Introduction
CHAPTER I
INTRODUCTION

The phenomenal growth and penetration of the Information and Communication Technologies (ICTs), more particularly the mobile phones is the resultant of the need for being connected and communicated. Mobile phone communication has transcended the geographic boundaries, socio-demographic barriers and the economic differences as a whole. The adoption of mobile phones has created enormous difference in the lives of people, the way they communicate, and involve in other activities including banking, health, agriculture and governance. According to the ITU, International Telecommunications Union, mobile phone coverage is now near ubiquitous, with an estimated 95% of the global population living in an area covered by a basic 2G mobile cellular network. On a more advanced level, the total number of mobile broadband subscription is expected to reach 3.6 billion by end of 2016 (ITU 2016). For majority of the people living in Low and Middle Income Countries, mobile phones are more than just a gadget; as it is the only access of communication and information.

The ubiquity of mobile technology allows the health care industry to address one of the pressing global challenges and for the provision of a quality, cost friendly and accessible healthcare to the poor and the needy. The presence of mobile phones has transformed healthcare into a patient centric, efficient and quality one. The overwhelming health necessities prevailing in the developing countries explains the rapid adoption of m Health in these markets.

According to WHO, m Health can be defined as the provision of health services and information via mobile technologies such as Mobile Phones and Personal Digital Assistants (PDAs) (WHO, 2012).

Mobile technology is capable of bringing in improvements in healthcare quality and access as evidenced in many cases around the world such as

- Treatment support provided through compliance reminders and medication reminders
- Patient Tracking through digital records which reduces errors in diagnosis, treatment and prescription
Supply Chain management for tracking and monitoring distribution of Healthcare commodities such as m Pedigree

Health financing for insurance and delivery of financial incentives similar to m Pesa

Health Emergency Services like 1298 in India

Inclusion of more patient into the broader health system through mobile phone enabled data collection & reporting by the health workers.

Surveillance & collection of time sensitive data during the emergence of epidemic disease conditions.

The above mentioned m Health interventions use text messaging, video messaging, voice calling, mobile applications and many other possibilities of mobile phone technology. m Health is appealing to the healthcare industry for one reason that it is possible to have interactive two way communication which is highly essential for patients ranging from self monitoring of chronic diseases to making improvements in the rural health infrastructure. It is also feasible to address the cultural behaviours through their access and use of mobile technology

Among the varied possibilities of mobile technology, text messaging is the widely accepted and used tool for health care improvements. The availability of the feature in almost all models of mobile phones, the cost involved, widespread use, low level of technical literacy to operate makes text messaging the most wanted tool of m Health. It is possible to design tailor made messages in their native language, allow for accessing the messages at their own convenience, and asynchronous delivery and receipt of messages. These are the reasons behind using text messages for many m Health interventions.

Maternal mortality is a health indicator that shows very wide gaps between rich and poor, urban and rural areas, both between countries and within them. The risk of a woman in a developing country dying from a maternal-related cause during her lifetime is about 33 times higher compared to a woman living in a developed country (WHO, 2016). Realizing the importance of this health gap, UN MDG 4 and 5 for 2015 and the present
Sustainable Development Goal 3 for 2030 have been framed to reduce child mortality and improve maternal health. Mobile phones are the most prevalent technology in all the developing countries which can be effectively utilized for bridging this gap.

1.1 Public Healthcare system in India

In India, the challenges of health are huge in magnitude due to its population, and also complex due to the diversified culture and prevailing poverty. There are interstate variations as they are in different stages of demographic transition, epidemiological transition and socio-economic developments.

The Indian Constitution (Article 21) guarantees the fundamental right to life. By this right the constitution casts an obligation upon the state to preserve the life of every person by offering immediate medical aid. (M. C. Gupta, 2002).

Indian public healthcare system has a three tier delivery system. The first tier and the peripheral contact point between a Primary Health Care system and the community is the Health Sub Center (HSCs) which serves a population of 3,000 in hilly areas and 5,000 in plains. The Primary Health Center (PHCs) is the second tier and the next contact point between community and a medical officer for every 20,000 people in hilly area and 30,000 people in plain areas. In the third tier, for every 80,000 people in hilly areas and 1,20,000 people in plain area there is a Community Health center (CHCs) and serves as a referral center for every 4 PHCs. The city hospitals and the civil hospitals are basically curative centers providing outpatient and in-patient services for primary, secondary and tertiary care.

In spite of the existence of such a strong Healthcare system, inadequacy in availability of health infrastructure, resources and poor service quality are still prevalent, especially in rural and remote areas. The Ministry of Health and Family Welfare introduced National Rural Health Mission (NRHM) with an objective to bring improvements in the access, affordability and effectiveness of healthcare to the poor and vulnerable population in the rural areas.
1.2 Maternal Healthcare system in India

A strong perception of the policies and programs initiatives for maternal and child healthcare by the Indian Government will give a deeper insight about the scope of maternal health in these programs.

National Health Mission was started with an objective to provide accessible, affordable and quality healthcare. The two arms of National Health Mission are National Rural Health Mission (NRHM) launched in 2005 aiming to serve the rural and vulnerable population and at a later stage National Urban Health Mission (NUHM) launched in 2013 for providing healthcare to urban poor in particular.

Integrated Child Development Scheme (ICDS) is considered to be one of the world’s largest schemes for pregnant women and early childhood development. This programme is executed with the help of Anganwadi workers (AWWs) who are responsible for services including immunization, health checkups, nutrition, health education to children below 6 years and women of reproductive age.

Mother and Child Tracking System (MCTS) gathers health information from antenatal and postnatal women in an attempt to ensure healthcare delivery to these women and to under-five children. The MCTS is an ambitious plan to register all pregnant women and children under the age of two and track the health services that are provided to them. This system also operates as a feedback system for Accredited Social Health Activisits (ASHAs), Auxiliary Nurse Midwifes (ANMs) and other health care providers to improve health services for pregnant women and children. Health workers record their services on paper-based forms, which then go to data entry operators who enter the data into the system at the block level (an administrative unit below the district where a normally public health center normally exists), after which the data is then uploaded to the central-server. This data is used to develop work plans and home visit schedules which are sent back to the ASHAs and ANMs via SMS.

Under MCTS, appropriate health promotion messages to beneficiaries that are relevant according to the month of pregnancy or date of birth of the child are being sent on mobiles of beneficiaries. MCTS is also being used for transfer of JSY benefits to pregnant women after delivery as is presently being done in over 120 districts.
To strengthen the public health infrastructure and enhance access in a cost effective manner, the government has recently launched four new mobile health services.

- Kilkari
- Mobile Academy
- M-Cessation
- TB Missed Call initiative

These initiatives are part of the Government’s Digital India program, aimed at leveraging India’s expanding mobile phone penetration.

1.3 Maternal Healthcare system in Tamil Nadu

Tamil Nadu has around 8,706 HSCs, 1,750 PHCs, 134 UPHCs, 239 taluk and non taluk hospitals and 31 district headquarters hospitals to serve a population of 7.21 crores. To enhance the quality of maternal health care and improve the access for the pregnant women and infants, Government of Tamil Nadu has deliberated several programmes and initiatives. Financial incentives for pregnant women delivering at Public Health facilities are provided through Janani Suraksha Yojana (Government of India) and Dr. Muthulakshmi Reddy Maternity Benefit Scheme(Government of Tamil Nadu). This has enhanced the rate of Institutional delivery in the State. Provision of free drugs, diagnostics and diet for the duration of the stay, free transport facility from home, inter facility transfer and transport facility back to home for women delivering in the Public Health facilities are also provided through Janani Sishu Suraksha Karyakram with an aim to reduce the out of pocket spending for the women. Pregnant women diagnosed with maternal anaemia are given with iron sucrose injection through Maternal Anaemia Control Programme and Screening and follow up of pregnant mothers with gestational diabetes is enabled through Gestational Diabetes Control Programme. To enhance the infrastructural facility the PHCs are placed with three contractual staff nurses to provide round the clock services and more number of PHCs will be included with such facility in the near future.

In addition to these programmes, Maternity Picnic and Bangle Ceremony is conducted for all the registered pregnant women to establish a mutual trust and
confidence between the service providers and the pregnant women. Also the Birth Companion Programme allows one family member to be with the pregnant women in the labour room to provide a psychological support for them.

Pregnant and Infant Cohort Monitoring and Evaluation is a local version of Mother and Child Tracking System (MCTS) application which is successfully functioning in Tamil Nadu for collecting data about the pregnant women and the children. Weekly PICME data is updated in state MCTS application and supported by National Informatics Center (NIC).

1.4 Setting the premises for the study

Mobile phones have become ubiquitous and are accessed by the rural and marginalized population as well. The wireless tele density in India is 81.18 at the end of May 2016 and Tamil Nadu ranks third largest in tele density with 117.36 among the Indian states (TRAI, July 2016).

With such a promising mobile subscription base, the most demanding and the needy transformation in the health sector can be fulfilled. Addressing to many of the stumbling blocks in the provision of healthcare for the developing countries including India, it can be seen that possibilities of m Health varies from enabling access to health workers, getting instant advice by the people from far flung areas, better handling of emergencies (Chib et.al, 2012) to bringing timely help and reducing the delay in seeking healthcare (Nquimfack et.al, 2012). Based on the review of studies, text messaging is found to be one of the most preferred modes of m Health for several reasons including its cost effectiveness, asynchronous delivery and content accessibility at any point of time. The only concern here is the language proficiency and the literacy level among the recipients.

Health care through technology can be approached in two dimensions – health and technology as such. To gauge the health behaviour of an individual several factors such as performance expectancy, social influence, behavioural intention etc are found to be influential. Similarly usage of technology depends on ease of use, self efficacy, facilitating conditions and attitude towards technology. Thus, it becomes essential to understand the factors that lead to the formation of attitude towards m Health along with the efficacy of m Health in bringing a healthier healthcare system.
It is visible concern that India contributes to 20% of the global maternal deaths (MNH Toolkit). According to Health Statistics, the Maternal Mortality Ratio (MMR) in India was 167 in the year 2015 (174 as mentioned in WHO statistics). However, there are inter-state and intra-state variations of this maternal mortality. With reference to Tamil Nadu, the maternal mortality ratio is found to be 68, according to State HMIS data, 2015. This is comparatively lower than the MMR of some states.

Though MMR is considerably low in the state, the need to address some issues relating to prenatal care of the expectant mothers arises, which will affect their health in the post-natal state too. Besides, the usefulness of m-Health has not been experienced by the people of Tamil Nadu, save the interventions on a small scale to reach the rural and marginalized. In view of this, the present study attempts to create an awareness of antenatal care during women’s pregnancy period through mobile text messages. Through this study the usefulness of the healthcare mobile messages in increasing the knowledge and also the attitude of people towards using mobile phones for other health purposes are analysed.

The area of study, Coimbatore is one of the most important and second largest cities in Tamil Nadu. According to Indian Census 2011, Coimbatore has a total population of 3472578, with a sex ratio of 1001 females for every 100 males, and female literacy percentage of 79.16%. The public health care system infrastructure in Coimbatore has 58 Primary Health Centers, 20 Urban Health Centers, and 328 Health Sub Centers that caters to the marginalized population.

With this pretext, the feasibility of using mobile phones for the provision of health care (m Health) among the public more effectively and efficiently is more promising in Coimbatore. Hence, the most important health concern of most of the developing countries, maternal health care is taken up for the study more precisely, the effectiveness of text messages in creating antenatal care awareness among the expectant mothers. The study also examine the attitude of the people towards using mobile phones for accessing health services based on the constructs of the Unified Theory of Acceptance & Use of Technology (UTAUT) theory.
1.5 Theoretical Background

The Unified Theory of Acceptance & Use of Technology was developed by Venkatesh et al. [2003] to present an integrated view of user acceptance and usage of new technology. The models reviewed and integrated into UTAUT include TRA, TPB, TAM, TAM2, IDT, Motivational Model, Model of PC Utilization (MPCU) and Social Cognitive Theory (SCT). It is widely established that the UTAUT has the highest power in explaining behavior intention and usage than any of the other theories as it brings the features of technology acceptance theories and behaviour change theories to understand the factors that determine behavior intentions.

The four key constructs, performance expectancy, effort expectancy, social influence, and facilitating conditions, affect intention to use. The key moderators in the model are gender, age, voluntariness and experience.

In greater detail, performance expectancy refers to “the degree to which an individual believes that using the system will help him or her to attain gains in job performance” [Venkatesh et al. 2003]. Effort expectancy refers to “the degree of ease associated with the use of the system” [Venkatesh et al. 2003]. Social influence is defined as “the degree to which an individual perceives that important others believe he or she should use the new system” [Venkatesh et al. 2003]. The added construct - facilitating conditions - is defined as “the degree to which an individual believes that an organizational and technical infrastructure exists to support use of the system” (Venkatesh et al. 2003).

Along with these factors, Attitude, Behavioural Intention and Self Efficacy, the indirect determinants of usage behaviour are taken as additional factors to study the attitude of the people towards using mobile phones for accessing health services.

By theory, Self-efficacy has been modeled as indirect determinant of behaviour intention fully mediated by perceived ease of use (Venkatesh et al. 2003). Attitude toward using technology is defined as an individual’s overall affective reaction to using a system and Behavioral intention is identified to have a significant positive influence on usage of technology (Venkatesh et al. 2003).
Fig. 1.1

CONCEPTUAL FRAMEWORK FOR THE STUDY

**Experimental Study**
Expectant Mothers

Pre-test

m Health Intervention

Post-test

**Survey**
Expectant Mothers

Demographic Variables
Age, Education & Family

Mobile Technology Usage Pattern
Attitude towards Using Mobile Health Services
Based on constructs of UTAUT
- Performance Expectancy
- Effort Expectancy
- Social Influence
- Facilitating Conditions
- Behavioural Intention
- Self Efficacy
- Attitude

Results
Reinforcements and Recommendations on m Health Interventions

**In-depth Interviews**
Health officials
Doctors
Village Health Nurses
Expectant Mothers

Insights into the UTAUT constructs
- Performance Expectancy
- Effort Expectancy
- Social Influence
- Facilitating Conditions
- Behavioural Intention
- Self Efficacy
- Attitude
1.6 Need for the study

At a closer scrutiny, it becomes evident that the lower status of women in terms of education, economic power, access to information and limited reproductive health conditions converge into a situation of alarming rate of maternal deaths happening in the developing countries. This is one of the most concerning health gap which exists between the developed and developing countries.

With the introduction of m health, mobile phones can facilitate for emergency transport, consultation, remote diagnosis and other reproductive health programmes for the women in rural and remote areas. An increase in the number of Antenatal Care (ANC) visits, consumption of Iron and Folic Acid (IFA) tablets and the recommended types of immunization are the most essential outcomes of m Health interventions aiming at maternal healthcare.

While the number of programmes using mobile technologies in health care is increasing globally, there exists a significant gap in knowledge regarding its impact on health outcomes, as well as intermediary factors like access, quality, and experience. Some within the development and global health communities are demanding more research evaluating if and how m Health improves the impact in global health programs. Accordingly, generating quality evidence through methodologically rigorous research has emerged as a priority for the broader m Health community.

It is a well-known fact that the field of m-Health is still in its nascent stage in many of the developing and the developed countries as well. The potential of mobile phones in the dissemination of health care for the marginalized is unquestionable. In India and other developing countries, the cost and accessibility factors have made quality healthcare a distant reality for such population. Very few studies have attempted to analyse the attitude of people and their behavioral intention to use m-Health for their health issues. This study can be a step towards understanding the factors that would make people considers m-Health a feasible solution for their long deprived health needs.
Given that the use of mobile phones as a mode of communication in healthcare is inevitable, it is necessary to assess rural end-user perceptions and experiences with the technology. This would help appraise healthcare delivery via mobile phones to 70% of the country’s population residing in rural India.

1.7 Statement of the Research Problem

Taking into consideration the need to study the effectiveness of m Health in India, the researcher undertook to find out the “Efficacy of m Health Intervention in Creating Essential Knowledge for Antenatal Care among the expectant mothers in Coimbatore”.

1.8 Scope of the Study

The study examines the efficacy of text messages in creating essential knowledge for the expectant mothers. It is a known fact that the maternal mortality ratio (MMR) in India is higher than the global standards. One of the major reasons for the high MMR is the lack of awareness on maternal healthcare. In addition to addressing this aspect, it is also considered imperative to understand the factors that lead to the formation of attitude to use mobile phones for accessing information and other health services among the public. M Health can galvanize in the development of healthcare system only if the attitude of the public is positive for the usage of mobile phones in accessing health services, which is analysed through this study based on the constructs of Unified Theory of Acceptance and Use of Technology (UTAUT).

1.9 Objectives of the study

The major objectives of the study are as follows:

- To examine the pre-intervention knowledge level on antenatal care among the expectant mothers.
- To find out the post-intervention response level on antenatal care among the expectant mothers.
- To find out the factors that influence the people’s attitude towards usage of mobile phones for health services based on the Performance Expectancy, Effort Expectancy, Social Influence, Facilitating Conditions, Behavioral Intention, Self Efficacy and Attitude.
In order to find a feasible solution for delivering quality healthcare through mobile phones to the rural and the marginalized, the following research questions were raised:

- To what extent the expectant mothers can use mobile phones in increasing their knowledge on antenatal care?
- What are the factors that will enable the people to adopt m-Health for their healthcare?
- What are the factors that will influence the attitude of the people towards m-Health based on the Performance Expectancy, Effort Expectancy, Social Influence, Facilitating Conditions, Behavioral Intention, Self Efficacy and Attitude?

1.10 Limitations of the Study

The text messages were sent to the expectant mothers only for a period of one month irrespective of the stage of pregnancy they were in. There is a chance that the messages would have gone unnoticed by the respondents. However, care was taken that the messages addressed the overall pregnancy period instead of each trimester. Some of the respondents were equipped with only a mobile phone shared with their husbands which might have led to the oversight of the messages sent. Another factor which is considered as an impediment is that, though there were 375 respondents who were interviewed for the pre-test and text messages sent to all of them, only 198 people could be reached for the post test despite the intervention of the Primary Health Centers. Though the attitude statements in the schedule were designed both in English and Tamil, in a simple and comprehensible language based on the pilot study results, it still stand as a doubt, if the respondents had understood the essence of the statements.

1.11 Operational Definitions

1. **Respondent** refer to the expectant mothers who visited the Primary Health Centers for their ANC visits and volunteered to participate in the study.

2. **Health messages** refer to the messages that addresses to the issues and complications that need to be taken care during the pregnancy period or antenatal period.
3. **Expectant Mother** refers to a pregnant woman whose baby is going to be born soon.

4. **Knowledge level** refers to the awareness level of the respondents on Antenatal care before the intervention of sending text messages on Antenatal care.

5. **Response level** refers to the awareness level of the respondents on Antenatal care after the intervention of sending text messages on Antenatal care.

6. **Essential Knowledge** refers to the awareness of antenatal care including Registration of pregnancy, ANC visits, TT injections, Scans, Folic acid supplements, Anaemia, Gestational diabetes, foetal movements, weight gain, nutritional aspects, birth preparedness, signs of labour and general advice.

7. **Performance Expectancy** refers to the expectations of the users of m Health to result in improvement in health behaviour, timeliness in access to healthcare, quality in the services, and usefulness of the messages.

8. **Effort Expectancy** refers to the expectations of the users regarding the ease of use they can experience in using the mobile phones for accessing the health services such as operating the mobile phones, understanding the content of m health and convenience in accessing the services.

9. **Social Influence** refers to the importance the users attribute to the views of the people surrounding them on their usage of mobile phones for accessing health services.

10. **Facilitating Conditions** refers to conditions that facilitate the users for accessing health services through mobile phones such as affordability, network connectivity, infrastructure and training.

11. **Behavioural Intention** refers to the intention of the user to indulge in the intended behaviour, in this case, use of mobile phones to access health services.

12. **Self Efficacy** refers to the perception of the users in their individual capacity to operate mobile phones for accessing health services.
13. **Attitude** refers to the feelings positive or negative, the user has in performing the target behaviour- using mobile phones for accessing health services.

14. **Maternal Health** refers to the health of women during pregnancy, childbirth, and the postpartum period. It encompasses the health care dimensions of family planning, preconception, prenatal, and postnatal care in order to reduce maternal morbidity and mortality.

15. **Antenatal care (ANC)** refers to pregnancy-related health care, which is usually provided by a doctor, an ANM, or another health professional.

16. **mHealth** refers to the use of mobile phones and communication devices to educate consumers about preventive health care services.

17. **Mobile application** refers to a type of application software designed to run on a mobile device, such as a smart phone or tablet computer.

18. **Intervention** refers to the text messages on antenatal care sent to the mobile numbers of the expectant mothers for a period of one month.

19. **m-Pesa** refers to a mobile phone-based money transfer, financing and microfinancing service, launched in 2007 by Vodafone for Safaricom and Vodacom, the largest mobile network operators in Kenya and Tanzania.

20. **mPedigree** refers to an anti-counterfeit ICT software application that seeks to empower the consumer so that they have a way of verifying their medication's safety.

21. **Dial 1298** refers to Ambulance presently operates in Bihar, Odisha, Punjab, Kerala and Mumbai. The ambulances are owned by Ziqitza Health Care and the service is made self-sustainable by charging the end user a fee that differs based on the choice of private or government hospital. Socially responsible corporates also extend their support by advertising on ambulances.

22. **Pregnancy and Infant Cohort Monitoring and Evaluation (PICME)** refers to the software started on 1st April 2008 (Pioneer to MCTS) in rural and urban from 2011. The mothers are given a unique ID called “PICME Number”. The details of
pregnant mothers are entered right from the date of early registration upto the completion of 1st birth day of the Child by VHNs. The Data’s used for high risk cases referral & Monitoring.

23. **Dr. Muthulakshmi Reddy Maternity Benefit Scheme (MRMBS)** refers to the scheme in Tamil Nadu with an objective of providing assistance to poor pregnant women to ensure the access to nutritional food and compensating the wage losses during pregnancy, since 2006. Cash assistance of Rs.12,000 under this scheme is disbursed in three instalments (Rs.4000/- Per Instalment) to poor pregnant women directly by ECS from treasury / treasury bank to beneficiary bank account.

1.12 List of Acronyms

1. **Village Health Nurses (VHN)** refers to the nurses who are first port of call for health services for people residing in rural and remote areas.

2. **Primary Health Center (PHC)** refers to the secondary tier of Primary Health System, to as public health centers which are state-owned rural health care facilities in India

3. **Auxiliary Nurse Midwives (ANM)** refers to a village-level female health worker in India who is known as the first contact person between the community and the health services

4. **Accredited Social Health Activist (ASHA)** is community health workers instituted by the government of India's Ministry of Health and Family Welfare (MoHFW) as part of the National Rural Health Mission (NRHM)

5. **Maternal Mortality Rate (MMR)** refers to the death of a woman who is pregnant or dies within 42 days of ending her pregnancy, with no regard to length of pregnancy or site of the pregnancy. MMR = No of deaths from puerperal causes in a given year and population/ Total number of live births in the same period and population.

6. **Health Management Information System (HMIS)** refers to a data collection system specifically designed to support planning, management, and decision making in health facilities and organizations
7. **Mother and Child Tracking System (MCTS)** refers to an information system for tracking maternal and child health beneficiaries in India's public health system, and improving service delivery planning and outcomes.

8. **National Rural Health Mission (NRHM)** refers to an initiative undertaken by the government of India to address the health needs of under-served rural areas, launched in April 2005.

9. **National Urban Health Mission (NUHM)** refers to a sub-mission of National Health Mission (NHM) has been approved by the Cabinet on 1st May 2013.

10. **Integrated Child Development Scheme (ICDS)** refers to an Indian government welfare programme which provides food, preschool education, and primary healthcare to children less than 6 years of age and their mothers.

11. **World Health Organisation (WHO)** refers to the directing and coordinating authority for health within the United Nations system

12. **Telecom Regulatory Authority of India (TRAI)** refers to an independent regulatory body established by the Telecom Regulatory Authority of India Act 1997 to oversee the telecommunications industry in India.

13. **International Tele Communication Union (ITU)** refers to an agency of the United Nations (UN) whose purpose is to coordinate telecommunication operations and services throughout the world.

14. **United Nations (UN)** refers to an international organization founded in 1945. It is currently made up of 193 Member States. International organization composed of independent states brought together to encourage diplomacy and peace between various countries.

15. **Millennium Development Goals (MDG)** refers to the eight goals with measurable targets and clear deadlines for improving the lives of the world's poorest people. To meet these goals and eradicate poverty, leaders of 189 countries signed the historic millennium declaration at the United Nations Millennium Summit in 2000.
16. **Sustainable Development Goals (SDG)** officially known as transforming our world: the 2030 Agenda for Sustainable Development refers to an intergovernmental set of aspiration Goals with 169 targets. The Goals are contained in paragraph 54 United Nations Resolution A/RES/70/1 of 25 September 2015.

17. **Janani Suraksha Yojana (JSY)** refers to the safe motherhood intervention under the National Rural Health Mission (NHM). It is being implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among poor pregnant women.