Social Status and Functioning of Women Health Workers: A Study of Health Care Services in Hardoi, Uttar Pradesh

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DOCTOR OF PHILOSOPHY

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DECLARATION

I hereby declare that this thesis entitled **"Social Status and Functioning of Women Health Workers: A Study of Health Care Services in Hardoi, Uttar Pradesh"**, submitted to Jawaharlal Nehru University for the degree of Doctor of Philosophy, is my original work. This thesis has not been previously submitted for the award of any other degree of this or any other university.

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CERTIFICATE

We recommend that the thesis be placed before the examiners for evaluation and consideration of the award of Degree of Doctor of Philosophy.

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DEDICATED TO MY PARENTS

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Date (Sonia Verma)

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List of Abbreviations

ABER	Annual Blood Examination Rate
AHS	Annual Health Survey
ANC	Ante Natal Check-up
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	*Anganwadi* Centre
AWW	*Anganwadi* Worker
CHC	Community Health Centre
CHW	Community Health Workers
EAG	Empowered Action Group
FGD	Focus Group Discussion
FRU	First Referral Unit
HCL	Hindustan Computers Limited
HCP	Health Care Provider
ICDS	Integrated Child Development Services
ICMR	Indian Council of Medical Research
ICSSR	Indian Council for Social Sciences Research
IFA	Iron Folic Acid
II	In-depth Interview

IMR	Infant Mortality Rate
IPHS	Indian Public Health Standards
IUD	Intra Uterine Device
JSY	*Janani Suraksha Yojana*
KI	Key Informants
LHV	Lady Health Visitor
MMR	Maternal Mortality Rate
MoHFW	Ministry of Health and Family Welfare
MOIC	Medical Officer in- Charge
MPW	Multi-Purpose Worker
NCDs	Non Communicable Diseases
NFHS	National Health and Family Survey
NGO	Non-Government Organisation
NHM	National Health Mission
NHSRC	National Health System Research Centre
NLEP	National Leprosy Eradication Programme
NRHM	National Rural Health Mission
NVBDCP	National Vector Borne Control Disease Program
OBC	Other Backward Caste
PHC	Primary Health Centre
PRIs	*Panchayati Raj Institutions*
RHS	Rural Health Statistics

RNTCP	Revised Nation Tuberculosis Control Programme
SC	Sub Centre
SCs	Scheduled Caste
SPY	Samajwadi Pension Yojna
ST	Scheduled Tribe
TB-DOTS	Tuberculosis Directly Observed Treatment Short-Course
TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
UP	Uttar Pradesh
UPNRHM	Uttar Pradesh National Rural Health Mission
VHND	Village Health Nutrition Day
VHSNC	Village Health Sanitation and Nutrition Committee
WHO	World Health Organization

CHAPTER 1

BACKGROUND

1.1 Introduction

Health is an integral constituent of development. However, it had been neglected in 1950s and 1960. Drivers of economic growth remained prominent till about 1960s, it was seen as the primary, and often the only, goal of development. In the later years it was realized, that inequalities were widening and therefore the ideas on development started to change. Improvement in health was regarded as necessary for integrated approach for development. The concern of lack of access to health services for rural population in developing countries gave birth to the concept of primary health care (WHO, 1978). The Alma Ata Declaration[1] was a turning point in connecting health and development.

The dominance of medical model was increasingly criticized as often ineffective, culturally inappropriate and inaccessible for poor rural communities. The need to involve communities in planning and provisioning of services was also recognized as essential to effective prevention and education for health (Rifkin, 2001 cited in South, 2013). All these factors led to the development of the community health care concept by the two leading development and global agency, United Nations Children's Fund (UNICEF) and World Health Organisation (WHO). This concept was adopted by the International Conference on Primary Health Care in Alma Ata in 1978.

It expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all people. It was the first international declaration underlining the importance of primary health care. The primary health care approach has since then been

[1] The Declaration of Alma-Ata was adopted at the International Conference on Primary Health Care (PHC), Almaty (formerly Alma-Ata), Kazakhstan (formerly Kazakh Soviet Socialist Republic), 6–12 September 1978.

accepted by member countries of the World Health Organization (WHO) as the key to achieving the goal of "Health for All". The declaration of Alma Ata identified primary health care and community health workers as a part of primary health care and this was considered as key to the delivery of *Health for All* 2000[2].

As documented by Lehmann and Sanders (2007), community health workers (CHW) are the lay people without clinical training who undertake basic health care prevention activities. According to the World Health Organization, a CHW should be:

> 'members of communities where they work, should be selected by the communities, should be answerable to communities for their activities, should be supported by the health system but not necessarily part of its organization, and have a shorter training than professional workers' (WHO, 2007).

The community health workers are the key health care providers to the village people. These health care providers or workers majorly are women and serve as a connecting link between the care seekers and the rural health centers. A conceptual understanding of the functioning of these women Health Care Providers (HCP) is impossible without alluding to their social status as Indian villages are highly socially stratified. The rural HCPs have to function within the maze of micro level challenges that are instrumental in rural setting.

The social identity of an individual determines, by and large, his social status. Though the women HCPs provide health services to the needy, yet it is important to realize the role of the social identity in shaping its trajectory. As such our study thus aims to present as far as possible wide-ranging social identity perspectives which take into consideration the interplay of the factors in influencing the functioning of the women health workers.

While discussing the social identity of women HCPs it is important to understand or analyse that which segment of her social identity give shape to her service provisioning. For matter of fact, is it caste component that adds/deduct her merits

[2] Health for all by the year 2000 (HFA 2000) (WHO 1981) has been launched at the thirteenth World Health Assembly

of being health care providers/workers or the training obtained or knowledge acquired are the marker? There have been numerous incidences where, individuals are discriminated not on the basis of skill or knowledge but on the basis of caste. Individual belonging to a particular caste on an average are thought to have low skill.

Indian society is stratified into various social groups like castes and religious minorities. In case of caste, social and economic rights of each caste are predetermined by birth. *'Caste is a complex and psychological construct'* (Jaspal, 2011) and is said to constitute the primary institute governing personal and social relationships. Exclusion is embedded in social relations, and it is through social inter-relation that the groups are wholly or partially excluded from full participation in the society in which they live. The concept of social exclusion entails the denial of equal rights to the group as a whole (Acharya, 2011). This implies that all individuals belonging to the particular group are denied equal rights, irrespective of their individual attributes. Caste is one of the important axis through which social exclusion is practiced in India.

With such established fact about the caste and social exclusion, it would be interesting to see the type of discrimination practiced during rendering of health care services and also it effects on utilization of the services. Caste plays important role in determining rendering and utilization of health services as it is an important socio-psychological phenomenon in all spheres of Indian social life and particularly within a village.

It is equally important to understand that how social exclusion is instrumental in causing deprivations. I would like to quote Borooah et al. here-

> "Some types of social exclusion may be a constitutive part of deprivation but not necessarily instrumental in causing deprivation. For example, the denial of access to the village well to some families would not have any consequences for them with respect to water supply if these families had piped water supplied to their homes. However, being denied access might constitute deprivation by robbing such families of a sense of 'belonging' to the village.

> Conversely, other types of social exclusion may not be a constitutive part of deprivation but might be instrumental in causing deprivation."

The health care providers and seekers both experience deprivation in health provisioning and seeking respectively, and always try to find a way out. It is crucial to understand these ways out that these health care providers and seekers practice. And also to understand that how these ways out impact the larger community in totality.

The health statistics of rural India is awful as compared to urban (AHS, 2012-13). The rural health centers are poorly equipped and minimally staffed (RHS, 2017). In such a scenario it is the women health workforces who mark the number and caters the health needs of the people (Maes and Kalofonos, 2013). Within the women health workforce, it is the Auxiliary Nurse Midwives (ANM) and Accredited Social Health Activist who serve the population of 5000 and 1000 respectively (NRHM, 2005). So at the village level these two key functionaries are the only health providers who are available round the clock.

The matter of fact is, these women have to work in a very strong patriarchal society and caste being the other constraint variable. These women health workers work under the three implicit situations, first, being women their mobility is constrained due to social and cultural norms that assign them responsibility for reproduction of progeny. Second, being a health provider they are accountable to the health centre but at the same time being resident of the village they assume responsibility for their village people. In such situation, they are trapped in dilemma of whose advocacy to do and whose expectation to fulfill. Thirdly, the situation becomes grave when the women health providers happened to be from the marginalized community. Therefore, the study endeavors to understand the combination of three characteristics of gender, caste and cadre of their work and all three are at the bottom of their respective hierarchal system.

The present research aims to understand the social relationship and dynamics of health interaction when Scheduled Caste[3] and Muslim women health care provider extend services to Scheduled Caste, Muslim and others (non-Scheduled Caste and non-Muslim); and when Scheduled Caste, Muslim and others (non- Scheduled caste and non-Muslim) seek services from providers belonging to different social groups.

The chapter plan for the study is as follows-

Chapter one deals with the background of the study and review of literature which gives an overview of health care in rural India while explain importance of primary health care and its planning. The chapter offers an understanding of fundamental role of women health workers and the hardship they go through while catering the health services. It shows the type of discrimination involved in health service provisioning to Muslims and Scheduled Caste population.

It further tries to conceptualise the process of social exclusion and marginalization in service provisioning and its utilization with intersection of caste and religion based identity of users and providers. The health system hierarchy and service provisioning by the grassroots health worker is taken in cognizance in this chapter. The role of women grassroots health worker as health provider and their social class is discussed. In context of discrimination against Muslims, their lower socio-economic and education status, the two very important committees, i.e., Sachar committee and Kundu committee recommendations are also added. At last the chapter provides a diagrammatic representation of the inter linkages between providers and users.

Chapter two provides the rationale and purpose of the study. The research questions, hypothesis, objectives and operational definitions are included in this chapter. It gives a detailed account of study design employed in the study where

[3] Scheduled Caste is various officially designated groups of historically disadvantaged indigenous people in India. The terms are recognised in the Constitution of India and the various groups are designated in one or other of the categories. The term 'Dalit' to refer to the ex-untouchable communities of India, who are constitutionally categorised as Scheduled Castes (SC). The researcher uses the term 'SC' interchangeably as well, especially while referring in terms of data.

the study area has been described. This section also provides a comparative demographic profile of the study district and the State. Need of the study, sampling frame, data sources, tool and techniques used for the study is described in detail. Ethical consideration and data analysis framework is described towards the end of the chapter.

Chapter three relates to the finding of this study. It begins with a brief description of ANM and ASHA followed by socio- demographic profile of the study participants. Nature of employment followed by an illustration of their training modalities and glitches is also presented. Their training duration, working experience, their roles and responsibilities and population coverage are illustrated in the chapter.

Chapter four presents an account of social identity and interaction pattern of health care service providers from the providers' perspective. It provides social characteristics of the study respondents along with the characteristics of the population served by ANMs and ASHAs. It focuses on the interface of the women health workers and community within and across castes. The types of services provided by the health care providers to different social group are presented. It further describes the providers' perspective on health seeking patterns among the seekers of various social statuses. It also illustrates the reason accounted for seeking care from ANMs and ASHAs. The chapter also emphasize on the assistance received by the health care service providers by different stakeholder. Dynamics involved in obtaining help from them is also reported in the chapter. The differential in interaction pattern is highlighted with help of verbatim quotes.

Chapter five focuses on interaction pattern among the health care service providers and the seeker across the social class from the seekers perspective. The chapter starts with a brief description of the background information of the care seekers. It examines the health interaction, determinant of health interaction, care seekers perceptions regarding ANMs and ASHAs behavior. Pattern in dispensing medicines to care seekers, patterns in providing health related information is also analyzed. The second section of the chapter focuses on the health service utilisation from the seekers experiences where the underlying factors influencing the health service utilisation is discussed in detail

Chapter six examines the structural factors affect the functioning of the women health workers in the first section. The health system structural anomalies such as nature of work (primary versus secondary), work time analysis, population coverage, health infrastructure, distance to be covered for work, the supply of medicine is described in detail. The second section, social anomalies found in the study area is emphasized. This chapter explicates the types of barriers confronted by the women health workers in service provisioning.

Chapter seven focuses on social identity and perception of health care services at grassroots. It provides an overview of the pathways involved for access and delivery of the health services. It outlines the importance of social identity in understanding social interactions. It further shows the influence of identity on perception and profession. Strategies used to perpetuate social identity is also discussed along with the conflict and dilemmas involved in perpetuating social identity. The chapter also captures that a sense of control and autonomy was visible among the care providers of different social group.

Chapter eight presents the summary and discussion of the findings of the study. It concludes the thesis with policy recommendations on the future prospects of the women health workers in context of social identity and professional responsibilities. It also recommends the policy maker to give more attention towards sensitizing element and it should be importantly added in the training module.

1.2 Review of Literature

The present section is divided into two sub-sections, first sub- section deals with the reviews of existing literature, and an overview of the healthcare services in India with special focus on rural health care services. It reviews the relevant studies on the importance of the women health workers and also the challenges faced by them during rendering of the services. This section also provides information on social exclusion and identity based discrimination and other barriers in health care service provisioning and access. The second sub- section of the chapter gives an impression of discrimination practiced during the service provisioning to SC and Muslim Population. From the available literature review a conceptual framework is evolved in order to understand the functioning of the women health workers with varied social identity in rural setting which is also diagrammatically represented.

1.2a Healthcare in Rural India: An Overview

This section presents the broader picture of health services in India with focus on Uttar Pradesh. It is imperative to understand how the health system planning started and then where it reached.

Health planning in India has gone through various phases of health system development (Duggal, 2002). Primary health care has been vital strategy and was considered mainstay of the health services delivery (Pandve and Pandve, 2013). But the poor rural dwellers continue to have poor access to the primary health care and hence widely suffer from preventable or curable diseases (Banerji, 2005). The existing vast primary healthcare infrastructure is not able to adequately respond to the health needs of the population (Kumar and Mishra, 2015).

For health planning, maternal and child health care has been the major component of primary health care and received significant support from the international agencies. A study conducted by Khan et al. (2009) in one of the districts of Uttar Pradesh with the objective to identify 'the existing maternal health care practices during pregnancy and childbirth and the barriers to avail of these services.' The study found that there is inadequate infrastructure in the district and the health care

facilities are not expanding according to the demand. The facilities related to maternal health practices like antenatal, postnatal check-ups and delivery care are not appropriately delivered to the people. This study also looked into the doctor-patient relationship and revealed that care seekers are not satisfied with the behavior of doctors as well as ANMs and other health care providers of the primary health centers in their district. They found that ANMs attached to the health center have very poor inter-personal skills, and they do not take care of the care seeker's autonomy and privacy while delivering services to them.

The utilization of maternal healthcare services is also not up to the acceptable level across the socio-economic characteristics of the population. It was revealed by Powell-Jackson et al. (2013) that utilization of public healthcare services is very low among the vulnerable sections of the society. Sufficient literature by Mehrotra (2008), Pandey (2011), Kumar and Singh (2016) have shown that utilization of maternal health care services available at public health facilities is very low in Indian states. This may be because of poor quality of the general health services, inappropriate location of the health center, unfavorable visiting hour, unavailability of facilities at health centers (Kumar and Singh, 2016). Owing to this a number of women have to face severe maternal complication while their pregnancy. According to Gupta et al. (2006), who by using NFHS data have quoted, 68 percent of the maternal deaths in India happen due to pregnancy related causes. However, most of the deaths occur during the postnatal period who did not receive any healthcare during the antenatal period.

Access to health services is limited to some particular peoples of the society due to certain system related bottlenecks (Kumar and Singh, 2016) which have led to under-utilization of public health services. The issue of under-utilization of the health services is more alarming in many of the less developed Indian State. It was reported by Pandey (2011) that utilization of public health services is abysmal in primary healthcare setting of Uttar Pradesh. The central and State governments across the Indian states are continuously striving to increase universal access to health services. There have several challenges identified in obtaining universal coverage; imbalance in resource allocation, inadequate physical access to high

quality health services and human resource for health (Balarajan et al., 2011). Baru et al. (2010) suggested that access to health care in India has been quite unequal among regions with several variations like caste and class. They also highlighted that even availability of health services has also been unequal in India which has been largely responsible for widening the differentials in health outcomes. The paper has also suggested that there are inequalities in utilization of preventive services such as childhood immunization and antenatal check-ups. The variations across the states exist which has been pronounced in terms of infrastructure, human resources, supplies, bed-population ratios and spatial distribution of health institutions. The high dependence on private health care was also underscored due to the weakness in the delivery of public health services. The researchers have also thrown light on regulatory and institutional mechanisms for promoting accountability to consumers of health services are extremely weak in public sector health facilities.

Uttar Pradesh has one of the lowest life expectancy in India. The poor standard of healthcare is a pressing issue in Uttar Pradesh. The infant mortality rate (IMR) in UP) in 2016 was 43 compared to an all India figure of 34[4]. During the years 2015-16, 39.5 percent children under the age of 5 years in UP were underweight and 63.2 percent children age 6-59 months were suffering from anemia, while India averages for underweight was 35.7 percent (NFHS-4). Health indicators for the poor, women and especially *Dalits* are disappointing (Jeffrey et al., 2008). In Uttar Pradesh, the quality of primary healthcare services is found disappointing (Kumar and Mishra, 2015) which precedes numerous preventable health problems to its advance stage and contributes to disability (Dasgupta, 2005; Mehrotra, 2008). Due to the poor quality of public healthcare services in Uttar Pradesh (Kumar & Singh, 2016), people suffer from the problems of worst health outcomes even among the Empowered Action Group (EAG) states of India (Bajpai, 2014).

The extent of inequality in health status and health care services was attempted to measure by Anand (2014) in two states - Uttar Pradesh and Bihar. The study

[4] http://social.niti.gov.in/uploads/sample/health_index_report.pdf accessed on 15.07.2018

showed low overall health status and wide inter-district and inter-region health disparity in the two states with the lower disparity in Uttar Pradesh as compared to Bihar in terms of health status and comparatively high disparity in health infrastructure. Acute scarcity of health infrastructure especially in backward and rural areas of the states was present. Greater commitment on the part of the government is required to create basic facilities and increase the role of educational institutions, media, political and social activists to create health consciousness. The study, further suggested that the diminishing public health system of the two states was not able to adequately cater to the health needs of the population.

Health status of a population is very much dependent on the utilization of the health services. Therefore, a study by Willis et al. (2011) on utilization and perception about existing neonatal health care services in *Shivgarh* - a rural block in Rai Bareilly district of Uttar Pradesh is important to document. The study found that the neonatal mortality is increasing tremendously due to the lack of quality curative services for sick newborns. The study explained that only 55% households were utilizing public health services, and they were satisfied with the entire health care received from the health centers. The patients were satisfied with the unqualified allopathic practitioners in comparison with qualified allopathic doctors. This was mainly due to the direct interaction of the patients with the unqualified allopathic practitioners, less waiting time, explanation of the immediate treatment by these unqualified doctors and the explanation of the follow-up care with them. It was also found that the unqualified health providers pay more time and attention to their patients in comparison to qualified physicians. So, the majority of the people opt to visit these private practitioners over public health facilities.

1.2b Crucial Role of Rural Health Care Providers

Reasonable amount of literature (Bender and Pitkin, 1987; Jenkins, 2008; Rosato.et al., 2008; Gopalan, 2012) is available to comprehend the crucial role of rural healthcare providers in improving the health statistics. Patel and Nowalk (2010) reviewed the effectiveness of community health workers (CHWs) in expanding immunization coverage in developing countries. The scholars have explained the

contribution of CHWs towards strengthening the immunization services in rural India. Immunization help to reduce under-five mortality and it is a basic service of any public health system. In the rural sector, only 39 percent of children aged 12-23 months have been fully immunized. Those who are not immunized are about 9.4 million in India. To strengthen the rural health system and reach to the goal of immunization, National Rural Health Mission (NRHM) trained 250000 CHWs because they are assumed to reach the vulnerable population better. The CHWs motivate community for the need of immunization and triggers them for its utilization. Interventions developed by the CHWs like village meetings disseminate the information and it has enabled substantial increase in utilization of immunization services.

Some scholars like Haines et al. (2007) examined that rural health workers also play a substantial role in child survival by doing case management of childhood illness, i.e., pneumonia, malaria and neonatal sepsis. They deliver preventive interventions such as immunization, promotion of healthy behavior and mobilization of communities for the child survival. Therefore, they are considered as the expertise in the case management and management of ill health among the children. Likewise, Poitevin (1988) describes the capacity of illiterate or hardly literate peasant women to understand the system of health relations within which they operate as health workers.

Grassroots level workers are the backbone of rural health services in the Indian health scenario, sub-centre works as a bridge between rural community and the primary health care system (Razee et al. 2012). A sub-centre is responsible for providing primary health care and makes the services more responsive and effective for the rural community. In rural health system ANM and ASHA play key role in delivery of basic health services, like immunization, and other preventive and primary health care services. ANM are the key field- level workers who interact directly with the community and have central focus of all the reproductive and child health programs (Mavlankar & Vora, 2008). ASHAs work at the interface between the community and public health system, mobilizing community members to obtain health services. Owing to the influence that ANM and ASHA

can have on families as they frequently interact with community member, the perception and practices of these frontline workers are important (Thacker et al., 2013).

1.2c Challenges Faced by the Rural Health Providers

Health workers are the key functionaries in health care delivery and their crucial role in improving health indicators has been widely acknowledged. Hongoro and McPake (2004) have put thrust on them by mentioning them as 'crucial core of a health system'. They have also very clearly articulated that they have been a 'neglected component' of health-system development.

The health worker goes through a numbers of barriers while delivering health services in rural areas. Sheikh and George (2010) explained the uneasiness that health worker goes through especially in rural areas. The researchers have found that the problems that these grassroots health workers face in the health system of India are complex, diverse and unregulated. They negotiate the interface between the health sector role and community expectation. Motivation of the worker to work and their perception towards co-workers as well as social origins and differences are important in this context. The informal relationships, boundaries and hierarchies that constrain and sustain the rural health workers as they negotiate the interface between health sector role and community expectations.

The subordinate position of the women in the family is extended at the work place was marked by Jesani (1990). The bargaining power of women at the workplace is limited due to their socio economic background. Women are subjected to sexual exploitation, along with other exploitative situation. The author have also discussed about the sexual and other type of harassments that the women health worker goes through at the work place. Mishra (1997) discussed the problems which the women health worker faces during their stay in the villages. These problems include unavailability of quarters, drinking water, electricity and other basic facilities at the health centers which further dissuade health workers to work in an efficient manner. Rizzo et al. (1970) has discussed about the dual role of ANMs. They

explained that it has been problematic as their duel role increase work burden and decreases their effectiveness. Similarly, Mavlanker and Vora (2008) and Yates et al. (2011) have discussed about the dual role of the midwives, where they work as nurse along with midwifery role and at the same time, how they are overburdened with workload and how their role is changing.

Most of the times people complained of ANMs unavailability at sub centre in the night times which limit the communities' access to health services. Mohan et al. (2003) revealed the factors that an ANM considers in deciding where to reside, such as non-availability of education facilities for children and perceptions of insecurity seem to be major factors that deter ANMs from staying in a sub center village. The supervisors or the community neither assist them in facing these difficulties nor enforce accountability for not residing.

Further, it was found that due to the insupportable behavior of medical staff, women are forced to conduct their deliveries in private facilities. Thus, utilization of maternal health care services provided by primary health care centers is declining. The women who cannot afford the expenses of private hospitals preferred home delivery over institutional delivery, where they use hazardous practices in home deliveries which increase risk of infection. The study also shows the meager role of health intermediates like ASHAs, ANMs and other workers attached to the primary health centers. They have failed to convince the people to utilize public health services available in their localities.

In a research paper 'Changing roles of grass-root level health worker in Kerala, India' Nair et al. (2001) discusses about the MPW (male and female) and their limited knowledge about certain health programs and even if, they have knowledge they are not equipped enough to provide the needed service. It becomes extremely difficult for the worker who works at lowest position in the hierarchy to make decision which way to move on with a number of expectations upon him. In absence of role clarity, the subordinate will work according to his understanding and will make trial and error to meet the expectation of the superior authority (Yates et al., 2011; Yates et al., 2013).

ANMs are burdened with the 'target' as depicted by Coutinho (2000); the author has also explained that they work under pressure of target approach. If, they achieve their target, then only they are encouraged otherwise they have to suffer a lot of criticism. Sometimes, because of the fear of their supervisor they had to work round the clock and therefore, it becomes difficult to get the case to complete the target. Jeffery (1988) stated that nurses have a low status in the community. They are mostly women from marginalised or the disadvantage groups. Low status is ascribed to them due to the notion of purity and pollution associated with their work.

With this backdrop, Mehrotra (2008) described various reasons highlighting the need for reform in Uttar Pradesh's public health system. The study revealed that after the introduction of National Rural Health Mission, the health services have become even more dismal. The study discussed weak health indicators in Uttar Pradesh such as child health, maternal health and nutritional outcomes. The article stated miserable conditions of health inputs in the health system of Uttar Pradesh like inadequate health infrastructure, lack of clean drinking water and challenges related to excreta disposal. The study also investigated the role of key players in primary health care system, i.e., the role of ASHA and found that there were lots of constraints present in their selection procedure and training which needs to be take care immediately by the policy makers.

According to Banerji (2005) the limited political commitment for the improvement of rural health services has confined National Rural Health Mission (NRHM). It was supposed to be largest public health program for the delivery of health services in rural areas especially, primary health care services, to superficial issues. As Banerji says-

> 'Each pattern of approach to health care emerges as a logical outcome of a given political, social and economic system. This forces generate an unwritten policy frame which influence the health of the population'

He suggested that there is always a gap in the policy commitment and their implementation in health services. Various infirmities act as a barrier in improving the situation of grassroots health care providers such as Auxiliary Nurse Midwives (ANMs) and Accredited Social Health Activist (ASHA) in rural areas. He also suggested a relook into the NRHM as the promises made have not been implemented.

According to Bajpai (2014)**,** despite the implementation of National Rural Health Mission a decade earlier, the public health system in the country continues to face formidable challenges. In the context of plans for rolling out Universal Health Coveragein the country, his paper analyzed the social, economic, and political origins of the major challenges embedded in the public health system of India. The paper also highlighted challenges confronting public hospitals across India. These challenges are inadequate infrastructure, manpower shortfall, high workload, equivocal quality of health services and high out of pocket payments. These issues are crucial to delivering health services effectively in rural areas. It was also explained that the health care providers of the rural health services are devoid of basic facilities at the health centers which is crucial for delivering health services at in rural areas.

A study carried out by Narang (2011) with the purpose to measure the patient's perception towards the quality of health services provided by the primary health centers in rural Uttar Pradesh. The study examined the quality of health care services and found that the health system of Uttar Pradesh is delivering the poor quality of health care services. The study revealed that due to the lack of supporting health facilities at the health centers, people had to wait for a long time to obtain the health services. The community health workers are overburdened with a lot of paper work and other duties assigned to them and thus they were not able to perform as per the need and expectations of the care seekers.

1.2d Health Services Provisioning to Muslim and SC Population

SCs are communities who historically have been subjected to social exclusion being at the lower rungs of a stratified Hindu society (ex-untouchables). For centuries, caste and occupation were interlinked in the traditional socio-economic order, and the lowest manual and menial occupations were reserved for the SCs. Hence, it also influences the socio-economic activities and in turn regulating their health status. Despite, the establishment of a large public network of health providers the poor Muslims and other marginalised group people (women, schedule caste and schedule tribe) in rural areas of India face a great difficulty in accessing basic healthcare services (Jeffery, 2014; Ramaiah, 2015). In the eastern region of India, caste differences in reproductive health are most prevalent. The study by Jejeebhoy (1997) has also shown that the outreach services continue to be poor, especially for women and disadvantaged sections of society. Variation in accessibility and status of reproductive health is vulnerable for the women and the people belong to schedule caste and schedule tribes were shown by Raj and Raj (2014).

The women of the lower caste are the worst hit and suffer from the dual discrimination. The differences in the health of lower and upper caste people are also marked by Roy et al. (2004), by divulging the difference in the status of antenatal care, BMI, anemia and safe delivery. Saroha et al. (2008) have noted that upper caste women were almost three times more likely to use antenatal care. They also were more likely to have a trained birth attendant compared to the lower caste women. Caste was a significant determinant of tetanus toxoid use. The differences between SC women and other women are high due to differences between socio-economic conditions. High rates of infant mortality and under-five mortality are in general inversely associated with income (Baru et al., 2010). These inequalities are also accompanied by wide gaps across gender and caste (Subramanian et al., 2006; Baru et al., 2010).

The findings of the study conducted by Sabharwal (2011) indicates the differences existing in child mortality rates between the SCs, Scheduled Tribes (STs), Other

Backward Castes (OBCs) and others in rural areas. Child mortality rates are over 15% for SC/ST children than for the "other" children. The OBCs are worse off in comparison to the "others", though better off than the SC/ST. The findings of the paper also measure similar differences for social groups by their religious background. The Christian and Sikh children have relatively better nutritional status from Hindu and Muslim groups. Similarly, the SC Muslims have the highest proportion of underweight children followed by ST and SC Hindus.

Also, women from the ST Hindus SC, and Muslims have the highest incidence of malnutrition. The conditions of women from these social groups are worse off than their male complements. It is clear that Muslim women seem to have a higher likelihood of being malnourished, followed by the women from the STs and SCs, in that order. This study brings out very important observation that in the case of SCs, STs and Muslims even after regulating factors such as income, educational level, access to health services, the malnutrition rates turn out to be high indicating the limitations that are related with their social and religious possessions.

A study by Acharya (2010) provides evidence of the discriminatory access of SC women and children to primary health services leading to lower utilisation of the health services. Women belongs to the scheduled castes and scheduled tribes have much poorer access to healthcare compared with, men and women belongs to the other castes and classes.

The National Family Health Surveys (NFHS I; 1992-93 to NFHS IV; 2015-216) have also divulged regional and socio economic gaps in health outcomes among the lower caste, poor and less developed states bearing the burden of mortality unevenly. The NFHS data in its four rounds (NFHS - I, II, III and IV) showed that the pace of reduction in IMR was low for SCs and STs between 1992 and 2016 as compared to Non-SCs and STs. Similarly, under-five mortality remained the highest for *Adivasis* during 1992-93, 1998-99, 2005-06 and 2015-16. NFHS data also showed that *Dalit* and *Adivasis* children have the higher burden of malnutrition than others. States, where proportion of underweight Dalit children remained above the all India average of *Dalits* in 2006, were Bihar and Madhya

Pradesh. Access to antenatal care was the lowest among *Adivasi* women as compared to *Dalits* and other social groups. Further, the data revealed that institutional delivery was the lowest among *Adivasis* followed by *Dalits*. Further, the National Sample Survey Organisation (NSSO,2006) data also displays that untreated morbidities are higher for the succeeding groups; rural and urban; females and males, SCs, STs, upper castes and lower consumption classes against the higher one.

In the same context, Bansod (2014) also conducted a study to assess the inequality existing in health and health care utilization among tribes and non-tribes of India. He suggested that there were massive inequalities existed in the utilization of health care among tribes and non-tribes of India. The study revealed that tribal women were availing less ANC services at the time of their pregnancy as compared to their non-tribal women. Further, it was observed that majority of the tribal women had received less medical assistance as compared to non-tribal women and thus tribal women have more unsafe deliveries as compared to non-tribal women.

Kumar and Singh (2016a) also analysed the latest round of NSSO data for the current antenatal care coverage (ANC) in India, and found that the percentage of women who did not receive iron folic acid supplement (IFA) and TT dose was higher in Muslim community women followed by the Hindu women in India. Further, women belonging to scheduled tribe were found to be more devoid of ANC as, 13.2% pregnant women of this group did not consume IFA tablets, 10.2% did not receive TT dose, and 13.8% had not received any ANC during their pregnancy. The researchers revealed that illiterate and lowest wealth quintile mothers especially, women belong to scheduled caste and scheduled tribes were the worst hit in receiving ANC.

The literature is evident of the fact there has been stark differences in the social and economic status of Scheduled Caste and Muslims (religious minorities) when compared to other social groups of India. Many scholars like Haan (1997), Thorat and Deshpande (2001) and Shah (2002) have tried to correlate their group identity,

material deprivation and poverty to their development deficient. These scholars have grounded the fact that they have been victim of discrimination and exclusion from the past and continue to suffer the same notwithstanding the fact that its nature and forms have changed overtime.

1.2e Identity based discrimination in health service provisioning

People are denied of the health services based on their identity of social origin, ethnic and religious background, gender and caste. Borooah (2010) showed that people's health outcomes are significantly affected by their social group and there is a 'social gradient' to health outcomes in India. It can happen through the web of resources available and providers' sensitivity to social heterogeneity as a factor of differential access; and perception of self. Thus utilization of resources and services is determined by the three factors access, availability and perception of self (Acharya, 2007). Such factors cause disparity in utilization and are relevant in addressing social inclusion of vulnerable populations.

It is noteworthy that while poverty has been recognized as an important determinant of access to public health care services (Carstairs 1955; Zurbrigg 1984) and some studies have highlighted the lower level of utilisation of health services among the *Dalits* as compared to the non-*Dalits* (Ram et al., 1998, Kulkarni and Baraik 2003, Baru et al., 2010), very scanty literature exist on the process of such disparities. Acharya (2007) drew attention to different levels of discrimination in *Dalits* accessing health services in the state of Gujarat and Rajasthan. Dasgupta and Thorat (2009) brought out the differentials in the rate of decline of Infant Mortality Rate (IMR) and maternal health between Scheduled Caste (SC)/Scheduled Tribe (ST) and other social groups. Saroha et al. (2008) based on the study among rural Hindu women in Maitha in Uttar Pradesh highlighted that caste is a significant barrier to maternal healthcare service use among the rural women.

The study by Acharya (2010) revealed that 94 percent of children experienced discrimination from grass root level workers in the form of 'ANMs not entering the

house'; 92 percent in the form of 'ANMs spend less time'; 69 percent in the form of 'ANMs do not speak gently'; and 55 percent in the form of 'ANMs do not touch while dispensing medicine' in the villages of Gujarat and Rajasthan. The study brings out both subtle and active practices of discrimination against *Dalits* by healthcare providers, which was presented as follows:

> "During diagnosis, doctors are sometimes less probing regarding the health problem, and adopt unsympathetic attitude and rude behaviour towards Dalits. The pharmacist, while dispensing of medicine, often keep it on the window still, without explaining the doses properly. The lab technician does not touch the Dalit children during the conduct of a test, and often tests are not conducted properly; the patient is told that the 'time for rest is over', and demeaning words are used as well. While applying medicine, or putting the bandage on to a Dalit user, nurses show lack of any concern or sympathy. They do not explain to the Dalits how to take care of the wound/dressing. The ANM/LHV/VHW often do not visit the Dalit quarters for counseling or dispensing medicine, or for dissemination of information regarding a health programme, a camp, except in the case of target based programmes like immunisation, particularly polio" *(Acharya 2010:221).*

Discriminatory practices against *Dalit* women and children while accessing health services in public and private centres in the villages of Andhra Pradesh, Tamil Nadu, Bihar and Uttar Pradesh was shown by Irudayam et al. (2006). The narrations given in the study provide a fair account on how untouchability taboos have resulted in casualties for a Dalit woman in the scenario of prenatal, delivery and antenatal care when 'touch' by care providers plays crucial role. Deshpande (2007) in a study conducted in the villages of Manvi Block, Raichur District in Karnataka have illustrated how the status of *Dalit* women as an equal citizen is at palisade while accessing public health services. Deshpande' study highlighted discriminations with regard to 'reluctance to touch', 'long waiting' and 'different treatments' for *Dalits* and non-*Dalits* in primary health centres.

Caste based discrimination plays vital role in health seeking behavior also. Navaneetham and Dharmalingam (2002) have shown in their studies that proportion of lower caste women who received maternal healthcare services are less when compared to upper-caste women. Irudayam et al (2006) details the changes in health seeking behavior due to discrimination in public health institutions and it adverse outcomes for Dalit women, children and their families.

There are many other available empirical evidences that indicate a substantial social gap in health status and access to health services existing for *Dalits*. Guha (2007) observes, 28.9 percent of persons from the ST and 15.6 percent of persons from the SC have no access to doctors or clinics and only 42.2 percent of ST children and 57.6 percent of SC children have been immunized. The social status and weak economic position is very much responsible for poor health outcomes of the socially backward groups.

A study by George (2015) has tried to find out status of *Dalit* representation in the health service system in rural India in the context of the already established caste based discrimination in service delivery. Drawing from official data, the paper finds out an overall domination of non-*Dalits* in healthcare services. The paper presented two scenarios to understand it further. First were the similarities in health disparities between SCs and non-SC/STs of Bihar and Tamil Nadu, which have huge presence of non-SC/STs in significant positions of healthcare delivery. Second is the case of Andhra Pradesh (undivided), which has less intergroup disparities and better distribution of health personnel from Dalit castes at all levels of health services. These cases confirm the persistence of unfavorable environments for *Dalits* with the domination of non-*Dalits* in health services. Another study by Khanijow (2002) has examined the gender stereotyping in medical specialization. It reflected which gynecologist and pediatrics have women, surgery has men. While this study brings out the gender dimension, it remains silent on the issue of social identity based disparities in selecting medical specialization.

1.3 Conceptual Framework

From the available literature and data, it is an established fact that majority of the Indian population (68.84 percent) lives in rural area followed by 77.73 percent in Uttar Pradesh (Census, 2011a). As per the Rangarajan Expert Group Report, (2014) about 31 percent of the rural Indian population and 38.1 percent rural population of Uttar Pradesh lives below the poverty line (Government of India, 2014b). According to Ministry of Social Justice and Empowerment (2004), 44.8%, 32.9% and 19.7% are SC, OBC and others respectively lives below poverty line in Uttar Pradesh against the national average of 36.8%, 26.7% and 16.1% of SC, OBC and other respectively.

At this point it is important to mention the situation of Muslims as the Muslims of India constitute a community of 180 million, amounting to a little over 14% of the population of the country. In this context Mohammad Hamid Ansari, the then President of India showed his concern on the abysmal condition of the Muslim community and referred to the Sachar Committee recommendation in the following words-

> " … on most socio-economic indicators, they were on the margins of structures of political, economic and social relevance and their average condition was comparable to or even worse than the country's acknowledged historically most backward communities, the Scheduled Castes and Scheduled Tribes. It specified the development deficits of the majority of Muslims in regard to education, livelihood and access to public services and the employment market across the states." -Ansari, 2015 (On 50th anniversary session of the All India Majlis-e-Mushawarat)

It is evident that the poor rural residents are the most underprivileged people with high health care needs (Soman, 1997). However, there is inadequate healthcare infrastructure and severe shortage of healthcare professionals in Uttar Pradesh which remains a major constraint in primary healthcare service delivery

(Government of India, 2011; 2014a). Consequently, Uttar Pradesh has the worst state of health outcomes (Mehrotra, 2008, GoI, 2018). In such scenario the grassroots health workers are the functionaries that deal with the health system inadequacy and people's health needs.

The grassroots health workers, the ANMs, ASHAs and male Multi- Purpose Worker (MPW) as per the norms, work for the community from which they come. Although Anganwadi Workers (AWWs) are also involve in health activities at the grassroots level, yet they are not considered as health workers' for the purpose of this study. There are two reasons for keeping them out of the ambit of health workers. First, they are formal employee of ICDS and hence come under ministry of women and child development. Secondly, the present study intends to understand the interaction between women workers who are governed by same systematic hierarchy. There comparison is between the salaried and the incentive based women health worker[5].They work as a connecting link between the community and the health center. It is important to evolve the link between the health system and the health workers and the way in which they address the people's health need in the situation of severe shortage of manpower, infrastructure and drugs. ASHAs and ANMs are at the lowest rung of the health service hierarchy. Therefore, their experience of subordination in work sphere is dual. In addition, their caste and religious identity is likely to accentuate the vulnerability of their position as a service provider. There are evidences of change in this hierarchy when the task identity is super-imposed with caste and religious identities. The stereotypes about the 'merit' of socially excluded groups like *Dalits* and Muslims often relegates them to a lower position than that of their other-caste co-workers, irrespective of their work position.

[5] The two type- ANMs are the salaried and the formal employee whereas ASHAs are the incentive based volunteer health functionaries. There is also uneven level of workspace between an ANM worker and an ASHA worker as the former is assumed to be at a higher level than the latter in terms of work and training.

1.3a Health System Hierarchy and the Grassroots Health Workers

The literature provides evidences of the potential role and achievements of grassroots health workers in improving health statistics. At the same time, there are several issues and challenges that these workers go through while delivering health services. There are three levels of health centres that the grassroots health workers have to deal with; community health centres, primary health centres and the sub-centres. A grassroots health worker primarily works for the village community but they get directions from the health centres. The health programmes and schemes that these health workers carry out are regulated from the health centres. Thus, they have to report to the health centres about the status of progress of those programmes and schemes. Many a time, they are maligned by the vertical relationship between them and the health centre. These health workers face paradoxical situation, such as on the one hand they serve the people with limited resources and services and on the other they are advice people to visit the resource poor health centre for their health needs. Drugs and vaccines are provided from the health centres by senior health workers at the health centres to the grassroots health workers. All the documentation and paper work is done in the health centres. The targets about certain tasks are monitored from the health centres. The grassroots health workers have to achieve those targets within specified time duration. Their salary and performance based appraisal slip is sent by the health centres to the higher authorities of the health system management. Therefore, it is important to understand the coordination between a grassroots health worker and their senior counterparts. Also, the grassroots health workers are people who represent the village communities while the senior health workers represent government personnel.

The Basic medical education has a heavy focus on urban curative care and is provided in tertiary care settings. This does not prepare doctors for their roles in the rural primary health care system (Rao et al., 2011). It is also documented that health professionals are often not trained to see any value in communicating with lay people about health concerns. *"This attitude of health personnel towards community health workers may simply reflect their attitudes towards community*

care in general" (Kahssay, 1998). The attitude of other health service personnel towards Community Health Workers (CHWs) is an important factor in enabling them to provide effective services. The health systems are strongly hierarchical which impedes their functioning. It is necessary to understand the vertical relationship between health personnel and CHWs, between health personnel and communities, and also the vertical relationship of attitudes of communities towards CHWs.

Grassroots health workers fall lowest in the health system hierarchy. They are given limited formal education and basic level training. A study by NHSRC, 2011 showed its apprehension that more education or training could turn the grassroots health workers into quacks. So they are placed in the field with limited knowledge, and work for the community as well as the health centres. The uneasiness that the grassroots health workers go through is well documented (Sheikh and George, 2010). They negotiate the interface between the health centres and community expectation. Also, being lowest in the hierarchy, they are bound not to ask questions or interfere in the work or targets given by their seniors at the health centres. Moreover, their limited knowledge about health care is a major constraint in any kind of discussion or clarification for the care seekers. Thus, the grassroots health workers are expected to deliver service and meet the targets as designed in specific programmes. As workers at the lowest most hierarchy of the health care services, they have to face many situations where the community members refuse using certain health facilities. Superimposition of social identity accentuates the complexity of non-use as well as no provision. In such situations they are reprimanded by their seniors overlooking the social realities which influence access to care. In this context, the motivation of a grassroots health worker to work with seniors and live within the community while coping with differences and similarities becomes important. Thus, informal relationships with people in the community, boundaries and hierarchies within the health centres, sustain and constrain the grassroots heath workers as they negotiate the interface between the health sector and community expectations.

1.3b Women Grassroots Health Worker as Health Provider

There was a shared view that the role of women as mothers makes them effective health workers as most of the health practices are located within the realm of the family (Lehmann and Sanders, 2007). That is how women got entry into the profession of health care. It was believed that the term nursing is closely related to women so this profession should be taken up only by women. India has a sound history of *dai* system (Traditional Birth Attendant) and an effort has been made to instruct them as trained birth attendants. Women health workers have been in the health system at various levels, but their role has considerably changed with the implementation of health programmes (Mavalankar and Vora, 2008).

It has been a general perception that women health workers are not as efficient as male health workers both in field and in health centres and that male health worker had more potential in every field (Sheikh and George, 2010). This is not surprising at all. In the prevailing patriarchal society in which women are given least importance in any field, healthcare is no different. Literature has ample evidence showing that women grassroots health workers are harassed by male seniors (Razee et al., 2012). In many instances women health workers are defamed by several villagers if they happen to work at night shift or have to stay away from their husbands. Further, women grassroots health workers are not provided any separate room, electricity, restroom and water facility, making their work conditions all the more inappropriate. Sheikh and George (2010) in their book *Health Providers in India on the frontiers of change*, have described their plight by comparing the situation of an ANM and a male MPW. People address an MPW as a doctor because he is a male and distributes malaria drugs whereas an ANM is a female and does not distribute medicine. This attitude serves to demean the preventive and promotive care that ANMs provide and also demean her identity for being a woman. Further, if her identity as woman is laced with yet another identity of caste and religion, other than that of the majority religion and caste, then their 'ability to perform' is further compromised.

1.3c Social Class and Women Rural Health Worker

The Scheduled caste or *Dalits* are the lowest social group in the caste hierarchy. Along with the *Dalits*, Muslims (though more in numbers) are also marginalized when it comes to health care delivery (Jodhka and Newman 2007). The *Dalits* and Muslims, besides having disproportionate access to health, are also less in number as health care providers. This means that along with the role of seekers, their role as care providers is also minimal. At the same time women in general are the lowest social identity in the Indian patriarchal society. Grassroots health workers come from across castes and social class. There have been certain instances of ill treatment to *Dalits* and Muslims, and the situation is not at all different for women (Unnithan-Kumar, 1999). Knowing that in the healthcare system hierarchy of the grassroots health worker is at the lowest rung, it can be assumed that social status of *Dalit* and Muslim women grassroots health worker is different from the backward or general caste women grassroots health worker. Rather, *Dalits* and Muslims stand marginalized while seeking care as well while providing care. It would be interesting to know the reason for this kind of marginalization in seeking care, and also to understand the functioning of marginalized providers. Although a committee called Sachar Committee, spoke about the marginalization of Muslim population, it did not touch upon their involvement in healthcare.

1.3d *Sachar* Committee Recommendations

Sachar Committee headed by late Justice Rajinder Sachar prepared a report in 2006 on the social, economic and educational status of the Muslim community in India. The key findings of the Committee were based on the 2001 census. India's Muslim population then was about 138 million (about 13.4% of the total population). The report states, "In India, populations of all major religions have experienced large growth in the recent past, but the growth among Muslims has been higher than average." Between 1961 and 2001 the per cent of Muslim population increased from 10.7% to 13.4%. According to the Sachar Committee Report, "the most striking feature is the relatively high share of Muslim workers engaged in self-employment activity," primarily in urban areas and for women workers.

Participation of Muslim salaried workers in public and private sectors is quite low (as is true for SCs/STs), and the average salary of Muslim workers is lower than others (possibly, as more Muslims are in less skilled and socially inferior jobs).

Participation of Muslim workers in the informal sector is much higher than the average population, and the percentage of Muslim women working from their homes (70%) is much higher than all workers' groups (51%). Based on its findings, the Sachar Committee suggested that state policies should "sharply focus on inclusive development and 'mainstreaming' of the Community while respecting diversity." This cuts across the work hierarchy in the health sector too.

1.3e Kundu Committee Recommendations

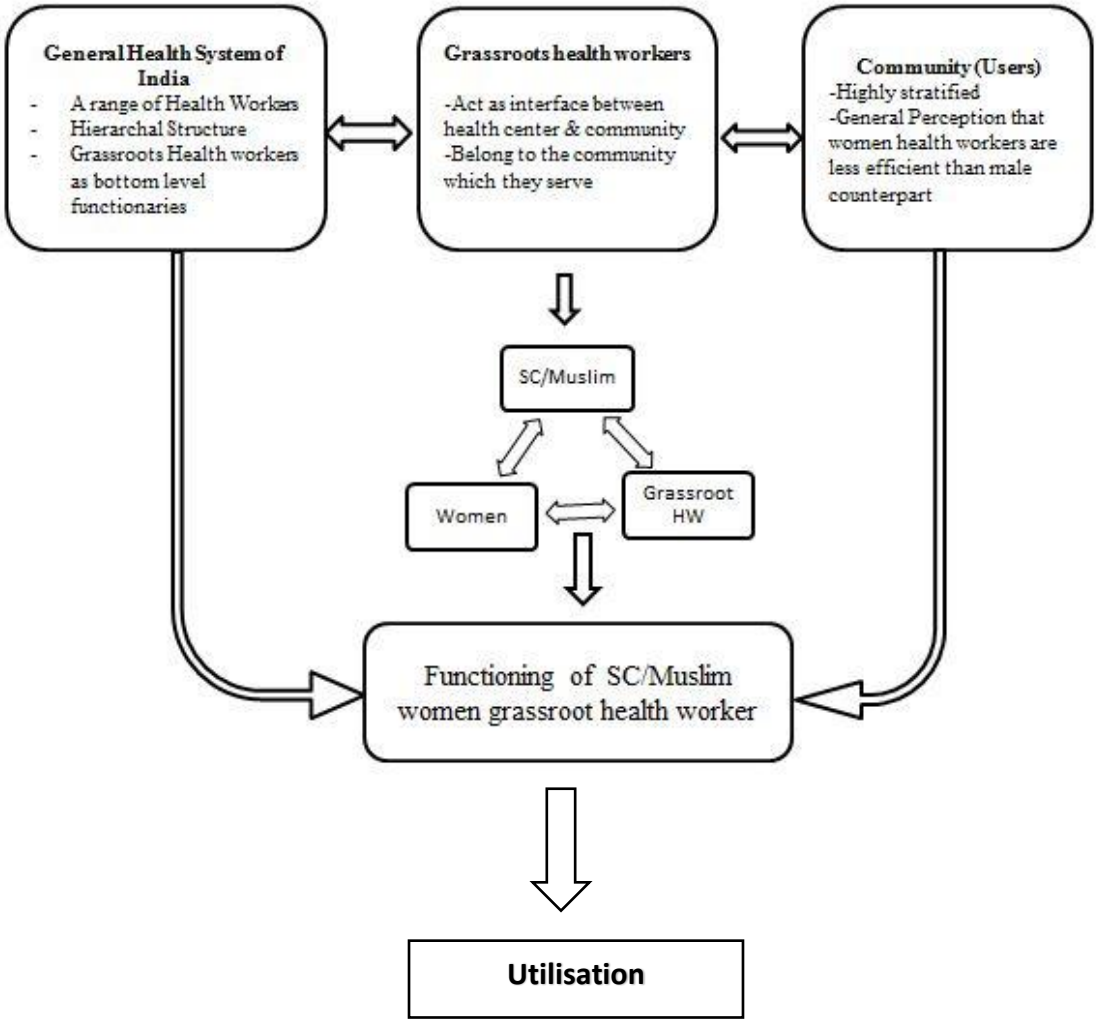
The government constituted Kundu Committee in 2013 to evaluate the process of implementation of the report of Sachar Committee and the Prime Minister's New 15 Point Programme. The committee has concluded that though a start has been made in addressing development deficits of the community, government interventions have not quite matched in scale the large numbers of the marginalised. The committee also observed that Muslims are still out of Government jobs and school, years after the implementation of most of the Scahar committee recommendations. Poverty levels among Muslims remained higher than the national average between 2004-05 and 2011-12. In terms of consumptions expenditure, Muslims are third from the bottom- after Scheduled Tribes and Scheduled Castes.

With such conceptual framework, this study is an attempt to understand the linkages between the health system and women grassroots workers of marginalized groups (Figure 1.1). The Figure shows a diagrammatic representation of the inter linkages between the providers and users, where the general health system, grassroots health workers and the community are interconnected and interact with each other. This picture tries to depict that how the interconnectedness and interaction among the three groups affects the functioning of the women health workers. It is noteworthy that these groups do not interact in vacuum. The social concept of caste/religion, gender and hierarchy are well present and interplay with them, hence affect the functioning of the women health workers. So, all these

components affect the overall utilization of health service and hence directly affect the universal health care.

Figure 1. 1

Inter Linkages between Providers and Users



Source- Prepared by the Researcher based on literature

CHAPTER II

RESEARCH DESIGN AND METHODOLOGY

2.1 Introduction

This chapter gives a detailed overview of the research methodology used for the study, where rationale of the study along with logical basis of the study is explained. It also tries to explain what and why the study seeks to understand. The research question that has evolved from the hypothesis of the study is also discussed. The chapter then provides the specific objectives that the study will follow in order to an effectively answer the research question. The study area description is provided in order to provide a picture of the study location to the readers. It also provides an understanding as to why the study is located in that particular geographical area. The chapter also gives a brief description of systematic plan of how and what research methods is used in order to conduct the study. The study design is explained where the researchers have tried to convince the reader about the need of the study. Sampling methods, the sources and tools and techniques of data collection is explained as well.

The ethical concern of the study has also been taken into cognizance by ensuring anonymity and privacy. The participants could discontinue their participation, if so deserved. The care was also taken that no harm was caused to them (within the scope of the study) for their participation in the study. The final section of the chapter gives a detailed description as to how the data will be analyzed.

2.2 Rationale of the Study

Improvement in health outcomes of rural areas depends mainly on the availability of trained human resources. Greater availability of the health workers has been shown to

be associated both with increase in service utilization as well as improved health outcomes such as immunization coverage and child and maternal survival (Haines et al., 2007). In Indian context, especially in rural areas there are huge shortfalls of human resources particularly of doctors. In the scenario of manpower shortage in health system, it can be noticed that it is the grassroots health worker whose shortage is proportionally less as compared to other health personnel (Figure 2.1 and 2.2). Among these grassroots health workers, it is the women grassroots health workers that make up the numbers to a considerable level and they form the lowest cadre of health workers' hierarchy. There is major shortfall of male health personnel as well at health centres.

From the literature, it becomes quite evident that male health assistant/ male Multi-Purpose Workers (MPW) hardly exist. The non-availability of MPW (Male) across the states has been one of the critical issues in implementation of national programmes including National Vector Borne Disease Control Program (NVBDCP), Revised National Tuberculosis Control Programme (RNTCP), and National Leprosy Eradication Programme (NLEP).[1] As the MPWs were originally supported by the Central Government, and the States had to take them over, but The National Rural Health Mission (NRHM) has a policy of neither substituting the State expenditure nor recruiting against posts created by the States. Most of the states could not fill up the vacant posts of MPHW (Male), while some states declared the MPW (Male) as dying cadre and stopped filling of vacant posts mainly due to resource constraints.

Those MPWs who were placed at health centre, is now either working on ad hoc basis or on contractual basis. At primary health centre and sub centre level there are huge shortfalls of the male health workers, resulting in overburdening of women health workers (Rao, 'human resource background paper' [2] not dated). At the village level

[1] www.health.mp.gov.in/fw/2015/MPHW-M-2010-Guideline.pdf accessed on 17 July 2017

[2] http://uhc-india.org/uploads/SituationAnalysisoftheHealthWorkforceinIndia.pdf accessed on 18 July 2017

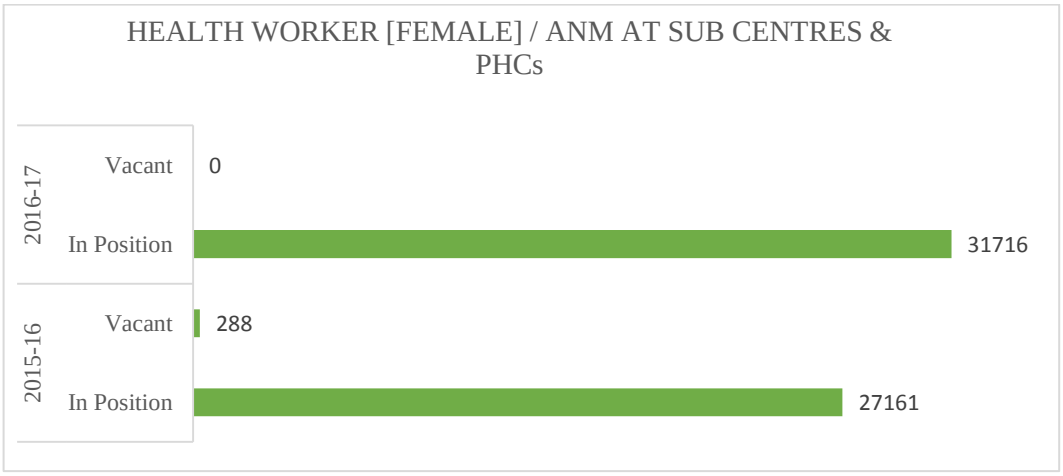
ASHAs are the only health workers catering to the health needs of people. In their work environment, ANMs and ASHAs often entangle in the superiority and subordination between them; there are also instances where these women health workers (ANMs and ASHAs) were harassed, maligned, questioned about their capability, their mobility, effectiveness, knowledge and restricted movement in the villages.

It is therefore important to understand the kind of problems that these women grassroots health workers face, while working in the community and at the health centres. The situation becomes more complicated when grassroots health workers, mostly woman; cater to the health needs in a shortfall of manpower. The social identity of women workers further accentuates the difficulties in rendering services over and above economic backwardness.

The grassroots workers are programmatically expected to be from local area and to be familiar with people and places in the vicinity. There is an expectation that familiarity will influence if not ensure, the health seeking behavior in the terms of both preventive and curative health care. However, familiarity thus produced due to local residence also impedes interaction for health care service seeking. It is therefore important to understand functioning of the women grassroots health workers in context of their social status. This would help us to understand how social identity of these women as providers as well as of health care seekers affects the health care interaction. Further it will also help to analyze the components that make up a particular social identity of the women health workers. The social identity determines the ease with which health workers can render services as well as access of services by the people of different social groups. Figure 2.1 and Figure 2.2 shows the proportion of women in different cadres of health workforce.

Figure 2.1

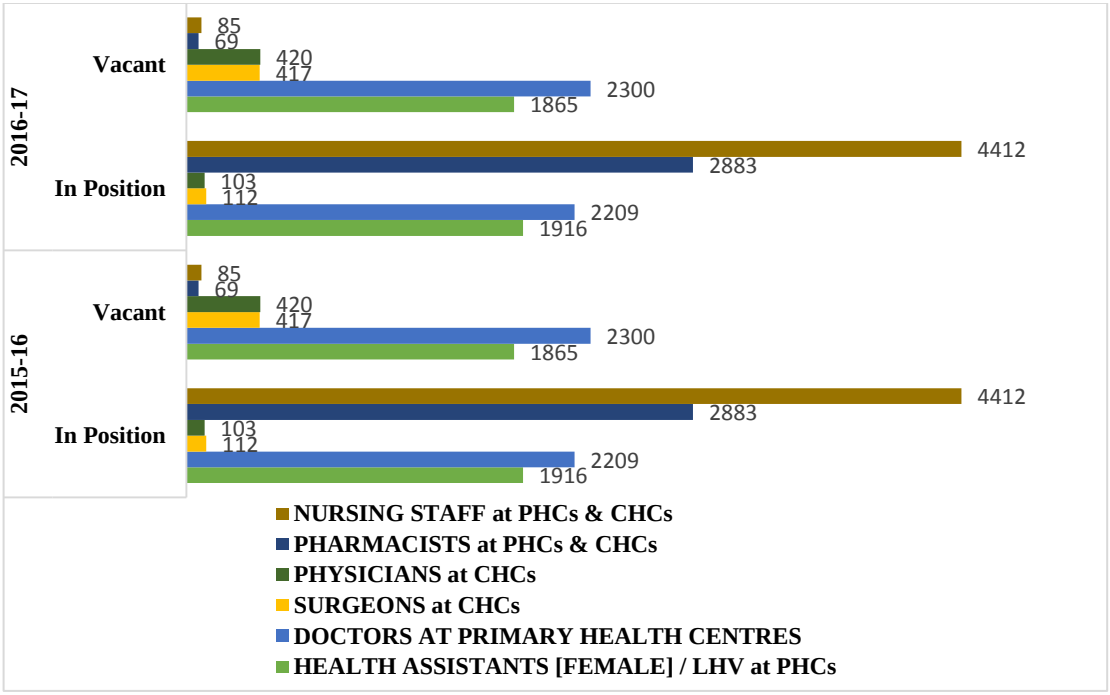
Health Worker [Female] /ANMAt Sub Centres & PHCs in Uttar Pradesh 2015-17.



Source- Rural Health Statistics (RHS), 2017

Figure 2.2

Health Worker In Postion and Vacant Seats in Uttar Pradesh, 2015 to 2017.



Source- Rural Health Statistics (RHS), 2017

2.3 Purpose of the Study

The study endeavors to understand the social relationship and dynamics of interaction when Scheduled caste and Muslim health care provider extends services to Scheduled Caste, Muslim and others (non-Scheduled Caste and non-Muslim); and when Scheduled Caste, Muslim and others (non- Scheduled Caste and non-Muslim) seek services from providers belonging to different social groups.

2.4 Research Questions

The research questions of the proposed study are as follows:

1. What are the social dynamics in which the providers and users are located?
2. Does social identity influence providing and accessing health care services?
3. How is the interaction between the SC providers with all other users (Muslim, SC and non-Muslim and non-SC) and Muslim providers with all users (Muslim, SC and non-Muslim and non-SC)?

2.5 Hypothesis

Social identity influence health care interactions at grassroots level as, those rendering and seeking services are located in the spaces where social hierarchies are strong.

2.6 Objectives

1. To study the social characteristics of the SC and Muslim women health workers and understand the social composition of the sub-center villages under study.
2. To understand the problems faced by health service providers of different social groups in rendering of services.

3. To examine the barriers responsible for unequal access for SC and Muslim seekers

2.7 Operational Definitions

- ***Women Health Worker**:* Women health worker is defined as the grassroots community health worker whose work is to provide primary health care services to the people and work as link between the health centre and the community.
- ***Health Interaction:*** The way in which the health worker interacts by sharing of information and provides services to the health service seekers in sharing information and providing services in the light of social hierarchy of the study population.
- ***Community:*** The people to whom these women health workers provide the health services or the people who fall under the work catchment area.
- ***Social Identity:*** According to Social Identity Theory[3], people tend to classify themselves and others into various social categories, such as organizational membership, religious affiliation, gender, and age cohort (Tajfel & Turner, 1985). The study will use the concept of social identity with respect to caste, religion, job type and other similar social elements.
- **Non SC/Muslim:** This classification of the social group comprises of community who administratively and socially neither belong to SC nor Muslim groups[4]. Essentially they were Hindu from OBC and General Caste. Muslim OBCs were not included in the Non SC/Muslim group in order to keep Muslim as a separate group. There is an enormous variance between socio-economic status of OBC Muslim and OBC.

[3] Tajfel,H., and Turner,J.C. (1985)The social identity theory of intergroup behavior. In S. Worchel&W. G. Austin (Eds.), Psychology of intergroup relations (2nd ed., pp. 7-24). Chicago: Nelson-Hal

[4] This social group essentially comprises participants of Non SC communities and non -Muslim Religion.

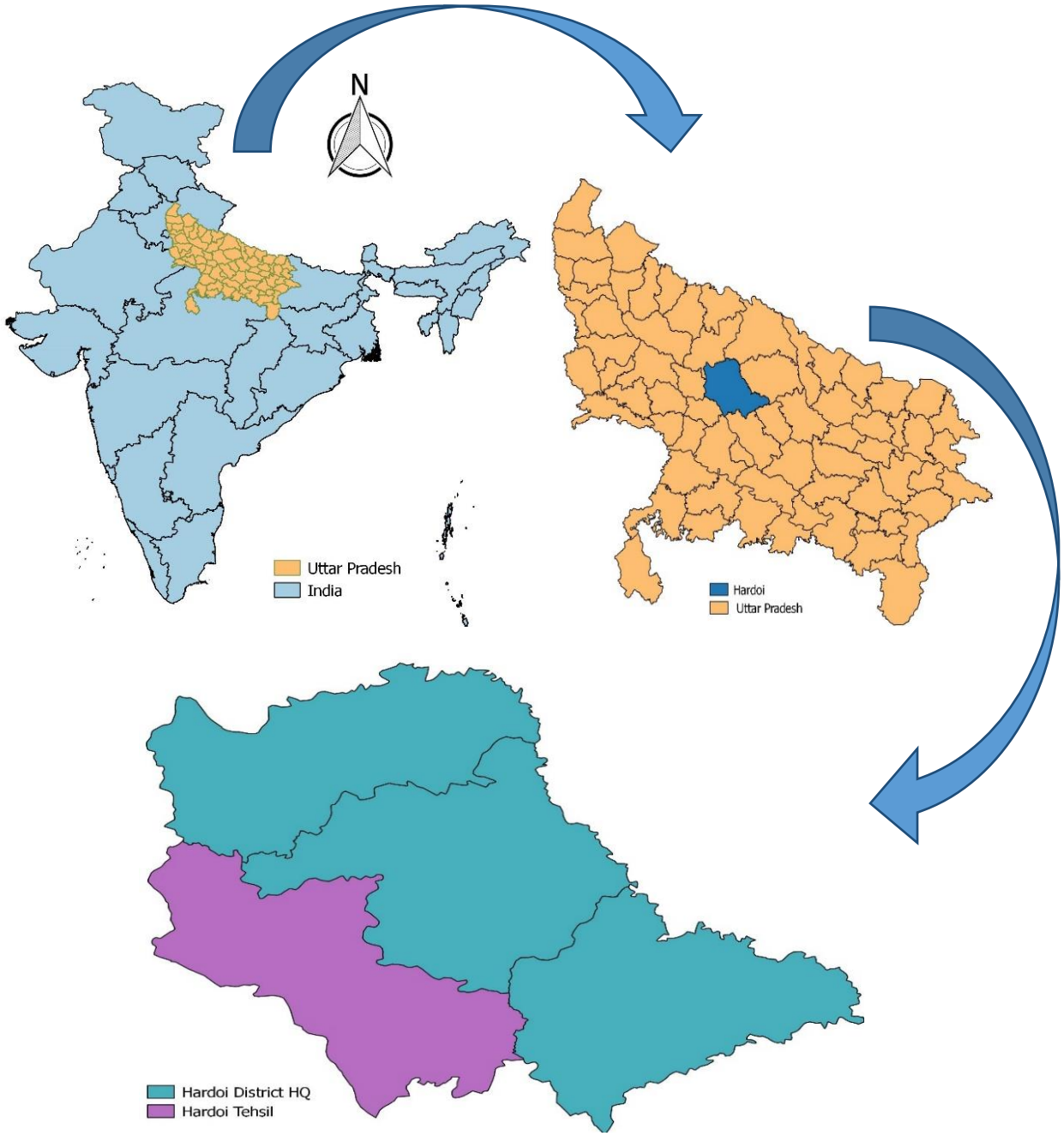
2.8 Study Design

The purpose of this study entails the use of qualitative and quantitative methods. While profile of the study sites, providers and users can be drawn from the secondary data and quantitative methods, understanding the dynamics of interaction requires a detailed in-depth analysis. Thus the present study proposes to use mixed methods approach to address the research questions.

2.9 Study Area

The present study was conducted in Hardoi district of Uttar Pradesh (U.P), a State in the northern region of India (Figure 2.3). Uttar Pradesh is most populous state (over 199.5 million populations) in India accounting for 16.4 per cent of the country's population. It is also the fourth largest State in geographical area covering 9.0 per cent of the country's geographical area, encompassing 2,94,411 square kilometers and comprising of 75 districts, 901 development blocks and 112,804 inhabited villages (Census of India, 2011; Government of Uttar Pradesh, 2017). The density of population in the state is 473 persons per square kilometers as against 274 for the country. As per the Rangarajan Expert Group Report, 2014, 38.1 percent rural population of Uttar Pradesh lives below the poverty line with high health care needs (Government of India, 2014b). Hardoi is one of the most populous district of Uttar Pradesh and falls under Lucknow division. The total population of the district is 4,092,845 comprising of 2,191,442 males and 1,901,403 females (Census of India, 2011). Of the total population, most of the population, i.e., 86.76 % lives in rural area (Table-1). The population growth rate over the decade 2001-2011 was 20.39%.

Figure 2.3 Study Area



Source: Compiled from Maps of India

Note: Not to Scale

Sex ratio of Hardoi district is 868 females per 1000 males, and literacy rate is 64.6. The length of this district from northwest to southeast is 125.529 kilometre and width from east to west is 74.83 kilometre. The district's north border touches Shahjahanpur & Lakhimpur Kheri districts, Lucknow (capital of U.P.) & Unnao are situated at south border, west borders touches Kanpur (industrial City of U.P) & Farrukhabad and on eastern border Gomati river separates the district from Sitapur. The district administration comprises of five *Tehsils*[5] (Shahabad, Sawayajpur, Hardoi, Bilgram and Sandila) and 19 Blocks for implementation of development schemes in the district (Figure 2.4).

There are 1101 *Gram Panchayats* and 2070 Revenue villages with 1907 inhabited villages and-163 uninhabited villages in the district. In urban area there are 13 statutory towns. Statutory towns comprise of seven *Nagar Palika Parishad* and six *Nagar Panchayats*. The primary health system of the district comprises of 432 Sub Centres, 62 Primary Health Centres, and 13 Community Health Centres (Government of India, 2014a) please see Map-2.1. The health services are mostly provided by these health centres and to a small extent by privately owned clinics in the rural areas of the district.

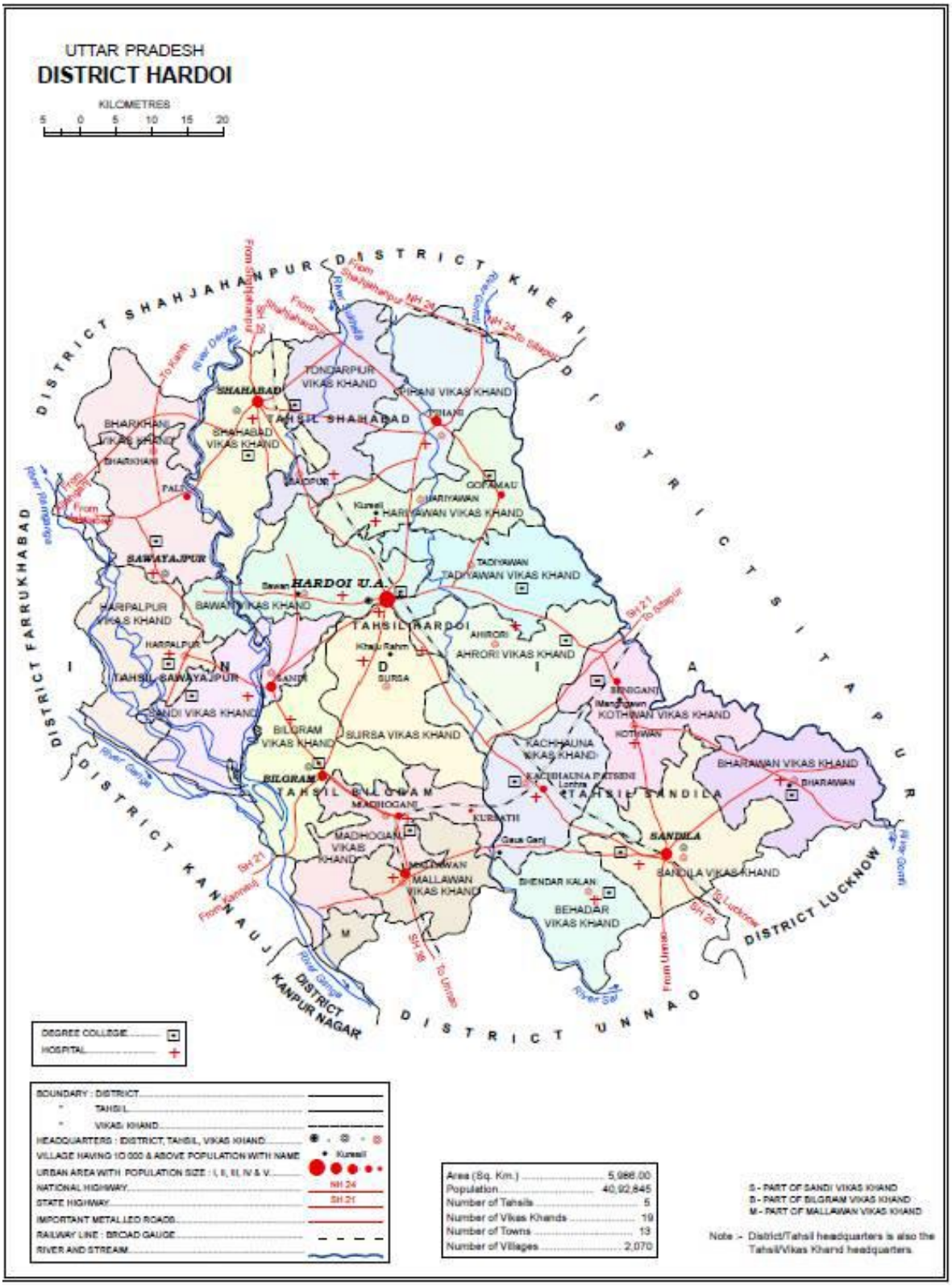
Table 2. 1
Demographic Profile of Hardoi District, 2011

Demographic Characteristics	Hardoi	Uttar Pradesh
Total Population	40,92,845	19,98,12,341
Male	21,91,442	10,44,80,510
Female	19,01,403	9,53,31,831
Sex Ratio	868/1000 male	912/1000 male
Child Sex Ratio	899/1000 male	902/1000 male
Population Density	684/km^2	829/ km^2
Literacy Rate	64.60%	67.70%
Urban Population	5,41,806 **(13.2)**	44,49,50,63 **(22.3%)**
Rural Population	35,51,039 **(86.8)**	15,53,17, 278 **(77.7)**
Schedule Caste Population	12,74,505 **(31.1)**	41,35,7, 608 **(20.7)**
Literacy Rate (SC Population)	57.70%	60.90%
Muslim Population	5,56,218 **(13.59)**	38,483,967 **(19.26)**

Source: Census of India, 2011, Government of India.
Note: Figures in parenthesis signify percentages of the total population

[5] A *Tehsil* is an administrative division which constitutes part of a district and serves as its administrative center in an area.

Figure 2.4: Hardoi District, Uttar Pradesh



Source- https://www.mapsofindia.com/maps/uttarpradesh/districts/hardoi.htm

Also, this district is considered as one of the largest and poorest districts of Uttar Pradesh (Government of Uttar Pradesh, 2015). Further, it has one of the worst health indicators among all the districts of Uttar Pradesh (GoI –Press Information Bureau, 2015). Also, it is the third high priority district among the 19 high priority districts (Table 2.2) out of the total districts of Uttar Pradesh selected under Uttar Pradesh National Rural Health Mission (UPNRHM). The high priority districts were selected on the basis of performance against service delivery indicators such as antenatal care (ANC), institutional deliveries, immunization, sterilization, IUD insertion, ABER (Annual Blood Examination Rate) for malaria (NRHM, 2014).

Table 2.2
High Priority Districts Selected under UPNRHM

District	Rank	District	Rank
Faizabad	1	Etah	11
Sant Kabir Nagar	2	Kanshiram Nagar	12
Hardoi	***3***	Shahjahanpur	13
Barabanki	4	Siddhartha Nagar	14
Pilibhit	5	Bahraich	15
Kheri	6	Budaun	16
Sitapur	7	Balrampur	17
Bareilly	8	Shrawasti	18
Gonda	9	Sonbhadra	19
Kaushambi	10		

Source: National Rural Health Mission (2014), Approval of state programme implementation plan: Uttar Pradesh 2013-14, Ministry of Health and Family Welfare, available at: http://upnrhm.gov.in/site-files/Approval_of_Programme_Implementation_Plan_2013-14_-Uttar_Pradesh.pdf (accessed 20 June 2017).

2.10 Need for the study

The study is largely descriptive in nature, interspersed with elements of the exploratory design. This research makes use of a mixed-method design in meeting its objectives, triangulating both quantitative and qualitative methods to gain a well-rounded understanding the social status and functioning of the women health workers. The present study had made an attempt to understand the functioning of the grassroots women health workers in the backdrop of their socio-economic, living and working conditions. It had also tried to understand the cadre dynamics within the health system. The social condition such as gender, caste, class, social identity also forms an inescapable part of their environment. The factors that affect grassroots health workers' functioning and rendering

of the health services and also the factors that affect the service utilization which have implication such as underutilization of health services too were considered in the study. In order to study these diverse aspects of women health workers' social identity and status, both quantitative and qualitative data was collected by the researcher. While the quantitative data helped in finding out heterogeneities in living and employment arrangements of the women health workers and the patterning of such differences, the use of qualitative research methods supplemented this initial data set by understanding the differential perceptions, motivations and experiences of the different categories of women health workers living in these conditions and daily coping with them.

2.11 Sampling Frame

The sampling frame for the study included women health workers working in the health centres and the health services seekers of rural areas of the Hardoi district. The health services seekers of the study primarily were women and were in contact with the selected women health workers for certain health ailments. Both, the women health workers and the health services seekers belonged to varied social and economic background. Additionally, male multi-purpose health workers, medical officers, some key informants of the villages sharing an interface with the aforementioned women health workers and health services seekers in Hardoi all constituted a part of the study universe.

The procedure for collection of the sample was finalised by the researcher after reading up on available literature on the grassroots health workers with special emphasis on women grassroots health workers and also the health service seekers and conducting basic conversation with them located in the study area during the pre-pilot and pilot phase of the study. Through these exercises, the researcher was able to gain a greater understanding of the nuances of the functioning of the women health workers with different social identity and also the way in which they interacted with the health services seekers of varied social identity. It also helped the researcher to point out the differentials in functioning among the women health workers based on caste, training obtained, age, economic status, experience of work, availability of health services, salary/incentives, distance between residence and health centre, knowledge network. Equipped with this knowledge, a sampling design was devised using the place of work (health centre),

caste/religion, and cadre of work and availability of the respondents as the parameters for sample selection.

For selecting sample of women health workers and health service seekers, the current study thus used stratified sampling design, using quantitative and qualitative research methods for data collection. As the main aim of the study was to understand the pattern of functioning of the women health workers of various social groups, therefore three strata was carved out of the universe. The three strata were SC, Muslim and non-SC/Muslim. These strata were purposely formed as huge body of literature is evident of differential and discriminatory experiences of these strata. There are commonalities among each stratum but there are considerable differences among the strata in many aspects. Since, each stratum is more homogenous than the total population, the researcher couldget more precise estimate for each stratum and by estimating more accurately each of the component parts, the researcher was able to get better estimate of the universe (Kothari, 2004).

The initial phase of such a sampling design involved listing of all the ANMs working in the study district. The list of ANMs working in the district was obtained from the district hospital, Hardoi. From the list obtained, Muslim and Scheduled caste ANMs were identified. A total of 459 ANMs, were posted across 432 sub centres, 62 PHCs and 13 CHCs. Out of 459 ANMs, 15 Muslim ANMs, 74 scheduled caste and 370 other (Non-SC/Muslim) ANMs were identified. All the Muslim ANMs were included in the sample of the study as per demand of the study, but when researcher went to the Sub Centre of these ANMs, two ANMs were not working as one had yet not joined and the other one had just retired a week before. One of the Muslim ANM was not ready to give her interview and she did not give her consent for the same. So, in total the researcher was left with 12 Muslim ANMs. The sampling process of Schedule Caste and other (Non-SC/Muslim) ANMs began with the selection of the same number as of Muslim ANMs i.e. 12 for the study, chosen by the systematic sampling methods after listing the two groups, schedule caste and other (Non-SC/Muslim) separately.

Table 2.3
Total number of ANMs selected for the study

Number of ANMs present in District		ANMs selected for study	Number of Health Facility in in the District	
Muslim ANM	15	12	CHC	13
SC ANM	74	12	PHC	62
Non SC/Muslim ANM	370	12	Sub Centre	432
Total	**459**	**36**		**507**

Sampling technique used for ASHAs, was to list all those ASHAs working under/with each of the ANMs selected for the study. There were maximum of 10 ASHAs and minimum of 4 working under/with each selected ANM. Total of 236 ASHAs were working under/with 36 selected ANMs. All the ASHAs were listed out and classified into Muslim, SC, and Others Non- SC/Muslim. There were a total of 12 Muslim, 102 SC and 122 others ASHAs. As per the requirement of the study all the Muslim ASHAs were included in the study. The sampling process of Schedule Caste and other (Non-SC/Muslim) ASHAs began with the selection of the same number as of Muslim ASHAs i.e. 12 for the study, chosen by the systematic sampling methods after listing the two groups, schedule caste and other (Non-SC/Muslim) separately.

For the selection of the health services seekers, the intention was to document the experiences of health services seekers of all dominant castes and religions and also to understand the interaction patterns among them and among the women health workers. Beneficiary Register of last one year was used to list the health services seekers who received care by ANMs and ASHAs. So, the women health workers were requested to show their 'beneficiary register'. From that register, all the beneficiaries of last one year were noted and for each of the woman health worker, three health services seekers were selected each belonging to Schedule Caste, Muslim and other (Non-SC/Muslim). In the case, when researcher was not able to get all the three type of health services seeker (beneficiary), those who have utilized health services with the help of the women health worker in past two years were interviewed.

Therefore following the same calculation, 216 (72 schedule caste, 72 Muslim and 72 other (Non- SC/Muslim) was the number of health services seekers who were to be interviewed. It was deemed important to understand the interaction of the care seekers with ANMs and ASHAs belonging to different social strata. The idea was to interview all of them, but the researcher realized that after 14-15 interviews in each of the strata, saturation sets in and repetitive responses were obtained.

The researcher then decided to select four health care providers from the list of 12 ANM/ASHA from each of the caste/religion group and then select their care seekers. For this purpose, the study area was divided into four equal parts by drawing two imaginary lines, one horizontal and one vertical passing through the centre of the district. In this way four quadrangles (North-eastern, North-western, South-eastern and South-western) was obtained. Then selected women health workers (ANMs and ASHAs) were listed and from each of the strata, and four women health worker from each of the strata were selected such that their functional area fall in any one of the quadrangle. In case if no women health worker could be located in any one of the quadrangle then women health worker from centre point were considered. There were 12 Muslim, 12 SC and 12 non-Muslim/SC ANM women health workers. Similarly, there are 12 Muslim, 12 SC and 12 non-Muslim/SC ASHA women health workers. As described in the research methodology section, three health service seekers for each of the women health workers were taken. Therefore, there are a total of 65 health services seekers included in the study with a break-up of 21 Muslim, 22 SC and 22 non-Muslim/SC respondents.as shown in Table 2.4.

Table 2.4
Details of selected health care seekers

Social Group ⇨ / Area ⇩	SC	Muslims	Non SC/Muslims	Total
Northern-east part of the district	1An+ 1As +6CS	1An+ 1 As+4 CS	1 An+ 1As+5CS	3An+3As+15CS
Northern-west part of the district	1An+ 1As+5CS	1An+ 1 As+6CS	1An+ 1As+5CS	3An+3As+16CS
Southern-east part of the district	1An+ 1As+5CS	1An+ 1 As+6 CS	1An+ 1As+6CS	3An+3As+17CS
Southern-west part of the district	1An+ 1As+6CS	1An+ 1 As+5CS	1An+ 1As+6CS	3An+3As+17CS
Total	4An+4As+22 CS	4An+4As+21C S	4An+4As+22 CS	**12An+12As+65C S**

Note- An= ANM; As= ASHA; CS= Care seekers

Therefore a total 137 respondents (ANM+ASHA+ Care Seekers) were selected. Also, four of the male multi-purpose health workers who were interested in the research shared their views and also became part of the study. Six Lady Health Visitors were also interested in the study and were delighted to share their experiences. Some key informants of the villages like Village *Pradhan*, AWW[6], AWW *Sahaika* too were included in the study as they also contributed with some interesting and important insights. In the present research study, the study participants were divided into major three groups, i.e., Muslim, SC, non-Muslim/ SC. Table 2.5 illustrates selection of the respondents across the social groups.

[6] Anganwadi worker is an employed woman who works at Aganwadi centre.

Table 2.5
Selection of the Respondents Across the Social Groups

Social groups	ANM	ASHA	Care Seekers
Muslims	12	12	21
SC	12	12	22
Non-Muslim/SC	12	12	22
Total	**36**	**36**	**65**

The purpose of the study is not to treat the selected sample as being representative of the all women health workers but to understand the interaction pattern between women health workers of specific social identity, as the study wanted to examine the differences in the pattern of functioning of the women health workers across class, caste and religion. It also tried to understand the factors which enhance and impede the women health workers in rendering of health services. And to examine those health services barriers that are responsible for unequal access for SC and Muslim seekers were the major objectives of the study.

While administering the open-ended interview schedule to the study participants during the initial round of data collection, the researcher used this opportunity to probe in greater detail some respondents about their daily work experiences and their perception of government health schemes, and their functioning in the sub centre and villages. Their role within the health schemes too was probed in an in-depth manner during this interaction.

It was realized that the data collected on the women health workers would be incomplete without an assessment of their interaction with the health service seekers of and within all the three strata i.e. Muslim, SC and other (Non- SC/Muslim). All the interviews being conducted during the course of this study were recorded on paper in Hindi. The case studies and the interview of the key informants were digitally recorded with their consents which was later transcribed and translated.

2.12 Sources of Data

Both primary and secondary sources of data collection were relied upon for data collection.

2.12 a Primary Sources- includes that data which is collected directly and first-hand by the researcher. The researcher used multiple tools for primary data collection, which are outlined shortly below. Triangulating or using a variety of primary data collecting techniques ensures the greater comprehensiveness of the data collected. This process is also referred to as 'multi-method research' (Fetterman, 1998).

The study utilized both qualitative and quantitative data for developing a clearer understanding of the interaction pattern, pattern of functioning, enhancing and impeding factors for women health workers, and service barriers responsible for inequities in access for the health services seekers. Keeping this in mind, the study relied upon diverse methods and sources of data collection such as interviewing and observation with the study participants.

- **Tools and Techniques**

The research instruments used to collect data for the present study were as follows:

1. ***Observation Checklist***

The researcher was a non-participant observer of the daily lives, interaction pattern with the people of certain social identity. Direct observation of the respondents in their daily real-life environment helps us to see, perceive and record situations as they occur in the natural progression (Majumdar, 2005).

For this purpose, an observation checklist was created by the researcher to guide her in the process of observation during her field-study and enhance her understanding of the social identity and perspective about the study participants about social identity. Observation categories included the interaction pattern among the study participants, the health centres at which the health workers were posted, the visiting hours of the health workers, the socio economic conditions of both the health workers and the health service

seekers. The type of services provided to the type of people was also kept under observation. The types of health seekers approaching these women health workers were also observed.

2. Open-ended Interview Schedule

A structured open-ended interview schedule, was formulated for eliciting information from the study participants regarding their social status and their functioning for the women health workers and health service barriers those are responsible for inequities in access for SC and Muslim seekers.

3. ***In-depth Interview Schedule***

While a close-ended interview schedule might be best suited for collecting quantitative data, an open-ended interview format is the preferred format for seeking collection of more qualitative data from prospective respondents. Such a tool better serves the purpose of obtaining more extensive information on the opinions, thoughts and perceptions of the respondents. Furthermore, this is the preferred mode of data collection when the information being sought cannot be reduced to pre-fixed categories that exist in the close-ended interview format as *"information in the working universe may be extremely variable or unknown…"(Smith, 1975)*

A qualitative semi-structured interview schedule, comprising a sequenced set of open-ended questions, was constructed for soliciting detailed accounts from women health workers on their social identity, including living and working arrangements, social conditions and interface with the health service seekers.

For other respondents in the study, including key informants (respondents excluding the health workers and seekers) such as male multi-purpose health workers, LHV, *Pradhan* of villages, qualitative semi-structured interview schedule, containing both open and close-ended questions, was constructed on their purported perceptions and opinions on the social status and functioning of women health workers.

2.12 b Secondary Sources

It comprises that data which is not collected first-hand by the researcher, but constitutes an invaluable part of the information gathering exercise undertaken in any research. In this study, secondary sources relied upon for data collection include Census data gathered by the Government of India, governmental reports including *Sachar* Committee Report, Kundu committee Report, Family Welfare Statistics in India, Statistics Division, Ministry of Health and Family Welfare Government of India, 2011. In addition, ICMR-ICSSR report on Health for All–An Alternative Strategy, and a report published by NHSRC 2011 titled ASHA which way forward…? Evaluation of ASHA program, Journal and newspaper articles, NFHS-4. RHS-2016, AHS 2012-13 were also included. Report by NITI AYOG (2016) and other studies and publications amassed which threw light on the area under study.

2.13 Ethical Consideration

The proposed research followed certain ethical principles which are considered to be paramount in the conduct of any field research.

Free and informed consent of the informants is an overriding principle of ethics in research (Bowling, 2002) and this was adhered to in this study at all times. Operationalization of this principle was done by the following means – each tool used by the researcher for data collection contained a prepared statement on the background initials of the researcher, her motivations for conducting the research and soliciting respondent participation, expected level of participation or input sought from the concerned person, maintaining the confidentiality of their responses and also of their participation in the study from other respondents in the study and during the stage of report-writing was ensured.

Any discomfort to the respondent before engaging them in an interview was sought to be minimised by making it clear at the outset the expected amount of time that would be required of them if they would give their permission to participate in the concerned study. Their right to refuse to answer any question pertaining to any aspect of the study was respected and they retained the freedom to withdraw their participation at any stage of the interview process, despite consenting to it in the beginning. Furthermore, it was made

clear that there should be absolutely no expectation of any quid pro quo or indeed such an exchange between the researcher and respondent for the latter's participation in the study.

All these instructions were read out to every prospective respondent while soliciting their participation. Any additional questions posed to the researcher by the prospective respondents pertaining to the study were fully entertained by the researcher.

Maintaining confidentiality and anonymity of the respondent is another central tenet of ethics in social science research[7]. While this research included collecting personal details of the respondent, the data has not been shared with anyone nor will such personal details of respondents be divulged to any other person at a later stage, even after the completion of the current research process. The researcher has tried her utmost to remove personal identifiers from the information presented in the report, to further prevent breach of confidentiality (Kaiser, 2009).

The identity of all respondents interviewed in this study has thus been kept confidential. The study does not name any of the respondents who participated in the process of data collection, except where explicit written consent has been obtained from the participants themselves who have agreed to allow their names to be mentioned. The reason is to prevent any harm to the informant accruing from their participation in the present study.

The Institutional Ethical Review Board (IERB) of the university has given the clearance to the proposed research vide letter number **IERB Ref. No. 2016/Student/98** dated on 17.11.2016

2.14 Data Analysis Framework

The quantitative data collected in this study was first entered in SPSS 20 and then analysed using the suitable statistical technique is utilized for attaining a greater understanding of the socio-economic differentials, the social identity related outcomes of health interaction between women providers and users.

[7] National Committee for Ethics in Social Science Research in Health (2000): 'Ethics in Social Sciences and Health Research: Draft Code of Conduct,' *Economic and Political Weekly*, Vol. 35, No. 12, pp. 987-991.

An in-depth scrutiny of the data also aided in classification of women health workers in different categories. The process of identifying the classes was as follows – given the variations in the socio-economic, working and employment conditions of the women health workers, it would have been a mistake to construe them as a homogenous group.

For the purpose of this study, women health workers were thus classified into the following groups – SC women health workers, Muslim women health workers, Non-SC/Muslim women health workers and the health services seekers. The categorisation intends to represent an income and economic gradient within the wider community of the health workers of the study district. This was based upon an examination of the quantitative data collected as well as the researcher's observations and interactions with women health workers across various settings.

After deciding upon the classification of the women health workers, the rest of the data was analysed using bi-variate cross tabulations to depict socio-economic, living and working conditions of different strata of the women health workers and the health service users. Furthermore, in keeping with the objectives of the study, a number of analytical themes were identified for systematic assessment of the data.

2.15 Limitations of the study

Although, the study had tried to answer the research question proposed for the present study, but there are certain limitations which it could not answer. It is important to indicate those limitations so that the study can be further investigated by other scholars. The following are the research limitation of the present study-

- The study has taken a small geographical area and the study participants belonged to the same area, therefore the findings of the study could not be generalized.
- It is important to note that some of the blocks of the district were dominated by a particular caste; therefore the findings of the study had implication of the same.
- The study is limited to women participants. It would have been a comparative study if male health workers and seekers were also involved.

- The month of the year during which data was collected have also impacted on the findings of the study.
- The data collection was done for almost a year but more follow-up of the study participants would have enhanced the data and findings.
- The study has largely used qualitative data and its analysis, quantitative analysis of certain variables at the district level is also one of the limitations of the study.
- Other women health workers apart from the lowest rung of the health system hierarchy were in not included in the study.

CHAPTER III

SOCIO- DEMOGRAPHIC PROFILE OF THE STUDY AREA

3.1 Introduction

The present chapter delineates socio-demographic profile of the participants involved in the study. The following section of the chapter gives a very brief general description about the ANMs and ASHAs, where their role, function in the health centre as well as in community is discussed. The general introduction of the women health workers would provide a backdrop in which the socio-demographic differentiation of the ANMs and ASHAs selected for the study is shown in order to make clearer understanding of their housing and living conditions. It would also provide a representation about how the women health workers, fit in the various responsibilities of the health centre and the community.

Auxiliary Nurse Midwife (ANM) is a village-level woman health worker. They are the first contact person between the community and the health services. ANMs are regarded as the grass-roots workers in the health organisation pyramid. Their services are important to provide safe and effective care to village communities. The role may help communities achieve the targets of national health programmes. The present context ANMs are envisioned to provide accessible, affordable, accountable, equitable, effective and reliable health care, especially to poor and vulnerable sections of population in rural areas. One ANM is given charge of a sub centre serve the population of 5000. They provide maternal and child heath along with the treatment of common illness. They are formal salaried employee of health department.

The Accredited Social Health Activists, acronym as ASHAs are a cadre of women health workers instituted in the National Rural Health Mission in 2005. They are at grass root of rural health services and are responsible to bring awareness in their

community about the state health advice, health scheme and facilitate the use of the public health system through mobilization, motivation and counseling. According to NRHM guidelines[1], ASHA must primarily be a woman resident of the village married/ widowed/ divorced, preferably in the age group of 25 to 45 years.

She should be a literate woman with due preference in selection to those who are qualified up to 10 standard wherever they are interested and available in good numbers. This may be relaxed only if no suitable person with this qualification is available. Their work concerns chiefly to mother and child health (MCH), thus pregnancy, delivery, newborn care childhood and pregnancy vaccination, and family planning. ASHA are volunteer health workers. They are programmatically volunteer based worker therefore are not formal employee and get incentives for the amount and type of work they do.

In Hardoi district, it was observed during the pilot survey, that most of the ANM and ASHA were aged between 25 to 50 and married. Most of the ANMs and all the ASHAs came from the villages and travelled in public transport like buses and shared auto rickshaws. Since most of them were married it is evident that their competence in their family household roles was judged as often as possible. Thus they were gauged of their 'ability' as a housewife, female member of house and as a health worker.

Their education and training enabled them to contribute in the household income. During interaction many of them reflected on their empowered status, like now they can 'go out and work'; 'buy things for themselves, children, home'; 'have choices'; 'make decision or at least are part of decision making at home'. Many of them also showed their satisfaction of helping poor women in various ways.

3.2 Background Characteristics of the participants' health workers

The following section delineates socio- demographic profile of the participants in the study. The varying degrees of the social indicator shown in this section will accorded to each stratum, as the indicators within rural set up plays an important role in shaping the interaction pattern. The other opportunities available to the women heath workers also have an influence on the social status of the participants.

[1] http://nhm.gov.in/communitisation/asha/about-asha.html accessed on 14 July 2018

The Table 3.1 illustrates basic social and demographic characteristics of the Participants of this study. It provides age-wise distribution of the study sample. There is a preponderance of ANM (17) women health workers in the 36-45 years age group and ASHA (20) women health workers in the 25-35 years' age group. This section communicates very relevant information about ANM - who are salaried women with more number of experienced years are recruited on contrary to this, ASHA who are incentives based workers; age is not important criteria for their selection.

Table 3.1
Background Characteristics of the participants' health workers

Characteristics		Health Workers	
		ANM	**ASHA**
Age	25-35	9	20
	36-45	17	16
	46-55	08	0
	56-65	2	0
Marital status	Married	31	35
	Unmarried	2	1
	Divorced	2	0
	Widow	1	0
Education	8^{th}	1	9
	High School	18	18
	Intermediate	7	7
	Graduation and above	10	2
Job Type	Full Time	36	16
	Part Time	0	20

Marriage is one of the universal social institutions established to control and regulate the life of mankind. It is closely associated with the institution of family which is one of the major constituent of Indian society. Among all the health workers selected for the study, most of them (31 ANMs and 35 ASHAs) were married. Two of the ANMs and one of the ASHA was never married; whereas two ANMs were divorced and one was widow.

Educational attainment of the health workers play crucial role in health service provisioning. It influences ability of the health workers to deliver health services in

an appropriate and effective manner. Table 3.1 shows educational attainment of the health workers, most of the ANMs (18) have attained education up to intermediate level; whereas most of the ASHAs (18) were high school passed. There were as many as seven ANMs who have educational attainment up to high school only, and one who had education attainment up to eighth standard. Among ASHAs there were nine ASHAs who had education attainment up to eighth standard and seven had attained education up to intermediate level. The variation in the education attainment can be noticed as there were women who had done graduation too, as there were 10 ANMs and two ASHAs who were graduated.

Income not only affects the standard of living and housing conditions of the health workers, but it also influences the ability of health workers to deliver health services in an effective manner and afford better amenities, including improved housing conditions. Table 3.1 could not illustrate the monthly income earned by the Participants as the mode of income was not uniform. ANM being salaried employee (whether permanent or contractual) got fixed salary. Among the ASHA Participants, all of them said that they do not earn any fix monthly income, because the ASHAs are incentive based health workers, and they receive the remuneration based on the health services they deliver in the community. All the ANMs reported to earn more than rupees 10,000 a month. One ANM was reported to have no fixed monthly income as she was the senior most ANM and the health department assigns her several other duties (other than her work at sub centre) therefore she gets some more additional incentives which add to her monthly salary income in most of the months.

Further Table 3.1 also helps to show the nature of employment as part time or full time these were involved. The concept of full/part time was involved as ASHA are incentive based worker[2] and most of the ASHA health workers were engaged in other work apart from ASHA's job for various reasons. So to this question, all ANMs unanimously said that they are working full time and are not involve in any

[2] The ASHAs receive performance-based incentives for promoting universal immunization, referral and escort services for Reproductive & Child Health (RCH) and other healthcare programmes, and construction of household toilets available on http://www.nhm.gov.in/communitisation/asha/about-asha.html accessed on 15 July 2018. (Full list of incentive is attached as annexure I)

other work from where they are salaried employee and get monthly income. Most of the ASHAs (20) said that they considered the ASHA's work as part time work as they are not able to support their families with the mere incentives obtained from the job of ASHA. Delay in the payments of incentives was also one of the drivers. This is corroborated by a study conducted by VIMARSH[3] and sponsored by SIFPSA[4]. For the same reason they were reported to be involve in other work in order to have a secondary source of income. Among all, 16 ASHAs said that they consider their work as full time work.

Training of health workers is seen as a potential instrument for achieving optimum health outcomes (Mavalanker et al. 2010). To provide better and reliable training, sources of training are also very important to health workers. The health worker Participants were asked that whether they have obtained any training to perform their job responsibilities, and found that all the health workers have obtained training to perform their jobs. After that health workers were asked about the sources from where they have obtained their training. The Participants revealed that they have received their training from varied sources. Most of the ANMs (34) and 30 ASHAs reported to obtained training from the government health department (Table 3.2) whereas two ANMs obtained training from the private sources (nursing homes). Of the total ASHAs, some of them (4) have received training from the non-government organizations (HCL foundation and World Vision International) which was working in association with the state government health department whereas two ASHAs received training from other sources.

Table 3.2
Sources of Training Obtained

Agency	Health Workers	
	ANM	**ASHA**
Health Department	34	30
NGO	0	4
Private	2	0
Others	0	2

[3] A Consultancy Group.
[4] http://upnrhm.gov.in/site-files/monitoring_and_evaluation/PDF_ASHA_final_10.10.13.doc.pdf accessed on 17 July 2018

Training of grass-root level women health workers has been common to all the public health plans and policies. But it has gained a vigorous attention in last few years under national rural health mission. Duration of training obtained by the health workers in previous one year was further explored. Table 3.3 shows the duration for which these health workers have attained their last training. The results indicate that most of the health workers have received training of only less than a week. There were as many as 15 ANMs and 28 ASHAs whose last training was for less than a week (3-5 days), meaning to that the government designs very less training programs for the rural grassroots level health workers.

As regard the training of the attainment between ANMs and ASHAs, it was found that training was seen as an issue in the case of ASHAs. As a bottom level health system functionary, they have lots of responsibilities which need rigorous training but only two ASHAs reported to have undergone training for a week in previous one year, the reference period of the study. Only two ANMs and two ASHAs received training for more than a week but less than 15 days. There were 13 ANMs who have received 30 days training whereas only two ASHAs obtained one-month training. None of the study participant, health worker has received training of more than a month in previous year.

Table 3.3
Training Duration of ANMs and ASHAs

	Health Workers	
	ANM	**ASHA**
Duration of Training		
<1 week	15	28
1-2 weeks	8	6
One month	13	2
Total	**36**	**36**

3.3 Experience of Work

Number of years of experience matters as this gives an impression of their knowledge about their work and about the transformation that they have seen in various forms. To know about the work experience, the women health workers were asked for how

long they were working in the health system. Table 3.4 inform about the number of years for which the women health worker has been working. The results reveal that the Participants selected for this research study were quite experienced. Most of the Participants have extensive working experience - 17 ANMs and four ASHAs had experience of more than 10 years of their work. Five ANMs and 11 ASHAs had experience of six to 10 years whereas seven ANMs and 12 ASHAs also had a long experience of four to five years.

Table 3.4
Years of Work Experience

Duration	Health Workers	
	ANM	ASHA
	N	N
less than 6 month	1	1
7 month to 1 year	0	3
1-2 year	3	2
2-3 year	3	3
4-5 year	7	12
6-10 yr.	5	11
more than 10 year	17	4

Table 3.5 makes it more familiar with the information that for how many years these women health workers have been working in the same health center (the present health center). The health workers who have been working for a long time in the same area are more informed of the health needs of the people due to the several recurring evidences of interaction with them. There were variations in the responses of the health workers in respect with the duration for which each of them working in a particular area. Most of the ANMs and ASHAs were reported to be working from a long time at the same health center but four ANMs and one ASHA got their new posting to the resent sub center as they have been posted there for less than six months.

It was found that 14 ANMs and 15 ASHAs were working for four to five years at the same health centers whereas four ANMs and six ASHAs were working for six to ten years. Most of the ANMs (11) were not transferred to any other health center since they got recruited and therefore they were found to be working for more than 10 years

at the same health center. These variations would be discussed further with certain outlined themes. Due to long working time at same health centers, the health workers are informed of the system related issues in their area and field expectations while health service provisioning, and accordingly in such a long time, they learned to cope with these difficulties. Long duration of experience in the area enables them to quickly locate the care seekers and their problems for different maternal and child health care services.

One of the ANM was proud to reflect that the years of her work experience given her confidence and ability to identify prospective user:

> *"I am working here for more than ten years. I know most of the villagers in my area. I know all the pregnant and lactating mothers, their health history and needs. I always try to treat them as best as possible. My experience and links help me to find the new pregnant women and other women facing health issues." (An8/Non-SC/II)*

Table 3.5
Experience of Work at Same Sub Centers

Time Period	Health Workers	
	ANM	ASHA
0-6 month	4	1
6 month to year	0	6
1-2 year	2	3
2-3 year	1	2
4-5 yr.	14	15
6-10 years	4	6
More than 10 yr.	11	3

The health care service providers were also asked about their roles and responsibilities in the health system. Following the same, another question was also asked that from the assigned role and responsibilities what are the main works of ANMs and ASHAs? The motive to ask these questions were to know their views about the work that they like (take interest) being doing and to understand the type of work that these health care service providers are majorly involve. All the health care service providers listed

the role and responsibilities that they were being told in their training and read in the manuals. But when they were asked about their main work almost all the ANMs unanimously said that vaccination and maintenance of the record register were their main work.

Table 3.6
Assigned and Perceived Roles and Responsibilities of ANMs

Assigned Roles and Responsibilities of ANMs	**Perceived Roles and Responsibilities of ANMs**
Responsible for submission of all the reports and returns to the higher Level	Record maintenance
Responsible for financial management at the sub Centre	No response from ANMs
Responsible for maintenance of Stock ledger of different family welfare materials and other articles	Record maintenance
Responsible for pregnancy registration, 1st, 2nd & 3rd antenatal Check-up at the clinic and 4th natal checkup at home	Vaccination
Responsible for routine immunization of infant and children and immunization of pregnant woman	Vaccination
Responsible for providing Vitamin A to the children up to 5 year of age	Vaccination
Counsel the pregnant woman regarding birth preparedness	No response from ANMs
Counseling and service regarding temporary methods family planning and counseling for permanent method	No response from ANMs
implementation of JSY Scheme	Vaccination
Attend the activities connected with the Village Health & Nutriti Day (VHND)	Meeting with ASHA
Report to the higher level in case of any disease outbreak	No response from ANMs

Source: Assigned Roles and Responsibilities of ANMs and ASHAs was accessed on 18 July from: https://www.google.co.in/url?sa=t&rct=j&q=&esrc=s&source=web&cd=5&cad=rja&uact=8&ved=0ahUKEwjs_a_dvpnUAhWJro8KHb3eAZMQFghFMAQ&url=https%3A%2F%2Fwww.askwb.com%2Fattachments%2Fduties_responsibility_health-pdf.276%2F&usg=AFQjCNGr571KQcoPhuhOCRm4AizyaNem2Q

Similarly, all the ASHAs said that their main work involved ushering pregnant women for institutional delivery and vaccination. This was very interesting to note that ANMs according to NRHM has been assigned with a range of works, i.e., conduct monthly meetings in villages with help of PRI, make village health plans, sanitation work,

report of any outbreak of diseases, counseling to pregnant women, organizing Village Health Sanitation and Nutrition Committee. By this kind of response, it can be inferred that ANMs do not consider the non-visible work as their main work unlike vaccination where the work done can be measure in terms of number of children vaccinated.

As far as ASHAs are concerned they too considered escorting pregnant women for institutional deliveries as their main work. While mentioning the main work of ASHA none of the ASHAs reported to attend any monthly meeting, counseling, information regarding health scheme or health information. All the ASHAs mentioned about the various types of surveys that they were involved in. Almost all the ASHAs reported and complained of the surveys as they consume most of their time. According to them, conducting surveys increased their burden as they consume most of their time and deviate them from their routine work. Most of them complained that they have not received any training on how to carry a survey, and every other day they were told to carry out survey of different health schemes. These type of work deviate them from major responsibilities of ASHA and most of their times passed in maintaining records of those survey. One of ASHAs clearly explained:

> *"Few days back, I was told to conduct a survey of the village residents for the beneficiaries and enrolled people for Samajwadi Pension Yojana. I also have done survey for Adhar Card Yojana in my village. I also have conducted leprosy and tuberculosis patients survey in my village. I know these type of surveys does not come under my job responsibilities but if the medical officer, ANM and LHV assign these works then who have courage to refuse?" (An6/Non-SC/II)*

Apart from this, there were persistent issues of large coverage area among these health workers. These health care service providers especially, ANMs have been serving four fold of the population that they should be serving. According to government guideline, an ANM should serve a population of 5000, but all the ANMs (included in the study), found to be serving population with a range of 8000- 16,000 people. According to government guidelines, an ASHA should serve a population of 1000 people, but all the

ASHAs (of the study), found to be serving population with of 1200-3000. The large coverage area left the health care service providers immensely overburdened.

Further, to cover this addition large coverage area, most of the ANMs had to travel long distances. Many a times they prefer to select a place; mid-way of two-three villages and start providing services to the people. In this situation they were not able to cover the entire population who were in need of their services. None of the ANMs reported to have a sub-center building. They were providing services either in a primary school of the villages, *Anganwadi* center[5], in front of any shop or any open space available in the village. The availability of the space was great concern for the ANMs no matter how convenient or accessible it was for others. Many times it happened that women do not prefer going to these places especially in summer as the primary schools (where ANMs provide health services) are located into interior villages.

As mentioned above that none of the ANMs reported to have any sub-center building, ANMs needs to carry the necessary health instrument along with her wherever she moves. Most of the ANMs complained of the health issues arising from carrying the instruments. They have developed persistent by carrying the heavy health instruments without any conveyances while provisioning of health services in their coverage area. Back and lower limb aches were the largely reported health issues, as they have to walk a lot with the entire instrument. According to them they could not keep the weighing machine, BP machine, and other health kit at one place because they need to visit different villages every other day and they have received only one set of instruments. They also complained of lack of conveyance in the villages and inconvenience caused while commuting to these villages.

[5] Anganwadi is a type of rural mother and child care centre in India. They were started by the Indian government in 1985 as part of the Integrated Child Development Services program to combat child hunger and malnutrition. Anganwadi means "courtyard shelter" in Indian languages. The AWW are also responsible for preschool learning and Adolescent health.

Table 3.7
Population Coverage for ANMs & ASHAs: (Proposed & Actual)

For ANMs (Proposed by NRHM)	Actual (as reported)
As per NRHM a ANM should serve 5000 population	Actually they are serving 8000-16,000
They should be working at sub-center building	No sub-center building available
Should be covering a population of 3-5 village on an average	Serving 7-10 villages
For ASHAs	
As per NRHM a ASHA should serve 1000 population	Actually they are serving 1200-3000

The Table 3.7 illustrates the population coverage actual and as per the guidelines issued by the ministry of health and family welfare, government of India.

3.4 Conclusion

This chapter has discussed the characteristics of the health care service providers. The training records of the health service providers have also been mentioned which enables the readers about the skill obtained by them. By these responses one can evaluate the difference in sources and duration of the training obtained by the health provider across cadre and caste. The chapter also informs the reader that not all the grassroots health providers are equally trained. Further we get to know about the roles and responsibilities assigned by government are huge but these health providers are majorly involved in different types of work and remained deviated from their actual work. These health providers are overburdened with huge set of responsibilities along with that they have to cater the need of population which are two three fold more than the government proposed population coverage.

CHAPTER IV

SOCIAL IDENTITY AND INTERACTION PATTERN: HEALTH SERVICE PROVIDERS' PERSPECTIVE

4.1 Introduction

This chapter gives a detailed description of the social characteristics of the health care providers selected for the study, i.e. how the staffing pattern of the health providers is there with respect to social composition of the villages of study area. Such type of backdrop information enables the reader to understand the interaction pattern among the health care service providers and the service seekers. Here interaction pattern specifically denotes interaction between health service providers and seekers. The idea is to understand the ways in which the health workers interacts, share health related information and provide services to the health care seekers. This chapter also attempts to delineate the information about the health interaction with the health care providers and seekers in the light of the social hierarchy of the study population. The first section of the chapter describes the characteristics of the population (health care seekers) as per responses obtained from the health care provider to which health care services are provided by (ANMs/ASHAs).

Further, based on the above information the health interaction pattern between the health care service provider and health care seeker is discussed. This chapter also gives us a detailed information about the type of health services provided by health care service provider (ANM/ASHA) to the health service seekers belonging to different social groups (SC, Muslim, non- SC/Muslim). Thus the dynamics between health service providers and seekers across caste and religion can also be examined. This is important because in Indian context, caste remain embedded in other religion too. Thus a Muslim provider is likely to face differential treatment from non- Muslim as well as high caste Muslims. Same may be the case with OBCs or Schedule caste.

Therefore locating social identities in providing and accessing care through the lens of caste and religion has been attempted.

4.2 Social Characteristics of the Respondents

This section begins with the explanation of sample of the health service providers that was carved out from the study area. However, the sample size has been already described in the methodology chapter where the sample that has been given for ANM and ASHA is as 12 Scheduled Caste (SC), 12 Muslim and 12 non- SC/ Muslim. Here, the breakup of non- SC/Muslim health service provider is given because OBCs form a larger chuck of the population and hence cannot be ignored. Moreover, the term OBC would not be used during the analysis of the study as the information in Table 4.1 is just to show the dominance of OBCs in numbers of the health care service providers. General caste and OBCs will be treated as one unit of non-SC/Muslim. Data for both Hindu and Muslim is shown in Table 4.1, as no other religious group could be identified in the study population. All the SC providers followed Hinduism that is why they were included under Hindu. Among the Muslim health care service providers, no SC provider could be found.

Table 4.1
Distribution and social characteristics of the selected health care providers

Caste	Service provider			
	Hindu		Muslim	
	ANM	ASHA	ANM	ASHA
General	4	3	5	4
OBC	8	9	7	8
SC	12	12	0	0
Total	24	24	12	12

As shown in Table 4.1 there were four general castes, eight OBCs and 12 SC ANMs who are among Hindu health care service providers. Similarly, among Muslims, there were from five general castes and seven were identified to be of OBCs. Among ASHAs similar trend was seen as most of the Hindu and Muslim ASHAs were from

OBCs i.e. nine and eight respectively. Three of the ASHAs were from Hindu general caste and four were from Muslim general caste. All 12 SC ANMs and 12 SC ASHAs belonged to Hindu religion and none of the Muslim ANMs and ASHAs reported to be SC. Although caste and religion breakup of the service providers is provided but the unit of comparison would be SCs, Muslims and non-SCs/Muslims, ANMs and ASHAs and same logic would be applied for the health care service seekers too.

Table 4.2 gives us information about the characteristics of the population that the ANMs were serving. Majority of the SC ANMs (four) reported to be serving the population of all caste and religion and according to one ANM she was serving Muslim dominated population. For Muslim, four of them were of the view that the populations that they serve have both Muslim and SC in equal numbers at the same time four of them said that their coverage populations have all caste and religion. Only one Muslim ANM said that functional area is dominated by Muslims. Non-SC/Muslim ANMs had perception that there is all type of people in the population that they serve, as three of them said that the coverage area has mostly SC population, other three said mostly Muslim population and some (three) were in the view that they serve all caste and religion population.

Table 4.2
Characteristics of the Population served by the ANMs

Characteristics of the Population	SC ANM	Muslim ANM	Non-SC /Muslim ANM
Hindu (mostly general and OBC caste)	2	2	1
Hindu (mostly SC)	3	1	3
Mostly Muslim	1	1	3
Muslim and SC	2	4	2
All caste and Religion	4	4	3
Total	12	12	12

The characteristics of the population that, the ASHAs were serving is well illustrated in Table 4.3. Majority of the SC ASHAs (five) reported to be serving the SC population and according to one SC ASHA she was serving of all caste and religion.

For Muslim, three of them were in the view that the populations that they serve have both Muslim and SC, at the same time four of them said that their coverage populations have mostly Muslim and other four said that they population have mostly SC. Only one Muslim ASHA said that functional area is dominated by upper caste Hindus. Non-SC/Muslim ASHAs had perception that there is all type of people in the population that they serve, as three of them said that the coverage area has mostly SC population, other two said mostly Muslim population and some (three) were in the view that they serve all caste and religion population. According to three of the ASHAs they had upper caste Hindus in their coverage area.

Table 4.3
Characteristics of the Population served by the ASHAs

Characteristics of the Population	SC ASHA	Muslim ASHA	Non-SC/Muslim ASHA
Hindu (mostly general and OBC caste)	2	1	3
Hindu (mostly SC)	5	4	3
Mostly Muslim	2	4	2
Muslim and SC	2	3	1
All	1	0	3
Total	12	12	12

4.3 Type of Services provided by the Health care service providers

Exploration of the pattern and type of health services used by the care seekers are crucial to locate the health needs of the people and also to understand what types of health care services are more frequently used. This will also help to understand that for what type of health services the health care seekers approach the service provider; thereby we can understand dynamics health interaction at all levels between the health care providers and seekers. The table 4.4 shown below illustrates the pattern and type of health services for which people frequently consult the health service providers in their area.

Table 4.4
Type of Services used through ANMs and ASHAs

Utilisation of Services	ANM	ASHA	Total
Vaccination	20	3	23
Health care suggestions	3	5	8
Pregnancy and Delivery Care	11	7	18
JSY Related	0	17	17
Medicine Need	2	4	6
Total	**36**	**36**	**72**

The Table 4.4 explains that vaccination, pregnancy and delivery care, and JSY were the most desired and accessed services used[1] by the service seekers in the study area. Of the total 72 health care service providers, 23 responded that the health care seekers mostly consult them for vaccination services only. Further analyses of the information given by different cadre of health workers, shows that most of the care seekers use vaccination related services and information from the ANMs only. Further, according to 18 health care service providers, they were consulted for mostly pregnancy and delivery care services or suggestions. Out of 36 ASHAs, 17 of them said that most of the women consult them to seek JSY services whereas not a single ANM was consulted about the same. Lowest response was obtained for the medicine need where only two ANM and four ASHAs were in the agreement that health care service seekers come to them for the medicine. This can be corroborated with the responses of the health care service providers in their own words-

> "*Most of the women come to me for vaccination, that too when they are called by ASHA. Only some of them ask for medicines other than contraceptive because they perceive me as 'reproductive health' worker and therefore may not have medicine for body ache or health*

[1] This may be also because the health services in rural areas predominantly provide MCH services therefore people know about the availability these services only and hence limit themselves to these health services. There can also be more reason that all the respondents of the study are women either provider or seeker hence the chances of women health provider to have women health seekers are more than men.

tonics. They rely more on medical store than us …they often complaint that the medicine that we give then are not as powerful (strong) as the ones they buy from outside"(An14/SC/ FGD2)

"We, also convey important health information/messages to the villagers but, they seem to be less interested in the preventive measures they look more interested in materialistic things like money, ointments, takat ki tonic (Health tonic), cough syrup,bandages, cotton, gauze or contraceptives." (As3/Non-SC/II)

Identity is important in understanding social interaction and hence health interaction, as health care service provider hold some or the other social identity in themself. The grassroots health care service providers work in the villages which has certain territorial division based on social values attached to it (Beteille, 1965). Also, these villages are stratified on the basis of different social categories (Gupta, 2004). Following these social categories of the villages, there are chances that the health care providers or the service seekers may prioritize one care provider or seeker on other depending on certain circumstances of social identity. Reserachers like Achaya, 2010; Borooah, 2010; Sabharwal, 2011 have found that, it plays very crucial role in provisioning of health services at the grassroots level. Considering the importance of social identity of the health workers in provisioning of health services, the type of services for people consult health workers across religion was further investigated.

The Table 4.5 shows the data of, for what type of health services ANMs and ASHAs across religion were approached. Among ANMs, 15 Hindus and five Muslims; among ASHAs two Hindus and one Muslim said that they were approached for the vaccination services. More number of ANMs were consulted for vaccination services as providing vaccination is one of the major responsibilities of ANMs. ANMs have duty roaster of immunization day and out of six working days, they have to be in different villages for four days and two days on sub center to provide vaccination services. Among ASHAs they are majorly approached to seek JSY, this may also

because of the programmatic design of NRHM as ASHAs are required to uthe pregnant women to the health institution for delivery and after that only the seekers as well as ASHAs will be entitled for JSY benefits. Here 11 Hindu ASHAs said that people approach them for JSY but only six Muslim ASHAs said that they are consulted for JSY. It is appropriate to quote perception of two ASHAs that why and why not people consult them for JSY.

> *"All the women in the villages know that they get JSY money for having institutional delivery, but not all of them approach me for the same only few with whom I am in regular touch, consult me. And there are lots of people in the village who do not want us to mix with us. Many a times they do not provide us information about the delivery and prefer going on their own"* (As16/SC/II) (ASHA narrated her experience of being consulted for JSY)

Table 4.5
Type of Services used through ANM and ASHA

Utilisation of Services	Service Providers Religion			
	ANM		ASHA	
	Hindu	Muslim	Hindu	Muslim
	N	N	N	N
Vaccination	15	5	2	1
Healthcare Suggestions	1	2	3	2
Pregnancy and Delivery Care	7	4	5	2
Janani Suraksha Yojana	0	0	11	6
Medicine Need	1	1	3	1
Total	**24**	**12**	**24**	**12**

> *"I am consulted by all the caste and religion people, but most of the Muslim women hesitate for institutional delivery, they say that they are ill-treated in the health facilities. Most of them complained of being beaten up by staff nurse. Muslim women are blamed of having more than desired number of children and responsible for high child mortality. Because of these prior experiences they prefer home delivery*

and prefer not to share the news of pregnancy and delivery" (As26/Muslim/II) (Muslim ASHA narrated her experience of being consulted for JSY)

4.4 Health Care Seeking Patterns

Caste is said to constitute the primary institute governing personal and social relationships (Dumont, 1980; Gupta, 2004; Jaspal, 2011). Caste groups are social identity categories and in self-identifying as members of these categories, individuals' social identities as caste group members became salient (Tajfel, 1978). The respondents clearly indicated their perception about each other is influenced by the wider social environment in which they live and work. Caste was an important element for the respondents in shaping their perception of social identity about others. This was reflected by the respondents in their perception about ASHAs and the care seekers of the villages. Table 4.6 shows that for what type of health services ANM and ASHA across caste were approached.

Table 4.6
Health Care Seeking Pattern by Providers across Caste

Services	Service Provider					
	ANM			ASHA		
	General	OBC	SC	General	OBC	SC
Vaccination	4	8	8	1	1	1
Healthcare Suggestions	0	2	1	0	2	3
Pregnancy & Delivery Care	4	4	3	0	3	4
Janani Suraksha Yojna	0	0	0	4	9	4
Medicine Need	1	1	0	2	2	0

As regards the ANMs, out of 12 SC ANMs, eight ANMs were consulted for vaccination, one for health care suggestion and three for pregnancy, child birth and delivery care. None of the SC ANMs were consulted for JSY or medicine need. Most of the OBC ANMs (eight) were approached for vaccination. Among ASHAs as much as nine OBC ASHAs were consulted for JSY services and three were approached for pregnancy and delivery care services. The higher number of seekers approaching OBC

service provider could be also because of the dominance of OBC in the study area as health care service providers and seekers both. Contrast to this, eight SC ANMs and one SC ASHA reported to be approached for vaccination. Only four SC ASHAs said that they were consulted for JSY services and this can be best illustrated in the words of one of them-

> *"Most of the people in my area are of OBC caste and our ANM is also OBC, so they bypass me for most of the services and directly go to the health center and inform ANM didi on phone about the health need. ANM is a good woman but she should tell the pregnant lady to come with me… most of them also do not go with me to hospital as they have to make the payments… so they think that if cannot help them in terms of conveyance or medicine need then what is my use… and therefore they go on their own." (As17/SC/II)*

Corroborating this with the reasons for the care seeking, Table 4.7 shows why the care seekers consult these health care providers. The responses mentioned below are the health care providers' perceptions. Of the total, 30 respondents said that they are the only health workers available in the village, and most of the people know that they are there for the delivery of above mentioned health services. Though, similar number of ANMs (15) and ASHAs (15) said about this. However, 27 respondents revealed that the care seekers consult them because they understood their health issues and address need carefully than anyone else.

Further, 15 health service providers said that they are easily accessible and therefore care seekers prefer them to consult about their health needs. However, the results show that ASHAs are easily accessible than ANMs in the village as Table 4.8 illustrate that 15 ASHAs said that service seekers consult them as they are easily accessible whereas at the same time only five ANMs said about the same. This is because they are the local residents and most of the time selected from the same village or area where they

work whereas ANMs are the salaried government employees and most of the time found to be residing in nearby towns or cities.

Table 4.7
Reasons for Seeking Services from ANMs and ASHAs

Reasons	service provider		Total
	ANM	ASHA	
Easy Access	5	10	15
Good Behavior	16	11	27
This is my work	15	15	30

If this information is further inflated among the different caste group respondents, behavior is seen as crucial factor for the service seekers. It was found that eight Non SC/Muslim ANMs and four ASHAs said that the service seekers consult them because of their polite interaction. Similarly, five Non SC/Muslim ASHAs reported that the service seekers use their services or consult them because of their 'decent behavior'[2] towards them. Most of the SC ANMs (eight) and ASHAs (six) revealed that service seekers know their work and thus they were contacted by them for their health needs. Easy access was also seen as significant factor in seeking health services from the health providers because three Non SC/Muslim ANMs and four Non SC/Muslim ASHAs said the service seekers contact them as they are easily accessible to all.

Among the Muslim respondents, six ANMs and six ASHAs said that people know them and their work and thus consult them.

[2] Decent behavior included three characteristics- first the provider did not show any reluctance in entering the seeker house. Second, speak softly and third did not practice untouchability in any form.

Table 4.8
Reasons for using of the Services; across Caste

Seekers		ANM		ASHA	
		Non-SC/Muslim	**SC**	**Non-SC/Muslim**	**SC**
Hindu	Easy Access	3	0	4	4
	Good Behavior	8	4	5	2
	This is my work	1	8	3	6
Muslim	Easy Access	2	0	2	0
	Good Behavior	4	0	4	0
	This is my work	6	0	6	0

4.5 Assistance Received by Health Care Service Providers

The health care service providers such as ANM and ASHA are the key field-level functionaries who directly interact with the community. However, they suffer enormous challenges at the field. The health service providers were asked that who were the people (concerned authority) in the villages that helped them when they faced any problem or need anything while working on the field? The responses of the health care providers are shown in Table 4.9. It showed that most of the ANMs (31) said that no body helped them at the field if they need any kind of help. They have to cater to the issues by their own experience or personal links. While only three ANMs said that '*Pradhan*[3]*' helped* them whenever they need any help in field. Though, 26 ASHAs also said they nobody help them in the field. Moreover, at the same time eight ASHAs responded that they got support from the *Pradhans* while delivering health services. *Pradhan* helped the village level health care providers to arrange vehicles to carry the patients to the hospitals. They provide place for organizing Village Health Nutrition

[3] A Pradhan is elected head of a Gram Panchayat (village council). A Gram Panchayat is the only grassroots-level of Panchayati Raj formalised local self-governance system in India at the village or small-town level.

Days (VHND), and in some cases, there was evidence of financial support too. One of the participants said:

> *There was no proper place to organize the VHND[4] in this area. For a year, I was organizing the VHNDs in the house of a villager. Only few women came to his house because of the social dynamics of the village. But, the Pradhan helped me to organize VHNDs in the Panchayat Ghar[5] (An1/Non-SC/FGD1)*

Another, respondent reported that *Pradhan* helped her in in organizing health promotion activities in the villages and also in the health centers. The health care providers have reported that when they organize any health promotion activities in the villages, the villagers do not actively participate in those activities. In such a situation, they ask *Pradhans* to help her in mobilizing villagers. The *Pradhans* are influential individuals in the villages. Therefore, the villagers are inclined to mind their instructions/suggestions. It enhances the awareness about benefits of health programs among the villagers. One of the ANM who got support from *Pradhan* said:

> *"In my area, women preferred home deliveries and never attended health talks. My job is to motivate them for institutional deliveries and make them aware about regular health check-ups during pregnancy to avoid health complications. For this, I usually initiate and organize health talks in the village so that I can make them understand the benefits and health facilities available in the health center. But they do not come to attend such talks and remain busy in their own works. I asked Pradhan to help me in convincing the people to attend health talks and to use public hospitals. Pradhan helped me in this work and*

[4] Village Health and Nutrition Days (VHNDs) are a major initiative under the National Rural Health Mission (NRHM) to improve access to maternal, newborn, child health and nutrition (MNCHN) services at the village level. Across the country, VHNDs are intended to occur in every village once a month usually at the *Anganwadi Centre (AWC)* or at any other suitable location.

[5] The *Panchayat Ghar* is the building where the *Panchayat* members meets to discuss its works and perform its functions.

as a result, now people of my area are much more aware of the benefits of the government health plans and schemes and also go for institutional deliveries".(An9/Non-SC/II)

Further, two ASHAs reported that they got help from the *Anganwadi Workers*[6] in locating the pregnant women in the village and organizing village level health promotion activities.

Two respondents also said that medical officer-in-charge (MOIC) of their primary health center support them in organizing Village Health Sanitation and Nutrition Committee (VHNSC) meetings in the villages. As per the NRHM guidelines, a VHSNC should comprise a team of at least 15 members including elected member of the Panchayati Raj Institutions (*Pradhan*) who shall lead the committee.

Table 4.9
Personnel providing support to providers

	Service Provider		
Functionaries	**ANM**	**ASHA**	**Total**
Pradhan	3	8	11
AWW	0	2	2
ASHA Supervisor	0	0	0
None of the other	31	26	57
MOIC[7]	2	0	2

All those working for health and health related services should participate including, community members/ beneficiaries or representation from all community sub-groups especially the vulnerable sections and hamlets/ habitations. The Auxiliary Nurse Midwives (ANMs) of the health department provides information to VHSNC about available health services, schemes, and services for maternity and child health. ASHA residing in the village acts as the member secretary and convener of the committee. One of the ANM respondents who seek support of the MOIC in organizing VHSNC said-

[6] Anganwadi Worker, are the women selected from the local community, is a community based frontline honorary worker of the ICDS Programme.
[7] Medical Officer-in-Charge

"I am a member of the VHSNC and hold the joint account for the VHSNC fund. I have to organize the meeting. Though, I am not able to organize these meetings on regular basis but whenever, I call the MOIC of my primary health center to deliver a talk on some health issues. He comes and people discuss their issues." (An31/Muslim/II)

4.6 Dynamics in Obtaining Assistance

Table 4.10 illustrates the differential attitude of people while extending their support to the health care service providers in the villages. It was found that the entire health service provider does not obtain equal and easy support/help from the villagers or other functionaries of health system or any other public service worker working together in the area. The result revealed that health workers are maligned by their seniors or the local level PRI leaders (mostly *Pradhans*) if they possess social identity which vary from their own. The table 4.10 shows that only one Hindu ANM said that *Pradhan* helped her when she was in need.

Table 4.10
Pattern of Seeking Help from other Functionaries Across Religion

	Religion					
	Hindu			**Muslim**		
	ANM	**ASHA**	**Total**	**ANM**	**ASHA**	**Total**
PRI	1	6	7	2	2	4
AWW	0	2	2	0	0	0
ASHA Supervisor	0	0	0	0	0	0
None of the Above	22	16	38	9	10	19
MOIC	1	0	1	1	0	1

PRI leaders prioritize one health care provider over another on the basis of their caste and religion identity (in the case of Muslims in their area). Further, they extend their help and support to these prioritized health care providers only. In such a situation, the health care providers who do not belong to their caste/religion suffer enormously. But, the health care providers who find the support of these PRIs leaders do not regularly

visit the health centers and households and take their duty for granted. One of the participants expressed:

> *"The ANM and the Pradhan are of the same caste. She has the support of the Pradhan; therefore, she rarely comes to the health center and hardly visits the field. If she visits; she only visits the households of her caste." (Cs10/SC/FGD4)*

When Muslim ANMs were asked about the dynamics of obtaining help from the other people while delivering health services in villages, one of them replied-

> *"I faced several challenges due to my Muslim Identity. The Pradhan of my health center is Thakur (Hindu Upper caste). He never supported me; rather he always tries to threaten me for my job regularity. But MOIC of my PHC help me whenever I need. I always work wholeheartedly and try to help as more people as I can. But, these evidence disheartens me."(An25/Muslim/II)*

Table 4.11
Pattern of Seeking Help from other Functionaries Across Caste

Functionaries	Religion							
	Hindu				Muslim			
	Non SC		SC		Non SC		SC	
	ANM	ASHA	ANM	ASHA	ANM	ASHA	ANM	ASHA
PRI	1	2	0	4	2	2	0	0
AWW	0	3	0	0	0	0	0	0
ASHA supervisor	0	0	0	0	0	0	0	0
None of the above	20	8	11	8	9	10	0	0
MOIC	0	0	1	0	1	0	0	0

Table 4.11 shows pattern of help seeking behavior from other functionaries across caste while working at the field. The results reveal that the Hindu upper caste health care providers more often obtain support of the PRI leaders than the SC health care providers. It was also found that Muslim health care providers got the support from the

PRI members than SC health care providers. Here SCs face more discrimination in terms of seeking support or help from PRIs in comparison to even Muslim health care providers as no SC ANMs reported to get support from *Pradhans* whereas two Muslim ANMs reported to obtain support from the PRI leaders. It was found that sometimes even the same caste *Pradhan* does not support the ASHAs due to her women and lower hierarchy health worker's identity.

One of the SC ANM clearly explained-

> *"I approached Pradhans several times to help us in organizing VSNSCs and VHNDs in the area. But he never helped me. He knows I belong to schedule caste. Sometimes he even used derogatory words for me using my caste identity."(An18/SC/II)*

The PRI leaders are empowered to enquire physical attendance, misconduct, and monitoring of certain public personnel such as ANMs & ASHAs. However, their participation has created more hurdles for the health providers. The health care providers, who belong to their caste and family relation and always stand in support of them, enjoy all kinds of liberty in performing their job and seeking help at any time. On the contrary, the other health care providers face a lot of challenges even if they perform better. In this way, the decentralization process has generated a biased system in primary health care. The caste internalization in the decentralized system of health care leads to dissatisfaction and mistrust among the service providers and thus most of the time they do not share their problems with the local leaders or any other local people.

4.7 Conclusion

This chapter has shown the social characteristics and the interaction pattern among the health care service providers. Although all the responses presented here are the provider's perception but this has provided important information about the dynamics between the health providers and the seekers on the basis of social status. The

information provided by the health providers will be further triangulated by the health care seekers responses and then complete picture would be drawn. This chapter has shown that the social status of the providers affects the health interaction of the providers in terms of restricted personal mobility in the villages' area, people not sharing their health problem, judgmental attitude of the people. Many people in the village approach lower caste providers only for the deliveries and never consult them for any kind of suggestion. The kind of help and support that these health providers get are also biased and highly dependent the social status of the health provider.

CHAPTER V

HEALTH INTERACTIONS AND UTILIZATION OF HEALTH SERVICES: SEEKERS' EXPERIENCES

5.1 Introduction

In the previous chapter, it has been explained how interaction matters, and what happens when it occurred between the health care providers and seekers keeping similar and contrasting social identity, particularly the caste identity. It has been found that it has affected quality, nature and amount of health services being delivered to the care seekers having different social identity. Significant variations were noted while examining their interactions which further leads to unfair prioritization of care seekers while health service provisioning. This brings us to further investigation of various dynamics that operates between care providers and care seekers in the present study.

The present chapter has two sections; in first section it updates about the micro level picture of the health interactions while accessing health services from care providers across and within social identity groups. It further, throws light on the interaction patterns, determinants, and its effects on the health seeking behaviour of the care seeker participants. While, in the second section it highlights the factors influencing utilization of health services at the grassroots level. To present the results, quotations from the participants' narratives were used to reflect the care seeker's views under various themes.

5.2 Background Information of the Care Seekers

The following section outlines the general characteristics of the care seekers selected for this research study (Table 5.1). As aim of the study is to analyse the role of social identity in access and delivery of health care services, particularly by the women health care providers and their care seekers at the grassroots level, all the participants (care providers and care seekers) selected for this study were women. However, of the total 65 care seeker participants, most of the women (29)

were from younger age group i.e., 19-25 years. All the participants were married. Out of all the participants, the number of uneducated participants were slightly higher (22) than care seekers who attained education up to high school.

Further, considering religious and caste identity of the participants, most of the participants were Hindus (44) followed by Muslims (21). As it has been shown in previous chapter that caste plays very significant role in delivery of health services at the grassroots level which further brings its role even in utilization of health services, and is discussed in the second section of the chapter. Among the caste groups presented in the study sample, 22 participants were Scheduled Castes, 21 were Muslims, and 22 participants were from the non-SC /non-Muslim - which is either from the OBC or from General castes (see Table 5.1).

Table 5.1
Background Characteristics of the Participants

	Background Characteristics	Number
Age Group (In Years)	19-25	29
	26-32	21
	33 and above	15
Educational Attainment	Illiterate	22
	8th Passed	13
	High School	14
	Intermediate	12
	Graduation and above	4
Religion	Hindu	44
	Muslim	21
	Others	0
Caste	Caste of SC	22
	Muslim	21
	Caste of Non SC/Muslim	22

5.3 Health Interactions

Health interaction in one of the important component of health care delivery system. It is important to analyse and acknowledge the determinants of health interaction as it has major in health service utilisation. The following section discusses the determinants of health interactions in detail.

5.3a Determinants of Health Interactions

Health of the populations has been primarily linked with range of health determinants widely discussed by many researchers, policy documents and other public health literature in general. The present section deals with the determinants of the health interactions which affect quality and nature of health services delivered at the grassroots level by the health care providers. The identified determinants reported to often influence the decision of care seekers which ultimately affects health services utilization. While exploring health interactions, it further revealed the practice of priority (that health care providers follow in addressing health needs even in emergency cases), time duration (given for the particular care seekers while offering their services), and amount of services being provided to the selected care seekers. The results presented here are indicative of care seekers voices that were reported at the time of data collection. The idea is to analyse and turn up with varied concerns of health interactions which takes place while interactions across and within social identity care providers and seekers. Recognising these issues may further help to the policy planners, executives, and local and state level monitoring and supervision bodies in addressing the issues.

- ***Caste of the Care Seekers***

It has been already described in the previous chapter that caste plays very important role in the access and delivery of health services at the grassroots level. Caste is also seen as one of the major determining factors in health interactions between care providers and care seekers. Owing to the particular caste identity, care seekers form a perception about the skills and knowledge of the health care providers, particularly in the context of ANMs and ASHAs who often belongs to the same area. In such a situation, it was found that when interaction happened, it was nowhere similar for all the care seekers irrespective of their needs rather it turned up in different prejudiced forms on the basis of their social identity. This trend was observed at almost all the data collection sites. One of the participants explained-

> *"I was pregnant, and was suffering from some vaginal discharge and pain. I told the ASHA who regularly comes to my house. But,*

she told me to come to the health centre or speak to the ANM. I could not go to the health centre as my husband was out of station. I wanted to seek some advice from the ANM of my village... But she did not tell me anything. She did not even speak to me properly. She has only given me Iron tablets[1]. Later, when I told my husband he made me understand that she is a 'Thakur'[2] and will not serve the Pasi's (Scheduled Caste). Then we had to consult a local doctor in a private hospital. Now I do not rely upon her for my health needs." (Cs21/SC/II)

Similar experience is accounted by another scheduled caste participant-

"*The ANM in my area does not take interest in speaking to the Scheduled Caste people. She is Kurmi[3]. If I go to her she may give me some medicines in a routine manner. But she does not touch us, and also she does not take the interest in talking or communicating about any health benefits. I know these people and can understand…they think we are fools." (Cs16/SC/II)*

It has been clearly evidenced by the care seeker participants that pressure of varied impact was exerted by higher officials from the health department on the ANMs & ASHAs. As a result of which ANMs & ASHAs have moderated the nature of interactions and health services delivered to the care seekers who do not belong to their caste. The results presented here revealed that the non-SC ANMs and ASHAs have restricted themselves to deliver very few health services to the SC/Muslims. They do not offer all available services to everyone as per their needs. In fact, it was clearly visible that when a SC care seeker needed any advice or counselling services from the non-SC ANMs, they were simply denied.

It may be because that non-scheduled caste ANMs and ASHAs were not willing to spend their time in making SC and Muslim care seekers understand about their health issues, as the evidence suggest that non-SC ANMs mostly sidestepped

[1] Iron Folic Acid
[2] General Caste Hindu
[3] Hindu OBC

counselling services for the SC/Muslim care seekers. They only prefer either to send or refer them to the health centre in such cases. To quote a Muslim care seeker-

> *"I have a 17-year-old daughter and she was suffering from some health issues (reproductive health). Sofia (a woman of the same village) suggested me that ANM madam comes on every Wednesday (VHND[4]) and I can speak to her, she will help me. So I waited till Wednesday and tried to explain the issue. But she at once got irritated and replied (with shouting) 'tum logon ko kaun samjha sakta hai bhala, bees-bees bacche paida karti ho fir bhi kuch malum nahi hai'. (who can make you understand as you people deliver lot of children and still you do not know anything). I felt disgusted and disgraced. I took my daughter to a private doctor in Hardoi, and since then I never saw her (ANM) face." (Cs26/Muslim/II)*

Recently the central as well state governments have enhanced focus on the health services strengthening in the state, active vigilance of local level *Panchayati Raj leaders* on ANMs and ASHAs (Kumar and Mishra, 2015), and involvement of non-government organizations in health service delivery at the grassroots. Owing to this, the non-SC care providers are forced to deliver health care services. But, again they find another alternative, and deliver only most visible services to the non-SC/Muslim care seekers such as - visit to their houses (but do not give adequate time), providing medicines, and most likely making referrals so that the higher officials remain informed about their functioning. At the same time, they remained away from the counselling and other promotive services.

Further exploration, revealed that it occurs because of the perception (that non-SC ANMs and ASHAs follow) that SCs and Muslims people are not educated and they do not easily understand the things explained to them. Thus most of the non-SC ANMs and ASHAs did not allow their time to offer preventive and promotive services to the SC care seekers, which particularly includes counselling and

[4] Village Health and Nutrition Day

awareness services. One of the SC care seekers who delivered a baby some time back articulated-

> *"I belong to scheduled caste. The ANM madam is Gupta*[5] *(Vaishya). When she comes to my house for the ANC, she hardly spent a minute to tell me about any of the precautions and diet/health needs. Whereas she almost spent an hour in my neighbours home who is Lohar (Hindu OBC). She makes her understand about the danger signs, diet and other necessary things which I come to know later. I feel sad about her behaviour." (Cs13/SC/II)*

In view of caste as a determinant of health interaction it really defines the nature of health interactions at the village level. Due to the discriminatory behaviour of the care providers the care seekers are often left with no choice, and forced to find some other alternatives for seeking health services while their health needs which drags them to bear out of pocket expenses.

5.3b Unsatisfactory Behaviour

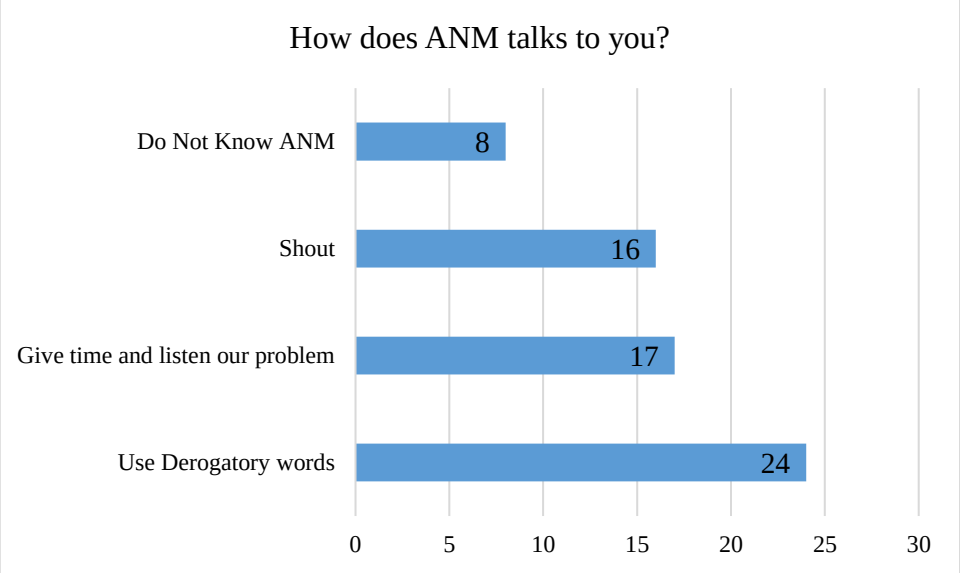
Behaviour plays crucial role in health interactions and health services utilization. It was reported from the field that most of the ANMs were very rude to the care seekers which further discourages care seekers to seek care from them in future. Berlan and Shiffman, (2012) also suggested that lack of health provider's accountability to care seekers may have adverse effects on the quality of health care they provide which further decides utilization of health care and ultimately affect health outcomes. At present in given situations, the people's expectations are tremendously increasing from their care providers, therefore there is a need to make the health care providers more accountable in terms of service delivery to the care seekers. Though, behaviour plays crucial role in this entire process of health service delivery however, the care seekers were extremely unsatisfied from the behaviour of ANMs. In the following sections, types of anxieties of the care seeker's regarding health care provider's (ANMs & ASHAs) behaviour were explored further.

[5] Hindu OBC

- **Experiences about ANMs**

Care seekers' responses regarding behaviour of ANMs is shown in Figure 5.1. Most of the participants (24) reported that ANMs did not talk properly and used derogatory words, when they contacted them for their health needs. The participants further expressed that whenever they went to meet the ANMs, most of them were in hurry and did not give adequate time to listen their health problems. The care seekers also reported that the ANMs were not even polite and showed harsh behaviour. Out of total participants who interacted with the ANMs 16 were unsatisfied with the behaviour of the ANMs as the ANMs shouted/screamed on them while their interaction. Only 17 participants revealed that ANMs behave properly while they contacted them for seeking care.

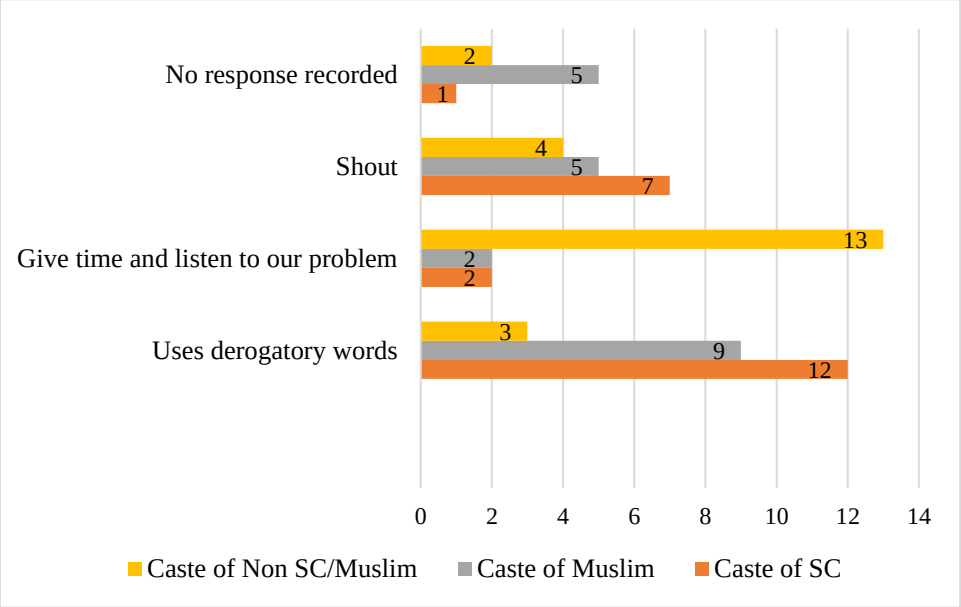
Figure 5.1
ANMs Behaviour while Interaction with the Participants



Further, the care seekers explained that the behaviour of the ANMs was not similar for all the care seekers as it depends upon their social identity tuning. It came up very clearly when it was further explored about type of behaviour ANMs express with the care seekers of different social identity, particularly caste. The results revealed that scheduled caste care seekers (12) were the largest sufferers as ANMs often avoided them and did not talk properly (see figure 5.2). Besides, the ANMs also did not provide adequate time to understand health issues of the scheduled caste care seekers rather shouted on them. The cases were almost similar for the Muslim care seekers (see Figure 5.2).

Whereas, at the same time most of the non-SC care seekers conveyed that ANMs behave gently with them. It was fairly validated when out of the total care seekers who responded about the ANMs, most of the Non SC and non-Muslim participants (13) expressed to have a mannerly interaction with the ANMs while their health needs. The discriminatory behaviour of the ANMs trigger the SC care seekers to seek care from alternative sources. As it was very clear from the field data that ANMs do not give priority to the SC and Muslim care seekers while interacting with them.

Figure 5.2
Interaction Patterns between ANMs & Care Seekers of Different Caste



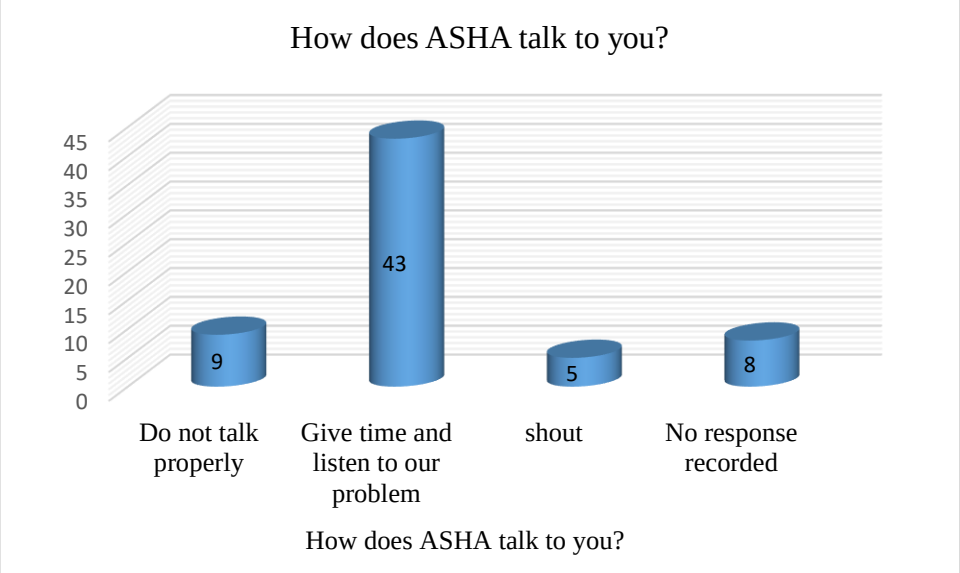
- **Experiences about ASHAs**

ASHAs' behaviour while interaction with the care seekers was also explored. There were substantial deviations from the responses for the ANMs (please see Figure 5.3). ANM being higher in the health system hierarchy and a salaried employee took more liberty to discriminate the people on the basis of social identity than ASHAs. Whereas, ASHAs being lowest in the health system hierarchy and incentive based workers talked properly with most of the care seekers (43). Still there were some instances that showed inappropriate behaviour of ASHAs with the care seekers. Very less but significant number of care seekers (nine) said that ASHAs also did not speak to them properly while interacting. It

was because some of the upper caste ASHAs followed such perceptions of caste and usually avoided communicating with the scheduled caste care seekers. One of the care seekers expressed-

> *"I wanted to seek the information from the ASHA of my village regarding my irregular periods. I approached her several times but each time she said that she will come to meet me next time. It has been a month but she has not talked me yet. I know she is avoiding me as I am "Dhobi" (scheduled caste) and she is Thakur." (Cs17/SC/II)*

Figure 5.3
ASHAs Behaviour while Interaction with the Respondents

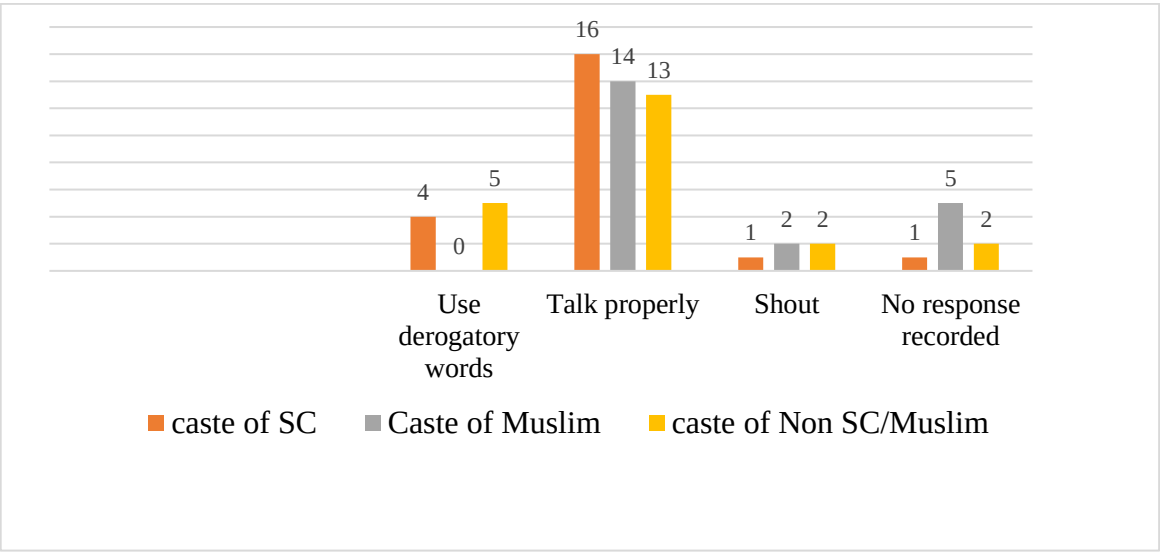


When ASHAs' behaviour was explored (Figure 5.4) for different caste groups it became evident that they talk properly with the care seekers normally. But sometimes when they are from lower caste and have background of the resourceful families of the village such as *Pradhan/others*, they also did not give importance to communicating with care seekers of any caste, and did not behave properly. Sometimes even ASHAs shouted on them as two non-SCs, two Muslim and one SC care seekers reported about the same. So, here the power dynamics have concrete implications in determining the nature of interaction and behaviour of ASHAs. One of the care seekers sorely expressed-

"The ASHA of my village is Pradhan's Bahu (daughter in law). She is Chamar (SC) but she never speaks well with any of the care seekers and rarely visits to the houses of any Brahmin or Thakur (upper castes)." (Cs10/non-SC/II)

This reflects assertion due to the position attained in the work hierarchy. In the entire interaction process caste and behaviour plays very significant role in deciding the pattern and nature of the interaction. It limits the resources even that is available for all. The unsatisfactory behaviour of the ANMs and ASHAs influences the interaction and decision of care seekers for the utilization of health services. Though, these health care providers (ANMs and ASHAs) often belong to the same community and have close acquaintance with each other. But, the unbiased and informative interaction can play a major role in preventing several health issues of the care seekers but such type of priorities driven by social identity are making health services highly unreachable. Care seekers having such experiences do not prefer to seek health services from them.

Figure 5.4
Interaction Patterns between ASHAs & Care Seekers of Different Caste



5.3c Patterns in Dispensing Medicines to Care Seekers

The patterns identified in dispensing medicines to the care seekers of different castes by the ANMs and ASHAs is one of the determinants of the interaction between care provider and care seekers. Most of the participants expressed that the

health care providers (ANMs and ASHAs) did not explain the treatment/medicines whichever they provide to them. Whereas other responses were that either they did not explain the medicine properly or give medicine without touching them. The most significant and remarkable thing turned up from the field was to ascertain the patterns (such as did not explain the dosage or timing, did not explain properly, give medicine without touching care seekers, do not give any medicine) followed by the health care providers of particular caste while dispensing medicines to the care seekers of different castes (see Table 5.2). The participants were quite unsatisfied from these patterns followed by the care providers.

The patterns identified in the Table 5.2 further help care seekers in making the perceptions about the ANMs and ASHAs as well as the public health services. The table illustrated that most of the scheduled caste care seekers (9) seeking care from ANMs expressed their dissatisfaction. They said that whenever the ANMs provided them any medicine they did not explain the timing or the doses of the medicines, whereas four Muslim participants and two non-SC/non-Muslim participants also reported about the same. The identified patterns demonstrated the caste based prioritization of the participants in dispensing the medicines by the ANMs.

Table 5.2
Patterns in Dispensing Medicines by ANMs & ASHAs

Patterns in Dispensing Medicines by ANM	**Caste/Religion of the Care Seekers**		
	Caste of SC	**Muslim**	**Caste of Non-SC / Muslim**
Do not explain dosages or timing	9	4	2
Do not explain properly	4	7	0
Give medicine without touching	1	2	0
Do not give us any medicine	7	2	2
No issues with medicine dispense	0	1	16
Do Not Know ANM	1	5	2
By ASHA			
Do not explain dosage or timing	9	8	11
Do not explain properly	5	1	3
Give medicine without touching	0	2	0
Do not give us any medicine	4	2	3
Inadequate dosage	3	3	3
Do Not Know ASHA	1	5	2

In addition, most of the non-SC/non-Muslim participants (16) conveyed that they did not have any issue from the dispensing of medicines by ANMs. When it was explored further, it came up very clearly that ANMs knew that who in the village can take action against them or can report their unfair behaviour to the higher authorities of the department. So, keeping it in the mind they interact and behave accordingly. One of the care seekers expressed about this-

> *"I am Dhanuk (SC). I know why the ANMs show such unfair behaviour with us. We are poor people and nobody listens to us, and ANM knows that I am not able to do anything." (Cs23/SC/II)*

Although it also came up from the field that sometimes the ANMs of the same caste also do such unfair activities with the people. In such instances too, being the local residents, the ANMs knows about the person who can take any action against them even if that person belongs to her own community. But, there were also some other possibilities that sometimes the ANMs really have other engagements and therefore, they do not provide the required times and then have to prioritise the care seeker for such situation. In such situation they gave priority to the non-SC women.

Further, there were some instances of untouchability reported by the Muslim and SC care seekers that non-SC and non-Muslim ANMs even avoided touching care seekers while providing them medicines. They did not provide the medicines and other required things directly in their hands whereas they put it either on the floor or any object kept nearby. Though it is very unacceptable but the poor care seekers were not able to raise their voices against such discriminating behaviour. One of the care seekers very clearly said that the ANM of her village always avoided them as much as she can and rarely touch them, expressed-

> *"Three months back when I was pregnant and registered with ANM for the check-up (ANCs) … ANM never entered in my house, she used to send a women or children to call me up to Anita (upper caste) or Rakesh's (OBC-non SC) house in my village. Once, she herself came and said to my husband standing at the door, 'Send your wife to Anita's home, I will see her there. My husband told*

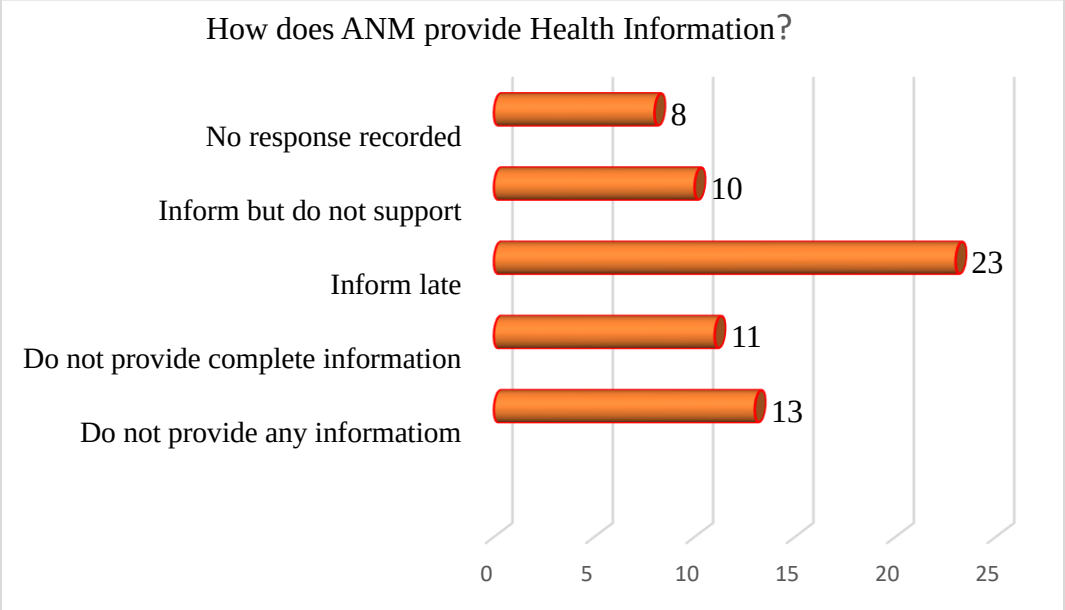
her why you cannot see her here in my house? she replied to my husband...dekhne aa ja rahen hain yahi kam hai kya? (is it not enough that we are coming?) And whenever I go to those women's home, then she never given me tablets (Iron and Calcium) in my hand. She always put the tablets on the cot and I picked them up from there." (Cs28/Muslim/II)

The interaction patterns between the ASHAs and the care seekers while dispensing medicines has also been examined by the researcher. The ASHAs also follow similar strategies while dispensing the medicines but the act of discrimination was not as intense as the ANMs. Because ASHAs are not regular and salaried employees and moreover their incentives are dependent upon their amount of work done (number of institutional deliveries conducted with their help). But still the caste notion plays significant role even with the ASHAs (see Table 5.2) in the villages.

5.3d Patterns in Providing Health Information

Providing health information to the care seekers at the grassroots is one of the crucial functions of the village level care providers such as ANM and ASHA. However, these health care providers were reported to be very careless in providing such information to the care seekers. When this question was administered to the care seekers that how do ANM provide health information? Of the total participants, 23 care seekers expressed that the ANMs did not provide any information to them (see figure 5.5), whereas 10 participants revealed that ANMs did not provide complete information, and 11 participants shared that ANMs informed lately when the date of seeking benefit from that information is either turned over or likely to expire.

Figure 5.5
Patterns Providing Health Information by ANMs



The patterns in providing health information to care seekers was examined further, again caste has been seen as playing very significant role in passing information to the care seekers. Some of the scheduled caste care seekers seeking care from the non-SC/non-Muslim care providers shared that either the information provided to them was very late or they got incomplete information. Owing to late and partial information, the care seekers faced a situation of dilemma that whether to use or explore the information in detail or not. Most of the time it happens that they could not avail benefits from that information. One of the care seekers expressed-

> *"The ANM of my village is Kurmi. She is very rude, and do not equally treat all the people in my village. She always provides health information to the people of upper caste or her own caste. Last month a health camp was organised at the PHC by some NGOs and they also distributed medicines. Nobody from my caste even got to know about that. But most of the upper caste women attended the same." (Cs15/SC/II)*

It was observed that due to some monitoring and other pressure, non-SC ANMs pass the health information to some of the scheduled caste care seekers but deliberately they did not provide full information to them. They provide

incomplete information just for the sake of showing that they have done their work. One of the care seekers expressed on incomplete information-

> *"I was waiting for an eye camp since last one year to get my mother-in- law's eye operated for Cataract. I inquired several times to the ANM about the eye camp. One eye camp was likely to be organised in Balamau (nearby) health centre, but the ANM did not tell us about the same. She always told us that...pata karte raho aas paas kisi health centre me hoga. We took my mother in law to Sandila (around 40 Kilometers from my home) for the operation. Later, I came to know that two people of my village got operated in Balamau in the same month, and the same ANM had informed them." (Cs8/non-SC/II)*

It was also observed that Muslim care seekers were more devoid of information. They reported that, sometimes even SC ANMs also do the same discrimination as the other non-SC ANMs do. Due to this, Muslim care seekers reported that they prefer to seek care from the private doctors which is nearby and also do not discriminate them. One of the Muslim care seekers expressed-

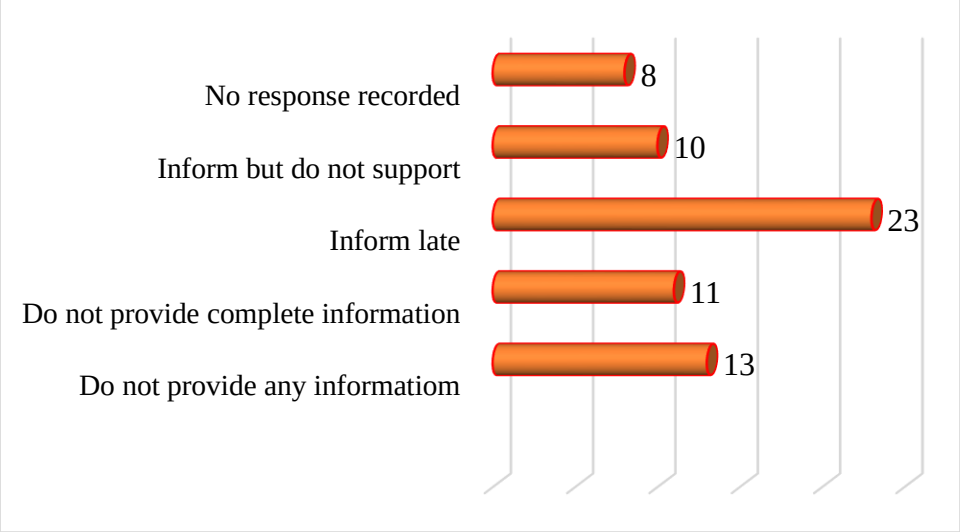
> *"I know ANMs do not want to interact with the Muslims. Agar Allah ka dhyan rakhkar wo kuch bata bhi deti hain to puri jaankari nahi deti. If I start asking more about the information. She tells us 'tum log jaan kha lete hoi isi liye tum logon ko kuch batate nahi hain' you people asks more questions that's why I do not tell you anything. So I use to prefer private doctors to seek health information rather these ANMs." (Cs31/Muslim/II)*

In addition, more exploration about how does ASHA provide health information to the care seekers of different social identity was done. Most of the care seeker participants (23) revealed that they use to receive delayed information which could be attributed to the excessive workload on the ASHAs. Eleven women expressed that ASHAs did not provide complete information whereas ten participants told that ASHAs inform them but they do not support them further in accessing those

facilities for which the information was meant. Figure 5.6 shows the patterns in providing medicines to the care seekers.

The ASHAs also reported to exercise some caste based discrimination to the care seekers but the forms of their discrimination were mostly not very visible. Still there were few instances where ASHAs prioritise the care seekers for providing health information to the care seekers. But here the dynamics is quite different as she prioritises those care seekers to whom she could take to public health centres for deliveries (child birth) and so she could get the incentives entitled for same.

Figure 5.6
Patterns in Providing Health Information by ASHAs



In some of the cases, it happens that due to such experiences of the care seekers, even those care seekers who were seeking care from ASHAs and remained under her vigilance during pregnancy, moved to the private hospital for their delivery. ASHA could not get the benefits in terms of incentives whereas she was following them from the inception of their pregnancy. Hence ASHAs start prioritising the care seekers for whom they are quite confident about. There were other similar responses reported about the ASHA that 'she does not inform care seekers likewise ANM'. Such type of prioritization seems to be common at the village level.

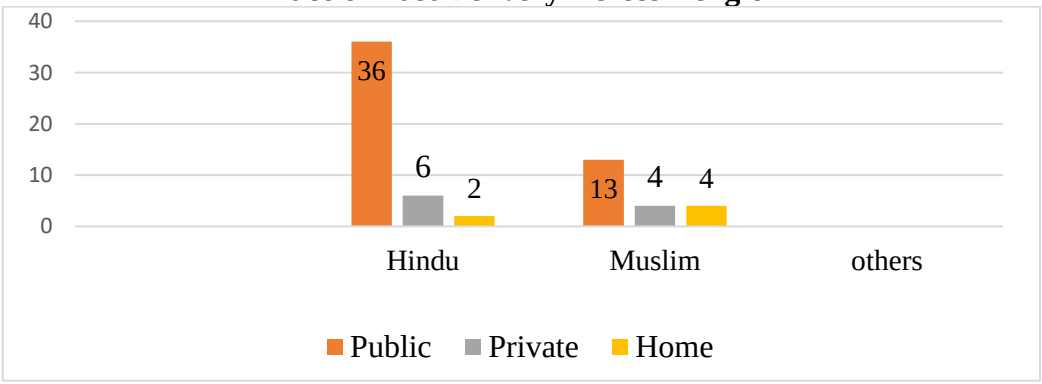
5.4 Health Services Utilization: Seekers Experiences

After taking a thorough look on the health interactions its determinants and pathways, the issues and challenges that arise in utilization of health services at the grassroots level were examined. Health services utilization can be better

understood from the two different perspectives; the service provider's perspective, and service seekers perspective. The previous chapter provides a detailed overview of the provider's perspective in context to the research questions raised. This section presents a deeper look into the health services utilization from the patients point of view. The results presented here were analysed on the basis of the experiences and voices of the care seekers that they have conveyed while their interviews. The crucial and most significant experiences were brought in order to understand health services utilization from the care seekers viewpoint.

The care seekers whose responses are presented here were those who have delivered baby within a year at the time of data collection, and taken health services from the care provider (the views of the providers are presented in previous chapter). Of the total 65 care seekers, 49 care seekers (please see Figure 5.7) have delivered their babies in government health centres, generally at primary health centres and community health centres whereas ten care seeker reported to deliver their babies in private hospitals (but they have taken care from the ANMs/ASHAs in initial trimesters). Also, there were six care seekers who delivered their babies at their homes under the supervision of local Dais/experienced family members. The results revealed that home deliveries are more common among the Muslim population in Hardoi district. Figure 5.7 given below shows the place of delivery across the participants' religion.

Figure 5.7
Place of Last Delivery Across Religion



Further exploration of the reasons for choosing particular place of delivery (public/private) was required. The participants who deliver their babies in public hospitals revealed that the health centres were either nearby to their houses or most

convenient in terms of accessibility and financial conditions (see Table 5.3), as 13 participants reported that they had selected the public health centres as they were not able to afford private health facilities and public hospitals were offering free health services for the delivery.

So, free health services were the most significant reasons for choosing public health centres whereas they were not satisfied with the quality of health services provided there. One of the care seekers said-

> *"We all brothers and sisters were born in the homes only. Now, I am so scared of the complications of home deliveries. I am not able to afford the delivery expenditure in private hospitals. Here I got all the services free, and I will also get money for the delivery."(Cs1/non-SC/II).*

Table 5.3
Reasons for Choosing Particular Place of Last Delivery

Place of last Delivery	Reasons						
	Quality Service	Good Behaviour	Proper time for check-ups	Explain the treatment	Free Services	Convenient	Suggested by ASHA/ANM
Public	0	1	0	0	13	19	16
Private	2	3	0	1	0	4	0
Home	0	0	0	0	0	6	0

There were also 16 participants who said they have delivered their baby in the public hospitals because of the recommendations of ANMs/ASHAs of their area as they were continuously following them and have suggested them to conduct their deliveries in their respective public health centres. Though, people in the Hardoi district are significantly using public health centres rather than the private health facilities as because of its high expenditure. However, nobody has responded that they got quality health services, adequate time to examine their issues over there.

The Hardoi district is one of the most backward and poorest districts of Uttar Pradesh with around 40% of the population living below the poverty line (Human Development Report: Uttar Pradesh. 2008). In such a situation, most of the people who seek care from the public hospitals - sub centres & primary health centres were poor and not able to afford health services from private health facilities

available in their areas. The current situation of the care seekers emphasizes the need to deliver quality health services in the public health centres to attract more number of care seekers, and save from high out of pocket expenditure in private health facilities.

There were care seekers who could not even afford the medicines worth rupees 50 and they were reported to visit to the health centres twice and thrice (in case of unavailability of the medicines in the health centres) to take medicines from the health centres, though meanwhile they suffered a lot but were not able to purchase from outside. As said by one of the care seekers-

> *"I was suffering from fever and doctor said you have jaundice. But he said that there is no medicine in the health centre that time, but I had to come again next week for the medicine. I was not able to purchase the medicine outside. I have to visit twice to get the medicines." (Cs6/non-SC/II)*

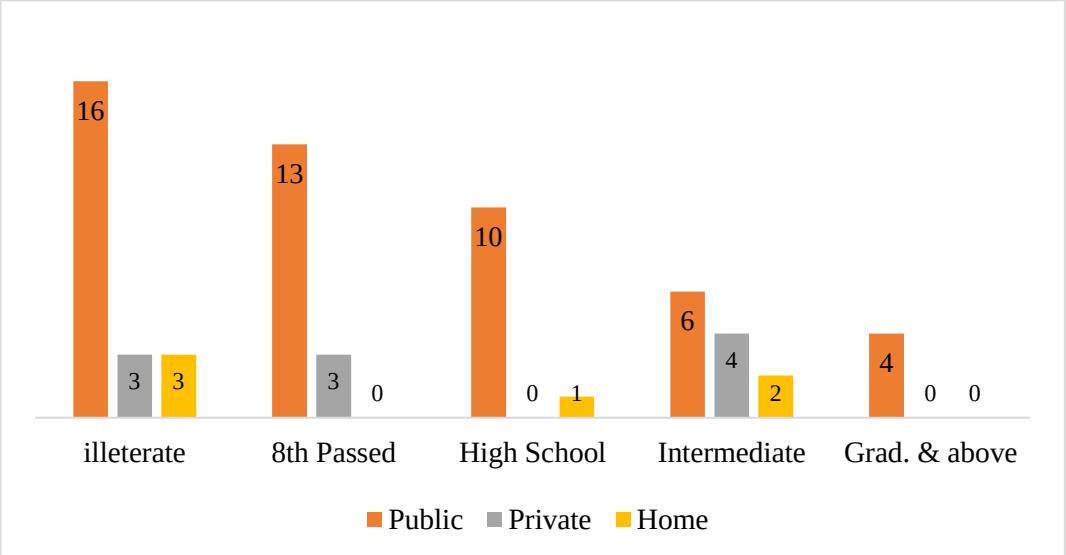
In such situations the public health centres play crucial role in providing health care/medicines to the needy people for free of cost. Though, sometimes the medical officers reported to have either inadequate medicine stock or the unavailability of essential medicines at the health centres but still they are the only hope of poor and unemployed in the rural areas of Hardoi district. However, in some of the cases when care seekers got disappointed from the public health centres and were not able to afford health care from private health facilities, they have to sell their assets to seek care from private health facilities. One of the care seekers whose family had to sell their land to get the treatment of tuberculosis for their daughter explained-

> *"My daughter has suffered from tuberculosis. I have taken medicines from this health centres for more than two months. But she did not get any relief and she was becoming more serious day by day. My village people suggested to seek health care from a private hospital in Lucknow. We had no money to seek care from private hospital. My husband was very upset. We bought some money from Yadav chacha (who usually lend money on interest in my village)*

and took my daughter to Lucknow for the treatment. Doctor told that he has to hospitalize my daughter and they have to spend around 35,000 rupees for her treatment…so we were having nothing to save my daughter except land…and my husband sold one Bigha land to Yadav chacha for her treatment." (Cs23/SC/II)

This highlights the need to strengthen public health centres in the Hardoi district so that the health centres can serve more number of people and provide better care. Because, the poor people are dependent on these health centres for seeking care. And if they did not get response from these health centres they feel helpless, and sometimes they have to sell their assets that are crucial for their survival. The people have to face such issues even after intensive public sector programs and focus, it raises question on health facilities and the government's focus. As in the above case though there are TB DOTS centres for the exclusive treatment of tuberculosis in the primary health centres of Hardoi district but those are very few and lacks adequate infrastructure and facilities. As Figure 5.8 also shows that among the care seekers most of them 16 (out of 49) were illiterate. Most of the home deliveries were conducted by illiterate (poor) care seekers (three out of six). There is need to raise awareness among people about the available health services and to focus on improving quality and availability of health services at these health centres.

Figure 5.8
Preferences of Health Facility for the Delivery across the education groups

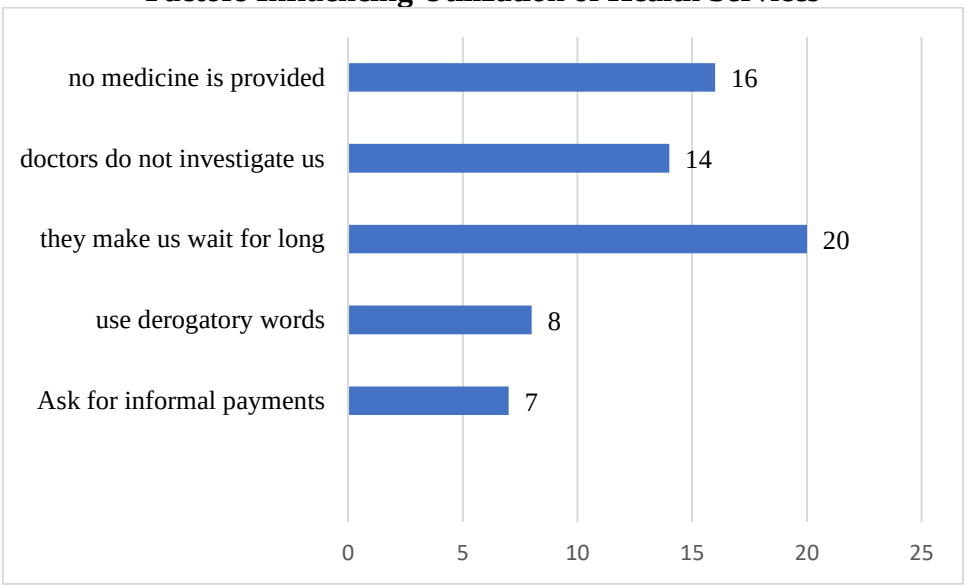


5.5 Factors Influencing Utilization of Health Services

This section deals with the factors influencing health services utilization from the public health centres in Hardoi district. Though, there were several infrastructures/ manpower related issues that affects health services utilization, and has been already widely recognised at the local and national level. Therefore, some practices that have been exercised by the women health providers at the grassroots level which influences health service utilization has been further explored. The practices/results presented here are the care seekers reported evidence against each influencing factor. These are: demand of informal payments, use derogatory words while interaction, deliberately make a long waiting time, do not investigate, do not provide medicines.

The Figure 5.9 illustrates number of care seekers along with the factors influencing utilization of health services from public health centres. Further, Table 5.4 shows that how these factors play with the care seekers of different caste groups- Scheduled Caste, Muslim and Non-Scheduled Caste /Non-Muslims. Variations in the responses of care seekers is reflected through the voices of care seekers conveyed while their interview.

Figure 5.9
Factors Influencing Utilization of Health Services



5.5a Waiting Time

It was reported by the care seekers that they have to face long waiting times for seeking treatment in public health centres. Though, it has been widely accepted in public health literature that long waiting time can have very devastating effect on the care seekers/patients and their families as well. This chapter also evidenced that long waiting time has been one of the greatest influencing factor for the utilization of health services at the grassroots level. Highest number of care seekers (20) have reported to face long waiting time for seeking care at the public health centres in Hardoi district (Figure 5.9).

The most pressing concern of care seekers reported for long waiting time was not the long queues at the health centres rather it was the care provider's prioritization/or negligence to see the care seekers of different caste equally. It was conveyed by the care seekers that the non-scheduled caste health providers, particularly ANMs and ASHAs do not take interest to see scheduled caste care seekers. It is reported by the scheduled caste care seekers that non-scheduled caste ANMs/ASHAs/other providers unnecessarily make them wait even if there are no long queue, and remained busy in other activities. As it is clearly visible in the table 5.4 that it was the largest number of scheduled caste care seekers (eight) who has to wait for long time in comparison to Muslim (seven) and non-scheduled caste or non-Muslim participants (five).

Table 5.4
Factors Influencing Utilization of Health Services across Caste Groups (Forms of discrimination)

Factors	Caste of the care seekers		
	Caste of SC	Caste of Muslim	Caste of Non SC / Muslim
Ask for informal payments	3	3	1
Use derogatory words	4	3	1
They make us wait for long	8	7	5
Doctors do not investigate us	5	4	5
No medicine is provided	8	4	4

The discriminatory intents of the care providers become visible in such forms that care providers can easily understand. Such incidences cause disappointment to the care seekers. One of the scheduled caste care seekers put her words-

"ANM didi do not give proper attention to the scheduled caste women. In the health centre (sub centre) she preferably see all the non-scheduled caste (upper caste) women first and then others. I do not want to seek any care from her. But I do not have any other option." (Cs20/SC/II)

Muslim care seekers have also reported to gone through long waiting time because of the negligence of health care providers towards them, as seven Muslim participants reported to face such incidences while their health needs were being addressed. Though, it was also reported that Muslim care seekers often face long waiting time because of discriminatory behaviour/prioritization of care providers. But they face this prioritization from both the sides – scheduled caste and non-scheduled caste both discriminate them and make them wait for long times. One of the Muslim care seekers stated-

"When I was pregnant, I was seeking care from the ANM in my area. She is Pasi (scheduled caste) Whenever ANM visits our village she often calls all the pregnant women at one place and asks everyone about their health condition and distribute iron/other required tablets. But I realized she always asks my condition and provided tablets in last." (Cs33/Muslim/II)

Long waiting time has been seen as one of the major factor influencing the health service utilization in Hardoi district. However, the most common reasons for this waiting time reported by the care seekers appear to cause long run effects on the health service utilization. Caste based prioritization and making seekers unnecessarily wait for long time is common in the public health centres, especially in the sub centres of Hardoi district. Though, it appears in different forms and spheres at the village level but it builds negative impression among the care seekers to utilize health services from these health centres. One of the care seekers expressed on the effects of long waiting time and behaviour of ANM-

"I have seen the long-long queues in the health center, and I know about the behaviour of ANMs is not similar for all therefore, I never wanted to communicate with these ANMs/ASHAs. That's why

I chose for home delivery and my baby was born in my home itself." (Cs9/non-SC/II)

5.5b Informal Payments

In public health centres all the health services especially maternal health care services are being delivered at free of cost since decades with an extensive focus. This section offers significant fresh insights into the incidence and nature of informal payments are being asked to pay in the health centres for seeking delivery care. Though, payments were very less but it influences health services utilization and throw the care seekers in a very complex and chaotic situation. However, the timing of informal payments with compulsion is a key factor which severely disappoints poor care seekers who preferably search for free health services, and also were recommended by ANMs/ASHAs for public health centres as a source of seeking free health services.

When it was asked to the care seekers regarding informal payments most of them replied that they have been asked for the informal payments but finally they escaped either because of some higher official/Pradhan's approach/tricks or unavailability of money. However, there were seven care seekers reported to have given money in some form of informal payments while delivering their babies at the health centres. One of the care seekers who has to pay informal payments replied-

"The ANM has asked my husband to pay rupees 200 as a delivery charge. She continuously pressurized my husband to pay the money. Though, the same ANM has told me about free of cost delivery in the health centres but now…I paid the same amount as being at health centre I could not do anything." (Cs22/SC/II)

Maternal and child health has been always in the centre of health programs and priority of the governments. Thus, the central and state governments are consciously striving to provide free of cost maternal and child health services, but still there are evidences that the scheduled caste and poor care seekers had to pay some informal payments for conducting their delivery in the health centres. One of

the care seekers shared her experiences about the informal payments for the delivery-

> *"ANM has asked us for 500 rupees for the delivery charges. When my husband refused to give the money she got angry and said 'sab kuch acche se kar diya miane nahi to mar rahi hoti ghar par' itna to chahiye kam se kam. All the things went well just because of me otherwise; you would have been dying at home. So I deserve at least for some incentives. Then my husband negotiated and gave only 200 rupees for the delivery." (Cs35/Muslim/II)*

It was also reported by the care seekers that they were asked to buy delivery stuffs (gloves, syringes, medicines - which is supposed to be borne by health centre itself) from outside the health centre. Health care providers, mostly ANMs did not offer these services to the poor and scheduled caste care seekers. Whereas they do not ask to buy these services from rich and upper caste people. The care seekers stated while interviews that health care providers do not use these items from the health centre stock as they make money by selling them in the market.

Though, there are high possibilities of unavailability of these things in the health centres as public health centres in Hardoi district are overburdened with patients load and big coverage area. There are also many issues that has been already reported in supply chain management which makes the issue more complex. But we cannot deny the practically faced micro level experience of the care seekers. One of the care seekers who asked to purchase some delivery stuff and medicines that are being provided free of cost at the health centres said-

> *"The ANM didi and doctor saab asked me to purchase gloves and medicines outside the health centre while my delivery. I know all these things are provided by the health centre." (Cs3/non-SC/II)*

A very significant and terrible example was reported by one of the Muslim participants. In her words-

> *"My sister has delivered her baby in this health centre (Pointing towards a nearby PHC). ASHA regularly visits us during*

pregnancy, she repeatedly told us that we do not have to spend even a single rupee for the delivery, and we will get all the services free of cost in the health centre. However, the ANM has asked us to buy most of the delivery things including medicines from outside the health centre, whereas she has not asked anything to buy from the other persons who came for delivery in the same room (ward). I know why they are doing this thing. They know I am poor and nobody will listen to me." (Cs7/Muslim/II)

A noticeable difference was recorded in the responses of the care seekers while their interview. When it was further analysed the responses regarding informal payments, a trend in nature of informal payments was observed– it was mostly asked from scheduled caste and Muslim care seekers. It is clearly visible in the Table 5.4 that these payments are largely paid by the SC and Muslim care seekers. The non-SC/non-Muslims are rarely asked for informal payments in the health centres as only one non-SC care seekers reported about this. The situation draws a clear picture that the health care providers have a sense of making money from poor and socially weak care seekers those who are often not able to afford even very small amount of money and also would never take any legal action. The health providers were well aware and afraid of the vocal attitude of the upper caste people and also their knowledge about the legal punishment for asking bribe. I will quote one of the Muslim care seekers on informal payments-

"The health workers in this health centre (a nearby health centre) are very rude. They do not like render health services to Muslims. All my village Muslim women face this problem. It is mandatory to give rupees 300 for delivery in this health centre, especially from Muslims. I also paid." (Cs25/Muslim/II)

The responses of the SC care seekers were almost similar to the Muslim care seekers. One of the SC care seekers reacted-

"…asking money for the delivery from Chamar-Pasi's (Scheduled Castes) is a trend in this health centre. I was knowing the fact and thus I have arranged some amount and given to the ANM without

asking her. My family was only concerned about my safe delivery. So I paid." (Cs23/SC/FGD1)

Informal payments thus appeared to be a problem for lower socio-economic individuals those are sometimes even not able to afford very small amount of money and private health services for seeking care. The findings revealed that the idea of comprehensive free health services especially, for the maternal health care services in Hardoi district has been significantly eroded at the bottom level. Therefore, such types of micro level evidences can be very useful to the policy planners and executives at the local/state/national level to understand the nature and intensity in the particular context of informal payments. Furthermore, initiating a public debate on informal payments may have a controlling alert to increase accountability of the care providers for poor people.

5.5c Shortage of Medicines

Shortage of essential medicines in public health centres is one of the crucial factor that influence health service utilization at the grassroots level. There is a tremendous body of literature about the shortage of medicines at the public health centres in India. There were 16 care seekers who reported to face shortages of medicines in the respective health centres, as they did not get medicines while their visit to the health centres. The care seekers reported that because of the shortage of medicines they have gone through several challenges which ultimately affected their health. The findings presented here are the patients who reported evidences for the unavailability of medicines in the health centres from where they sought health services, and had significant implications for the health service utilization. One of the care seekers expressed on shortage of medicines-

"After my delivery, I have suffered from continuous fever. I visited health centre several times, the doctor has told me that there is no medicine in the health centre stock. Every time I bought the medicine from the local chemist. Now I do not prefer to go to the health centre as my husband says if we have to buy medicines from the market, then it's better to take it from Rakesh Mishra Ji –a

local private practitioner so that we can save time and money in travelling to the health centre." (Cs3/non-SC/II)

In some of the cases it was also reported that though the medicine is available in the health centre stock but it was not for the health issues the care seekers required. It may be because of the limited drug regime supplied to the primary health centres/sub-centres or sometimes the high demand of the medicines in the area and limited supply to the health centre. But, the expectations of the care seekers to get the free medicines make them disappoint which helped them to make negative perceptions about the health centre's facilities which further affects health services utilization. One of the care seekers said-

"Sometimes back my leg continuously started swelling. I went to the primary health centre…The doctor told me that I have symptoms of Filaria…and I will get free medicine for my health problem…and I will recover with the use of that medicine soon. But the medicine is not available in the health centre and I had to visit again after two days. I visited several times but I could not get the medicine. Meanwhile, my leg has swollen up a lot and I could not even move. And then my husband took me to a private hospital in Sandila...Now I cannot rely upon these government health centres." (Cs27/Muslim/II)

On further exploration of the shortage of medicine, it was observed that there is also a very pathetic trend in dispensing the medicines for the care seekers. It was found that the availability and dispensing of the medicine is somehow related to the caste identity of the care seekers. The care providers those are aware about the caste identity of the care seekers categorically prioritize them for dispensing the medicines. So, at this point it can be inferred that shortage of medicines for particular care seekers is not always related to the shortage of medicine in the health centre stock. It may be because of the caste of the care seekers.

The Table 5.4 clearly witnessed that of the total care seekers (16) who reported that they have not obtained medicines most of them were SC (eight) care seekers whereas it was almost similar for Muslim (four) and non-SC care seekers (four).

The caste based discrimination in providing medicines to the care seekers have miserable implications on the health of the care seekers. It is well reflected by one of the care seekers-

> *"I wanted contraceptive pills. I approached ANM for the pills. I was not able to purchase the pills and could not even go to the market. She told me that currently she does not have pills…whereas she has provided the pills to a woman in my village same day. I know ANM is Kurmi she does not like people of my caste, and thus she has not given me the pills." (Cs19/SC/II)*

After having extensive focus of the government and several vertical health programs on the family planning services still the care seekers are not getting these services at the bottom level. They are being prioritised for even free family planning services that needs to be given equally to all the needy irrespective of their caste. Whereas, it is clearly visible from this section that the medicine supply, including family planning services in the villages is not need responsive whereas it depends upon the caste identity of the care seekers.

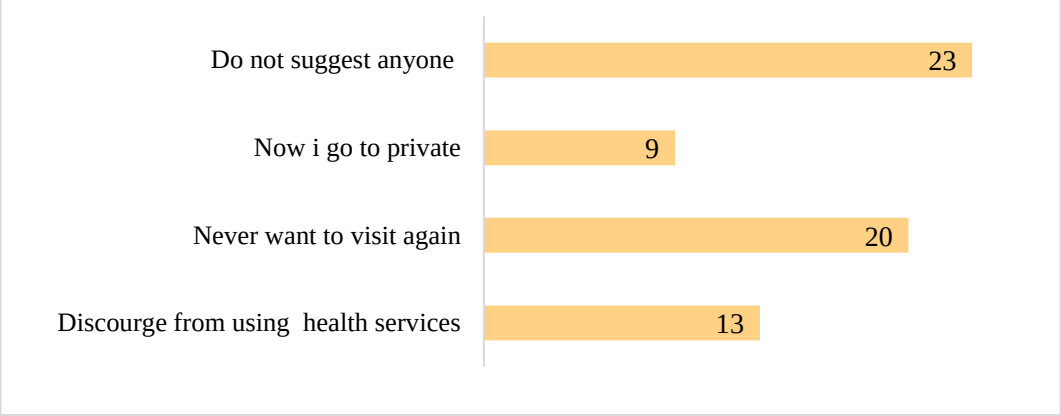
5.5d Other Factors

There are some other factors that influences utilization of health services at the bottom level – of the total 14 care seekers reported that the doctors do not investigate their health issues properly whereas there is no significant difference found in the responses of care seekers of scheduled-caste, non-scheduled caste and Muslims. It may be entirely because of the limited time period and overwhelming number of patient's/care seekers at the health centre. Further, the care seeker also reported that sometime the health care providers use derogatory words for the care seekers, and the significant difference was noted as they use derogatory words mostly for scheduled caste (4) and Muslim (3) care seekers which often affects health service utilization.

After having a close look at the experiences of care seekers, it was further asked to care seekers about how the revealed challenges affect them. Of the total health care seekers most of them (23) said that they do not suggest anyone to visit public

health facilities whereas 20 care seekers said that they do not want to visit public health centres anymore (Figure 5.10).

Figure 5.10
Influences on Care Seekers



As the available health facilities have disappointed them and could not cater to their health needs. In some of the cases the care seekers have to finally visit private health providers even after seeking care for few days in public health centres as there were no medicines available in the public health centres and the health providers have not behaved properly. Owing to these types of incidences the care seekers are not convinced to visit public health centres. As said by one of the participants-

> *"I went to the health centre for my delivery, I got frustrated there. I was not able to understand that how one can behave like an inhuman in such a matter of health services. I do not want to come here again." (Cs30/Muslim/II)*

Further, 13 care seekers stated that the issues identified discourages them to use public health services but they do not have any other options to get the health services because they cannot afford private health services, and nine care seekers conveyed that now they do not consider public health centres for their health needs and moved to the private health provider while their health needs. So, the implications for such type of issues are very serious and are pressing to the care seekers to go for unaffordable private health care services which sometimes drag them into huge debts.

5.6 Conclusion

Though, the Alma-Ata Declaration in 1978 has recommended that every person should have access to primary healthcare equally irrespective of their caste-class-region or ability to pay with their sound participation. However, the current chapter throws light on the issues that we have still been unable to achieve this even after four decades of the Alma-Ata declaration. The health services are not equally available for all in the villages. They are selectively available for the people who matches social identity with the care providers. The caste based identity matters in all the forms ranging from supplying health information to delivery of preventive and promotive health services.

The results presented in this chapter are very alarming and can have vigorous health consequences. Delivering primary care to large populations is always challenging, but such caste based prioritization will help care providers to minimize this challenge as they are not bother about the health of the populations rather they are more worried about their social status and income. Though, patient satisfaction always remained a key factor in healthcare delivery but this has been entirely neglected at the grassroots level. The current evidence makes the health services unable to respond effectively to local realities and needs. This reflects the growing need of research in improving the service delivery of primary healthcare at the village level.

CHAPTER VI

FUNCTIONING OF WOMEN HEALTH WORKERS: STRUCTURAL AND SOCIAL FACTORS

6.1 Introduction

The present chapter is divided into two sections; the first section explains structural anomalies present in the health service system at the bottom level. The second section presents a list of proxy sentences that were used to understand the social status of the women health workers. An understanding of their functioning in the context of their social status was also developed. The sentences were read in front of the women health workers and their agreement and disagreement with the same were recorded. The data presented patterns of agreement and disagreement among ANMs, ASHAs, Hindu and Muslim women health workers. The micro level challenges as reported by the women health workers were listed and were categorized with the varying impact. It is equally important to discuss and address these underlying factors as they affect the overall functioning of the health workers.

6.2 Structural Anomalies

There are structural factors along with the social factors which impede functioning of the women health workers. These factors are instrumental in making a non-conducive environment for the women health worker which causes barriers in various terms and hence affect the utilization.

6.2a Primary versus Secondary work

The issue specifically pertains to the ASHAs as they are the informal employee of the health centres. The question was administered to know the working attitude of the

women health worker in a sense to get an idea of their consideration their work as full time occupation or part time. This question was significant with ASHA workers and all of them agreed it (work of ASHA) to be their part time work. But the matter of fact was that although they considered it a part time but in actual they were working as a full time worker as they had to be available round the clock for any kind of emergency work. They go to health centre with patient or for meeting as and when required. While discussing about their working hour, the researcher came to know that although they are the incentive based workers but they are working more than the stipulated work and time.

It was found that they were involved in all the government flagship health programs. Along with that they have to carry out numerous surveys too. The issue of non-full time was serious as monetary deprivations create a feeling of alienation towards their responsibility and this hampers their accountability towards health centers. As presented in the Table 6.1, 20 ASHAs reported to be involved in secondary work and considered the work of ASHA as their part time work. The secondary work includes stitching, farming working in some NGO or other activities.

While taking note of the extra working hour of the ASHAs, the researcher could sense a lack of knowledge among them. These ASHAs were equally ignorant of the appropriate way of handling the task given. Most importantly ASHAs should not be blamed for the same as one government document[1] itself say- "more training to ASHAs me lead them turning in quacks." Apprehension raised in concern of ASHAs turning into quack, could have also been seen as a more informed health worker who can provide a satisfactory service to the people and also able to imbibe the training/ teaching of the health centre. With more and more health scheme flourishing in, ASHAs are expected to do their way in more efficient manner. In such a situation it is unimaginable to expect to a quality service provisioning, correct entry in surveys and also other paper work.

[1] http://www.nipccd-earchive.wcd.nic.in/sites/default/files/PDF/Evaluation_of_ASHA_Program_2010-11_Executive_Summary.pdf

The agony of these less informed ASHAs was where do they belong? They are neither considered as a health worker from health centre nor for community, does the opinion about ASHAs vary from individuals to households.

Table 6.1
Type of job (full time or part time)

Cadre of Service Provider	Type of job full time or part time		Total
	Full Time (Primary)	Part Time (Secondary)	
ANM	36	0	36
ASHA	16	20	36
Total	52	20	72

Out of all the ASHAs who reported to be involved in secondary work in order to augment their income most of the women (nine) were involved in farming. As shown in Table 6.2, four women were involved in stitching, five were reported to be working in some NGO and two agreed to be involved in some other kind of work. It is interesting to note that its OBC women who are involved in farming as they have more land holding as compared to general caste or SC. Three and two SC women were reported to be involved in secondary work of farming and others respectively.

Table 6.2
Part time or the Secondary work; across Social groups

Caste	Part time or the secondary work					Total
	Stitching	Farming	NGO	others	99.00	
General	2	2	5	0	15	24
OBC	2	4	0	0	18	24
SC	0	3	0	2	19	24
Total	4	9	5	2	52	72

Similar was the case with Muslim, as most of the Hindus were involved in secondary work and among that six of the Hindu women were reported to be involved in farming

work as Muslim have less agricultural land as compared to Hindu. As depicted by Table 6.3 Hindu women were also involved in stitching work thereby augmenting their income as compared to Muslim women whose income generation was limited to the incentives earned by the work of ASHA.

Table 6.3
Religion versus Part Time or the Secondary Work

Religion	**Part Time or the Secondary Work**					Total
	Stitching	Farming	NGO	others	99.00	
Hindu	4	6	3	1	34	48
Muslim	0	3	2	1	18	24
Total	4	9	5	2	52	72

From the above data it was clear that ASHAs were not satisfied with the incentives that they receive for their work. Along with that, late arrival of the money graved their situations. As clearly indicated by table 6.4, only 14 ANMs said that they do not receive their salary on time but in the case of ASHA 35 out of 36 said, they never got their incentives on time. A very interesting fact was uncovered when probed further, the ASHAs incentives are work based incentives. They get certain amount after completion of a/ set of work/s. The late arrival of incentives disables them to keep a track of which amount of what work is when given. It will be more visible with quote of an ASHA-

> *"I have not received any amount of money in my bank for last four months, meanwhile I have completed two surveys, four complete immunization, brought one sterilization case and assisted two institutional deliveries. Along with this I am also following a TB patient. I have already submitted all my bills duly signed by ANM. I don't know which money will come when and what amount will they deposit. They do not mention the service for which money is deposited. This is deliberately by the clerks; many of them have eaten most our money. But being at receiving side we cannot object and when we ask*

for the detail, they just excuse us by saying 'go and inquire in Bank we have sent all data there rest we don't know'." (*As7/Non-SC/II*)

Table 6.4
Cadre Versus Salary/Incentive on time

Do not get salary/incentive on time	ANM	ASHA	Total
Yes	14	35	49
No	22	1	23
Total	36	36	72

6.2b Work time analysis

It is extremely important to note the duration of work of ASHAs as they do not have any fix working time and therefore they do go for work in night also. In such situation they have to depend on family members to go along with them given as women have safety concern in mobility during dark hours of the day. In such scenario it becomes extremely important for her to take the family members in confidence. Monetary benefit could be one way to satisfy her family, some entitlement of basic facility could be the other. The economic drivers were completely missing and the basic entitlements were least thought off.

As it is evident from the programme and policies, ASHAs are incentive workers and the remunerations paid to them are based on the amount of task done by them. The ASHA submit the claim form and then the amount is directly transferred to their bank account. While tracing back to the remunerations that they receive for the stipulated task, the researcher came to know about their unawareness about the incentive amount. The worse form was they were unable to trace the amount for which they have worked as the amount deposited in their account was very erratic. It can make a sense with the following case study-

Case study 1- Anjum (name changed), aged 31 years, SC ASHA, from a village of northern part of the district-

While talking to the ASHAs about their work and incentive, researcher happens to meet an ASHA named *Anjum*, who started sobbing as I started my interviewed. I was consoling her. She expressed her grief and agony-

> *"I have not received any amount in my bank account for last seven months, I go for work and my family expect that at the end of the day I will earn something and can make our life better. The account section people are very wicked…… (She mentioned name of the person responsible for account section of the CHC), have taken all my pink receipt but till now I have not received any money. I come to CHC every day in the hope that they will pay me my money. Last month I brought three cases of delivery, eight full immunizations and do surveys as and when I am asked for. We women are not allowed to step out of our house and roam freely either in day or in night, but I do go out of my house as and when required, fighting- answering my family people. In return they also have some expectation from me; you tell who will allow you go out in night or even in day."*

The above case holds relevance with ASHAs who get their incentive on time. It was realized that they are not able to trace their incentive. For example if an ASHA submit a bill of Rupees 1000 of one delivery case and three full immunization in month of September. In month of October suppose she brought three delivery case and two surveys and submit a bill of Rupees 1900. There are different amount stipulated for each of the work. But she did not receive Rupees 2900 in month of November or whenever the amount is deposited. She got Rupees 2100. When she complained about same to account section, they gave them some abrupt answer, like the other receipt are in process or it must be delayed and you may get it later. But they never happen to receive it.

6.2c Population coverage

The population coverage problem was pertinent to each of the women health workers as all of them were serving two to four fold of the assigned population. The overpopulation coverage was undoubtedly affecting the quality of the care along with the reputation of the care providers. It is one of the major drivers of the health care prioritization. The resource poor health centres and the overpopulation play pivotal role as the grassroots health care providers connect the two. It is important to understand that the grassroots health care providers are the connecting link between the two very fragile systems. Fragile in the sense, the previous one follows a vertical relationship, and is very individualistic in nature where selected health services are available/ accessible to a section of population, but the later has a holistic approach. A population is a unit of different type of people with varied health need, it has its own culture of understanding health. The health workers programmatically informed to cater the health services to population under their coverage. The paradox is the services that these health workers have to cater are the health services that are guided by the rural health system and not on the basis of the need of the people.

6.2d Health Infrastructure

The health infrastructure has direct influence on the health care utilization. The rural health statistics is evident of the fact that there are no or sufficient infrastructure available for sub centers. The researcher could not locate any sub centre building where the health activities are performed in the study area. ANMs locate themselves either in the primary school or at the *Aganwadi centres* for providing health services. All the ANMs were reported to be staying in their own or rented houses as they were not provided with the accommodation. It is important to note, during inception the sub centre, they were designed to be functional round the clock (24*7) and ANMs to be round the clock available, and this could not be imagined without availability of the proper infrastructure. Moreover, the ANMs do not get proper facilities for the checkups of the pregnant women.

Due to lack of the toilet facilities they are being forced to attend natures call in open. This may lead to various infections. Here I saw the paradox where the ANMs themselves were not able to follow the hygiene but at the same time preach others to follow the hygienic practices. There were other barriers also that the ANMs spoke about. Table 7.5 shows a detail depiction of the inadequacy, such as unavailability of rooms, lack of water facility and safety, electricity. Fourteen ANMs and 17 ASHAs considered unavailability of room as barriers in providing the health services. Similarly Nine ANMs, Seven ASHAs said that lack of water facility and safety concerned them while rendering the services. Eight ANMs and eight ASHAs complained of electricity services.

Table 6.5
Barriers Faced Due to inadequate Infrastructure of Health Department

Barriers faced by inadequacy of health department	**ANM**	**ASHA**	**Total**
Unavailability of room	14	17	31
Others (water, safety)	9	7	16
Electricity	8	8	16
All above	5	4	9
Total	**36**	**36**	**72**

6.2e Distance to be covered for work

Due to lack of sub centre buildings, ANMs had to find suitable locations for them to sit and do their work. In such cases they manage to work in any suitable/convenient place in the village or nearby where they have to provide the services. All the ANM stated that they need to travel a lot as their functional areas or the villages are very far off. The important thing to mention is that they have reach from one place to other either by walking or by taking lift from travellers. This bothered them a lot as in the summer it becomes tough to walk in sun and in rainy season most of the routes are muddy and no public transport facilities were available.

Table 6.6
Distance between the residence and the functional area

Distance between the residence and the functional area	ANM	ASHA	Total
1-2 km	7	20	27
3-5km	15	16	31
6-10km	7	0	7
15+km	4	0	4
Total	33	36	69

Figure 6.1
Distance between the Residence & Sub Centre

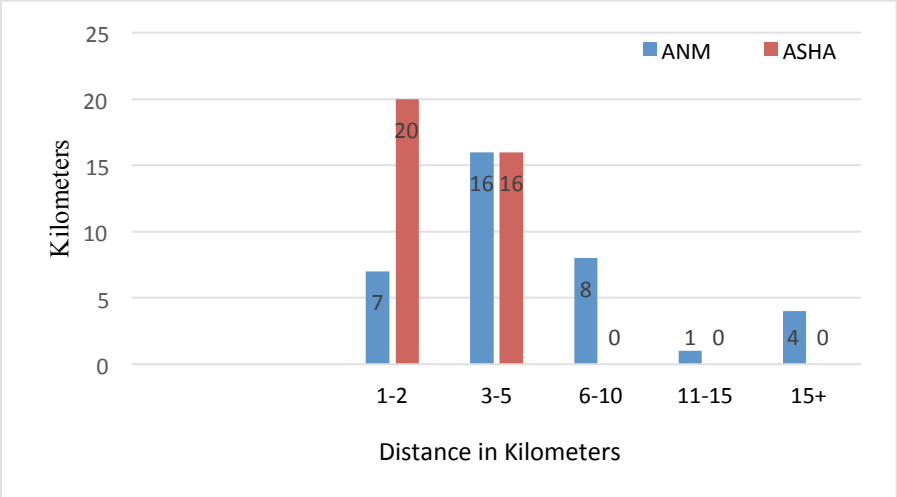


Table 6.7
Means of Conveyance

Means of Conveyance	ANM	ASHA	Total
Own vehicle drove by self	2	3	5
Own vehicle drove by others	8	12	20
Public conveyance	16	10	26
By walking	10	10	20
Taking lift by village people or others	0	1	1
Total	36	36	72

6.2f The Supply of Medicine

Delayed or no medicine supply was pertinent concern of both ANMs and ASHAs. It was widely acknowledged by most of the health workers. It has direct implication on the utilization of health services; this issue is discussed in detail in the next chapter. As shown in the Table 6.8, 22 ANMs and 28 ASHAs complained of delayed medicine supply. Many of the ASHAs reported delayed supply of delivery kit too. It is important to note that how these health system barriers affect the functioning of the women health workers. These barriers are also responsible for the people's lack of faith in government health services. Patients are made to buy medicine from outside, it aggravate their situation as first they have to wait long to consult the doctor then they are asked to buy medicine from the private chemist shop. Many of the health worker also complained that the medicine supply that they get in the rural health centers are of low quality. They also complained of limited supply of medicine.

Table 6.8
Irregularities in services

Irregularities in services	ANM	ASHA	Total
Delayed supply of medicine and delivery Kit	22	28	50
Less frequency/ no ambulance services	29	12	30

6.2g Support services (Ambulance or other transport service)

Ambulance service is most boasted services in terms of advertisement and in speeches of the subsequent governments, but ground reality portrays different picture. Ambulances were found to be present in the periphery of the CHC premises but they were non-functional as sufficient funds for fuel (Petro/Diesel) were not provided, full time driver were not hired. There were no evidences of any ambulance technician to be available in any of the ambulances. These were some of reason, most of the ANMs and ASHAs considered for non-function of most of the ambulances. Table 6.8 also indicate that 29 ANMs and 12 ASHAs spoke about less frequent or no ambulance service. There were many instances where ASHAs informed that Ambulance driver

ask for money from the patients and relative of patient and this was a regular and ubiquitous phenomenon.

6.3 Social Anomalies

There are different discriminatory variables responsible for the functioning of the women health workers. It was important to understand the overt behavior of the people which were visible to the health workers at the point of service rendering. For the same purpose, some closed end sentences (well researched) were read in front of the health workers and they were asked to answer either they agree or disagree with the same sentence. A total of eight sentences were formulated to get the sense of the environment in which they work and also what are the health workers perceptions about the people who make their social environment.

The Tables obtained from data with the help of SPSS are presented here in order to show the differentials. The data would be presented separately for each of the sentences. The following are the sentence that were read in front of the health workers

1. Work is judged by caste
2. Work is judged by capabilities
3. Other caste people appreciate work
4. Constantly under supervision by other caste people in villages
5. Constantly under supervision by own caste people in health center
6. Very little freedom to decide how to do your work
7. Social status affect one's functioning

Table 6.9
Caste as a Barrier in Rendering Services

Sl. No.	Barrier in Rendering Services	ANM		ASHA	
		Agree	Disagree	**Agree**	Disagree
1	Work is judged by caste	8	28	19	17
2	Work is judged by capabilities	33	3	30	6
3	Other caste people appreciate work	33	3	21	12
4	Constantly under supervision by other caste people in villages	8	28	23	13
5	Constantly under supervision by own caste people in health center	10	26	26	10
6	Very little freedom to decide how to do your work	20	16	20	16
7	Social status affect one's functioning	24	12	26	10

The purpose to present Table 6.9 is to explicitly illustrate responses that the researcher obtained while understanding their social status and how it affects their understanding about perception pattern. The responses were chosen very carefully in order to get an idea of the does these type of responses bothers them? Or do they give so much of weightage to the responses while doing their services. This was important to capture in order to understand psychology of the health worker as a social being. It is noteworthy to understand the psychological connection of the individual to their caste group and indeed how members of one caste group will interact with members of another. Furthermore, it allows for important socio-psychological contributions to the field, which will undoubtedly enhance the understanding of this complex socio-psychological phenomenon (Jaspal, 2011).

The previous chapters have articulated that the perception of the health care seekers is shaped by the wider environment. The same may be applicable for the health providers too. So herein the researcher wants to bring in the concept of the mental satisfaction how does a provider feels of herself while rendering services to people of varied socio-economic ground. The table 6.10 shows the comparative responses of the ANM and

ASHA, Majority of the ANM were in the view that their work was not judged by their caste but it was their capability that mattered. The same did not hold true when it came to ASHA, 19 out of 36 agreed that their work is judged by their caste whereas 17 ASHAs said that they never felt the same therefore they disagree.

For the ANM, aggregate of all the responses, where they agreed, were taken. It was found that out of total 143 agree responses, 30 agreed that they have very little freedom to do their work in the genre they want to do and are bound to work as their seniors wanted them to do. This showed the loss of autonomy towards the ANM work. Some of the ANM complained that they adopt several techniques in order to make the services accessible for the people. An ANM shared her experience about vaccination-

> *"I have to vaccinate the children with three different vaccine, we have been trained to put the injection one by one i.e. open a vial take the require amount of injection, inject it and then the do same with the other two. What I have learnt, this is a time taking process and after putting injection once the child become very cranky and do not get ready for the next one. I fill all the three injection in three syringes all together and keep it on table, and vaccinate the child one after the other in one shot. This I can do on my own but if I happen to be supervised by any of the health official I tend not to this and will do what I have been trained. You see here whatever we do in the field should be patient /seekers convenient otherwise from the next time the patient /seekers may not turn up." (An7/non-SC/II)*

Most of the ANMs (30) and ASHAs (26) agreed that their work is judged by their capabilities. This showed that people liked and want to seek care from the capable health workers. This attitude also provides confidence to the health workers, as they wear a pride of having knowledge. More ASHA (19) as compared to ANM (8) said that their work is judged by their caste. This could also be because ASHA have much familiarity with its coverage population than ANM, as ASHA serve the population of her vicinity whereas ANM have larger coverage population. The ANMs highly agreed

that people from all other caste appreciate their work, the scenario with ASHAs were slight different form ANMs, as 21 ASHA said that other caste people like their work but 15 out of 36 said that people from other caste than of their own did not appreciated them and the most probable reason could be the familiarity of the people and hence is the driving factors for such responses of ASHAs.

The question of autonomy was pertinent to both ANM and ASHA as 30 ANMs and 20 ASHAs said that they have very little freedom to work according to them and most of the time they need to follow their senior's orders and their work priority is decided by them. It is important to quote the two experiences of the ANMs and ASHAs-

> "*My coverage area includes four villages and 3 purva*[2] *, and there are only three vaccination day when I can vaccinate them and we need to inform them before vaccination so that they should be available for it. Last time the vaccination day was schedule and I was to go to one purva but in the morning I got a call saying that we need to go to District hospital as CMO wanted to have meeting with us. So in such case what can I do I skipped my earlier plan of vaccination and had to go Hardoi. I don't know what happened to the women and the children; they must have come and waited. Most probably they may not turn up for the vaccination next and we will get scolding from our MOIC that we don't motivate women to utilize the public health services*" (*An22/Muslim/II)*

Similar experience was shared by ASHA

> *"I had to take a woman for sputum check-up as she was suspected of TB. Her check-up was already delayed by many months. Somehow I got to know about her case and she was ready for the check- up. We schedule a day convenient for both of us, but a day before my supervisor told that we need to submit all our bills for the payment on*

[2] A small settlement of 10-15 houses situated at the outskirts of villages.

that day and if we fail to do so we would not get any payment. I should not lie but I could not take her to the health centre as money came in between and I thought I should submit my bills as we rarely get money as we are not salaried employee" (As15/SC/II)

The last sentence of all the variables read in front of them to get their view was very important as it was the nucleus of all other responses. It asked their view about their social status affecting their functioning. It was vital to understand, how these women health worker felt about their work/functioning in context of their social status. Out of 36 ANMs, 24 agreed that their social status affect their functioning and almost of them those who agreed said that being 'women' health worker is a tough task. Some associated about their caste and religion identity economic status to their social status but all of 24 ANMs unanimously agreed that gender aspect of any health provider play a very important role for people in shaping their perception about the health workers. Many of them gave examples of the MPW (male) and how ANMs are looked down upon when both are compared. The MPW (male) were more authoritative than ANMs and also people valued MPW over ANMs. An ANM narrated her experience –

"My work is judged by my caste, my religion, my husband, my home, my children, my friends, to whom I talk, to whom I meet, who are friend. Do I stay with my husband? How many children I have? How do I come? Do I wear saree or do I wear salwar suit? Do I ride scooty or I come by public conveyance. Everything I do or associated with me decides my functioning. But for the Male MPW nobody dares to speak, he just gives orders and everybody follow. Though he is not a formal employee anymore he is treated as my senior by the village people. We are of vulnerable caste[3] (gender) ANM" (An28/Muslim/II)

[3] Vulnerable caste here is used in context of gender. In Local dialect, people talk in the terms of caste and women too are considered as one caste on opposite to man. So here the respondent wanted to say that they are from a vulnerable group as they are women and men are stronger in the patriarchal caste hierarchy

Similarly 26 ASHAs agreed their social status affect their functioning and they too spoke about the gender component is the major driving factor of their functioning. There was slight variation in the ASHA's responses as compared to the ANMs. ANMs did not speak much about their caste identity as marker of their social identity but in the case of ASHAs they did gave importance to the caste identity. In the case of ANM may be the large coverage area and the distant location of the ANM residence camouflage the caste identity. The more familiarity if the ASHAs were the major identity marker as they have been staying in the same locality.

According to many of the ASHAs, people in the vicinity did not consider them to be appropriate enough to provide care to them as they considered them to be illiterate or less educated. The religious identity was significant marker of the social identity in both ANMs and ASHAs. Muslims being religious minority were the only religion apart from Hindu available in the study area. All the health workers with the Muslim identity had similar agony as they were not treated fairly either in the health centers or in the field. One of the Muslim ANMs shared her problem by saying that we do not provide any contraceptives to the people of Hindu religion and it is necessary to quote her experience of working in field and dealing with the people.

> *"Once it happened with me that I counseled a woman for family planning and gave contraceptive pills. Next day her mother-in -law came to me with the tablets and threw the tablets on me and abused me like anything saying that you Muslim are responsible for over population and you our daughter-in-laws to use contraceptive." (As32/Muslim/FGD3)*

This was the reason that she commuted everywhere with her husband and while speaking to her. It was noticed that she was not very much confident about her work and the way she answered was full of apprehension. It will be a good to present her as a case study. Case study 2- Saleha (name changed), aged 29 years, Muslim ANM, from a village of southeastern part of the district.

"The researcher happened to meet Saleha four times. All the four meeting happened at different place; first one was in the sub centre, second was in a health camp, and third in village and fourth meeting was a follow-up meeting at her home. This ANM was selected for case study as her mother-in-law was also an ANM. Saleha started working as ANM after her mother- in- law approached various health officials in order to get her ANM job. It was interesting to know that the mother in law selected a bride for her son who should be educated enough to qualify the ANM eligibility criteria. At the same time, the paradox was Saleha never go out alone and she was always accompanied by her husband everywhere. Long distance and lack of public conveyance one of the major reason as stated by Saleha. It is very important to mention, that whatever question was asked to her, her husband was answering on her behalf. The researcher tried to make him understand that she wants her views and understanding. To this he added- 'Maam inse zyada toh hum jante hain ANM ka kaam, samajh lijiye naam aur chehra inka hai baki mehnat toh hami krte hain.'(Ma'am I know more than her about ANM's work, I do all the labour. She is here just for her name and face). Saleha supported her husband and said 'ANMs job is very tough job, I cannot manage it alone. I cannot go alone in the villages; people pass comment and ask disgraceful questions regarding Condoms and other contraceptive. I feel safe if I am with my husband".

Further the computation of the variables was done between Hindu and Muslim respondents. With no surprise, Table 6.10 presents the similar data that many of the literature already have been saying. Out of total 48 Hindu respondents 22 agreed that their work is judged by their religion whereas 19 out of 24 Muslim respondents said that they face discrimination and their work is judged by the religion. Similarly, the others variable also showed the discrimination pattern they face based on their religious identity. Muslim women reported to be under continuous supervision of other

people and compared to Hindu women. Muslim women also reported to have very less autonomy to do their work and also their social status highly defined by their religious identity. Therefore, their functioning was highly affected/defined by their social status.

Table 6.10
Religion as a Barrier in Rendering Services

Sl. No.	Barrier in Rendering Services	Hindu		Muslim	
		Agree	Disagree	Agree	Disagree
1	Work is judged by caste	22	26	19	05
2	Work is judged by capabilities	40	8	23	01
3	Other caste people appreciate work	39	9	18	3
4	Constantly under supervision by other caste people in villages	22	26	16	8
5	Constantly under supervision by own caste people in health center	30	18	16	8
6	Very little freedom to decide how to do your work	19	29	11	13
7	Social status affect one's functioning	29	19	21	03

6.4 Conclusion

The chapter have presented the structural and the social barriers faced by the women health workers. The structural barriers have been well known and have been already reported but here the researcher has presented the ground situation and what the women health workers feel of these barriers. The quotes presented here, acquaint the reader with the issue that create barriers in service provisioning. The quotes also reflect the exact location of the problem and hence small intervention can bring change and glitches could be fixed to larger extent. It is necessary to understand agony and dilemma that women health workers go through because of the social barriers. Sufficient training and more autonomy will provide them confidence to confront the situation and hence will smoothen their functioning.

CHAPTER VII

SOCIAL IDENTITY AND PERCEPTIONS: PATHWAYS FOR ACCESS AND DELIVERY OF HEALTH CARE SERVICES AT GRASSROOTS

7.1 Introduction

Access to civic amenities and social facilities has always been a concern in the context of the SCs. Although the constitutional provisions of India have been in place for penalising those practicing discrimination, yet it continues to thrive. SCs, officially termed as scheduled caste, means they are on a government schedule that entitles them to certain protections and affirmative actions (Patil, 2014).

> 'Discrimination against Dalits has metamorphosed over time from overt, open and accepted norm to subtle, invisible, hidden and 'unaccepted' behaviour. In the present context, the divide is between those who had the benefits in the past and were oppressing the Dalits in the worst possible way as their right; and those who have now been given privileges as part of the positive discrimination policy of the state. In the past, the former had internalised oppressing the oppressed as their right, and the latter had internalised being oppressed as their normal lives. This continues today, though with a difference. What used to be obvious and overt has become subtle, covert and surreptitious' (Acharya, 2011).

The present chapter shows perception of health care provider and seekers belonging to various social strata. The chapter also discusses the importance of social identity in everyone's life and the strategies instrumental in perpetuating social identity is also focused.

As shown by empirical data of the previous chapters, caste based discrimination is evident in care provision the Accredited Social Health Activist (ASHA) and the Auxiliary Nurse-Midwife (ANM). The chapters have informed that ANMs are the formal (salaried) government employees who provide health facilities in the health centre along with field visit. ASHAs are informal (non-salaried) functionaries whose remunerations are based on their motivational activities which lead to utilisation of public health facilities. Also it has been well described in the literature review; the health workers like ANM and ASHA form the major portion of the health worker cadre in rural health system (Rao et al., 2011; Razee et al., 2012). They deal with the ground reality and function at the maze of micro level challenges and serve their people's health need (Bender, 1987; Heines et al., 2007; Jenkins, 2008; Patel and Nowalk, 2010; Sheikh and George 2010). The grassroots health workers work in the villages which have certain territorial divisions based on social values attached to them.

The distribution of the population is not random in Indian villages, (Beteille, 1965) they are stratified on the basis of different social categories of caste and class (Gupta, 2004). People are not permitted to cross the definite territorial division, as the concept of pollution (of caste) not only attaches to the people but also to the places. As shown by the findings of the earlier chapter, because of these social categories of the villages, there is a chance that the health care providers may prioritise one care seeker over another depending on circumstances of social identity. Discrimination is likely to be present in health care access in the form of refusal to observe certain norms which are mandatory in care giving, but are often violated while rendering care to the SC care seekers.

> 'These may be manifested in the form of refusal to touch, enter the house, and share the seating place, sharing food, water, and transportation. The spheres in which discrimination is likely to be visible are care delivery 'spaces' which could be the care centre or the users' house' (Acharya, 2013).

Identity is important in understanding social interaction. It is socially located because it is through this concept that the personal and the social are connected (Patil, 2014). The social identity approach is comprised of two related theories: social identity theory (Turner, 1985) and self-categorisation theory (Hogg and Ridgeway, 2003). The social identity theory explains group behaviour relating to intergroup conflict and discrimination. This is valid with specific reference to the sense of self that the individual derives from the membership of a social group (Jetten et al., 2012). Self-categorisation theory explains the ways in which people define and understand themselves in a given context. This further shapes their perception of themselves and others. Perception of self is both a collective and an individual phenomenon (Acharya, 2013). It has elements of the image created by others. It is therefore important to know the factors that are responsible for such perceptions in the light of these two theories.

The chapter conceptualises of caste/religion as a social identity and marks an important transition in social scientific research into caste. It enables researchers to explore the meanings and functions associated with caste group membership for the self-concept. It is clear from theoretical strands that social identity theory is useful in understanding the psychological connection of the individual to their caste group and indeed how members of one caste group will interact with members of another (Tajfel, 1982).

A large section of care seekers in rural areas are deprived of or are denied access to health-care resources owing to their social identities (Nayar, 2007; Baru et al., 2010; Acharya, 2013). Moving a step ahead of doctor-patient relationship, the chapter intends to understand and explore the perception of the care providers about the care seekers and vice-versa on the basis of social identity. Additionally, the ways by which the social identity of the care providers and the care seekers affects the rendering and utilization of health services respectively is also discussed. Further, the chapter aims to build linkages between the social identity of care seekers and the care providers along with their perceptions.

In presenting the results quotations are used to reflect the participants' voices to illustrate the findings of the study. The particular themes discussed below were considered as important about their perception and social identity within the wider social environment; caste, perception and social identity, profession and social identity, maintaining identity, conflicts and dilemmas, control and autonomy.

7.2 Caste/ Religion and Perception

The participants clearly indicated that their perception of each other was influenced by the wider social environment in which they lived and worked. Caste and religion was an important element for the participants in shaping their perception of social identity about others. This was reflected by the participants in their perception about the care seekers of the villages-

> *"The people on the other side of the village (mostly lower caste) are not much educated and also do not easily understand the prescription or any other health information given to them. These care seekers (symbolized with the derogatory term) are ill-mannered and do not know how to speak to other people interpersonal skills." (An12/non-SC/II)*

A woman (care seeker) shared her experience of the health centre, about the differential attitudes of the grassroots health-care providers on the basis of their caste-

> *"Whenever I visit the health centres; first of all, my name and my caste will be asked and then accordingly I am treated which quiet varies from the treatment of other upper caste patients." (Cs8/Muslim/FGD3)*

A Scheduled Caste (*Dalit*) ANM narrated difficulties faced during her visits for Ante Natal check-ups (ANC) because of her lower caste identity. She reported lack of cooperation from the non-SC (non-Dalit) families in the villages as they do not follow the health advice given by her-

"We work as per the directions of the health centre to achieve the full ANC coverage. However, it is not possible without the support and cooperation of the village people. The upper caste people of village take us for granted and do not take note of our advice just because we are of lower caste. They do not cooperate in ANC and also, never attend the health meetings organised by us." (An15/SC/II)

7.3 Profession Influencing Social Identity

The two elements, profession and social identity interplay very closely with each other to make it a comfort or danger zone. Health provider with lower educational qualification and training like ASHAs were arbitrated on the basis of their caste. ASHAs of schedule caste were not treated well by the people. But this was not in case of ANMs of Schedule Caste; they get some type of relaxation of their caste as they were more educated and trained than ASHA. Non-SC ANMs was treated very well by the schedule caste people however; at the same time, they were not welcomed by their own caste people. As being non- SC women they were not supposed to involve in profession of pollution i.e. midwifery (child birthing, cord cutting and disposal of placenta).

The non-SC caste ASHA's situation is still better than non-SC ANM as ASHA were belived not to be involved in the process of child birthing and hence are not dealing with pollution profession. These types of answers were very common, as health seekers being resident of the same village had much familiarity with their ASHAs than ANMs. According to most of them ASHA main work involved passing information about *Janani Suraksha Yojna*, vaccination or any other health scheme, whereas ANMs conduct deliveries and put injections.

One of the Non-SC ASHAs was of the view that she is more capable health provider and her work requires more time and energy than ANM. The following illustration reflects the prejudices which are nurtured against the SC workers in other spheres too-

"The ANM do not know anything about her profession; I have more knowledge than her. She has become ANM just because of caste reservation[1]; otherwise I am more knowledgeable, and also I never wanted to get involved in such kind of work (polluting)." (As7/non-SC/II)

The health providers who belonged to the family of village *Pradhan*[2] enjoy all sort of freedom because of their social status as they were elite people of the village-

"One of ASHA of my area is daughter- in- law of Pradhan; she never visits the houses of the pregnant women. She has not taken any ANC but if anything goes wrong, I will be the only person who will be pointed and held responsible." (An10/non-SC/II)

The SC care seekers articulated the complete negligence from the providers as non-SC providers did not visit the households of these care seekers. This is well exemplified from the following quote-

"No one, neither ASHA nor ANM comes to our house for any type of health services, because we are lower caste poor and our lives are worthless for them." (Cs14/SC/FGD1)

For a non-SC ANM, it was said that they should not be involved in this kind of pollution profession. But, on the other hand, this was looked on as an inherited profession for a SC ANM; this shows the extent of caste internalization. It leaves the individual in situation of dilemma-

"Most of the people in the village do not feel good of my ANM job, as this is a profession of pollution and is considered as lower castes' profession. Being an upper caste woman, I am not supposed to do this type of work, but I don't have any other means of survival." (An13/non-SC/II)

[1]As per Indian Constitution Scheduled castes and Scheduled tribes people come under Indian caste based reservation.

[2] *Pradhan* is the chairperson of the Gram Panchayats, which is the lowest part of local self-government in rural parts of India.

7.4 Perpetuation of Social Identity

The health care service providers reported that they used a variety of strategies to protect and maintain their social identity. A perception of control was vital within the non-SC care providers. They attempted to retain a degree of control within their working environment in order to have a feeling of greater social identity than others. One way of doing this was potentially not sharing any advantageous information about any health scheme or programme to the care seekers who do not share an equal social identity. An ANM described how they would limit sharing information with others; this approach was often used to prevent interference or questioning about care provisioning-

> *"I usually avoid conversation with the lower caste people and half-literate ASHAs. They do not understand anything and if I try to teach anything they may do malpractice and may point my name to defame me." (An4/non-SC/II)*

Most of the care seekers spoke about how they maintained their identity while choosing their care providers of their choice. The caste of the providers played a major role for care seekers, in setting preferences while choosing their care providers at the village level. One typical response was encapsulated by a mother of a six months old child from non-SC family-

> *"The ASHA of my area is of lower caste; my family members do not allow her to enter our house. They were not in favour of taking any kind of help from her. We went to the health centre on our own without taking her help." (Cs8/ non-SC/II)*

7.5 Conflicts and Dilemmas in Perpetuation of Social Identity

Conflict was a cross cutting theme throughout the study and was apparent at many levels, particularly between individuals and groups. The 'caste is high' or 'post is high' was one of the interactions that gave rise to conflict. In all settings, the participants of different castes had different opinions about the respondent

belonging to caste group. Some of the SC ASHAs spoke about their being appreciated in their own community and at the same time being criticized in another community. A SC ASHA was widely acknowledged by her community people as being 'hard working' and 'supportive' but was equally criticised for being 'lazy' and 'greedy' in another community-

> *"The people of my area are happy with me and, they come to me whenever they need my help. I help them in every possible way. But the upper caste people do not allow me to cater for their health needs and complain every time that I don't have knowledge about my work, and I don't deserve to be an ASHA." (As21/ SC/FGD2)*

Non-SC (non-Dalit) ASHAs did not speak much about the SC community people as they did not interact with them. Most of the non-SC (non-Dalit) ASHAs were known for not visiting health centres as they were not allowed by the family members to visit the SC houses, and most of their work was done by their family members-

> *"They have become ASHA because of their family connection in health center, but they never come to the health centre. The male members of their family do all the work for them." (An17 /SC/ II)*

Along with the caste-class agony, the resource-poor health centres troubled the health care providers and seekers extremely. ASHAs were questioned about the facilities and services of the health centres by the care seekers. Being veteran to health centre ASHAs was well informed of the scanty services but at the same time could not disclose the real situation to the care seekers. In such situation they were told by the health official (seniors) to motivate the people to use the health services and hence they were thrown in dilemma. The situation can be reflected from this quote of an ASHA as-

"I know nothing is there in the health centre. I cannot cheat on my people by giving them wrong information about the services. And moreover if I do so next time my people will not believe me and will not call me for any help." (As5/non-SC/II)

7.6 Control and Autonomy

Following the social structure of villages, the study participants reported to be under the control of social obligation and social responsibility. The SC health workers were bound to work under the general caste or the elite people of the villages. Being health provider, it hardly allows them any autonomy to go out of the social structure. The participants very openly reported that this is what they have learnt through the life process and, if they discontinue the same procedure they might get punished by other people of that particular community. The movements of non-SC ASHAs was restricted in the periphery of SC houses, it was confirmed that they were not allowed to pay visits to the houses of lower caste people as, in her own words-

"As an upper caste ASHA, I should not visit the lower caste houses." (As11/ non-SC/II)

ASHAs complained about ANMs that they mostly visit the house of non-SC and affluent people of the village and neglect the poor-

"ANM herself pay visit to only Pradhan's house and ask us to visit all other houses, I understand her motive behind the same." (As17/SC/II)

However, at the same time ANM refuted it, by saying that they were bound to visit such houses as the affluent people of the village keep a close watch on them-

"It is not possible for us to work without maintaining good relations with the elite people of the villages. Because, they are

the resourceful persons of the village and have good contacts with the higher officers of health system." (An1/non-SC/II)

In-depth interviews were used to explore the role of social identity of the care providers and care seekers in shaping perception about each other. The study has further highlighted the social context in which the grassroots health workers live and work.

There were variations across the caste about the perception about the grassroots health workers. SC ANMs' social identity was entirely different form the non-SC ANM. Similar was the case with SC ASHAs who were subject to many atrocities. Non- SC ASHAs had good rapport and were respected in their own community at the same time these ASHAs were not comfortable with the SC community. More than the training and position of ANM and ASHA, their social attributes of caste were not in their favor.

SC ASHAs discussed their dilemma towards their profession as they were not allowed to enter in some of the house (mostly general caste). In such cases they were misguided as they have to rely on information about the pregnant women provided by the family members without meeting the patient and knowing exact situation. Many a time's false information was conveyed by the family member due to lack of knowledge. The prejudice and belief that providers of certain social identities are less efficient and therefore less 'dependable' rests upon the age old perception which places the SCs provider as less experienced. Care seekers were reported to have biases which make them perceive that SC providers as less efficient and hence not worthy of approaching for care needs. The SC ASHAs were not considered as active as non- SC ASHA, reason being of lack of mobility and their non-acceptance among certain community. The SC ASHA could not interact much with the non- SC people.

The caste- based prejudices do not allow the general caste to treat SCs and Muslims as equal. Hence they do not even allow their family members to attend the meetings organized by lower caste ASHAs and ANMs. The village people

relate the ANM with the traditional birth attendants or the *dais* and consider their work as 'polluting'. In contrast, the general caste ASHA as well as ANM are restricted in reaching out to the care seekers belonging to the lower caste. Very often due to prejudice, and systemic as well as locational problems the SC users remain outside the net of provisioning of care services by non-SC providers. Therefore, it is important to identify the prejudices and work on them to eliminate the biases which act barriers for the SCs, both as users and providers to be able to connect with the non-SCs for exchanges and interactions for care services.

Through history, the practice has been to assume that SCs are the serving class and therefore what they need at best is the skill to be able to serve the rest (Gosh, 2003). Any reflection of their upward mobility on the social scale above the level of servitude has more often than not, raised unpleasant questions and derogatory comments from the non-SCs.

It came up very clearly in the results that family kinship plays important role in functioning of these grassroots health providers. ANM (of any caste) get the job of ANM purely on the basis of her educational qualification, at the same time the ASHAs were recruited on the basis of education attainment along with recommendation of the *Pradhan*. In such situation these health providers work as per need and advantage of *Pradhan*, not the people. Following to this general caste people may get visit of health worker regularly on contrary to the needy, poor and SC. It has been observed that care providers like ANM and ASHA when hail from non-SC communities, there are three out of four chances that they will give a miss to a routine visit to a SC household.

Following these incidences ANM, ASHA and care seekers build their perception about each other. On the basis of such understanding and perception the care provider prioritises their users; that to whom will they pass the information and service in the limited available resource scenario. This leads to a biased attitude of the provides and consequently, the care seekers start looking for some kind of method by which he/she can show their affection towards the care providers in

order to get the preference from them. This could be dangerous for the person with maximum health need but fail to do so.

The caste structure of the villages provides a platform of social control to its residents, where all the individuals come under some social obligation. Following the same, discriminated behaviour is executed to keep the phenomenon of discrimination in process. It leads to a situation where SC care providers are always under the obligation of non-SC. The obligation of these heath workers of being in control of the general caste people is also because of their being in lowest cadre. This came up very clearly in one of the FGDs, the non- SC ASHA compared their professional status with ANM; whereas the SC ASHA considered her work was to assist ANM.

7.7 Conclusion

Women Health workers working within the social structure of the villages confront a lot of issues and challenges based on their social identities. The social identity-based prioritisation and perception were visible from both the providers as well as seekers. Women SC health providers suffer double discrimination of their identity of being women as well as SC. SC providers are questioned of their skills, and health care seekers are suspicious of their knowledge. It disappoints them and keeps them under pressure to prove themselves as good as a non-SC provides. Non-SC health providers preserved their identity and limited their interaction with SC care seekers and providers as well. Similarly, health care seekers also get discriminated by these health care providers based on their identities. The social structure of the villages and close acquaintance of the providers and seekers did not allow the providers to build a professional relationship with the care seekers. In this way, the caste of the provider and seekers was given more weight than the profession and need respectively.

CHAPTER VIII

SUMMARY AND CONCLUSION

8.1 Summary

The present study aimed to understand functioning of grassroot level women health care service providers carrying different social status. More precisely it endeavored to understand functioning of grassroots women health workers in the backdrop of their socio-economic, living and working conditions; the cadre to which they belong within the health system. It has been already acknowledged that social identifiers such as gender, caste, class, religion, and position in the work hierarchy form an inescapable part of their environment. Factors that affect grassroots health workers' functioning and rendering of health services including factors that affect the service utilization which have implications on the health of the service users were considered in the study.

The grassroots health worker commonly known as community health worker, and caters need of the people living in the villages. It is a well-known reality that all the villages in India are stratified in a structure where the strata are divided on the basis of caste. Hence community health workers also come from these diverse strata of the villages and provide health services to the people of different caste and class of the villages. So, the health workers belong to varied socio-economic and demographic background that provides health related services to various socio-economic and demographic background people.

The study has cautiously addressed the literature gaps and then conceptualized the research questions. The huge body of literature has talked about of numerous health system infirmities but the research question that the present study answers has not

been investigated before. There have been various studies which have mentioned the dominance of medical model and the unequal access of the health services among the poor people. The previous studies have shown the shift in health services planning according to changing priorities, the studies have also pointed out the need and introduction of the grassroots health workers at the several point of health service planning.

There are ample studies have shown the major role played by the grassroots health workers and their role in improving health statistics have been widely acknowledged. Many of the studies have also shown the problems faced by grassroots women health workers in Indian patriarchal society, while rendering the services. At the same time there are various gaps that no studies have yet explored. Those gaps are - there are no study which discusses the problems that a women health worker faces because of the social identity. There are lack of studies which shows trends and patterns in health interaction between and among the provider and seekers of different social identity. The available literature is deprived of studies on the social identity of the providers and also how it affects their functioning. There are scant literatures on the health service utilization on the basis of the providers' and seekers' social identity.

The Scheduled Caste or *Dalits* are the lowest social group in the caste hierarchy. Along with the Dalits, Muslims (though more in numbers) are also marginalized when it comes to health care delivery. The Dalits and Muslims, besides having disproportionate access to health, are also less in number as health care providers. This means that along with the role of seekers, their role as care providers is also minimal. At the same time women in general are the lowest social identity in the Indian patriarchal society. Grassroots health workers come from across castes and social class. There have been certain instances of ill treatment to Dalits and Muslims, and the situation is not at all different for women. Knowing that in the healthcare system hierarchy of the grassroots health worker is at the lowest rung, it can be assumed that social status of Dalit and Muslim women grassroots health worker is different from the backward or general caste women grassroots health worker. Rather, Dalits and Muslims stand marginalized while seeking care as well while providing care. The

findings of Sachar Committee which spoke about the marginalization of Muslim population, it did not touch upon their involvement in healthcare. The Kundu Committee looked at the implementation of the Sachar Committee recommendation but nothing concrete came out as a result.

The present study is unique in its own way as it identifies the literature gaps and address with its research question. It has aimed to explore the social interface between the women health workers and the care seekers at grassroots level as in the rural settings which has profound impact on the access and delivery of health services in the rural settings where it is the women health workers who mark up the health human resource. The women health workers negotiate with their role as a public health system worker; as a woman; and a woman of certain caste. These three components constitute their social status. These three components have been contextualize in the social structure within which they manoeuvre and hence agency available to them is explored.

Various aspects of the women health workers' position and agency are explored, mainly through lens of social identity, health interaction and health utilisation. Along with the women health workers (providers), health service seekers were the important component of the study as responses from both (provider and seekers) were corroborated to draw a complete and authentic picture. The narratives, case studies and quotes were used as verbatim precisely, to show extent, intent of the response obtained during interaction at field work. The grassroots workers are programmatically expected to be from local area and to be familiar with people and places in the vicinity. There is an expectation that familiarity will influence if not ensure, the health seeking behavior in the terms of both preventive and curative health care. However, familiarity thus produced due to local residence also impedes interaction for health care service seeking. It was therefore important to understand functioning of the women grassroots health workers in context of their social status.

This study was conducted in Hardoi district of Uttar Pradesh, a state in north India and infamous for its poor health indicators. The study largely relies on descriptive analysis,

interspersed with quantitative and qualitative evidences from the field. The study sought following objectives- it had tried to study the social characteristics of the SC and Muslim women health workers (and social composition of the sub-center villages under study). The study had tried to understand the problems faced by health service providers of different social groups in rendering of services. It has examined the barriers responsible for unequal access for SC and Muslim seekers.

This research has used a mixed-method design in meeting its objectives, triangulating both quantitative and qualitative methods to gain a more well-rounded understanding of the social status and functioning of the women health workers. The study is exploratory in nature due to it merit of investigating the socio-religious dynamics of the grassroots level women workers which comes into play when service provisioning and utilisation happens. This aspect has been much less examined in the existing literature.

In Hardoi district, it was observed that most of the ANM and ASHA were middle aged married women. They all belonged to rural areas and travelled in public transport like buses and shared auto rickshaws. Since most of them were married. It is evident that their competence in their family household roles was judged as often as possible. Thus they were gauged of their 'ability' as a housewife, female member of house and as a health worker. Their education and training enabled them to contribute in the household income. During interaction many of them reflected on their empowered status, like now they can 'go out and work'; 'buy things for themselves, children, home'; 'have choices'; 'make decision or at least are part of decision making at home'. Many of them also showed their satisfaction of helping poor women in various ways.

At the same time there were instance of misbehaving with these women as most of the women commute alone from one village to other. Some of the ANMs reported to be visiting the health centre or the villages with their husband. This showed that somewhere they felt comfortable when they were accompanied by a male member who shares a close relationship with them. In the case of ANM it was their husband as

majority of them were married. The sense of insecurity was more within the Muslim women. There have been more instances of stalking with the Muslim women than other women. Muslim health workers faced more challenges than other women. They received criticism from other as well as other community too. Their 'working status' was not welcomed within their own community and they were not accepted as a 'good' health worker among the other community. In this way they faced three- four fold of discrimination and challenge while rendering services to the people.

The analysis of the data showed that the health care service providers selected for the study have variation in the background characteristics. There are variations in education obtained, income, and housing condition both within and across the health cadre. There are differential in training obtained and also for the duration of which training was obtained. The information about the training records of the health service providers enables the readers about the skill obtained by them. By the responses obtained it was inferred that there was difference in sources and duration of the training obtained by the health provider across cadre and caste. This shows that all health care service providers are not adequately trained. Further we get to know about the roles and responsibilities assigned by government are huge but these health providers are majorly involved in different types of work. These health providers are overburdened with huge set of responsibilities along with that they have to cater to the need of population which is two to three folds more than the government proposed population coverage.

The voluntarily work in which the ASHAs are involve often regarded as part time work by them. The very obvious reason for the same was the inconsistent payment and unstructured work schedule. Most of the ASHA reported to have a feeling of non-full time worker. As a result of which ASHAs were involved in other secondary work as depending on their capabilities and acceptance in larger society, to augment their family income. One of the important reason for why the ASHAs felt that they are a part time worker as most of their work i.e. providing information, giving health care suggestion go unnoticed and only the visible works are considered as 'Work'. For

example, if any family could take benefits of JSY by institutional delivery, then only they will recognize her otherwise her other efforts of conveying the health related information or escorting the ANMs during the field visit, go in vein. ANMs also considered the most visible work as her duty. Vaccination was one of the favorite works of ANMs they felt respected and dignified while performing the same. Vaccination is technical work and require skill, hence they got a feeling of technically sound and 'equivalent' to doctor. From this it was inferred that the health workers get a sense of pride when they have something technical to perform hence little training and technical equipment would bring more value to their work and also more acceptance within the people.

The health care interaction recorded at the ground shows that there was an affinity among the women of similar social identity. Along with this, not all the care seekers approached either ANMs or ASHAs for all type of health care needs. There was a pattern identified that for a particular set of health care need a particular caste identity women approached the health care providers of a particular caste identity. This could be majorly attributed to the acceptance shown from both the sides. It is evident that some care seekers do not welcome the providers if they have any prejudice. They choose to seek services from the providers who show concern for their health needs and are sensitive towards their social identity. In case of providers too, rendering of services is often governed by existing social prejudices. Often some groups of service seekers are given preference over the others. There were instances where a particular health care provider was not approached just because they had prejudices that 'women of lower strata (caste) are incompetent' and hence won't be able to provide them with their health care needs.

The finding of the study also showed the trajectory between the social characteristics and the interaction pattern among the health care service providers. Although all the responses presented were the providers' perception but this has provided important information about the dynamics between the health providers and the seekers on the basis of social status. The information provided by the health providers was triangulated with the health care seekers' responses to draw a picture of complete

interaction between the providers and the seekers. The analysis has shown that the social status of the providers affects the health care interaction of the providers. Their mobility is restricted between villages due to distance and within the village due to restrictive social norms which allow or not allow entry into certain quarters based on social identity. Often people do not share their health problem among themselves and the providers due to their judgmental attitude. They may consider themselves as 'healthy' and may not consider provider 'good enough' to be able to provide services to them. Many people in the village approach Scheduled Caste providers only for the deliveries and never consult them for any kind of suggestion. The kind of help and support that these health providers get are also biased and highly dependent the social status of the health provider.

Health workers working within the social structure of the villages confront a lot of issues and challenges. The social identity based prioritization and perception was visible from both the providers as well as seekers. Social identity of the care providers plays important role in shaping the perception of the care seekers about the intent and ability to seek care from them. The general caste people have kind of perception that puts lower caste ASHAs and ANMs as not eligible for the job they got. They are cautious of their skills and suspicious of their knowledge. It takes them double their merit to prove themselves as good as a non- SC provider.

The 'caste preference' issue was not limited within the interaction between providers and seekers it was also pertinent with the affluent or the influential people of the villages. *Pradhan* play important role in motivating people to use the health care services from the health centre. It is one of his roles as an elected head of the village. But in many cases it has been seen that in spite of motivating people he demoralizes the women health workers by providing a non-conducive environment. He uses his politico-administrative power to control people and support only those who work in his favor irrespective of its positive or negative repercussion. Gender dynamics was involved in the assistance provided to the women health workers. The male *Pradhans* always harassed women in some or the other way by taking advantage of their 'weak'

feminine voice. They were well aware of their 'powerful' position and no women would dare to raise their voice against them. So they consider themselves to be able to weild power to suppress any descending voices from the women health workers. It is also noteworthy the united fund seldom used and often return to state.

There are efforts towards services strengthening in the state, active vigilance of local level *Panchayati Raj leaders* on ANMs and ASHAs (Kumar and Mishra, 2015), and involvement of non-government organizations in health service delivery at the grassroots. Owing to this, the non-scheduled caste care providers are forced to deliver health care services to all. But, again they find another alternative and provide only most visible services to the Scheduled caste/Muslim care seekers such as - visit to their houses (but do not give adequate time), providing medicines, and most likely making referrals so that the higher officials are informed about their functioning. These providers 'escape' from the counselling and other promotive services which are delegated to SC/ Muslim seekers. Further exploration has revealed that it occurred because of the perception (the non-Scheduled Caste ANMs and ASHAs follow) that Scheduled Caste and Muslim people are not educated and they do not understand easily the suggestions given to them. Thus, most of the non-Scheduled Caste ANMs and ASHAs did not give their time to provide preventive and promotive services to the SC/Muslim seekers, which particularly includes counselling and awareness services.

ANM being higher in the health system hierarchy and a salaried employee took more liberty to discriminate the people on the basis of social identity than ASHAs. Whereas, ASHAs being lowest in the health system hierarchy and incentive based workers, talked properly with most of the care seekers. Untouchability was practised by most of the women health worker while dispensing of medicine depending on the social identity of the care seekers.

Along with the caste and religion based challenges, there were many of the public health system challenges that go unnoticed and it would be unfair if those challenges are not discussed briefly. The health of the health workers has been completely ignored by the public health system and there are no provisions of incentives or health

cards for the grassroots workers. The women health workers are not covered under any health or insurance scheme. The grassroots health workers work very hard to meet the targets given to them, they commute from one village to the other by walking. There have been several instances where these women were on daily medication to avoid muscle pain and cramps. The health of the health worker is completely missing from the planning of the health system and moreover they do not get benefit of being part of the health system.

There was permanent issue of manpower shortage in the study district and so the working manpower is over stressed with work load. In such scenario the grassroots women health worker were not getting leave from their duty. There were certain incidences where the women with health need were not able to get leave from their duty and were regularly working on the field. While field work two of the ASHAs were pregnant and were doing door to door survey called '*samajwadi pension yojna*.' They shared their anguish while stating the paradox that they advised pregnant women to take good diet and have sufficient rest but they themselves were not able to follow for them. I was also found that if they would take leave for rest it will at the cost of their loss of their salary or incentives.

Shortage of essential medicines in public health centres is one of the crucial factors that influence health service utilization at the grassroots level. There is an exhaustive body of literature on the shortage of medicines at the public health centres in India. However, the consequent problem encountered by the grassroots level health workers has been examined by very few studies. Informal payments also appeared to be a problem for people from lower socio-economic strata. They are sometimes not able to afford even very small amount of money for seeking care from private health. So it can be said that in the rural areas poor health providers are serving the poor health service seeker with poor equipment in poor situation. The findings revealed that the idea of comprehensive health services to be provided free for women and children especially in rural area requires more attention and rigorous implementation.

The study can finally conclude that social status of the health care service provider affects their function in vary many ways. The finding of the study has shown the constraint felt by the health care service providers while rendering of the health services. At the same time the health care seekers too suffer the identity based differential attitude of the health care service providers. These kind of health providers' attitude contribute a lot in health seeking behavior of the poor seekers. There were ample incidences where the health seekers bypass the health providers present in their villages and prefer going to the private health facilities.

8.2 Conclusion

There are discord between the providers and the seekers as regards the interaction for the services based on the social identity. Prejudices govern the provision as well as utilisation of the services based on the social identity of the providers and the users. Therefore it is imperative that the training component is infused with a sensitization module for addressing the need to eliminate the prejudices against people of certain community such as SC and Muslim.

The visible services like vaccination, paper work were appropriated by non SC providers and the time consuming and arduous services are relegated to the SC and Muslim Workers. Therefore appropriate distribution of work load should be necessarily done to ensure adequate provision of services to seekers across social groups.

The results reveal that the Hindu upper caste health care providers more often obtain support of the PRI leaders than the SC health care providers. It was also found that Muslim health care providers got the support from the PRI members than SC health care providers. The SCs face more discrimination in terms of seeking support or help from PRIs in comparison to even Muslim health care providers as no SC ANMs reported to get support from *Pradhans* whereas two Muslim ANMs reported to have got the support from the PRI leaders.

The PRI leaders are empowered to enquire physical attendance, misconduct, and monitoring of certain public personnel such as ANMs & ASHAs. However, their participation has created more hurdles for the health providers. The health care providers, who belong to their caste and are related to them, always support them. They enjoy the liberty in performing their job and seeking help at any time. On the contrary, the other health care providers face a lot of challenges even if they perform better. In this way, the decentralization process has generated a biased system in primary health care. The caste internalization in the decentralized system of health care leads to dissatisfaction and mistrust among the service providers and thus most of the time they do not share their problems with the local leaders or any other local persons. Therefore it is important to create a structure within the system which can overlook the undue interference from the PRI personnel. At the end of the conclusion, the researcher would like to preset some quotes-

> *"Worldwide, women form a huge part of the informal workforce. They are preferred as informal workers since they appear more submissive and are less likely to form unions or demand high wages. For the same reasons, they are unemployed during times of recession (Ghosh, 2004).*

> *"Women's time and mobility are constrained due to social and cultural norms that assign them responsibility for social reproduction and discourage investment in their education and training. This weakens their position in the labour market" (Chen, n.d.).*

> *"Thus, traditionally, women volunteer for social welfare services in far greater numbers compared to men, especially in social welfare, this differentiation is due to structural factors. It is not just due to a woman's position in the family but also because of organisations that marginalise women's labour." (Baldock, 1998).*

One of the very important conclusions that the study has drawn is that now more numbers of the health care seekers are going for the private health facilities as now they are being compelled to rely more on the bio medicine and not on indigenous method of treatment. At the same time the resource poor health centres are not able to cater their health needs. This can also be concluded that as more number of health prorgrammes is being in fluxed more private health facilities have mushroomed in the villages or nearby area of the villages to cater the need generated by the public health system. The private health facilities though provide care to the needy but the doctors' consultation fee, admission charges, medicine costs and other are highly costly.

Therefore it is peak time for the policy makers to take the issue in cognizance and strict and speedy action should be taken in order to improve health statistics of India, particularly the rural India.

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ANNEXURE I

List of Participants

1. Non-SC/Muslim ASHAs - As1…As12
2. SC ASHAs- As13…As24
3. Muslim ASHA- As25…As36
4. Non-SC/Muslim ANMs - An1…An12
5. SC ANMs- An13…An24
6. Muslim ANMs- An25…An36
7. Non-SC/Muslim Care Seekers- Cs1…Cs22
8. SC Care Seekers- Cs23…Cs45
9. Muslim Care Seekers- Cs46…Cs65

List of Focus Group Discussion

1. FGD1- As6+ As21+As18+Cs20+Cs8…….Site 1 (in VHND meeting)
2. FGD2- An5+ An16+As8+Cs4+Cs4+As25……..Site 2 (a village)
3. FGD3- As36+ As2+An6+Cs12+Cs14+An28……...Site 3 (an Eye Camp)
4. FGD1- Cs18+Cs6+Cs25+Cs1+Cs3……Site 4 (a village)

ANNEXURE II

Interview Schedule for the ANM/ASHA

ए.एन.म./ आशा के लिए अर्द्ध संरचित साक्षात्कार अनुसूची

नमस्ते!

मेरा नाम सोनिया वर्मा है. मैं एक शोधकर्ता हूँ. मैं जवाहरलाल नेहरु विश्वविद्यालय, नई दिल्ली से पी.एच.डी. कर रही हूँ. मैं हरदोई ज़िला की महिला स्वस्थ्य कार्यकर्ता की सामाजिक स्थिति एवं उनका कामकाज के विषय पर शोध कर रही हूँ. आपसे मुझे जो भी जानकरी प्राप्त होगी, उससे मुझे ग्रामीण क्षेत्र की महिला स्वास्थ्य कार्यकर्ता के कामकाज के तरीकों को समझने में मेरी मदद होगी. आप से प्राप्त जानकारी गुप्त रखी जाएगी एवं किसी को भी नहीं बताया जायेगा. यदि आपको मेरे किसी प्रश्न से कोई आपत्ति तो आप मना कर सकती हैं और मैं आपसे अगला प्रश्न पूछूंगी.यदि आप को मुझसे कुछ भी पूछना है तो आप पूछ सकती हैं. क्या आप इस संरचित साक्षात्कार अनुसूची के लिए तैयार हैं.

I- सामान्य विवरण

1. आयु (पूर्ण वर्षों में)
2. वैवाहिक स्तिथि
3. शिक्षा (उच्चत्तम शिक्षा कहाँ तक पूर्ण की है)
4. धर्म
5. जाति (दलित मुस्लिम और दलित इसाई के बारें में भी पूछें)

6. क्या ए.एन.म./ आशा का कार्य आपका फुल टाइम कार्य है(यदि हाँ तो क्यों?)/यदि नहीं तब प्रश्न नंबर 7 पे जाएँ)
    - यदि यह आपका पार्ट टाइम कार्य है तो आपका दूसरा (फुल टाइम) कार्य क्या है और क्यों?

    - आपने ए.एन.म./ आशा के कार्य को फुल टाइम /पार्ट टाइम कार्य के लिए क्यों चुना?

II- नौकरी सम्बन्धी जानकारी

7. क्या आपने ए.एन.म./ आशा बनने के बाद कोई प्रशिक्षण प्राप्त किया है?

8. आपने यह प्रशिक्षण कब पूरा किया?

9. आपने यह प्रशिक्षण किसके द्वारा प्राप्त किया?

10. कितने समय के लिए प्राप्त किया?

11. आपकी मासिक आय कितनी है? (सभी श्रोतों से)

12. आपको अपने कार्य का कितने वर्षों का अनुभव है?

13. ए.एन.म./ आशा का मानक कार्य क्या है?

14. ए.एन.म/ आशा के प्रमुख कार्य क्या हैं?

15. आप किस स्वस्थ्य केंद्र पर कार्यरत हैं?

16. आपका स्वस्थ्य केंद्र आप के निवास स्थान से कितनी दूर है?

17.आप अपने स्वस्थ्य केंद्र तक कैसे जाती हैं?

18.आप कितने समय से इस स्वस्थ्य केंद्र पर कार्यरत हैं?

19.आपका कार्यक्षेत्र कहाँ है?

20.आपका कार्यक्षेत्र आपके निवास स्थान से कितनी दूर है?

21.आप अपने कार्यक्षेत्र तक कैसे जाती हैं?

III- बातचीत के तरीके

22. आपके कार्यक्षेत्र में किस प्रकार (मुल्सिम/ अनुसूचित जाति/ अन्य) के लोग हैं?

- वो लोग आपसे किस प्रकार के स्वस्थ्य कार्य (टीकाकरण/प्रसव/ परामर्श/जननी सुरक्षा योजन/ दवाई) के लिए संपर्क करते हैं?
- वो लोग आपसे इन कार्यों के लिए क्यों संपर्क करतें है?

23.आपके सह- कार्यकर्ता कौन-कौन हैं?

- इनमे से आपका सबसे करीबी सह-कार्यकर्ता कौन है जिसके साथ आप अपनी परेशानियां एवं उपलब्धियां बांटती हैं?
- और उन्हीं से ही क्यों, दूसरों से क्यों नहीं?

- क्या वह भी आपके साथ अपनी सभी परेशानियां एवं उपलब्धियां बांटती हैं?

- और आप से ही क्यों, दूसरों से क्यों नहीं?

- आप अपनी परेशानियों एवं उपलब्धियोंके बारे में कहाँ (स्थान) एवं कब (खाली समय/ क्षेत्र -भ्रमण/ स्वास्थ्य केंद्र) चर्चा करती हैं?

24. गाँव में ऐसे कौन से लोग (पी.आर.आई., आंगनवाडी) हैं जिनसे आप अपनी स्वस्थ्य सेवा से सम्बंधित परेशानियां एवं उपलब्धियां (दवाइयों की, तनख्वाह/मानदेय) के बारे में बात करती हैं ?

IV- सामाजिक स्थिति सम्बंधित जानकारी (इंटरव्यूह चेकलिस्ट)

25. इस नौकरी या कार्य के बारे में अपने विचार बताइये-

- आप नौकरी में कैसे आयी?

- आप अपनी नौकरी के बारे में क्या सोचती एवं महसूस करती हैं?

- आपके के अनुसार कौन- कौन से ऐसे कार्य हैं जो आपके अधिकार क्षेत्र में हैं?

- आपके के अनुसार कौन- कौन से ऐसे कार्य हैं जो आपके अधिकार क्षेत्र में नहीं होना चाइए?

- आपको अपने कार्य सूची में कौन कार्य सबसे ज्यादा पसंद है?

26.क्या आप क घर परिवार में ऐसा कोई और है जो ऐसी ही नौकरी करती है? यदि हाँ तब प्रशन न. 27 पूछें.

27.उनका कैसा अनिभव रहा है अभी तक इस कार्य/नौकरी को करने में?

28.मैं आपके सामने कुछ वाक्य पढ़ूंगी, आप को सिर्फ इतना बताना की आप उस वाकया से सहमत हैं या फिर असहमत.

क्र. न.	**लक्षण**	**सहमत**	**असहमत**
1.	आप का कार्य आप की जाति .धर्म से आकां जाता है/		
2.	आप का कार्य आप सक्षमता/काबिलियत से आकां जाता है.		
3.	अन्य जातिधर्म के लोग आप के कार्य की सराहना/प्रसंशा करतें हैं		
4.	अन्य जातिधर्म के लोग आप के कार्य की सराहना/ प्रसंशा नहीं करतें हैं		
5.	आप सदा दूसरें जातिधर्म/ के लोग की नज़रों में रहतें है.		
5.1	आप सदा अपने ही जाति.धर्म के लोग की नज़रों में रहतें है/		

5.2	आपको अपना काम अपने तरीके से करने की पूर्णतः आज़ादी नही होती है.		
6.	आपका सामाजिक स्थिति आप के कार्य पे प्रभाव डालती है.		

29.आपका कार्य के आंकलन किस मापदंड पर किया जाता है?

- आपके ही लोगों (समाज) द्वारा

- आपके सह कार्यकर्ता/ स्वस्थ्य केंद्र कार्यकर्ता द्वारा

V- मदद/ बाधा उत्पन्न करने वाले करक/तत्त्व

30.ऐसे कौन कौन से करक हैं जो आप को आपके काम में बाधा करती है प्रभावित करती है

- सामाजिक-सांकृतिक बाधक

क्या आपके समाज/ धर्म के लोग को, आप का इस नौकरी में होना पसंद है? क्यों?	
क्या आपके घर के बड़े-बुड्ढों को आप की इस नौकरी में होना पसंद है? क्यों?	
क्या आपको आपके परिजनों द्वारा स्वस्थ्य केंद्र या गाँव में अकेले जाने की अनुमति	

है? अगर नहीं, तब आप के साथ कौन जाता है? क्यों?	
क्या लोगों का वयवहार आप के लिया अप्रिय होता है? (Probe further)	
क्या वो लोग आपके लिए अभाद्र्य भाषा का उपयोग करतें हैं? (Probe further)	
क्या वह आपको अपने घर में आने की अनुमति देतें हैं?	

- भौगोलिक बाधक

आपका स्वस्थ्य केंद्र आपके निवास स्थान से कितना दूर हैं	
आप आपने स्वस्थ्य केंद्र में रात में कैसे जाती हैं? (Probe further)	
अगर आपके स्वस्थ्य केंद्र पहुचने तक का रास्ता गड्ढेदार होता है तोह आप कैसे जाती हैं?	

- स्वस्थ्य विभाग सम्बंधित बाधा

स्वस्थ्य केंद्र के लिए उपुक्त कमरा/घर न होना (अन्य सामान जैसे की वजन करने की मशीन, बी.पी मशीन इत्यादि)	
वेतन/ मानदेय समय पर न	

मिलना	
दवाई एवं डिलीवरी किट की सप्लाई में अनिरंतरता	
एम्बुलेंस सर्विस की सुविधा न होना (Probe further)	
सिमित दवाइयों का होना (पता करें की ऐसी स्थिति में को किस को दवाई देते हैं और किस को मना करते हैं?)	

- आर्थिक बाधक

क्या आप को समय से वेतन/ मानदेय मिलता है? (Probe further that how do they manage and do they demand from seekers and then cross check with the seekers)	
क्या आपको समय से वेतन/ मानदेय नहीं मिलता है इसिलिय आप दूसरा कार्य भी करती हैं? (Probe further)	
क्या आपको इतने कम वेतन/ मानदेय में अपना घर चना मुस्किल पड़ता है?	

31.यह सारी बाधाएं आपको और आपके कार्य पर किस प्रकार प्रभाव डालती है?

32.ऐसे कौन कौन से करक हैं जो आप को आपके काम में मदद करती है या प्रभावित करती है?

33.वह किस प्रकार से को आप के कार्य पर प्रभाव करती है?

ANNEXURE III

Interview Schedule for the Care Seekers

स्वास्थ्य प्राप्तकर्ता (केयर सीकर) के लिए अर्द्ध संरचित साक्षात्कार अनुसूची

नमस्ते!

मेरा नाम सोनिया वेर्मा है. मैं एक शोधकर्ता हूँ. मैं जवाहरलाल नेहरु विश्वविद्यालय, नई दिल्ली से पी.एच.डी. कर रही हूँ. मैं हरदोई ज़िला की महिला स्वस्थ्य कार्यकर्ता की सामाजिक स्थिति एवं उनका कामकाज के विषय पर शोध कर रही हूँ. आपसे मुझे जो भी जानकरी प्राप्त होगी, उससे मुझे ग्रामीण क्षेत्र की महिला स्वास्थ्य कार्यकर्ता के कामकाज के तरीकों को समझने में मेरी मदद होगी. आप से प्राप्त जानकारी गुप्त रखी जाएगी एवं किसी को भी नहीं बताया जायेगा. यदि आपको मेरे किसी प्रश्न से कोई आपत्ति तो आप मना कर सकती हैं और मैं आपसे अगला प्रश्न पूछूंगी.यदि
आप को मुझसे कुछ भी पूछना है तो आप पूछ सकती हैं. क्या आप इस संरचित साक्षात्कार अनुसूची के लिए तैयार हैं.

I- सामान्य विवरण

1. उम्र (पूर्ण वर्षों में)
2. विवाहित/अविवाहित
3. शिक्षा प्राप्त

4. धर्म
5. जाति

II- स्वस्थ्य कार्यकर्ता के बातचीत का तरीके

6. क्या आप अपने गाँव के स्वस्थ्य कार्यकर्ता को जानती हैं?

7. जब आप के घर में कोई बीमार पड़ता है तो आप किस स्वस्थ्य कार्यकर्ता से इलाज करना ज्यादा पसंद (मुनासीब) करती हैं? क्यों?

8. आपके गाँव में कौन-कौन सी स्वस्थ्य सुविधा मौजूद है?
9. स्वस्थ्य केंद्र आप क घर से कितना दूर है?

10. आप उस स्वस्थ्य केंद्र तक कैसे जाती हैं?

11. आप किस स्वस्थ्य सुविधा (सरकारी अस्पताल या प्राइवेट अस्पताल) में जाना पसंद करती हैं और क्यों?

12. कौन सा स्वस्थ्य कार्यकर्ता आप के घर नियमित रूप से आता है? और क्यों?

13. यह स्वस्थ्य कार्यकर्ता किस प्रकार की स्वस्थ्य सुविधाएँ आप को देता है?

14. आखीरी बार आपने किस स्वस्थ्य कार्यकर्ता से मदद ली थी?

15.उस स्वास्थ्य कार्यकर्ता को चुनने का क्या मकसद था?

16.आप अपने छेत्र के ए. एन. म. से किस प्रकार की स्वस्थ्य सुविधा की उम्मीद रखती हैं?

17.आप अपने छेत्र के आशा से किस प्रकार की स्वस्थ्य सुविधा की उम्मीद रखती हैं?

18.आपके आपने छेत्र के इन दोनों स्वस्थ्य कार्यकर्ता के बारे में क्या राय है?

ए.न.म

- उसकी जाति
- उसका आपसे बात करने का तरीका
- उसका आपके घर आना
- उसका टिका लगाने का तरीका
- उसका दावा वितरण करने का तरीका
- उसका आपको स्वस्थ्य सम्बंधित सूचना देने करने का तरीका
- उसका और लोगों से वय्वहार

आशा

- उसकी जाति
- उसका आपसे बात करने का तरीका
- उसका आपके घर आना
- उसका दावा वितरण करने का तरीका
- उसका आपको स्वस्थ्य सम्बंधित सूचना देने करने का तरीका
- उसका और लोगों से वय्वहार

III- प्रजनन एवं शिशु स्वस्थ्य सम्बंधित जानकारी

19.आपका आखिरी प्रसव कहाँ हुआ था?

20.आपने उस स्थान पर ही प्रसव करना क्यों उचित समझा?

21.इससे पहले आपके कितने बच्चे हैं?

22. आखिरी बच्चे से पहला वाला बच्चा कहाँ हुआ था? क्यों?

23.क्या आपका कोई गार्भ नुक्सान हुआ है?

24.आप गार्भ से सम्बंधित जानकारी किस से लेना पसंद करती हैं क्यों?

IV -मदद/ बाधा उत्पन्न करने वाले करक/तत्त्व

25.ऐसे कौन कौन से करक हैं जो आप को आपके काम में बाधा करती है प्रभावित करती है

- सामाजिक-सांकृतिक बाधक

क्या आपके समाज/ धर्म के लोग को स्वस्थ्य केंद्र की सुविधों का उपयोग करतें हैं?	
क्या आपके घर के बड़े-बुड्ढों किसी भी स्वस्थ्य सम्बंधित समस्या या फिर प्रसव के लिए स्वस्थ्य केंद्र का उपयोग करतें है या पसंद करतें है?	
क्या आपको आपके परिजनों द्वारा स्वस्थ्य केंद्र या गाँव में अकेले जाने की अनुमति है? अगर नहीं, तब आप के साथ कौन जाता है? क्यों?	
आपके पास पड़ोस में ज्यादातर लोग प्रसव के लिए कौन सा स्थान उपयुक्त मानते हैं? या प्रसव से सम्बंधित कोई सांस्कृतिक धरना है क्या?	

- भौगोलिक बाधक

आपके क्षेत्र का स्वस्थ्य केंद्र आपके निवास स्थान से कितना दूर हैं	
आप उस स्वस्थ्य केंद्र में रात में कैसे जाती हैं? (Probe further)	
अगर आपके स्वस्थ्य केंद्र पहुचने तक का रास्ता गड्ढेदार होता है तो आप कैसे जाती हैं?	

- स्वस्थ्य विभाग सम्बंधित बाधा

आपको वहां के लोगों का वयवहार पसंद नहीं आता है.	
वहां के लोग आपसे बात करते वक्त अभाद्र्य भाषा का उपयोग करतें है.	
वहां पर आपको बहोत देर तक इंतजार करना पड़ता है.	
डॉक्टर आपको सही से नहीं देखतें है.	
एम्बुलेंस सर्विस की सुविधा न होना (Probe further)	
दवाइयों का ना होना.	

- आर्थिक बाधक

स्वस्थ्य केंद्र पहुँचने में बहुत भाड़ा लग जाता है	
वहां के लोग आप से अतिरिक्त पैसे की मांग करतें हैं (Probe further)	
आपको दवाइयां एवं अन्य सामग्री खुद ही खरीदनी पड़ती है (Probe further)	

26. यह सारी बाधाएं आपको किस प्रकार प्रभावित करती हैं?

27. ऐसे कौन कौन से करक हैं जिससे आपको स्वस्थ्य सुविधा लेने में सहूलियत होती है?

28. यह आपको किस प्रकार प्रभावित करती हैं?

Duties & Responsibilities of Auxiliary Nurse Midwife/ Nurse Midwife/ GNM attached to Post Partum Unit:

[Source: No. FW/437/1P-8/86 dated 12.3.87]

1. She will assist in all the family welfare clinics organized in the hospital and organize such clinical services (FW & MCH) as are required. Her services are not to be utilized in general outdoor.
2. She will assist the Gynaecologist and in conducting the various Family Welfare clinics and organize such clinical services (FP & MCH) as are required.
3. She will select a population of 5000 near to the hospital for her field work in connection with the delivery of family welfare services by home visits. She will carry out the target couple survey and maintain the relevant register giving the classified information about the couple surveyed.
4. During the home visits she will carry out:
    a) Education (group and inter-personal) and motivation for Family Welfare Services
    b) Education and delivery of MCH Services (Antenatal, Post-natal Immunization etc.).
    c) Education regarding nutrition.
    d) Follow up of cases of sterilization, IUD distribution of Nirodh & Oral Pills, a follow up of ante-natal, post-natal, infant cases registered by her in the clinic
5. She will also assist in the training programme conducted at the sub-district hospital.
6. She will maintain the necessary register and assist in preparing the monthly report of FP and MCH of the hospital.
7. She will not be allotted any word duties unless there is an emergency.
8. She will maintain close liaison with the Indigenous Dais in her area and improve their practices
9. She will be responsible to the Lady Health Visitor.

Appendix II

ASHA reported as under that they are receiving incentive for following services and the amount of incentive against each service is mentioned below as mentioned by them

Provision for incentive for services provided and the amount of incentive as reported by ASHA

Sr. No.	Services	Amount
1.	Complete immunization	100
2.	Routine Immunization	150
3.	Polio	75
4.	**Sterilization** Male Female	 200 150
5.	TB control (complete)	250
6.	Blindness control	20
7.	Institutional delivery	200
8.	Escorting women to hospital in case of complications during pregnancy	200
9.	Birth/death registration	20
10.	Attending Block level meetings	50
11.	Maternal death reporting	50
12.	Leprosy (complete)	500
13.	VHIR writing	500
14.	Home visits to new born and mothers (6-7 visits)	250

AMOUNT CLAIMED AND AMOUNT RECEIVED DURING 2012-13

Sr.No.	Amount	Average per ASHA
Amount claimed	4151393	9025
Amount received	4115823	8947

Table No.70

Incentive while assisting ANM in vaccination

Contents	% (N-225)
Got incentive voucher while assisting ANM in getting women and children vaccinated in the village on immunization day	91.1

Table No.71

The tables above depicts the payment of incentives to the ASHAs during 2012-13 and 91.1% of them reported that they got incentive voucher while assisting the ANMs in getting women and children vaccinated on immunization day.

Submission of claim for incentive

It was reported that 54.89% of ASHA submitted their monthly claim form for incentive, while 45.10% (26.25% within 7-10 days and 18.85% within 10-20 days respectively) of them reported that they submitted the claims between 7 to 20 days.

Within	% (N-460)
7-10 days	26.25
10-20 days	18.85
More than 20 days	54.89

Table No.72

Reasons for not getting full payment

ASHAs were probed for not getting full payment and they faced hardships faced accounted for a larger percentage of 73% while 21.6% reported that funds were not available and 2.7% each reported that forms were not filled properly and rules were not followed.

Reasons for not getting full payment	% N 74
Funds not available	21.6
Forms not filled properly	2.7
Rules not followed	2.7
Others (various hardships faced) such as abnormal delay, bribery etc.	73.0

Table No.73

Incentive in cash for services provided

Sr. No.	Incentive received in cash for services provided	N 460	%
1.	Sterilization	403	87.3
2.	Polio	418	90.80
3.	Filaria	51	11.08

Table No.74

ASHA reported that they are getting incentive in cash for above services. Sterilization accounted for 87.3%, Polio 90.80% and Filaria accounted for 11.08%

Difficulties faced while receiving incentive in cash

Sr. No.	Incentive received in cash for services provided	% (N-460)
1	Facing hardships for getting incentive	48.26

Table No.75

Time Gap between Submission of Claim Form and Receipt of Incentive

It was revealed in the survey findings that 72.2% of ASHA got their claims after 20 days from the date of submission of claims. 27.8% ASHA informed that 7-20 days was the time gap between form submission and receipt of incentive.

Within	% (N-460)
7-10 days	12.6
10-20 days	15.2
More than 20 days	72.2

Table No.76

Receipt of travel exp. for attending Block PHC/CHC meeting

Receipt of travel exp. for attending Block PHC/CHC meeting	% (N-460)
Receipt of travel exp.	84.35

Table No.77

84.35% ASHA reported that they are getting travel exp. for attending meeting at Block PHC/CHC