10 standard	9	8.82
4.4 (2)	Occupation	House wife	47	46.08
		Working	55	53.92



**Graph: 4.4**

The first segment of the table 4.4 (1) deals with the educational details, it shows that 61% of the participants are illiterates followed by 11% of the participants who can read and write (only signature), the 20% of the participants have completed 7<sup>th</sup> Standard and 9% of the participants have completed their 10<sup>th</sup> Standard.

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This table reveals that majority of the participants in the study are illiterates. Muthurayappa R, Yoganand C, & Prabhuswamy P (2001) in their study on Maternal

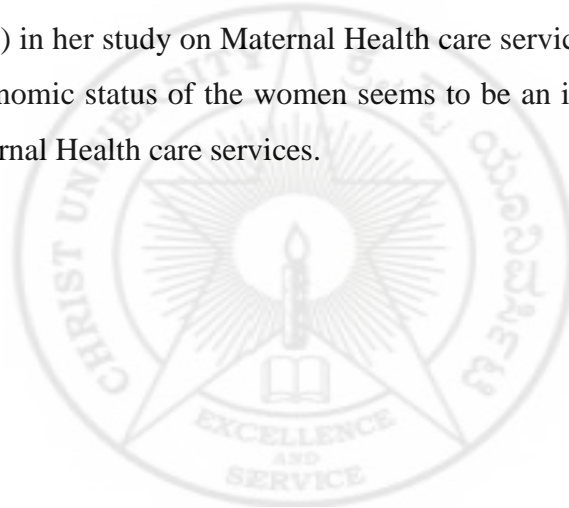
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health care in 3 Districts of Karnataka mentions that 90% of the non institutional deliveries occur where literacy rate is low.

Raju, K.N. & M. Rayappa (2008) in their study, Normative and Actual provision of antenatal healthcare services in Karnataka mention that the percentage of women receiving all essential antenatal care services is higher among literates and it is lower among the illiterate women.

The second segment shows that 46% of the participants are housewives and 54% of the participants are engaged in some occupation. From this data we can conclude that majority of the participants are economically dependent on their family members. This may be considered as one of the reasons for non-institutional delivery.

Sivakami M (2002) in her study on Maternal Health care services in Karnataka states that education and economic status of the women seems to be an important in enhancing the utilization of Maternal Health care services.



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**Table 4.5: Showing the details of Education and Occupation of Spouses of the participants**

Sl. No	Socio-demographic details	Category	Frequency N=102	Percentage
4.5 (1)	Spouse's Education	Illiterate	63	61.76
		Read & write	11	10.78
		1-7 Standard	15	14.71
		8-10 standard	12	11.76
		Degree/Diploma	1	0.98
4.5 (2)	Spouse's Occupation	Agriculture labour	46	45.10
		Artisans	10	9.80
		Animal Husbandry	30	29.41
		Others	16	15.69

The first segment of the table 4.5 (1) shows that 62% of the spouses of the participants are illiterates followed by 11% who are able to read and write (only signature), 14% of the spouses of participants have completed 7<sup>th</sup> Standard and only 12% of the husbands have completed their 10<sup>th</sup> Standard and 1% of the spouses have completed graduation.

This table reveals that majority of the spouses of participants in the study are illiterates.

Sivakami M (2002) in her study on Maternal Health care services in Karnataka states that educational status of the family of women seems to be an important one in enhancing the utilization of Maternal Health care services.

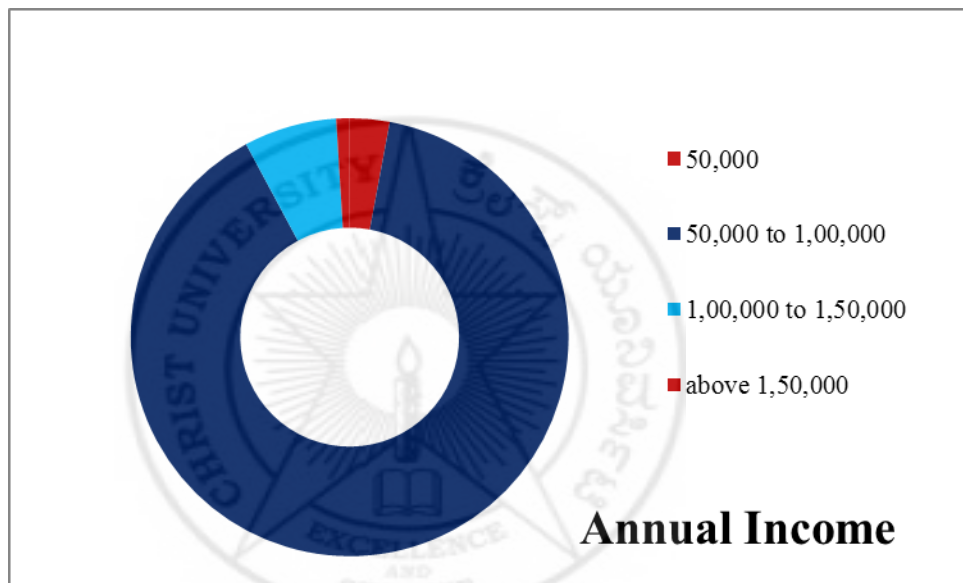
The second segment of the table 4.5 (2) shows that 45% of the spouses of participants are involved in Agriculture activities and 30% of the spouse are involved in Animal Husbandry. 16% of the spouses of participants is involved in other occupation and 10% of spouses are Artisans.

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**Table 4.6: Showing the details of annual income of the family**

Annual Income (Rs.)	Frequency	Percent
50,000	3	2.94
50,000 to 1,00,000	91	89.22
1,00,000 to 1,50,000	7	6.86
above 1,50,000	1	0.98
<b>Total</b>	<b>102</b>	<b>100.00</b>



**Graph: 4.5**

The table 4.6 reveals that 89% of the families of participants have an annual income in the range of Rs. 50,000 to 1,00,000 and 7% of the families have an annual income in the range of Rs. 1,00,000 to 1,50,000 and only 3% of the families of participants have an annual income of less than Rs. 50,000 and only 1 family shows an annual income of Rs. 1,50,000 and above.

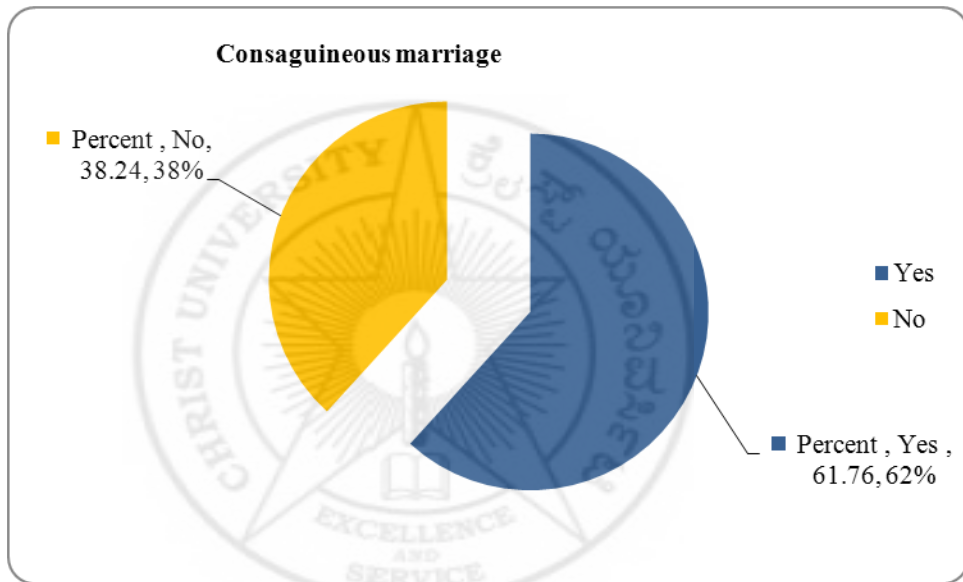
The data shows that 97% of the participant families annual income is in range of Rs. 50,000 to 1,50,000.

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**Table 4.7: Showing the details of consanguineous marriage & marriage within the village**

Sl. No	Marriage details	Category	Frequency N=102	Percentage
4.7 (1)	Consanguineous marriage	Yes	63	61.76
		No	39	38.24
4.7 (2)	Married within the village	Yes	34	33.33
		No	68	66.67



**Graph: 4.6**

The first segment of the table 4.7 (1) shows that 62% of the participants marriage is consanguineous and 38% of the participants marriage is non-consanguineous. The data reveals that home deliveries are higher in consanguineous marriages. According to tradition in India most families get there children married to close relatives.

The second segment of the table 4.7 (2) shows that 34% of the participants are married within the village and 66% of the participants married in outside their village community.

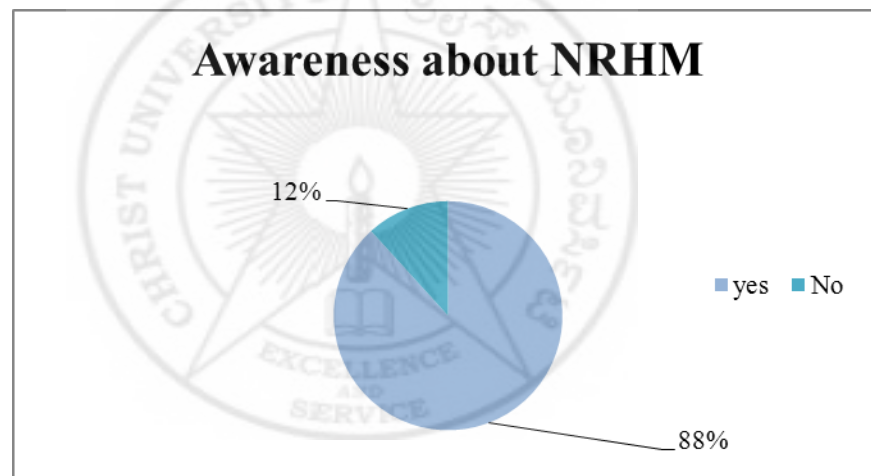
Suresh 2009 in there study of Indian families mentions that in Scheduled Caste and Tribes, and in backward communities consanguineous marriages are more and in these communities marriages within the villages also a custom or traditional practices.



**Awareness and benefits related to National Rural Health Mission.**

**Table 4.8: Showing the awareness about NRHM**

Sl. No	About NRHM	Category	Frequency	
			N=102, N==90	Percentage
4.8 (1)	Awareness about NRHM	Yes	90	88.24
		No	12	11.76
4.8 (2)	Benefits of NRHM	Cash Benefit	74	82.22
		Health services in Rural Areas	8	9
		Advanced health care	8	9



**Graph: 4.7**

The first segment of the table 4.8 (1) shows that 89% of the participants are aware about National Rural Health Mission programme, which is designed to provide better and quality healthcare services, especially for poor and vulnerable people, 11% of the participants are not aware about National Rural Health Mission. This shows that 11% of the participants not aware about NRHM even after receiving benefits from NRHM.

The second segment of the table 4.8 (2) shows that 82% of the participants believe that National Rural Health Mission is for providing cash benefits only. 9% of the participants are aware that National Rural Health Mission is dedicated to providing better healthcare

services in rural areas and 9% of the people aware that National Rural Health Mission is providing advanced healthcare.

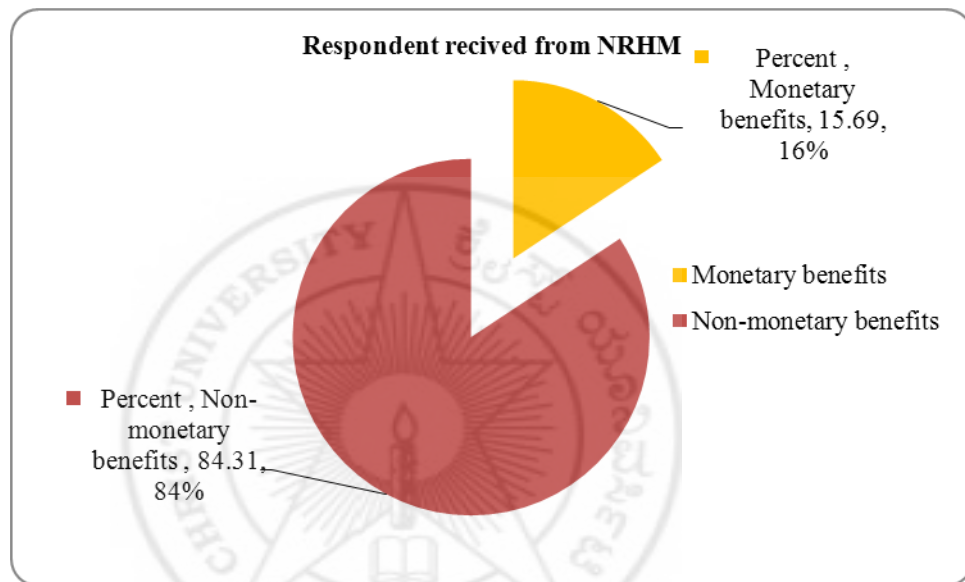


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**Table 4.9: Showing the type of benefit received from NRHM**

Participant received	Frequency	Percent
Monetary benefits	16	15.69
Non-monetary benefits	86	84.31
<b>Total</b>	<b>102</b>	<b>100.00</b>



**Graph: 4.8**

The table 4.9 shows that 16% of participants benefited from monetary benefits 84% of the participants benefited from non-monetary benefits.

Under National Rural Health Mission cash benefits like Janani Suraksha Yojana, Prasuthi Arike will be provided only for first two deliveries. In this study 49% of the participants (50 persons) are eligible for cash benefit scheme. But only 16% of participants (16 persons) have received Cash Benefits from National Rural Health Mission. Nearly 33% of the participants could not receive cash benefits under National Rural Health Mission. Nearly 51% of the participants were not eligible for cash benefits, because they have undergone more than two deliveries.

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The reason for not benefiting from NRHM are:

- More deliveries than prescribed in the NRHM.
- 51% Participants delivery is more than two deliveries.
- Non availability of Budget.
- Improper documentation provided by the participants.

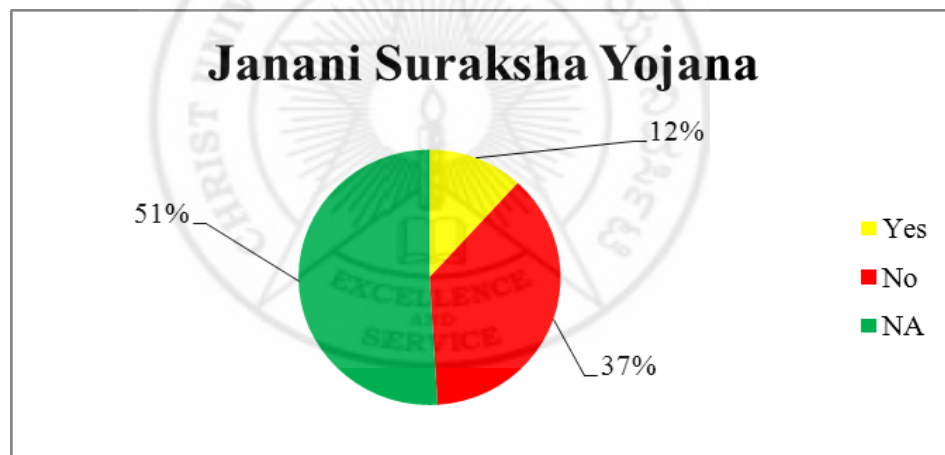


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**Table 4.10: Showing the detail number of participants benefiting from Janani Suraksha Yojana, Madilu kit and Prasuthi Arike.**

Sl. No	Benefits	Category	Frequency N=102	Percentage
4.10 (1)	Janani Suraksha Yojana	Yes	12	11.76
		No	38	37.25
		Not eligible	52	50.98
4.10 (2)	Madilu Kit	No	50	49
		Not eligible	52	51
4.10 (3)	Prasuthi Arike	Yes	3	2.94
		No	47	46.07
		Not eligible	52	50.99



**Graph: 4.9**

The first segment of the table 4.10 (1) shows that Janani Suraksha Yojana a cash benefit scheme is provided only for two deliveries, 50 beneficiaries are eligible for this scheme, only 12 people (11.76%) have been benefited from this scheme and 37.25% of the participants have not benefited for this scheme. The non-availability of budget in the primary health centre and inadequate documentation provided by participants are the main causes for participants not getting benefits from this scheme.

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The second segment of the table 4.10 (2) reveals that 49% of the participants have not received Madilu Kit and 51% of the participants are not eligible for this scheme. The madilu kit consists of soaps and clothes for child and mother. As all the participants have delivered at home. This scheme is not available to them. The Madilu Kit is provided only for Institutional Deliveries.

The third segment of the table 4.10 (3) shows details related to prasuthi arike which is a cash benefit scheme which is providing for only first 2 deliveries. The case benefits are Rs. 1,000/- during third trimester of pregnancy and another Rs. 1,000/- within 48 hours of the delivery, 50 people are eligible for this scheme, only 3 people (3%) have been benefited from this scheme and 50% of the participants have not benefited for this scheme. The non-availability of budget in the primary health centre and inadequate documentation provided by participants are the main causes for participants not benefiting from this scheme.

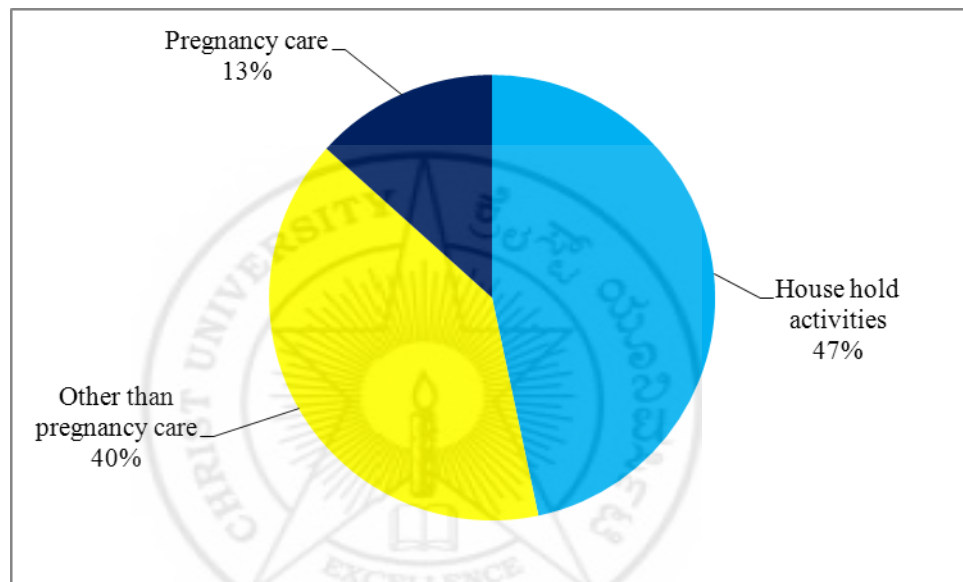
It is seen that 15 participants (15%) have received cash and 87 participants (85%) have received non-cash benefits under National Rural Health Mission. These participants have delivered at home inspite of these benefits.

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**Table 4.11: Showing utilization of cash benefits**

NRHM amount used for	Frequency	Percent
House hold activities	7	46.67
Other than pregnancy care	6	40.00
Pregnancy care	2	13.33
<b>Total</b>	<b>15</b>	<b>100.00</b>



**Graph: 4.10**

The table 4.11 shows that 46% of the participants who are benefited from cash schemes of National Rural Health Mission have used the amount for house hold activities, 40% of the participants have used the amount other than pregnancy care. Only 13% of the participants have used National Rural Health Mission amount for pregnancy and health checkups.

This table reveals that nearly 50% of the participants who have received cash benefits from the National Rural Health Mission have utilized this amount for household and non-pregnancy care activities.

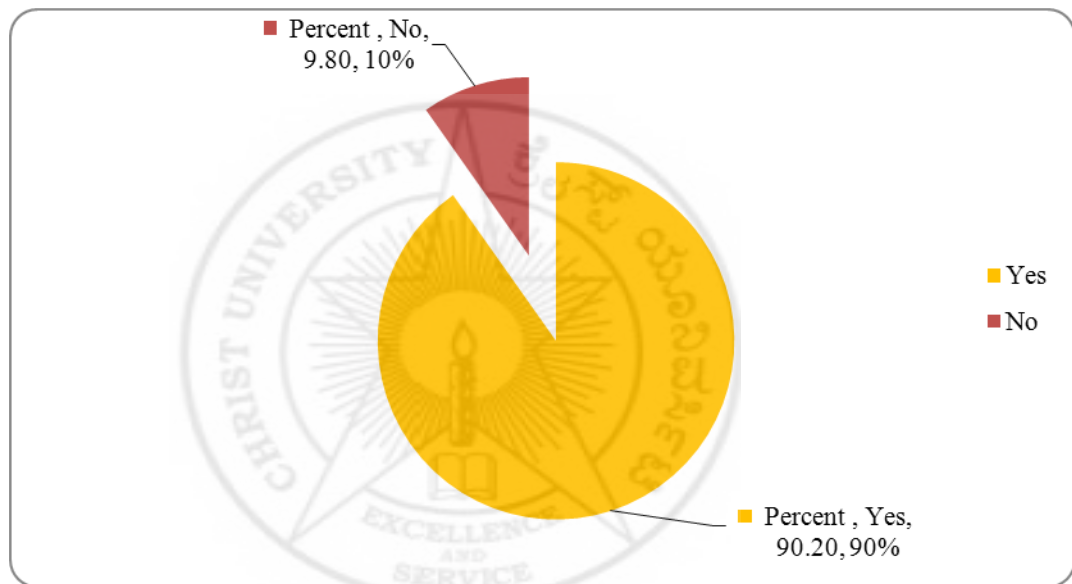
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**Non cash benefits/Antenatal care.**

**Table 4.12: Showing the visit of Auxiliary Nurse Midwife at home of participants.**

ANM visited your home	Frequency	Percent
Yes	92	90.20
No	10	9.80
<b>Total</b>	<b>102</b>	<b>100.00</b>



**Graph: 4.11**

The table 4.12 shows that 90% of the participants received Auxiliary Nurse Midwives services at their doorstep during the pregnancy period, only 10% of the participants have not received Auxiliary Nurse Midwives visit during their pregnancy period.

Under National Rural Health Mission Auxiliary Nurse Midwife has to perform many activities like regular visit to the homes of pregnant women's irrespective of eligibility of criteria and has to provide necessary information like date of the immunizations, antenatal checkups, information about institutional deliveries and benefits of National Rural Health Mission. She has to maintain records of pregnant women in sub-centers and has to report for primary health centers. She has to regularly monitor the health status of



pregnant women and dates of delivery along with this activities, she has to co-ordinate with ASHA workers in respective villages.

The above data indicates that 90% of the participants homes have been visited by Auxiliary Nurse Midwives. With all these advantages and information from Auxiliary Midwives the participants have still undergone non-institutional deliveries.

Sagir, Afrin, Swaroop Thomas (2009) in their study Maternal and Child Health services in Karnataka stated that 90% of the women had at least three antenatal visits.

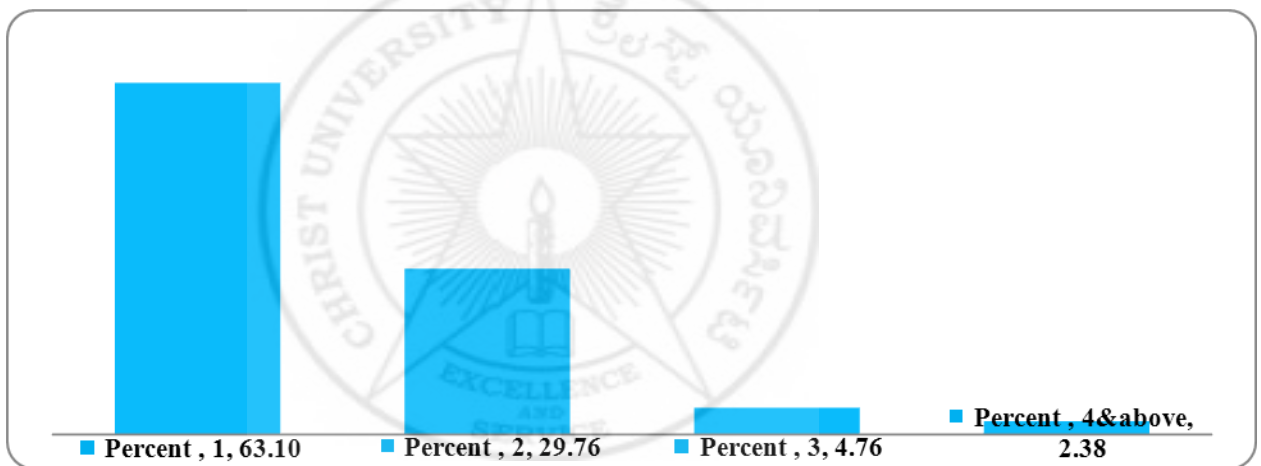


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**Table 4.13: Showing the details of participants visit to Primary Health Centre for antenatal checkup.**

Sl. No	Visits	Category	Frequency N=102	Percentage
1	Visit to PHC for Antenatal checkup	Yes	86	84.31
		No	16	15.69
2	No. of Antenatal checkup	1	53	63.10
		2	25	29.76
		3	4	4.76
		4 & above	2	2.38



**Graph: 4.12 – Showing the no. of ANC visited**

The first segment of the table 4.13 (1) shows that 86% of the participants visited Primary Health Centers for Antenatal checkup , only 16% of the participants have not visited Primary Health Centers Antenatal Checkup.

The visit to Primary Health Center is necessary because many pregnancies related checkups are conducted at the center and necessary treatment is provided, if any complications are identified during pregnancy. The data reveals majority of the participants visited for Primary Health Center but still they have undergone non-

institutional deliveries.

The second segment of the table 4.13 (2) indicates that 63% of the participants have visited Primary Health Centre only once for antenatal checkup during their pregnancy period and 30% of the participants visited the Primary Health Centers twice for Antenatal Checkups, the only 5% of the participants visited the Primary Health Centers three times for Antenatal checkup. Only 2% of the participants visited four or more times to the Primary Health centers during their pregnancy period.

Minimum 3 antenatal checkups/visits is necessary during pregnancy period, the above table indicates only 7% of the participants undergone more than 3 antenatal checkups.

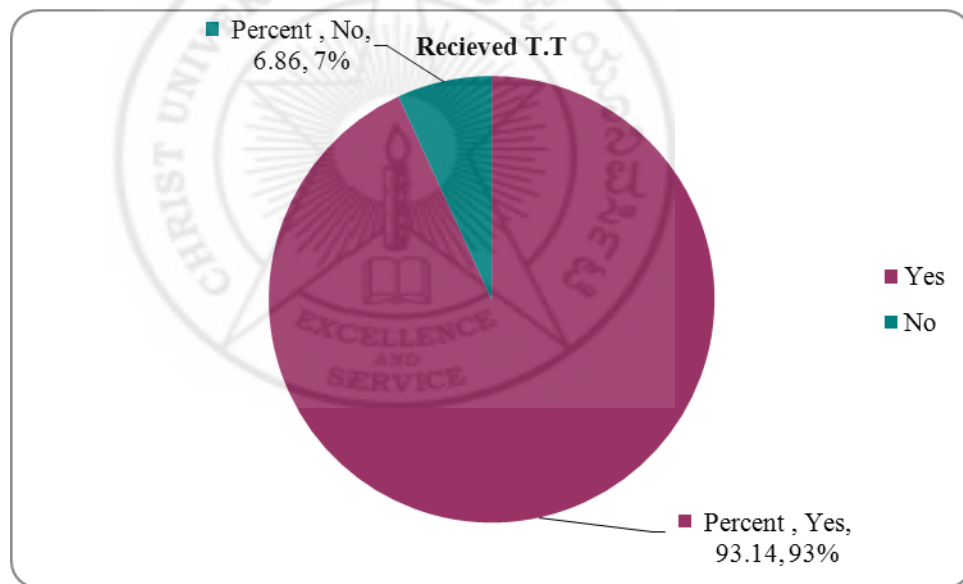


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**Table 4.14: Showing the details of medication and medical examination received during the pregnancy**

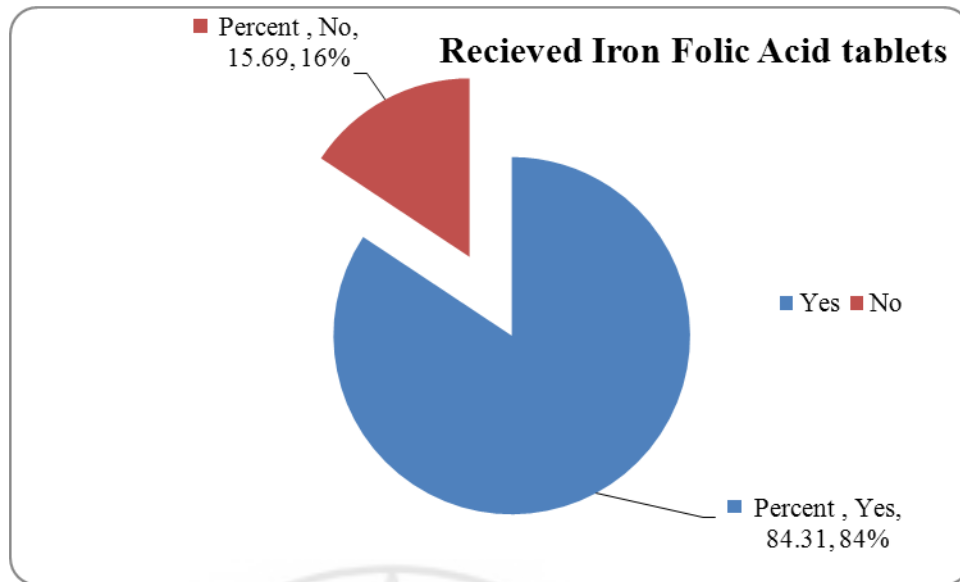
Sl. No	Details	Category	Frequency N=102	Percentage
4.14 (1)	Received T.T. Immunization	Yes	95	93.14
4.14 (2)	Received Iron & Folic Acid Tablets	Yes	86	84.31
4.14 (3)	Hemoglobin Estimation	Yes	88	86.27
4.14 (4)	Urine Test	Yes	84	83.00
4.14 (5)	BP Measurement	Yes	86	85.00



**Graph: 4.13**

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**Graph: 4.14**

The first segment of the table 4.14 (1) shows that 93% of the participants have received T.T immunization during their pregnancy, only 7% of the participants have not received T.T immunization during their pregnancy.

Metgud C.S, Katti (2009) in their study “Utilization of patterns of antenatal services among pregnancy women in rural Karnataka”, identified that 71% of the pregnant women received T.T. Immunization. The report of concurrent evaluation of National Rural Health Mission 2009, fact sheet of Karnataka indicates 98% of the pregnant women received T.T. Immunization.

The second segment of the table 4.17 (2) shows that 86% of the participants have received Iron Folic Acid Tablets during their pregnancy, only 16% of the participants have not received Iron Folic Acid Tablets during their pregnancy period.

Metgud C.S, Katti (2009) in their study “Utilization of patterns of antenatal services among pregnancy women in rural Karnataka”, identified that 60% of the pregnant women received Iron and Folic Acid Tablets.

The third segment of the table 4.14 (3) shows that 86% of the participants undergone Haemoglobin Estimation test during their pregnancy, only 14% of the participants are not undergone Haemoglobin Estimation test during their pregnancy.

The fourth segment of the table 4.14 (4) shows that 83% of the participants undergone Urine test during their pregnancy, only 17% of the participants are not undergone Urine test during their pregnancy.

The fifth segment of the table table 4.14 (5) shows that 85% of the participants undergone Blood Pressure Measurement during their pregnancy, only 15% of the participants have not undergone Blood Pressure Measurement during their pregnancy.

The Tetanus Taxied Injection is provided to prevent tetanus for mother and child, the blood pressure measurement is carried to know the blood pressure status during delivery, because blood pressure variation in pregnancy could lead to complications. An iron and Folic Acid tablet is provided to improve the hemoglobin status because during pregnancy. The hemoglobin count should be more than 12 mg. The lesser level hemoglobin will leads to complications.

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## History of Deliveries

**Table 4.15: Showing the history of deliveries.**

Sl. No	Delivery details	Category	Frequency	
			N=102, N==88	Percentage
4.15 (1)	Order of the present delivery	1 <sup>st</sup> delivery	14	13.73
		2 <sup>nd</sup> delivery	36	35.29
		3 <sup>rd</sup> delivery	30	29.41
		4 and above	22	21.57
4.15 (2)	Place of previous Delivery	Home	68	77.27
		Health Institution	20	22.73

The first segment of the table 4.15 (1) shows that 35% of the participants had delivered their second child, 29% who delivered the third child, 22% of the participants had delivered four times or more. Only 14% of the participants delivered for the first time. The average delivery rate is 2.58, which is much more than the State average.

There was one participant who delivered 13 children and it is fourteenth delivery for her. The above table shows that 51% of the participants had delivered 3 children or more. The State average stands at 1.9.

The financial incentives like JSY, Prasuthi Arike and Madilu are provided only for first 2 deliveries under National Rural health mission. From this data we can conclude only 49% of participants are, eligible for cash benefits from National Rural Health Mission.

The second segment of the table 4.15 (2) indicates that 78% of the participants have delivered at home previously and 22% of the participants previously delivered at hospitals.

Majority of the participants have experience of delivering at home, only 13.73% participants have delivered at home for first time

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**Table 4.16: Showing the details of Antenatal care.**

Sl. No	Delivery details	Category	Frequency	
			N=102, N==88	Percentage
4.16 (1)	Register of First Antenatal checkup	3 <sup>rd</sup> Month	5	4.90
		4 <sup>th</sup> month	63	61.76
		5 <sup>th</sup> Month	25	24.51
		After 5 <sup>th</sup> Month	9	8.82
4.16 (2)	Place of Antenatal checkup	Home	7	6.93
		Anganwadi	54	53.47
		Sub Centre	31	30.69
		PHC/CHC	10	9.50

The first segment of the table 4.16 (1) shows that 62% of the participants registered in 4<sup>th</sup> month of pregnancy for antenatal checkup. 25% of the participants registered at 5<sup>th</sup> month and 9% of the participants registered for Antenatal checkup only after 5 months .only 5% of the participants registered in 3<sup>rd</sup> month of pregnancy for antenatal checkup.

The data reveals that 95% of the participants have registered in the second trimester of their pregnancy cycle.

Navaneetham K & Dharmalingam in their study “utilization of maternal health care services in Southern India”, most of the antenatal checkup registration are in second trimester which means after third month. It is necessary that women have to register antenatal checkup in the third month for getting better health services. It was seen that 84% of ANCs had their registration & checkup at Anganwadi centers/Sub Centers, because anganwadi centers will be located in the villages, even village contains anganwadi centers.

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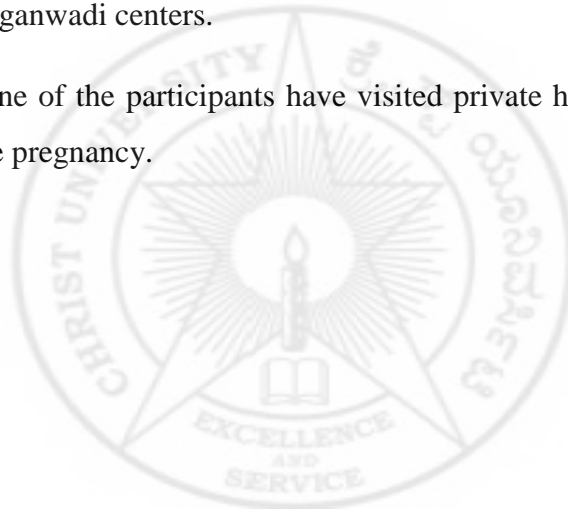


Metagud C.S., Katti (2009) in their study “Utilisation patterns of antenatal services among pregnant women: A longitudinal study in rural area of Karnataka state that the antenatal visits occur late in the pregnancy.

The second segment of the table 4.16 (2) shows that 54% of the participants have undergone their Antenatal checkups at Anganwadi Centers and 31% of the participants undergone their Antenatal checkup at Sub Centers. Only 10% of the participants have visited Primary Health Centers for their Antenatal checkups. About 7% of the participants have undergone their ANC at their house itself.

The above data reveals that 80% of the Antenatal care happens at Sub Centers and Anganwadi Centers, because Anganwadi’s and Sub Center are near to their homes. Each village contains anganwadi centers.

It is found that none of the participants have visited private hospitals for their antenatal checkup during the pregnancy.



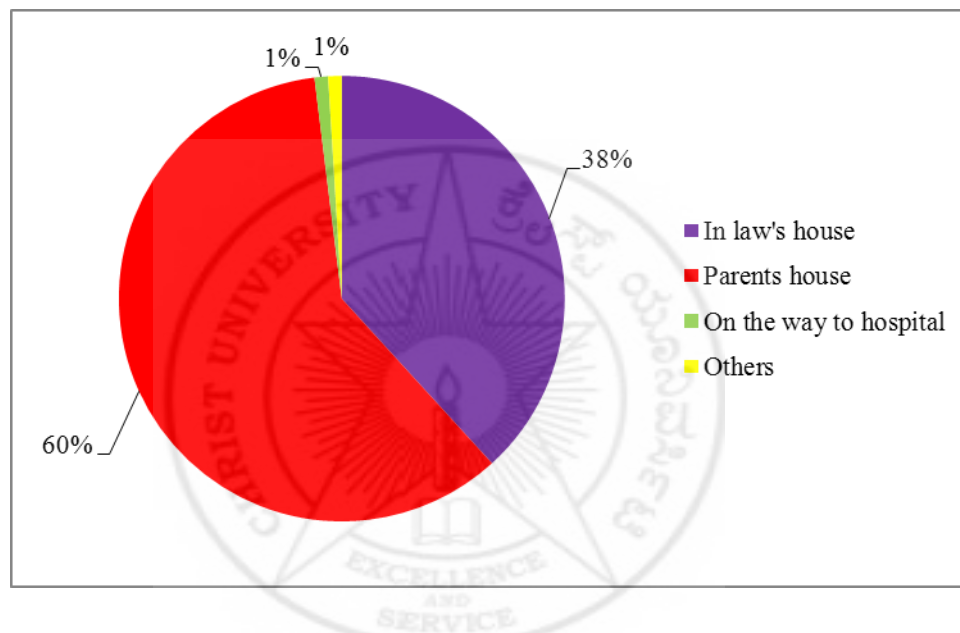
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**Details related to Non-institutional deliveries.**

**Table 4.17: Showing the details of place of delivery:**

<b>Delivered at</b>	<b>Frequency</b>	<b>Percent</b>
In law's house	40	39.22
Parents house	61	59.80
On the way to hospital	1	0.98
<b>Total</b>	<b>102</b>	<b>100.00</b>



**Graph: 4.15**

The table 4.17 shows that 60% of the deliveries have taken place in parents house of the respondent, 39% of the deliveries have taken place at in-law's house. 1% of deliveries are taken place on the way to the hospital.

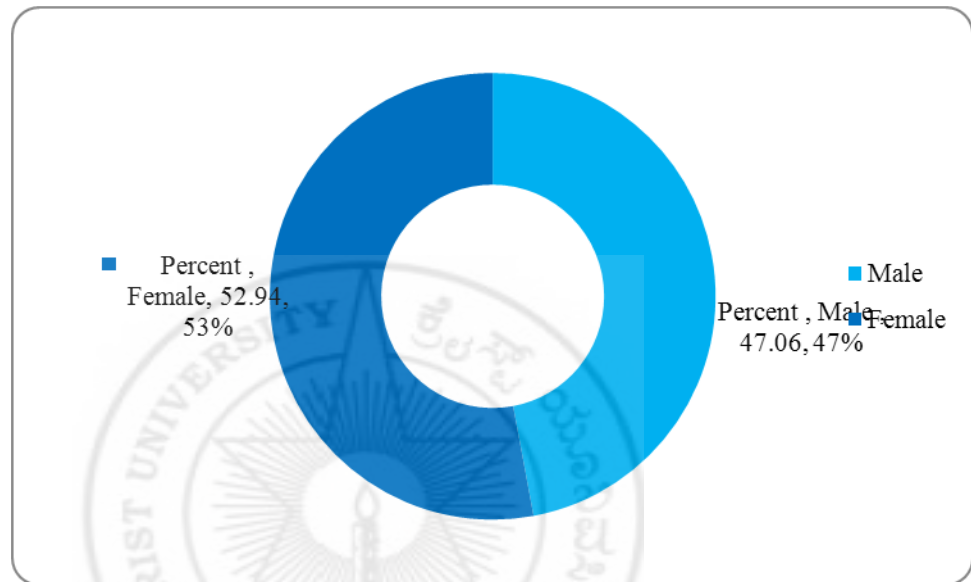
In Indian culture, the women normally deliver in the parent's house, the data shows that the majority of the participants received pre-antenatal care, pregnant care and delivery at parents house.

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**Table 4.18: Showing the sex of Child**

Sex of Child	Frequency	Percent
Male	48	47.06
Female	54	52.94
<b>Total</b>	<b>102</b>	<b>100.00</b>



**Graph: 4.16**

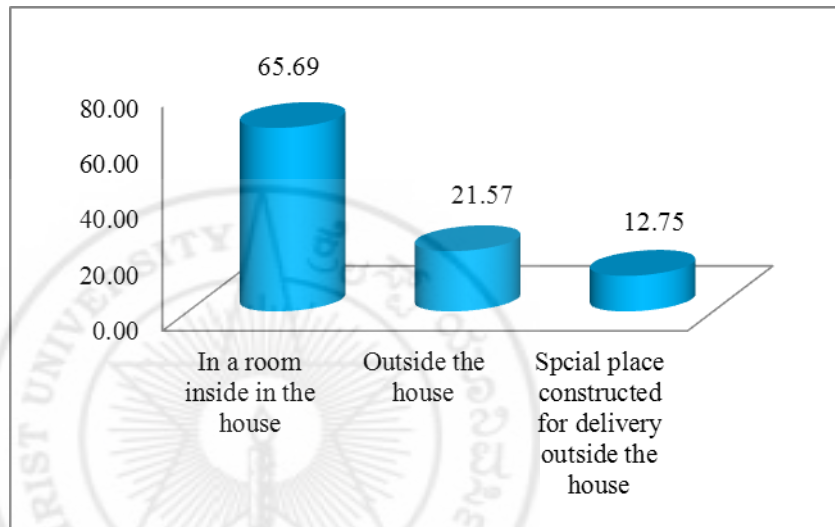
The table 4.18 shows that 53% of the participants who have delivered at home have female babies and 47% of the participants delivered male babies. From this data we can conclude that there is no major difference in the sex of the baby with reference to home deliveries.

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**Table 4.19: Location with the home where delivery has taken place.**

Delivery place in home	Frequency	Percent
In a room inside in the house	67	65.69
Outside the house	22	21.57
Special place constructed for delivery	13	12.75
<b>Total</b>	<b>102</b>	<b>100.00</b>



**Graph: 4.17**



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This table 4.19 reveals that 66% of the home deliveries occurred inside the houses, 22% of the deliveries occurred outside the houses & 13% of the deliveries occurred in special place constructed for conducting deliveries which is a practice in backward (Golla) communities.

This reveals that nearly 34% of the deliveries have not occurred in hygienic places, especially in backward communities (Golla) deliveries occurred outside the villages. A small hut is constructed where there is no ventilation and hygiene. The mother has to take care of herself and also has to take care of her child. In the Golla community the mother & baby not allowed into the house for 90 days after the delivery. They have to stay in the Special place constructed for them as show in above picture.

The proper health education especially behavioral change communication is necessary to eradicate these traditional practices in order to achieve 100% institutional deliveries.

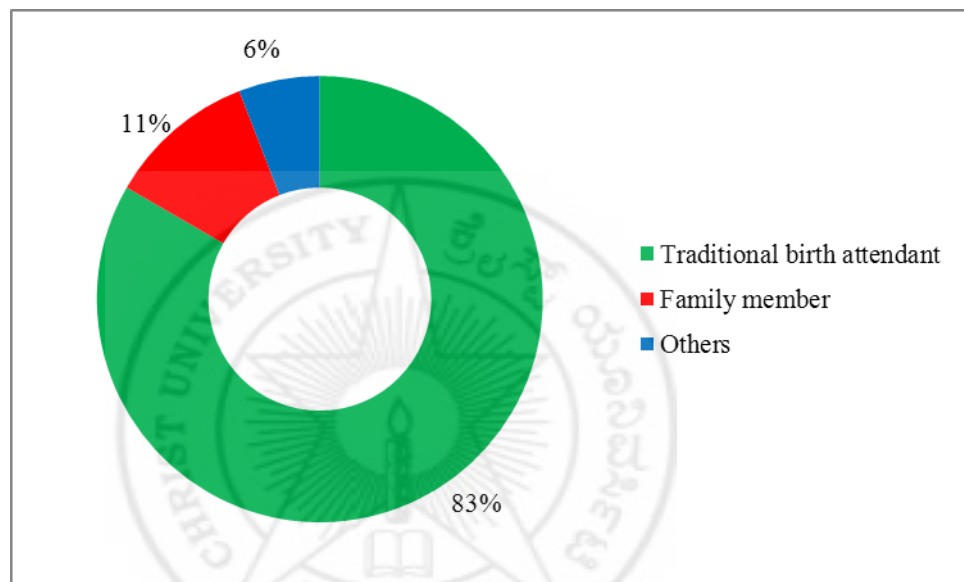


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**Table 4.20: Showing the information about who conducted delivery at home.**

<b>Delivery assisted by</b>	<b>Frequency</b>	<b>Percent</b>
Traditional birth attendant	85	83.33
Family member	11	10.78
Others	6	5.88
<b>Total</b>	<b>102</b>	<b>100.00</b>



**Graph: 4.18**

The table 4.20 shows that 83% of the home deliveries are conducted by traditional birth attendants who have not undergone any training in conducting deliveries, 11% of the deliveries are conducted by family members (mother, mother-in-law and other family members) and 6% of the deliveries conducted by others (neighbor, health assistant) .

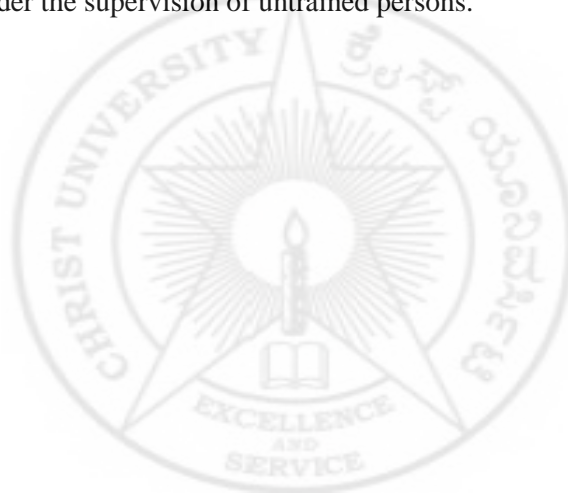
This data reveals that 99% of the home deliveries are assisted by un-trained persons, they don't have any formal training in conducting deliveries, 83% of the deliveries are attended by traditional birth attendants. They regularly attend to the deliveries in each village and they have the practice of conducting home deliveries since many years. These attendants use new blades for cutting the cord during delivery, to separate mother and child. 5 cleans namely, clean place, clean hands, clean blades, clean thread, clean stump are necessary for conducting safe delivery.

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The National Rural Health Mission provides many facilities like ASHA, who resides in each village, to monitor the pregnant women's reach and has to call ambulance or refer to nearby hospitals, but due to non co-operation of participant and her family members ASHA do not refer women to institutions.

Kumar, Dinesh, Goel (2008), in their study titled "Gap between awareness and practices regarding maternal and child health among women", indicate that there is 70% of awareness regarding birth attendants, but practiced only in 40% of cases. This shows there is a significant gaps between awareness and practices.

Concurrent evaluation of National Rural Health Mission 2009. Karnataka fact sheet indicates that with respect to the type of attendance at the time of delivery in case of home deliveries, data suggests that only 24% of the home deliveries are assisted by trained persons and majority 76% of them occurred under the supervision of untrained persons.

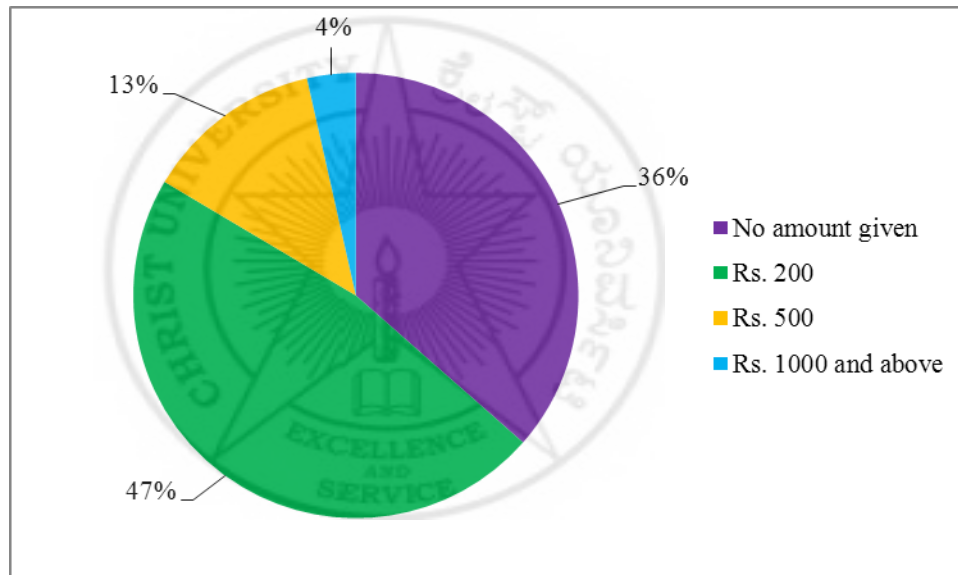


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**Table 4.21: Showing payment made to Traditional Birth Attendant**

<b>Amount given to Traditional Birth Attendant</b>	<b>Frequency</b>	<b>Percent</b>
No amount given	31	36.47
Rs. 200	40	47.05
Rs. 500	11	12.94
Rs. 1000 and above	3	3.52
<b>Total</b>	<b>85</b>	<b>100.00</b>



**Graph: 4.19**

This table 4.21 is in continuation with previous table, shows that 48% of the traditional birth attendant received an amount Rs. 200/- per delivery, 36% of the traditional birth attendants have not received payments for conducting deliveries, 13% of the traditional birth attendants received Rs. 500/- from participants and 3% of the participants received above Rs. 1,000/-.

The traditional birth attendants along with the money also receive food grains from the participants. From this table we observe that majority of the traditional birth attendants receives money from participants. In some villages health workers complained to the researcher that the

traditional birth attendants play major role in home deliveries. They prevent villagers/participants



to attend hospitals by telling false stories and creating fear and they also tell that hospital delivery is expensive and sometimes infant and maternal mortality may occur.

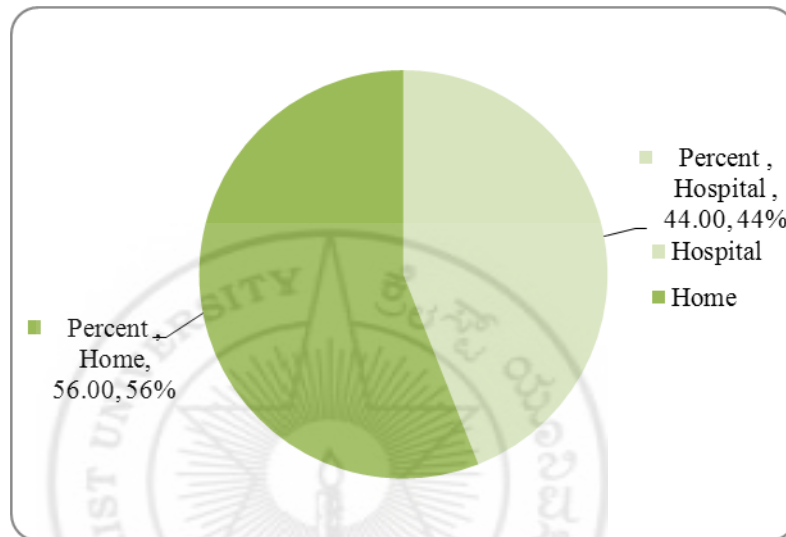


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**Table 4.22: Showing the decision made prior to delivery:**

Planned to deliver at	Frequency	Percent
Hospital	45	44.00
Home	57	56.00
<b>Total</b>	<b>102</b>	<b>100.00</b>



**Graph: 4.20**

The table 4.22 shows that 56% of the participant had planned to deliver at their home interestingly 44% of the participants planned for their deliveries at hospitals. From this we can conclude that nearly 56% of the participants had decided to deliver at home in spite of all the awareness programmes.

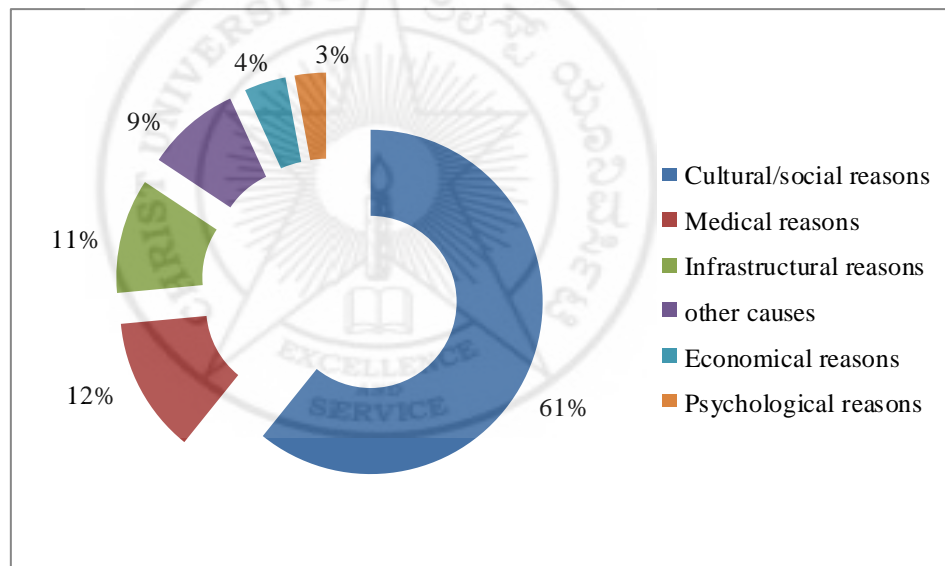
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**Details related to Non-Institutional Deliveries.**

**Table 4.23: Showing the reasons for non-institutional delivery**

Reasons for not going to the institutional delivery	Frequency	Percent
Cultural/social reasons	62	60.78
Medical reasons	13	12.75
Infrastructural reasons	11	10.78
Economical reasons	4	3.90
Psychological reasons	3	2.94
other causes	9	8.84
<b>Total</b>	<b>102</b>	<b>100.00</b>



**Graph: 4.21**

Table 4.23 shows 61% of the participants informed that they were not allowed to go to hospital for delivery due to cultural/community reasons. Due to infrastructural reasons 11% did not go to hospital for delivery where as 9% gave other reasons and 3% attributed to psychological reasons, 4% of the participants gave economical reasons as the cause for non delivery at hospitals and due to medical cause 13% of the participant not attended Institutional delivery.

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The reasons for not going to hospital deliveries are explained in detail under each of the causes in further tables. The above table clearly indicates that cultural/community reasons remain

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dominant reasons for home delivery. Hence, more focused health education for the participants and their family members is required to eradicate socio/cultural factors associated with non-institutional deliveries & it is also required to explain the benefits of institutional deliveries and complications of non institutional deliveries to the pregnant mother and her family.

The concurrent evaluation of NRHM 2009, Karnataka fact sheets suggests that customary/social reasons were most important reasons for having home deliveries. This was reported by about 56% of women. Non availability of transport to reach health facility was reported in 25% of cases. Fear of medical procedures and indifferent behavior of the staff in 19% of cases for non institutional delivery.

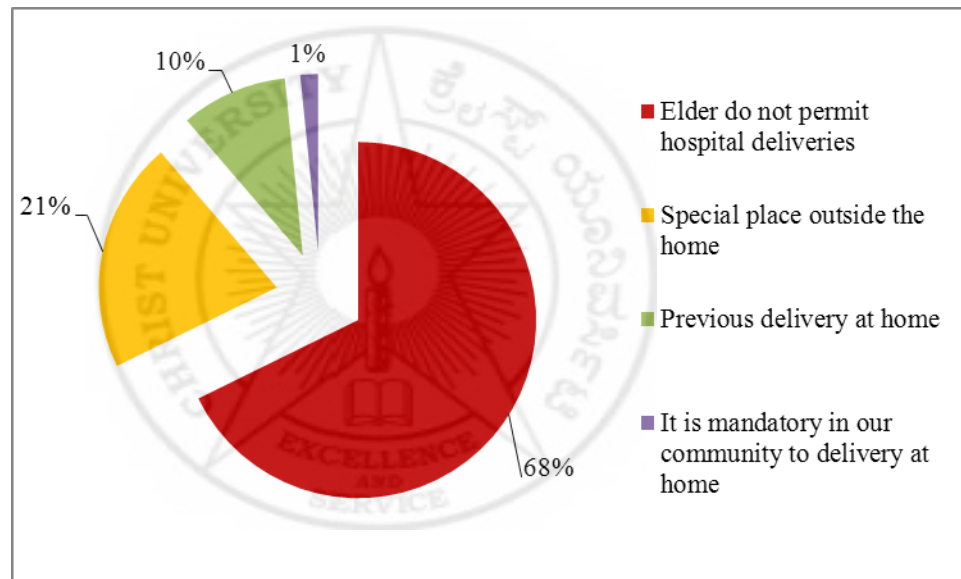


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**Table 4.24: Showing the details of Cultural reasons**

Cultural reasons	Frequency	Percent
Elder do not permit hospital deliveries	42	67.74
Special place outside the home	13	20.97
Previous delivery at home	6	9.68
It is mandatory in our community to delivery at home	1	1.61
<b>Total</b>	<b>62</b>	<b>100.00</b>



**Graph: 4.22**

Table 4.24 shows that 62 deliveries that took place at home were due to cultural/social reasons. A few cultural/social reasons expressed by them are as follows:

68% (42) explained that in their community all the previous deliveries occurred at home and the elders did not permit them to go for hospital for delivery, even though a few of them were willing to go to hospital (Ref Table 4.40). 21% of the total 62 participants informed that delivery always take place in a separate place constructed specially for delivery, which is a traditional practice. 11% of the participants answered that it is a mandatory practice that the delivery should take place at home as it is the custom of the community.

The coverage evaluation survey of UNICEF 2009, Karnataka Fact Sheet reports that 47.6% of home deliveries occurs due to cultural/social factors.

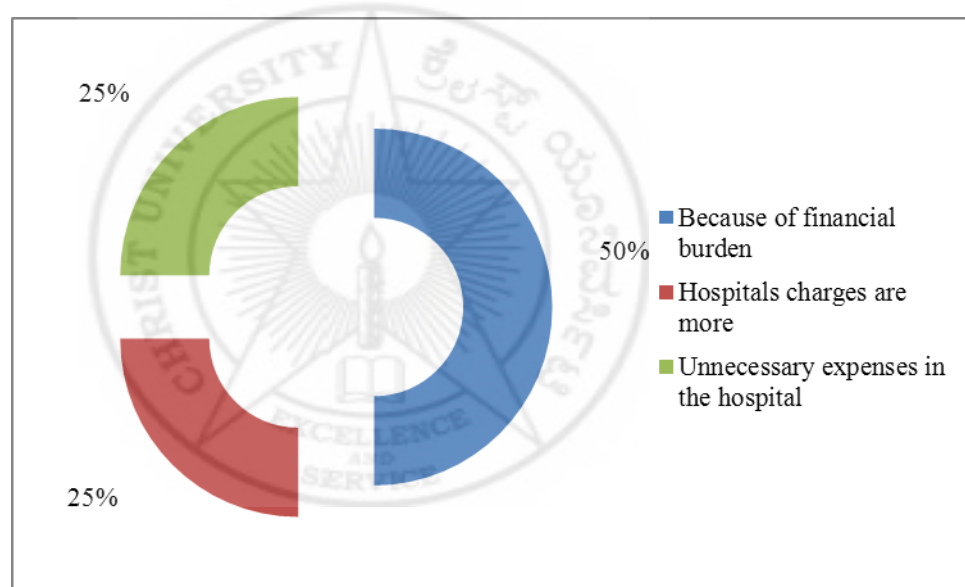


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**Table 4.25: Showing the details of Economic reasons**

<b>Economic reasons</b>	<b>Frequency</b>	<b>Percent</b>
Financial burden	2	50.00
Hospitals charges are more	1	25.00
Unnecessary expenses in the hospital	1	25.00
<b>Total</b>	<b>4</b>	<b>100.00</b>



**Graph: 4.23**

Table 4.25 reveals the details of economic reasons for delivery of home to the 4 participants, one of the participants informed that hospital charges are more and another participantsaid that it was an unnecessary expenditure for them. As per another 50% of participants the financial burden was their main problem.

The National Rural Health Mission programme in spite of providing ANC/PNC care free of cost to the BPL/SC/ST families, the participants did not avail these facilities as the awareness about

the Government programmes have not reached them properly so as to bring out a behavioral change in their community.

The coverage evaluation survey of UNICEF 2009, Karnataka Fact Sheet reports that 31.4% of home deliveries occur due to economic reasons.



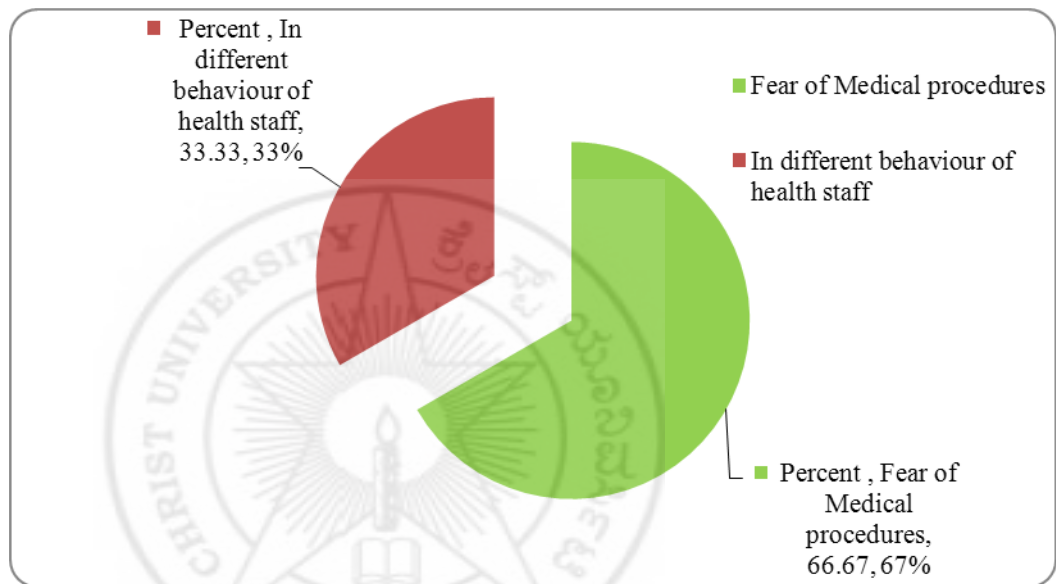
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**Table 4.26: Showing the details of Psychological reasons**

Psychological reasons	Frequency	Percent
Fear of Medical procedures	2	66.67
In different behavior of health staff	1	33.33
<b>Total</b>	<b>3</b>	<b>100.00</b>



**Graph: 4.24**

In the psychological causes 67 % of the participants have fear of Medical procedures and this is the cause for non-institutional delivery. 33% of them said that hospital staff behaves badly with females.

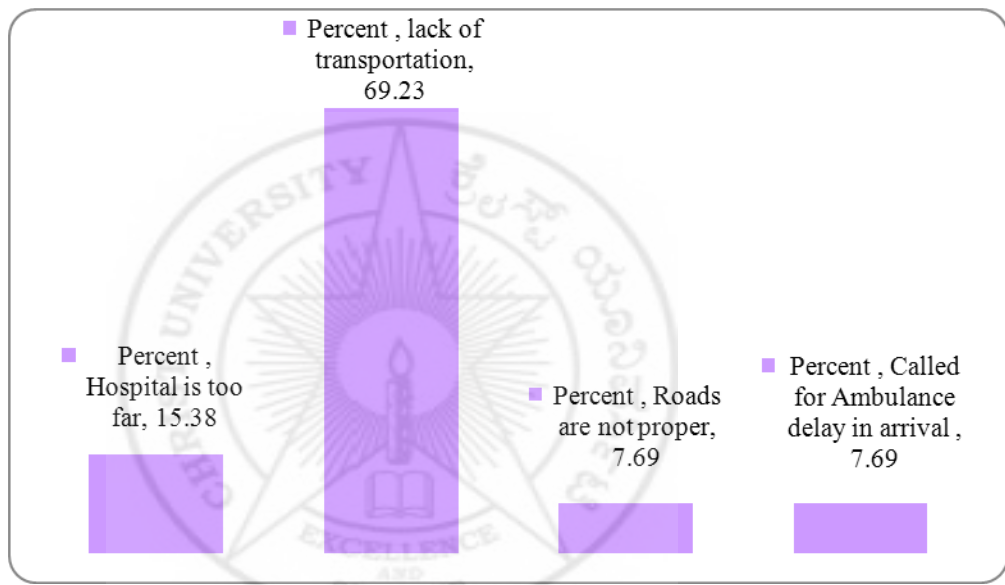
The coverage evaluation survey of UNICEF 2009, Karnataka Fact Sheet reports that 4.8% of home deliveries occurs due to lack of knowledge and fear of medical procedures.

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**Table 4.27: Showing the details of Infrastructural causes**

Infrastructural causes	Frequency	Percent
Hospital is too far	2	18.00
lack of transportation	7	64.00
Roads are not proper	1	9.00
Called for Ambulance delay in arrival	1	9.00
<b>Total</b>	<b>11</b>	<b>100.00</b>



**Graph: 4.25**

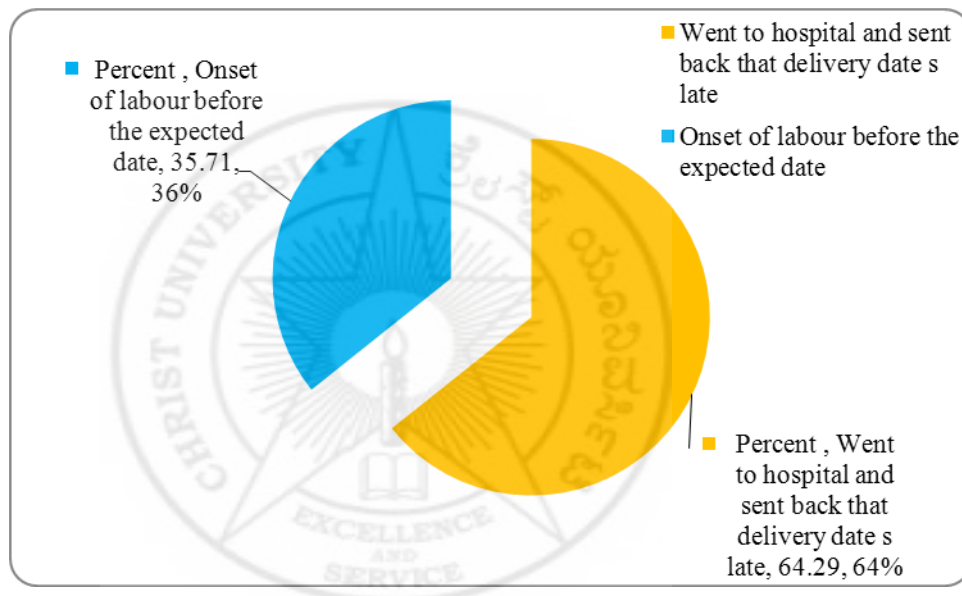
Table 4.27 shows that 11 participants who complained that lack of infrastructure is the reason for Non Institutional Deliveries. 64% of the participants indicated that lack of transportation as the main reason where as 15% have stated that the hospital is too far from them. Improper roads and delay in arrival of ambulance were the reasons stated by the 18% of the participants.

The NRHM and other do not provide for basic facilities like road. Hence the role of social development department is also needed from the success of schemes like NRHM. The coverage evaluation survey of UNICEF 2009, Karnataka Fact Sheet reports that 0.7% of the home deliveries occurs due to lack of transportation.

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**Table 4.28: Showing the details of medical causes:**

Medical causes	Frequency	Percent
Sent back by Hospital staff	8	61.54
Onset of labour before the expected date	5	38.46
<b>Total</b>	<b>13</b>	<b>100.00</b>



**Graph: 4.26**

The table 4.28 shows that total of 13 participants who complaint medical causes for home deliveries, 64% of them informed that even though they visited hospital for delivery and were in labour pain, they were sent back by the medical fraternity because of confusion due to date of delivery.

The main reason for non-admission into hospitals was that they had come to the hospital before the expected date of delivery.

36% of the participants delivered at home before the expected date of delivery as mentioned in the thair card.

In case of 64% participants, the health authorities would have done a good follow up Health Education for the hospital delivery.

It shows that there was no regular visit by the Auxiliary Nurse Midwife in case of earlier deliveries that took place before the Expected date of delivery.

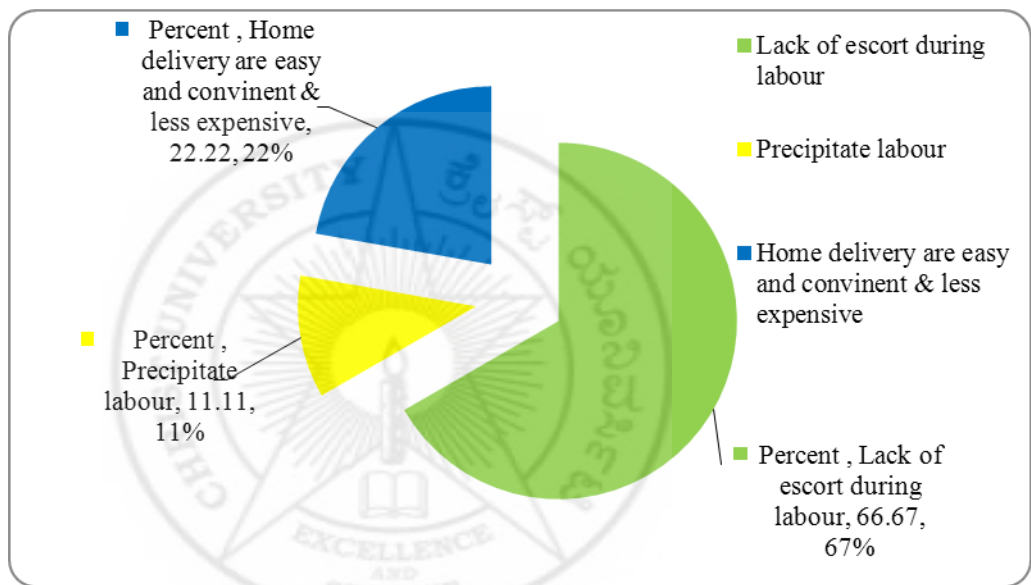


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**Table 4.29: showing the details of other causes**

Other causes	Frequency	Percent
Lack of escort during labour	6	66.67
Precipitate labour	1	11.11
home delivery are easy and convenient	2	22.22
<b>Total</b>	<b>9</b>	<b>100.00</b>



**Graph: 4.27**

The table 4.29 shows that 9 participants who attributed other causes for non-hospital delivery have given 3 reasons for the same. 67% have narrated that due to the non-availability of a person to accompany them to the hospitals and 22% have said that delivery at home is easy and convenient.

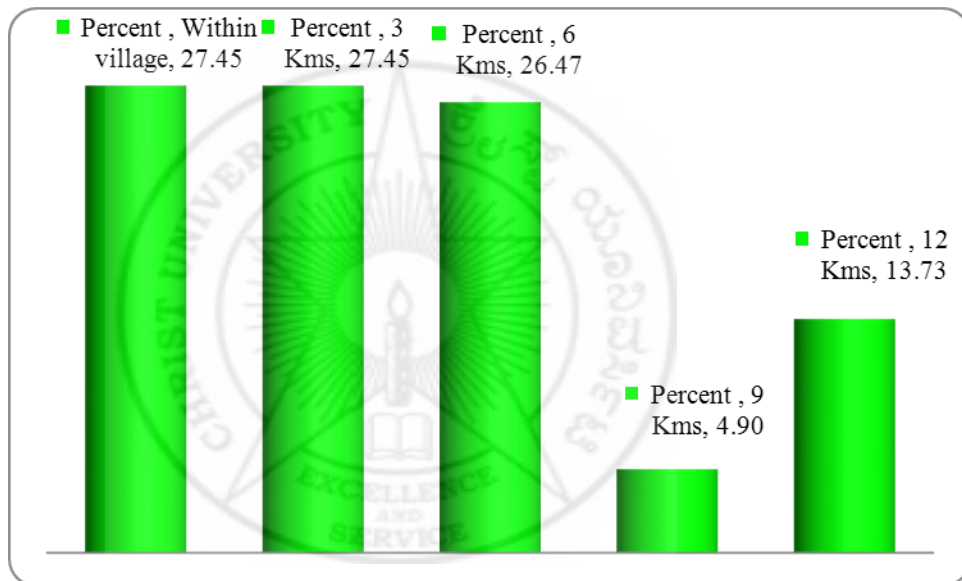
The coverage evaluation survey of UNICEF 2009, Karnataka Fact Sheet reports that 11.2% of the home deliveries occur due to other reasons.

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**Table.4.30: Distance from place of delivery to Healthcare facilities**

Distance from place of delivery to Healthcare facilities	Frequency	Percent
Within village	28	27.45
3 Kms	28	27.45
6 Kms	27	26.47
9 Kms	5	4.90
12 Kms	14	13.73
<b>Total</b>	<b>102</b>	<b>100.00</b>



**Graph: 4.28**

The table 4.30 data shows that for 28% of the participants, the Health care facility (Sub Centre/ PHC) is situated within the village and for other 28% of the participants the nearest healthcare facility (Sub Centre/ PHC) is within 3 kms and 27% of the participants the nearest health care facility (Sub Centre/PHC) is within 6 kms and for the 14% of the participants the distance is above 12 kms from their house to nearest healthcare facility (Sub Centre/PHC) and for 5% of the participants the distance is within 9 kms.

From this table we can conclude that 50% of the participants who have delivered at home have health care facilities that are within 3 kms but still these participants preferred home deliveries.

This clearly indicates ignorance and negligence on the part of participants and their family regarding institutional deliveries.

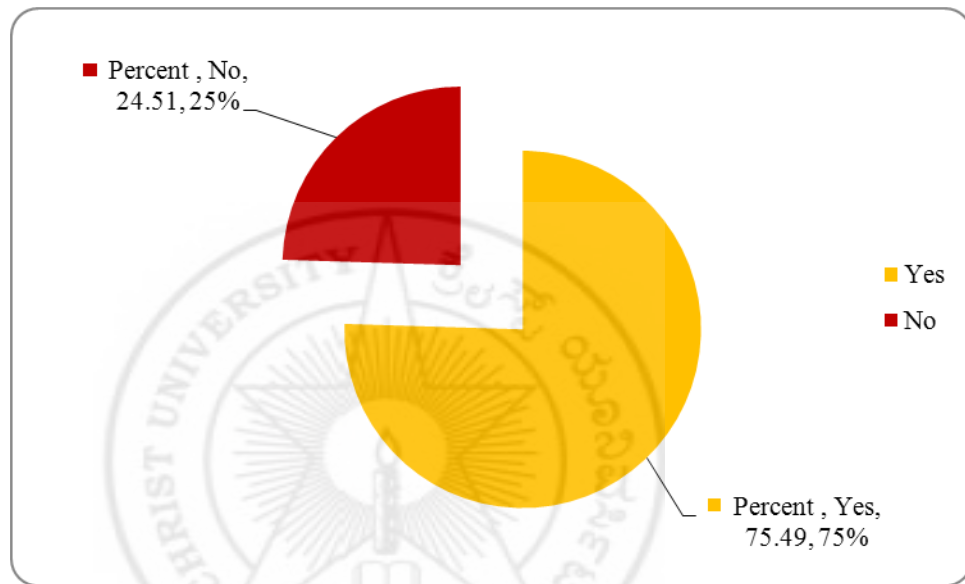


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**Table 4.31: Showing whether delivery has taken place at hygienic place.**

Delivery place was clean	Frequency	Percent
Yes	77	75.49
No	25	24.51
<b>Total</b>	<b>102</b>	<b>100.00</b>



**Graph: 4.29**

The table no. 4.31 reveals that 75% of the participants delivered at a clean and tidy place and 25% of the participants feel that they did not deliver at clean and tidy place. The very fact of delivering at a non-hygienic place indicates their ignorance about health, apart from their negligence as well as economic status of families.

The education on five cleans as earlier stated needs to be taken up at a speedy pace in order to avoid maternal and infant mortality rates.

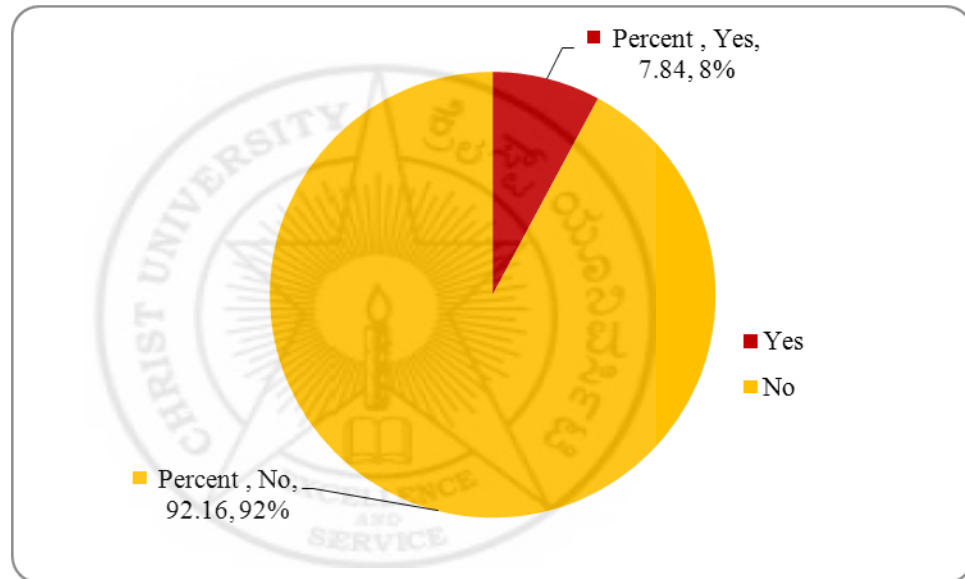
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**Table 4.32: Showing Medical complications during home delivery**

Sl. No	Health Indicators	Category	Frequency	Percentage
4.32 (1)	Any Medical Complications	Yes	8	7.84
		No	94	92.16
4.32 (2)	Types of Medical Complications	Prolonged labour	2	25
		Twin Delivery	2	25
		Excessive Bleeding	4	50



**Graph: 4.30**

The first segment of the table 4.32 (1) showing medical complications that occurred during delivery. The table shows that 92% of the participants have stated that no medical complications occurred during delivery and 8% experienced medical complications during home delivery.

The second segment of the table 4.32 (2) further shows that among participants who had medical complications among them 50% of Participants (4) expressed that the main medical problem was excessive bleeding. 25 % of the participants had twin births and other 25% of participant had prolonged labour. All of these complications has the potential to turn fatal for the mother as well as the infant.

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It has to be agreed that the affirmative answers would have been more had the probe in this regard be of in depth nature. Further if the interviewer female then more details would have emerged.



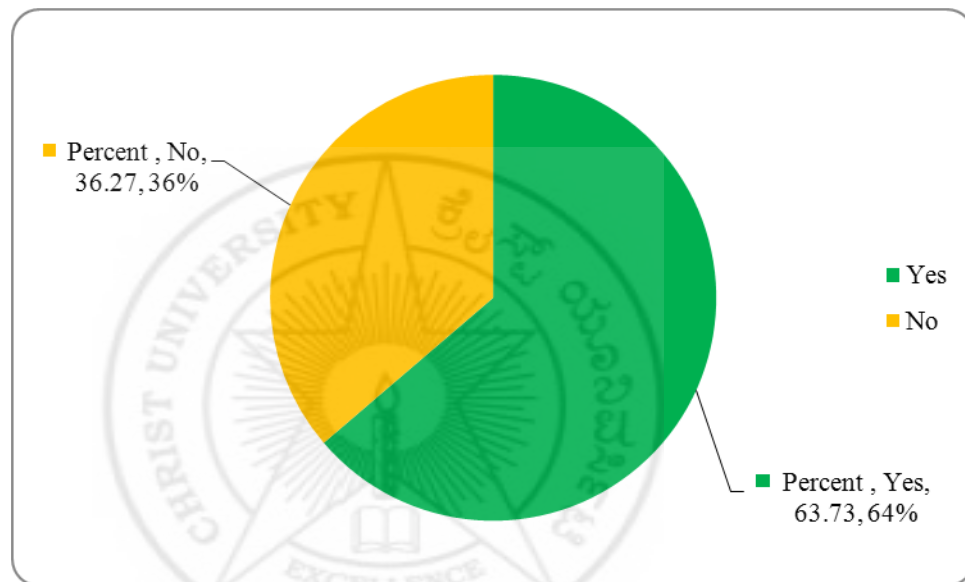
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## Postnatal care

**Table 4.33: Showing the branding of babies after their birth.**

Branding	Frequency	Percent
Yes	65	63.73
No	37	36.27
<b>Total</b>	<b>102</b>	<b>100.00</b>



**Graph: 4.31**

The table 4.33 shows that 64% of the babies were branded after their birth which is really a pathetic one, even after the advancement of science showing that ignorance, illiteracy and customs are still prevalent in their areas and health education has not percolated. It is good at least 36% of the babies did not get brandings.

Branding of a baby is an traditional practices in the communities of participants. It has to be eradicated by proper health education.

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**Table 4.34: Showing the feeding of Infant immediately after birth and time of breast feeding.**

Sl. No	Health practises	Category	Frequency	Percentage
4.34 (1)	Feeding of infant immediately after birth	Breast milk/colostrum	46	45.10
		Honey	38	37.25
		Others	18	17.65
4.34 (2)	Time of the Breast feeding	60 minutes	46	45.10
		1 to 12 hours	17	16.67
		12 to 24 hours	6	5.88
		72 hours	33	32.35

The first segment of the table. 4.34 (1) shows 45% of the participants breast fed their children immediately after birth. 37% of the participants fed their new born with honey, 18% of the participants fed their new born with others (breast milk from other women, formula fed, plain water, cow's milk/sugar water).

The above table reveals that the unhygienic and traditional custom of non-breast feeding immediately after the birth is still prevalent in the community which may lead to water borne diseases like diarrhea and other infections that may weaken the health of the baby and may lead to the mortality of the infants. This can be avoided through systematic health education of the community involving all stake holders.

The second segment of the table 4.34 (2) shows that only 45% of the mothers had breastfeed their new born within 1 hour of delivery which is a good beginning, thereby protecting the child from immediate infection and the babies had the privilege of getting colostrum by developing good immunity. It is regrettable that 32% of the participant have not breast fed their children after 72 hrs which is not a good practice. 22% of mothers have breast feed their new born between 1 hr to 24 hrs after delivery.

Colostrum is the substance which is present in the breast milk gives immunity to the child of it is given at the first instance. This should be encouraged. The concurrent evaluation report of

National Rural Health Mission 2009, Karnataka fact sheet gives information that nearly 48% of the women fed their child within 1 hr after birth and another about 13% did so within 6 hours after the delivery and 2% of the never breast fed their children. Another about 33% of the children were breast fed only after they given pre-lactel feeding like water/honey etc.,

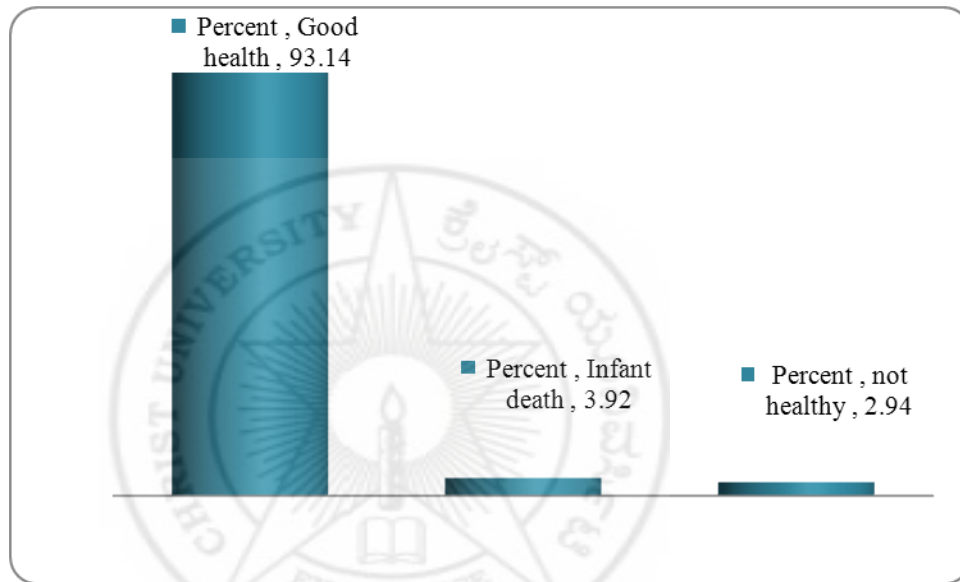


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**Table 4.35 Showing the health status of infant**

Health Status	Frequency	Percent
Good health	95	93.14
Infant death	4	3.92
not healthy	3	2.94
<b>Total</b>	<b>102</b>	<b>100.00</b>



**Graph: 4.32**

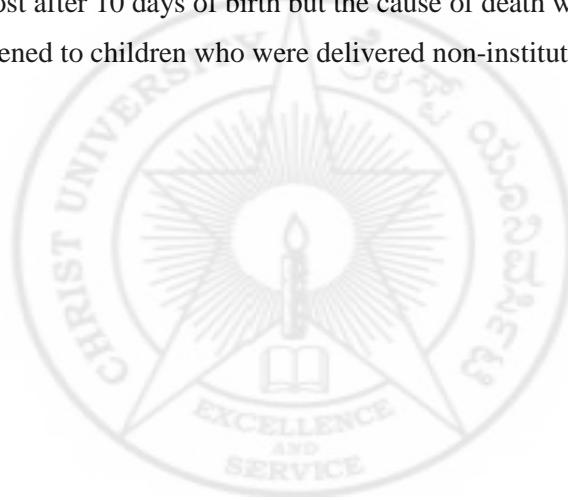
At the time of study, it was found that 93% of infants were healthy and 3% reported to be sick due to fever and diarrhea. It is regrettable to note that four neo-natals (1 male and 3 female) (4%) had died within 15 days of delivery and out of four neonatal, one was a twin. This mortality would have been prevented had they delivered at health institutions.

The infant motility in Karnataka is 39 per 1000 births.

There were 4 infant deaths detected during the period of the study from non-institutional deliveries. These deaths comprised of 1 male and 3 female infants.

Although the reasons for these deaths could not be accurately ascertained, some of the social behaviours of the communities seem to have contributed in this regard. For example, 3 of these deaths happened in children born to parents from the 'Golla' Community. The 'Golla' community

has a very peculiar social custom of making the expectant mother deliver her baby in a hut which is about 50 feet from the home. This hut is made of plastic tarpaulin, has very little ventilation and the woman and the child have to fend for themselves during the delivery. Further, the mother is not allowed to breast-feed her child for the first 3 days after delivery. The baby is fed wild honey obtained from the nearby forest. The mother is not allowed to enter the home for a period of either 1 month, 45 days or in some cases 3 months. Some food is provided to the mother and is placed outside the hut where she lives with her newborn. There is no special nutrition provided to the mother and she has to completely take care of herself and the baby during this stage. It therefore not surprising that there are cases of infant deaths being reported from this community. From what was heard, one of babies (female) died because DDT powder was sprayed near the baby to ward away ants which were biting the child. Another death was of a female child which was born with a twin; again the exact cause of death was not known. The other female child and male child died almost after 10 days of birth but the cause of death was again not known. All four of these deaths happened to children who were delivered non-institutionally.

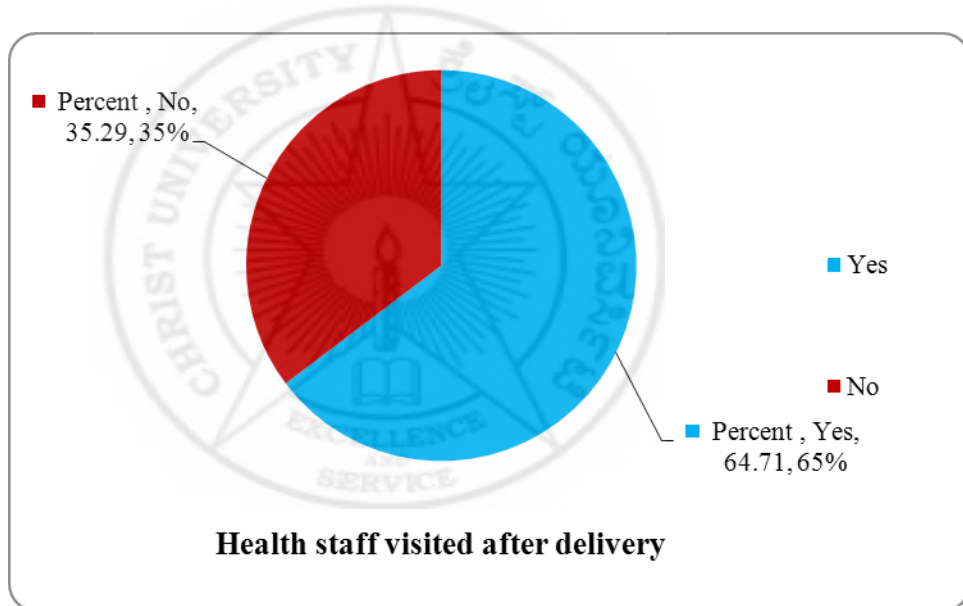


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**Table 4.36: showing the information whether health staff visited participants house after delivery**

Sl. No	Health facilities	Category	Frequency	Percentage
4.36 (1)	Health staff visited after delivery	Yes	66	64.71
		No	36	35.29
4.36 (2)	Time of medical care	Same day	19	28
		Next day	19	28
		One week	28	42



**Graph: 4.33**

The table 4.36 (1) shows visit of field staff of the Health and Family Welfare Department visited only 65% of participants (66) soon after their delivery at home. 36 participants (35%) responded that none of the health staff visited them after delivery. It was mandatory on the part of the Auxiliary Nurse Mid Wives to visit all the postnatal cases in her area and provide the health facility as needed by them. The health services have been toned up in these areas.

The table 4.36 (2) further shows 28% of the 66 participants who were visited by the health staff have reported that the health functionary visited them on the same day after the delivery and 44%



inform that the health staff visited them after one week of delivery. It can be concluded that the follow up visits are not in time and against the guidelines of NRHM.

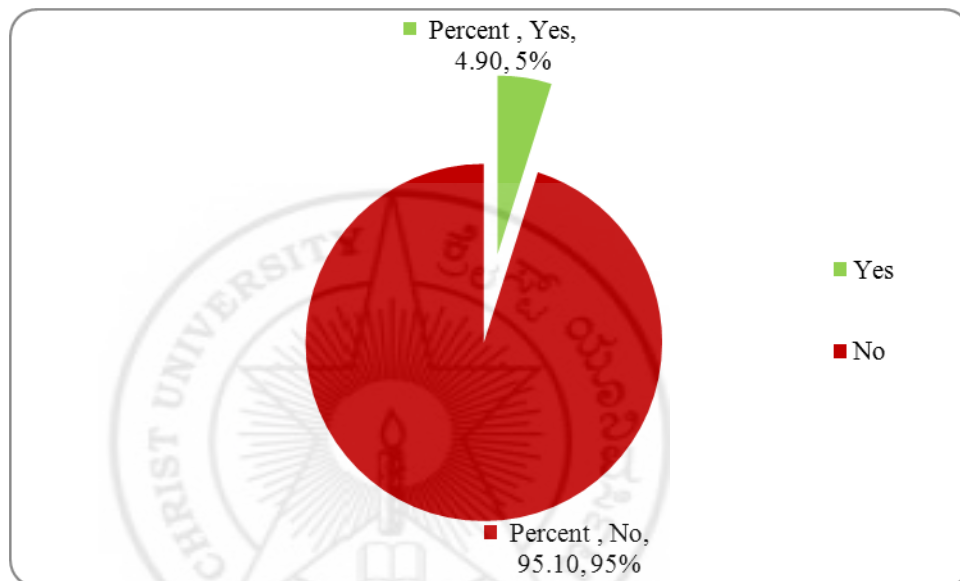


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**Table 4.37: Showing the details of post delivery visits to hospital.**

After delivery visited to Hospital	Frequency	Percent
Yes	5	4.90
No	97	95.10
<b>Total</b>	<b>102</b>	<b>100.00</b>



**Graph: 4.34**

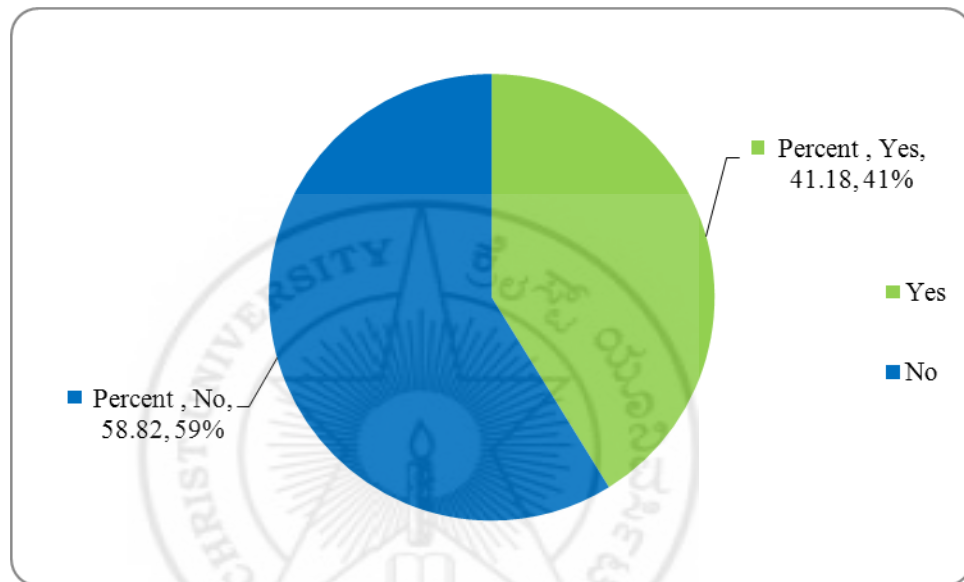
The table 4.37 shows that 95% of the mothers did not visit the hospital even after delivery and the 5% of post natal mother visited the hospital for checkup on the next day (1 respondent) and after one week (4 respondent) after delivery.

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**Table 4.38: Deliveries at Home are Safe**

<b>Deliveries at Home are Safe</b>	<b>Frequency</b>	<b>Percent</b>
Yes	42	41.18
No	60	58.82
<b>Total</b>	<b>102</b>	<b>100.00</b>



**Graph: 4.35**

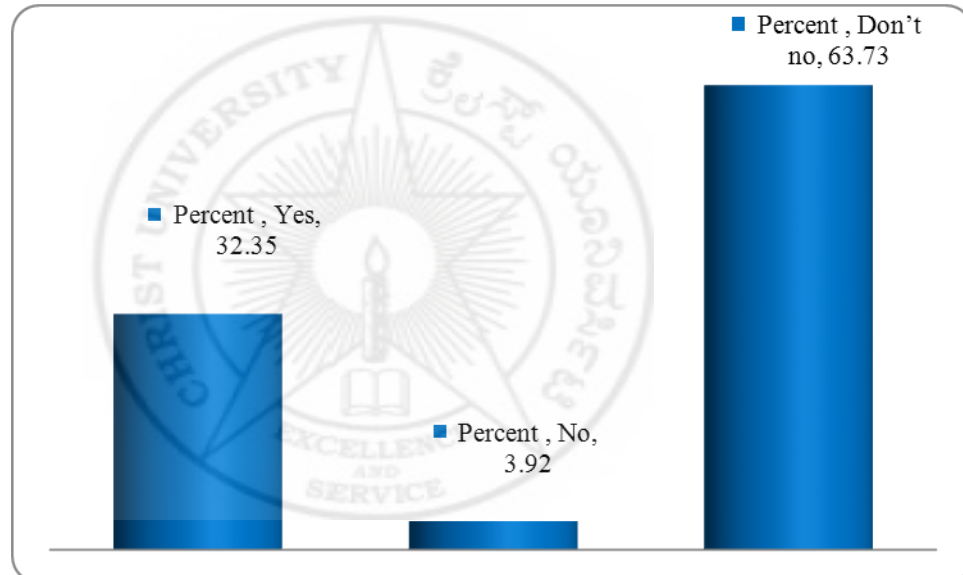
The table 4.38 indicates that 41% (42) of the participants who delivered at home feel that home deliveries are safe while 59% feel that home deliveries are not safe and it shall be under medical supervision showing that if regular follow up and health education is given. These people or their relatives of these participants will definitely opt for institutional delivery in future.

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**Table 4.39: Showing the National Rural Health Mission benefited in providing good Maternal and Pregnancy care**

NRHM benefited in providing good M&P care	Frequency	Percent
Yes	33	32.35
No	4	3.92
Don't know	65	63.73
<b>Total</b>	<b>102</b>	<b>100.00</b>



**Graph: 4.36**

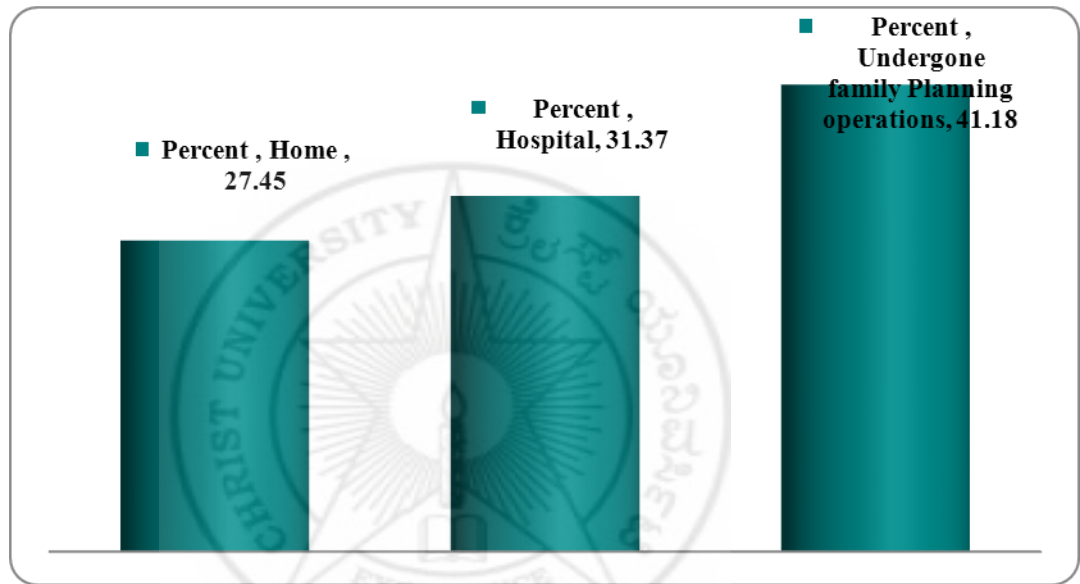
The table 4.39 indicates that 41% (42) of the participants who delivered at home feel that home deliveries are safe while 59% feel that home deliveries are not safe and it shall be under medical supervision showing that if regular follow up and health education is given. These people or their relatives of these participants will definitely opt for institutional delivery in future.

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**Table 4.40: Showing the plan for next delivery**

Next Delivery	Frequency	Percent
Home	28	27.45
Hospital	32	31.37
Undergone family Planning operations	42	41.18
<b>Total</b>	<b>102</b>	<b>100.00</b>



**Graph: 4.37**

It is seen from the study that 41% (42 participants) out of total 102 participants, have opted for terminal method of family planning indicating that they have planned their families, even though they have delivered at home. This reveals that they know about planning their families and these services are available only at health institutions and not at home.

When asked the planning of next delivery to the remaining 60 participants who wish to have one more child, 27% of the another preferred home delivery and 32% (32 respondent) preferred hospital delivery. This statement is supported by their statements as indicated in table.

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**Table 4.41: showing the details of association between cultural and non-cultural causes of Non Institution deliveries with community, educational status, annual income, consanguineous marriages, type of family and occupation of the participants.**

Sl. No		Causes			P- value	
		Cultural	Non Cultural	Total		
4.41 (1)	Community	SC	24 (38.7%)	15 (39.5%)	39 (39.0%)	0.177
		ST	8 (12.9%)	10 (26.3%)	18 (18.0%)	
		BC	30 (48.4%)	13 (34.2%)	43 (43.0%)	
4.41 (2)	Educational Status	Illiterate	47 (75.8%)	15 (39.3%)	62 (62.0%)	0.001
		Literate	14 (24.2%)	23 (60.5%)	38 (38.0%)	
4.41 (3)	Annual Income	<50,000	3 (4.8%)	0 (0%)	3 (3.0%)	0.169
		50,000+	59 (95.2%)	38 (100.0%)	97 (97.0%)	
4.41 (4)	Consanguineous marriages	Yes	51 (80.6%)	12 (30.6%)	62 (62.0%)	0.001
		No	12 (19.4%)	26 (69.4%)	38 (38.0%)	
4.41 (5)	Family	Joint Family	37 (59.67%)	20 (52.63%)	57 (57.0%)	0.088
		Nuclear	25 (40.33%)	18 (47.37%)	43 (43.0%)	
4.41 (6)	Occupation	House wife	39 (62.90%)	7 (18.42%)	46 (46%)	0.001
		Working	23 (37.10%)	31 (81.58%)	54 (54%)	

Looking at the association between the communities and cultural, non-cultural causes of Non Institutional deliveries. In the first segment of the table 4.41 (1), communities and the causes of non-institutional deliveries were not significant.

Looking at the association between the educational status and cultural, non-cultural causes of Non Institutional deliveries. In the second segment of the table 4.41 (2), it was found that a significant

association exists between education status and causes of non-institutional deliveries, this shows in the cultural reasons 76% of the participants are illiterates and in the non-cultural reasons 61% of the participants are literates.

Mutharayappa, R on their study “Reproductive morbidity of women in Karnataka” mentioned that education plays a major role in women’s health-seeking behavior.

Looking at the association between the income and cultural, non-cultural causes of Non Institutional deliveries in the third segment of the table 4.41 (3), when this was cross tabulated and the chi-square was applied, the association was not significant.

Looking at the association between the consanguineous marriage and cultural, non-cultural causes of Non Institutional deliveries in the fourth segment of the table 4.41 (4), when this was cross tabulated and the chi-square was applied, the association was significant. This shows that among the cultural reasons 81% of the participants marriage is consanguineous and non-cultural reasons 70% of the participants marriage is not consanguineous.

This shows that there is a relation between consanguineous marriage and causes for non-institutional deliveries.

Looking at the association between the family and cultural, non-cultural causes of Non Institutional deliveries, in the fifth segment of the table 4.41 (5) when this was cross tabulated and the chi-square was applied, the association was not significant.

This shows that there is no difference in joint families and nuclear families, it respect to causes for non-institutional deliveries.

Looking at the association between the occupation and cultural, non-cultural causes of Non Institutional deliveries, in the sixth segment of the table 4.41 (6), when this was cross tabulated and the chi-square was applied, the association was significant, from this we can see that among the cultural reasons 63% of the participants are housewives. In the non-cultural reasons 82% of the participants are working.

This shows that there is a association between occupation of the participants and cultural, non-cultural reasons for non-institutional deliveries.

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## Chapter 5 – Findings, suggestions and implications of the study

### Socio Demographic details:

- Majority (67%) of the participants belongs to Sandur Taluk Bellary District.
- 36% of the participants belongs to age group of 20 to 22 years.
- 83% of the participants are married below the age of 18 years..
- Majority of the participants belongs to the Hindu religion (88%).
- 42% of the participants belongs to Backward caste.
- Majority (56%) of the participants are belongs to the Joint family.
- Study reveals that 61% of the participants in the study are illiterates.
- 53% of the participants are involved in occupation.
- 89% of the participants family annual income is in between rupees 50,000 to 1,00,000.
- Majority (62%) of the participants marriage is consanguineous.

### Awareness and benefits related to National Rural Health Mission, Non-Institutional Deliveries and pre-natal care.

- In the study it was found that 88% of the participants are aware about National Rural Health Mission schemes.
- Majority (82%) of the participants consider National Rural Health Mission as a cash benefit scheme.
- Study reveals that 84% of the participants have received non-monetary benefits.
- Majority (12%) of the participants benefited from Janani Suraksha Yojaane and 3% of the participants benefited from Prasuthi Arike.

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- In the study among the beneficiaries of the monetary benefits, majority (86%) of the participants used National Rural Health Mission amount for other than pregnancy care.
- In the study it was found out that 62% of the participants registered for antenatal checkup at 4<sup>th</sup> month means during the second trimester.
- The 54% of the participants have undergone antenatal checkups at Anganwadi centers.
- In the study it was found out that Auxiliary Nurse Midwives visited 90% of the participants house during their pregnancy.
- In the study it was evident that 84% of the participants visited for Primary Health care for antenatal checkup.
- In the study 88% of the participants have undergone various medical checkups.

### **History of Deliveries**

- The study reveals that 60% of the participants have delivered at their parents house.
- In the study it was noted that 53% of the participants delivered female child.
- Majority (83%) of the participants delivery was conducted by traditional birth attendants.
- Study reveals that 22% of the participants delivered outside the house and 13% of the participants delivered at a special place constructed near their house.

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### **Details related to Non institutional deliveries**

- Among 62 participants who declared that due to cultural causes they could not go to hospital for delivery, 42 participants informed that due to non-approval of parents to go to hospital for delivery, they had to deliver at home only.
- Majority (50%) of the participants under economic causes delivered at home because of financial burden.
- The study reveals that 67% of the participants under psychological causes delivered at a home because of fear of medical procedures.
- Among infrastructural causes 64% of the participants delivered at a home because of lack of transportation.
- 62% of the participants citing medical causes delivered at a home because they had gone to hospital and were sent back by hospital authorities because of confusion due to date of deliveries.
- Among other cause 67% of the participants delivered at a home because of lack of escort during labour.

### **Post-natal care**

- 92% of the participants in this study did not have medical complications during delivery.
- The study reveals in non-institutional deliveries 64% of the babies were branded after the delivery.
- Majority (45%) of the participants breast fed their babies within one hour of the delivery.

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- The 78% of the participants who had not breast fed their babies reported that this was due to non-availability of milk for 3 days.
- The study reveals 4 infant deaths among 102 participants due to non-institutional delivery.
- 42% of the participants have undergone family planning operations after their deliveries.
- The study reveals that 47% of the participants feel that health education is necessary regarding hospital delivery and pregnancy care.

### **Suggestions**

- As the marriage age of 82% of the participants is below the age at marriage as per the Hindu Marriage act 1955, it clearly shows that early marriage custom in their community. Hence more of education on age at marriage in respect of Health, Nutrition, Physical growth and Pregnancy etc., especially of girls is necessary as the child marriage is illegal.
- As the illiteracy is about 61% among female, it can be easily assessed that illiteracy is one of the reasons for non-institutions / home delivery, so education of women is a top priority for development of the country.
- Education on ill-effects of consanguineous marriage is to be taken up in the rural areas.
- In spite of taking financial and medical facility of National Rural Health Mission.

All of them delivered at home. Hence intensive Health Education, qualitative field

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work, regular Health checkup good interpersonal regular follow up and involvement of local community along with other state holders is major component to remove rumors, misconceptions tradition and beliefs and also to change the attitude of community towards non institutional delivery.

- The early registration of antenatal cases is the mantra of the day. This should be geared up under proper supervision and guidance by National Rural Health Mission because the registration of participants for ANC check up in the 4<sup>th</sup> month.
- Intensive IEC activities have to be taken up at the peripheral level in order to educate the community about the facilities and incentives provided under National Rural Health Mission.
- Even though there is a demand generation in case of JSY and Prasoothi Arike, there is non-availability of budget which needs to be looked in to by National Rural Health Mission
- Authority apart from eradication of corruption at the peripheral in case of payment of incentives to participantso as to avoid getting bad name to National Rural Health Mission
- Visit of Jr. Health Assistant (Female) (ANM) to pregnant mothers and post natal mothers must be made mandatory and be given top priority during their field visits in order to provide better health services and to avoid both mother and child mortality rates.
- Branding of Children which is a heinous crime needs to be discouraged and eradicated from the community.

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- Encouraging breast feeding within one hour of delivery to provide immunity to the child is necessary. The customs related to the detrimental effects on the child should be discouraged.
- It is important to raise community awareness regarding early marriage and pregnancy. Misconceptions about nutrition and health pregnant women, and the families in which they reside.
- Even though institutional delivery is very important to save both mother and child, due to medical reasons, it is always necessary to provide safe delivery kits by National Rural Health Mission to all the pregnant women.
- When the Antenatal mothers visit the hospitals, due care should be taken for their treatment.

The community should be educated

- a) about the untied funds available at subcentres
- b) Service provided by Junior Health Assistant (Male and Female)
- c) The facilities available at the Primary Health Centers
- d) The benefit under JSY, Prasoothi Araiike Madilu etc.,
- e) The emergency services of 108
- f) Advantages of delivery which pays way for institutional removing all the undersigned customs and tradition prevailing in the community.

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## **Implications**

### **Practical implications**

Practical implications are provided to fulfill the research, which is to provide strategies for future preventions of non-institutional deliveries. There are some points for practices as follows:

- ✓ Providing Health education and behavioral change communication for the family members of the pregnant women and pregnant women.
- ✓ Changing the attitude of particular communities scheduled caste, scheduled tribe and backward communities, eradicating the misconceptions and false beliefs attached towards institutional deliveries.
- ✓ Explaining the complications and risks associated with home deliveries, where maximum home deliveries will take place.
- ✓ Use of folk media and mass media for eradicating non-institutional deliveries.
- ✓ Providing training programmes for health staff to prevent non-institutional deliveries.

### **Implications to research**

The implications described this dissertations, contribution in the prevention of non-institutional deliveries by identifying the causes for the non-institutional deliveries, this study offers descriptive analysis associated with non-institutional deliveries, this study provides future measures and suggestions in preventing non-institutional deliveries and promoting institutional deliveries. The results shows that the necessity of eradicating cultural/social causes or problems associated with non-institutional deliveries.

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## **Implications for social work**

The social work profession deals with social problems and helps the individual, group, community to solve the problem themselves. Social workers working the field of community and the health, have to play important role in eradicating the indigenous practices related to health and motivate the communities to practice the best health practices and make use of government schemes like National Rural Health Mission.

## **Suggestions for future Research**

- Researchers can conduct case studies in particular communities, to identify the cultural/social causes associated.
- Comparative studies can be made with reference to institutional and non institutional delivery among beneficiaries of National Rural Health Mission.
- Researchers can select more number of participants and they can conduct research on child rearing and breast feeding practices in non-institutional deliveries.
- Research has to take place on effects of traditional practices related to health.

## **Limitations of the study**

- In the study the researcher has great difficulty to find out the samples, who have delivered at home and beneficiaries of National Rural Health Mission.
- Review of the literature was a challenge.
- This study is limited to 4 taluks of Bellary District.

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## **Conclusion**

This dissertation has addressed to provide an interesting evaluation in identifying causes for non-institutional deliveries. The objectives are to identify the causes associated with non-institutional deliveries. Researcher used descriptive design and collected data by interview method by using schedule. Findings explained that research project lightened on causes social and cultural causes and various other factors which leads non-intuitional deliveries. The Government of Karnataka through the department of H&FW Services is implementing various health and welfare schemes to the down trodden community for their improvement and lead health life. These projects schemes like India population project – I, III & IX, World Bank Projects like KHSDRP, National Rural Health Mission have taken up a lot of measures and activities to create awareness, to provide infrastructures and better services to the citizens of one State. In spite of all these activities it has been found that there is still lacuna in acceptance of the programmes and this study shows there is deep-rooted social and cultural customs prevail upon these efforts. Hence mutli dimensional approach is necessary to remove the superstitious & beliefs in the community.

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## Appendix

### Informed consent

The study is conducted partial fulfillments of my M.Phil dissertation under the guidance of Dr. Hemalatha K, Associate Professor, Christ University, Bangalore. This study is on “Identifying Causes For Non-Institutional Deliveries among the beneficiaries of National Rural Health Mission”.

The study will be carried out in Bellary District. The purpose of this study is add to the research knowledge and identifying the causes for non-institutional deliveries who are benefited from National Rural Health Mission and enabling the policy makers to understand which are the factors prevented in utilizing health institutional services.

The participants are the women of Bellary District participation is voluntary and the participants are free to withdraw from the study, if they feel any discomfort or inconvenience from answering the questions at any point of time. They have the right to clarify the doubts or asks for more information through out the study. It is purely for academic purpose and confidentiality will be maintained.

I request you to support this effort, if you have understood the study and wish to participate. Please sign the consent form and answer the interview schedule.

Signature of the Respondent \_\_\_\_\_

Name of the researcher:

Karthik B

Date:

Signature

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**A STUDY ON IDENTIFYING CAUSES FOR HOME (NON INSTITUTIONAL DELIVERIES) AMONG BENEFICIARIES OF NRHM**

<b>Taluk:</b>	<b>Village:</b>	<b>PHC:</b>
---------------	-----------------	-------------

**SOCIOECONOMIC PARTICULARS:**

1. Name of the Respondent : .....
- Husbands Name : .....
2. Age of the Respondent : .....
- a) 18-20                      b) 20-22
- c) 22-24                      d) 24-26
3. Marriage age of Respondent/Beneficiary : .....
- a) Below 18 years                      b) above 18 years
4. Religion
- a) Hindu                      b) Muslim
- c) Christian                      d) Others (specify:.....)
5. Community
- a) Scheduled Caste                      b) Scheduled Tribe
- c) Backward Caste                      d) Others
6. Type of Family
- a) Nuclear                      b) Joint
7. Marital Status of Respondent
- a) Married                      b) Widow
- c) Diverse/separated                      d) Unmarried

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8. Educational Status

- a) Illiterate                      b) Read & Write                      c) 1-7 standard
- d) 8-10 standard                      e) P.U.C                      f) Degree/Diploma

9. Occupation of the Respondent

- a) House wife                      b) Agriculture Labour                      c) Artisans (Tailor, Potmaker etc)
- d) Business                      e) Other (Specify: .....)

10. Physical Status of Respondent

- a) Normal                      b) Handicapped.

11. Husbands Educational Status

- a) Illiterate                      b) Read & Write                      c) 1-7 standard
- d) 8-10 standard                      e) P.U.C                      f) Degree/Diploma

12. Husbands Occupation

- a) Agriculture Labour                      b) Artisans (Tailor, Potmaker etc)
- c) Business                      d) Other                      e) Unemployed

13. Family Size

- a) 1-4                      b) 5-8
- c) 8-12                      d) 12 and above

14. Annual Income of the Family

- a) 20,000-40,000                      b) 40,000-80,000
- c) 80,000-1,20,000                      d) 1,20,000 & above.

15. Your family has any income from Landholdings:

Yes/No

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16. Type of Marriage .....

- a) Love                      b) Arrange

17. Your Marriage Consanguineous:

Yes/No

18. Married within the village

Yes/No

List of the Family Members:

Sl. No	Name	Relationship with respondent	Age	Sex	Qualification
1.					
2.					
3.					
4.					
5.					
6.					

**A) PREGNANCY CARE AND NRHM BENEFITS PARTICULARS:**

1) Delivery : .....

- a. Ist                                      b. IInd

Your previous deliveries are at (for deliveries more than one)

- a. Home                                      b. Hospital

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2) When did you attend/register the first antenatal check up

- a. In 3<sup>rd</sup> Month                                      b. In 4<sup>th</sup> Month

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- c. In 5<sup>th</sup> Month                      d) after 5 month

3) With whom did you register the pregnancy

- a) Anganwadi worker                      b) ASHA  
c) ANM                                      d) Other (Specify: .....)

4) Where do you undergone ANC care generally?

- a) Home                                      b) Anganwadi                      c) Sub Centre  
d) PHC/CHC                              e) Private Hospitals                      f) Others

5) Do you know about National Rural Health Mission

Yes/No

If yes, What are the benefits of National Rural Health Mission

- a) It helps in providing better Health services in Rural Areas  
b) It provides cash benefits  
c) More health care has been initiated  
d) Don't about the benefits  
e) .....

6) Did you receive Janani Suraksha Yojana Scheme Benefit (Rs. 500 under NRHM) for Home Delivery

Yes/No

7) Did you receive Madilu Kit (under NRHM) after delivery?

Yes/No

If so where?

8) Have you receive Prasuthi Arike (under NRHM) cash benefit of Rs. 1,000/- during second trimester end another Rs. 1,000/- within 48 hours of the delivery

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Yes/No

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9) Have you paid any goodwill to obtain NRHM benefits?

Yes/No

If so, how much ..... & to whom .....

10) For what have you used the amount from NRHM?

- a) Pregnancy care and health checkups
- b) Other than Pregnancy care.
- c) House hold activities.
- d) Husband used the money and not provided to health checkups.
- e) .....
- f) .....

11) ASHA (Accredited Social Health Activist) visited you in your house during pregnancy?

Yes/No

12) Auxiliary Nurse Midwife visited at your home and provided any information and checkups for pregnancy

Yes/No

If, yes how many times, she has visited .....

13) Health staff visited and provided health education and information about NRHM

Yes/No

14) Health staff visited (ANM, ASHA) provided information that delivery should be at Hospital (Institutional).

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15) Have you visited PHC for Antenatal check ups during the pregnancy.

Yes/No

If, yes how many times you have visited .....

If, no why? .....

- a) No faith
- b) Not aware of the need
- c) Place is not accessible
- d) Timings inconvenient
- e) Loss of wages
- f) Cause of Cost.

16) Have you received TT Immunization during pregnancy

Yes/No

17) Have you received Iron Folic Acid Tablets during pregnancy

Yes/No

18) What tests have you undergone during your pregnancy under NRHM?

- |                                |     |    |
|--------------------------------|-----|----|
| a). Haemoglobin Estimation.    | Yes | No |
| b). Urine Test                 | Yes | No |
| c). Blood Pressure measurement | Yes | No |

19) Have you came across any means of Health education on Antenatal care, Post natal care & child care?

Yes/No

- a). If yes, by whom
- b). Do you suggest any specific improvements.

20) How did you know about NRHM?

- a). From Advertisement.

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- b). From Health care providers.
- c). From Family Members.
- d). Others .....

Participant received

- a. Cash Benefit from NRHM
  - b. Cash less Benefit from NRHM
- Because
- i. Participant belongs to above poverty line.
  - ii. Participant delivery is more than second.



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**B) PARTICULARS REGARDING DELIVERY & CAUSES FOR NON INSTITUTIONAL DELIVERY**

- 1) Where you deliver?
  - a) In law's house
  - b) Parent's house
  - c) On the way to the Hospital
  - d) In the work place
  - e) Others .....
  
- 2) Were you aware of the expected date of delivery from Health care providers  
Yes/No
  
- 3) Date of Delivery .....
  
- 4) Baby
  - a). Male
  - b) Female
  
- 5) Where exactly in the home did you deliver?
  - a) In a room inside the house
  - b) Outside the house
  - c) Backyard of the house
  - d) Special place constructed for delivery outside the house
  - e) Other .....
  
- 6) Who assisted during the delivery
  - a) No attendant
  - b) Neighbour
  - c) Mother
  - d) Mother –in- law
  - e) Other family member
  - f) Auxiliary nurse midwife
  - g) Health assistant
  - h) Traditional birth attendant
  - i) Others (specify: .....





- f) Other causes
- Lack of escort during labour Yes/No
  - Precipitate labour Yes/No
  - Home delivery are easy and continent & less expensive Yes/No

9) The distance from nearest health care facility (Sub-Centre/PHC) to your place of delivery.

- a) Within in the village
- b) Within 3 Kms.
- c) Within 6 Kms.
- d) Within 9 Kms.
- e) Within 12 Kms.

10) Was the place you delivered clean and tidy?

- a. Yes
- b. No
- c. Don't no

11) Have you received any Medicines or any other feeds during labour pain

Yes/No

If so mention: .....

12) Were there any medical complication during delivery

Yes/No

If yes what

- a) Obstrunatal labour
- b) Prolonged labour
- c) Compulsion during labour
- d) Malpresentation during labour
- e) Delayed 3<sup>rd</sup> stage of labour
- f) Still birth?
- g) Delayed baby care
- h) Twin delivery
- i) Extensive tear of perineum during delivery
- j) Post natal infective/reports.
- k) Excessive bleeding.

13) What was the baby fed on first

- a) Breast milk/colostrum
- b) Breast milk form other woman
- c) Formula feed
- d) Cow's milk
- e) Glucose water
- f) Plain water
- g) Honey
- h) Others (Specify: .....

14) How soon after delivery did the baby breast fed

- a) 0 to 60 minutes
- b) 1 hour to 12 hours
- c) 12 hour to 24 hours
- d) 1 to 3 days

15) After delivery the baby was healthy at present

- a. Yes
- b. No
- c. Don't No

16) Did ANM/ASHA/Staff Nurse visited you after delivery

Yes/No

When .....

- a). Same day
- b). Next day
- c). One week

17) After delivery did you visited Health care facilities

Yes/No

If yes where .....

When

- a). Same day
- b). Next day
- c). One week

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18) Anybody in your house restricted in utilizing health care services

Yes/No

If yes mention who .....

19) Do you think that deliveries at home are safe

a. Yes/No Yes                      b. No                      c. Don't No

20) Do you think deliveries has to be under Medical Supervision

a. Yes                      b. No                      c. Don't No

21) Do you think that National Rural Health Mission has benefited in providing good Maternal and Pregnancy care.

a. Yes                      b. No                      c. Don't No

22) Do you think that NRHM amounts are sufficient for present situation

Yes/No

If No mentioned the required amount .....

23) Do you know that 108 also gives free delivery and transport services?

a. Yes                      b. No                      c. Don't No

If yes, why not utilized the services .....

24) Did you deliver at home

- a). By your own will.
- b). By pressure from family/community.

23) Where do you wish your next delivery

a). Home

b). Hospital.

24) Do you think that institutional deliveries are necessary

- a. Yes                      b. No                      c. Don't No

If yes mention reason for .....

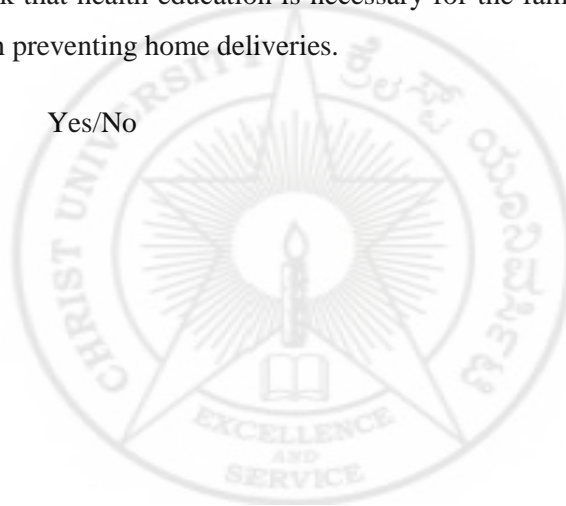
If no mention reason for .....

25) Do you think that more health education is necessary regarding institutional delivery and pregnancy care.

Yes/No

26) Do you think that health education is necessary for the family members and community members in preventing home deliveries.

Yes/No



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