A Study of the Role of ANMs in the Delivery of Health Services in Jaipur District

Dissertation submitted to the Jawaharlal Nehru University in partial fulfillment of the requirements for the award of the Degree of

MASTER OF PHILOSOPHY

DEEPA GARG

CENTRE FOR SOCIAL MEDICINE AND COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI-110067
2000

CENTRE OF SOCIAL MEDICINE & COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
New Delhi-110067

Date: 27 July 2000

CERTIFICATE

This dissertation entitled "**A Study of the Role of ANMs in the Delivery of Health Services in Jaipur District**" is submitted in partial fulfillment of six credits for the degree of Master of Philosophy of this university. This dissertation has not been submitted for any other degree of this university or any other university and is my original work.

Deepa Garg
(Deepa Garg)

We recommend that this dissertation be placed before the examiners for evaluation.

(Dr. K.R. Nayar)
CHAIRPERSON

(Dr. K.R. Nayar)
SUPERVISOR

Tel. : (011) 6107676, 6167557/2420, 2492 Gram : JAYENU Fax : 91 (011) 6165886, 6198234

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I would also like to take this opportunity to show my deepest gratitude to all my family members. It was the support of my father because of which I was able to come to this place for my M.Phil. and will be completing my coursework of 2 years successfully. He has always been there as a father, teacher and guide whenever I needed him showing me the right way. I stand where I am today all because of him. My mother also deserves my gratitude towards her with the same intensity. Her love and care have been my emotional support throughout my life. My special thanks are due to my younger sister Ms. Meeta Garg for helping me out with my filed work and proof reading my chapters. She has been my friend, colleague and a sister in true sense of these terms. My younger brother is not the last or least in my thanking list. He has supported me with all his innocent love and care doing things under his power which may appear to be trivial but have been very important for me.

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Indebted

Deepa Garg

CONTENTS

Abbreviations

ANC	Ante-Natal Care
ANM	Auxiliary Nursing Midwives.
ARD	Acute Respiratory Diseases
AWW	Angan-Wadi Workers
BIMARU States	Bihar, Madhya Pradesh, Rajasthan, Orissa and Uttar Pradesh.
CD	Communicable Diseases
CHC	Community Health Centre.
CMHO	Chief Medical and Health Officer
CNA	Community Needs Assessment
FP	Family Planning
FPP	Family Planning Programme
HIS	Health Information System
HSS	Health Service System
IFA	Iron and Folic Acid.
IMR	Infant Mortality Rate.
LHV	Lady Health Visitor.
MCH	Maternal and Child Health
MO	Medical Officer
MPW	Multi-Purpose Worker
NFHS	National Family Health Survey.
PHC	Primary Health Centres.
PHN	Public Health Nurse.
PNC	Post-Natal Care
PP	Post Partum
RCH	Reproductive and Child Health
SC	Sub Centre.
TFA	Target Free Approach
TFR	Total Fertility Rate

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CHAPTER 1

CHAPTER I
INTRODUCTION

Throughout the world, over a period of time various models and approaches have been developed to ensure a good health for the people. India had adopted the Primary Health Care concept after considering various Health Service Models against the backdrop of the existing socio-cultural, economic, political and educational scenario of the country and the fact that a large population was to be served with available scarce resources. This model envisaged to provide health services to the smallest unit of the population through a net work of Primary Health Centres (PHCs) throughout the country. The main strength of the entire set up lies with the institutions at the grass root level, of which the grass root level workers form an integral part. Within the grass root level functionaries, the Auxiliary Nurse Midwives (ANM) have been the most important component.

ANMs are the backbone of the Health Service Delivery System particularly in the rural areas and for the economically backward and deprived sections of the society even in the urban areas. These semi-qualified professionals are the first contact points of the community and the health service delivery system. They possess the minimum of medical & educational qualifications and are provided with training deemed essential to their functioning. They are placed at the lowest level of the organizational hierarchy. All the health programmes which are chalked out at the policy making level are finally implemented by ANMs. At the same time, the responsibility of collecting all the relevant information from the targeted population also lies with them. Such information are transferred through consecutive higher levels to ultimately reach the level where they are used as the basis of formulating all the health policies and programmes.

It is evident from the above background that the ANMs are crucial to the overall success of the health service delivery system. ANMs have been a part of the health service delivery system from the very beginning. Width, scope and depth of ANMs functioning has been changing frequently according to the changing policies and according to the 'felt need' of the policy makers[1]. They were initially incorporated simply to provide health services at childbirth but as the health service policy evolved the ANMs have been given additional

[1] Prakasamma, (1989), *Analysis Of Factors Influencing Performance Of ANMs In Nizamabad District*, Unpublished Thesis of Ph.D., CSMCH, JNU, New Delhi.

responsibilities like Maternal and Child Health services (MCH), Family Planning services (FP), to deal with Communicable Diseases (CD) e.g. malaria, tuberculosis etc. and Survey Work and Reporting.

Since the launch of the Family Planning Programme in India in 1952 the ANMs have been an inseparable part of it because they are the primary delivery points of the various services proposed under this programme. With time the FP programme assumed greater importance among all other health programmes owing to the increased concern of the demographers of national and international level with respect to the high rate of population growth in India. Accordingly the importance of FP in ANM working assumed greater significance. Infact the emphasis laid on it increased so much so that in the last two decades it virtually overshadowed all other functions of the ANMs. The ANMs were concentrating only on female sterilization so as to get the required number of cases according to the demographic targets set for them.

A major breakthrough in the entire pattern of working of ANMs took place with the adoption of Target Free Approach (TFA) in 1996. A further shuffling is expected to take place with the launching of the Community Needs Assessment (CNA) approach in 1997-98. These two approaches have been visualized to initiate the process of decentralization for now the planning has been envisaged to begin at the grassroot level. In this process the ANM will become the real decision-maker, because depending upon the assessed needs of the people of her area, she will be able to set targets for herself under different programmes.

Though the role of ANMs has been very crucial in the entire process of health care delivery at the grass root level, which has an impact on the overall health scenario of the people of our country, in no case their involvement has been sought in the process of decision making. Particularly, when modifying and adding up additional responsibilities on them, they have never been consulted. In the recent years though the health department boasts highly of decentralizing the power of decision making to the grass root level workers, ANMs continue to execute only the tasks assigned to them by the higher authorities.

Need of the Study

No matter how efficient a system may appear during its formulation, its efficiency gets verified when it is actually executed. The executors of the system have a crucial role to play in

this respect. Since, they are the last in the system's organizational hierarchy and they remain in direct contact with the environment from which the system takes its inputs and into which outputs are released, they attribute significantly to the final success of the system. ANM, as discussed, is one such functionary. The success of the health care delivery system depends on her performance to a large extent.

The significance of ANM in the health care delivery system and her nature of work makes it important to understand holistically her role in this system by considering the social-cultural, economic, educational, political and other possibly related aspects. The lack of such an understanding of an ANM has necessitated the present study.

One needs to critically analyze her functioning in the light of the fact that she is a woman who in a patriarchal society as ours gets placed next to man. According to the social norms she has to play the role of a homemaker. Even when she is working she is expected to look after her family and do all household works also along with her service. The working environment may not be favourable to her because of her gender; in this case this issue becomes critical for an ANM's work is mainly a field-oriented work. Her going out of the house, visiting unknown areas, going to people's houses, interaction with all kind of people including males, etc. are some issues that affects her functioning and her personal life. It has to be borne in mind that no person's professional and personal life can be unrelated- each does and gets influenced by the other. Moreover, the social structure from which an ANM comes moulds her psychology and behaviour and controls her perception. The social structure of the community/society in which she functions is quite crucial for her efficient working. It is desirable that she is accepted as a part of that society and she adapts herself according to the social norms of that community/society. This all is being said to point out that actual field situations are quite different from the environment that is generally assumed by those who are sitting at the policy formulation level and that ignorance and disregard for the socio-cultural factors of the people who are to be served and of those who will serve can lead to undesirable failures and wastage of valuable resources.

Objective of the Study

The present research work is an attempt to study the role of the ANMs in the delivery of health services in Jaipur district of Rajasthan.

1991

RAJASTHAN

KILOMETRES
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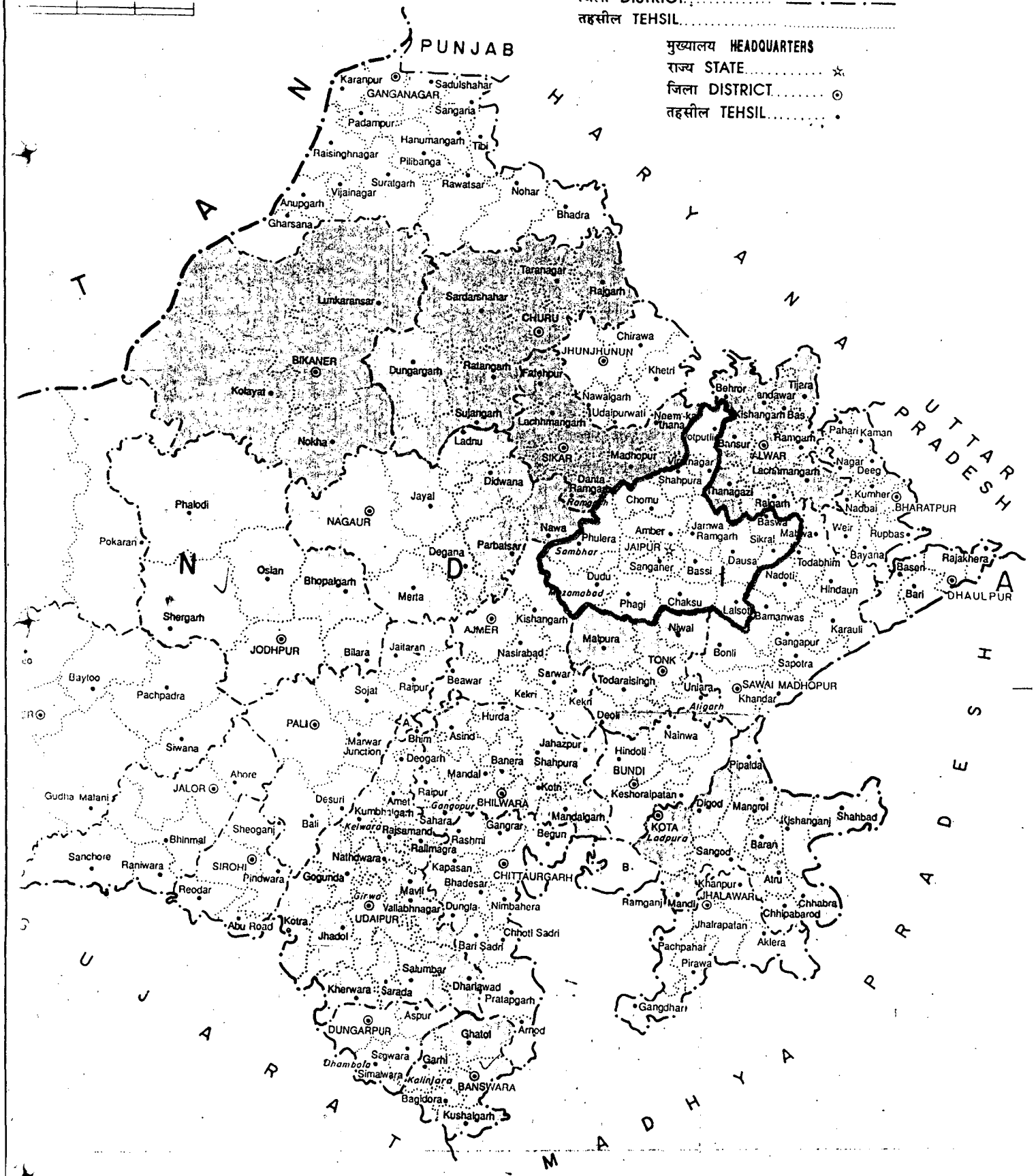
सीमायें BOUNDARIES
अन्तर्राष्ट्रीय INTERNATIONAL
राज्य STATE
जिला DISTRICT
तहसील TEHSIL

मुख्यालय HEADQUARTERS
राज्य STATE ☆
जिला DISTRICT ⊙
तहसील TEHSIL •



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Specific Objectives

To achieve the above stated broad objective following specific objectives have been outlined as follows:

1. To understand the changing responsibilities of ANMs in the backdrop of the Target Free Approach (TFA) and Community Needs Approach (CNA).
2. To provide a content analysis of some of the important forms that have been introduced as a part of TFA and derive implications from this for ANMs work.
3. To study the perception of ANMs regarding the problems in their living and working environment.

Data Required

As this is primarily a qualitative study which tries to understand the functioning of ANMs in the social setting, all aspects of an ANMs life that have a bearing on her functioning will be worked with, such as:

- the social, economic and educational background of an ANM,
- the circumstances under which she joined this service,
- the time schedule she follows in her work and the way she coordinates between her home and her work,
- her perception of her role as an ANM,
- the various functions she carries out and the changes that have taken place in them in her entire working period, specifically to understand the changes that have been introduced since TFA and CNA and her perception of these approaches,
- it is critical to study as to what extent she is involved in decision making process with respect to her work- whether the TFA and CNA have actually involved her actively in this process,
- the method by which she collects data, the time and frequency of data collection and how this data is compiled and analyzed the various levels through which it will pass etc.,
- the problems she encounters in her functioning particularly seen in the light of her being a woman and being placed at the lowest rank in the organizational hierarchy.

Background & Health Scenario of Rajasthan

The present study, as the very topic would clearly indicate, is placed in the state of Rajasthan. Geographically, Rajasthan is the second largest state located in the northwestern part of the country. The state is marked by unique geographical and cultural characteristics.

Aravalli ranges divide the region into roughly two parts. On one hand while the south-eastern part is green and rich in natural resources, the north- western part is a large desert which is a part of the larger Thar desert. The state is one of the driest parts of India. Inspite of this fact, it continues to be an agricultural land where about 40% of the total state income comes from agriculture and its related areas. Rajasthan is rich in mineral deposits occupying second place after Bihar.

The state has always been listed as one of the most backward states of India- it features among the BIMARU states[2]. Among the various areas of backwardness, health is one. This gets clearly reflected from the comparison of general health indicators for the state vis-à-vis the figures for all India. See **Table 1.1.**

Table 1.1
Comparative profile of Rajasthan and India

Item	India	Rajasthan
Area (in sq Km)	32.87	3.42
Number of districts	467	32
Total number of habited villages	5,87,226	37,889
Desert areas	-	84
Other areas	-	203
Population, 1991 census (in lakhs)		
Total	8463.03	440.06
Male	4392.31	230.43
Female	4070.72	209.63
(in percentages)		
Urban	74.29	77.12
Rural	25.71	22.88
SC	16.48	17.29
ST	8.08	12.44
Population growth rate	2.14	2.50
% Decanial growth rate (1981-91)	+23.85	+28.44
Population density (per sq Km)	?	129
Sex ratio	927	910
Literacy (1991) %		
Total	52.21	38.55
Male	63.86	54.99
Female	39.42	20.44
General health indicators		
Birth rate (1991)	35.0	29.5
Death rate (1991)	9.8	9.8
IMR (1991)	80	79
MMR (1991)	4.31	4.56
Couple protection rate (1991)	44.1	28.9
Net reproductive rate	3.60	4.60

Source: Census of Jaipur District, 1991 and the Annual Report of Family Welfare Bureau, Jaipur, 1999.

The NFHS survey of 1992-93 gives further insights into the status of health of the people of Rajasthan and the environment in which the ANMs function in the state. The data related to family planning issue shows that Total Fertility Rate (TFR) though decreasing is still much higher at 3.6 children per woman (about 7% higher than the national average). A strong unmet need for spacing methods among women is revealed alongwith potential demand for the terminal methods. However, the study also finds that a substantial percentage of women are not using and also do not wish to use any contraceptive.

The performance of MCH programme has been found to be dismal. The high Infant Mortality Rate (IMR) is attributed to conduction of deliveries by untrained personnel and a large number of children not being immunized. The morbidity figures are also undesirably high and diarrhoea and Acute Respiratory Diseases (ARD) have been found to be main factors behind it.

The status of women in Rajasthan is indicated to be negative. Infact the girl child is stated to be in a disadvantageous position. Though the age of marriage among women has been found to be increasing yet majority of them are married much below the legal age of marriage (18 years). The literacy rate is quite low among women and has been shown to be negatively linked to women's status and her health.

This information from the government and NFHS has been outlined to present the environment in which the ANM has to deliver health services. The dismal health scenario in the state appears to be a challenge for her effective functioning. With regard to peoples undesirability to use contraceptives her performance under Family Planning Programme becomes an interesting area to be researched. The most important issue would be to study and understand her functioning in an environment which is so unfavourable towards women particularly when she herself is a woman and comes from a similar social structure. In addition the increasing emphasis on women's health at the international, national and state levels makes it important to find out to what extent this gets reflected in ANMs work and the health status of the people.

[2] Bihar, Madhya Pradesh, Rajasthan, Orissa and Uttar Pradesh are called BIMARU states due to their very low development index.

RAJASTHAN

DISTRICT JAIPUR

KILOMETRES

HARYANA

KOTPUTLI

VIRATNAGAR

SHAHPURA

KISHANGARH RENWAL

CHOMU

AMBER

JAMWA RAMGARH

JAIPUR

DAUSA

BASSI

LALSOT

SIKRAI

BANDIKUI

SAMBHAR

PHULERA

NARAINA

BAGRU

SANGANER

DUDU

MAUZAMABAD

PHAGI

CHAKSU

NAGAUR DISTRICT

TONK DISTRICT

SAWAI MADHOPUR DISTRICT

ALWAR DISTRICT

Study Area

This study has been conducted in Jaipur District in Rajasthan. Initially the researcher had planned to conduct her study in Tonk or Dausa districts in Rajasthan as these were the first districts to be covered under TFA on an experimental basis in 1994 and theoretically either one would have been ideal to study the changes since the introduction of TFA. However, discussions with the health officials at the district level revealed that after TFA has been implemented in all districts, there would be no difference between the districts. Also, Jaipur is the capital of Rajasthan and so is the place where maximum number of facilities and the most efficient staff is recruited.

Jaipur is situated in the north-eastern part of Rajasthan. It is surrounded in the east by Alwar and Sawai Madhopur Districts , in the west by Nagaur and Ajmer Districts, in the south by Tonk district and in the north by the Sikar District of Rajasthan and Mahendragarh Disrict of Haryana,. The important statistics about Jaipur vis-à-vis Rajasthan are presented in **Table 1.2.**

Table 1.2
Important Statistics of Jaipur

Item	Rajasthan	Jaipur	Percentage
Population			
Total Persons	44005990	4722551	10.73
Male	23042780	2496799	10.84
Female	20963210	2225752	10.62
Rural Persons	33938877	2855912	8.41
Male	17686463	1500436	8.48
Female	16252414	1355476	8.34
Urban Persons	10067113	1866639	18.54
Male	5356317	996363	18.60
Female	4710796	870276	18.47
Decennial Population Growth Rate (1981-91)	+28.44	+37.44	
Area In Sq Km.	342239	14068	4.11
Sex Ratio (No. Of Females / 1000 Males)	910	891	
Literacy Rate			
Persons	38.55	47.88	
Male	54.99	64.83	
Female	20.44	28.69	
% Of SC To Total Population			
Persons	12.44	11.26	
Male	12.31	11.3	
Female	12.58	11.21	
% Of ST To Total Population			
Persons	17.29	16.23	
Male	17.34	16.16	
Female	17.18	16.30	
No. Of Villages			
Total	38810	3088	7.96
Inhabited	37889	2990	7.89
Uninhabited	1921	98	5.10
No. Of Towns	222	20	9.01

Source: Census of Jaipur District, 1991 and the Annual Report of Family Welfare Bureau, Jaipur, 1999.

The advantages of this place, as outlined in the annual report of District Family Welfare Bureau, Jaipur are as follows (only those that have a direct bearing on this study):

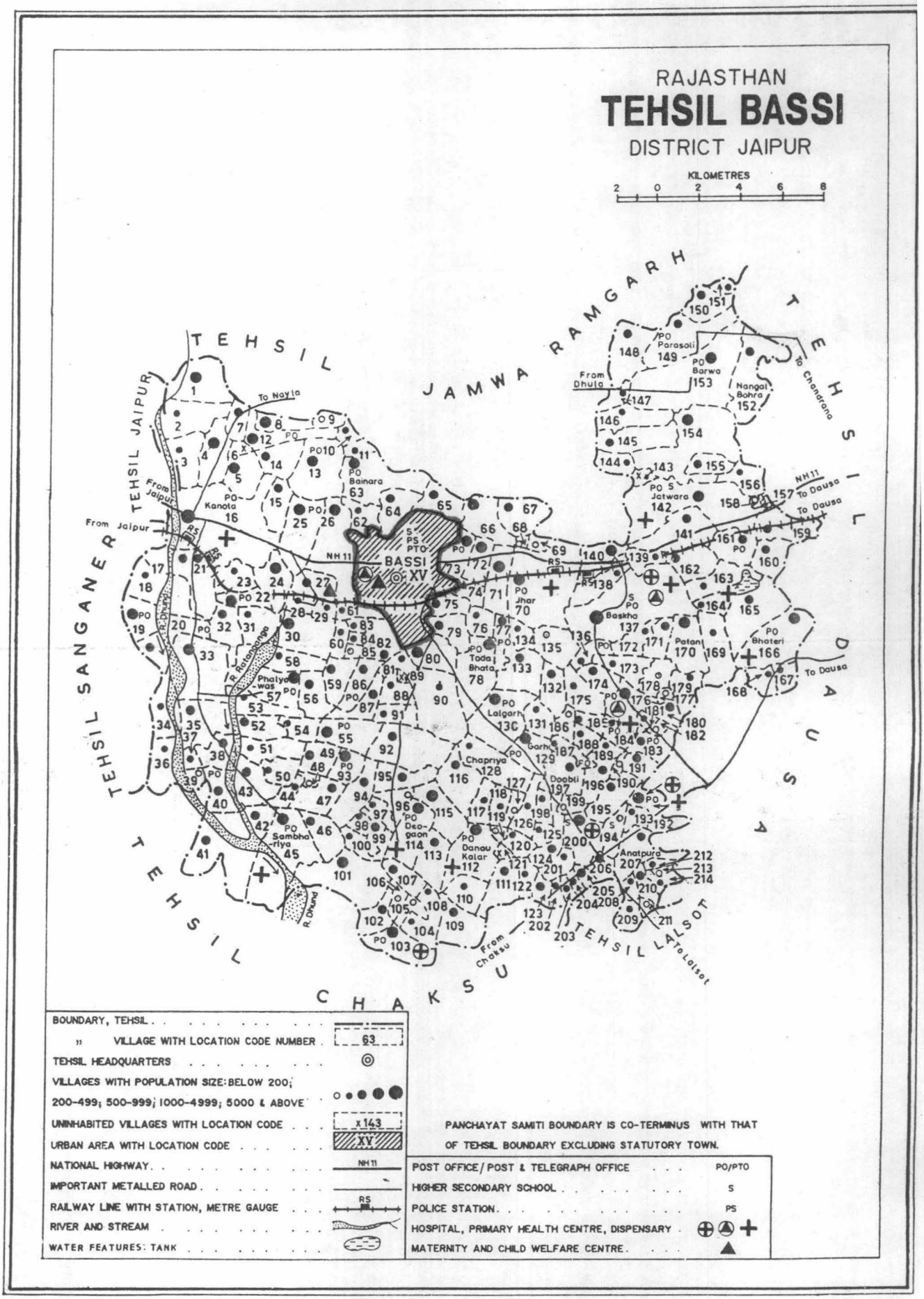
1. Jaipur district has nearly 95% of grass root level workers' posts filled out of the total manpower proposed at this level.
2. The eligible couple survey which was done in 1996 itself is nearly complete & has provided latest baseline data regarding exact number of Eligible Couples, their unmet demand regarding adoption of temporary or permanent FW methods.
3. Similarly, baseline data regarding exact number of children between 0-1 year of age, their immunization status and also the requirement of different types of vaccines needed for 100 % coverage are also available.

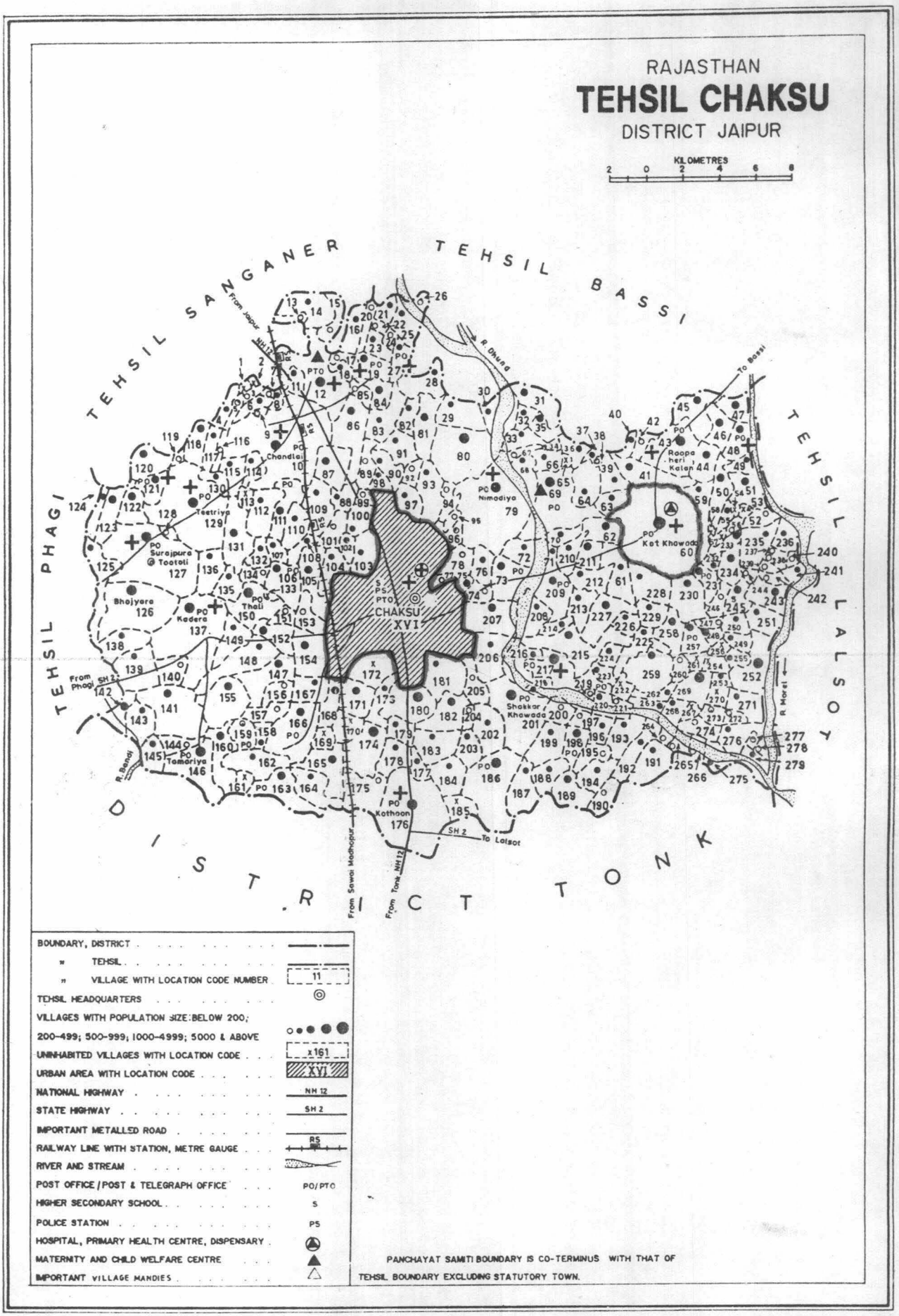
It is evident from the report that Jaipur district has sufficient Health Service Delivery System and Health Information System (HIS) infrastructure among the 32 districts of Rajasthan and has nearly filled in cadre of grassroot workers that includes ANMs also. Besides the report clearly recognizes that presently an ANM has to cover more than 5000 population scattered in an area of more than 5 Km. radius from her headquarter which is not an ideal situation. The non-stay of majority of ANMs at their respective headquarters has been pointed out as a major pitfall in successful implementation of Family Welfare Programme. A caste-religion wise analysis done here reveals that the Family Planning (FP) finds low acceptance among Muslims/ Gujar /Jogis due to the prevalent health and illness concepts in these communities/ religion. Also immunization programme has not been accepted by all the people. The people targeted to be served as reported in the Annual Report do not have faith in the services provided. The delivery of health services bear the setback due to unavailability or poor condition of vehicles and vacant posts of drivers, non functional state of cold chain equipment, shortage of vaccines and recurrent power failures in rural areas.

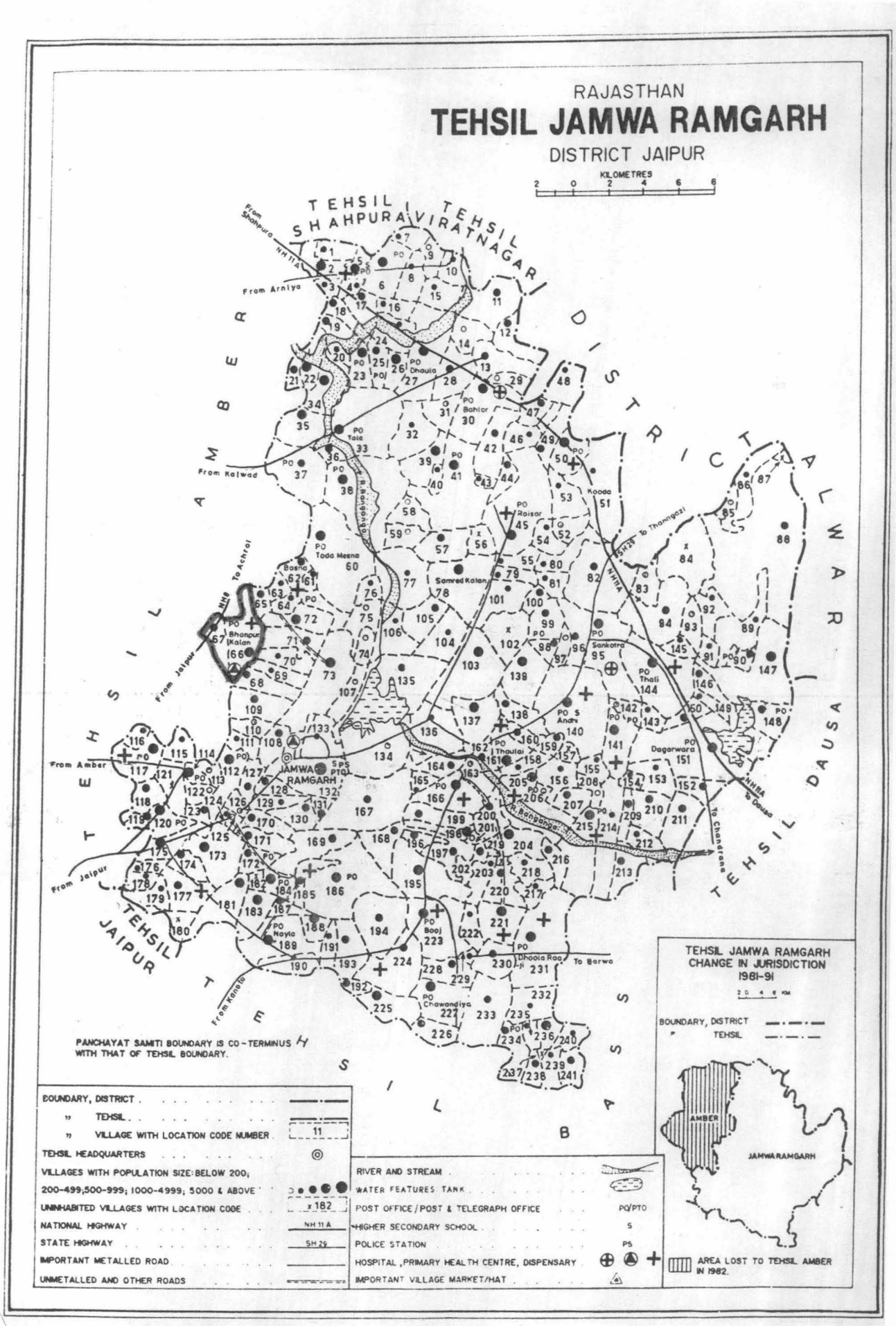
The above background illustrates the rationale behind selecting Jaipur district as the study area. Moreover, since the researcher belongs to Jaipur, it was comparatively accessible. Further, due to time constraints Jaipur district has been the most feasible choice.

Sampling

The Jaipur district is divided into a total of 13 blocks. Out of a total of 13 blocks, 4 rural blocks have been selected for this study. This is 25 percent coverage, which is considered to be an adequate representation. The selection of the 4 blocks selected for this





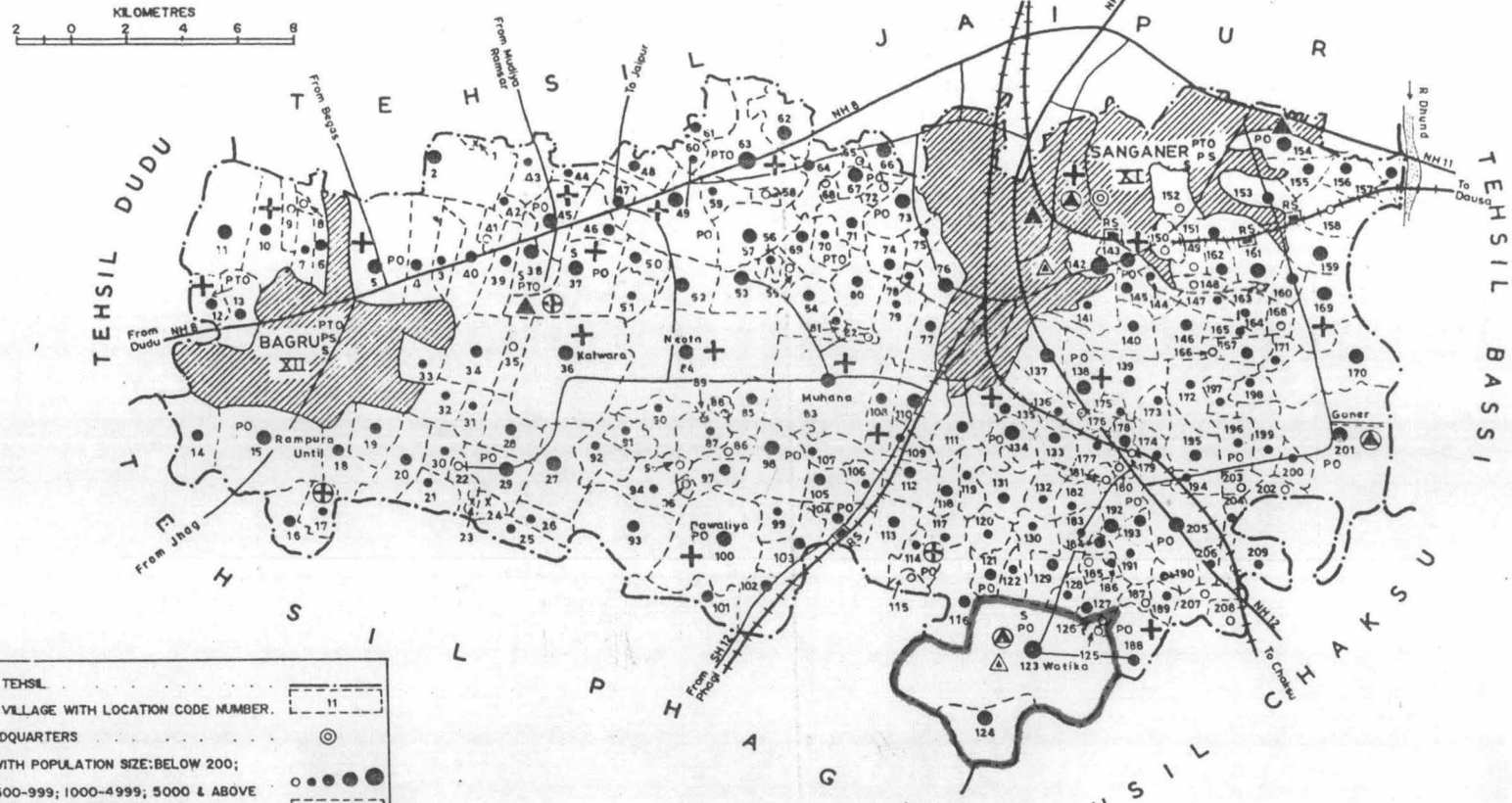


Based upon Survey of India map with the permission of the Surveyor General of India.

RAJASTHAN

TEHSIL SANGANER

DISTRICT JAIPUR



BOUNDARY, TEHSIL

" VILLAGE WITH LOCATION CODE NUMBER. 11

TEHSIL HEADQUARTERS

VILLAGES WITH POPULATION SIZE: BELOW 200; 200-499; 500-999; 1000-4999; 5000 & ABOVE

UNINHABITED VILLAGES WITH LOCATION CODE X 24

URBAN AREA WITH LOCATION CODE XI

NATIONAL HIGHWAY NH 12

STATE HIGHWAY SH 12

IMPORTANT METALLED ROAD

UNMETALLED AND OTHER ROADS

RAILWAY LINE WITH STATION, METRE GAUGE RS

RIVER AND STREAM

POST OFFICE/POST & TELEGRAPH OFFICE PO/PTO

HIGHER SECONDARY SCHOOL S

POLICE STATION PS

HOSPITAL, PRIMARY HEALTH CENTRE, DISPENSARY

MATERNITY AND CHILD WELFARE CENTRE

IMPORTANT VILLAGE MARKET/HAT

PANCHAYAT SAMITI BOUNDARY IS CO-TERMINUS WITH THAT OF TEHSIL BOUNDARY EXCLUDING STATUTORY TOWNS.

RAJASTHAN

TEHSIL JAIPUR

DISTRICT JAIPUR

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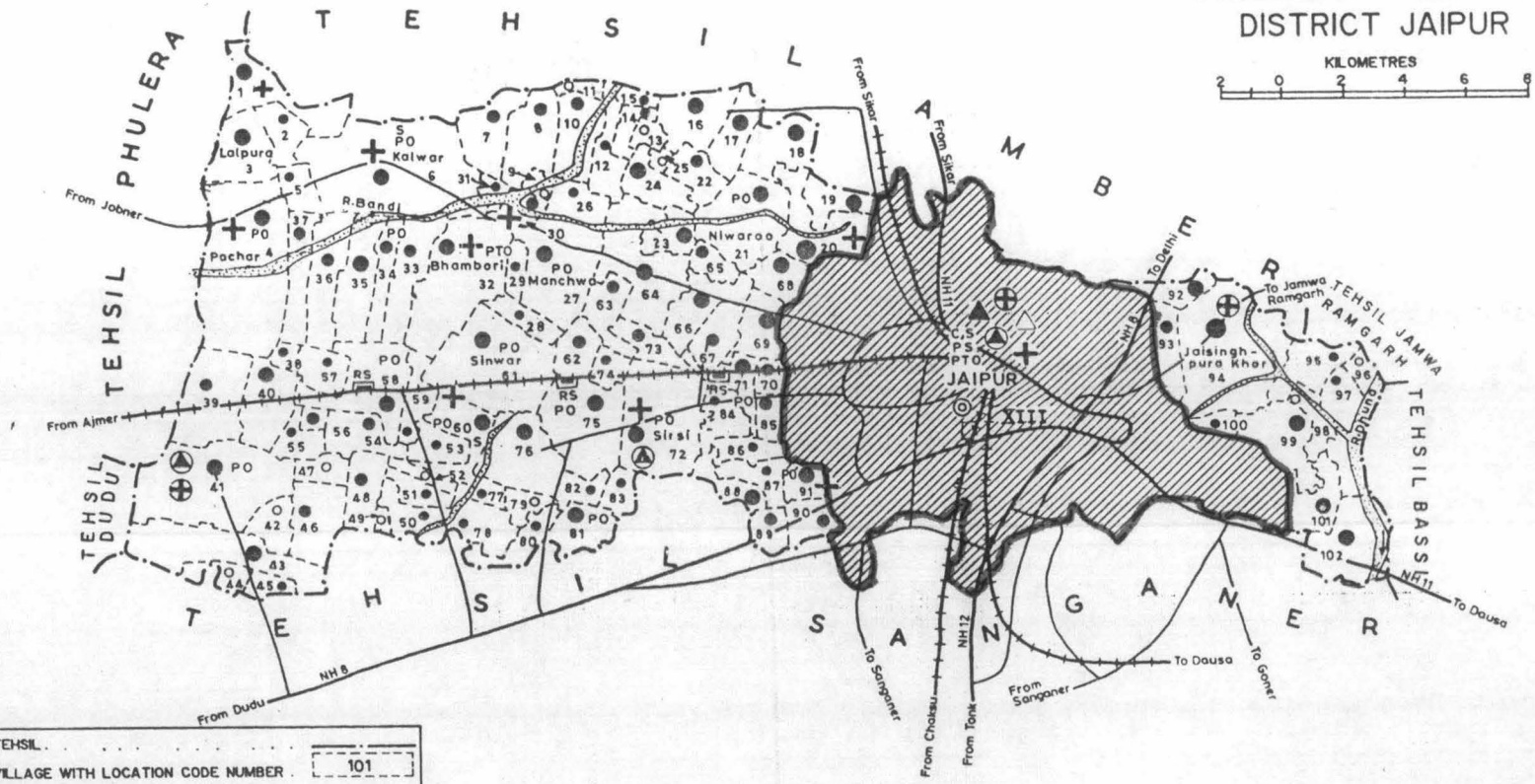

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TEHSIL HEADQUARTERS	◎
VILLAGES WITH POPULATION SIZE: BELOW 200; 200-499; 500-999; 1000-4999; 5000 & ABOVE	○ ● ● ● ●
URBAN AREA WITH LOCATION CODE	XIII
NATIONAL HIGHWAY	NH 11
IMPORTANT METALLED ROAD	
RAILWAY LINE WITH STATION, METRE GAUGE	RS
RIVER AND STREAM	
POST OFFICE / POST & TELEGRAPH OFFICE	PO/PTO
SECONDARY SCHOOL, COLLEGE	S,C
	PS

HOSPITAL, PRIMARY HEALTH CENTRE, DISPENSARY	⊕ ◬ +
MATERNITY AND CHILD WELFARE CENTRE	▲
IMPORTANT VILLAGE MARKET / HAT, MANDIES	◬ △

PANCHAYAT SAMITI BOUNDARY IS CO-TERMINUS WITH THAT OF TEHSIL BOUNDARY EXCLUDING STATUTORY TOWN.

study has been done under the guidance of and in consultation with the officials at the district level. When asked to grade the various blocks performancewise, they categorized all these 13 blocks into 3 categories- best performing, average performing and worst performing ones. Out of the 4 blocks, which were randomly selected, Bassi falls in the best performing category, Watika and Bhanpur Kala in average and Kotkhawada in worst performing category.

Table 1.3 presents a list of all the 13 blocks alongwith important statistics about them (the selected ones have been highlighted).

Table 1.3
Blocks In Jaipur District and Important Statistics

Sl. No.	Block	Population		Birth Rate	IMR	MMR
		1991	1999			
1	Amarsar	166764	200117	25.67	26.09	0.00
2	Bassi	174884	209861	26.69	66.94	0.00
3	Bhanpur Kala	190822	228986	27.12	56.04	0.00
4	Bichoon	222886	267463	24.90	37.84	0.11
5	Jahota	205355	246426	19.92	36.25	0.00
6	Kaladera	248611	298744	23.66	53.75	0.06
7	Kishangarh Renwal	233158	279790	21.63	33.7	0.10
8	Kotkhaweda	146111	175333	22.69	52.76	0.00
9	Maid	168439	202127	24.05	42.78	0.04
10	Nareda	209357	251228	24.71	35.12	0.13
11	Phagi	130453	156544	20.82	71.78	0.21
12	Sirsi	105576	126691	23.73	37.58	0.00
13	Watika	170775	204930	21.09	51.72	0.05
	Total Rural	**2373191**	**2848240**	**23.63**	**45.77**	**0.05**
	Jaipur City	1154704	1385645	23.63	45.77	0.05
	Revamping Centres	360000	400000	22.42	46.06	1.23
	Total Urban	**1514704**	**1785645**	**23.36**	**45.83**	**0.07**
	Jaipur district	**3887895**	**4633885**	**23.53**	**45.79**	**0.06**

Source: District Reproductive and Child Health Plan, 1999-2000 prepared by district Family Welfare Bureau, Jaipur.

A review of the general health indicators reveals some discrepancies between the categorization as suggested by the officials and figures for Family Planning performance viz. number of Eligible Couples, sterilizations, tubectomies, oral pills distributed, 'Nirodh' distributed, etc. except for data on number of tubectomies, oral pills and MTPs. The district officials had often commented that they are quite confident of the staff particularly ANMs- their capability to answer questions of survey teams and efficiency in work at Bassi. The various SCs, PHCs and CHC in Bassi as reported by them to have maximum number of facilities reflects to some extent that the categorization suggested by them has been guided by the number of tubectomy cases. The observation of the researcher about the ANMs and the facilities available verified these.

The various villages that get covered under each of the selected blocks is given below:

1. Bassi- this is block PHC and also a CHC. It covers Bassi, Baskhon, Badawa, Toonga, Rojwari.
2. Kotkhawada- this is a block PHC. It covers Kotkhawada, Chaksu, Padampura, Chandlai, Kadeda.
3. Bhanpur Kala- this is also block PHC. It covers Bhanpur Kala, Jamwa Ramgarh, Bhawani, Aandhi, Chandwadiya, Dhola, Gathwari (Jamwa Ramgarh and Aandhi are CHCs)
4. Watika- This is also a block PHC. It covers Watika, Beelawa, Dadiya, Goner, Jagatpura, Sanganer, Bhankrota, Bagru.

Of each block atleast 4 ANMs have been selected. The selection has been guided by their availability. Out of these 4, atleast 1 ANM can be called 'new' and atleast 1 as 'old'. This classification into old and new is based on the number of years an ANM has been in service. Those who have been in service for less than or equal to 5 years have been called as 'new' and those in service for 16 or more years have been called as 'old'. See **Table 1.4**.

Table 1.4
Classification of Respondents According To Years of Service/Experience

AREA	Upto 5 Years	6-10	11-15	16 Or More Years	Total
Bassi	1	1	0	2	4
Watika	1	1	0	2	4
Kotkhawada	1	1	1	1	4
Bhanpurkala	3	1	2	1	7
Total rural	**6**	**4**	**3**	**6**	**19**
Jaipur Rev. centre	1	3	1	3	8
All total	**6**	**5**	**5**	**10**	**27**

Source: Data collected from the field.

Besides these 4 rural areas some ANMs included in this study are from the urban area- those working in main Jaipur City. This has been done so as to understand and analyze differences between ANMs working at these two levels. Out of the various institutions in the city where ANM can be functional, the study focussed on the revamping centres. The establishment of revamping centres has been done by the government of Rajasthan in view of the increased urbanization leading to proliferation of the slums. The various health institutions present in the city viz. hospitals, dispensaries, MCH centres, etc. were found to be inadequate to provide health services to the people living in slums. In context of this situation and with a view to adopt remedy measures, a conference of Chief Executive Officers of Municipal Corporations was held in New Delhi on 7th April, 1982. The conference

recommended adopting sub-centres area approach in order to provide integrated health services including family planning & MCH. The setting up of revamping centres in Jaipur city is a part of the decision of GOI based on this recommendation.

In all 6 such revamping centres have been established. These are:

1. Chandra Shekhar Ki Bageechi, Chandpole.
2. Sardar Patel
3. Malviya Nagar
4. Ragairon Ki Khoti, Ghatgate
5. ICDS, Raj Bhawan
6. ICDS, Nari Ka Naka

Each such centre is manned by 1 LHV and 7-9 ANMs. In this study the Sardar Patel Revamping has been included (on random basis). All the ANMs and LHV of the centre were selected as respondents.

Thus in all a total of 24 ANMs and 2 LHVs have been included in this study. See **Table 1.5.**

Table 1.5
Categorywise Sample Coverage in the Study

AREA	ANM	LHV	TOTAL
Bassi	3	1	4
Watika	4	0	4
Kotkhawada	4	0	4
Bhanpurkala	7	0	7
Total rural	**18**	**1**	**19**
Jaipur Rev. centre	7	1	8
All total	**24**	**2**	**27**

Source: Data collected from the field.

Also 1 Public Health Nurse (PHN), statisticians and other officials at the district level were included in the study for additional information.

Tools and Techniques of Data Collection

The study has been qualitative in nature. The various tools and techniques employed in the present research work are enumerated below:

(i) **Case Reports**- the case reports of all selected 24 ANMs and 2 LHVs have been prepared. The district level officials at the Dy. LHV office in Jaipur guided the researcher in the fieldwork. At each of the respective block PHC/ CHC the

researcher introduced herself to the Medical Officer (MO) of that centre and explained the purpose of coming to the centre. The MOs gave permission to talk to the ANMs of that centre and also guided her to various PHCs and SCs under that centre (in case of CHC to all SCs/PHCs that refer cases to this CHC). After being able to locate an ANM either at her respective only or after having traveled to some SC or PHC under that block PHC, once again the researcher introduced herself to the ANM and described the purpose of the research at length.

This initial introduction and detailed explanation of the research to the concerned ANM was a step towards rapport building. A strong rapport with the ANM was required so as to gain her confidence and to be able to build the ANM's trust in the researcher so as to create an atmosphere that may be conducive for interviews with the ANMs to take place. At this point mention may be made of an experience of the researcher with most of the ANMs. The ANMs were very happy when they came to know that the study is focussing on them and for the first time somebody has come to understand their functioning and ask them about their problems in their work. Such an attitude of the ANMs proved to be quite advantageous for conduction of in-depth interviews on all aspects- even the sensitive questions like their family problems, mishaps during field visits, which works they actually do, the circumstances under which they have joined this service and so on.

This introduction was followed by in-depth interviews of the ANMs that were conducted sometimes at the respective centre of the ANM or at her home. Many a times the researcher had accompanied the ANMs to their respective fields- villages in rural areas and to the slums in the urban areas. The interviews continued over an average of 1-2 days per ANM - a couple of hours each day and extended over the next day/days depending on the circumstances like availability of time with an ANM. The interviews were unstructured in nature where the ANMs were allowed to talk freely on various aspects enquired of them or about what they wanted to inform the researcher. However, to ensure that the interview moves in a definite direction in line with the objectives of the study and also to check that the researcher had not missed out any relevant question, a checklist was used. This contained a list of broad areas framed in form of questions with appropriate probes attached to them. The sequence of these listed areas has not been important and the questions were asked depending

upon the circumstances at hand (see Checklist 1 in the **Appendix 2**). Normally the researcher had carried a field diary with her in which she noted down her experiences the interviews details and other relevant information. However, at times, in order not to distract ANMs' free flow of responses and not to miss out some important points in the long interviews a tape recorder has been employed. The important portions were recorded and replayed to fill in gaps that have been left in the information collected through interview conducted for the respective respondent. All the information collected from the ANMs have been compiled in the form of case reports.

Besides, the ANMs, the case reports of 2 LHVs have also been prepared. LHVs are promoted from ANMs. They have the experience of working as an ANM and after becoming LHVs to supervise the ANMs. They are, therefore, able to provide insights of an ANMs work and her life as an ANM as well as being ANMs supervisor.

(ii) **In-depth interviews of the district level officials and other functionaries:** This included statistical assistants at the Dy. CMHO office, the Demographer and Evaluation Officer in the Directorate of Health in Jaipur, the Public Health Nurse (PHN) at the Dy. CMHO office, some MOs at the PHCs/CHCs covered and the Principal of the ANMs training college at Amarsar in Jaipur District (see Checklist 2 in the **Appendix 2**). These functionaries have a close association with the ANMs' functioning.

The district level statisticians are responsible to compile, tabulate and prepare reports for the Jaipur district based on the information collected through various forms. They are in constant touch with the ANMs and other grassroot level workers and also the higher district level authorities. As a result, they have been able to give information from both the sides. The Demographer and Evaluation Officer is a person who is responsible to recompile, re-tabulate and reanalyze the data coming form all the health institutions in the district and state levels and thus, has been an important source of information for the present study.

She is well aware of their potentials, the functions they actually do and are ideally expected to do and has been quite helpful in providing a critical opinion about the problem under focus.

The Principal of ANMs training school has been one of the most important key persons. She has during her long period of experience at this post seen changes that have taken place in ANMs' responsibilities and training (syllabus and procedure of training); knows from what background the ANMs usually come and has there been a change of pattern in this; the various problems the ANMs face; who decides and as to what is the process to decide about the syllabus of ANMs training; the works she has to carry out, the data she has to collect, etc.

The MOs are heads of their PHC or CHC and ANM at that centre has to function under them. The attendance register of an ANM gets signed/ approved by the LHV who supervises her and the MO of the centre at which ANM works or is supposed to report, only after which her monthly salary is released. The MOs are also serving people of that area though this is mainly confined to clinical work. And since they are their supervisors they have proved to be potential sources of deriving information useful for this study.

(iii) **Observations**- Observations were taken down of the living conditions and family of the ANMs, the field situations in which they work; the infrastructure, the medicines, medical equipment and other facilities available to them; the registers they maintain; their interaction with the other health functionaries viz. LHV, PHN, MO, etc. and with the people for whom and among whom they work. This enabled the researcher to feel the prevailing working and living condition of the ANMs and at the same time to verify the authenticity of the information being collected.

(iv) **Informal discussions**- informal discussions were held with the community covered by the ANMs selected for the study, as and when possible either at the health centres or at their home.

(v) **Content analysis of the forms**- a content analysis of the main forms used by the ANM to collect the information has been done in order to critically analyze the

nature, extent and relevance of the data being collected. These forms are related to family welfare programme and have been introduced in 1996 as part of TFA.

(vi) **Bibliographical studies**- these have been the main secondary sources which have helped in the conceptualization of the study and hypothesizing of the problem and from which the study draws its theoretical content.

Chapterization Plan

This study has been compiled into 4 chapters. These are described below:

Chapter1- this is the present chapter that introduces the study and explains the rationale behind undertaking it. The methodology adopted in this study finds a detailed discussion in this chapter.

Chapter 2- this chapter is the compilation and analysis of the information collected from the secondary sources. It talks about the evolution of health services in India and the ANMs place in it. Specific portions have been devoted to Family Planning Programme (FPP) and its progress. The concept of ANM and her proposed position has been derived particularly with reference to TFA and CNA. The last part of this chapter reviews the literature that is available on ANMs or issues related to her functioning that are the focus of this study.

Chapter 3- this contains the analysis of the primary data collected in the form of case reports from the ANMs and LHVs and after interviews of district level health officials while referring to the secondary sources where ever required. Along with the analysis wherever relevant analytical discussions have been done.

Chapter 4- in the concluding chapter the previous chapters have been summarised and the conclusion is drawn.

Limitations of the Study

The present study work is a qualitative study dealing with the perceptions of the ANMs about their work, service conditions and the attitudes of the people towards them. The communities, who are receiving their services, have only been superficially included in the study. It was strongly felt while doing the analysis that the inclusion of the community's

perception about the ANM and the health service delivery system as a whole would have certainly added usefully to the overall study. However, since no definite checklist was prepared for the purpose these discussions were not focussed and were also not recorded so as to be included in the analysis.

An ideal way of conducting fieldwork for writing case reports of the ANMs is to prepare a checklist while doing participatory observation. Such a norm could not be adhered to due to paucity of time mainly arising due to the two month long strike of all government workers including the health workers in whole of Rajasthan during the months of December-January. One more month was lost before the workers joined back their offices. Owing to time limitation thus created the fieldwork had to be limited to a span of about one-month concentrating on each case roughly for 1-2 days. It is genuinely felt and accepted by the researcher that if more time could have been given to each case more support for the facts stated and conclusions drawn could have been gathered.

Inspite of these limitations the study has succeeded in bringing forth the ANMs perceptions to a great extent. Their problems have been particularly highlighted and their impact has been studied in relation to the health service delivery system. Also the study has touched upon the health information system though only to a limited extent. The study also highlights the various other issues related to the health service delivery system.

CHAPTER 2

CHAPTER II
HEALTH SERVICE DELIVERY SYSTEM AND ROLE OF ANMs

Evolution of Health Service System in India:

After gaining Independence, India found itself a land with acute problems like poverty, unemployment, high mortality and morbidity, inadequate food production etc. One of the major areas of concern for the planners of India was the health of its people. It was felt by the health planners of India that there is a need for adapting the practice of modern medicine to improve the health of its masses. However, as the system had evolved in the socioeconomic setting of the west that was totally different from the prevailing situation in India, the need to suitably modify the 'Western medicine system' according to the sociocultural milieu of this nation was clearly felt. Owing to the scarcity of the resources and the low level of economic development, the state could provide medical and health services in India at the minimum cost consistent with effectiveness. This health system was supposed to cater to the immense disease load per unit of population, much higher than that in industrialized countries.

After working out cost and physical feasibility for various health service models, the government of India adopted the approach of "The Primary Health Care". The PHC concept implied the delivery of integrated health services through an appropriate institutional framework to the smallest unit of the population possible. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process[1]. In this direction the role to be played by self-help and auxiliary workers units in reducing mortality and morbidity was recognized during the formulation of this model.

The Bhore committee in 1946 had given form to this model in its long and short-term plans in which the PHC constituted both the periphery as well as the core of health services development proposed for the country. The government of independent India, in accordance with the policies that recommended by the Bhore committee took the task of establishing a PHC network throughout the country. The establishment of the first family health center in

[1] World Health Organization, (1978), *Primary Health Care; Report of the International Conference of Primary Health Care*, Alma Ata, USSR; Geneva.

October 1952 was a major landmark in this context. The PHC was intended to be the nucleus for all health activities in an area, providing integrated preventive and curative health care.

The Community Development Programme (CDP) launched in 1952 had envisaged the establishment of one PHC with three sub centers for every Community Development Block covering approximately sixty thousand people. The PHCs were conceived as the nuclei from which the primary health services would radiate through sub-centres in the rural areas. These PHCs with the sub-centres under them were supposed to provide medical care to the people of the area falling under them, controlling the communicable diseases, providing maternal and child health care, ensuring environmental sanitation and collection of vital statistics[2].

The health care providers are an important component of this vast health setup. Lack of trained and skilled manpower often has been identified as an important factor responsible for the unsuccess of well-planned costly developmental health programmes in our country. At every PHC 1 Medical Officer (MO), 1 Sanitary Inspector (SI), 1 Lady Health Visitor (LHV), 1 compounder and 4 Auxiliary Nursing Midwives (ANM) were available that were not adequate to be able to serve a population of 60000[3]. Further, their training was insufficient and inadequate vis-a-vis health needs of the people.

The Health and Planning Committee 'Mudliyar committee' in 1962 noted that the PHCs need to be strengthened instead of mere expansion. Further, in order to achieve the standard of health services as envisaged by the Bhore committee, the population served under one PHC should be decreased to 40,000. There should not be any establishment of any new PHC. The unserved population in the new system should be served through the mobile services through the district centres or from the taluks instead of ill-equipped PHCs[4].

During late sixties it was increasingly realized by the health planners of India that mere focussing on provision of health services to the people without making an effort to ameliorate their general social, educational, economical and environmental conditions would not bring the desired level of improvement in people's health. This realization culminated in

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[2] Banerji Debabar, (1985), *Health and Family Planning Services in India: An Epidemiological, Socio-Cultural and Political Analysis and a Perspective*, Lok Paksh, New Delhi.
[3] ibid.
[4] ibid.

launching of Minimum Needs Programme in 1972 that envisaged to provide a package of services viz. Health, education, water supply and environmental improvement.

Then in order to integrate health services at the grassroot level the unipurpose workers were converted to multipurpose workers in 1971. This has been a major landmark in the development of health service system. A male and female multipurpose workers form a team to serve the rural population of about 5000. They are to provide an integrated package of services - medical care, maternal & child health services, family planning services, control of malaria and other services for communicable diseases, environmental sanitation, collection of vital statistics and health education.

Evolution of the concept of health auxiliary

The health auxiliary staff has been the backbone of the health setup at the grass root level. The term is used to describe someone trained for aspects of health care whose responsibilities are defined by the tasks to be performed rather than by traditional professional roles; whose training is primarily oriented to the responsibilities the particular worker will undertake rather than being based upon a wide background of theoretical studies as in traditional medical and nursing education; and whose authorities are derived from the public or private health care organisation or the team within which he or she works rather than from the traditional professional licensing bodies. (Miles Hardie, 1978)[5].

WHO in 1961 has defined the auxiliary workers as 'the auxiliary worker is a technical worker in a particular field with less than full professional qualifications'. During 1970s, there was a sudden significant rise in the use of health auxiliaries, in developed and developing countries alike. This was mainly attributed to the growing realisation that preventive and other positive health components as community's involvement in health programmes and their implementation; provision of safe drinking water, etc. hold equal importance to the curative or clinical aspects of health services and can have far reaching positive consequences in comparison to solely hospital based medicine. The health auxiliaries were conceptualized to function at the interface between the local community and the major health professions. They are expected to fulfill a distinctive function which for many reason can not be fulfilled equally well by other members of the health team. As pointed out by King in 1971, they are within

[5] Miles Hardie, (1978), *Health Auxiliaries and the Health Team*, ed. by Muriel Skeet and Katherine Elliot, Groom Helm, London.

the means of the poor where as doctors in any number are not and they are less likely to move away from those who need them.

Such a category of health auxiliary workers fill in gaps in the present medical system and it is at their level of working that integration of otherwise fragmented health services (due to specialization and vertical programmes) takes place. The health auxiliary may also, through improving communication, enlarge the health teams understanding of the community's range of health needs and problems[6]. Such an information is then utilized by the health planners and implementers in framing of policies for the people. This is important because as Siegerist said more than thirty years ago- "Health can not be forced upon the people. It can not be dispensed to the people. They must want it and be prepared to do their share and to cooperate fully in whatever health programme a country develops"[7].

Role of ANMs in health service delivery systems in India:

It has been recognized that a well trained highly motivated cadre of nursing personnel working at the sub center level are critical for the achievement of health for all - the goal adopted by all nations at Alma Ata conference held in Geneva in 1978. According to WHO (1961), the type of auxiliaries could be divided into four categories - medical assistant, auxiliary nurse, auxiliary midwives and auxiliary sanitarian. In general we can have three categories of nurses - a fully qualified registered nurse, ANM and midwife.

The Bhore committee had also stressed the need for qualified midwives and LHVs to decrease the high maternal and infant mortality and morbidity noted by it. It suggested that there should be three grades of nurses viz. the basic nurse with four years of training, the ANM with two years of training and the nurse with a degree qualification. It was proposed that there should be one ANM for a population of 5000 at the end of fifteen years.

WHO Experts Committee on nursing in 1950 recommended that it is essential to employ the auxiliary nurse midwives as for delivering health care to rural communities particularly for covering the health services in the area of MCH and FP.

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[6] Ibid.
[7] ibid.

The auxiliary nurse midwives stands last in the organisation hierarchy of the health setup in our country. They as qualified as a PHN and yet the responsibility of providing health care to the people at grass root level particularly the women and children of rural areas falls on their shoulders.

Realizing the need for better qualified persons and also to provide opportunities to midwives to undergo training, the Indian Nursing Council started ANMs' training course in 1952 which was supported by the Government of India and WHO. She was to be trained for a period of two years in basic nursing and in MCH.

The Shetty committee (a nursing committee), was appointed in 1954 when the then union health minister emphasized the importance of good nursing and drew attention to the factors hindering its development. The committee said that ANMs and midwives may be appointed to work in the health centres and sub-centers provided they are supervised by the public health nurse or health visitor.

In the sixties, one ANM was responsible for serving a population of ten thousand doing maternal and child health work and family planning work among women. After the introduction of multipurpose workers scheme, the ANM is suppose to provide integrated FP and MCH services besides other health services and is therefore, referred to as female multipurpose worker. One MPW (F) is to serve a population of 5000.

In 1972, a committee had been set up to review the ANM training programme. The report submitted by this committee recorded - "during the last two decades the concept of the role of ANMs as a health functionary has undergone evolutionary but significant changes from service to motivation and education, from individual to community health work and from MCH services to total and integrated health service in the community in which she is placed. The evolutionary development in the concept of this health functionary who operates at the primary level necessities redefining her role. In this attempt the groups spelt out, as the first step, the services expected to be rendered by her in the integrated health service system. Broadly, they could be grouped into MCH and FP, nutrition, education, environmental sanitation, health education, control of communicable diseases, collection of vital statistics and school health.

Gyan Prakash in his inaugural session in 1975 on trends in health care system and its implication on nursing has stated that there was a change in emphasis in the present day health services delivery system. It was no longer confined to hospital based curative treatment alone. In order to expand it to rural areas, he suggested that nursing course and training should reflect this change. He emphasized the need for more nurses to take up community health work in rural areas.

To keep pace with the changing responsibilities of the ANMs and the changing health scenario, the INC revised the curriculum of ANM course in order to make it more field based and job oriented. The educational qualification for the entrance into this course was raised from 7^{th} to 10^{th} standard and the duration of the training was reduced from two years to a year and half in the year 1978 (ANM school).

The ANM is an important functionary at the SC level that is the only available peripheral health organisation to the community in the rural areas. SC covers a population of 5000 in plain areas and 3000 in hilly and tribal areas. It is manned by one ANM and one male health worker. In order to facilitate speedy development of infrastructure the establishment of sub-centers was made under the centrally sponsored scheme from the year 1981-82 and the same was included in the 20 points programme. Further, keeping in view the operational aspects, the establishment of SCs with ANM was made essential. In order to train the required number of ANMs in the country additional training schools were established.

The ANM is the final executor of all the health programmes formulated at higher levels. The entire burden to carry out the health tasks to ameliorate the health status of the people fall on her. Her functions and role have been changing with changes in the approaches adopted by the health planners of India. With great emphasis on family planning programme in India, high priority has been given to it all through the planning period so far by the health planners of our country, ANMs role has been closely linked to it. In fact the functions allocated to them and those actually carried out by them clearly reflect the impacts of FPP. Before detailing out the changing role of ANMs with changing health scenario and health planning in India, it therefore, becomes essential to peep into the development of FPP in India.

Family planning programme in India:

The government of India has been a powerful proponent of population control. Concern about population growth was felt in India as far back as 1891 when the Census Report invoked Malthus to contend that overpopulation was responsible for Indian poverty. The theme was repeated by subsequent census reports till 1951 and over population was adopted as the cause of India's backwardness particularly in the economic field. The need of birth control to curb population growth was strongly advocated by the All India Women's Conference in 1932 (Raina, 1968). Mukherjee committee in 1938 stated- man who has come to this developed stage has not realized the importance of intelligent breeding. This reflects the prevalence of ideas of Eugenics. It was proposed that due to high population growth a lot of capital in developing countries, which already lack capital, has to be invested in non-productive sectors of the economy. So, consequently capital for productive sectors is limited. Large population growth eats away the productive benefits.

The National Planning Committee of the Indian National Congress, setup in 1938, had strongly supported family planning as a state policy (National Planning Committee, 1949). This environment of awareness throughout the country to check population growth by controlling births led to the launch of a family planning programme as the National Health programme in 1952. The Indian government was the first government in the entire world to do so, and this drive to promote and ensure family planning became stronger year after year.

A review of the first five year plan reflected a conscious and sensible approach to FP since it clearly recognized that there is no relation between the population growth and economic development and that it is not possible to define and accept a concept as 'optimum population'.

The second five-year plan, however, again boosted the FP drive that accepted to control population growth through FP to let the economic development take place.

After the 1961 census, that highlighted the fact that population is growing at high rate, feeling the urgent need to control it in the third five year plan, the objective of stabilizing the growth of population was posited at the very center of planned development (Banerjee, 1971).

By fourth five-year plan, the FPP came to assume highest priority. The increased emphasis on FPP vis-a-vis other health programmes got clearly reflected in the outlays on FP and health during the various five year plans.

Table 2.1.
Plan outlays under various five year plans.

(Rs. in Crores)

Period	Total plan investment outlay (all heads of development)	Health	FW	Sub total
1st plan (1951-56)	1960.0	65.2	0.1	65.3
	(100.0)	(3.3)	(-)	(3.3)
2nd plan (1956-61)	4672.0	140.8	5.0	145.8
	(100.0)	(3.0)	(0.1)	(3.1)
3rd plan (1961-66)	8576.5	225.9	24.9	250.8
	(100.0)	(2.6)	(0.3)	(2.9)
Annual plan (1966-69)	6625.4	140.2	70.4	210.6
	(100.0)	(2.1)	(1.1)	(3.2)
4th plan (1969-74)	15778.8	335.5	278.0	613.5
	(100.0)	(2.1)	(1.8)	(3.9)
5th plan (1974-79)	39426.2	760.8	491.8	1252.6
	(100.0)	(1.9)	(1.2)	(3.2)
6th plan (1980-85)	109291.7	2025.2	1387.0	3412.2
	(100.0)	(1.8)	(1.3)	(3.1)
7th plan (1985-90)	218729.6	3866.8	3120.8	6809.4
	(100.0)	(1.7)	(1.4)	(3.1)
8th plan (1992-97)	434100.0	7582.2	6500.0	14082.2
	(100.0)	(1.7)	(1.5)	(3.2)

Source: Economic Survey 1992-93 & Planning Commission.

In the fifties and in early sixties, following the tradition of the planned parenthood movements of western countries, FP clinics were established in urban and rural areas in India. When, however, it was realized that the outreach of such clinics is very limited and being inspired by the success of the experience of USA in the field of agriculture, the FP adopted an extension education approach. An extension wing was added to FP clinics and extension education staff was added to the programme in 1963. An extension educator (the Block Extension educator) was made available for each of the 5300 blocks. To promote FP a major programme for mass communication was launched around this time. The entire team recruited for this task could not, however, give the desired direction and pace to FP.

In mid sixties the IUD (Intra Uterine Device) was projected as wonder device that could lead to sure success of FPP. The government of India undertook a massive programme to popularize it. At the same time, on recommendations of WHO, MCH was delinked from FP and the FP was separated from health. The IUDs were used on a large scale ignoring the fact they have to be used only in healthy and willing women. These devices were used to eradicate population growth just as any other disease. In 1966-67, around 1 million women were fitted with IUDs. Within a year, in 1967-68, this number fell by 40% and then to 2 lakh in 1968-69 and finally it was just minimally used. Thus, IUD programme had proved to be inadequate. Soon after, the GOI adopted the cafeteria approach under which the FP was made a target-oriented time-bound programme. This involved:

a) offer of monetary incentives to doctors, motivators and acceptors;

b) mobilization of government functionaries belonging to all departments including revenue collection staff for FP work;

c) Exerting administrative pressure of field workers to ensure that they attained certain predetermined FP targets.

However, when this again proved inadequate, the GOI adopted a more severe approach through taking up of the mass vasectomy camp approach in the early 70's (National Institute of FP, 1973). Thousands of sterilization units sprung into action. Dr. Krishan Kumar organised one of the historical vasectomy campaigns. As many as 15000 vasectomies were made in the first month itself and by the end of six months, almost 60000 vasectomies have been done. This was regarded as great achievement. The action was supported by international agencies like World Bank, UNFPA and Swedish fund. Camps were organised at several places to which the people were literally dragged to undergo sterilizations. The health care providers were given targets that had to be met. Such a policy of coercion and meeting the target failed completely because the organization of camps was an expensive process and studies showed that most of the women sterilized were above 45 years of age and had 6 or more children.

While there were 33 million sterilizations in 1972-73 in 1973-74 only 0.94 million sterlizations were reported. Also 6 cases of death due to tetanus owing to improper IUD insertions were reported. The programme managers at that time recognized the need to reorient FPP in favour of reversible methods. Since 1977, FP has been implemented on a voluntary basis completely. The government made the efforts to provide the services and at

the same time has also made efforts to promote people to use these services through IEC campaigns. We learned from the experiences of other countries that in tackling the problems related to population growth, the reproductive age group women and children upto 5 years have a vital role to play and their health must be ensured. This dawn of realization led to the change of Family Planning to Family Welfare. Such programmes were implemented during the seventh plan (1985-90). Universal immunization programme was started in 1985-86. Though these programmes proved to be beneficial yet each of these was identically different and so the desired success could not be achieved. From 1992-93 CSSM was formulated and implemented. Though on a national level much improvement was witnessed in the major health indicators, the success was not uniformly spread over all the states.

However, despite growth in the number of acceptors, birth rate did not decline. This led to a reorientation of the quality of data both on the number of acceptors of different methods of FP and of the demographically driven goals themselves. There was also a mounting concern regarding the quality of the services provided to the people which evolved into a commitment for providing more comprehensive Reproductive and Child Health (RCH) services.

The shift in emphasis was marked by abolition of method-specific family planning targets throughout the country. Several factors had contributed to shift India's government strategy in FPP. It was realized that inspite of all efforts the birth rate has been declining at a slow rate, there is a lack of motivation at all levels in the promotion of FP services. Several of the women's groups and other non-government al organisations have brought forth the fact that the programme so far has totally neglected the felt needs of women. The final thrust was given by International Conference on Population and Development (ICPD) held at Cairo in 1994.

Initially, in April 1995, the secretary to the Department of FW had proposed that one or two districts from each of the major states could be made target free on an experimental basis. The districts selected for this purpose in most states were the best performing district. A year after the government of India took a bold step by taking the decision of making the whole nation target-free.

The Rajasthan government outlined the following reasons for the failure of FPP in the last 40 years in its publication wherein target free approach, as proposed to be adopted from 1996-97, has been explained in detail:

1. The programme implementation has so far mainly focused on the achievements of quantitative targets and has almost neglected the qualitative aspects.
2. Till now the sterilizations have been performed on such clients who already had 3 or more children and were aged over 35 years.
3. Enough attention has not been given to spacing methods. No efforts were made to find out whether the people who have been given some spacing method are actually using them or not.
4. The reasons for comparatively less popularity of spacing methods can be attributed to irregular supply and not ensuring of their correct method of usage.
5. There was inadequate representation of the community in the programme due to which it remained as a governmental programme only and could not take the shape of people's programme.
6. The state's economic and social backwardness.
7. Intense desire for son.
8. Marriage at less age.
9. The illiteracy prevalent in the state particularly among women has been cited as an important reason for the programme failure.
10. Desired level of success could not be achieved in proper integration and implementation of information, education and communication components of the programme.

The target free approach does not imply that now there will be no targets for the health department under the programme. It is rather a 'self-targeted' approach where the programme implementers set targets for themselves after assessing the needs of the population being served or to be served by them. Thus, TFA means that the centrally determined targets, assigned since mid- 1960s are no longer to be the driving force behind the programme' rather now the driving force would be the community's demand for quality services. (MHFW, 1996). Thus, though the policy of fixing targets would be continued, the method for fixing them and the pattern of thinking behind it would get changed.

Thus, this approach envisaged to carry out decentralized planning where the planning begins at the grassroot level, i.e., at SC/PHC where the grassroot workers like ANMs would

set targets for themselves after a survey of the population being served by them. There has been a tremendous and significant change in the health planning because planning at grassroot level by grassroot workers is what is commonly termed as ' bottom -up' approach of planning. This turns the working pattern of entire health machinery upside down. Thus, the flow of control which till now was from National ⇒ State ⇒ District ⇒ Block ⇒ CHC, PHC ⇒SC starts moving in the reverse direction, i.e., from SC ⇒ PHC, CHC ⇒ block ⇒ District ⇒ State ⇒ National Level.

The TFA, as outlined by the Rajasthan government[8], has been proposed to possess the following working pattern.

I. **To determine unmet and met needs through survey:** in order to assess the desire of the community towards FP and for determination of targets by health care providers, yearly surveys will be conducted. Form no. 1 (see **Appendix 3**) will be used for the purpose. The basic information in this regard will be collected by the health care provider at the SC level by collecting information from the eligible couples of their area.

II. **Annual plans:** on the basis of such a survey the health worker will form the annual plan for his SC area and also fix targets for himself. The information as will be send from various SCs under a PHC will then be used to prepare annual action plan for that PHC. Similarly, the information as will be sent from various PHCs to the district will be compiled to prepare district action plan for the coming year. Various forms have been prepared for collection, compilation and analysis of information at these various levels.

III. **Ensuring filling up of 'Seva-Panjika' at SC:** it was noted that seva-panjikas (daily register used to maintain daily work record at SC) is not regularly and properly being maintained by the health worker at SC. This prevents the estimation of progress of the programme regularly. TFA aims to concentrate on this weak aspect of the programme specifically by ensuring filling up of seva-panjika by the HW at SC

[8] Government of Rajasthan (1996), *Parivar Kalyan Karyakram Ke Antergat Swah-Lakshit Pranali, Department of Health and Family Welfare,Jaipur, Rajasthan.*

regularly and take interest in this work. Adequate and proper instructions have been given in the seva-panjika at appropriate places to make the task easy and efficient.

IV. **Determination of required supply:** the survey will also enable the Health Worker (HW) in determining the need for basic facilities and supply of important items like oral pills, condoms, various vaccines and medicines. The maintenance of the required inventory efficiently would ensure regular supply of critical items and would thereby prevent a situation of lack of any item.

V. **Monitoring and evaluation:** under TFA regular and objective monitoring of the programme at each level has been given a priority. To meet this objective in the manual for TFA the responsibilities of HWs at various levels has been outlined. In the given format monthly report has to be sent from each level to its higher level on some fixed date of every month. The provision for field supervision and monthly meetings is also there. For evaluation of the programme beside these reports provision for external and internal evaluations has been kept.

VI. **Maintenance of records:** a register called seva-pustikas will be provided at each SC for recording information on various health services related to Family Welfare (FW). Other registers to be maintained at this level are Out Door Register, Stock Register and Survey Register.

VII. **Implementation of the programme in urban areas:** looking to shortage of manpower to provide health services in urban areas, provision has been kept to provide health services to people of slum areas, Muslim and Harijan Katchi Bastis through establishment of Revamping Centres, Urban Family Welfare Centres, Post Partum Center and ICDS. The ANM will undertake this task on definite days after a survey of the related area.

After the 18 months experience of TFA approach in 1996-97 the health planners came to know that most of the health workers were facing problems in working according to TFA manual and in determining the community's needs through in discussion with the local population. Also the counseling method has not been explained through which the ANM

would set targets for her area. Following problem areas have been identified in the two workshops held in National Family Welfare Organisation on 19th and 27th August, 1997:

1. Almost throughout the country monthly report from PHCs, ANMs and District Medical Officers is not being received. In the workshops these workers told that according to TFA 's manual a number of forms need to be filled and in each of these much detailed information is to be recorded that is not practically feasible at ANM's and the PHC levels.
2. The procedure of counseling and consultation with the local people through which the felt needs related to family planning were proposed to be assessed, has not been outlined. Therefore, the aim of activating the local consultation procedure has remained unachieved.
3. Many things included in this manual have not been found relevant to TFA's implementation.

The above review formed the basis of modifications proposed to be done in TFA manual. These have been outlined as follows:

a) Proper arrangement to be made for determination of targets related to reproductive health and birth prevention methods in consultation with the local population and all other related works should be based on this.

b) The forms that have to be used to collect information should be less in number and only that much information should be asked in each as is relevant and possible at that level.

In the following month of September, this change in the strategy was appreciated in the meetings of State Governments Secretaries. At this point of time the TFA was renamed as Community Need Assessment Approach (CNA)[9]. This manual has highlighted the fact that ANM has the most important role to play in family planning programme and that the success of the programme largely draws from her performance. This manual has detailed out what a good ANM is expected to do, how she has to counsel people to promote family planning. The works to be carried out at each institutional level under this programme have been outlined and at each level the various forms have been reduced in number and have been simplified. In particular the male health worker has been presented to help the ANM in

[9] MHFW (1998), *Samudaik Avyashakta Nirdharan Niti Pustika,* Department of Family Welfare, GOI, New Delhi.

immunization, distribution of ORS packets, detecting and treating ARI, counseling for sterlizations and in condom distribution.

Linkages between ANMs' responsibilities and FPP

As already stated right from the 1st planning period, ANMs functions have been closely associated with FPP. The pressure on them to check population growth by controlling birth rate though through implementing and popularizing FP methods among the population they are to serve has always been there.

During the adoption of target bound approach/camp approach they were given 'do or die targets' for FPP. After it was realized that FP cannot be forced on people but it has to be accepted willingly and that in absence of a basic health infrastructure and success of FP cannot happen without the amelioration of all over health and living condition of people, since 1960s attempts were made by the Indian government to integrate FPP with other programmes such as Minimum Needs (MN), MCH and CSSM. An effort to link family welfare and primary health care was made with steps to alleviate poverty in the country, to reduce infant and child mortality by providing immunization against various preventable diseases to all children and to decrease mortality through emergency obstetric support. Despite these efforts of integration the demographically driven goals for reducing the birth rate and consequently, the rate of population growth have continued to dominate its monitoring and assessment. (Leela Visaria & Vimala Ramchandran, 1999).

The TFA in 1996 has been launched to remove the stringent targets that have been indicated to block the success of the programme. As written earlier the approach proposed to bring about decentralization whereby the ANMs are to prepare work plans for themselves depending upon the data collected by them through various daily, weekly and monthly reports and the annual survey of eligible couples that will reflect the people's needs. An evaluation of the approach in 1997-98, as indicated while discussing CNA, revealed serious flaws in this otherwise well designed strategy after which it has been modified and renamed as Community Needs Assessment Approach (CNA). It has not been implemented in all the states of India out of which Rajasthan is one.

The ANM has a major role in the health information system. The basic data that will form the basis of formulation of various health policies and health programmes gets collected

at the primary level by the ANMs. Thus, the process by which data is collected, what data is collected and in what form, what are the sources from which the data is collected, the extent to which the data reflects the health needs of the people, how it will be analyzed and presented, the process of transfer from one level to another and the acceptance of data on face value or extent of manipulation done are various issues which demand exploration. The present study would examine the process of data collection for the HIS by attempting the content analysis of the main forms and on the basis of the discussions held with the concerned district level health officials. It would also explore the perception of problem faced by ANMs in this process.

In the following section of this chapter, some of the available literatures relevant for this study will be reviewed.

Review of Literature:

Available literature on health systems in India shows a progressive increase in the studies on health delivery system. Various dimensions and sub components of health service delivery system have been getting the attention of the researchers. However, exclusive studies on, the grass root level functionaries particularly on ANM, are quite less in number. The available literature on ANMs is not only scanty but also does not present a comprehensive picture of ANMs' work and related issues.

Most of the studies on ANMs have concentrated only on one or a few aspects of ANM as a part of health service delivery system. Some of these studies have attempted to assess their performance by measuring their activities with time as variable and others have discussed their performance in some programme like MCH and FP. There are only one or two comprehensive studies on ANMs which have addressed the issues like ANM's performance against her socio-economic background, the social structure of the village where she works, people's perception of ANMs' work, the organisational factors that affect and control the role performance of ANM. Furthermore, there are only few studies, which have analyzed the ANM's perceptions about her work, people's perceptions about the ANM and her work and supervisors' perceptions of ANMs' role. In a few studies ANM's role in health information system has also been discussed (like record maintenance by the ANM, the type and frequency of register maintenance). However, comprehensive study or detailed research on ANM's role in the health information system is lacking throughout.

The available literatures on the ANM's role in health service delivery system can be studied under the following headings: -

1. Type and Number of activities performed by ANM.
2. Time allocation for various activities
3. Training and role performance
4. Factors responsible for differential performance
    - Organizational factors
    - Socio-economic factors
    - Individual factors
5. ANM & the health information system
6. Changes in ANMs role under different approaches of health service delivery

7. Perception of ANMs' role by her supervisors or by the community

1. Types and Number of activities performed by ANM

Among the studies, which have analyzed the ANM's activity profile, Reid[1] carried out the earliest one in 1967. The ANMs choosen for the study were from three states of India- Haryana, Punjab and Gujarat The methodology included time activity observations as well as interviewing. The main activities carried out by the ANMs were found to be:

- 50 percent gave advice concerning need for regular Ante Natal Care (ANC) check-ups and diet
- 70 percent of the ANMs gave advice for proper diet during ANC
- 40 percent gave advice on home environmental condition
- the FP advice was given only to 20-30 % of maternity contacts in Haryana and Punjab and 47% in Gujarat.

A similar study undertaken by John E. Sarojini[2] at one PHC in Chhani village of Gujarat gave some different results compared to the Reid's study. A sample of 9 ANMs who have been working in that PHC for more than one year was drawn for this study. The researcher mainly looked into MCH and FP services. He further identified 5 important areas as important health care services given by ANMs. These were:

- Antenatal care (ANC)
- Intra natal
- Post Natal Care (PNC)
- Child care from birth upto 3 years
- Family planning

The data was collected using observation schedule that was supplemented by record analysis sheet to increase the reliability of data. A four point rating scale was used to grade the performance of ANMs in the degree of excellent to poor. The quality of health care was also categorised as satisfactory and unsatisfactory. The findings indicated that PNC was unsatisfactorily performed. Though registration of all children delivered was done for health

[1] Reid M.,(1969), *A Study of the Activities of Auxiliary Nurse Midwives in Haryana, Punjab and Gujarat States*, WHO Regional Office for South East Asia, New Delhi.
[2] Sarojini John E., (1976), *A Study to Evaluate Health Care given by ANMs working in Selected Primary Health Centres, Chhani in the state of Gujarat*, Rajkumar Amrit Kaur College of Nursing, University of Delhi.

supervision and direct care, ANMs were not properly evaluating growth & development of children. The regular medical check-ups and health education to families was also unsatisfactory. It was found that the work related to FP was most satisfactorily performed. The study pointed out that the ANMs were not well aware or rather they did not give enough importance to essential immunisations and were unable to identify delivery complications and other conditions, which usually result into high MMR and IMR.

PNC, the poorly performed activity (as reflected in the above-mentioned study) was further studied by Savithrimine[3] in Karnataka state. The researcher used observation checklists to collect data regarding the services that were provided to mothers and children by ANM. The study findings showed that ANMs performance was high in areas of maintaining records and giving nutrition advice but low in case of primary care and identifying vital signs.

Dutta D[4] in 1986 had done a study in the Burdwan district of West Bengal in which he had studied the various tasks under MCH with time as a variable. One upgraded PHC was selected for the study. The tool used was case study. It was found that though all workers performed all the tasks, the time varied. A large part of the total time (44.06%) was being spent on non-productive work. The study also pointed out some major problems that are responsible for poor or non-performance of activities by ANM as desired. These included lack of clarity in their assigned job responsibilities, inadequacy of facilities available to them, inadequate training and communication gap. The study emphasises on the quality of activities delivered by an ANM rather than on their number

Gupta and Sood (1993) analyzed the working of health workers (male and female). The knowledge of correct presumptive treatment for malaria was not known to most of the workers. As regards the radical treatment, its knowledge was found in much greater percentage of male workers (62.5%) as compared to the female workers (13.3%). The female workers were also reported as having poor knowledge about screening of women for oral pills and handling of side effects caused from their usage. They were also found to be inadequately trained for taking care of side effects of IUD insertions. The record maintenance was also a weak area of these workers.

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[3] Savithrimine B., (1979), *A Study of Postnatal Care as Given by ANMs during Home Visits in PHCs in Karnataka State*, Unpublished Master of Nursing Thesis, University of Delhi.

[4] Dutta K., (1985), *A Study of the Opinion of Female Multipurpose Workers Employed in West Bengal Health Services on Performance of the tasks laid down by Ministry of Health & Family Welfare*, Unpublished Master of Nursing Thesis, University of Delhi.

A thesis work by Sangeeta Narang[5] was carried out in 1996 on the functioning of the health care providers in a rural area. The female health functionaries have been reported to possess adequate knowledge regarding ANC while the male workers knowledge in this respect was found confined only to TT immunisations. However, performance of child survival and safe motherhood programme (CSSM) tasks were not being properly performed. With regard to ANC particularly the general physical and abdominal examinations, pulse and BP monitoring, measuring height and weight, foetal monitoring, conducting haemoglobin and urine tests were reported to be not being performed. The performance of the workers was unsatisfactory to such an extent that the analysis of the interviews with ANC mothers in this study recorded that all of them were planned to have the village 'Dai' attend their deliveries as the health workers were not available most of the times.

Rita Gawari's[6] (1999) study has blamed the health care providers of the grass root level for having a casual attitude to natal care. This gets coupled with the less importance attached to women's health by the community to explain why nearly half the women are not being provided with ANC and PNC services even in one of the most progressive districts of Haryana.

An evaluative study in 1990 by the Rural Health Division of DGHS, MHFW, Govt. of India (GOI) was carried out regarding the functioning of ANMs School[7]. Besides commenting on the ANMs schools, it touched upon the health services delivered by the ANMs. The working knowledge of ANMs in administering vaccines and identifying complications during pregnancy was found to be far below satisfactory. The most satisfactorily delivered services were found to be those related to family planning.

2. Training and role performance of an ANM

A strong link between the training and the performance level of functionaries is well proved in various studies. Some of the above reviewed studies have commented on the training of ANMs and there are few others that have exclusively concentrated on this aspect.

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[5] Narang Dr. Sangeeta, (1996), *A Study of Health Care Providers and their Functioning in a Rural Area*, Unpublished Thesis Submitted to Faculty of Medical Sciences, University of Delhi, New Delhi.
[6] Gawari Rita, (1999), *Need for Quality of care in women Health,* Population Research Centre, Punjab University, Chandigarh.
[7] MHFW, (1990), *Evaluation Study of the Functioning of the ANM School*, Rural Health Division DGHS, MHFW, GOI, Nirman Bhawan, New Delhi.

Reid[8] having found a wide gap between the training imparted to ANMs and the functions being performed by them in the field has suggested to modify the curriculum so that it leads to adequate preparation of the ANMs. He also mentions the need to identify the criteria for determining workload on ANMs and to consider the 'consumer demands' or the people's need in such a modification.

An evaluative study of family welfare services was undertaken by ICMR in 1991, a total of 1089 ANMs were observed in the field for this purpose. The administration of ANC was limited to giving to and distribution of iron folic acid tablets. Most of the deliveries were taking place at home. The delivery kit was not available with more than half of the ANMs. The procedure of conducting deliveries was satisfactorily performed by 50-60% of the ANMs, however, ensuring aseptic environment and monitoring vital signs was being done only by a small percentage of them. The PNC services were overall reported to be satisfactory in all the states of India except Assam. Neo natal care was limited to "feeding practices" and "cord care" and childcare was centered around immunization only.

In 1970 the training division of the Department of Health and Family Planning, MHFW[9], a government of India conducted a survey of 183 ANM schools to study the adequacy of ANM training programme in the light of the recommendations made by Reid. The study found that the most neglected part in the various courses taught/ studied was the stress on experience in the community that was outlined as the minimum requirement by the Indian Nursing Council. It recommended and stressed the community nursing experience for all ANM students and that a national study of the functions and the role of ANM should be undertaken as soon as possible.

John E. Sarojini[10] had also emphasized that the ANMs role need to be strengthened through review of the curriculum from time to time so as to make them capable enough to deal with all the field situations.

The evaluative study of the functioning of ANM's school by the rural health division[11] in 1990 was done with the aims of the evaluative study of the functioning of ANMs schools

[8] Reid, as per footnote 1, page 34.
[9] MHFW, (1972), *Survey of Auxiliary Nurse Midwife Training Programme,* Training Division, MHFW, Department of Family Planning, New Delhi.
[10] Sarojini John E, as per footnote 2, page 34.
[11] MHFW, as per footnote 7, Page 37.

consisted of identifying facilities available to ANMs in training schools, to assess the quality of training, to assess the extent of knowledge of teachers, students and ANMs on various areas, to identify the problems in ANM schools and suggest means by which quality of training programmes can be improved. The study used observation and interview as tools for data collection from the selected teachers, students and working ANMs. The findings indicated gross inadequacy of infrastructural buildings, furniture, essential vaccine carriers, etc. A lack of books in regional language was reported. Funds were found to be inadequate and supervision was not being done regularly. Some important areas as close association with Dais and VHGs was not properly stressed in training programmes.

Karthyani's[12] has interviewed the ANMs to gather information on their perception regarding the effectiveness of their training programme in service. The responses of ANMs were not in tune with those of LHVs. Only 1/3rd of ANMs felt that they knew their role well and a majority of them felt that their training was inadequate for the roles they are expected to perform. The author concluded that the roles to be performed by the ANMs as expected by the administration are difficult to achieve in real field situations owing to the fact of large population that ANM is aimed to serve. He stressed the need to bridge gap between the health department and the community's expectations of an ANM by thorough investigations.

In this respect a committee on MPWs under the Health and Family Planning[13] in 1973 had stated that emphasis should be placed in the fifth five year plan for increasing the training facilities for female health workers (ANMs), their curriculum to be made more practical and job oriented and their performance be evaluated from time to time. The study emphasized that the ANM's role need to be strengthened through review of the curriculum from time to time so as to make them capable enough to deal with all the field situations.

A mismatch in the responsibilities assigned to the ANMs and their training courses particularly with respect to MTP and RTI has been reported in a study conducted in Gujarat

[12] Karthyani P. K., (1971), *Effectiveness of Auxiliary Nurse Midwife Training Programme as Perceived by the Supervisors and Qualified Auxiliary Nurse Midwives in Service*, Department of Family Planning, MHFW, New Delhi.

[13] GOI (1973), *Report of the committee on Multipurpose workers under Health and Family Planning Programmes,* Department of Health and Family Planning, MIHFW, New Delhi.

and Rajasthan[14]. The services of the qualified people available were found to be underutilized. The ANMs training did not cover the entire range of services that they were to deliver.

The Directorate of Public Health and Family Welfare[15], Bhopal in 1994 carried out the evaluation of the IPP-VI project. This project was launched in 1991 with the aid of the World Bank with the aim of imparting in-service training to the health functionaries working at PHCs, SCs, and urban family welfare centres in the state so as to upgrade their knowledge and skills. Among the various categories of staff who had received training from August 1991 to March 1993, the Multipurpose Workers (Female) were one. The study found the highest percentage of ANMs were reported to be married, above 30 years of age, Hindu and were matriculates. The average period of experience was of 5 years and they used to cover around 4000 population and 4 villages.

3. ANMs' performance

Prakasamma undertook a comprehensive study on ANMs[16] in 1989 in the Nizamabad district of Andhra Pradesh. Prakasamma studied and analyzed the various factors that influence the performance of ANMs. The influencing factors are mainly of three categories- individual like background of ANMs, organizational like relationships between ANMs and other staff members and social like acceptance by villagers. The researcher analyzed the ANMs' performance against the fact that she is a woman and her female status and role within the society influences her performance.

The study sample consisted of 30 ANMs, 5 from each 6 PHCs through random sampling. In addition to interviewing ANMs, their supervisors and other health related persons and the community people and village leaders were also included. The study was multidimensional in nature being both qualitative and quantitative in nature. The study found that the maximum number of ANMs (70%) show medium performance that is neither too bad nor too good. Due to constraints of time and transport ANM was found unable to do all the eleven functions that have been outlined for MPW and cover the entire population under

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[14] Kapoor Indu, Patel Pallavi, Esmail Selena and the Chetna team, *Survey of 10 PHCs in Gujarat and Rajasthan*, IIHMR, Jaipur, Rajasthan.

[15] Operations Research Group, (1994), *Evaluation of Health Functionary Training Programme in Madhya Pradesh (IPP-VI Project)*, Study undertaken for Directorate of Public Health and Family Welfare, Bhopal, Madhya Pradesh, Baroda.

[16] Prakasamma, (1989), *Analysis of Factors Influencing Performance of ANM in Nizamabad District,* Unpublished Thesis submitted to the Centre for Social Medicine And Community Health, JNU, New Delhi.

them. The ANMs concentrated mainly on three functions- FP, immunization and MCH with FP. Moreover, within these functions also there was selective coverage- doing only some out of the total activities meant to be carried out under these functions. In MCH the Post Natal Care was found to be most neglected; the tubectomies dominated all other forms of FP methods and TT, DPT and polio were given precedence over all other vaccines. This was the period when ANMs were pressurised to achieve FP targets, failing which they would be rebuked, transferred and their salary cut. The author has stated that in most of the functions, the quality and quantity of performance were sacrificed for achievement of FP targets.

The need for this study as explained by the researcher arose owing to the crucial role the ANMs play in health service system, their changing role from a midwife assisting in delivery to the ANM providing MCH services and then to a multipurpose worker, the fact that her performance is influenced by many factors. The ANMs were found to be facing problems with record keeping owing mainly to two factors- organizational priorities and lack of knowledge and skill.

The study found the health organization and the PHC within it were responsible for the low performance of ANMs in conducting clinics by not providing the necessary facilities and place for clinics and the poor supervision and guidance for clinic activities. The ANMs were not provided with adequate facilities to conduct clinics and attend to common ailments that were the most frequent problems of the people they served. Due to inability to do so they were less popular among the people as compared to the PMPs (Private Medical Practitioners). Their personal lives were getting disturbed due to irregular working hours and nature of work. They were not able to devote much time to their families and husbands and a number of ANMs were having strained relationships with their husbands. The study clearly pointed out that sheer burden of work and disruption of personal life resulted in low performance and low morale, loss of interest to take initiative and made them work for immediate results in specific areas.

The schedule used in Reid's[17] study also consisted of questions inquiring about ANMs attitudes towards their present posts. Analysis of the answers revealed that though none of the ANMs disliked her job yet more than 50 percent were unhappy either with the place of posting or the accommodation given to them.

[17] Reid M, as per footnote 1, Page 34.

The lack of proper infrastructural facilities, accommodation and transport facilities have been again and again pointed out as being a major hindrance in the work of the grassroot workers in the rural areas particularly in the case of ANMs. Reid's study pointed out the ANMs' dislikeness and unhappiness arousing either due to her place of posting or the accommodation given to them. The inadequacy of such facilities in case of training schools has already been indicated in studies evaluating the training programmes of ANMs. Prakasamma's work clearly showed gross inadequacies of medicines for common ailments, basic equipments required for effective functioning of the ANMs and lack of infrastructural and accommodation facilities for ANMs which had been reported to be responsible for loss of faith of people in the ANMs and their drifting away towards the Private Medical Practitioners (PMPs).

The findings of a study undertaken to assess the quality of RCH services and the overall primary health care system in six districts of Gujarat and Rajasthan[18] indicated that in many cases the PHCs were located more than 5 km away from the villages they were to serve; some were even upto 60 km distant. Due to improper roads, particularly in case of Rajasthan where there are unpaved, dirt roads, and owing to the lack of transport facilities, the health services were not within the reach of the people. Per PHC population coverage was also not according to the suggested primary health care norm. In most of the cases it exceeded the limit of 30,000 making it beyond the capacity of the health care providers at the PHCs to provide health care services at people's homes.

The poor and inadequate infrastructural facilities as drinking water, toilets, residential quarters for health workers at or near the PHCs, basic medical equipment as sterlizers and refrigerators to store vaccines etc. were also pointed out as limiting the reach, quality and range of the health care system. The drugs available at the PHCs were inadequate and many a times found to be of expiry date. The patients in such cases were compelled to buy fresh drugs from the market from their pocket. The IEC material were lacking or not in functional and purposeful state.

As regards the staff availability and competence serious gaps were found. Many important posts were lying vacant or not sanctioned. The ANMs were not living at the sub-centres due to lack of improper or a total lack of quarters and other infrastructural facilities

[18] Kapoor Indu, Patel Pallavi, Esmail Selena and the Chetna team, as per footnote 14, page 39.

and danger to their personal safety. Due to this they are not available regularly and were of no use during emergencies.

The non-stay of health workers (female) was reiterated in the Sangeeta Narang's[19] work. This as written by the researcher is an opposite finding to the one given by Gupta et. al. for according to them more than 45 percent of female workers were reported to be residing in their respective sub center villages. The other main difficulty faced by therm was the non-availability of transport facilities.

A comparative study of doctors and nurses working in the complex organizations instead of the pursuing private practice was taken up by T. K. Oomen[20] from a sociological point of view. The objective of the study was to understand the impact of the change from individual working environment to organizational environment on these professionals. A sample of 1022 doctors and nurses located in ten public hospitals in Delhi was choosen. They were interviewed and direct observations of their activities were undertaken over a period of 4 years. The researcher had studied the role performance by these professionals in the social structure in which they get placed and to which they belong. In case of nurses it was found that they were mostly Christians and generally hail from Kerala. The factors barring entry of nurses was due to the concept of consideration of nursing profession as ritually unclean in case of Hindus and low prestige associated with this profession generally owing to the fact that the nurses have to handle male patients. The researcher analyzed that these nurses have taken up this profession as they need to do some service and with their low middle class background they are able to afford the nursing education that is imparted free and for which they do not require high qualifications. This was also a way to move up in the social hierarchy for them. The nurses were reported to be less committed to their work and maximum of them did not opine their daughters to take up this profession, as they do not regard it as being prestigious.

[19] Narang Sangeeta, as per footnote 5, page 36.
[20] Oomen T. K., (1978), *Doctors and Nurses: A Study in Occupational Role Structures*, The Delhi School of Social Work, New Delhi.

4. ANMs role in health information system

The issues related to the reporting and recording work done by ANMs and their supervision based on this has been taken up superficially in some studies. Karthayani[21] recognized that the registration of all children delivered was being done by all the ANMs.

Sunil Kumar Narula[22] studied the prevailing surveillance system for Vaccine Preventable Diseases (VPD) in Faridabad district of Haryana in 1991. The researcher found that the responsibility of collecting data and reporting of VPDs as well as maintenance of relevant records was placed on health workers and health supervisors. Though they were reported to be well aware of all 6 VPDs, the major emphasis was placed on poliomyelitis only and as such information on other VPDs was missing. Reporting was not proper and reflected the need for training in this area of the health workers. The study recommended to adequately train the health worker and health supervisors, to encourage them to report even the untoward reactions of the people after immunization and to make available spot maps at the block to provide current geographical location of cases of VPDs for taking timely and appropriate action.

Field reflections recorded by Leela Visaria & Pravin Visaria[23] show that since the new TFA the workload for grassroot health workers is done through an improved version of the former eligible couple register. The method of information collection is found to vary for Rajasthan and Tamil Nadu. In Rajasthan survey format designed by IIHMR, Jaipur is being used to collect information on the unmet needs and other ancillary characteristics.

In case of Tamil Nadu district specific estimate of the current BR (based on 1995 survey with a sample large enough to provide district level estimates) was applied to the SC population covered by the village HW to arrive at the number of births likely to take place in her area. This provided a basis for the number of pregnancies that the health workers would have to register in a year.

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[21] Karthyani, as per footnote 12, page 38.
[22] Narula Sunil Kumar, (1991), *Study of Surveillance System for Vaccine Preventable Diseases in a District,* Thesis submitted to the Department of Community Health Administration, University of Delhi, New Delhi.
[23] Visaria Leela & Pravin, (1998), *Health Watch Case Study: Rajasthan & Tamil Nadu,* IIHMR, Jaipur, Rajasthan, pp. 108-42.

In both cases the so calculated workload gets translated into annual targets for the grassroot HW. This method is called the 'client segmentation method'. Regarding record keeping it is found that the health workers' involvement in the whole process remains minimal. The health workers in both the states have not been able to appreciate record keeping and report following problems:

i. Record keeping leaves no time for a fieldwork.
ii. TFA has increased the number of registers and causes a lot of duplication.
iii. Are not able to handle the paperwork and have to seek help of other people.
iv. The information we collect is not relevant for a task or help in our working.

Prakasamma's[24] study found the ANMs to be facing problems with record keeping owing mainly to two factors- organizational priorities and lack of knowledge and skill. In terms of data collection, the study reports that the entire male population except for children below 5 years of age (covered for immunization) was left out. Among females only those in the age group of 15-45 year age group were being covered and in this partial coverage also only the pregnant ones were getting served with emphasis on those who were willing to undergo operation.

5. Changes in ANM's role under different approaches of health service delivery

There have been certain studies that have evaluated and analyzed the changing scenario of the health care service system since the introduction of TFA/ CNA approach. Leela Visaria and Pravin Visaria[25] have reviewed the extent to which the central elements of the Programme of Action as tabled in the ICPD conference have got translated into action. This study was carried out in two states of India- Tamil Nadu and Rajasthan. This was a qualitative study that involved discussions with district level officers and focus group discussions and in-depth interviews with the health workers and with the clients at PHC and SC levels. The important issues explored by the study are the way the workload of the health workers the programmes' responsiveness to the needs of the clients and the improvement in the range and quality of services.

[24] Prakasamma, as per footnote 16, page 39.
[25] Visaria Leela & Pravin, (1998), *Health Watch Case Study: Rajasthan & Tamil Nadu*, IIHMR, Jaipur, Rajasthan, pp. 108-42.

The study notes that the introduction of TFA has been able to bring improvement in all fields of MCH and FP services. The work pressure on the health workers to achieve the targets has reduced considerably. No longer are the people forced to undergo sterilization but rather they are explained about different methods of FP and their plus and minus points. The pace of improvement was noted to be much slower for Rajasthan is compared to Tamil Nadu. The services of MTP and RTI however, were not available in either case.

Another similar kind of study was undertaken in Gujarat by the Lok Swasthya Sewa Co-operative and SEWA in Ahmedabad and Anand Districts[26]. The performance of ANMs was reported to be low and according to the women interviewed there has been no remarkable improvements observable in their work. The mode of functioning of PHC is reported to be unsuitable for their need even after the proposed improvements since TFA.

The ICPD as being the main thrust force behind the TFA and CNA approaches in India has been reiterated in yet another research paper by P. Hanumantha et. al.[27] the evaluation of changes since then has been done with the caution that it may be too early to make any generalizations at this stage. However, it has succeeded in bringing forth certain patterns. The sudden strategical shift in the family planning programme's strategy resulted in confusion at all levels. The less time of its introduction has not given enough time to the health personnel to be able to prepare themselves leading to lack of clarity among them regarding the new approach. The misunderstanding on their part caused the performance of the FPP to dip low in the first year of TFA. The quality of services also did not show signs of improvement. The study estimated that realization of RCH services calls for heavy investments of resources- both physical and human.

C.V.S. Prasad[28] has done similar review of TFA/ CNA in the state of Gujarat. The data was generated through in-depth discussions with the concerned officials at the state and district levels, DGOs, MOs and paramedical staff in two selected districts of the state. The completion of first round of training having been completed in the state has not been found

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[26] Chatterji Mirai, (1998), *Community Needs Based Reproductive and Child Health* , Health Watch Case Study- Gujarat, SEWA, Ahamedabad, pp. 33-44.

[27] Rayappa P. Hanumantha, Reddy M. Rama, K. N. M. Raju, (1999), *Target Free Approach in Family Welfare: Indian Experience*, Paper Presented at XXII Annual Conference of Indian Association for The Study of Population, March 1999, West Bengal.

[28] Prasad C. V. S., (1999), *A Review of TFA/ CNA Approach & RCH Programme in the State of Gujarat,* Paper Submitted to the Policy Project, The Futures Group, New Delhi.

to make the ANMs particularly at the grassroot level confident in calculating workload and setting up their own targets; they need frequent assistance from their supervisor's. With particular reference to RCH services the study notes that the paradigm shift in the policy has yet to get percolated down to the grassroot level even after almost three years. The main factor responsible for this is found to be the lack of necessary skills and comprehension on the part of the SC staff the only solution to which is seen in organising frequent in-service trainings for them. The study founds that the transfer of information regarding policy changes taking place at the national and state level gets delayed in reaching to the staff at the implementation level.

An in-depth study to assess the quality of RCH services and the overall primary health care system was carried out in six districts of Gujarat and Rajasthan[29]. To be able to understand and analyze the situation from all perspectives interviews of health care providers as well as the community people were conducted. Besides interviews on-site observations as well as personal interviews with the selected village members were also carried out. Commenting on the TFA the authors say that lack of knowledge among the workers regarding the basic philosophy of RCH programme has been a large hurdle in the success of the programme. The ANMs have been reported to say that targets are still to be achieved; the source of such targets is questionable.

Among the suggestions the need to involve men and make them feel and take up the responsibility of contraception has been clearly spelt out. The need to modify ANMs training programme so as to bring conceptual clarity with respect to TFA (renamed as CNA) and in order to incorporate changes in family planning services as per RCH guidelines.

6. Perception of ANMs' role by her supervisors or by the community

Karthyani[30] did a study to assess the role performance by ANMs as perceived by her immediate supervisors. The study was conducted in Orissa and included 7 LHVs and 20 ANMs in the sample choosen for the study. The tools used were a checklist and an interview schedule. The checklist was used for grading performance of ANMs in 3 areas - nursing, community health and family planning by the LHVs. According to LHVs ANMs were performing the tasks as checking the fever, giving health education and testing urine quite

[29] Kapoor Indu, Patel Pallavi, Esmail Selena and the Chetna team, as per footnote 14, page 39.

[30] Karthayani P.K, as per footnote 12, page 38.

satisfactorily. Also she was stated to be competent enough in giving vaccination and other medications and was handling the task of providing family planning advice and distributing contraceptives equally well.

The perceptions of the community towards an ANM were studied by Tavenner[31] in late 1970 in a village of Bihar. During that time the health situation in the state was pathetic. In the village choosen for the study ANM was the only medical personnel to cater to the health needs of the people as nearest doctor was almost 3 miles away and that too was a male doctor and also because there was no transportation available. The sample consisted of respondents from three neighbouring villages each of which was close to SC, where more than 1 ANM was posted and that was situated in a remote area. The interview schedule having structured as well as unstructured questions was used to interview the respondents. Conclusions were based on interpretations of data both with the help of descriptive as well as inferential statistics. The findings of the study show that villagers do not attach much importance to ANMs caste, religion and her living in the village. They wanted her to be knowledgeable and competent and to be available whenever they need her. They neither preferred very young ANMs nor too old as to be lethargic. A high moral conduct was expected of her. They wanted her to be married and live with her family or else with some Dai. All other living arrangements were not appreciated. They expected her to deliver the ANC services at their homes. Not much importance was attached to PNC or collection of vital statistics. She was not supposed to give FP advice to men. The villagers regarded ANM with respect and were concerned about her safety. The findings of this study presented a contradiction to the panel of experts then appointed by the government that was entitled to revise the ANM syllabus.

Ashok Kumar[32] undertook evaluation of the monitoring system for selected National Health Programmes in a district of Haryana. The sample study population comprised of District Programme Officers, Senior Medical Officers, Medical Officers, Health Assistant, health workers, Anganwadi workers, Dai and beneficiaries using services of sub centres

[31] Tavenner Jerome M. (Sister), (1973), *Study of role Expectation for the Auxiliary Nurse Midwife as Perceived by a Group of Villagers in Bihar*, Unpublished Thesis submitted to Rajkumari Amrit Kaur College of Nursing, University of Delhi, New Delhi.

[31] Kumar Dr. Ashok, (1997), *A Study of the Existing Monitoring System for Select National Health Programmes and to suggest Monitoring indicators for these Programmes in a District*, Unpublished Thesis to the Faculty of Medical Sciences, University of Delhi, New Delhi.

through the multistage simple random selection. The health workers (female) were reported to be attending most of the meetings of ICDS and MSS. According to these workers said that the monthly meetings are mainly meant for submitting reports and collection of their salaries. The supervisor's visits were not many as will be desirable and their main supervision area has been mostly concerned with FP achievements and malaria work and they have been of not much help to the workers. A large percentage of female workers felt that maintenance records was time consuming with little contribution from health workers (male), there has been duplication in information being recorded and they experience procedural difficulties in completing their records.

The review of the available literature as done above clearly shows that the studies conducted so far have mainly been quantitative in nature. Most of them have assessed activity performance of the ANMs against time. Also the main concentration had been on a few activities like MCH and FP. An exploration into the various factors that may explain the non-performance of all or some of the activities has rarely been done. The most comprehensive study in this context had been carried out by Prakasamma, but that was in 1978. However, in the contemporary time such studies are totally lacking. Thus a qualitative study on ANMs and their functioning within the health service delivery system is being undertaken.

CHAPTER 3

CHAPTER III
ANALYSIS AND DISCUSSION

The finding of the study will be discussed under three different heads given according to the objectives of the study: The analysis and discussion will be done along with the findings itself.

(A) Socio Economic Profile of ANMs

Education and training

The in-depth interview conducted with the Principal of ANMs' training college at Amarsar in Jaipur District gave insights into the pattern of training programme of ANMs, qualifications required for applying for it and the changes in it overtime. Till 1968 the training period was of 10 months. Midwifery was almost exclusively taught. The clinical work was taught in a period of 1 month. 8th class pass candidates were eligible for undergoing this course. After training they were appointed in Post Natal Centres (PP). During this time period a candidate who had done Diploma in General Nursing was given appointment as LHV.

The change in this pattern took place in 1970 (for 2 years in between from 1968-70 there was no batch) when training period was extended to 2 years broken down into 3 semesters. Besides teaching midwifery for 1 year, other subjects were also taught. These included Anatomy, Sociology, Chemistry, Physics, Nutrition, Hygiene, Pharmacology, Microbiology, Medicine, Psychiatric Medicine, etc. The minimum qualification required for the candidates applying for it however did not change (8th pass). This type of training pattern continued till 1986. The candidates successfully completing the training till this period were designated as ANMs.

After 1986 the training period was once again shortened to 1-½ years but the qualification required for this course was raised to 10th class. The designation of an ANM from now on changed to 'Female Health Worker'. The PHN gave information about the current syllabus of ANMs' training course. It broadly consists of 12 subjects: (1) Anatomy & Physiology (2) Midwifery (3) Nutrition (4) Community Health (5) Paediatrics (6) Family Planning (7) Psychology (8) Medicine (9) Sociology (10) Nursing (11) Medicine (12) Supervision. Fieldwork is particularly being stressed now. For one whole month the participants in a concluding batch are taken to the field and given practical training.

according to the currently followed system of ANMs training of 1½ year. The latter are the ones who have received the training of fieldwork also.

It is interesting to note that out of those who have undergone training during the period of 1970-86, when only a minimum qualification of 8th class passed was required to apply for an ANMs job, most of them were having the qualification of 10th or 12th passed. Also the entering of 4 ANMs with over qualification for this post is a matter to be explored. Since this issue is linked to many other factors, an analysis of it will be done along with or at the end of the analysis of other aspects studied in the present research work.

Religion/Castes of ANMs and Reason for Their Entering into This Profession

A look at the breakup of ANMs included in this study reveals a very interesting fact that most of them are Hindus. Further, out of these most of the ANMs belong to generally termed clean and higher castes such as Brahmin. Out of total 27 respondents including LHVs, 6 are Christian and rest are Hindus. Among Hindus 8 are Brahmin. These figures indicate a conspicuous change in the trend from what T. K. Oomen had observed in the late 1970s. He had found an over representation of Christians among the semi-professional job of nursing. The main reason cited by him to explain such a trend was the consideration of nursing profession as 'ritually unclean'. The other major reason was stated to be the low prestige associated with this profession due to the requirement of nurses to deal with the male patients also. He had explained that since such norms and values were prevalent among the Hindus and not in the Christians, so the latter community did not feel any kind of socio-religious interference in adopting such a profession.

Although these are not one to one comparisons, as T.K.Oomen had talked about the nurses; who were working in hospitals and were well qualified for their job; while this study deals with ANMs who are less qualified than nurses and whose mode of functioning is quite different as compared to nurses; the trend is socially important. It rather assumes greater importance because the ANMs job is placed at a level lower than that of nurses and they have to work in fields instead of doing a daily duty of fixed timings in the hospitals or clinics or other medical institutions. Thus according to T.K. Oomen's theory of ' ritual purity' low prestige of the job is a hindering factor in allowing the entry of women from clean and high castes into the job of an ANM should be more applicable in this context For the possible and plausible reasons for this difference we need to go into the socio-cultural and economic background of the ANMs.

Majority of the ANMs included in the study are 10th passed or 12th passed. Only two of the ANMs are reported to have passed 8th class. 3 ANMs in this sample are graduates and 1 is even a postgraduate, see **Table 3.1**.

Table 3.1
Educational and Training Details of the ANMs

Sl.No.	Name	Area	Age	Education	Year of training	Duration of training	Years of service
1	Radhika Amma K. M.	Kotkhawada	40	10th	1982-83	2	16
2	Sarla Sharma	Kotkhawada	35	8th	1989-90	1½	8
3	Urvashi Sharma	Kotkhawada	28	B.A.	1990-91	1½	7
4	Jyoti Sharma	Kotkhawada	46	10th	1982-83	2	15
5	Radha Sharma	Bassi	34	12th	1989-90	1½	10
6	Rakhi Nagar	Bassi	46	12th	1977-78	2	21
7	Lakshmi Amma C.	Bassi	50	10th	1976-77	2	22
8	Rama Agarwal	Bassi	35	11th	1991-92	1½	5
9	Lalita Amma Nayar	Watika	47	10th	1969-70	2	28
10	Kavita Amma Mathew	Watika	53	10th	1968-69	2	29
11	Rupinder Kaur	Watika	28	12th	1991-92	1½	1
12	Sujata Singh	Watika	29	12th	1989-90	1½	9
13	Aditi Rawal	Bhanpurkala	25	B.A.	1997-98	1½	2
14	Kusum Dhabai	Bhanpurkala	30	10th	1988-89	1½	11
15	Poonam Pareek	Bhanpurkala	35	10th	1986-87	1½	13
16	Prerna Devi	Bhanpurkala	26	B.A.	1994-95	1½	4
17	Sonal Gupta	Bhanpurkala	30	10th	1988-90	1½	9
18	Sangeeta Pareek	Bhanpurkala	24	12th	1991-92	1½	5
19	Noopur Arora	Bhanpurkala	42	8th	1976-77	2	22
20	Sapna Kumari	Jaipur city	34	M.A.	1990-91	1½	7
21	Rajni Jain	Jaipur city	30	12th	1983-84	2	13
22	Sareeka Sharma	Jaipur city	50	10th	1967-68	1½	31
23	Vimla Sharma	Jaipur city	46	10th	1979-80	2	20
24	Preeti Jain	Jaipur city	42	12th	1984-85	2	14
25	Lilasamma Saharia	Jaipur city	35	12th	1983-84	2	16
26	Dolly C. L.	Jaipur city	50	10th	1971-72	2	27
27	Usha Sharma	Jaipur city	38	10th	1982-83	2	17

Source: Data collected from the field.

As can be seen from the above table 13 respondents (ANMs and LHVs) are those who had undergone training of 2 years and 14 have taken training of 1½ years. Only one respondent who is one of the oldest ANMs among the 24 ANMs covered under this study is of the batch when 10 months training mainly of midwifery was imparted. The rest had taken training

The portion in various case studies dealing with the reasons as to why a particular respondent chose to adopt this profession throws some light on this present issue. All the Christians in this study (6) hail from Kerala and have been in service for a long time (15 or more years). They opined that everybody in Kerala would do service. All of them are educated and since there is scarcity, rather saturation, in the number and range of jobs available for the large number of job aspirants, they have to come out of their native state to other states like Rajasthan in search of jobs.

Radhika Amma K. M. came to Rajasthan on the beckoning of her distant cousin who was already working as a staff nurse in a hospital at Jaipur. On her advice she had applied for the job. She was already 27 years of age by then and before this job had failed to get any employment in Kerala inspite of her qualifications. She was desperate to enter into some service and this service was no less attractive. Also initially there was not much difference between a staff nurse's and ANM's job because though placed in a rural area the ANM was also just almost exclusively doing clinical work (Refer to Case report No.1).

The case of Lalita Amma Nayar reveals a different trend. Her family's adverse economic conditions created due to meagre income of her father, who was a 'majdoor' after he got retired, and the need to feed her huge family had prevented her from paying her school fees of just Rs. 15 per month. Due to this she was unable to continue her studies and achieve her dream of becoming a teacher. In search of job, she had to migrate to Rajasthan. At the time of migration she was married and her husband had also migrated with her in view of the availability of job for her in the state. Presently, her husband has retired from military and is a truck driver transporting mud and stones from this area to nearby cities. Her income is substantial for both the families- in-laws side as well as her parental side. Also, she needs to save some money for her only son who has not been good in studies and so would probably not be able to secure a reasonably good job. Similar economic reasons of the family have influenced Kavita Amma Mathew to choose this profession. (Refer to Case reports No.9 & 10)

Similar reasons have been given by the rest of them. Lilasamma Saharia added that in Kerala no work is stigmatised and it is essential for everybody to do some job. She also remarked that she was not aware of the fieldwork component in ANM's job responsibilities before entering into it. (Refer Case Report No.25).

As for Lakshmi Amma C., she had joined the service for the same reasons but was not able to leave it after her training period, as she and her family were not in the financial position to repay the bond's amount that had been executed at the beginning of her training. This bond is meant for 5 years and she was at that time supposed to repay Rs. 20000 for disobeying the bond. As for the last case in this category, Dolly C. L. had filled up ANM's form on coming across an advertisement in paper and in order to fulfil her desire to do some service, had applied for it inspite of opposition by her family members. (Refer Case Reports No. 7 & 26). However, as regards the caste of nurses, the entry of Schedule caste and Schedule tribes is still insignificant.

For other ANMs particularly those hailing from high Hindu castes, the reasons to come into this profession have been mainly economic. With time the social rigidity and stigma associated with this job has diluted and its attraction as a government service attainable with less qualifications and insignificant investments, with surety of employment after training period, have been very instrumental in this regard. As will become evident from the reasons given by the ANMs to choose this job and continue in it in majority of the cases have been due to economic reasons. A number of respondents reported financial scarcity after marriage compared to those who had entered this service before marriage All such cases who had joined the service before marriage have continued it even after marriage, again most of the time, due to economic reasons. This fact emerges clearly out of a single review of such case reports and from the income pattern of their husbands (Refer Case Reports No. 2, 4, 5, 6, 8, 11, 12, 16, 17 and 23, and also Case Reports No. 3, 14, 15, 18, 19, 20, 21, 22, 24). See **Table 3.2.**

Table 3.2
Marital Status and Income Details of the ANMs.

Sl.No	Name	Area	Marital status	Husband working	Husband's income	Self Income	No. of Children
1	Radhika Amma K.M.	Kotkhawada	Single	NA	NA	8000	NA
2	Sarla Sharma	Kotkhawada	Married	Yes	2500	6000	2
3	Urvashi Sharma	Kotkhawada	Married	Yes	2000	6000	2
4	Jyoti Sharma	Kotkhawada	Married	Yes	5000	9000	3
5	Radha Sharma	Bassi	Married	Yes	2000	6000	2
6	Rakhi Nagar	Bassi	Married	Yes	6000	9000	4
7	Lakshmi Amma C.	Bassi	Married	Yes	4000	9000	1
8	Rama Agarwal	Bassi	Married	Yes	6000	5000	3
9	Lalita Amma Nayar	Watika	Married	Yes	2500	9000	2

Sl.No	Name	Area	Marital status	Husband working	Husband's income	Self Income	No. of Children
10	Kavita Amma Mathew	Watika	Married	Yes	7000	9000	2
11	Rupinder Kaur	Watika	Married	Yes	15000	5000	1
12	Sujata Singh	Watika	Married	Yes	5000	6000	2
13	Aditi Rawal	Bhanpurkala	Single	NA	NA	5000	NA
14	Kusum Dhabai	Bhanpurkala	Married	Yes	2500	7000	2
15	Poonam Pareek	Bhanpurkala	Married	Yes	2700	8000	2
16	Prerna Devi	Bhanpurkala	Married	Yes	6000	6000	2
17	Sonal Gupta	Bhanpurkala	Married	Yes	5000	6000	2
18	Sangeeta Pareek	Bhanpurkala	Married	Yes *	Nil *	Nil *	2
19	Noopur Arora	Bhanpurkala	Married	Yes	7000	8000	3
20	Sapna Kumari	Jaipur city	widow	No	NA	6000	2
21	Rajni Jain	Jaipur city	Married	Yes	5000	6000	1
22	Sareeka Sharma	Jaipur city	Married	Yes	6000	8000	3
23	Vimla Sharma	Jaipur city	Married	No	Nil	7000	1
24	Preeti Jain	Jaipur city	Married	No	Nil	7000	2
25	Liliamma Saharia	Jaipur city	Married	Yes	4000	6000	1
26	Dolly C. L.	Jaipur city	Married	Yes	7000	9000	2
27	Usha Sharma	Jaipur city	Married	Yes	7000	9000	1

Source: Data collected from the field.

NA= Not Applicable.

** Refer Case Report No.18.*

In 6 cases, the husband's income is only around Rs.2500 and as such the respondent's income is the only major source of their families' income. The husband of Vimala Sharma is an asthmatic patient and because of his illness he left his job after 4 to 5 years of marriage. Preeti's husband has taken a voluntary retirement from his service due to his transfer to Guwahati. In both these cases the respondents' income remains the sole source of earning for the family. As regards all the ANMs who are working in revamping centres that are located in slums the ANMs are forced to work in very unhygienic conditions. They are bound to continue in the service and they want to continue with it as they are paid relatively better due to longer period of their services. A change of profession at this point of time is not an intelligent and practically feasible option with them for the obvious reason that today's world is intensely competitive and thus confines their entry into any other profession owing to their lack of required qualifications (Refer Case Reports No. 23 & 24).

In the case of Sangeeta, her husband has been suspended for the last 13 months and she also has not received her salary for the past six months. Firstly she was on maternity leave and later on she joined the ongoing strike of all government workers in Rajasthan. Even after the strike was called off, her salary had not been released till the time of the study due to the normal time taken in processing to make the pay slip. Under such circumstances her only source of income remains the money coming from occasional deliveries conducted by her during off duty timings, although the amount is can be none but meagre. (Refer Case Report No. 18).

There are some who have expressed their reason of entering into this profession due to their desire to do some job and on being fascinated by the medical profession (doctors and nurses in hospitals). They had applied for the job on the basis of the advertisement in the newspaper or on some relative's advice. They say that at the time of joining the ANM's training course they were unaware of the actual responsibilities of an ANM particularly its field work component. After the training was over they did not leave or change the job because of the 5-year bond and owing to the surety of employment after training.

A few ANMs e.g. Jyoti, Urvashi and the LHV Dolly, have also stated that inspite all difficulties they feel that they are serving ill and needy people and this gives them satisfaction. Similar philanthropic expressions were noted down by T.K.Oomen in case of nurses.

Place of stay

In the present study, maximum number of ANMs are originally inhabitants of Jaipur (16), 2 are from Alwar and 1 from Dausa (the districts adjoining Jaipur), 1 from Bharatpur, 2 from the state of Haryana and the rest 6, as already mentioned earlier, hail from Kerala. The fact that majority of the respondents are originally the inhabitants of Rajasthan indicates that now days even the local people do not consider this job as unclean or lowly placed. Infact, again in this case the economy rules over socio-regional or cultural values and seems to play a significant role in reducing the stigma associated earlier with ANM's work. Now, instead of preponderance of candidates from Kerala, as was noted by T. K. Oomen, the local ones take a lead.

Presently, leaving aside 4, all the other respondents live in the city of Jaipur irrespective of their allocated place of service in the Jaipur District. This fact is in congruence with a point noted under weaknesses in the Annual Report of the District Family Welfare, 1998-99. All such respondents were reported to daily commute between Jaipur City and their respective place of

work. Radhika Amma K. M. lives in a small house at her present posting village. She is single and does not have to worry about other family members. Sarla has her family staying at Jaipur but she stays all by herself at Chaksu, as daily commuting from Jaipur was a problem for her. Her mother-in-law looks after household activities at Jaipur. She would go there on off days. She says that she has joined this service only after her children grew up and she was able to leave them at home. She has no other option beside this arrangement owing to the financially weak position of her family. Sujata stays with her family in a quarter at the PHC where she is currently working. So also is the case with Sangeeta (Refer Case Reports No. 1, 2, 12 & 18).

The reason for not staying at the place of their present posting as will be desirable according to the prescribed responsibilities of an ANM and also from the point of convenience of the respondent needs to be probed. The living of ANM at the very place of their service would in theory prove to be an ideal and desirable arrangement both for these health care providers and the people who are being served by them besides contributing significantly in meeting the set goals of Primary Health Care. Such an arrangement would enable them to live with and take care of their family along with performing their duty. In this situation they will also be available to the people throughout day and night and so even at odd timings medical help through ANM particularly in case of deliveries can help the people to a great extent. Why this does not happen, is therefore, quite an obvious and much relevant question.

Presently, out of total 27 respondents, 8 are working at a Revamping center in Jaipur City and therefore, their living in Jaipur is justified. The respondents from rural areas in this study are mostly placed at Sub Centres, 4 are at CHC, 5 at PHC (one at Block PHC and two at Mini PHC) and the remaining 10 are at SC (1 is at upgraded SC). (Refer **Table 3.3**).

Table 3.3
Details Of Place of Working, Living and Belonging of the ANMs

Sl.No.	Name	Area	Type of centre	Original inhabitant of	Place of present residence
1	Radhika Amma K. M.	Kotkhawada	CHC	Kerala	Chaksu
2	Sarla Sharma	Kotkhawada	CHC	Dausa	Chaksu
3	Urvashi Sharma	Kotkhawada	SC	Jaipur	Jaipur
4	Jyoti Sharma	Kotkhawada	SC	Jaipur	Jaipur
5	Radha Sharma	Bassi	SC	Jaipur	Jaipur
6	Rakhi Nagar	Bassi	SC	Jaipur	Jaipur
7	Lakshmi Amma C.	Bassi	SC	Kerala	Jaipur
8	Rama Agarwal	Bassi	PHC	Bharatpur	Jaipur

Sl.No.	Name	Area	Type of centre	Original inhabitant of	Place of present residence
9	Lalita Amma Nayar	Watika	CHC	Kerala	Jaipur
10	Kavita Amma Mathew	Watika	CHC	Kerala	Jaipur
11	Rupinder Kaur	Watika	BPHC	Jaipur	Jaipur
12	Sujata Singh	Watika	Upgraded SC	Jaipur	Watika
13	Aditi Rawal	Bhanpurkala	SC	Jaipur	Jaipur
14	Kusum Dhabai	Bhanpurkala	SC	Jaipur	Jaipur
15	Poonam Pareek	Bhanpurkala	SC	Jaipur	Jaipur
16	Prerna Devi	Bhanpurkala	SC	Haryana	Jaipur
17	Sonal Gupta	Bhanpurkala	PHC	Jaipur	Jaipur
18	Sangeeta Pareek	Bhanpurkala	BPHC	Jaipur	Bhanpurkala
19	Noopur Arora	Bhanpurkala	BPHC	Jaipur	Jaipur
20	Sapna Kumari	Jaipur city	Revamping centre	Jaipur	Jaipur
21	Rajni Jain	Jaipur city	Revamping centre	Alwar	Jaipur
22	Sareeka Sharma	Jaipur city	Revamping centre	Alwar	Jaipur
23	Vimla Sharma	Jaipur city	Revamping centre	Jaipur	Jaipur
24	Preeti Jain	Jaipur city	Revamping centre	Jaipur	Jaipur
25	Liliamma Saharia	Jaipur city	Revamping centre	Kerala	Jaipur
26	Dolly C. L.	Jaipur city	Revamping centre	Kerala	Jaipur
27	Usha Sharma	Jaipur city	Revamping centre	Jaipur	Jaipur

Source: Data collected from the field.

In case of those placed at SCs, living at their place of work has not been possible due to some seemingly valid reasons. First and foremost, SC is run by ANM in 1 room taken on rent by the government or given by the villagers. At none of the sub centres, covered under this study, has a residential quarter available for the ANM. The house rent, if taken by them, will need to be paid from their own pockets. Secondly, if their husbands are working in or around Jaipur, they would prefer to stay in Jaipur. Thirdly, staying in a city and that too the capital of Rajasthan is no less an attraction in itself. The difficult terrain of their work areas would not let them and their family members be psychologically prepared to accept this offer of living in a rural area instead of the city. It gives them an opportunity to be able to arrange for good education for their children and enjoy other obvious facilities of city life. They do not want to sacrifice their children's future for their job that is being done by them mainly for the economic reasons. This also allows them to be with their family during off duty times. These indirect but quite significant advantages work together to ease the trouble the ANMs have to take in daily commuting.

The situation at CHCs and PHCs is not much different. Not at every place quarter meant for the ANMs are available and even where they have been built they are generally not suitable for habitation due to lack of infrastructural facilities such as drinking water, electricity, toilet, etc.

Sangeeta is living at the block PHC in which she is posted. As already described earlier she is facing acute financial scarcity due to the suspension of her husband from his job and her not having been paid for around six months. A free residential quarter, saving on money spent on travel to the field and the opportunity to be able to attend deliveries during off duty hours are some advantages she enjoys while staying here. However, she clearly expressed her dissatisfaction regarding the living arrangements. First of all there are no proper toilets, drinking water facilities and other basic infrastructure available here. Secondly, she does not want her children to go to schools in the village. As soon as the financial condition is going to improve she proposes to change her residence. The gains of city life attract the respondents further and make them opt for living in the city. Regarding this issue the ANMs have expressed that they would and can consider the option of living at their respective place of stay if they are provided a proper quarter by the government.

A review of the case studies would also reveal the fact that during their postings in their entire period of service so far, ANMs have lived at their respective places of postings. Sometimes they had to stay alone at these places away from their families. Sometimes they even had to carry their small child/ children with them to the field as reported by Nupur for there was no one to take care of him/them at home. This fact can be presently seen in case of Sangeeta where she has to employ a maid to look after her children when she is doing duty at the center inspite of her weak financial position. Looking at all such problems it becomes clear that as and when possible the ANMs would try to live with their family members. (Refer Case Reports No. 18 & 19).

Linguistic pattern

Conversing with the people in local language is not a constraint for most of the respondents as they are from the same language belt as their clients. As for those hailing from Kerala, language had been a problem in their initial days of service when they were new to this region. However, with time they have been able to pick up the local language and now converse with the people conveniently in a language understandable to them.

Radhika said that initially she started learning by imitating others. Similar has been the case with other such respondents. Now after living in this region for such a long time even their accent has started resembling to that of a localite. This has been an important factor in their acceptance by the people, which is essential for their work. From an anthropological viewpoint,

this fact is significant particularly in today's context when entire work of ANMs is proposed to be based on the information collected from and disseminated by them among the local people through use of counselling and discussion methods.

(B) The FUNCTIONS of ANMs: The Trends

Till 1968 complying with their training and place of posting (Post Partum centres), ANMs were exclusively doing the task of midwifery. They were midwives responsible for conducting safe deliveries and taking care of immunisation.

During the period 1970 to 1986 motivating people for family planning was added as one of their major functions along with doing survey work and training the Dais of their respective areas. Infact, as has already been indicated in the earlier chapter while discussing FPP and ANMs' association with it, the pressure for achieving targets for FP was so much that all other functions of ANMs had taken a back seat in comparison to FP work. Among all methods of FP main stress was placed on sterilizations. ANMs were bound to give 20 cases per month failing which they were liable for suspensions, transfers, punishments such as deduction of salaries, etc. Such measures had made them run madly behind people for cases and use all tricks to get people in desired number to undergo operations. Such stringent measures did not yield the desired results. On the contrary there was an adverse effect on people. The worst consequence has been the distortion done to an ANM's image in the view of the people. The people started perceiving the ANMs as merely coming to catch the eligible women for sterilizations and not for any other health service. This factor has got embedded so deeply that it has resulted in alienating people from the health workers particularly the ANMs.

The scope of the ANMs work has been broadening ever since and it has become broadest in the contemporary times. She is vested with all rights and family planning. ANM functions basically in the field in a definite area allotted to her where she is supposed to provide all kinds of curative and preventive health services. Like other traditional medical professionals, she is present at her respective centre and treats patients for simple ailments, give medicines, does dressing up of wounds, etc. Basically at the clinic she dispenses the duties equivalent of a general doctor at a hospital.

The responsibilities to be carried out by her get defined according to the number and nature of various health programmes that are being implemented in that area by the health department. Any new health programmes formulated at the national or state level gets automatically included in ANMs responsibilities when it comes to be implemented. For long she has been invariably working in the following areas:

1. Sanitation that includes chlorination of wells or disinfection of all water sources.
2. To do complete immunizationof all children upto 5 years of age. These days great emphasis is being placed on achieving complete immunizationthat would mean that all children have had all the vaccines thart are given at their age group and none of them misses even a single dose of these. The well known Pulse-Polio Campaign has been going on during this study period[1]. During each such campaign all the ANMs do this work exclusively for atleast 5-6 days in that month allotted for the programme, 3 days when oral vaccine is given and 2-3 days prior to each such campaign when the ANMs would go to their respective immediate head offices to collect the required vaccines in estimated amount for their area. They are in theory required to meet 100 percent target of immunisation.

3. She is responsible for checking/controlling the outbreak or spread of seasonal diseases and attend to patients coming with such ailments. If the facilities required for the purpose are unavailable with her , she will inform the higher authorities and if she finds herself unable to handle the case, she refers it to the CHC.

The various currently ongoing health programmes that feature in the ANM's work are:

1. National Programme for Blindness Control.
2. National Tuberculosis Control Programme- Due to the high incidence rate of TB in Rajasthan, this disease has in recent years being given much importance which resulted in pressurising ANMs in identifying TB patients in their area and complete the DOT therapy on them.
3. National Leprosy Control Programme- she needs to identify such patients and give them regular medicines for its cure.
4. National Malaria Eradication Programme- during the period from 1970 to 1994, there was a post of MPW (male) in each SC and PHC/CHC who was mainly looking after

[1] The time period available to the researcher was again reduced by 5-6 days due to this campaign.

the malaria work beside helping out ANM in her field work and other responsibilities. After this post was removed the work of malaria also came to be included as one important responsibility of an ANM. She will prepare blood slides of patients coming with fever. She ensures its control by chlorinating the water sources. They would also bring back blood reports of the people suffering from fever and in case of confirmation of the disease in a patient, she gives him medicines for the disease.

5. National Guinea Worm Eradication Programme- this disease has been eradicated and so this year government has not sanctioned any fund under this head. Consequently it does not feature in ANMs work now.
6. School health programmes- ANMs go to schools and lecture students on sanitation and personal hygiene. They also organize health camps on fixed dates in the schools where a doctor would come from CHC to do general checkup of the students. This programme has been taken up because as explained by the health officers at the district level, the village people remain unaware of the fact that children may have diseases and if not treated now, the problem could aggravate beyond curable stage when the child grows up. Such cases which are complicated or beyond the knowledge of this doctor, are referred to specialists of the concerned area.

7. Family Planning and RCH-
   i. Registeration of ANC cases- on confirmation of a women's pregnancy the ANM would record her name as an ANC client. She would give full health education to the client about food she should eat, precautions she has to take and danger signs that would indicate the need to immediately rush to some doctor. The pregnant women have to be informed about atleast 3 antenatal visits to the center for regular health checkup. The ANM must give 2 TT (Tetanus Toxoid) injections to her ANC clients, 1st right after the confirmation of pregnancy and 2nd after 2-3 months. As maximum number of Indian women have been found to be suffering from anaemia the severity of which increases during the pregnancy period, ANMs have been specifically instructed to give IFA (Iron Folic Acid) tablets to all ANC clients.
   ii. The conduction of safe deliveries remains an important function of ANMs. The ANMs in this case report have reported that they do not conduct deliveries during night. First reason as described earlier owes to non-availability of most of them

during night as they have by then gone back to their homes at Jaipur. The few who remain at the centres would also not go due to safety issue (discussed in detail later in this chapter). They are instructed to use the delivery kit for each delivery in their area whether conducted by them or by the Dai at the patient's home. This delivery kit named as 'Mamta-kit' is being provided to them since 1986 onwards. The ANM at the SC is not supposed to handle complicated cases but to refer these to the next higher appropriate health institution. She is required to make an entry of all referral cases.

iii. To provide health services during the post natal period is no less important. This phase of health care begins right after the birth of baby and extends over a period of 6 weeks. ANM has to take care of both the mother and her infant. Besides postnatal care, neo-natal care is also a part of ANMs' work. She gives advice for adopting family planning methods to the mother right after she has delivered the child and gives IFA tablets to her. All other related information as breast feeding the child, weaning period, immunisation, etc. comes under the purview of her work. This phase as discussed in the review of literature on ANMs' work assessment shows that this phase has been receiving least importance. Infact during the stringent target approach the whole of MCH services had been ignored by ANMs; the reasons for which lies in the demands made on ANMs work under this approach.

FP work also includes motivating women for FP, distributing oral-pills and Nirodhs, preparing cases for tubectomy, inserting Copper-T and handling 'Jan-Mangal' Couples.

The ANMs also handle MTP cases. At the SC levels they are not authorised and equiped to conduct MTP at the centre and so here they refer cases to higher levels such as to PHC ar CHC. At PHC or CHC they conduct MTPs.

8. Children health- Besides neonatal care and immunisation, ANM has to concentrate on diseases that have been major causes of death in infants and small children. These include diarrhoea, acute respiratory infection (ARI) and Pneumonia.

9. Attending regular meetings of Mahila Swasthaya Sangh (MSS) and identifying the Jan-Mangal Couples for FP work and co-ordinating and monitoring their working is also an essential feature of the ANM's work.

10. Making various reports and survey work- According to the plan of work proposed under TFA, this aspect of an ANM's work has received particular emphasis since 1995-96. The respondents equivocally supported this fact. Infact they said that this work consumes much of their valuable time. Now ANMs' supervision is mainly based on the review of various reports maintained by them. This function of ANMs deserves separate discussion, as this is the primary source of all data collected and compiled at grassroot level and sent through various levels to reach finally to the health planners of our country.

Reports and Survey Work

Before 1970s there was no fixed format or registers provided to ANMs for recording daily information and monthly work progress. Each of them used to write such information on a plain paper. The format followed by them for recording information related to FP and MCH particularly has been given in **Appendix No.3**. As for other seasonal diseases they would write on a separate plain paper the names of all the diseases names and against each the respective number of cases were reported. Besides they had their usual OPD registers.

From 1972 onwards till 1986, registers were provided to ANMs. It was a large single register divided into 3 sections:

1. ANC
2. PNC
3. FP

The format was more or less same as described earlier (when it was maintained on a simple plain paper). Now, they had to record complete details of all family members. The ANMs were not found to be filling these properly and so amendment was introduced in 1995-96.

Since the first implementation period of TFA, several registers / forms have been in use. A content analysis of two main forms used at the SC level that have been proposed as the basic strength of TFA will be done in the following paragraphs.

1. **Seva-Panjika:** This is a register in which work done daily by the ANM in her area related to family welfare is recorded. It includes data on FP and MCH. At the SC level there is one register per village. Then on a fixed date (generally every 20th) of the month ANM sends a compiled report of the work in all the villages covered under the SC, at which she is posted, to the PHC under whose jurisdiction this SC falls. There is a separate form for sending this monthly report. This form in 1995-96 as given in TFA manual was numbered as Form 4. This form has been modified in 1998-99 and now it is called Form 6. Both these forms have been attached at the back in **Appendix No.3.**

A review of the two would reveal the differences. In general the important sections of the forms are FP, MCH, stock condition and discussions & reactions of the community. In the new form while the section on FP has been simplified, that on MCH has been expanded and sections on MTP and communicable diseases have been incorporated. Also the new form has columns to simultaneously record corresponding data of the same month of the previous year. This allows for a comparative analysis and allows to keep a check on performance level of ANM for herself and to be used by her supervisors. Great discrepancies indicate possibility of some error. e.g. a decrease in achievement level inspite of increase in eligible population is not acceptable for the department and needs to be immediately reviewed and corrected.

The section on FP in the later version of the form is divided into six main sub heads that were 8 in number in the earlier version of this form. The number of children after which and the age group of the client at which he is adopting a certain FP method and the number of follow ups done for each case has been removed. In case of sub head on IUD, only the total number of cases whose follow-up has been done after inserting IUD is recorded as opposed to the previous form where the number of times was also being recorded. From the sub-head on oral pill users the question on number of clients who had stopped using Oral pills but have restarted has been removed. The cut has been specifically done in case of Nirodh users where the entire information now to be recorded is only the total number of users. Further, head on users who have adopted natural or indigenous methods of FP has been removed altogether.

Discussions with the statisticians at the district level, who would finally use this information to prepare their report of Jaipur district for that year, revealed that this

simplification though reduces the amount of data to be collected, thereby simplifying the procedure and the work of ANM, cannot be appreciated because it misses out much relevant information on number of children and age group wise information of FP client. This data being critical, now has to be asked to for separately on a plain paper. Since this is an added work on the ANMs many a times surety to get back the requested information is not guaranteed. Moreover such information most of the times is incomplete and there is no way to test/ensure its reliability. A gender bias creeps in the new format for the information on male contraception gets reduced particularly on *Nirodh* that is the only available and most popular spacing method for males.

As written the section on MCH has been made much more comprehensive. Also in the new format it has been placed before FP. The increased importance of MCH can be realised through this. The information of the newborn baby now also includes its birth order. Stress on RCH has made the designers of the new format to include a head on RTI/ STD. An extensive section on diseases that occur during childhood is now present instead of the earlier simple form that simply recorded the number of cases and deaths due to main childhood diseases in a columnar fashion.

An important positive step towards the integration of FP and MCH with general health services is evident from the fact that a separate section on communicable diseases has been included now. This section captures data on two main diseases- malaria and tuberculosis that have become of much relevance particularly in Rajasthan because of the increased incidence of these diseases there. The section that will record the information on number and forms of interactions of the ANMs with the community has been renamed in the new form and is highly reduced. This section now actually just deals with the interactions with the Panchayats, Mahila Sanghs and the Angan Wadi workers. The inclusion of questions related to IEC materials distribution have been removed. The section on stock list has increased considerably. Increased emphasis on immunization in recent years has resulted in a separate stocking column for various vaccines that enables the ANMs to monitor their stock on a regular basis.

As discussed for SC level, similar pattern is followed at subsequent higher levels. The number of sections on which data has to be gathered at various levels get a little modified according to the services to be provided at that level. Similar kind of changes as

have been explained for SC level form of seva-panjika are found at higher levels also. (for reference purpose the forms used at PHC and CHC levels are also given in the appendix).

On a fixed date of every month when ANMs hand over the compiled report of that month, the LHV or PHN would check the form. The Computer[2] at the PHC and district levels feed this data into the computer to create tables that will be used for further analysis. Lalita Amma Nayar, Kavita Amma Mathew, Sonal Gupta, Sangeeta Pareek and many others had commented that the computer almost always do not accept the values as filled by the ANMs as it is but tells them to modify (decrease or increase the values) according to the targets available with them. This fact has also been pointed out by the Principal of ANMs training college at Amarsar. Also many of the ANMs and the LHVs and PHN in this study, accepted the fact that many a times complete forms are not filled up. The reasons sited for this are either the inability of the ANMs to fill up certain sections in the forms or the unavailability of the required data because of non response or lack of coverage by the ANMs. The data is also many a times modified to reflect the targets to be achieved according to the standard set at the higher level.

2. **Annual Survey Form** - this is the most important form introduced in 1995-96 and forms the very basis and strength of TFA. Since the inception of TFA in 1995-96, every year an annual survey is conducted by ANMs in their respective areas. This survey is done on all respondents that fall into the category of eligible couples (age group of 15-45 years) during March-April. They have survey registers- one per village. After the completion of survey in all villages included under one SC, the data is compiled and filled up in a form named as Form 1. This information is to be used by the health workers of grassroot level in setting the annual targets (preparing the action plan for the coming year) for themselves. As in the case of 'Seva-Panjika', this form has been modified in 1998-99.

The main aim of this data collection is to enable the grassroot workers in setting up targets for themselves for the coming year. The reviewing exercise, as done in the case of 'Seva-Panjika', would reveal the details about the data collected through this form and changes introduced in it since 1998-99.

[2] Computer is a name of the post at the PHC, CHC or in the higher levels, is responsible for handling all the data feeding, tabulation and analysis work on the computer relevant to that level.

The new form- Form 1 has been made more comprehensive, clearly categorised, systematic with proper instructions and formulas given at appropriate places. Though the main data collected is similar in the old and new versions of Form 1, some of the sections have been renamed, expanded and/ or categorised further or included as a different head. Further, where ever possible and relevant the categorisation into male-female has been done. This would become quite evident on a simple review of the two. Discussion on this issue follows:

The first section on general information has been expanded in the new version. The second section that is the real crux of this form has also been modified. It deals with finding out the unmet need of the population regarding FP, the value of main health indicators and the improvement to be brought in the coming year and estimation of achievements of Family Welfare Programme for the coming year. The first subhead of this section deals with assessing the unmet needs of the targeted population. This process begins by finding out the total number of eligible couples, their desire to have more children in future, the current prevalence of FP methods- permanent (sexwise) and spacing and methodwise future demand for FP methods. Then by simple subtractions and additions the unmet need of the population can be estimated. Previously, in old version this sub-section also included details on number of live births, infant deaths and maternal deaths and distance of SC from the head quarter but now it exclusively deals with assessing FP needs of the population method wise. However, one finds increase in the number of columns owing to the fact that questions have been added to find out the number of couples aspiring for more children in future, and to probe for specific period after which they will want to have the next child- within one year, after one year but before two years or after two or more years.

The second sub head calculates the value of main health indicators on the basis of current year's corresponding figures and estimates the likable achievements in these for the coming year. The third sub head calculates the probable achievements of FPP for the current year according to accepted standards. The fourth and fifth sub heads have been made a different section in the new version and placed after the third section.

The third section is devoted to MCH. This section in the new version records data sexwise (wherever relevant), data on last year's performance and then according to the

specified formula (written for that column) calculates the desirable achievement level for a particular item. The main sub heads as can be envisaged are ANC, natal and PNC services. The sub heads on MTP and RTI/ STD have been added and causes of deaths of infants less than 1 month old have been attached.

The fourth section once again repeats the achievements made in family welfare and setting target for the coming year. This is limited to four FP methods- sterilizations, IUDs, oral pill users and Nirodh users. It also records all the organisations other than SC that are functional in that area.

The fifth section is an inventory section to find the current stock position of important items crucial for the functioning of ANM. On the basis of already calculated targets for the coming year, the estimation of demand to be raised is done. The sixth section is to record status of equipment and facilities available at SC- their availability, number, whether functional or not and extra requirement. The seventh section is the IEC section. All kinds of important IEC activities viz. Mahila Swasthya Sangh meetings, Panchayat meetings, dissemination of education material regarding seasonal and diseases causing mortality and morbidity in children and organising of film shows towards these ends is included here. The achievements made during the current year are written and in the subsequent column the probable achievements in this regard would get recorded. The last part is the final form of the formulation of action plan duly signed by the ANM. Then this form is checked and signed by the LHV/ sector supervisor and the Medical officer. In addition, in the new version it is proposed that the Sarpanch and Head of the village advisory committee must also sign it.

This discussion on a few major forms introduced under TFA indicates that TFA in theory s an ideal way of capturing the unmet needs of the population and formulating the future work lan on the basis of data collected through survey using this form. However, a close scrutiny of its ield implications and its contents vis-a-vis laid down objectives shows a not too attractive picture.

First of all making the form more comprehensive has resulted in making it lengthier and ıore time consuming. The inclusion of more number of questions to find out the exact time eriod within/ after which the respondent would like to have the next child in the newer version f the Form-1 though policy wise seems to be an ideal step; fails considerably at the practical level.

This fact has come out very strongly in the various case studies. The respondents are not able to tell the exact time as required. Rather they get pretty irritated when so specifically probed and say its God's wish / or it will happen when it has to. Rajni and Sarika informed that accurate responses in terms of Yes and No are not given by the people for such kind of questions. The women would not tell about the LMP (Last Menstruation Pericd) because of which it becomes difficult for them to detect ANC cases during early pregnancy. (Refer Case Reports No. 21 & 22).

One of the most serious problems with this form is its designing. This form is meant for someone quite well educated particularly in handling statistics and suitably trained for this job. Moreover, the person responsible for filling it up must be able to appreciate its need and be capable enough for handling it. Inspite of being very systematic and proper instructions been given at every point, this form is not simple to handle.

All the ANMs in the study have responded that before switching to TFA they were not informed or involved in the process. The introduction of various forms as part of TFA was not accompanied by organisations of trainings for them on this aspect. They were simply explained about the TFA and the various forms in the monthly meetings. Rakhi informed that at the time of changing the registers in 1998 a seminar was held in the Directorate of Health in Jaipur district. To this one ANM and one LHV from every PHC in the district were also invited. Same kind of response was received from only one or two more ANMs in the study. Such an invitation was not received by all the ANMs and LHVs. A few of them who had had not attended the seminar because first of all they do not appreciate the process of data collection and secondly because at such occasions they are not given a chance to air their point of view.

On enquiring about their knowledge on TFA, some of the ANMs were not able to identify it by name, but when explained as to what has been proposed as TFA, they could respond in positive. In fact most of the ANMs are not aware of the theory and the principle of TFA as proposed but can comment upon the changes that have taken place since 1995-96 particularly with respect to target setting and the new forms for reporting their daily works and conducting annual survey of eligible couples. This fact was invariably reported by all the ANMs.

The above discussion shows that the ANMs as one of the most important grassroot workers have not been vested with decision-making power for their own area of work also. Though it was stated by the district officials that an ANM is equivalent to a CMHO (Chief Medical & Health

Officer) in her area of work and can therefore, exercise power of that level, the reality does not match these statements. It has been reported by many of the ANMs that the data that are collected by them is not accepted at face value. According to the targets available with the Computer at the PHC/ CHC or District level, the ANMs are directed to increase or decrease the figures. (Refer Case Reports No. 9, 10, 15, 16 , etc.).

Most of the ANMs stated that they find difficulty in filling it up because they do not understand it completely and face difficulties in calculating the percentages and other formulas. Infact almost all of them find it cumbersome and useless additional work. The LHVs and PHN have stated that they face problems in getting the form filled up by the ANMs under them because they are not so educated and well trained as to handle this work. This can be said particularly for the eight pass ones. Moreover, the fixation of targets is not completely under their wish. Though now the targets are not given in absolute numbers but in terms of percentages they continue to exist and be a constant pressure on the ANMs.

The only place where ANMs are supposedly given a chance to express their viewpoints and problems regarding their work are the monthly meetings. Every month at Block PHC/PHC a meeting of all ANMs is organised headed by MO(s) of that area. Ideally the main aim of this meeting is to listen and solve the ANMs problems and have discussions about the health care delivery in the area. In most of the places this day is also the day when monthly salary is disbursed to the ANMs. The ANMs situated far off from their respective headquarters also bring with them their monthly reports to be submitted here. This is an ideal way to interact with the ANMs and involve them in decision making. The reality however, does not match with this idealism.

The ANMs' responses and the direct observation of one such meeting in which the researcher herself participated revealed the general trend at such meetings. The MO(s) speaks about the general performance of the health care services in the concerned area e.g. what has been the performance of different centres i.e. to say to what degree the desired targets have been met; to what extent and how efficiently an ANM of this area has fulfilled her duties; what has been the generally observed drawbacks in the strategy adopted by them that has caused failures and similar issues. He/ they would also inform the present attendants about new programmes, if any, which has to be introduced and the way it will be implemented. Out of all these issues the most important remains the performance level of an ANM. This is judged mainly and rather solely from the monthly reports. The interaction between the MOs and other higher officials if present remains

one way kind of interaction in which the MO speaks and the ANMs would simply listen. It was observed that none of the ANMs was willing to express her problems in front of the MOs and appeared hesitant to ask about their doubts. Even the MO had repeatedly probed them to come forward with their views but none of the ANMs spoke. When asked as to why they should not speak up about their problems they face that they had informed the researcher some time ago, they replied that it is of no use as no action would be taken. This kind of a reaction by the majority of the ANMs in the monthly meetings showed clearly the adapted psychology of the ANMs. They have understood that if they are told to do a certain task they will have to accomplish it by any means.

The TFA approach was explained to the ANMs in 2-3 such monthly meetings that also included explanation on the various forms to be used for collection of information from the community. No formal training has been held for this purpose. The transfer of knowledge and skill in this regard from higher officials to the ANMs when seen in the light of the general behaviour of MOs and the ANMs at monthly meetings casts shadows on such a process of teaching and learning.

(C) Problems Faced By the ANMs

This section deals with the problems being faced by the ANMs as revealed from the various case studies. Comparisons among the respondents on the basis of rural-urban, married-unmarried and old-new will be done wherever relevant. These have been dealt with one by one in the following paragraphs drawing references from the various case studies at appropriate places as required.

In the rural areas the ANMs reported that although the people have become more aware about their health and the kind of services an ANM can provide them, the ANMs continue to face difficulties while handling them. The reasons for this are many. The image of an ANM in the eyes of the villagers continues to be that of medical personnel who would come merely to catch people for operations and would not provide any other services. This has been the negative impact of the target approach followed by the Family Planning Programme for over two decades in a coercive manner. Due to great emphasis on achieving targets of sterilisation placed on ANMs, during this phase the ANMs have been mainly concentrating on getting cases according

to the assigned targets as a result of which they were not providing other health services as was desired by the people. The four years of removal of targets since adoption of TFA in 1996 has succeeded only partially in altering the perception of the people towards ANMs in a positive way in this respect. The people often comment-

> "operation ke liye pakadwa aagayee" (she has come to catch us for operation).

In contemporary times also many a times people's behaviour towards the ANMs' is very negative.

The religious beliefs and prevailing misconceptions among the people many a times obstruct the ANMs' interaction with the people. People still have apprehensions towards various vaccines for instance the child would get fever and therefore, would not get their child immunised, etc. As pointed out in a number of case studies of the ANMs, the Muslims consider that adoption of family planning to stop childbirth temporarily or permanently as a sin and so would not allow their wives to go for operation. According to the ANMs another caste posing such problems is the Meena caste. Many ANMs said that the men of this caste are often found drunk even in daytime. Since their houses are located in 'dhanis' that are thinly and sparsely distributed habitations, the ANMs are afraid of visiting their households. The ANMs also informed that often these people keep dogs. They are afraid of dogs and as such the ANMs would preferably avoid visiting such households. This fact of non-acceptance of immunization and FP methods by Muslim and Meena castes as stated by the ANMs has also been clearly spelt out in the Annual Report of District Family Health Bureau, Jaipur. Prerna expressed her perception about the villagers that they are illiterate and superstitious and therefore would not come forward for sterlizations.

Similar kind of problems being faced due to non-cooperation from the people was also reported by all the ANMs and LHV in the urban areas covered under this study. Vimla said that the Muslim women in Mehnat Nagar Katchi Basti are a constant problem for her. She has tried all the ways but has not succeeded in convincing them for adopting of Family Planning methods. Preeti is also not happy working in the slums due to non-cooperative behaviour of the people. She said that the people are not ready to understand the advantages of family planning and would go on producing children saying that it is God's will. However, Sapna reported that though the people were highly non-cooperative in the beginning, with time their attitude towards her and immunization and FP Programmes has become more positive. Her relationships are now

so cordial with most of the residents of the slums in which she works that even when 1-2 sterilisation cases failed, she was not blamed for those and the people were not rude towards her.

Lack of respect and love by the people was expressed as a severe cause of dissatisfaction by the ANMs regarding their work environment. This was the main reason due to which Rama and her husband expressed their dislike for the job. The economic constraints that were faced earlier by the family have been minimised since her husband got the job and therefore the motivation for the job has also diminished. As such, she was found to be seriously thinking about leaving the job. Lakshmi Amma said that at some places people dishonour them and rebuke them like dogs (Refer Case Report No. 7). She expressed such humiliation as;

"humein kutton ki tereh bhaga dete hein"

Sangeeta pointed out the people think that it is the ANMs interest in getting operations done. Lakshmi Aroara who has been in the service for over twenty-one years is now particularly unhappy regarding people's reactions. She expressed her feelings in this way-

> "Earlier we used to receive due respect from the villagers. Now these people do not respect us. We are treated like class IV workers"

Many other ANMs reported similar kinds of expressions.

The ANMs have invariably commented that this job is not safe, as they have to work in places, which are unsafe. Some ANMs at Bassi- Lakshmi and Rama reported to the researcher about the occurrence of some rape cases in this area secretly. In such cases the ANMs were called in the pretence that they need to attend to some complicated delivery and then were taken to some lonely place and raped. When this matter was brought to the notice of Sarpanch he clearly refused to do anything about it. He is quoted to have said-

> "tum humse poonch ke jati ho kya? Tum to paise ke liye jati ho. Ab hum kya karein?" (Did you ask me before going? You go for money. So what can I do now?)

Most of the ANMs, infact none of them, would attend to cases in nights as most of them are not residing in the villages of their respective areas and particularly because they are afraid due to such incidents. A few of them who are accessible in the night will also not attend to night deliveries except when the case is in some house they are well acquainted with or the patient has been brought to the center, again due to the same reason of insecurity.

Working in city does not pose such problems of such insecurity most of the time. In the daytime there is no problem and in the nights the people can call on Dais if present in that area; or go to nearby clinic including the one under which that slum is covered; or can even go to the SMS Hospital in case of emergency.

Almost all the ANMs presently working in the urban area have also had the experience of working in the rural areas during their earlier postings. They expressed their experience as the working condition in the rural areas are worse in comparison to the urban areas. Preeti narrated her experiences when she was unmarried and was posted in the rural area for a period of four years before coming to the present place of posting as-

> " Gaun ka mahol to shahar se bhi kharab hein. Unmarried ladki ko bahut problems ka samana karna padta hein. Gaun mein gunde ladke peeche pad jatein hein. Ek baar ek aadme mere peeche pad gaya tha. Mana karne se bhi nahin man raha tha. Baad mein gaun vallon ko bola to unhone use data or mera peecha chudaya" (the nvironmentof in the villages is worse as compared to that of the city. Unmarried girl has to face many problems. In the villages the rural youth would tease and comment on them. Once a man had chased her to her house inspite of her repeatedly asking him not to. When the villagers intervened then only she could get rid of him).

In this respect of the problems faced by married and unmarried ANMs, similar have been the experiences of Aditi who is very young and is placed in the rural area. She says that unmarried ANMs should not be posted in the rural areas. Prerna who is now married also had similar experiences when she was unmarried.

It can be pointed out at this point that the period of stay of an ANM at a particular place is directly proportional to her acceptance among the people. An earlier study conducted by Mckim Marriot[3] in 1950s can throw some light on this aspect. He had stated his experiences as a western doctor not being successful in providing services to the local rural community. He was considered as an outsider which resulted in people's lack of trust and confidence in him. He was an alien to them since he was not from amongst them, spoke a different language and followed different customs and traditions. He was unable to interact meaningfully with the people and was

[3] Mckim Marriot, (1950), " Western Medicine in a Village of Northern India", Pg. 239-265.

not able to understand their ways of expressing illness. It was only gradually that he started understanding their ways of expressing their illness and his services were accepted and appreciated by the people. D. Bannerji's study of nineteen villages[4] has given the concept of 'health culture'. It was said that in a community, perception of a health problem, meaning of the state of health and disease, response to various institutions that exist for dealing with these health problems. All form an integrated whole and it was this sub culture complex that was termed as the health culture of a community. Being a sub culture it definitely it is effected by the overall changes in the culture of the community that are taking place through social, economic and political forces. In this study it was shown that the villagers consider the ANM as 'Memsaab' and considers her inaccessible for she would go only to rich and influential people. Thus, it can be said that until and unless people accept the medical worker it is not possible to be able to serve them and their needs assessment be done.

The present study also reports similar trends. The ANMs hailing from Kerala reported that they had faced problems in smoothly interacting with the people in the initial years of their service in Rajasthan. It took them many years to communicate with the people in the local language. Radhika started picking up the language by imitating the people and now after having served the people for around 16 years she feels confident of speaking the language (Refer Case Report No. 1). She has been living in the same village for quite many years. Both these factors have contributed towards her acceptance by the people and in helping her to understand people's ways of expressing their illness and doubts. This improves her level of working. Similar experiences were put forward by other ANMs hailing from similar backgrounds.

As for those ANMs who come from a similar background as the people they serve, they do not face problems in understanding and communicating with the people regarding their health needs and problems. However, since they are not the inhabitants of the same area that is assigned to them, only their long association with the people and satisfactory functioning builds up people's trust and confidence in them. These trends indicate that an ANM must be well conversant with the concepts of health and illness prevalent in the community she serves, the social structure of the community/ society she serves, the various social customs, values and beliefs imbibed in that community/ society. Only then, she will be able to understand people's behaviour towards the health services provided by her and their needs and would be accepted by

[4] Bannerji Debarar (1982): *Poverty, Class and Health Culture,* Lok Paksh, New Delhi.

the people. A good rapport with the people thus built will then help her in providing services to the people.

It has been pointed out by a number of research works that the people do not mind her belonging to a different or even a low caste if she functions properly and meets people's needs. This fact is indirectly evident from the present study also as none of the ANMs covered under the present study belonging to different castes and religions have expressed their caste or religion as posing problems in their work. However, a high morality and good character is expected of her. People prefer older and married ANMs who live with their families.

Another problem encountered by the ANMs arises due to the belief of the people that it is ANM's duty to give them medicines and do immunisations. Especially the TB patients would not come to the center but would take it for granted that the ANM would come to their home for this purpose. In the various case studies, ANMs have reiterated this problem that they have to literally chase the TB patients. The ANMs need to make repeated visits to their homes as most of the time they are not available and have to coax them to take medicines as if it is in their own selfish interest. Similar is the attitude of the people in case of immunisations. When immunisations are done in the center people will not come assuming that the ANMs would come to give the dose at their homes as it is their duty. Such an attitude of the people has slowly set in people's psychology since according to their nature of work, the ANMs are supposed to visit people's households to give services. Since the inclusion of fieldwork as an important area of her work this aspect has been emphasised much. Besides the ANMs reported that the repeated assurances by the doctors of their areas to the people that they will be given services at their homes by the ANMs has also been largely responsible for this attitude. ANMs feel that this further reduces their respect in the eyes of the people and the people fail to appreciate their importance. These findings are similar in rural as well as urban areas.

The lack of adequate and proper infrastructural facilities is reported to be a major hazard in the proper functioning of the ANMs. Though in this study most of the ANMs have been found to be residing in Jaipur presently, at some time or the other during their entire working period they had been posted in some rural area away from their homes where they lived alone or with their family members. They were not given any quarters and had to take rooms on rent. Even at places where such quarters were available they were in non-habitable conditions. In case they had small children then, they had either to carry them to the field with them as in case of Poonam Pareek or would request some of their relative to live with the children and take care of

them or they were forced to leave their children with someone back home (Refer Case Report No. 18). Present situation as reported is no bettter. Sangeeta is living in a quarter in her PHC. Her quarter does not have proper toilet facilities (Refer Case Report No. 16). She has two small children and since during her duty hours she cannot take care of them she has to employ a maidservant for the purpose. Her case report reveals her economic condition and explains the reason to live in the quarter away from the city and continue job even when her children needs her attention. Sapna informed that she has small children whom she leaves with her mother when she is on duty. She has to work because her husband is dead and so she is the sole earner of bread for her family. Normally she is able to go back to take care of her children by afternoon. She said this is yet other advantage of living and working in the city as compared to rural areas. However, when at times any of her child is ill, she faces problems because she cannot take an off always and her children demand her attention (Refer Case Report No. 20). Many other ANMs have reported similar kind of problems particularly when they had just joined the service and had small children. Thus, the nature of this job places them in a difficult situation regarding adjusting between their work and their family.

The direct observation made by the researcher and also as mentioned in the Annual Report of the District Family Welfare Bureau, Jaipur, revealed that the various facilities like the basic infrastructure, medical equipment and medicines, transport facilities, etc. are not sufficient to deliver the health services in line with the laid out objectives of the Primary Care model and in congruence with the felt needs of the people being served. Jyoti and Urvashi reported that thin needles are not provided to them inspite of repeatedly reporting the unsuitability of thick needles in giving injections (Refer Case Reports No. 3 & 4). Since the ANMs are the ones who will function among the people they require the people's cooperation for their proper functioning which is possible only when people are satisfied with the level of services provided to them by the ANMs. In view of this fact Jyoti said that that she has to purchase thin needles with her own money. She showed a packet of thin needles she had recently purchased to the researcher. Similarly Sapna has to constantly ask for favours from one of her friends who is a staff nurse at a private clinic in Jaipur. Her friend give her medicines that come to her as sample from various pharmaceutical companies. In absence or irregular supply of medicines even for common ailments, this is a great help for Sapna. She informed that because she is able to give medicines to the people instead of just providing them with contraceptives and IFA tablets, she has been able to establish good relationships with the people.

The inadequacy of the training facilities was pointed out by the principle of the ANMs' Training College at Amarsar in Jaipur district. Due to lack of proper laboratory facilities where the practical training could be imparted are not available at Amarsar. Due to this the trainees have to be brought to the government hospital in Jaipur for about a month. This creates undesirable delays in the training and causes a great deal of inconvenience to both the trainers and the trainees. Also at the same time she accepts that the proper training is hampered under such circumstances.

The ANMs have to cover villages some even upto 8-10 Kilometres away from their headquarters. The dhanis included in their work area that are even more difficult to cover since they are quite sparsely populated. Due to lack of transport facilities to all such places they have to traverse long distances on foot and have to cross difficult terrain in all seasons. Moreover they are not paid any travel allowances. Besides they have to carry a heavy load of vaccination boxes on scheduled dates of immunization, records to record the work daily, their own small bag, etc Poonam expressed her views as follows:

> "Is kam main pair tordna parta hain, bojha dhona parta hain" (in this work one has to strain her legs and lift and carry a lot of weight)

As such the ANMs accepted that they do not pay requisite number of visits to all villages in her purview of work. She attends to the health needs of the people of nearby areas more frequently as compared to those that are distantly placed.

The increased work after MPW scheme is not acceptable to them particularly the older ones because it was not taught to them in their training. Lalita and Kavita expressed their disappointment to the researcher in the following words:

> " Pehle to hum keval clinic ka kaam hi karte the. Ab to sub kaam ANM ka kaam hein. Ganda pada ho to kahatein hein ki apne ghar par bhi tocharu lagati ho, yahan saaf kar dogi to kya ho jayega. Baccha tatti kar de to bhi hum saaf karein. Har bbat ki report banti hein. Har chhez ka survey hein. Bahut kaam hein"(Initially we were doing only clinical work. now every work is ANMs work. if the centre is not lean, she is told to clean the place saying that don't you clean your house? Even if a child shits, we are told to clean. The reporting and survey

work has to be done for all health programmes. The work is too much).

The increased survey work is totally unacceptable as it is time consuming, too long, are not able to calculate percentages. It is too much of paper work that leaves little time for any other works. Jyoti commented that they feel as if they have been reduced to mere clerks (Refer Case Report No. 4). In her own words:

" humein to babu bana diya hein" (we have been made clerks)

With the removal of male MPW workers, the work pressure on the ANMs has increased to such an extent that they find it beyond their capacity to fulfill every task assigned to them. The male MPWs used to accompany them during field visits earlier and share the work of ANMs. Those male MPWs who are still continuing are reported to be of no help since their only major work now is to collect malaria slides. The entire burden has come on the ANMs who feel overburdened with responsibilities. The stopping of new recruitment of male MPWs by the state government seems to be a decision taken without doing any ground work and working out the possible impact of it.

The district officials informed that the work of an ANM is shared and facilitated by 3-4 agencies. These are the Anganwadi workers, Dais, Mahila Sangh members and the 'Jan Mangal Joda'. The Anganwadi workers are expected to teach the children and their mothers about personal hygiene like regular pruning of nails, taking bath every day, wearing clean clothes, maintaining cleanliness in and around houses, to keep all eating items covered, etc. Awareness thus created can help reduce the frequency of occurrence of common diseases like malaria, dengue, tuberculosis, etc. thereby reducing much of the burden on an ANM as well as improve the general health condition of the people. A major help from the Anganwadi workers is expected in the form of dissemination of information to the people about the day and time when the ANM would come to the Anganwadi of the area to do immunization work related to various diseases from time to time. This would ensure a larger coverage per unit by an ANM by saving her the trouble of going from house to house.

The Dais can be found in every village and in the urban slums in most of the cases even today. Instilled faith in her that has developed due to long years of association with her and her easy availability even at odd hours as compared to the ANM makes her a preferable choice for

most of the local people. The Dai is viewed as an elderly woman of the village in whom the rural women can confide their problems freely. These special advantages enjoyed by the Dai can be instrumental to the ANM in many ways. The responsibility of normal deliveries can be left to the Dai after she has been trained in the conduction of safe delivery and has been provided with adequate supply of the Mamta kit[5]. She can refer complicated cases to the ANM. She can keep the ANM informed about the health condition and the problems of the pregnant women in her area, and the new ANC cases. She can help impart education to the pregnant women regarding hygiene, vaccines and IFA tablets to be taken and about the diet that she should take during ANC and PNC phases. The Dai can also assist the ANM in motivating women for adoption of FP methods.

The Mahila Sangh consists of 5-6 women who because of belonging to the same village in which the Sangh will function enjoy closeness with the village women. The monthly meetings of the Mahila Sangh are attended by the ANM. Any work related to women and child health is a concern of the Mahila Sangh. However, the main function of the Mahila Sangh members is related to FPP like contraceptive distribution and motivation for FP adoption. Thus, they share most of the motivational part of the work of an ANM.

The scheme of 'Jan Mangal Joda' has recently been started in Rajasthan. They are eligible couples who have adopted FP method after 1-2 children and thus can be a source of inspiration for their community members. They are paid an honorary amount for motivating people for FP and distribute contraceptives.

Such kind of expected help as emphasised by the district officials was denied by the ANMs.many of the ANMs have denied any help from the AWWs or the help is reported to be confined to only the immunization day. (Refer Case Report No. 6, 23,14, etc.). The Anganwadi workers are not willing to help because they get minimal amount for running Anganwadis and therefore have no motivation to extend help to the ANMs. The help from the Dai is dependent on the kind of relationship ANMs share with them. If the relationship is harmonious then only Dais could be of help to the ANM and this is not the case most of the time. A tussel between the two often props up on the issue of money received per delivery. Prakasamma made a similar observation in 1978 while analysing the factors influencing the performance of ANMs[6]. The

[5] Mamta kit is a plastic bag given to ANMs by the health department in order to be distributed to all pregnant women in her area. It contains basic material required at the time of delivery conduction like new blade, clean thread, spirit, etc.

[6] Prakasamma, (1989), " Analysis of Factors Influencing Performance of ANM in Nizamabad District", Unpublished Thesis submitted to the Centre for Social Medicine And Community Health, JNU, New Delhi.

Mahila Sangh members have not been of much help to the ANM. The 'Jan Mangal Joda' are rather a burden on the ANM, as reported by them in the various case reports. The ANMs reported that these couples have not proved to be of much help to them. All the more handling of these is an added responsibility on her since the ANMs also have to maintain records about the number and progress of 'Jan Mangal Joda' of their area besides various other records. Thus, in practice none of these agencies have shared the burden or facilitated the work of an ANM.

The ANMs also expressed their sadness on the attitude of the higher officials towards them. Inspite of putting in so much labour to accomplish the various tasks assigned to them, they will never hear one word of appreciation from them. All the time they are rebuked for not having achieved the given targets. The higher authorities are not ready to listen to the problems they encounter in the field. Sapna has expressed her unhappiness about the action taken by the MO of her revamping centre. The MO had sent the complaint against her when she was found unavailable during a surprise visit to one slum under her area without giving a chance to explain the reason for her absence.

Urvashi and Jyoti have informed the researcher about the problems some of the ANMs in their block are facing due to tension betweeen the MO and the ANMs. They said that recently a new system has been started. According to it the salary ofan ANM is released only when her attendance as marked in the attendance register is approved by the LHV and the MO of the PHC/ BPHC in which or under which she functions. the MO was reported to have stopped the release of salary of 1-2 ANMs because he was not happy with them as they have not achieved the given targets. Urvashi and Jyoti commented that it is wrong to give power of sanctioning the salary to the MOs as they never visit the field and so are not aware of the practical problems the ANMs have faced whch has resulted in non-achievement of the assigned targets. Many other ANMs in this regard said :

> Koi hamari nahin sunta. Hum itni mehnat karte hein. Dhoop, barsat, thand har mausam mein kaam karte hein. Itni itni door paidal chalte hein. Logo ko samjhate hein. Vo nahin samajhte to hum kya kar sakte hein. Hum sab mushkile sahkar ye naukri paise ke liye karte hein. Yein hamari tankha rok dete hein. Bataon apna kharcha kaise chalaein?" (no body listens to us. We do hard work in all kind of weather. We go on foot to long distances for our work. we try to convince people but if

they are not ready to listen what can we do? We are doing this job inspite of all troubles so as to earn money. They stop our salary. You tell how we would manage our expenditures if we do not get our salary on time?)

Some of the ANMs including Urvashi and Jyoti have also given positive feedback about the MOs of their respective areas. Radhika's trust and confidence in the MO of her CHC was displayed clearly when she went to ask him as to whether the researcher can be told what she is asking and only after getting assurance from him was she ready to answer to the researcher. The other staff members were reported to be cooperative. Some of the ANMs have also expressed that the MOs and the LHVs would help them in their work like filling up of the forms. They would at times even go with them to convince a case if the ANM had failed in her efforts to do so. However, this cooperation is not universal and is not enough to take away the workload of the ANMs.

The ANMs in all the case reports have said that they are not happy with the job. Such a perception of the ANMs is due to the several problems they face in doing their work. As such they clearly expressed that they would not advise any other girl to enter this service. All those ANMs who are having girl child clearly said that they would certainly not want their daughters to do this job. They said that they would give good education to them so that they can opt for better jobs if needed.

The ANMs said that they have never been asked about their problems and involved in the decision making process. For years they have simply carried out the responsibilities assigned to them. Their involvement in the decision making process was conceptualised under TFA but that too has been reported as not to have been translated into implementation. The TFA has not brought about any changes in the nature of ANMs work besides reducing stress on FP. Their setting up of targets for themselves depend on the assessment they make themselves through data collection under TFA. However, the data is not accepted at the face value and is manipulated by the computer according to the desired targets as reported by Vijay Amma Nayar and Kavita Amma Mathew. The targets have not been completely removed since they continue to exist in the form of percentages (10% of the assigned population). This fact was invariably given by all the ANMs. Now though the targets are not mentioned in terms of the number of cases an ANM has to give over a year they are expressed indirectly in the form of percentage of population to be

covered by an ANM. For example there has to be 1% sterilisation cases of the total married women, 100% of immunization cases and so on.

As described earlier in this chapter, the only channel through which ANMs are given a chance to express their views are the monthly meetings. This all goes to prove that the aim of decentralisation envisaged by the health planners through TFA has not been achieved. In fact many of the ANMs are unfamiliar with TFA as theory. They only know that since 1996 their chase for sterilisation has reduced. However, they express the target removal for FP has not occurred, all the more they now have targets under almost all health programmes. The TFA has not been a help to them particularly because since its introduction the paper work of ANMs has increased considerably. It was a sudden change for which they were not prepared and adequately trained. As such the desired results as were envisaged by the TFA formulators and higher levels implementators have not been quite visible after 4-5 years of its implementation.

The CNA approach though adopted by the Health Department by the Government of Rajasthan since 1997 has not been implemented so far. None of the ANMs were found to be aware of this approach. The complete information about it is not available even with the district officials. Only the Demographer and Evaluation Officer at the Directorate of Health and the Principal of the ANMs' training college at Amarsar contacted in this study had knowledge about the CNA approach. This is because these people have been involved in the CNA's approach formulation and the strategy to be adopted to implement it. Though the manual for this approach has been released but as the CNA has not been implemented yet, an analysis of its impact on Health Service System with regard to ANMs functioning has not been possible.

Some Critical Issues

In addition to the above stated problems, there are some critical issues that demand a discussion at this point. First of all the major drawback of this method of data collection is that it includes only the eligible couples in the age group of 15-45 years. This leaves out the rest of the population falling in other age groups. Since ANMs being women themselves approach only women, the survey population further narrows down to only eligible females in the age group of 15-45 years. The people would not appreciate the ANMs approaching men particularly on FP issues. Further, as pointed out earlier, the ANMs in this study belong to the similar socio-cultural background, as

the population being served by them and as such are themselves hesitant in talking to the males. Th interaction between the ANMs and the men among the population they serve is particularly less in the rural areas as compared to the urban areas. Moreover, children bearing and rearing are considered to be female responsibilities and male duty remains specified only to earning bread for the family. So the data in this form can be collected only through females. The men folk are ignorant as to what all facilities/ services their wife are taking from the ANM and are least interested in knowing about this. This problem has been particularly aggravated since abolition of male MPW post who were functioning and serving as an important link between the Health Service System and males of the targeted population.

In a patriarchal society where the women are not the deciding factors even of their sexual life, the data collected from them raises serious doubts regarding its validity. Such a process of data collection fails to involve men. Discussions with the key persons in this study and also direct interaction with some of the community people[7] have indicated this trend. There have been instances when ANMs were able to motivate a woman for undergoing sterilization and took her to camp for this purpose but that woman's husband had come to take her back shouting that how could they bring their wife without his consent for the operation. The doctor had to allow him to take his wife back then. The family planning methods are adopted by women only mainly because the males do not want to adopt any FP method themselves. They believe that undergoing sterilization would render them unsuitable for the agricultural work and would reduce their vigour. The women folk also wish to continue bearing this entire burden of family planning due to such beliefs. Moreover, they have seen or heard the cases when the wife of a man who has undergone operation got pregnant after which the husband and the entire community has blamed the wife for having extramarital relations and she has been thrown out of the house. Such happenings have generated negative attributes towards vasectomies. Though in theory now a days emphasis is being placed on male sterlizations but in practice it is not occurring. Even with respect to the use of contraceptives for spacing births the maximum users are the females. The ANMs, key persons and people's responses in the present study have clearly pointed out towards this lacuna and the sterilisation figures for male and female sterlizations at the district level highlights this fact. This trend exists irrespective of the fact that as compared to female sterlizations the male sterilisation is

[7] As explained while discussing the limitations of the study, the research design of the study does not include the community since it focuses on ANMs. The community people however were contacted at the centres- SCs/ PHCs/ CHCs and at their residences. The feedback on issues related to the health service system particularly those related to the ANM of their respective area as perceived by them was received through informal discussions with them on issues related to the health service system particularly the ANM of their respective area as perceived by them.

a very simple operation with apparently no side affects and with non-scalpel vasectomy it has become even more simpler. On the other side, females often develop some kind of reproductive tract problems like constant gas trouble, headache, white discharge, indigestion, etc. Out of these, the problem of white discharge (medically called Leucorrohea) was found to be present in many of the women beneficiaries contacted during this study. This is a problem which in medical terms will be categorised as RTI/STD but which was found to go unreported almost completely. The main reason in this regard was hesitation on women's part and not being probed on this aspect by the ANM of their area. Further the health problems of males such as Sexually Transmitted Diseases (STD) remain unaddressed.

The second issue is to enquire who all have been the designers of these forms and strategies adopted under TFA. All the ANMs said that they have never been involved in this process. Studies done in Rajasthan and other states to find out the success of TFA that have been reviewed in Chapter II show that these forms have been formulated and finalised at high levels. The important decision-makers are health ministers, trainers, doctors and heads of health institutions and the health funding international agencies like WHO, World Bank, etc. The ANMs have never been consulted on these issues ignoring completely the fact that the success of the whole exercise would ultimately depend on them. They who are the actual dealers at the field and the first contact points of the targeted population seem to play no part in the process. Not only the ANMs, but even the statisticians at Deputy CMHO office who compile the data at the district level have also been completely left out. Immediate supervisors of ANMs - the LHVs and medical officers also do not have an adequate representation and say in this decision process. The strategies and programmes are designed at top levels and the grassroot workers are told to implement them.

The policy formulation and implementation of it seems to completely overlook the practical feasibility part. The removal of male MPWs[8] and promoting the ANMs to MPW status was a decision taken to reduce the programme cost ignoring the fact that handling of so much work is practicably unfeasible, particularly owing to the fact that the ANMs have to serve a population already large to be beyond their capacity to serve efficiently. ANMs are less educated

[8] The Gehlot government in Rajasthan has stopped any new recruitment in the salary scale 1 to 6. With retirement of the last employee in one such category the corresponding post would automatically be abolished. The Male MPWs fall in one such category. As such, no new male MPW is now recruited; only the old ones at very few places are still working.

and majority of them have not been trained for this purpose. So doing the reporting and survey work is a cumbersome and wasteful exercise for them. Though the ANMs feel the tension of target achievement relieved to a large extent now, the pressure on them has increased tremendously. As discussed earlier, the various agencies at the primary level e.g Anganwadi workers, Dai, etc. have not served as helpers to the ANMs as envisaged by the health planners.

The travel part of her work has never received due attention while her workload was increased. She has to travel on foot to long distances on difficult terrain with heavy load to carry. This load is unwelcome even on normal days what to talk of days. So on days when she is facing health problems specific to her gender (menstruation, pregnancy, etc.) she is unwilling to do field visits. In an exhausted state when she reaches her field all her energy and motivation to do good work has left her. In the beginning when she has just joined she makes field visits inspite of such problems for the fear of losing service, but once she gets acquainted with the work well. She starts skipping visits to the filed particularly the areas that are distantly located. The policy makers of India have always overlooked this aspect of an ANMs work and once even when efforts were made to provide relief to the ANMs on this aspect, the step undertaken was impractical as always. The ANMs were provided with easy loans at minimal interest rates to buy Moped (Hero Puch). While providing this option to the ANMs the government failed to consider other things like - do the ANMs know how to drive, even if they know are they expert enough to drive on difficult terrain and muddy roads, will they have money to spend on petrol and such other things. On the other hand in the urban areas where the ANMs could have actually used the Moped in their work, no loans were provided there. It will be needless to add here that the measure failed to fulfil its purpose. The ANMs are on same ground as they were before the measure was undertaken. All the more, the measure has taken away the right of the ANMs to express their grievances on this point and it remains one of the major hurdles in the success of an ANMs work. Manipulations then could creep into data. One of the District officials had remarked, "they do not do the field work properly and neither can they do it". At this point a question arises as to why inspite of being well aware of the limitations of ANMs, she has been burdened with so many responsibilities.

In the end it may be said that the present chapter reveals the problems being faced by the ANMs as her role in the health delivery system has changed with time. The increasing workload has added on to her already existing problems. These problems have been described and discussed in the light of her being a woman who is working in a patriarchal society, her being placed at the lowest strand in the organisational hierarchy and her having no role in the decision making

process. A summarisation of the major findings and conclusions that can be drawn will be done in the next chapter.

CHAPTER 4

CHAPTER IV
SUMMARY AND CONCLUSION

The study has been conducted in the Jaipur district of Rajasthan. Out of the 13 blocks in Jaipur district 4 rural blocks were choosen. The sample consisted of a total of 25 ANMs and 2 LHVs. Out of these 8 respondents belonged to an urban area of the same district. The study also included the PHN, Principal of the ANMs' training college and other district level health officials who have acted as important sources of information related to the present study.

This is a qualitative study that draws on the various case reports of all the ANMs and the LHVs prepared through extensive and in-depth interviews conducted with them. Similar of interviews were conducted for the other informants as well. Checklists according to the category of the respondents were utilized. Some informal interviews were also conducted with the community being served by the ANMs at some places.

The study has repeatedly emphasized the need to look at the functioning of an ANM from various angles before one outrightly blames her for the failure of non-performance of the assigned duties. It can once again be emphasized here that the practical nature of any task desired to be undertaken has to be worked out before its actual execution irrespective of the fact how well formulated and well-designed the methodology to carry out that task may be. The task will not be done if it fails on practical grounds even if it was being done with the best of intentions. An ignorance towards this fact is one of the major reasons why the ANMs are not meeting the desired levels of performance and why so well designed health programmes fail to give desired results at the implementation level.

ANM is a woman who in a patriarchal society is placed next to the man even today. In most of the cases this woman has stepped out of the four walls of her home due to the financial constraints being faced by her family. Inspite of getting economically empowered she has to follow the norms set for all women by a patriarchal society. She is not allowed or rather will not be appreciated if she interacts with men in the course of her work. She is vulnerable to fall prey to sexual harassment by the males. She is to strike a balance between her family and her job and failing at either end may be quite undesirable for her. It may be argued at this point that this kind of problems may be faced by any other working woman and so why these are specifically being

pointed out in the case of ANMs. This argument can be answered in the light of the working and living conditions that are unique for an ANM.

The conclusions of the study will be now drawn, which will also explain this fact of uniqueness of the working and living environment of an ANM.

- **Field work:** The inclusion of field work as an integral part of her functioning makes her standout in comparison to all categories of working women, e.g. nurses, sales girls, executives etc. She has to make house visits to deliver health services to the people. A proper interaction with the people is hampered due to prevailing superstitions and misconceptions among the people even in the contemporary times; the distortion done to her image due to the coercive way in which Family Planning Programme was implemented for the past two decades; and above all her inability to meet all the health needs of the people. With respect to the latter reason, it needs to be highlighted at this point that though the ANMs have to provide health services under all health programmes, she even today continues to function for Family Planning Programme. *** The target removal has not taken place. Her functioning is controlled to a great extent by the facilities that are available to her with respect to delivering of health services. She can not stay at her respective health centres because she does not have a place to stay and would not like to part with her family. As indicated earlier that in the name of medicines what she delivers are mainly contraceptives, vaccines and Iron and Folic Acid tablets (IFA) and this is what she has to offer to the people. When she is of no help to the people even in the case of common and minor ailments, the people loose their trust and confidence in her and start diverting towards the indigenous and traditional healers or the private practitioners. They are irritated when all the time she is asking them to adopt FP methods.

The areas to be covered by an ANM may be widely scattered and distantly located. In the rural areas the ANMs may have to cover villages upto 8-10 km and many 'dhanis', which are located in even more remote places. Due to the lack of transport facilities, she has to go on foot to long distances and has to cross-difficult terrain. She is not even paid the travel allowances. As discussed in the previous chapters the step taken by the government to resolve with respect to this problem, the ANMs were offered to take a loan upto Rs. 15,000/- to purchase mopeds. However, the initiative has failed completely. The reasons behind it are: firstly, as was found by the present study the

ANMs in the rural areas do not know how to ride the moped and secondly, the topography of Rajasthan is very uneven that makes this solution unfeasible. However, this could have offered a solution in the urban areas, but in these areas the ANMs were not offered any such loan.

- **Her being a woman:** Being women ANMs have certain limitations, which cannot be ignored. During house visits in her assigned areas, she has to encounter all kinds of people. Besides being rude to her, as pointed earlier, she may be subjected to sexual harassment. An ANM becomes vulnerable to such harassment particularly during nights and in the lonely places. Previously there were male MPWs who used to accompany them to the field visits. The government's decision of removing the MPWs from the service has left the ANMs alone to the responsibilities, which earlier were shared between them and the male MPWs. If they cannot live at their respective health centres and are afraid of such mishaps that may occur, the ANMs do not attend delivery cases at night and also avoid visiting far off and lonely places even in the day time.

Her travel to distant villages and 'dhanis' is further made difficult by the amount of load she has to carry e.g. vaccine boxes, registers, her own handbag etc. Then her responsibilities towards her family and her job put her in a difficult situation. Due to long and indefinite hours of service, that in an ideal situation she must do, would not leave her with enough time for her family. Particularly, in case when she has small children she is compelled to carry them to the field or leave them back home if there is some one to look after them.

Interaction with the people of opposite gender is yet another problem for the ANMs. Despite being a health practitioner she is not appreciated to talk to the men about sensitive issues like family planning, diseases of sexual organs etc. An ANM because of coming from similar social structure would also not feel free and motivated to interact with the males on such issues. In the present study none of the ANMs reported that her working has created tensions in her family either from the in-laws side or from the husband's side - this would show the co-operation and understanding on her family's side. However, it may be pointed out that all the families are in need of her to continue with the job due to their financial constraints. Most of the ANMs do not attend to late

night calls. They live with their families thus managing to perform both her duties- of an ANM and that of a housewife and mother.

Another point as indicated in our discussion earlier can once again be highlighted. The Family Planning Programme (FPP) though has been made to function according to the felt needs of the people through an improved version of data collection for the purpose of need assessment, it continues to promote only female specific FP methods. The main among these methods is still the female sterlizations- tubectomies. This trend would also supported by the ANMs functioning under this programme as they would not go and motivate men on this aspect and also because the facilities and motivation from the health department lacks completely. Whereas the sterlization camps for women are organized every week in a block, no such camp organization would take place for males. Males are particularly hesitant to come forward due to their fear of loosing strength and vigour. Females also have similar fear and moreover, have their genuine apprehensions in case a male vasectomy fails. The bitter experiences of 1970s are still remembered and so the wives would like to take all the burden of Family Planning. There has been no campaigns or information dissemination of knowledge on vasectomies from the health department. The removal of male MPW has in reality seriously disrupted communication between the males and the health delivery system. due to emphasis on female sterlizations the entire load falls on the ANMs.

- **Forms used by ANMs to collect data:** the process of data collection is being emphasized and has been proposed to be strengthened through the introduction of different forms for this purpose under TFA. These forms were designed at the higher levels in which the grassroot workers had no role to play but to whom the responsibility of filling them up has been given. No formal training has ever been organized to train the ANMs for this purpose. The knowledge in this regard was given to them through the MOs in usual monthly meetings. Most of the ANMs find problems in filling these forms. The pointed out that the form are too lengthy, all of them are not able to calculate percentages and it is not easy to get answers to all questions. Above all the ANMs do not appreciate the entire process of data collection, compilation and transfer. This work has been a useless burden for them. Due to these problems the data collected is incomplete. Moreover the data collected by them is not accepted at face value. It is often manipulated according to the targets

available with the Computer that have been set at the national and international levels. They do not plan out action plan for themselves. They continue to work towards targets handed over to them by the Computer and are rebuked when they fail to do so.

The system of data collection through ANMs is partial in the sense that it covers only the females in the eligible age group of 15-45 years. The males who are the main decision-makers in a family in a patriarchal society are left out. Such a process can be criticized because it ignores completely the fact that the main decision-makers in a family in a patriarchal society and that a woman does not even has the right to decide about her sexual life. The focus of the increased focus on the women may be presented as a step taken towards women's empowerment but we cannot assume an ideal world to do work with such ideal thoughts. The practical aspect cannot be ignored because it will remain there even if we close our eyes from it. Also the family is the responsibility of both wife and her husband and therefore, any Family Welfare Programme including the FPP must equally involve both of them.

- **Workload on an ANM:** the workload on ANM has been ever increasing. She was initially absorbed to deliver health services of a midwife, slowly was also given work of FP, MCH, etc. of which FP ruled for two decades and presently they have become MPWs who are to perform all functions of all health programmes running in the state. Since the removal of male MPWs, all the workload has come on their shoulders. They are to serve a population of over 5000 scattered in atleast 4-5 villages and many 'dhanis'. The coverage of such large and widely scattered population in absence of transport facilities and to do all functions efficiently is too much to ask from an individual. The study clearly reveals that it is well accepted and known at the district and the state levels that the ANMs are overburdened with work and often skip their scheduled visits to the field. The transferring of the ANMs, and rebuking them on detecting such failures from ANMs has not improved the situation. Limiting supervision to report checks and surprise visits to keep control over the ANMs is also no solution. Expecting them to work without any motivation or encouragement in the form of appreciative and lack of incentives for their hard work and the scope for promotions; non-cooperation from the people; lack of adequate facilities available

to them to live and to deliver health services are factors which preclude effective functions of ANMs.

- **Decision-making power:** the ANMs being placed at the lowest in their organization's hierarchy are to carry out what has been told to them. They can neither decide on what has to be done and how it should be done inspite of the fact that they are well acquainted with their areas where they have been working for long periods. They are well aware of the various health problems the people of those areas and can be an important source to give insights into the alternatives sought to solve them. However, the ANMs have never been involved in the decision-making process. During the top down approach they were not the definitely deciding factors and after the adopted bottom -up approach to health planning through the TFA and CNA strategies, the ANMs role in decision making process has not been realized practically. They have not been empowered to take decisions on what are the needs of the people in her area and what work she must plan out for herself accordingly. She is handed down targets and is told to do what has been assigned to her and in the way she is instructed to. Moreover, the system controls her through regulating the supply of medicines, equipment, etc. for some particular diseases and not others. The state has traditionally used or exploited ANMs to fulfill its Family Planning targets.

It can be concluded that the ANMs' non-performance of duties and inefficiency is to a large extent due to inadequate training, inadequate infrastructural facilities, the lack of transport facilities, lack of motivation for them, etc. She being a woman is faced with some practical problems and a total ignorance or rather neglect towards these by the health planners is definitely not going to give the desired results. Her role as a grassroot worker that may be critical to the whole health delivery system has not received due attention. The TFA and the proposed CNA have not shown encouraging signs of decentralization whereby the ANM can be empowered to take decisions at their level and can be actively involved in the decision making process. The data collection is partial, incomplete and is indicated to be manipulated. The practical feasibility of all these aspects has been totally ignored which has resulted in failures or non-achievement of the desired results and a lot of wastage of scarce resources including human power. The ANMs are then blamed under such circumstances. This study has once again highlighted the importance of grassroot workers in the delivery of health care in a situation when the system is faced with the challenge of meeting the needs of so diverse population, in so different environments- social,

cultural, economical, political and ecological and that too with so scarce resources. A realization of the goal to be able to meet this challenge cannot happen without the active involvement of the grassroot level workers. ANMs of these are most important because she is the one who is in direct contact with the people. With the advent of TFA and CNA, ANMs have become the most important and most overburdened health workers. Therefore, need to equip her well with knowledge and skills of her level, providing her with all required facilities and giving her the decision making power are all steps that should be taken for achieving the goal of health services from below.

APPENDICES

APPENDIX 1

Case Report No. 1

Name: Radhika Amma K. M.

Age: 40 years

Religion: Christian

Marital status: Unmarried

Family:

She originally is an inhabitant of Kerala. Her family consists of her father, mother three brothers and four sisters. She herself is on third child of her parents. Her father had a shop and earned about Rs. two thousand per month. Two brothers are in private service and the third one is serving at Jodhpur (he previously was in Kanpur and shifted to Jodhpur because his wife is a stenographer there). One sister is settled in Jodhpur. Her husband is an electrical technician in a hotel. One is an ANM in Kerala because she was able to score good marks and the young one is studying in Kerala.

Educational Qualifications:

10th pass (1978). She has also done courses of type writing and short hand. She did her ANM training from Tonk in1982-83 of 2 years. The main courses taught were midwifery, anatomy and medicine. The course also included practical in wards.

Reasons for becoming ANM:

She became an ANM because she wanted to do some service that she would not get in Kerala. Her family condition was financially not too bad. She had a cousin in Tonk, Rajasthan who is a staff nurse in Jaykay Lon hospital at Jaipur who had called her here when she was 27 years old.

Postings:

1983 at Bhandarja, Dausa PHC for 1 year. Then from 1984-88 she was posted at Khadera, Dispensary for 5 years. After that she was transferred to her present place of working in 1989- CHC, Chaksu. When she started working she was able to speak English-Hindi mix. She tried to imitate another person and gradually learnt the local dialect. Now she can work in Hindi and converse in Rajasthani fluently.

Responsibilities:

When she has started working her work was confined to clinical work only such as bed making, mouthwash, bandage injection, etc. she was never sent to field. The fieldwork now includes motivating women for FP, malaria, TB, immunization, surveys, etc. She has 7 wards under her and has plan tours to them. Immunization is fixed for Thursday.

Changes since TFA:

Since 1995-96, targets under TFA have been removed and they are supposed to fix targets for themselves according to the data collects from that year's survey. However, targets continue to exist though not in absolute number. E.g. atleast 35 Laprioscopic Tubectomys to be done in a year. Immunization coverage is to be100 percent. Work has increased now due to surveys. Earlier they noted on a plain paper name, etc. of entire population. Now have to cover only specific group population - 15-49 years.

Since last year surveys have become more extensive. e.g. previously just asked how many children. Now will ask how many children, want more or not, which method they want to adopt, after how much gap, etc. etc. Format is lengthy and difficult to understand but doctors and compounders would help in filling it. They were explained about this format (introduced in 1996) in a PHC meeting held at Kotkhawada. She is able to do survey but there are some questions for which getting answers is very difficult e.g. after what gap you want next child? They get the answer - we will think later. Such answers are difficult to interpret and filling the relevant column. Then Muslims would not give the right information regarding whether they have undergone LT or not. When ANMs approaches them for FP they would say that they have got LT done whereas no such operation has been done.

Currently most important works are malaria, TB, FP. No particular in the population covered by her; only seasonal ones.

Perception:

There are many ANMs in her family and so this profession is perceived as a good one. In Kerala any kind of service is considered essential, and so all services are acceptable to them.

Their Reaction is mixed. Some say we have come only to catch for operation (e.g. Muslims, Punjabis). This ANM is living near CHC on rent alone. Brothers and sisters would come on visit. Villagers do not consider living alone bad.

The staff at this CHC consists of 4 ANMs, 1 LHV, 5 doctors, 5 compounders, 4 class IV workers, 2 sweepers, 2 Lab-technicians and 2 clerks. Staff members are very cooperative. Doctors help them while filling the formats *.

She would not suggest anybody to become ANM because of too much work. According to her teacher's job far better since they get holidays and have definite time of service. ANM's job is tedious.

Problems:

They have to visit some households even 10-10 times to give TB medicine or counseling for FP. A number of surveys in a month which take away much of the valuable time and leave less time for other responsibilities. They have to go on foot to 'dhanis' and that too alone and so many things to carry.

After all these troubles when asked as to whether she would leave this job, she said no as she would not get other job. Now as she is places at this CHC and has been working and living in this village for quite many years now, she is in a better position as compared to those ANMs who are posted at SCs in interior areas.

She is not married because she never wanted to do mariage earlier. Parents forced a lot. She now at times feel very lonely and would marry if somebody is ready to accept her but then she says that she is old enough and she does not think that she would marry.

Suggestions:

1) Somebody should accompany them when they go to far off places for survey work.

2) Should have a male MPW so that they are not afraid of going out in night and he can help them in communicating with the male clients.

Case Report No. 2

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* *When the researcher approached her for the first time she got nervous and to confirm that the researcher is genuine and she can talk to her without any fear, she went to the doctor to seek his advice and permission. This indicates her trust in the doctor and close bond among the staff members.* [1]

Name: Sarla Sharma

Caste: Brahmin

Marital Status: Married

Family:

S he is married; her husband does private work. Earns around Rs. 2000-2500 per month. 3 children- 1 daughter and 2 sons. Daughter is 18 yrs old, has passed 10^{th}, and now married. 1 son is studying and other is learning stone work (precious).

Her in-laws live in Jaipur & have own house. She lives in this village in house on rent goes to Jaipur on leave days & on every weekend. Her mother in law manages the house at Jaipur. Her parents lived in Dausa, both parents now not alive.

Reasons for becoming ANM:

She joined ANMs job after her children grew up for economic reasons. She never had any desire or ambition in her life. She was informed of this job by her elder- in law. Father worked In khadhi bhandar which he left after wards the household expenditure was run by the money given by her mamma she has two brothers the younger brother is working in RSEB elder brother was superintendent officer at Kota; now retired.

Education:

8^{th} pass 10^{th} fail (2-3 times)

1989 - 90 2 years ANM training at Jhunjhunu, Rajasthan.

Postings:

Her first posting was at Jhunjhunu Jasrapur village SC in 1991. However, she did not join because it was very far from her home and she cannot leave the family. 2nd posting at Bhodki Jhunjhunu for one year. Since 1992 posted at this CHC Chaksu.

Responsibilities:

She has 7 wards under her (2,7,8,9,14,15,19). Thursday is fixed for immunization. She visits and work mostly in 7 & 8 number wards because they are near this CHC and least work is done in ward no.19 because it is farthest (she goes there once a month).

Problems:

Survey work 2 tedious. She faces difficulties in categorizing her clients according to the format given in the register. She also difficulty in calculating percentages. Her staff members are very helpful in filling up the forms. People do not answer properly so it is difficult to fill up the forms. She also does not under understand various devices. This survey work has recently (1995-96) onwards has became so difficult

Cover couples in the age groups of 15-49 years. Do not talk to males go to only women. Males are too shy to come forward to ask for condoms so they have kept these open in the CHC now they come and take so atleast they are using but cannot keep the record as to who has taken and how many and other related details.

Suggestions:

1. Should stop survey work.
2. Number of ANMs should be increased to decreased work.

Case Report No. 3

Name: Urvashi Sharma

Age: 28 years

Marital status: Married

Family:

She is the original inhabitant of Jaipur. She got married in 1996.Husband works on a stationary shop at Jaipur. Earns around Rs. 2000 per month Has two children 1 son of 3 years and 1 girl of 6 months.

Her parents are residing in Jaipur. Her father was driver in railways. His monthly salary was around Rs. 12000-13000 per month. Eldest sister is ANM at Gangapur PHC. (They together have undergone training). 2 sisters are in final year and 1 is in IInd year. All are in Gangapur.

Reasons for becoming ANM:

The reason for entering into this job was that it is a government job and ensures employment and does not require much qualification. So, she went head with the training and on completion joined as an ANM. After marriage since her husband's income has been insufficient to run their household's expenditure, she has to continue in the service.

Education:

She did her graduation from Gangapur in 1992. In 1990-91 she did one & half year ANM training at Karoli. CMHO was their neighbour who informed them about this job.

Postings:

First posting was at Gangapur PHC in October 1992. Worked there for 3½ years. Presently posted at Jaiprakashpura SC in Kotkhawada block. She has only 1 room there.

Responsibilities:

Previously she had 10 villages but now a separate staff appointed for 3 villages. Therefore she covers 7 villages and a total population of 4635. Every village is 6-7 km away atleast. She is afraid of going alone so she goes with another ANM of the area adjoining her area. She lives in Jaipur and comes daily to her SC at 9:00 a.m. and goes back by 5:30-6:00 p.m.

The main works include:

1. vaccination
2. conducting deliveries
3. FP work like distributing oral pills, inserting Copper-T, motivating women for sterlizations, etc.
4. Survey work: yearly survey in March-April, Monthly report, pulse polio survey and others.

Change since TFA:

Since the adoption of TFA by the government they do not have to force people, they are self-aware. 4 years back used to get Rs. 15 per case, now this provision has been removed. Now area wise motivation is counted.

Perception:

Her family has a good perception of her doing this work. Her mother in law takes care of her children and would help her in other household works when she is too tired her mother in law would prepare tea for her and also cook dinner. Husband is also cooperative. Never fight due to her work.

She perceives this job as very difficult and unsafe. Hard to travel on foot to long distances, cross 'nails'. Do not get travel allowance. She has to leave her daughter of just six months old with her mother in law. Her younger sister keeps coming so she gets help. After all day's hard work too tired to attend her children but has to because otherwise the children would feel neglected. She also does not like her old mother in law to work and even after getting tired she does the house hold work.

Problems:

Face problems in Dhani where Meenas live because they are rude, have dogs and are not ready to accept FP methods. It is also unsafe as a woman for them to go to such places.

Case Report No. 4

Name: Jyoti Sharma

Age: 46 years

Marital status: married

Family:

She was married in 1972, husband is UDC in roadways, three children one son (12 years in VIth class) and two daughters (one 25 years married her husband is a mechanic in Videocon company, and the other is 22years in service as a teacher).

On her parental side she has mother and father, three brothers and 2 sisters. Her mother is an ANM, now about to retire. Her father has retired as compounder after serving in SMS hospital Jaipur in 1973. One brother is a compounder at TB center Jaipur, the other two run a tailoring shop in their home (one among them is deaf and dumb).

Education:

Had passed 10th before marriage. In 1982 she underwent one and half year ANM training at Tonk. Her husband was then working in Delhi and visited her in every eight months. Rest of her family was living with her. They have taken a house on rent for Rs. 150/- per month.

Reasons for becoming ANM:

After marriage her family has been facing a lot of financial problems. On her mother's advice she filled up the form for ANM's course. Initially her husband did not want her to do service, subsequently in his office one of his colleagues convinced him about his wife's joining the ANM's job and therefore he permitted her to go.

Postings:

First posting at Tela PHC in Alwar, 1984. here she worked for five years, then worked for five years at Padampura, Alwar. Now for the last five years she is placed at Kraparampura SC in Kotkhawada block.

Responsibilities:

She has four villages under her and covers a population of 5535. She visits one village per wee She would the SC at 9-10 am and goes in the field from 12 am to 5-6 p.m. Her main responsibilities are:

1. Give medicines to TB patients, if she fails to go to any village, she send the information to the patient to come to her and take the medicine.
2. Prepare malaria slides.
3. Under FP she distributes condoms and oral pills during her field visits. The 'copper T' inserted only at the SCs.
4. The MCH work includes immunization and ANC.

5. Prepare monthly reports. Till 6 years back she said they used to get their work report on a plain paper. 1996 on wards they were given registers of definite format to record their work progress. This format was modified in 1998. The main change according to her is the inclusion of the column for previous year's achievement along with the current year's achievement. According to her there are few problems in the new format, like

   i. Difficulty in understanding the forms.

   ii. They find it difficult to do calculations, particularly to find the percentages.

   iii. The format is too long and so time consuming.

   iv. Due to the above problems and inability to get answers to many questions many a times they have to leave the forms incomplete.

From five years ANMs have been given the survey registers to collect data related to family welfare on the basis of annual survey of couples in the reproductive age groups. Before this period also they used to conduct survey, but the registers were of different format. They were bigger and according to her though they contained less number of columns, the information collected were much more comprehensive.

Problems:

Besides above indicated problems she listed out a few others as below:

1. Have to travel long distances, at times through sparsely populated and unknown areas. This very tiring and also involves high risk of their personal safety.
2. People are some times not cooperative and rather rude to them. At times when asked for some information, would provide wrong ones.
3. The reporting work has increased considerably. She said "hamein to babu bana diya hein" (we have been converted to clerks).
4. The thick registers, vaccine carriers and their own handbags in which they keep the contraceptives and other medicines make heavy and inconvenient load to carry to the field. Particularly owing to the fact that they have to walk on foot all alone.
5. Needles are given to them are very thick and unsuitable for use in. she has to buy thin disposable syringes from her own pocket. Many a times they reported this fact to the higher authorities at BPHC, from where they collect their required inventory items, but they get the answer

   " hamare paas to yahin aati hein" (we get only these).

Perceptions:

People are now more aware and themselves come forward for FP and immunization. However, still a good number of people are not ready to accept the FP methods and going for immunization particularly this trend is prominent with the Meenas and the Muslims. The Muslims would give wrong answers and Meenas keep dogs, and because of this ANMs are afraid to go to their houses. In general peoples perception about the ANM and her job is good.

Her family is quite cooperative; she gets due respect among her kin. However, she would not advice anybody for this job because it is too tedious and risky. Her staff members are very good particularly the doctor, he would himself go the field with her to convince the people if they are not ready to accept the immunization. She feels very comfortable and confident to work with him and considers herself fortunate enough to have him as her medical officer. She respects him a lot and can not say no to any work assigned by him.

Case Report No. 5

Name: Radha Sharma

Age: 34 years

Marital status: Married

Family:

She is an original inhabitant of Jaipur. She has been married for 14 years, presently lives with her husband, two sons, mother in law, elder brother in law and his wife and their son. Husband works in medical shop in Jaipur and earns about Rs.2000 per month.

She herself earns about Rs.6000 per month. Her both the children are going to the school. The eldest one (10 years) studies in 5th standard and the youngest one is in nursery. Both of them are studying in a private school. She does not live at SC because then there will be 2 houses that would be difficult to manage 2 houses financially. Children education is also costly.

Her parental side's family consists of her mother, father, brother, his wife, two younger unmarried sisters and a nephew. Her father is a carpenter in railways and brother works in a shop.

Education:

She has completed her higher secondary from Jaipur. Then she joined the course for ANM and completed the training of one and half years and gave a service bond of five years.

Reasons for becoming ANM:

Her mother in law was an ANM. She advised her to undergo ANMs course, as the income of her husband was very low.

Training:

Besides ANM training she has received in-service training for 15 days about MCH under IPP IX project and 6 days training on RCH. She has also been trained in TB sometimes. She does not feel that training brings some kind of change in her work.

Postings:

Bhanpurkala- for 1 year.

Jaipur- for 1 year.

Bichcha- 1 year.

Bhurla (SC under Baskhon PHC, block Bassi) - 7 years.

Responsibilities:

She has 7 villages under her covering a population of about 5000. She sits at Bhurla SC 2 days/ week. Out of the rest of the 6 villages, she goes to 2 villages 1 day/week and to the remaining 4 1 day per week or in two weeks. She would open the SC everyday at 10:00 a.m. then would go in the field by 12:00 a.m. and returns home by 5:00 p.m. The main works listed by her are:

1. ANC
2. Immunization: every Thursday is fixed for it (earlier date would be fixed no it's the day)
3. Conducting deliveries
4. MCH
5. Family planning work: this work includes motivating people to adopt FP methods to restrict their family size. She educates about and distributes oral pills, 'Nirodhs', inserts Copper-T and would take willing women for undergoing Laprioscopic operation during camps held at Baskhon PHC or Bassi CHC.

Men do not lend to vasectomy. Even the women (their wives believe that their husbands would get weak and will have problems in their work and so do not like their husbands to undergo vasectomy. She said that ANMs do not talk freely to the men; they motivate them through their wives only.

6. Malaria
7. Survey and reporting work: Monthly report has to be submitted every 20th of every month. Yearly survey done each year during March-April. For outpatients coming to SC she maintains OPD register
8. Tuberculosis, Cataract, AIDS
9. Giving free medicines

After TFA self survey method started to fix targets according to people's desire of specific methods. Targets are still present e.g. sterlizations (laproscopy) have to be 1% of the total population.

Problems:

Far-off villages; sometimes have to traverse through the jungles. She is afraid of going alone and therefore either LHV or nurse of PHC will go along.

Perceptions:

Her family members like her job. From villagers she would get the respect as given to any teacher; infact she also sometimes teaches. However, she would not advise any other person to enter this job because it is tedious, family is neglected, there are no fixed working hours and its unsafe.

Staff members are very cooperative. She does not face any problem with them.

Suggestions:

Need one more helper preferably a male.

Case Report No. 6

Name: Rakhi Nagar

Age: 46 years

Marital status: Married

Family:

She has been married for 24 years. Her husband is food inspector at CHC, Bassi. She has 4 children - 3 daughters and one son. First daughter is 23 years old, married and is a teacher. 2nd daughter is 22 years; doing B.Sc. Nursing. 3rd one is 18 years of age; studying in 1st year. The son is 20 years old and studying in 2nd year.

Education:

Senior secondary (12th) and 1 and a half year training of ANM at Tonk. According to her the training become more practical. Village visits have been made compulsory.

Reasons for becoming an ANM:

She says that she lives this job. Her most of the family members - parents side as well as in-laws side, are associated with some medical profession. Earlier she was a teacher now she has shifted to this job because of good salary and her personal preference for it*

Postings:

1st posting at Bhanpur Kala for 3 years. Then at Bassi CHC for 3 years. Now at Jhar SC for 7 years. For 8 years she lived at Bassi. Now for 6 months she has shifted to Jaipur.

Responsibilities:

Now days she says maximum pressure is placed on immunization as compared to FP. She is having 3 villages under her and covers a population of 6000. Maximum people in her area are of Meena caste and almost 80 percent of them are service class employed in railways or telephone.

Earlier register was good. She informed that prior to change of the survey register a seminar had been held in the Directorate of Health at Jaipur. 1 ANM and 1 LHV were called form each PHC in the district. She has attended the seminar but her presence sake only. She also accepts that survey work has increased, its lengthy and consumes much time.

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* Though this ANM was speaking in favour of ANM job, she does not want her daughters to enter this job. She said why should they become ANM when they are studying so well and are eligible for better posts such as staff nurse.

Problems:

1. No support from Panchayat members and Anganwadi workers.
2. During night unsafe to attend deliveries or other complicated cases in people's houses.

Suggestions:

1. At 1 sub-center there should be atleast 2 ANMs because this will reduce the load and they together can go to long distances and unknown places.
2. According to her, male worker is not needed. The male worker at Baskhon PHC is of no help to the ANM there. His responsibility is just to make malaria slides of patients coming to the clinic.

Case Report No. 7

Name: Lakshmi Amma C.
Designation: LHV.
Marital status: married

Family:
She has been married for 23 years. After marriage she and her husband migrated to Rajasthan because here she got the job of ANM. Her family consists of her husband, one son and herself Her husband is 2 years older to her. Previously he was in military now he is a driver who takes stones and mud from the hills in this region to the city. She earns around Rs. 6000 p.m. and her husband around Rs. 4000 p.m. now she is not facing financial problems. She has only one child -boy-18 yrs old. He is living with his mama in Kerala. He is not good in studies. Flunked in 10th once. She says he would not do any service due to low qualifications and cannot say what he will do.

She belongs to Kerala. Her father was in military. When he got retired he started doing 'majdoori'. They are 10 brother and sisters.

Education:
She passed 10th in 1963. Then she underwent a 4 year course of Malyalam Viduan meant to become teacher. She has also done short courses in typing. She did ANM course of 2 years from Boondi in 1973.

She informed that the ANMs course then comprised of 1year of basic nursing and 1yr in midwifery.

Reasons for becoming an ANM:

Due to large family size and meager income they were in bad condition. It was difficult for her father to pay even Rs. 15 per month as her school fee. She wanted to become a teacher but could not because she was not able to continue her studies. During that phase she came across an advertisement for ANM's service in some newspaper. Since the jobs are not easily available in Kerala and this was one opportunity to get a secured government job. She had just got married then. So she and her husband both migrated to Rajasthan where she was getting the job.

Postings:

She got her first posting in 1977 at Lavan. After that she has been transferred to 5 places: Lavan, Amarsar, Baskhon, Lavan, Badnagar and Rojvadi. Rojvadi is a Mini PHC. She was an ANM till 1989 when she became an LHV. The mini PHC at Rojvadi, where she is currently posted, has the following staff-

2 compounders, 1 doctor (male), 1 LHV, 1 ANM, 1 technician, 1 4th class worker and 1 sweeper

Responsibilities:

She has the work experience of 22 years. It was not compulsory for ANMs to give cases till 1988. From 88-96-it became compulsory. Now these have again been removed but they continue to give cases. Till 1988 she was doing work only at the clinic. After this period only, she has started going to the field visits.

She has under her 8 sub-centres so she has to organise 8 tours per year visiting 1 sub-centre per month. She holds Mahila Sangh meetings per month in which the women from that area (around 10-15) are called and are taught about seasonal diseases e.g. during summer they will be told about diarrhoea-> how to prepare the liquids to be given to the child, etc. maximum number of cases of sterilization come during winters because people believe that it is better to undergo operation during this period.

Now a days every Thursday immunizations are done at the PHC.

Perception:

She does not face any difficulty in her work except for people's perceptions towards ANMs. Initially their behaviour was very rude. They did not allow her to enter their house. With time as she became familiar with these people their behaviour has softened a bit. She says that people have become aware and they therefore, themselves come to her for the operation and she no longer have to chase the cases but still in

new areas they have to suffer rude and harsh behaviour of the people. They scold them and ask them to run away saying that

' yein to naukri pakanein aayein hein' meaning they have come because they have to as its their duty.

She has learned Rajasthani language and so is able to talk to the people and staff people in local dialect, which has helped her in interacting smoothly with the village women.

She did not support of other girls or if she had a daughter of her becoming an ANM because though she was not ready to complain against her job she was not happy as there is no respect in this job, they have to walk on foot long distances, still have to meet targets defined now in so much %age of the population under them.

Problem:

She faces problems like:

1. People's behaviour is still rude. They still view them as coming merely for operations. Moreover this thing has emerged that people believe that it is their duty to give them medicines and do immunizations. So particularly the TB patients would not come to the center but would take it for granted that they would come to their home for this purpose. ANMs have to chase them most of the time they are not available. Similarly now when there will be immunizations done in the center people will not come assuming that they would come to give the dose to their homes.
2. People still are not fully aware of vaccinations and would not take the dose. Some castes are a constant problem like Muslims & Meena. Muslims would not easily accept FP methods and handling Meena is not safe.
3. Their job is not safe, as they have to go to lonely areas. Some rape cases have occurred when some ANMs were called on the pretence that they need to attend to some complicated delivery and then were taken to some lonely place and raped. When the matter was brought to the notice of Sarpanch, he clearly refused to do anything about it saying that before going have they asked him.
4. Today they reported that facilities are not sufficient to deliver the services.
5. Since the MPW scheme workload has increased considerably.

Case Report No. 8

Name: Rama Agarwal.

Age: 35 years (1965 born)

Marital status: married

Family:

She has been married for 16 years. Her husband is a LDC at Jaipur High Court. She is the original inhabitant of Bharatpur, Rajasthan. She has 3 children, one daughter (12 years old and studying in VII th class) and two sons (one 6 years studying in class I and the youngest one is 4 years old, studying in Kindergarten).

Education:

She studied upto 11th class (1984). In 1991-92 she had undergone ANM training at Amarsar.

Reasons for becoming an ANM:

When she got married, her husband did not have any job. After all children were born, it became difficult to run the house. She filled the ANMs form and her number came, so she joined. Soon after she got her 1st posting her husband also got service in High Court (on somebody's recommendation) but then she did not leave her job because it's a government service and says who will leave after getting a government service and paying reasonably well.

Postings:

Her first posting was in 1992 at Sikar, Rajasthan but she did not join because then she will have to live away from her family. She joined the next posting in 1994 at Baskhon mini PHC, Bassi, Rajasthan. She has been working here for 5 years.

Responsibilities:

She has 5 villages under her and a population of about 9000. She has to do the clinic work as well as field work. She comes to the PHC between 9:00 and 9:30 am. for the clinic work. After working till 12:00 p.m. she leaves for the field, there she works till 5:00 to 6:00 p.m. She does not do any duty at night or attend any delivery case. She also does not stay in the PHC village but at Jaipur, where her husband and other family members are residing.

Her main work includes:

1. FP - distributing contraceptives, motivating women for FP, handling 'Jan Mangal Couples'. Etc.
2. MCH
3. Immunization
4. Preparing malaria slides and giving medicines to the suspected and confirmed cases of malaria.
5. Giving medicines to TB patients
6. Leprosy, etc.
7. Survey and reporting work

Changes since TFA:

According to her the pressure in terms of target achievement continues to exist but not directly. Targets are still there though not in terms of absolute numbers but in terms of percentage of the population e.g. 1 percent of total eligible population of women to be sterilized, 284 immunizations till measles third dose. Since the introduction of TFA the survey work has increased considerably. New formats to collect and compile data have been introduced. The respondent informed that no proper training has been organized till now regarding the filling up of these forms but they were explained superficially in one of the monthly meetings. Moreover, the survey work is quite time consuming; almost complete 2-3 days are utilized for preparing monthly report from 'Seva-Panjika' which they maintain for each month. Apart from the regular record ledgers, they are also to conduct many other occasional surveys like pulse-polio, leukorrhea etc. They are generally not consulted before inducting such surveys or deciding upon the change in the formats of the various forms used by them.

Problems:

1. Even today ANMs do not get due respect from the people they serve. Though awareness level of the people regarding FP and immunization has gone up as compared to what it was some 4-5 years back yet at times people are rigid and would even resort to harsh treatment to the ANMs. The belief that ANMs are solely meant for catching women for sterilization has not been wiped away completely and continues to affect the relationship between the ANM and the villagers.
2. She has to travel long distances on foot and at the same time has to bear the load of carrying all the things critical to her functioning.
3. She expressed her inability to do service in the night because, as already written, there is no place for her to stay in her area of work and also finds it quite risky to attend cases in the night. She informed that there have been cases where ANMs were called on the pretence of requiring to attend a complicated delivery case but were raped on the way. When the matter was reported

to the Sarpanch, he denied to offer any kind of help saying that the ANMs go without seeking his permission/ advice and for their own monetary gain.

4. She feels that the targets are still existing. Their entire work assessment depends upon the various records maintained and reports submitted by them totally disregarding the actual work they do in the field.
5. The department is insensitive to their practical problems. Though the Anganwadis and 'Jan Mangal couples' are proposed to be there to help them, no help is given by them to the ANMs and they are alone to handle all the works. The male MPW in this PHC is of little help. His responsibility is limited to preparing malaria slides of the patients coming to the PHC. He lives in a village that is farthest in her entire area of work. If he can cover the information of his and nearby area, she could be saved of the trouble of traveling that far and would also get more time to devote to other important works.

Perceptions:

Her husband does not like her job and always insists her to leave it. However, the service does not become an issue of tension between them.

She too does not appreciate the job much but had to continue with this due to financial constraints in her family.

Her colleagues are quite cooperative. However, she feels that because of being placed at the lowest ladder in the organizational hierarchy, they are bound to listen and do as told.

Case Report No. 9

Name: Lalita Amma Nayar.

Age: 47 years.

Marital status: married

Family:

She was married in 1976. Her husband was working in sales department of a transformer manufacturing company at Sudarshanpura. In 1996 he suffered from a head injury and had to stop working since. All these years he was receiving treatment and now he is 90% fit for work. In last January

he has joined in a Marble company at Morena. Presently his monthly income is about Rs.2500/- only.

She has two children the elder one is a girl and younger is boy. They are 18 and 14 years old respectively. Both of them are studying. The girl is in B.A. 1st year and the boy is in 8th standard.

Her parental family lives in Thiruvananthapuram. Her father died. They are 5 brothers and sisters in all. She is the eldest. One brother is inspector in state police department and the other one is an accountant in state roadways. Both her sisters are married, one sister's husband is working is a foreign country and the husband of the other sister runs an autorickshaw workshop.

Education:

She is an original inhabitant of Kerala. She studied there till class 10th. After that she joined 2 years ANMs' training in 1969-70 at Bharatpur.

Reasons for becoming an ANM:

Her father was working was serving in defence forces and was posted at Delhi. She came to Delhi in 1968 and went through an advertisement in a newspaper and applied for the job. As per the norms during the time of training the ANMs were to sign a 5 years' service bond, which she was unaware of. And after that when she wanted to quit the service she had to pay Rs.20,000/- approximately, but her family's financial condition was such that she was not able to pay that much of amount. And she continued with the service.

Postings:

After the training she got posting to Sawasimadhopur. In 1983 she got her next posting to Amrasar CHC but due to her sickness from breast cancer she is working at MCW centre at Purani Basti, Chandpole in Jaipur.

Responsibilities:

Her work area covers 5 villages and 6000 population, this includes 800 couples.

The main works are:

1. FP services.
2. Conducting deliveries.
3. Immunization.
4. Hygiene and health education.
5. Survey works.

Changes since TFA:

There has not been much change since the introduction of TFA in her nature of work. The targets are still there. Though there has been a difference in the sense that pressure for the cases has been reduced. However, now the targets are in terms of percentage of the population. Like per 1000 people there should be 35 ANC, 32 deliveries etc. however, a lot of survey work has been introduced with the new forms. She informed that the information they are collecting presently was also being collected by them previously also but now they have separate registers to record the same information at separate places. This has unduly increased their work of reporting and survey work. Also they are told to send copy of daily work as recorded in the 'Seva-Pustika' to the district office. For this they have to get around 10 pages per day Xeroxed since they also need to maintain the same pages for their own record. They are not paid any money for this purpose and on complaining are threatened of their being transferred.

She revealed that the data collected by them is not almost always accepted by the Computer in its original form. He would manipulate the data according to the desired targets set by the state/ national government for that year.

The ANMs are never called when the formats of these forms are being changed and one or two times they have been called, most of the ANMs did not attend that meeting because of the less value they place on the reporting work.

Problems:

Fieldwork was not taught to them during the training. The training mainly focussed on clinical works. The survey work and report preparation separately for each head is a cumbersome process and certainly not welcomed. They have increased the workload on ANMs to a great extend. Now every work is ANMs work. From the job of a cleaner to a doctor all works is their work. She is very unhappy about this.

Case Report No. 10

Name: Kavita Amma Mathew

Age: 53 years

Marital status: married

Family:

She is married for 26 years. Her husband is a P.A. in the office of income tax. He earns about Rs 7000/- pre month. She has 2 sons. Both are married. One is settled in America and the other is settled in Jaipur. There are no financial problems in the family.

She originally belongs to Kerala. Her whole family is involved in agricultural activities. She lost her father when she was quite young.

Education:

Her formal education is upto class 10^{th}. In 1968-69 she has joined for 2 years' ANM's training at Ajmer.

Reasons for becoming an ANM:

Due to early death of her father her family had ben facing financial problems. Therefore on coming across an advertisement in paper about the ANMs post in Rajasthan, she applied for it. Upon being selected she joined the course and became an ANM. After getting married she continued her service because her income is required to run the household efficiently. Moreover, this is a government job and now then she is getting paid around 8000-9000 Rs per month, she is not leaving the job inspite of her expressing severe dissatisfaction about it.

Postings:

She worked in Ajmer for around 10 years and after that she got posted in Jaipur District.

Responsibilities:

Her work area covers 5 villages and 6000 population, this includes 800 couples.

The main works are:

1. FP services.
2. Delivery services.
3. Immunization.
4. Hygiene and health education.
5. Survey works.

Changes since TFA:

Her perception about newly introduced TFA approach is that the targets are still there. Though they feel the difference in the sense that pressure for the cases has been reduced. Now the targets are in terms of percentage of the population. Like per 1000 people there should be 35 ANC, 32 deliveries etc. However, a lot of survey work has been introduced with the new forms.

Problems:

Fieldwork was not taught to them during the training. The training mainly focussed on clinical works. Now every work at a centre- SC / PHC /CHC is her work. Work pressure has been increased far beyond their capacity to carry out the responsibilities given to them.

Case Report No. 11

Name: Rupinder Kaur

Age: 28 years.

Marital status: married

Family:

She was married in 1994. This was an arranged mariage. Her husband is running a showroom of readymade garments in Germany. He is settled there before he got married. He comes to India in every 2-3 years.

Presently she is staying with her parents at Jaipur. The reason behind her not going to Germany along with her husband is that her mother has advised her to brought up her daughter India only as the climate in Germany is not favorable. Her husband too thinks the same.

She has one daughter of 4½ years old. She has started going to school. Her mother and younger sister look after her when she is away from home on duty.

She has her father, mother and 2 sisters. Her father is now retired as principal of Industrial training Institute (ITI), Jaipur. She is the eldest among the sisters. Both the daughters are now studying, elder one is in B.A. 1st years and the younger on is in 12th class.

Education:

She had completed senior secondary education before joining the ANM's training. She had undergone the training of 1½ years during 1991-92 at Amarsar.

Reasons for becoming an ANM:

When she was studying in her 12th standard she came across the advertisement of ANM's training. She applied for it. however that time she was totally unaware of the responsibilities of ANM's

job. Her father had some other future plan for her, so he didn't want her to join this service. But she insisted to go for it and requested her father to allow her to join the service, though she would face some difficulties.

She wanted to become a doctor. She had secured 1st division in her class 10th examination but could never appear for PMT because immediately after her class 12th examination she joined in ANM's training. And again she got married after the completion of the training.

Postings:

She was 1st posted to Kishangarh SC in Jaipur in 1992 but she didn't join there because it was very far from her maternal house. Also her family people didn't allow her to go away from the home and stay alone. She is now posted at Mohanpur SC since 1998.

Responsibilities:

She has 10 villages under her, which covers 5000 population approximately.

The main works are as below:

1. Slide collection for malaria.
2. Vaccination (on a fixed day in the week- Thursday).
3. Entire work of ANC and PNC.
4. To attend delivery cases.
5. Survey works-> yearly survey in the month of March and April for preparing SC action plan, monthly report of SC for AIDS, leprosy, TB etc.
6. Get copper 'T' and LT cases.

Changes since TFA:

She has joined the service when the TFA approach has already stared, so she is not much aware of any changes taken place as a result of TFA's implementation. She fixes the targets according to the SC action plan prepared on the basis of yearly survey. The computer professional and the LHV help them in this process of target fixation. The actual figures are generally manipulated, either increased or decreased according to the prescribed standard e.g. on every 5000 population there have to be 30 LT cases.

Problems:

1. The population she covers is 5000, which is according to the prescribed norm, but she is to cover 10 villages. As these villages situated in scattered places she has to do extensive

travelling on foot. To reach one village from another she is to travel atleast 4-5 kms. However, no conveyance facilities are provided to them.

2. Her husband is always away from the home, at times when her daughter falls sick she feels the absence of her husband. During those days she has to leave her daughter at home under the care of her mother or other family members.
3. The ANMs are not provided with any MPW so they themselves are to carryout all the works, which she can not carry out with same efficiency.
4. She is not able to calculate the percentage. Again the figures are manipulated according to the desired results.
5. The forms are too lengthy to be filled.
6. She finds that the surveys are too difficult to carryout.

Case Report No. 12

Name: Sujata Singh.

Age: 29 years

Marital status: married

Family:

She got married in 1990. Her husband is doing silk printing work along with a partner at Motinagar in Jaipur. From this profession he earns about Rs.5000-6000/- per month. She has one daughter of 4 years old. These days she has started going to school.

She originally belongs to Jaipur. Her parental family consists of mother and father, 2 sisters and 1 brother. Her father is a compounder in a private clinic. Her elder sister is married and settled in Meerut. The other sister has expired. Her brother is three years younger to her; he was doing a computer course some time back. However, he fell into the bad company and started taking liquor and left the study.

Education:

Her formal education is upto 12th standard. In 1989-90 she joined for ANM's training of 1½ years at Amarsar.

Reasons for becoming an ANM:

She was impressed by the nurses in childhood during her visits to her father's clinic. The dressings of the nurses impressed her and she wanted to become like them. After seeing the advertisement

she filled the application form. The family opposed strongly to her decision, particularly her father never wanted her to join ANM's service. But she was determined to join in this job and didn't listen to anybody. She left eating and drinking for two days and shut herself in a room. This made her father to give her the concent to go ahead with her plans. Even after her marriage she continued with the job because her husband's income was not sufficient to pull the family expenditure comfortably. Her income has not only been the support to the family but has also provided a government accommodation to the family to live in.

Postings:

She was posted for 8 months at Jawata Rampur PHC then she worked for 9 years at Amarsar SC. Presently she is working upgraded SC at Watika.

Responsibilities:

She covers 2 areas - Watika and Ram Singhpura, in which she serves a total population of 10,000. She comes to the clinic at 10 AM, and stays there till 12 o'clock. In the afternoon she goes for the field visits. She is able to cater to the need of the people in odd hours because she stays in the SC accommodation itself.

The main works are as follows:

1. Slide collection for malaria.
2. Vaccination (on a fixed day in the week- Thursday).
3. Entire work of ANC and PNC.
4. To attend delivery cases.
5. Survey works-> yearly survey in the month of March and April for preparing SC action plan, monthly report of SC for AIDS, leprosy, TB etc.
6. Get copper 'T' and LT cases.

Changes since TFA:

She feels that there has not been much change after the introduction of TFA. The targets continued to exist not in the form of absolute quantity but in percentage. Because of which the ANMs continue to feel pressurized. Particularly the introduction of the survey work has totally been undesirable and according to her. This is an added but wasteful burden on them.

Perceptions:

Her parental family has never been supportive to her job. Her husband specifically doesn't like her going to the houses of the people and working at odd hours. Sometimes it has even resulted into tension between them. He often comments that she is more devoted to the job than to the family.

The villagers are both good and bad. If someone comes to seek her help in conduction of a delivery and she is not well acquainted with that person she first asks the villagers living close to her house, some person would even accompany her in such a case.

The staff members are cooperative.

Problems:

1. The population she covers is 10,000, which is not according to the prescribed norm. She finds it difficult to cover the entire population. The problem is further aggravated due to the lack of transport facilities.
2. Because of the job the family often gets into some tensions. She is sometimes not able to give due attention to her 4 year's old daughter owing to the long and indefinite hours of the job.
3. She is not able to calculate the percentage. Again the figures are manipulated according to the desired results. The forms are too lengthy to be filled. She finds that the surveys are too difficult to carryout.
4. Though the ANMs do hard work but still the officials never appreciate their efforts.

Case Report No. 13

Name: Aditi Rawal.

Age: 25 years.

Caste: Yaduvanshi.

Marital Status: Unmarried.

Family:

She is an original inhabitant of Jaipur. Her father died when she was studying in 8th standard. They are 6 sisters and one brother. Her 4 sisters are already married. The brother is still unmarried and presently working at a shop, from which he earns about Rs. 2000/- per month.

Education:

Presently she is undergoing her third year graduation in arts with the subjects' combination of economics, political science and sociology. When she was in her second year B.A. she joined the ANM's training at Amarsar during 1997-98. The duration of the training was 18 months.

Reasons for becoming an ANM:

After her father' demise it was difficult for them to meet the expenses of the family. That time she started taking tuition of the school children and her brother also stared working. From whatever they were able to earn her family managed to pull on. During this phase when she came across an advertisement in a newspaper about ANM's service she applied for the post. At the time for applying for it she was unaware of the actual job responsibilities of an ANM, she took it to be like other nurses' work one usually sees in the hospitals. After completing her training she immediately got the posting. Now She has been in the service for around 2 years and has got sufficient exposure of the work they are to carryout. She is continuing mainly because it is a government job and so secured and reasonably well paid.

Postings:

After her training she got posted at Sainthal, Dausa, for about one month. She lived there in a rented room in one of her relative's house. Now she is placed at Dhaulai, upgraded SC which is 15 kms away from Bandikui. This SC falls in Bhanpurkala block of Jaipur district. She will be completing 2 years there in June this year. Upgraded SC is bigger than SC there are three posts in all, one-fourth class, one ANM, and one compounder.

Responsibilities:

She has 6 villages under her and covers a total population of 7000. There is a provision for 1 post of mail worker at this upgraded SC but he is on deputation at some other center and so she is left alone to cover the entire population all by herself. She daily comes to the headquarters to mark her daily attendance. She visits each village at least once in every week. The main works to be carried out by her as out lined by her are:

1. Immunization of all children in the age group of 1-5 years.
2. ANC, PNC, motivation of women for undergoing sterilization.
3. Motivate for FP and distribute Nirodh and oral pills.
4. Prepares slides for malaria.
5. Surveys- AIDS, TB, Leprosy, Blindness, Pulse Polio (1-5 years old children). Prepares monthly reports and send to block PHC.

6. People come to her during morning clinic hours to take medicines for seasonal diseases.
7. Give TT injection to 15 to 45 years age group women once in a year.
8. Give health education particularly to maintain hygiene to all women whether married or unmarried or going to be married.

Problems:

1. Being unmarried and young she faces difficulty in going to the field alone. Therefore the fourth class worker accompanies her most of the time. She had taken loan for the HERO PUCH and has purchased it. Her family members are afraid of sending her alone and therefore do not allow her to use it.
2. No solution to the problems the used to tell in the monthly meetings observing which she has stopped raising her problems in such meetings.
3. The population to be covered is 5000 theoretically, but she has been given much more, which is beyond her capacity.
4. She feels that those ANMs who are placed in cities are in a better position mainly because they are saved the trouble of doing daily up and down from home to the center.
5. Survey work is very tedious for there are separate registers and different surveys for every programme. This increases their work unnecessarily.

Perceptions:

The behaviour of the village people is mixed - some are good some bad. Her family considers this work as good. For her it is a government job due to which she has been sticking to it, but at the same time she finds it very tedious and unsafe. There are no rewards for good works. She says that the TFA has not removed the targets, they still get scolded if found unable to meet the given target. She would not suggest anybody else to join the service. According to her a teacher's job is better than this.

Suggestions:

1. Any unmarried ANM should not be posted to rural areas.
2. Those who are educated and do good work should be given incentives as in other services.
3. The practical training should be more extensive. Due to lack of this those ANMs who are 8th pass and trained under the old programmes (in which the fieldwork was not taught) do face problems in doing the field works and filling up the registers.
4. There should be only one register to be maintained.
5. Population covered by them should be decreased so that they are able to cover the entire population.

Case Report No. 14

Name: Kusum Dhabai.

Age: 30 years.

Caste: Gujar.

Marital status: married

Family:

She is married for 4years. Her husband is a technician in a clinic in Jaipur. His monthly income is about Rs.2500/-. She has two children. The elder one is going to school and the younger one is about to join the school. She says her husband is very cooperative, he helps her in various household works.

On her parental side she has her father, mother and younger brother. Her father was a senior teacher and presently he is retired from his job. Her brother has completed his B.Sc. but he is not yet employed.

Education:

She could not get through her 10th standard examination. However, she joined for ANM's training and completed 2 year's training at Byawar.

Postings:

She got her first posting at Ajmer SC for three years. Then she got the posting at Roopwar SC at Bhanpurkala block, where she remained posted for last 8 years.

Reasons for becoming an ANM:

While she was studying the financial condition of her family was not that favorable. According to her the ANMs service was the easiest government job to get into.

Responsibilities:

Her work area spreads over 4 villages and again they are situated 6-8 kms away from each other. The total population in this area is about 3700.

1. Immunization of all children in the age group of 1-5 years.
2. ANC, PNC, motivation of women for undergoing sterilization.
3. Motivate for FP and distribute Nirodh and oral pills.
4. Prepares slides for malaria.
5. Surveys- AIDS, TB, Leprosy, Blindness, Pulse Polio (1-5 years old children). Prepares monthly reports and send to block PHC.

6. People come to her during morning clinic hours to take medicines for seasonal diseases.
7. Give TT injection to 15 to 45 years age group women once in a year.
8. Give health education particularly to maintain hygiene to all women whether married or unmarried or going to be married.

Problems:

1. To cover all the villages she has to travel long distances, which is not only difficult but also dangerous, because she has to cross the terrain. So her husband accompanies her many a times. Her husband is very adjustable and co-operative.
2. Her working area is mainly inhabited by Meena caste people. Often the males quarrel with her while they are drunk.
3. The pay revision has not been implemented yet though the revised pay scale has been announced long back.
4. She feels that TFA approach failed to bring any change to the work attitude as far as the meeting of targets is concerned. Still they are to meet 10 cases on 1000 population in every year.
5. According to her the registers are too lengthy and too heavy to carry to the field. To fill these registers it takes a lot of time. She also feels that though some changes have been made in these registers and field forms but no much changed could be observed in the basic structure of these.
6. The ANMs are not provided with any conveyance or travel allowances, this results into an extra spending for travelling to bring the cases to the clinic.

Perception:

Husband and in laws- > as most of her family members are in medical profession, therefore, consider the job of ANM is good.

Staff-> the LHV is very cooperative to her.

Herself-> she would not suggest any one to inter into this profession. So far she had to undergo cyst operation for 3 times and appendix operation once, however, no medical facility was extended to her.

Suggestions:

1. She thinks that the employment of a part time female worker would be able to takeoff some of her burdens.
2. Travelling allowance should be paid to the ANMs.
3. Revised salary should be brought into the force as soon as possible.

4. Some of the survey works should be taken away from the ANMs.

Case Report No. 15

Name: Poonam Pareek.

Age: 34 years

Caste: Brahmin (Purohit).

Marital status: married

Family:

She is married for 11 years. Her husband is a compounder in an Ayurvedic clinic. His monthly income is about Rs. 2700/-. She has two children the elder one (a boy) is 10 years old and studying in 4th standard. The younger daughter is 7 years old and presently studying in 1st standard.

At home she has her father, mother and two brothers. Her father is a retired man, and was serving in nawab tahasildar. Her one of the brothers is working in Nagar Nigam as daily wageworker. The other one is doing some private job.

Education:

She had studied upto 11th standard. Then she joined 18 months ANM's training at Amarsar.

Reasons for becoming an ANM:

She said her father asked her to join the ANM's job. She joined the ANM's job when she was not married, but continued even after marriage. From this job her earning is about Rs.4000/- per month, which is a substantial help to her family.

Postings:

She has already put up 13 years of service. Her 1st posting was at Badiakala SC near Bandipur. After that she got the posting at Samraidkala SC in Bhanpurkala block in 1989 and remained here since.

Perception:

Husband and in laws-> they like the service, even her elder brother in law's wife is also in the same service.

Villagers-> villagers treat her like their own sister or daughter since she has been working in this area for last 13 years.

Herself-> she herself would not suggest any body to get into this job. According to her "is kam mein pair tordna parta hein, bojha dhona parta hein"- in this work one has to strain her legs and lift and carry a lot of weight.

Responsibilities:

1. FP.
2. MCH.
3. Immunization.
4. Malaria, leprosy, TB, and blindness programmes.
5. Survey.

She told she doesn't go to conduct any delivery in the night, however, she attends the patient if she comes to the SC. She is able to talk to the gents even for the purpose of motivating them to accept the FP methods but she finds women are more ready to go for sterilization than men are. She also says that the newly introduced TFA approach didn't make any difference.

Problems:

1. She finds only problem with calculating the percentages, rest all the other works she is able to do.
2. She has to visit all the houses for immunization, she finds that availability of one helping staff who can stay and look after the clinic while she is in the field and also to help her in other matters.
3. She didn't take the loan to purchase the HERO PUCH because the area she covers is mostly muddy and also she doesn't know how to ride it. As a result she has to walk on foot all the distances.
4. She feels there are too much of load the ANMs are to carry to the field.

Case Report No. 16

Name: Prerna Devi.

Age: 26 years.

Marital status: married

Family:

She is married for 8 years. Her husband is working as a programmer in Indian Air Force. She has two daughters, elder one is 7 years old and the younger one is 2 years old. Her in father in law and mother in law are staying in Deora at Delhi along with two elder brothers in law and their families. Among her brother in laws one is a head master in a school and other one is engaged in agriculture, the younger brother in law is a businessman. She has two sisters in law as well. One among them is settled in Alwar and whose husband runs a private school and the husband of other one serving in army and they are staying at Rewari.

On her parental side she has mother, father, 4 brothers and 4 sisters at home. The eldest brother is a conductor in Haryana roadways; the second one is a commissioned officer in Army (Captain) and presently posted at Jodhpur. The 3rd one has car business in Haryana and the youngest one is engaged in agriculture activities.

Among the sisters she is 3rd in number. The eldest ane the second sisters are settled in Behrod. The profession of the husbands of the eldest sister and the 2nd sisters are agriculture and compounder respectively. The husband of the youngest sister is engaged in agriculture and they are settled in Rewari.

Education:

She is a B.A. in 1994-95 she had undergone the training of ANM at Amarsar.

Reasons for becoming an ANM:

The economic condition of her family was more or less good. She wanted to do a service and came across an advertisement in a newspaper and applied for the training. However, during that time she was not aware of the actual responsibilities of the ANMs.

Postings:

She got her first posting at gad PHC in Dausa in 1996. Then she got her next posting at Sahipura SC in Bhanpurkala block in Jaipur district only in September 1999.

Responsibilities:

1. FP.
2. Immunization.
3. She is to conduct Swasthya meetings where she is to gather 10-12 women and conduct counseling.
4. ANC PNC.
5. Group meetings.

6. Malaria.
7. Sterilization.
8. Leprosy detection.
9. Survey work.

Perceptions:

Husband, in laws and her parents-> her husband is very cooperative. Her family members do not differentiate this job from any other jobs. Some or the other relatives always keep coming to take care of her children.

Village-> she is not very happy with the attitude of the villagers, she says they are illiterate and do not cooperate to her.

She herself-> she wants to leave this job to devote more time to her family. She is not very happy with the nature of the job, because always she has to interact with the illiterate masses of the villages. She feels that they (ANMs) are over burdened with the works and at the same time do not receive any kind of cooperation from the villagers. Personally she would not like her daughter to enter into this profession.

Problems:

1. The ANMs do not get any transport facility, as a result she has to walk on foot many a miles through muddy roads.
2. The villagers are illiterate ane superstitious and do not understand the benefits of sterilization. Hence do not allow to get sterilizations to be done.
3. Due to the lack of transport facilities people are not ready to come for the sterilization.

Case Report No. 17

Name: Sonal Gupta

Age: 30 years.

Marital status: married

Family:

She is married for last 10 years. Her husband is a male nurse at Kharkhara PHC in Jaipur district. She has 1 daughter and 1 son. The daughter is 6 years old and is studying in 2nd standard and the age of the son is 1 and half years.

She has her father-in-law and mother-in-law and one elder bother-in-law, they all are living in Dhaulpur. Her father-in-law is a Patwari there. Her sister-in-law is married and living in Aligarh.

At home she has her father, who is a government servant, her mother, 2 brothers and two sisters. All her brothers and sisters are still unmarried. The eldest brother is engaged in precious stone work, one brother and sister (twins) are studying in 2nd year graduation another sister does painting work at home itself.

Education:

She has studied upto 11th standard. In 1988 she joined 1 ½ ANM's training, which she completed in 1990.

Postings:

After completion of her training she got her first posting at Monoharpur SC in Sikar district in 1990 for 2 years. In 1993 she was posted to Jaipur district hospital for another 2 years. In 1995 she got her latest posting to Newar SC in Bhanpurkala block in Jaipur, and staying here since.

Responsibilities:

During her first posting she lived in a rented room with her husband. Her main works were to distribute oral pills, Nirodh, ANC, PNC, malaria sterilization, give medicines for common ailment such as cough and cold, fever etc. She had never done any delivery then, as she was not trained to do that.

It was during her posting at district hospital at Jaipur that she learned the process of conducting delivery. Apart from that she used to do all kinds of clinical works including applying drips. However, there were no field visits during this period.

At present, there are 5 villages under her SC and it covers about 6000 population. The distance of the farthest village from the SC is about 8 kms. She visits 1 village in a week, and does all kinds of works an ANM is supposed to do.

She is not aware of the TFA approach but was able to tell the changes that have taken place since 1996. This indicates that she does not have an understanding of the policy level happenings. Regarding the various surveys and reporting work she informed that on 21st of every month they (ANMs of this block) are to send the monthly report of their respective areas. Yearly survey is conducted every year in March-April. Prior to 1996 this included the entire family but since 1996 only eligible couples (15-49 years age group) both men and women are included. The Computer at block PHC computes the targets based on this collected data.

Perceptions:

Her husband being in the same kind of job has a good perception of an ANM's job. Infact she had joined ANM's training after her marriage on her husband's suggestion. Her in-laws also consider her work as good. However, She herself is not happy with the job.

Problems:

1. She faces problems in filling up percentages. In fact she is unable to fill the form herself.
2. The responsibilities assigned to her are many which leads to too much of work and also she is not able to cover the entire population.
3. The timings and the nature of her job do not leave enough time for her to be able to look after her children. Owing to this cause her younger child has been living with her mother.

Suggestions:

1. Decrease the population to be covered so that they are able to increase the frequency of visits to the villages under their jurisdiction.
2. Facilities in terms of adequate infrastructure, medicines, medical equipment etc. should be provided to the ANMs so that people are attracted to avail the services provided by the government through them.

Case Report No. 18

Name: Sangeeta Pareek

Age: 24 years

Marital status: married

Family:

She has been married for 3 ½ years, her husband works as a word boy at Kanwatia hospital in Jaipur. She has 2 children, one son of 2½ years and a daughter of 6 months. She is presently living with her family in a quarter at the block PHC where she is presently posted.

Her father died when she was quite young. Her mother initially did tailoring then she took to teaching in a private school to primary classes where she is continuing till now.

They are 4 sisters and 1 brother and she is the third child of her parents. One of her sisters is an ANM at Bichoon, one is working as a teacher and the youngest one is studying in 10th class. Her brother is 20 years old and is studying in B.A. final year.

Education:

She has passed 12th and underwent 1½ years ANM's training in 1991-92 from Tonk.

Reasons for becoming an ANM:

Her mother asked her to do a service due to the prevailing weak financial condition of her family. She continued her service even after her marriage. This is a government service and her monthly income that is around Rs. 6000/- per month and also the extra money she is able to earn from the deliveries conducted by her during th4e off duty hours or at people's home together exceed her husband's income. At the time of collecting the data for the study she informed that her husband has been suspended for 13 months from his job. He was found absent from his duty when a flying squad came for a surprise check. For six months she hasn't received her salary because she was on maternity leave for 4 months and then had joined the ongoing strike of the medical staff in Rajasthan. Under these circumstances her family's only income is now some money she gets from people on conducting deliveries. This description clearly shows the circumstances under which she joined the service and reason for continuing in the same.

Postings:

She got her first posting at Aligarh PHC, Tonk district. She worked there for 2 years since 1994. The second posting was at Sirsi PHC again for 2 years. Presently she is posted at Bhanpur Kala PHC.

Responsibilities:

This block PHC covers 8 Small Villages and 15-16 Dhanis (hamlets); the total population comes to be 9338. She shares this workload with one other ANM posted at the same PHC. They together make the tour programmes to these villages and Dhanis on a weekly basis. The clinic hours are normally from 9:00 a.m. to 1:00 p.m. and 5:00 p.m. to 6:30 p.m. On tour days the timing is changes to 9:00 a.m. to 12:00 p.m. after which they leave for the field visits. Monday and Wednesday are fixed for immunization. The main works are:

1. Prepare malaria slides
2. Give medicines for common ailments
3. Conduct deliveries. Since she is staying at this PHC only with her family she is available during night hours also but she informed that she attends only to the cases that come over to the PHC or who she is well acquainted with.

4. Distribute Nirodh and oral pills
5. Motivating people for family planning
6. Propagating health education
7. Doing survey and reporting work
8. Detecting and giving medicines to patients of leprosy and TB patients

Changes since TFA:

The TFA has come into existence since 1995-96 and new forms have been introduced for conduction of annual survey after that. This survey covers eligible couples in the age group of 15-49 years. No formal training was organized for the ANMs to explain the forms and the procedure to conduct survey; only they were informed and explained about this in 2-3 monthly meetings. Some modifications in these forms have been done in the last year whereby few columns were added. Consequently the forms have become complicated and lengthier consuming more time. Also the past years record has to be now kept. The calculations are many and complicated.

Perceptions:

Her family perceives this job to be good. Her own family's sustenance is totally dependent upon it She is not happy with the ANMs job but is forced to do under her present conditions.

Problems:

1. Conduction of surveys is a tedious and difficult job. She faces problems in calculations and often commits mistakes.
2. The population large and they together fail to cover it entirely.
3. The main problem encountered in the field reported by her from the people's side is that often the men are found drunken.
4. Anganwadis do not cooperate because they get less money to run AWWs. The Jan Mangal Couples also of not much help. The village Sarpanch does not interact and cooperate with them
5. The transport facilities are not available to most of the villages and they have to walk on foot to long distance and difficult paths.
6. People have the attitude that the ANMs have their own vested interests in getting people sterilized.
7. She opined that unmarried girl should not be placed in the rural areas.
8. She faces problems in adjusting between her family and her work. Her small children are neglected due to her work. She has employed a maid to look after her children when she is working.

Case Report No. 19

Name: Noopur Arora.

Age: 42 years.

Marital status: married

Family:

She is married for 21 years. Her husband owns a shop of general goods at Sanganer. She has three children, two daughters and a son. The daughters are 17 and 13 years old respectively and the son is 15 years old. All the children are in study. The boy is studying in 11th standard and the girls are in B.A. 1st year and 10th standard respectively. She stays in Jaipur and commute to her work place daily.

Her parental family consists of 2 brothers and 1 sister. Both her parents expired when her brothers were quite young. Now her brothers are 21 years and 15 years old and both are serving in private sector. The sister is married now, whose husband owns a shop in Delhi. She only brought up her whole family and got her sister married.

Education:

She studied upto 8th standard. Then she joined for ANM's (then it was known as MPW) training in 1976-77 and completed the training of 2 years.

Reasons for becoming an ANM:

In the days of financial scarcity this was the service she could manage to get into it without having to make any investment and also with a nominal educational qualification in her credit. She came across an advertisement in a newspaper and applied for the job, this job helped her a lot to meet the expenses of the family when she was going through a financial hardship. She continued doing the service even after marriage because this is a government job and she would need money to brought up her children well.

She expresses her dissatisfaction with today's condition of the service as earlier there were no much field work and also a male worker used to accompany the ANMs to the field, which has been withdrawn these days. She feels that the ANMs used to enjoy more respect from the people earlier, now that is no more there.

Postings:

While remembering her training days she recalls that in her batch there were only three girls, and the trainers and their families used treat them like their own daughters. They used to live in the hostel

without any difficulty. The monthly charges for the hostel used to be only Rs.75/- per month. And at the end of the training they had to sign a 5 years compulsory service bond.

Her 1st posting was at Mandoli SC under Sirohi PHC in Sikar district in 1978 and she was there for 2 years. In 1980 she got her 2nd posting to Kaladera PHC and she was there for next 15 years. Then she got posted to Singodhkala SC for 3 years. She got her 4th posting to Jaipur TB sanatorium for 10 months. Presently she is serving at Bhanpurkala PHC.

Responsibilities:

1. Prepare malaria slides
2. Give medicines for common ailments
3. Conduct deliveries. Since she is staying at this PHC only with her family she is available during night hours also but she informed that she attends only to the cases that come over to the PHC or who she is well acquainted with.
4. Distribute Nirodh and oral pills
5. Motivating people for family planning
6. Propagating health education
7. Doing survey and reporting work
8. Detecting and giving medicines to patients of leprosy and TB patients

Problems:

1. She has to do too much of fieldwork.
2. Work pressure has increased considerably after abolition of MPWs and introduction of the survey work since 1995.
3. No travelling facilities are provided to them though they have to do intensive travel.
4. The respect they used to get from the people in earlier days is no more there.
5. Earlier MPWs used to communicate with the male folks regarding the FP matters. After the post has been abolished this work has been difficult for the ANMs to carryout.
6. When her children were very small she used to carry them to the field, encountering lots of problems.

Case Report No. 20

Name: Sapna Kumari

Age: 34 years

Caste: Jatav

Marital status: Widow

Family:

She is a widow now, was married in 1993. Her husband was posted at Jammu & Kashmir border. In 1996 he martyred while fighting with the enemy. She had received some gratuity and compensation on her husband's death, which she has utilized to buy a small house for her family. She has two children- 1 son (6 years studying in U.K.G.) and 1 daughter (3 ½ years studying in playgroup). Her in-laws live in Bulandshahar.

On her parental side her family consists of her mother, father, 1 brother and 6 sisters. Brother is a Junior Engineer in Mines at Jodhpur. Father was Office Superintendent in Railways, now retired. All the sisters except for 1 are married.

Education:

M.A. in Sanskrit in 1990-91 and 1 ½ year ANM training at Amarsar.

Postings:

After finishing her training she got her first posting at Nareda SC. After serving there for 4 years she was transferred to the present working place - Sardar Patel Revamping Centre.

Reasons for becoming an ANM:

She has tried for many competitive examinations like ICS etc. but could not get through. When no other option was left she joined the ANMs job in 1992 and continued to do it after her marriage inspite of the fact that her husband did not like her doing it. Now after her husband's death her only source of income is the monthly salary she gets as ANM.

Perceptions:

She is not satisfied with this service because of high aspirations from them, which are practically sometimes not possible. They are usually chided if they are not able to meet targets. She says that her seniors do not appreciate their problems.

Responsibilities:

She has 6 Katchi Bastis under her and covers a total of 10,000 population. The main works performed are:

1. FP
2. Immunization

3. TB, Leprosy, malaria
4. Conducting survey

She comes to the dispensary at 9:00 -10:00 a.m. and goes back to her house around 2:00 p.m. She says that she has small children to attend to. Though her mother's home is nearby yet she tries to reach home in time because she feels that since their father is now no more and if she is also away most of the time, they will feel neglected.

Problems:

1. There is no room in any of the bastis where she can sit. The rent asked by the people is very high for her to afford because the department is not ready to give that amount. She sits in the Anganwadis but after it closes at 12:00 p.m. she has no place to shift.
2. According to her the city people considers them to be sales girls. Earlier their attitude was very rude but now with time it has improved to such an extent that even if some case gets spoiled, she is not blamed for it. Village life for an ANM is more difficult particularly because sometimes they have to face derogatory comments from the youths. When she worked in rural area once a fellow had chased her to her home inspite of her telling him not to. Later villagers had chided him. One positive point about the rural area according to her is that since all the villagers know about each other, one can collect the entire information from one place. Such is not the case in the city and she needs to go to each household individually to collect all the required information to fill the various registers.
3. They do not get medicines for all diseases and people can not be made to trust them to seek their health by just distributing Nirodh and oral pills. She takes medicines for common ailments such as cold cough fever etc. from one of her friends who is a nurse in a government hospital in Jaipur. People sometimes taunt that if you do not have medicines why should you come? Sometimes she has to buy medicines from her own pocket.
4. There is too much load to carry to the field.
5. Then she has to leave her children with her mother when she is on duty. She feels that due to her job she unable to look after her children properly particularly when either or both of them are ill.
6. After the TFA now there is no pressure to achieve the sterilization targets. The government has now the stopped the incentive given to them per case during the target approach period. She does not face any problems in filling up the forms, except for the column of eligible couple details on 11th page of 'Seva Pangika', because she says that she is well educated; other ANMs who are less educated do face difficulties. At the same time she said that there are some questions the answers to, which are difficult to get, form is lengthy and eats away much time.

According to her the staff is very good and cooperative. However, in a recent incident, the doctor (Female) who came to the place recently on posting made a surprise visit to a Katchi Basti in her area where she was supposed to be present, but unfortunately on that particular day the ANM made an early visit to the area and went back to home due to her daughter's illness, and at the time of check was found absent from the duty. The doctor did not even ask for any explanation from her regarding the absence and sent a complaint report against her to higher authorities. The ANM sounded very unhappy about not been given a chance of airing her explanation. She explained to the researcher that she has gone to the field that day but since her daughter was very ill she had gone a little earlier than the scheduled time. She said that the doctor should have atleast asked for clarification before sending the report. According to her the department is not ready to listen to our problems, they just give us the work and we are supposed to do it anyhow. The authority does not consider that we also have a family to attend to. We do our work with full sincerity that practical problems are there which are not considered ever and in case of failure to do the desired work, we are chided. Such an attitude of the health department is some times very discouraging. She expressed her feeling of distress through the Hindi saying

> "Banne ko to dus khasam ban jate hein, pur nibhane ko ek bhi nahin hein" (lots of people are available for giving instructions, but no body is available for sharing the responsibilities and lend cooperation and help in case of difficulties).

Perceptions:

Her husband did not approve of her doing this job when alive. Her children are too young to be able to express their like or dislike of their mother's job. As far as her own perception is concerned, as already indicated she has no other choice but to continue. However, she would not suggest any body else to enter into this profession because of the problems she is facing.

Suggestions:

1. Government should provide for government accommodation in slum areas so that they are saved from people's taunts and have a definite place to sit and keep their things related to their profession. This would help them to stay for longer hours and organise their work more systematically and she would be saved the trouble to go to each individual house.
2. A male helper should be provided who can help in communicating with the males in order to motivate them for FP. In the last four years of her working in this area only one male sterilization (vasectomy) has been done.
3. Medicines besides Nirodh and Mala-D should be provided.

An observation: She was very happy that a researcher has approached her to gain an understanding of the nature of her (ANM's) work and enquire about her problems. She said that these have never been asked of her by any body

Case Report No. 21

Name: Rajni Jain

Age: 30 years

Marital status: married

Family:

She has been married for 10 years. Husband is LDC in Education Department at Chaksu. She has only one child- daughter of 7 years studying in 3rd class.

She is original inhabitant of Alwar, presently living in Pratap Nagar in a housing board house (own), Jaipur. Her parental family includes father, mother, 1 brother and 7 sisters. Father died some years ago: he used to work on a shop. Brother is Inspector in Settlement at Alwar. All sisters except one are married. 4 sisters are settled in Jaipur; one among them is a staff nurse at Mental Hospital, Sethi Colony, and Jaipur. 2 sisters are settled in Bharatpur. The youngest one is living with her mother; she is 18 years old and handicapped (cannot stand).

Education:

10th passed. In 1983-84 she did her ANM training at Alwar.

Reasons for becoming an ANM:

Father's income was not sufficient to run the house. Also she wanted to enter into medical profession and this was the easiest get through.

Postings:

First posting at Gandala PHC, Alwar. She was there for 3 years. Then she was posted at Mundawari SC, Alwar for 1 year. Now since 1990 she is working at Sardar Patel Revamping Center in Jaipur.

Responsibilities:

She covers a population of 10,000 and has one 'Kutchi Basti' under her.

1. Distribute 'Nirodh' and oral pills.

2. Insert copper 'T'.
3. Get sterilization cases to camp held on 5th of every month.
4. Refer TB patients to this revamping center for medicine.
5. Give medicine for leprosy.
6. Organise health camps - main works includes ANC check ups, immunization etc.
7. Put bleaching powders in drinking water tanks to purify water.
8. Survey works.

Problems:

1. Can not get yes or no for adopting FP method related questions.
2. Too much load to carry to the field.
3. LMP (Last Menstruation Period) is not told accurately by women, so she (ANM) faces difficulty in assessing pregnancy.
4. People are not happy with us because we do not have any medicines to deliver.
5. We have not been provided with exclusive training to fill the forms. In her training during ANM course they have only been taught how to fill in the names of all the members of each house holds, so she faces difficulty in doing survey work.
6. After launching of MPW scheme in 1984 the workload has increased considerably.
7. TFA was launched in 1996. Targets were removed but the pressure continues to be there though now expressed in terms of percentage of population. A lot of emphasis on immunization (100% coverage has to be achieved), 1% of population has to be sterilized, TB patients have to be chased to take medicine.
8. People take it for granted that ANM bound to visit their home to do immunization, give TB medicines etc. and so do not bother to come to the center.

Case Report No. 22

Name: Sareeka Sharma

Age: 50 years.

Marital status: married

Family:

Married for 25 years, husband is sanitary inspector in Nagar Nigam Jaipur. She has three children, two sons and one daughter. Her Elder son is married and a graduate, working in a sales

department in a private company. The younger son is doing his graduation. The daughter is 23 years old; she is married and settled at Bassi. Her husband is working in an electrical shop as technician.

Her both mother and father have died (mother 25 years ago, and father 11 years ago). She has two brothers and two sisters. Both the brothers are working at a battery shop in Alwar. One sister is married and the other is 35 yeas old and unmarried so far.

Education:

Matric fail; did two years ANM training in 1967-68 at Alwar.

Reasons for becoming an ANM:

She had interest in medical profession she used to get fascinated whenever she would observe the doctors and nurses giving injections. Her maternal uncle had a medical shop and seeing her interest and also the need to do service due to financial constraints advised her for ANM's job.

When she was posted at PHC at Alwar she was given a government quarter to live. After getting married in Jaipur, she used to visit the place every weekend. When her daughter took birth she engaged a servant who would carry and take care of the child when she would go to the field. For first one year she kept her daughter with herself and there after her mother in law started looking after the daughter.

Posting:

Her first posting was at Nogaun PHC, Alwar in 1968; from there she came to Jaipur and has been posted at Sardar Patel revamping center since 1977.

Responsibilities:

She covers a population of 10,000 and has one 'Katchi Basti' under her.

1. Distribute 'Nirodh' and oral pills.
2. Insert copper 'T'.
3. Get sterilization cases to camp held on 5th of every month.
4. Refer TB patients to this revamping center for medicine.
5. Give medicine for leprosy.
6. Organise health camps - main works includes ANC check ups, immunization etc.
7. Put bleaching powders in drinking water tanks to purify water.
8. Survey works.

Problems:

1. Reasons for not adopting family planning methods are not told by the people.

2. Population to be covered very large and as such she is unable to cover the entire population.
3. No promotions for ANMs, LHV posts are exhausted and are being filled by those ANMs who have already undergone LHV training.
4. Do not like home visits for the villagers and even the city people do not pay respect to them. They have to interact with all short of people more over she has not been taught of fieldwork during her training period.
5. They have to chase the TB patients to give medicines. The TB patients would not come to the clinic and since the ANMs are required to give full course of medicines in her area, they have to go to each individual house of the TB patients.
6. No officer of their department is willing to listen to the problems and cooperate with them.
7. People do not have faith on them because they do not have medicines with them.
8. MPW scheme has over burdened them.
9. Survey work is too much. She faces difficulties in filling up the forms they are very lengthy she faces difficulty particularly in calculating percentage and in getting answers to all questions.

Suggestions:

1. Decrease the population to be covered.
2. Sanction the loan to purchase two wheeler (Hero Puch) as it was done in rural areas.

Case Report No. 23

Name: Vimla Sharma
Age: 46 years
Marital status: married
Family:

She is married for 25 years. She lives in a joint family that includes her husband, 1 son, mother - in-law and father-in-law and herself. Her husband is an asthmatic patient right from 4-5 years of marriage. He left his service of home guard about 15-16 years back due to this disease. Her son is 18 years of age and is studying in 1st year in Jaipur. Her father -in -law is blind. Other in-laws are live at Eta in Agra. She has 2 younger brother-in-laws and 1 elder brother-in-law. All of them are engaged in agriculture. Also she has 3 sister-in-laws; all married.

Education:

10th passed from Jaipur. She did 2 year ANM training in 1979-80 from Amarsar.

Reasons for becoming an ANM:

1. Due the illness of her husband, he was facing problems in continuing his service and had finally decided to live it. Under such circumstances it became essential for her to do some service. During this phase she came across the advertisement for ANM's job in newspaper, she applied and on getting selected, she joined.
2. She has been impressed with the nurse's work during her childhood when she had been admitted in SMS hospital in Jaipur for treatment of fracture in her hand.

Postings:

First posting in 1979 at Kathoom PHC, Alwar where she worked for 2 years. She used to live in a house on rent near the PHC with her husband. Then in 1980 she got transferred to Bapu SC in Jaipur. She has somehow managed to get this transfer. At this place also she was living with her husband in a rented house. Now since 1994 she is been working at Sardar Patel Revamping center in Jaipur. Presently she is living at Khatipura, Jaipur in a house that originally to her parents. Considering her condition, her parents have been continuously helping her financially and have also helped in bringing up her son.

Responsibilities:

She has to cover 3 Kutchi Bastis. 1st Kutchi Basti has 2 AWWs and 2nd has 3 AWWs while the third has none. She serves a total population of 10,200. Before 1995, she used to do only clinical work besides conducting deliveries that involves attending to and giving medicines to patients of common ailments e.g. cough, fever, etc. After this period fieldwork has been included in her responsibilities. She herself does not conduct deliveries now but refer them to this revamping center. If delivery is taking place during night she goes along with some known woman.

Main works to be done are:

1. family planning
2. MCH
3. immunization
4. TB
5. leprosy
6. malaria
7. AIDS
8. survey work

Problems:

1. Muslim women in Mehnat Nagar Kutchi Basti are quite difficult to handle. They would not adopt FP methods, would give wrong answers and do not treat them (ANM) well.
2. Environment in Kutchi Bastis is very dirty and unhygienic. She says that she has developed Asthma due to such an environment and her only son is also becoming asthmatic.
3. When she goes to the field maximum number of houses are closed because most of the women go out to work. Hence, difficulty in meeting them and thereby achieving targets.
4. Too much load to carry to the field.
5. Regarding survey and reporting work she faces difficulties in calculating percentages; form is too lengthy. They do not get answers to all questions. Too many surveys to be done.
6. Do not have other medicines besides Mala-D and Nirodh to give because of which people are not happy with them.
7. She faces a lot of problems in getting her medical bills passed. In her income of Rs. 6000 per month it is very difficult for her to meet her household's expenditures.

Case Report No. 24

Name: Preeti Jain

Age: 42 years

Marital status: married

Family:

She is married for 14 years. Her in laws are living in Jaipur. Was husband was working in a private company. He took compulsory retirement 4-5 years back when he was transferred to Guwahati. She has two children; one son is of 9 years, studying in class 5th and one daughter of 12 years, studying in 7th class. Her elder brother pays her daughter's school fee in law. She has a joint family, which also includes her mother in law, two younger and three elder brother- in-laws. Two of the brothers in laws are settled outside Jaipur. All of them have their own business.

Her parental family includes her mother, father, 8 brothers and 8 sisters (including her). Father was in PWD, now retired; all the brothers are in government service. Besides herself and one more sister who is a librarian, rest all are housewives.

Education:

She passed her higher secondary from Udaipur and underwent one and half year training at Bhilwara in 1984-85.

Reasons for becoming an ANM:

She had joined the service three months before getting married. Her family was huge and her father's income was insufficient to sustain all of them. Therefore she needed to do a service. With less education and not having attended good marks, the ANMs job was what she could manage. Her parents and other bothers and sisters did not want her to do this service but she had insisted to join the ANM's job. Still in dilemma she was not able to join the then current batch, but subsequently joined in the following batch. After marriage she had to carry on with the service because her husband's income was inadequate. After her husband had left his service, the ANM's service had become a necessity.

Postings:

She got her first posting at MCW center, Sanganer in 1985 where she worked for one year. From 1986to 1990 she was working at Malvya Nagar PHC at Jaipur. Then in 1991 she got transferred to Barkatnagar, Jaipur. From there in 1995 she was transferred to Rajkiya Chikitsalaya, C- Scheme, Jaipur. Now since 1996 she has been working at the Sarder Patel revamping center, Jaipur.

Responsibilities:

She comes to the center at 9 am and leaves for the field by 9.30- 10 am from there she returns home by 5-6.30 pm. She comes to the center also on Sundays from 9 am to 11 am. She takes weekly off on Wednesday.

The main works are:

1. Distribute Nirodh and oral pills.
2. Insert copper-T.
3. Motivate eligible couples for FP.
4. Immunization.
5. TB leprosy.
6. Survey work.

She does not attend to burn cases and serious injuries. She informed that during the target approach increment was with held if the target was not fulfilled, also some times holidays would get cancelled. Sometimes to meet the target they even had to force or request people known to them to undergo tubectomy. She personally does not feel any difference between target and target free approach

because the targets are still given to them. For example, in one year 60 operations (leproscopic) have to be done.

Problems:

1. She feels the responsibilities given to them are beyond their capacity to carryout.
2. No benches are available in the clinic for the patients to sit.
3. No regular supply of medicines.
4. Atmosphere in Kutchi Basti is not good.
5. People are reluctant to adopt fp methods saying that it is God's will.
6. The behaviour of the people towards the ANMs is also not good.
7. Survey work has added on to the already heavy workload unnecessarily. It is difficult to get answer to all questions. And the increased number of survey registers adds on to the load to be carried to the field.

She did not wish to give any suggestion.

Case Report No. 25

Name: Liliamma Saharia.

Religion: Christian.

Age: 35 years.

Marital status: Married

Family:

She got married in 1995. Her husband is working in a stereo shop in Delhi where he was transferred 2 years ago. He manages to earn about Rs. 7000/- per month. These days he comes to Jaipur every weekend to meet the family. She has only one daughter of 2 and half years old. No other relatives are staying in Jaipur.

Originally she is an inhabitant of Kerala. Her parental family consists of her mother and mother. Her father is a farmer. She has three sisters and one brother. All the sisters are married. The brother is presently working as a mechanic in one of the gulf countries.

Education:

She is higher secondary passed. After that she went through the ANM's training in Tonk, Rajasthan in 1993-94.

Reasons for becoming an ANM:

In Kerala every work is considered good and it is also essential to do a service. So she joined the ANM's training. Moreover, at the time of joining the ANM's course she was unaware of the fact that it would include extensive fieldwork.

Postings:

She has been in service for last 16 years. After the completion of the training she got her first posting at Sawai Madhopur. She was posted there for 5 years. Her second posting was at Fagi, Jaipur. She is presently posted at Sardar Patel revamping center in Jaipur.

Responsibilities:

This includes Bais Godam and Rajeev Nagar slums. She comes to the center at 9 am and leaves for the field after reporting at the center. Her fieldwork continues from 10 a.m. to 2 p.m. The works include-

1. Distribution of condoms.
2. Inserting IUDs.
3. Distribution of oral pills.
4. Motivating women to adopt FP methods. And also sometimes talking to the men regarding the FP.
5. Preparing the slides of malaria.
6. Detection and distribution of medicines to TB and leprosy patients.
7. Maintaining the registers like survey registers, daily diary i.e. 'Sewa Panjika' etc.

Problems:

According to her

1. Field job is hectic, tiring and rewardless.

2. She gets mixed kind of reaction from the people. According to her only some people with whom she has become well acquainted would respect her while the rest do not perceive the ANM's job as respectable; they are sometimes even rude to the ANMs.

3. The workload is heavy and she is therefore, unable to carry out all the activities assigned to her.

Suggestions:

She would never suggest to any one to join the ANMs job. She feels it is a difficult job for the women to carry out.

Case Report No. 26

Name: Dolly C. L.

Designation: LHV.

Caste: She is originally a Christian but after getting married to a Brahmin she now tells that she is a Brahmin.

Family:

Her marriage was a love marriage and she is married for 25 years. Her husband is a radiographer in SMS hospital, Jaipur. She has two children, one son and one daughter; both are married. The son is working as an engineer in a private company at Dher ke Balaji, Jaipur. Her mother in law is living in their ancestral house in their village.

Original inhabitant of Kerala. Her father was a clerk in a cooperative society. She has two brothers; both of them are working in bank. All her sister in laws are housewives.

Education:

She has passed matric standard. She did two years ANM's training from Shri Ganganagar, Rajasthan. For 8 years she was working as an ANM. After undergoing 6 months LHV training in 1980 she was promoted as LHV.

Reasons for becoming an ANM:

In Kerala no job is inferior and ideally everyone must be working. Behind choosing ANM as a career there were two main factors- her interest in the medical profession and secondly, her not being highly qualified. When she came across an advertisement in the paper of ANM's service she applied for

the post inspite of resistance from everybody in her family. Despite of not being happy with the nature of the job she has continued with the service even after getting married and reasonably good income of her husband because this is a government service. Moreover, after being in the service for about 27 years she has somewhat compromised with the unfavourable conditions, which have been further minimized due to her posting in Jaipur. She added that the feeling that through this service she gets a chance to serve needy and ill people she has developed a philanthropic liking for it.

Postings:

She got her first posting at Ganganagar in 1972 and she worked there till 1989. She was then given a posting in Jaipur at one of the revamping centers and since then she got postings to all six revamping centers one after the other. Presently she is posted at Sardar Patel revamping center.

Responsibilities:

When she was an ANM she did all works that an ANM was supposed to do then. After being promoted to LHV her main responsibility has been supervising ANMs working under her. The second major task has been reporting e.g. prepare monthly report for the revamping center at which she is posted from the reports submitted by the ANMs of that revamping center. The medical officer of the respective center at which she gets placed supervises her in turn.

Perception:-

According to her the people's perception is good towards the ANMs. Her entire family members and relatives do not dislike her job and she is respected by all. However, she would not suggest anybody to come into this service due to the several practical problems.

Problems:

1. There are no promotions for the ANMs. Due to already existing large number of ANMs who have completed their LHV training long back and have been unable to get the desired post till now, the state government has stopped the LHV training. The various existing LHV posts have already been exhausted. Though the increments are given, the opportunities of getting promoted are absent.
2. The responsibilities are many and no one can do all of them efficiently. The work has been increased on ANMs without giving due consideration to their physical and mental capabilities. The reporting and survey work has been an unwanted and useless pressure on them. Most of the ANMs are not able to fill the forms satisfactorily and then the entire burden of preparing the monthly report from the insufficient information comes on her.

Case Report No. 27

Name: Usha Sharma

Age: 38 years

Family:

She has been married for around 20 years now. Her husband is a teacher in a government school at Sanganer in Jaipur district. She has only 1 daughter studying in 7th standard. Her in-laws are living in Watika. She has mother-in-law, father-in-law, 2 elder brother-in-law and 2 younger brother-in-law. Her husband is on fourth number among the brothers. All the brother-in-laws are working- one in electricity board, one is an Ayurvedic doctor, one is a teacher and the other runs a small shop.

Her parental family consists of her mother, father, 3 brothers and 2 sisters. Her father has a readymade garment shop in Jaipur. One of the brothers is working in roadways, second is an accountant in mini Secretariat and the third is a teacher in a government school. All of them are settled in Jaipur. Her elder sister is also married and settled in Jaipur. Her husband is working in Secretariat in the environment section.

Education:

She is 10th passed. She had joined ANMs training in 1980-81 of 2 years from Tonk.

Reasons for becoming an ANM:

She had joined ANMs job after marriage due to financial weaker position of her family. She had heard about the job in the Rojgar Samachar (Hindi bulletin of employment).

Postings:

Her first posting was at Malanadoongri PHC in Sawaimadhopur district in Rajasthan where she worked for 3 months. Then she was at Dudu for 2 months. From there she came to Nareda and worked for 2 years here. After that she got transferred to Jaipur. Her next posting was in Kotputli in 1991 after she was transferred to Jaipur again in 1995 and she is presently posted in the Sardar Patel Revamping Centre.

Responsibilities:

She has 3 Katchi bastis under her. She comes to the centre to mark her attendance around 9:30 a.m. after which she leaves for her field. The various done by her are:

1. Work related to malaria like slide preparation and giving medicine in case of confirmation of the disease.

2. Detecting malaria cases and giving them medicine regularly.
3. Giving health services for other diseases like leprosy, blindness, ARI, diarrhoea, etc.
4. Doing FP work- motivating women for FP, distributing contraceptives.
5. Immunization- under both FP and MCH. Full coverage of all children upto 1 year of age is nowadays being emphasized.
6. The AIDS programme has assumed much importance nowadays. they are to record cases of STD if any in their area
7. Conduction of surveys and reporting work.

Perception:

Her family's perception is good towards this job. The slum people are sometimes highly non-cooperative and rude. It is very difficult to motivate them.

She is not happy with the job because of heavy workload, unhygienic environment of the slums, no promotion and incentives.

Problems:

The environment of the slums is very unhygienic. It is very difficult to work there. She does not have a place to sit in the absence of any centre for her. The people are illiterate and superstitious. She finds problems in calculating percentages and other formulas. The forms are very lengthy and time consuming.

APPENDIX 2

Checklist 1

- Name
- Age
- Marital Status: If married - for how many years you have been married?
- Family: who all are there in your family? (If married then details about her husband and other in-laws? Details about children if any):
  - Age
  - Sex
  - Place of living
  - Their education
  - If they are earning their occupational details

  Who all are there in your parental family? Where do they live? In which occupation they are involved? To which Religion / Caste you belong to? Where do you originally hail from?
- Her present address? Living alone or with family or some family member?
- Educational details: what are your academic and technical qualifications? Other qualifications if any. (Details of these).
- What were the reasons behind your choosing ANMs job as your career? What were your childhood aspirations?
- What is your husband doing? His income details. How much do you earn?
- Years of working as an ANM, her postings during her career, alongwith the place of present posting and the duration already passed.

- What all duties you perform as ANM? The schedule of performing these duties on a daily, weekly, monthly and yearly basis. What according to you have been the changes in these responsibilities over a period of time?
- What all information you collect? What is the procedure followed? In what format? Who designs the format? How do you convey this compiled data? To whom and how frequent?
- Are you aware of these 3 approaches-TA, TFA & CNA? If yes what do you understand about these? What have been the changes under each in terms of responsibilities, data collection and decision making power?
- How do you manage between your family and the work?
- What all problems you encounter in your work? (Probe for problems that arise because of her being a woman and being placed lowest in the organizational hierarchy).
- What is the perception of village people about you and your profession? Have the people of your assigned area have accepted you as a member of their community? If no, what may be the probable reasons? (Her friends and the support and co-operation of people that she has been able to secure when she goes for the collection of data)
- Her family's and other relatives' perceptions about her job? Perception of the other staff members about your job? How do you perceive your job? Would you suggest any other girl to come into this profession? If not, what are the reasons?
- The suggestions you will like to give regarding the ways you can perform smoothly.

Checklist 2

- What are an ANM's responsibilities? Which all activities are mainly performed by her? What have been the changes in these with time?
- What are TFA and CNA approaches? How the ANMs role has been modified under these? To what extent the decentralization has occurred?
- Please explain the process of collection, compilation, analysis of the data by the ANMs? Who decide as to what information will be collected and who designs the formats of various forms used for this purpose? What is the role of ANMs in this respect? Were they given any formal training before change of any form? If yes, please give details? **(For Statisticians and LHVs)** How do you compile and analyze the data you get from them? What according to you are the problems you face in this process? According to you to what extent does this data reflects the felt needs of the community?
- Is the ANM able to give desired level of performance? If no, what are the reasons?
- What kind of problems she has to face? What have been the solutions provided by the health government to solve these?
- How she is involved in the decision making process on issues related to delivery of health services and to what extent?
- Why have the male MPW posts been abolished?
- How is an ANM been conceptualized to function effectively when she is not so well educated and has heavy workload?
- What are your perceptions about the ANMs work and her performance?
- What is the process of supervision of ANMs undertaken by you?
- What are your views on the system of health delivery of health services being followed in the state? How can it be improved?

APPENDIX 3

Form 1

I. Immunisation
1. Total number of ANC Registration
2. Total number of deliveries
3. Total number of PNC cases
4. Total number of TT I
   II
   Booster
5. Total number of BCG
6. Total number of DPT-Polio I
   II
   III
   Booster
7. Measles
8. Total number of children given Vitamin A solution I
   II
   III

II. Family Planning
1. Total number of LT cases
2. Total number of VT cases
3. Oral pill distribution
   i. Number of regular users
   ii. Number of casual users
4. Nirodh distribution
   i. Number of regular users
   ii. Number of casual users
5. Total number of Copper-T cases
6. Total number of eligible couples contacted

III. Malaria
1. Total number of malaria slides examined
2. Total number of chloroquine tablets distributed

प्रपत्र संख्या - 4

उप स्वास्थ्य केन्द्र का मासिक प्रगति प्रतिवेदन

निर्देश :

1. जो लागू नहीं हो उसे काट देवें।
2. प्रपत्र भरने से पूर्ण दिशा निर्देशों को भली प्रकार से पढ़ कर ही तद्नुसार इन्द्राज करें।
3. जहां विशेष रूप से नहीं बतलाया गया हो इस प्रपत्र में संदर्भित माह की उपलब्धि ही अंकित की जानी है

1. सामान्य सूचना

1.1 राज्य राजस्थान — राज्य कोड..... 2 0

1.2 जिला..... — जिला कोड..... ☐☐

1.3 ब्लाक प्रा. स्वा. केन्द्र..... — ब्लाक प्रा. स्वा. केन्द्र कोड..... ☐☐

1.4 प्रा. स्वा. केन्द्र..... — प्रा.स्वा. केन्द्र कोड..... ☐☐

1.5 उप केन्द्र..... — उप केन्द्र कोड..... ☐☐☐

1.6 माह ☐☐ 1.7 वर्ष ☐☐ 1.8 प्रतिवेदन प्रेषित करने का दिनांक DD ☐☐ MM ☐☐ YY ☐☐

1.9 उप केन्द्र की जनसंख्या (1991)..... वर्तमान जनसंख्या.....

1.10 योग्य दम्पत्तियों की संख्या (1 अप्रेल, 19..... की स्थितिनुसार)

.....

2. परिवार कल्याण कार्यक्रम

2.1 माह के दौरान सम्पर्क किये गये योग्य दम्पत्तियों की संख्या

2.2 नसबन्दी (माह के दौरान) ❋

2.1.1 वार्षिक सम्भावित उपलब्धियाँ		
नसबन्दी	अन्तराल साधन	योग

2.2.1 पुरूष नसबन्दी

2.2.1.1 सन्तान संख्या अनुसार				
1	2	3 या अधिक	उपलब्ध नहीं	योग

2.2.1.2 आयु वर्ग अनुसार (आयु पत्नि की)									
<15	15-19	20-24	25-29	30-34	35-39	40-44	>=45	उपलब्ध नहीं	योग

2.2.2 महिला नसबन्दी

2.2.2.1 सन्तान संख्या अनुसार				
1	2	3 या अधिक	उपलब्ध नहीं	योग

2.2.2.2 महिला की आयु वर्ग अनुसार									
<15	15-19	20-24	25-29	30-34	35-39	40-44	>=45	उपलब्ध नहीं	योग

❋ समस्त उप केन्द्र क्षेत्र के योग्य दम्पत्तियों के सम्बन्ध में सूचना देनी है चाहे उन्होंने नसबन्दी कहीं भी करवाई हो।

2.2.2.3 तकनीक अनुसार महिला नसबंदी			2.2.2.4 राज लक्ष्मी योजना		
परम्परागत	दूरबीन	मिनी लेप	केसेज की संख्या	प्रेषित प्रार्थना पत्रों की संख्या	प्राप्त बाण्डों की संख्या

2.3 नसबन्दी केसेज की देखभाल					
माह के अन्त तक सम्पर्क संख्या अनुसार फोलोअप				प्राप्त जटिल कैसेज	मृत्यु
1	2	3	4		

2.4 आई.यू.डी. निवेशन

2.4.1 सन्तान संख्या अनुसार						
	0	1	2	3 या अधिक	उपलब्ध नहीं	योग
@ कुल						
(x)उपकेन्द्र						

2.4.2 महिला की आयु वर्ग अनुसार										
	<15	15-19	20-24	25-29	30-34	35-39	40-44	>=45	उपलब्ध नहीं	योग
कुल										
उपकेन्द्र										

@ I.U.D. चाहे कहीं से भी लगवाई गई हो/उपकेन्द्र क्षेत्र में रहने वाले योग्य दम्पत्तियों में से जिन महिलाओं के I.U.D. लगी है, उनकी संख्या देनी है।

(x) उपकेन्द्र क्षेत्र में A.N.M. अथवा L.H.V./Doctor द्वारा लगाई गई संख्या देनी है।

2.5 आई.यू.डी कैसेज की देखभाल							
माह के अन्त तक सम्पर्क संख्या अनुसार फोलोअप				प्राप्त जटिल कैसेज	आई.यू.डी. निकलने वाले कैसेज की संख्या		मृत्यु
एक बार	दो बार	तीन बार	चार बार		निकाली गई	निकल गई	

2.6 ओरल पिल्स उपयोगकर्त्ता एवं विवरण

गत माह तक उपयोगकर्त्ताओं की संख्या	माह कें दौरान बनाये गये उपयोगकर्त्ताओं की संख्या	जटिलता/ शिकायत प्राप्त हुई	माह के दौरान उपयोग छोडने वाले दम्पत्तियों की संख्या	वर्ष के दौरान उपयोग छोडने वालों में से पुनः साधन अपनाने वालों की संख्या	माह के अन्त तक कुल ओरल पिल्स उपयोगकर्ताओं की संख्या 1+2-4+5=6	माह के दौरान बाँटे गये ओ.पी. चक्रों की संख्या
1	2	3	4	5	6	7

2.7 निरोध उपयोगकर्ता व वितरण

गत माह तक उपयोगकर्त्ताओं की संख्या	माह के दौरान बनाये गये उपयोगकर्त्ताओं की संख्या	माह के दौरान उपयोग छोडने वाले दम्पत्तियों की संख्या	वर्ष के दौरान उपयोग छोडने वालों में से पुनः साधन अपनाने वालों की संख्या	माह के अन्त तक कुल ओरल पिल्स उपयोगकर्ताओं की संख्या 1+2-3+4=5	माह के दौरान बाँटे गये निरोध की संख्या
1	2	3	4	5	6

2.8 परिवार नियोजन के अन्य साधनों के उपयोगकर्ता

	दम्पति जो परम्परागत/स्थानीय साधन उपयोग कर रहे है	दम्पति जो प्राकृतिक साधन उपयोग कर रहे है
माह के दौरान नये		
माह के अन्त तक कुल		

मातृ शिशु स्वास्थ्य सेवायें

3. मातृ सेवा

3.1 प्रसव पूर्ण देखभाल

3.1.1 पंजीकृत गर्भवती महिलाएं

पंजीकृत महिलाएं	वार्षिक लक्ष्य	माह के दौरान पंजीकृत	माह के अन्त तक पंजीकृत
कुल			
गर्भ धारण के 12 सप्ताह के अन्दर			

3.1.2 माह के अन्त तक पंजीकृत कैसेज की संख्या जिनसे तीन बार सम्पर्क किया जा चुका है। ☐☐☐☐

3.1.3 माह के दौरान पाये गये जटिल कैसो की संख्या ☐☐☐☐

3.1.4 रेफर किये गये जटिल कैसों की संख्या ☐☐☐☐

3.2 प्रसव सेवाएं

3.2.1 घर पर कराये गये प्रसवों की संख्या

ANM/ महिला स्वा. कर्यकर्त्ता द्वारा	प्रशिक्षित दाई द्वारा	अप्रशिक्षित दाई द्वारा	अन्य

3.2.2 उपकेन्द्र/प्रा.स्वा. केन्द्रों पर/निजी चिकित्सालयों में हुए प्रसव ..... ☐☐☐☐

3.2.3 जटिल केस रेफर किये..... ☐☐

3.2.4 प्रसव पश्चात सेवाएँ

	माह के दौरान	माह के अन्त तक
प्रसव पश्चात नसबंदी		
प्रसव पश्चात आई.यू. डी. निवेशन		
प्रसव पश्चात फोलोअप		

3.2.5 जन्म के समय नवजात शिशु का वजन (बच्चों की संख्या)

1	लडका 2	लडकी 3	योग
1. जीवित जन्म			
a. वजन 2000 ग्राम से कम			
b. वजन 2000 से 2500 ग्राम के बीच			
c. वजन 2500 ग्राम से अधिक			
d. वजन नहीं पता			
2. मृत जन्म			
3. गर्भपात			

4. टीकाकरण (माह के दौरान)

	बी.सी.जी	पोलियो				डी.पी.टी.				खसरा	माह के अन्त तक पूर्ण टीकाकरित बच्चे
		1	2	3	B	1	2	3	B		
4.1 एक वर्ष से कम											
4.2 एक वर्ष से अधिक											

4.2 बूस्टर	DT 2B/5 YEARS (B)	TT 10 YEARS (B)	TT 16 YEARS (B)	गर्भवती महिलाओं के टिटनेस का टीका		
				1	2	3

4.3 टीकाकरण सत्र की संख्या

निर्धारित सत्र	सम्पन्न सत्र	सम्पन्न नहीं होने वाले सत्रों की कारण अनुसार संख्या		
		टीके उपलब्ध नहीं	कार्यकर्त्ता उपलब्ध नहीं	योग

5. एनिमिया और विटामिन ए

5.1 आयरन की गोलियां दी गई	प्रारम्भ की	निरन्तर चालू	चालू माह में पूर्ण की
a. गर्भवती माताओं की संख्या			
b. दूध पिलाने वाली मातायें व आई.यू.डी. लगवाने वाली महिलाओं की संख्या			
c. बच्चे 1 वर्ष से अधिक व 6 वर्ष से कम की संख्या			

5.2 नौ माह से अधिक व पाँच वर्ष से कम उम्र के बच्चों की संख्या जिन्हें विटामिन ए का घोल दिया गया (खुराक संख्या अनुसार लिखें)

1	2	3	4

6. डायरिया

6.1 1	5 वर्ष से कम 2	5 वर्ष से अधिक 3
a. गम्भीर रूप से डायरिया से पीड़ित		
b. ओ.आर.एस. से उपचार किया गया		
c. मृत्यु हुई		

6.2 ओ. आर. एस. वितरण			
उप केन्द्र द्वारा	स्वयं सेवी डिपो द्वारा	आंगनबाड़ी कार्यकर्त्ता द्वारा	अन्य

7. मृत्यु

7.1 शिशु मृत्यु	पुरुष	महिला
7.1.1 0 से 6 दिन		
7.1.2 7 से 27 दिन		
7.1.3 28 दिन से 1 वर्ष		
7.1.4 1 वर्ष से 5 वर्ष		
7.2 मातृ मृत्यु (प्रसव मृत्यु)		
7.2.1 प्रसव पूर्व		
7.2.2 प्रसव के दौरान		
7.2.3 प्रसव के 6 सप्ताह के भीतर		

8. भण्डार स्थिति

क्र. सं.		ईकाई	माह के प्रारम्भ में उपलब्ध स्टॉक	माह के दौरान प्राप्त	माह के दौरान उपभोग/ वितरण	माह के अन्त में शेष	अगले माह के लिए मांग
1	2	3	4	5	6	4+5-6=(7)	8
8.1	ओ.आर.एस. पैकट						
8.2	परिवार कल्याण						
	निरोध						
	ओरल पिल्स						
	कापर–टी						
8.3	आयरन और विटामिन "ए" घोल						
	आयरन गोली बड़ी						
	आयरन गोली छोटी						
	आयरन घोल (100 मिली बोतल)						
	विटामिन "ए" घोल (100 मिली बोतल)						
8.4	प्रसव के डिस्पोजिवल डिलवरी किट्स						

9. बीमारियों का सर्वेक्षण

क्र.सं.	बीमारियों का नाम	केस	मृत्यु
9.1	दस्तरोग		
9.2	गलघोटू		
9.3	पोलियों		
9.4	टिटनेस नवजात		
9.5	टिटनेस		
9.6	काली खांसी		
9.7	खसरा		
9.8	निमोनिया		
9.9	योग		

10. सामुहिक शिक्षात्मक गतिविधियाँ

	वितरण	संख्या अंकित करें	
		लक्ष्य	उपलब्धियाँ
10.1	महिला स्वास्थ्य संघ बैठकों की संख्या		
10.2	माताओं की बैठके		
10.3	पंचायत की बैठके		
10.4	फिल्म शो		
10.5	कठपूतली प्रदर्शन		
10.6	उप केन्द्र स्वास्थ्य सलाहकार समिति की बैठक		
10.7	नमूनियां एवं दस्त रोग हेतु लोगों को शिक्षित करने हेतु आयोजित बैठके		
10.8	अन्य गतिविधियां		
10.9	बाँटे गये पेम्फलेटों की संख्या		

(ए.एन.एम. का नाम)

दिनांक.....

एवं हस्ताक्षर

राजस्थान सरकार

(प्रा.स्वा.के. को अनुवर्ती महीने की 15 तारीख तक प्रस्तुत किया जाए)

फार्म 6

उपकेन्द्र/शहरी स्वास्थ्य चौकी/पुनः नवीयन (रीवैम्पिंग) केन्द्र के लिए मासिक रिपोर्ट
(ए एन एम/एम पी डब्लू (पुरुष) की रिपोर्ट)

सामान्य सूचना

1. राज्य : **राजस्थान**
2. जिला : .....
3. पी एच सी (प्रा.स्वा.के.) : .....
4. उपकेन्द्र : .....
5. प्रा.स्वा.के. की वर्तमान जनसंख्या : .....
6. उपकेन्द्र की वर्तमान जनसंख्या : .....
7. माह का प्रतिवेदन ..... प्रेषण दिनांक .....
8. पात्र दम्पतियों की संख्या (वर्ष की पहली अप्रैल को) : .....

II. सेवाएं

क्र.स.	सेवाएं	गत वर्ष इसी महीने के दौरान निष्पादन	रिपोर्टाधीन महीने में निष्पादन	गत वर्ष के इसी महीने तक संचयी निष्पादन	चालू वर्ष के वर्तमान महीने तक संचयी निष्पादन	चालू वर्ष के लिए योजनाबद्ध आवश्यकता
1.	प्रसव-पूर्व देखभाल					
1.1	पंजीकृत प्रसव - पूर्व मामले					
	(क) कुल					
	(ख) 12 सप्ताह से कम					
1.2.	उन गर्भवती महिलाओं की संख्या जिनकी तीन जांच की गईं					
1.3.	अत्यधिक खतरे वाली उन गर्भवती महिलाओं की कुल संख्या जिनको रेफर किया गया।					
1.4.	टी टी डोज की कुल संख्या					
	(क) टी टी 1					
	(ख) टी टी 2					
	(ग) बूस्टर					
1.5	उन गर्भवती महिलाओं की संख्या जिनका रक्त की कमी का उपचार किया जा रहा है					
1.6	उन गर्भवती महिलाओं की संख्या जिनको सम्भावित रक्त की कमी के उपचार के लिए आई. एफ. ए. दी गई।					

फार्म 6 क्रमशः

2. 2.1	**प्रसव देखभाल** प्रसवों की कुल संख्या										
2.2	घर पर कराए गए प्रसव										
	(क) (i) ए एन एम द्वारा										
	(ii) एल एच वी द्वारा										
	(ख) प्रशिक्षित प्रसव परिचर द्वारा										
	(ग) अप्रशिक्षित प्रसव परिचर द्वारा										
2.3	उप-केन्द्र पर कराए गए प्रसव										
2.3A	अन्य प्राईवेट नर्सिंग होम आदि पर										
2.4	प्रा.स्वा.कें./एफ आर यू को रेफर किए गए जटिल प्रसव										
3. 3.1	**गर्भधारण का परिणाम** प्रसवों की संख्या	पु.	म.	पु.	म.	पु.	म.	पु.	म.	पु.	म.
	(क) जीवित जन्म										
	(ख) मृत जन्म										
3.2	3.1 (क) में जन्म क्रम										
	(क) पहला										
	(ख) दूसरा										
	(ग) तीसरा										
	(घ) चौथा या अधिक										
3.3	जन्म के समय नवजात शिशु की स्थिति										
	(क) 2.5 कि.ग्रा. से कम										
	(ख) 2.5 कि.ग्रा. या अधिक										
	(ग) जिनका वजन नहीं लिया गया										
	(घ) अत्यधिक खतरे वाले नवजात शिशुओं की संख्या जिन्हें प्रा.स्वा.केन्द्र/ एफ़ आर यू को रेफर किया गया।										

4. 4.1	**प्रसवोत्तर देखभाल** उन महिलाओं की संख्या जिनकी प्रसवोत्तर तीन जांच की गईं										
4.2	प्रा.स्व.के./एफ.आर यू को रेफर किए गए जटिल मामले										
5. 5.1	**मातृ मृत्यु** गर्भावस्था के दौरान										
5.2	प्रसव के दौरान										
5.3	प्रसव के 6 सप्ताह के भीतर										
6. 6.1	**आर टी आई/एस टी आई** वे रोगी	पु.	म.	पु.	म.	पु.	म.	पु.	म.	पु.	म.
	क) जिनका पता लगाया गया										
	ख) जिनका इलाज किया गया										
	ग) जिनको रेफर किया गया										
7. 7.1	**टीकाकरण** एक वर्ष तक के शिशु										
	बी सी जी										
	डी पी टी 1 डी पी टी 2										
	डी पी टी 3										
	ओ पी वी 0										
	ओ पी वी 1										
	ओ पी वी 2										
	ओ पी वी 3										
	मीज़िल्स										
	पूर्ण टीकाकरित बच्चे										

फार्म 6 क्रमशः

7.2	18 महीने से अधिक आयु वाले शिशु										
	डी पी टी बूस्टर										
	ओ पी वी बूस्टर										
	पूर्ण टीकाकरण										
7.3	5 वर्ष से अधिक आयु के बच्चे डी टी										
7.4	10 वर्ष से अधिक आयु के बच्चे टी टी										
7.5	16 वर्ष से अधिक आयु के बच्चे टी टी										
7.6	वे रोगी जिन पर टीकाकरण के बाद प्रतिकूल प्रतिक्रिया हुई।										
8.	विटामिन "ए" देना (9 महीने से 3 वर्ष तक) डोज 1										
	डोज 2										
	डोज 3-5										
9.	बाल्यावस्था के रोग										
9.1	वैक्सीननिरोध्य रोग										
	(क) रोहिणी (डिफ्थीरिया)										
	(i) रोग पीड़ितों की संख्या										
	(ii) जिनका इलाज किया गया										
	(iii) जिनको रेफर किया गया										
	(iv) मृत्यु										
	(ख) पोलियो (ऐ.एफ.पी.)										
	(i) रोग पीड़ितों की संख्या										
	(ii) जिनका इलाज किया गया										
	(iii) जिनको रेफर किया गया										
	(iv) मृत्यु										

9.2	(ग) नवजात शिशु टेटनस											
	(i) रोग पीड़ितों की संख्या											
	(ii) जिनका इलाज किया गया											
	(iii) जिनको रैफर किया गया											
	(iv) मृत्यु											
	(घ) मीजिल्स											
	(i) रोग पीड़ितों की संख्या											
	(ii) जिनका इलाज किया गया											
	(iii) जिनको रफर किया गया											
	(iv) मृत्यु											
9.3	5 वर्ष से कम आयु के बच्चों को ए.आर.आई. (निमोनिया)											
	(क) जिनका को-ट्राइमोक्सोज़ोल से इलाज किया गया											
	(ख) जिन्हें प्रा.स्वा.के./एफ आर यू को रेफर किया गया											
	(ग) मृत्यु											
9.4	5 वर्ष से कम आयु के बच्चों को तीव्र अतिसार रोग (डायरिया)											
	(क) ओ आर एस द्वारा उपचारित											
	(ख) पी एच सी/एफ आर यू को रेफर किया गया											
	(ग) मृत्यु											
10.	शिशु मृत्यु											
	(क) 1 सप्ताह के भीतर											
	(ख) 1 सप्ताह से 1 महीने की भीतर											
	(ग) 1 महीने से 1 वर्ष के भीतर											
	(घ) 1 वर्ष से 5 वर्ष के भीतर											

11.	गर्भनिरोधक सेवा						
11.1	पात्र दम्पत्तियों की संख्या जिनसे संपर्क किया गया						
11.2	पुरुष नसबंदी						
	(क) परम्परागत (वैसेक्टोमी)						
	(ख) नॉन-स्केल्पल						
11.3	महिला नसबंदी						
	(क) उदरीय (ट्यूबैक्टोमी)						
	(ख) अंतरुदरदर्शी (लेप्रोस्कॉपिक)						
11.4	कुल आई यू डी निवेशन						
	(क) वे मामले जिनमें लगाने के बाद जांच (फालोअप) की गई						
	(ख) जटिलताएं						
	(ग) बंद किए गए						
	(i) हटाए गए						
	(ii) स्वतः निकल गए						
11.5	ओरल पिल्स युजर						
	(क) पुराने युजर						
	(ख) नए युजर						
	(ग) जटिलताएं						
	(घ) बंद किए गए						
11.6	निरोध युजर						
12.	गर्भपात						
	(क) एम टी पी के लिए रेफर की गई महिलाओं की संख्या						
	(ख) वे मामले जिन पर कार्रवाई की गई						
	(ग) जटिलताएं						
	(घ) मृत्यु						

13. 13.1	संचारी रोग मलेरिया					
	(क) ज्वर पीड़ितों की ज्ञात संख्या					
	(ख) प्रा.स्वा.के. को प्रेषित रक्त की स्लाइडों की संख्या					
	(ग) उन ज्वर पीड़ितों की संख्या जिनका इलाज अंदाज से किया गया					
	(घ) मलेरिया के पॉजिटिव रोगियों की संख्या					
	(ड) उन पाजिटिव मरिजों की संख्या जिनका रेडीकल उपचार किया गया					
	(च) मच्छररोधी कार्यकलाप					
	(ज) अत्यधिक खतरे वाले गाँवों की संख्या जिनका पता लगाया गया					
13.2	क्षय (टी.बी.) (क) आशंकित रोगियों की संख्या					
	(i) अभिज्ञात					
	(ii) रेफर किए गए					
	(ख) स्पुटम पाजिटिव रोगियों की संख्या					
	(ग) टीबी के रोगी जिनके संबंध में कार्रवाई की गई					

iv समुदाय के साथ विचार विमर्श एवं प्रतिक्रिया

क्र.सं.	निम्नलिखित के साथ बैठकें	बैठकों की संख्या	दिनांक
1.	पंचायत स्वास्थ्य समिति/ग्राम सलाहकार समिति		
2.	महिला स्वास्थ्य संघ		
3.	आंगनबाड़ी कार्यकर्ता		

V मासिक स्टॉक स्थिति

क्र. सं.	मद	आरंभ में स्टॉक	प्राप्त	जोड़	उपयोग	शेष	अतिरिक्त/ अवश्यकता
1.	आई एफ ए - बड़ी						
2.	आई एफ ए - छोटी						
3.	विटामिन "ए"						
4.	कोट्राइमोक्सोज़ोल						
5.	ओ आर एस पैकट						
6.	मेथिल - अर्गोमेट्रीन						
7.	क्लोरोफेनेरामाइन						
8.	पैरासीटामोल						
9.	ऐंटीस्पैस्मोडिक टेबलेट						
10.	इन्जेक्शन मेथिल -आर्गोमेट्रीन						
11.	मेबेंडाइज़ोल						
12.	सिरिंज और सुइयां						
13.	वैक्सीन डे कैरियर						
14.	स्टेरीलाइजर/आटोक्लेव						
15.	क्लोरमफेनीकोल						
16.	सेट्रीमाइड-पाउडर						
17.	पावीडोन मलहम 5 प्रतिशत						
18.	काटन-पट्टी						
19.	गर्भनिरोधक						
	(क) निरोध						
	(ख) मुखीय गोलियां (ओरल पिल्स)						
	(ग) आई यू डी						
20.	प्रयोज्य प्रसव किट						

प्राथमिक स्वास्थ्य केन्द्र से प्राप्त वैक्सीन

क्र. सं.	वैक्सीन का नाम	साप्ताहिक सत्र 1 के लिए प्राप्त वैक्सीन की तारीख/डोज	साप्ताहिक सत्र 2 के लिए प्राप्त वैक्सीन की तारीख/डोज	साप्ताहिक सत्र 3 के लिए प्राप्त वैक्सीन की तारीख/डोज	साप्ताहिक सत्र 4 के लिए प्राप्त वैक्सीन की तारीख/डोज	साप्ताहिक सत्र के लिए प्राप्त वैक्सीन की तारीख/डोज	माह के दौरान प्राप्त वैक्सीन	माह के अन्त तक प्राप्त कुल वैक्सीन
1	डी पी टी							
2.	ओ पी वी							
3.	डी टी							
4.	टी टी							
5.	बी सी जी							
6.	मीजिल्स							

गत प्रशिक्षण जिसमें भाग लिया .....
(महिना और वर्ष का उल्लेख करें)

निम्नलिखित द्वारा रिपोर्ट मास में
किए गए निरीक्षण की तारीख : .....

एम.पी.डब्ल्यू. (पुरुष) / एम.पी.डब्ल्यू. (महिला/ए.एन.एम.)

एल एच वी ....

एम ओ (पी एच सी) ....

बी. एच. एस. ....

डी एम ओ ....

अन्य ....

की गई प्रगति पर टिप्पणी तथा वे रुकावटें या उपलब्धियाँ जो क्षेत्र में सेवाओं और कार्यक्रम के लिए आवश्यक कर्मचारियों के रिक्त पदों के कारण अथवा दवा या वैक्सीन की कमी के कारण महसूस की गई तथा सामाजिक और सांस्कृतिक विश्वासों के कारण किए गए विरोध।

(इनके लिए निर्धारित स्थान से अधिक स्थान का प्रयोग न करें)

निरीक्षण अधिकारी की टिप्पणी/सुझाव

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निरीक्षणकर्त्ता के हस्ताक्षर
नाम, पद व दिनांक

हस्ताक्षर, पुरुष स्वास्थ्य कार्यकर्ता हस्ताक्षर ए. एन. एम.

परिवार कल्याण कार्यक्रम
उप स्वास्थ्य केन्द्र
की वार्षिक योजना

वर्ष .....

1.1 सामान्य सूचना

1. उप केन्द्र का नाम _____
2. कुल गांव (संख्या) _____
3. कुल जनसंख्या वर्ष 1991 _____
4. कुल जनसंख्या वर्तमान _____
5. पात्र जोड़ों की संख्या _____

2.1 उपकेन्द्र में आने वाले गांवों की अनापूरित मांग का विवरण

	क्र. सं.	गांव का नाम	जनसंख्या 1991	जनसंख्या 1996	कुल योग्य दम्पतियों की संख्या	दम्पतियों की कुल संख्या जो भविष्य में और बच्चा नहीं चाहते (जिन्होंने स्थाई साधन अपना रखा है उन्हें भी सम्मिलित करते हुए)	कालम संख्या 6 के वो दम्पति जिन्होंने स्थाई साधन अर्थात् नसबन्दी करा रखी है।	स्थाई साधनों की अनापूरित मांग कालम सं. 6 – कालम सं. 7	दम्पतियों की संख्या जो एक वर्ष तक बच्चा नहीं चाहते हैं। (अस्थाई साधन अपना रहे दम्पतियों के सम्मिलित करते हुए)	कालम सं. 9 के उन दम्पतियों की संख्या जिन्होंने वर्तमान में अस्थाई साधन अपना रखा है।	अस्थाई साधनों की अनापूरित मांग कालम सं. 9 – कालम सं. 10	उन दम्पतियों की संख्या जिनके दो या दो से अधिक बच्चे हैं परन्तु जिन्होंने परिवार नियोजन का कोई साधन नहीं अपना रखा एवं परिवार नियोजन की इच्छा भी नहीं बतलायी है।	गर्भवती महिलाओं की संख्या	1 वर्ष से कम आयु के बच्चों की संख्या	पिछले कलेण्डर वर्ष में (1 जनवरी से 31 दिसम्बर)			उप केन्द्र मुख्यालय से गांव की दूरी
															जीवित जन्में बच्चों की संख्या	एक वर्ष से कम आयु के मरने वाले बच्चों की संख्या	माताओं की प्रसव मृत्यु संख्या	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
योग																		

2.2 उप केन्द्र के स्वास्थ्य सूचकों की सम्भावित वार्षिक उपलब्धियाँ

क्र.सं. 1	वर्तमान (सर्वे की सूचना पर आधारित) 2	वर्ष के अन्त में सम्भावित उपलब्धि 3	वर्ष 2000 तक कहां पहुंचाना है 4
1. जन्म दर (प्रति हजार जनसंख्या)			21
2. शिशु मृत्यु दर			60
3. मातृ मृत्यु संख्या			2 प्रति हजार जीवित जन्म
4. दम्पत्ति संरक्षण दर :–			
(चालू) (i) कुल			60 प्रतिशत
(ii) स्थायी साधन से			
(iii) अस्थायी साधनों से			

2.3 परिवार नियोजन की वार्षिक सम्भावित उपलब्धियाँ

क्र. सं.	दम्पत्तियों का वर्गीकरण	कुल मांग	वर्ष 1997-98 के लिए लक्ष्य निर्धारण के मापदण्ड	वर्ष 1997-98 की वार्षिक सम्भावित उपलब्धि				
				स्थाई साधन से	अस्थाई साधनों से*			
					आई.यू. डी.	ओरल पिल्स	निरोध	योग
1.	योग्य दम्पत्ति जो भविष्य में और बच्चा नहीं चाहते है –	..... (अपूरित मांग, स्थायी साधन की)	स्थाई साधन की कुल मांग का (i) 60% स्थाई साधन से (ii) 20% अस्थाई साधन से					
2.	योग्य दम्पत्ति, जो एक वर्ष तक बच्चा नहीं चाहते है	..... (अपूरित मांग, अस्थायी साधन की)	अस्थाई साधन की कुल मांग का 80%					
3.	जिन दम्पत्तियों के दो या दो से ज्यादा बच्चे हैं व जिन्होंने परिवार नियोजन का कोई साधन भी नहीं अपना रखा है एवं अभी परिवार नियोजन की इच्छा भी नहीं बतलायी है।	.....	दम्पत्तियों की संख्या का 15%					
4.	योग्य दम्पत्तियों की संख्या जो मार्च 1997 तक अन्तराल विधियों का उपयोग कर रहे है उन्हें निरन्तर इस वर्ष भी साधन उपलब्ध कराने हैं।		वास्तविक संख्या का शत प्रतिशत					
	योग							

* साधन वार वर्गीकरण स्वास्थ्य कार्यकर्त्ता सर्वेक्षण के दौरान दम्पत्ति से वार्त्ता तथा प्राप्त सूचना के आधार पर करें।

2.4 सम्भावित उपलब्धियों की पूर्ति हेतु गर्भ-निरोधक साधनों की वार्षिक मांग :

साधन का विवरण	कुल वार्षिक मांग (संख्या	31 मार्च तक स्टॉक में उपलब्ध	शुद्ध मांग (कॉलम 2– कॉलम 3)
1	2	3	4
1. ट्यूबल रिंगस			
2. कॉपर टी			
3. गर्भ निरोधक गोलियां (साइकल)			
4. निरोध			

2.5 क्या आपके उपकेन्द्र में निम्न संस्थान कार्य कर रहे है :

1.	गैर सरकारी संस्था (एन.जी.ओ.) जिसे परिवार कल्याण की कोई योजना स्वीकृत है।	हाँ/नहीं
2.	आंगन बाड़ी केन्द्र	हाँ/नही यदि हाँ तो संख्या ☐
3.	गर्भ–निरोधक वितरण डिपो	हाँ/नहीं
4.	जन मंगल जोड़े	हाँ/नहीं यदि हाँ तो संख्या ☐
5.	आयुर्वेद औषधालय	हाँ/नहीं
6.	दाईयों की संख्या 1. प्रशिक्षित 2. अप्रशिक्षित	☐ ☐
7.	गाँवों की संख्या जिनमें दाई कार्यरत नहीं है	☐

2.6 उपरोक्त संस्थानों से आप परिवार नियोजन व मातृ शिशु कल्याण कार्य में क्या सहयोग लेंगी व कैसे

1. गैर–सरकारी संस्थाऐं (एन.जी.ओ.)
2. आयुर्वेद
3. दाई
4. आंगनबाड़ी

3. मातृ शिशु स्वास्थ्य

3.1 प्रसव पूर्व सेवायें		
3.1.1. गर्भवती माताओं का पंजीयन जनसंख्या x $\frac{\text{जन्म दर}}{1000}$	लक्ष्य 100 प्रतिशत	संभावित उपलब्धियाँ
3.1.2. 12 सप्ताह से पूर्व गर्भवती महिलाओं का पंजीयन	60 प्रतिशत क्रमांक 1 का	
3.1.3. जटिल प्रसवों का पता लगाना व रेफर करना (15 प्रतिशत गर्भवती माताऐं High Risk cases होती है)	समस्त High Risk cases को रेफर करना	
3.1.4. एनीमिया से पीड़ित माताओं का पता लगाना व इलाज करना	50 प्रतिशत क्रमांक 1 का	
3.1.5. गर्भवती महिलाओं के टीका (टी.टी.) लगाना	100 प्रतिशत क्रमांक 1 का	
3.1.6. समस्त गर्भवती महिलाओं से ए.एन.सी. हेतु तीन बार सम्पर्क	क्रमांक 1 का 100 प्रतिशत	
3.2 प्रसव दौरान सेवाएं		
3.2.1. संस्थागत प्रसव (उपकेन्द्र/प्रा.स्वा.केन्द्र/पी.पी. सेन्टर/चिकित्सालय/ नर्सिंग क्षेत्र)	33 प्रतिशत कुल प्रसवों का	
3.2.2. प्रशिक्षित व्यक्तियों द्वारा प्रसव (ए.एन.एम./प्रशिक्षित दाई संस्थागत प्रसव)	कम से कम 95 प्रतिशत कुल प्रसवों का	
3.2.3. नये जन्में बच्चों का वजन	क्रमांक 8 के प्रसवों का 100 प्रतिशत	
3.3 प्रसव पश्चात सेवाएं		
3.3.1. नये जन्में बच्चों के जटिल मामले रेफर करना	नये जन्में बच्चों का 10 प्रतिशत	
3.3.2. बच्चों का टीकाकरण (क) 0–1 वर्ष के बच्चे (ख) 1–5 वर्ष के बच्चे	100 प्रतिशत	
3.3.3. तीन वर्ष तक के बच्चों को विटामिन–ए की पांच खुराके, प्रत्येक 6 माह में	3 वर्ष तक की उम्र के समस्त बच्चे (100 प्रतिशत)	

3.4 डायरिया निमूनिया इत्यादि		
3.4.1. डायरिया से पीड़ित बच्चों का ओ.आर.एस. घोल द्वारा उपकेन्द्र/घर पर इलाज (0–5 वर्ष की उम्र के प्रत्येक बच्चे को वर्ष में कम से कम 3 बार डायरिया होने की सम्भावना रहती है)	100 प्रतिशत	
3.4.2. ए.आर.ई./नमूनिया से पीड़ित बच्चों का इलाज		
1. 0–5 वर्ष के प्रत्येक बच्चे को वर्ष में दो बार ए.आर.आई. होने की सम्भावना रहती है	100 प्रतिशत	
2. 10 प्रतिशत मामले की कुल ए.आर.आई. केसेज में से नमूनिया के हो सकते हैं।	100 प्रतिशत	
3.5 शिशु एवं मातृ मृत्यु		
3.5.1 पिछले वर्ष में 1 वर्ष से कम उम्र के मरने वाले बच्चों की संख्या : (सर्वे के आधार पर)		
मृत्यु के कारण : (जन्म मृत्यु पंजीयन के आधार पर)	संख्या	
1. नमूनियां		
2. खांसी बुखार		
3. दस्त रोग		
4. टिटनेस		
5. खसरा		
6. अन्य		
योग		
3.5.2 'पिछले वर्ष में 1 माह से कम उम्र के मरने वाले बच्चों की संख्या' मृत्यु का कारण (जन्म मृत्यु पंजीयन के आधार पर) 1. टिटनेस		
2. नमूनियां		
3. कम वजन		
4. समय से पूर्व प्रसव		
5. बुखार		
6. मरा हुआ बच्चा पैदा हुआ		
7. दस्त रोग		
8. अन्य		
योग		

3.5.3 'पिछले वर्ष प्रसव से/के दौरान हुई मातृ मृत्यु की संख्या'	
मृत्यु का कारण 1. Eclampsia	
2. ए.पी.एच.	
3. पी.पी.एच.	
4. प्रसव संक्रमण	
5. टिटनेस	
6. अवरूद्ध प्रसव	
7. एनीमिया	
योग	

3.5.4 बच्चो, शिशुओं व माताओं की मृत्यु दर में कमी लाने के लक्ष्य को प्राप्त करने हेतु वर्ष के दौरान आप द्वारा क्या कदम उठाऐं जाऐंगे ?

1.
2.
3.
4.
5.

3.6 मातृ शिशु स्वास्थ्य सेवाओं हेतु साधनों की मांग : 3.6.1. विभिन्न टीकों की संख्या	संख्या जो वर्ष के दौरान चाहिए
1. BCG	
2. DPT	
(i) DDT (1,2,3)	
(ii) DPT (18 months)	
3. OPV (i) Routine	
(ii) P.P.I.	
(iv) 18 months	
4. TT (i) TT (PW)	
(ii) TT (10 Years)	
(iii) TT (16 Years)	
5. Measles	
6. DT (5 Years)	
3.6.2. कोट्रामेक्साजोल गोलियां (नमूनियां हेतु) प्रति बच्चा (5 वर्ष व कम उम्र का)2 episode औसत मान कर गणना करें।	

3.6.3. ओ.आर.एस. पैकेट (पांच वर्ष तक की उम्र के कुल बच्चों की संख्या x 4)	
3.6.4. आईरन की गोलियां (100 प्रति गर्भवती महिला के हिसाब से)	
3.6.5. डिलेवरी किट	
3.6.6. विटामिन–ए (100 एम.एल.)	
3.6.7 सामान (Equipment) 1. आई.यू.डी. किट	
2. परीक्षण टेबल (Examination Table)	
3. Weighting Machine	
4. B.P. Instrument	
5. दाई किट्स	

3.6.8. अन्य सामान जो आपको परिवार कल्याण कार्यक्रम लागू करने हेतु आवश्यक है परन्तु उपलब्ध नहीं है :

1.	
2.	
3.	
4.	
5.	
3.7 **आई.ई.सी.**	
3.7.1 **वार्षिक लक्ष्य** 1. महिला स्वास्थ्य संघ की बैठकें	
2. माताओं की बैठकें (मदर मीटिंग) सी.एस.एस.एम. जिलों में	

3. पंचायत की बैठकें जो आयोजित करानी हैं	
4. फिल्म शो जो आप द्वारा आयोजित कराना चाहेंगी	
5. ग्राम संपर्क अभियान जो वर्ष के दौरान आयोजित की जाएगी	
6. पैम्फलेट की संख्या जो बांटने है	
7. उपकेन्द्र स्वास्थ्य सलाहकार समितियों की बैठकें	
8. नमूनियां व दस्त रोग हेतु लोगों को शिक्षित करने हेतु कितनी मीटिंग आयोजित की जायेगी	

हस्ताक्षर

(ए.एन.एम.)

योजना का अनुमोदन

(चिकित्सा अधिकारी प्रभारी, पी.एच.सी./सैक्टर सुपरवाईजर/एल.एच.वी. द्वारा)

(क) मैनें योजना का परीक्षण कर लिया है। लक्ष्यों का निर्धारण सही किया है।

इस वर्ष इस उपकेन्द्र में उपरोक्त गतिविधियों द्वारा निम्न उपलब्धियाँ होगी।

1. जन्म दर.....(बच्चे प्रतिहजार) से कम होकर .....प्रति हजार सम्भावित है।
2. शिशु मृत्युदर.....से कम होकर.....होनी सम्भावित है।
3. माताओं की मृत्यु में.....कमी सम्भावित है।
4. वर्तमान दम्पत्ति संरक्षण दर.....से बढ़कर.....होनी सम्भावित है।
5. इस योजना का नाम पंचायत की बैठक में अनुमोदन करवा लिया गया है/आगामी बैठक में करवा लिया जायेगा।

प्रभारी चिकित्सा अधिकारी

.....

हस्ताक्षर

एल.एच.वी.....

सैक्टर सुपरवाईजर.....

राजस्थान - सरकार

प्रपत्र - 1

उप स्वास्थ्य केन्द्र

परिवार कल्याण कार्यक्रम की वार्षिक कार्य योजना

वर्ष 1999-2000

कोड सं. | | | | | | | | | |

जिले का नाम.....

1.1 सामान्य सूचना

1. उप केन्द्र का नाम _____

2. प्राथमिक स्वास्थ्य केन्द्र का नाम _____

3. ब्लाक प्राथमिक स्वास्थ्य केन्द्र का नाम _____

4. उपकेन्द्र के अधीन कुल गांवों की संख्या _____

5. कुल जनसंख्या 1991 जनगणना के अनुसार _____

6.कुल जनसंख्या वर्तमान (1 अप्रेल 1999) _____

7. उपकेन्द्र के अधीन योग्य दम्पत्तियों की संख्या _____

8. उपकेन्द्र का क्षेत्रफल (वर्ग कि.मी.) _____

2.1 उपकेन्द्र क्षेत्र के प्रत्येक ग्राम के प्रपत्र ''क'' की महत्त्वपूर्ण सूचनाओं का संकलन

क्र. सं.	गाँव का नाम	जनसंख्या मदसं. 2.1		कुल योग दम्पतियों की संख्या (मद सं. 2.2)	योग्य दम्पतियों की संख्या जो भविष्य में सन्तान नहीं चाहते है - (मद सं. 2.3)	योग्य दम्पतियों की संख्या जो एक वर्ष में सन्तान चाहते है - कोड '0' (मद सं. 2.4)	योग्य दम्पतियों की संख्या जो एक वर्ष बाद तथा दो वर्ष पहले, सन्तान चाहते है कोड '1' (मद सं. 2.5.1)	योग्य दम्पतियों की संख्या जो दो वर्ष या उससे अधिक समय पश्चात सन्तान चाहते है। कोड सं. '2' (मद सं. 2.5.2)	योग्य दम्पतियों की संख्या जिन्होंने सन्तान के सम्बन्ध में निश्चय नहीं किया है। कोड सं. '3' (मद सं. 2.5.3)	गर्भवती महिलाओं की संख्या (मद सं. 2.6)	सर्वेक्षण के अनुसार - प. क. का साधन अपना रहे दम्पत्तियों की संख्या							अनापूरित मांग (मद.सं. 2.9)			साधन का उपयोग नहीं करने वाले दम्पत्तियों में से साधन के उपयोग की इच्छा व्यक्त वाले दम्पत्ति		
		1991 जनगणना के अनुसार	आधार 1-4-99								भविष्य में बच्चा नहीं चाहने वाले दम्पत्ति							भविष्य में बच्चा चाहने वाले दम्पत्ति जो अन्तराल साधन काम में ले रहे हैं (मद सं. 2 7 3)								
											नसबन्दी (मद.सं. 2.7.1)			अन्तराल साधन (मद.सं. 2.7.2)												
											पुरुष	महिला	योग	आई यू. डी.	ओरल पिल्स	निरोध	योग	आई. यू. डी.	ओरल पिल्स	निरोध	योग	स्थाई साधन (कालम-6-14)	अन्तराल साधन (कालम -8+9-22)	योग (कालम - 23+24)	हां करने वाले (मद. सं. 4.1)	ना करने वाले (मद सं. 4.2)	कालम सं. 7 व 10 के उन दम्पतियों की सं. जिनके दो या दो से अधिक सन्तानें है तथा परिवार कल्याण का कोई साधन नहीं अपना रहे एवं और सन्तान चाहते है।
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
1.																											
2.																											
3.																											
4.																											
5.																											
6.																											
7.																											
8.																											
9.																											
10.																											
योग																											

नोट : - (कोष्टक में प्रपत्र ''क'' की मद संख्या लिखी गई है प्रपत्र ''क'' से भरें।)

2.2 उपकेन्द्र क्षेत्र के प्रत्येक ग्राम के स्वास्थ्य सूचकों की गणना एवं वर्ष के अन्त तक सम्भावित उपलब्धि (सूचना प्रपत्र 'क' से संकलित)

क्रम सं.	ग्राम का नाम	जनसंख्या		जन्म दर			शिशु मृत्यु दर			मातृ मृत्यु दर			दम्पत्ति संरक्षण दर				
													स्थाई साधन	अस्थाई साधन			
		1991 की जनगणना अनुसार	वर्तमान 1-4-99	वर्ष 1998 में कुल जीवित जन्म (मद संख्या. 1.1)	जन्मदर = कालम सं. 5 / कालम सं. 4 × 1000	वर्ष 1999 के अन्त तक सम्भावित जन्म दर	वर्ष 1998 में एक वर्ष से कम आयु के मृत शिशुओं की संख्या (मद संख्या 1.2 का योग)	शिशु मृत्यु दर = कालम सं. 8 / कालम सं. 5 × 1000	वर्ष 99 के अन्त तक सम्भावित शिशु मृत्यु दर	वर्ष 1998 में मातृ मृत्यु की संख्या (मद - 1.3)	मातृ मृत्यु दर = कालम सं. 11 / कालम सं. 5 × 1000	वर्ष 1999 के अन्त तक सम्भावित मातृ मृत्यु दर	तालिका सं. 2.1 से कालम सं. -14 / कालम सं. 5 = × 100	तालिका सं. 2.1 से कालम सं. -(18 + 22) / कालम सं. -5 = × 100	कुल दम्पत्ति संरक्षण दर (कालम 14 + कालम 15)	वर्ष के अन्त तक सम्भावित दम्पत्ति संरक्षण दर	उपकेन्द्र मुख्यालय से गांव की दूरी कि. मी. में
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
योग																	

नोट : - (1) सम्पूर्ण उपकेन्द्र क्षेत्र के स्वास्थ्य सूचकों की गणना के समस्त गांवों की घटनाओं को जोड़ कर गणना करनी है। सभी गांवों का औसत निकालना गलत होगा।

(2) दम्पति संरक्षण दर के कालम 14 एवं 15 लिए उपकेन्द्र क्षेत्र के गणना के लिए तालिका 2.1 के कालम की सूचना लेनी है।

2.3 परिवार कल्याण कार्यक्रम की सम्भावित वार्षिक उपलब्धियों की गणना

क्र. सं.	योग्य दम्पत्तियों का वर्गीकरण	वर्ष 1999-2000 के लिए लक्ष्य निर्धारण हेतु स्वीकृत मापदण्ड	कुल अनापूरित/पूरित मांग	वर्ष 1999-2000 की सम्भावित वार्षिक उपलब्धि				
				स्थाई साधन	अन्तराल साधन	अन्तराल साधनों कालम सं. 6 के योग का साधन वार विवरण (सर्वे रजिस्टर के कालम 43 के अनुसार)		
						आई. यू. डी.	ओरल पिल्स	निरोध
1.	2.	3.	4.	5.	6.	7.	8.	9.
1.	योग्य दम्पति जो भविष्य में और सन्तान नहीं चाहते हैं तथा जो कोई साधन काम में नहीं ले रहे हैं ।	स्थाई साधन की अनापूरित मांग का (i) 60 प्रतिशत स्थायी साधनों से (ii) 20 प्रतिशत अन्तराल साधनों से	(तालिका सं. 2.1 का कालम 23 का योग)	(कालम 4 का 60%)	(कालम सं. 4 का 20 %)			
2.	योग्य दम्पति जो एक वर्ष या उसके पश्चात सन्तान चाहते हैं तथा जो कोई साधन काम में नहीं ले रहे हैं ।	अन्तराल साधन की अनापूरित मांग का 80 प्रतिशत	(तालिका सं. 2.1 का कालम 24 का योग)	Nil	(कालम सं. 4 का 80 %)			
3.	योग्य दम्पतियों की संख्या जो 31 मार्च 1999 को अन्तराल साधनों का उपयोग कर रहे हैं तथा जिनको इस वर्ष भी निरन्तर साधन उपलब्ध कराने हैं ।	वास्तवित संख्या का शत प्रतिशत	(तालिका सं. 2.1 का कालम 16, 17, 20 एवं 21 का योग)	Nil	(कालम सं. 4 का 100 %)	Nil	(तालिका 2.1 का कालम 16 एवं 20 का योग)	(तालिका 2.1 का कालम 17 एवं 21 का योग)
4.	जिन योग्य दम्पत्तियों के दो या दो से ज्यादा सन्तानें हैं तथा जिन्होंने परिवार नियोजन का कोई साधन भी नहीं अपना रखा है एवं और सन्तान की इच्छा के सम्बन्ध में कोड संख्या 0 तथा 3 दर्शाया है ।		(तालिका सं. 2.1 का कालम 28 का योग)	(कालम सं. 4 के दम्पतियों में 15 % दम्पतियों को किसी न किसी साधन से लाभान्वित किया जाता है साधनवार वर्गीकरण अनुभव के आधार पर)				

नोट : - सन्दर्भित कालम में नीचे कोष्ठक में कालम में संख्या भरने के लिए दिशा निर्देश दिए गये हैं कृपया तदानुसार सूचना अंकित करें ।

3. मातृ शिशु स्वास्थ्य

3.1	प्रसव पूर्व सेवायें	लक्ष्य	वर्ष 1998-99 की वास्तविक उपलब्धि		वर्ष 1999-2000 में संभावित उपलब्धि	
3.1.1	कुल जीवित बच्चों का जन्म जनसंख्या $\times \frac{\text{जन्म दर}}{1000}$	100 प्रतिशत	पु.	म.	पु.	म.
3.1.2	गर्भवती माताओं का पंजीयन	क्रमांक 3.1.1 का 110 प्रतिशत				
3.1.3	12 सप्ताह से पूर्व गर्भवती महिलाओं का पंजीयन	क्रमांक 3.1.2 का 60 प्रतिशत				
3.1.4	जटिल प्रसवों का पता लगाना व रेफर करना (15 प्रतिशत गर्भवती माताऐ High Risk cases होती है)	समस्त High Risk cases को रैफर करना (क्रमांक 3.1.2 का 15 प्रतिशत)				
3.1.5	गर्भवती महिलाओं के टीका (टी.टी.) लगना पहला टीका- दूसरा टीका-बूस्टर टीका	क्रमांक 3.1.2 का 100 प्रतिशत				
3.1.6	एनीमिया से पीड़ित माताओं का पता लगाना व इलाज करना	क्रमांक 3.1.2 का 50 प्रतिशत				
3.1.7	समस्त गर्भवती महिलाओं से ए.एन.सी. हेतु तीन बार सम्पर्क	क्रमांक 3.1.2 का 100 प्रतिशत				
3.2	प्रसव दौरान सेवाएं					
3.2.1.	संस्थागत प्रसव (उपकेन्द्र/प्रा. स्वा. केन्द्र/पी.पी. सेन्टर/चिकित्सालय/नर्सिंग क्षेत्र)	क्रमांक 3.1.2 का 33 प्रतिशत				
3.2.2.	घर पर कराये गये कुल प्रसव	कम से कम 95 प्रतिशत कुल प्रसवों का (3.1.2 का 95 प्रतिशत)				
	(I) ए.एन.एम. द्वारा					
	(II) प्रशिक्षित दाई द्वारा					
	(III) अप्रशिक्षित दाई द्वारा					
	(IV) अन्य द्वारा					
3.2.3	नये जन्मे बच्चों का वजन	क्रमांक 3.2.2. के प्रसवों का 100 प्रतिशत	पु.	म.	पु.	म.
3.2.4	महिलाओं की संख्या जिनको प्रसव हेतु रेफर किया गया	क्रमांक 3.1.2 का 15 प्रतिशत				
3.3.	प्रसव पश्चात सेवाएं					
3.3.1.	नये जन्मे बच्चों के जटिल मामले रेफर करना	नये जन्मे बच्चों का 10 प्रतिशत (क्रमांक 3.1.1 का 10 प्रतिशत)	पु.	म.	पु.	म.
3.3.2.	बच्चों का टीकाकरण (0-1 वर्ष के बच्चे)	क्रमांक 3.1.1 का 100 प्रतिशत	पु.	म.	पु.	म.
	1. बी. सी. जी.					
	2. डी. पी. टी. 1					
	3. डी. पी. टी. 3					
	4. ओ. पी. वी. 0					
	5. ओ. पी. वी. 1					
	6. ओ. पी. वी. 2					

	7. ओ. पी. वी. 3					
	8. मीजिल्स					
3.2.3.	एक वर्ष से अधिक उम्र के बच्चों का टीकाकरण	कुल जनसंख्या का लगभग 13 प्रतिशत				
	1. डी.पी.टी. (18 माह)					
	2. ओ. पी. वी. (18 माह)					
	3. डी. टी. (5 वर्ष)					
	4. टी.टी. (16 वर्ष)					
3.3.4	तीन वर्ष तक के बच्चों को विटामिन-ए की पाच खुराके, प्रत्येक 6 माह में	3 वर्ष तक की उम्र के समस्त बच्चे कुल जनसंख्या का लगभग 8 प्रतिशत				
3.4.	**डायरिया निमूनिया इत्यादि**	कुल जनसंख्या का लगभग 13 प्रतिशत X 3				
3.4.1.	डायरिया से पीड़ित बच्चों का ओ.आर.एस. घोल द्वारा उपकेन्द्र/घर पर इलाज (0-5 वर्ष की उम्र के प्रत्येक बच्चे को वर्ष में कम से कम 3 बार डायरिया होने की सम्भावना रहती है)					
3.4.2.	ए.आर.ई./नमूनिया से पीड़ित बच्चों का इलाज (i) 0-5 वर्ष के प्रत्येक बच्चे को वर्ष में दो बार ए.आर.आई. होने की सम्भावना रहती है	कुल जनसंख्या का लगभग 13 प्रतिशत X 2				
	(ii) 10 प्रतिशत मामले कुल ए. आर. ई. केसेज में से नमूनिया के हो सकते है ।	उपरोक्त क्रम सं. 3.4.2 ने. का 10 प्रतिशत				
3.5.	**MTP (गर्भ समापन सेवाऐं)** महिलाओं की संख्या जिन्हें गर्भ समापन हेतु रैफर किया गया					
3.6.	**RTI/STI** केस जांच के दौरान पाए गए और रैफर किए गए		पु.	म.	पु.	म.
3.7	**शिशु एवं मातृ मृत्यु (1 जनवरी, 1998 से 31 दिसम्बर, 98 तक) संख्या**					
3.7.1	पिछले वर्ष में 1 माह से कम उम्र के मरने वाले बच्चों की संख्या :		पु.	म.	पु.	म.
	मृत्यु का कारण :					
	1. टिटनेस					
	2. नमूनियां					
	3. कम वजन					
	4. समय से पूर्व प्रसव					
	5. बुखार					
	6. मृत बच्चा पैदा हुआ					
	7. दस्त रोग					
	8. अन्य					
	योग					

3.7.2	पिछले वर्ष 1 माह से अधिक 1 वर्ष से कम उम्र के मरने वाले बच्चों की संख्या : (सर्वे के आधार पर) मृत्यु के कारण : (जन्म मृत्यु पंजीयन के आधार पर)		पु.	म.	पु.	म.
	1. नमूनियां					
	2. काली खांसी					
	3. दस्त रोग					
	4. टिटनेस					
	5. खसरा					
	6. दस्त रोग					
	7. अन्य					
	योग					

3.7.3	पिछले वर्ष जनवरी 98 से 31 दिसम्बर, 98 तक मातृ मृत्यु की संख्या			
	मृत्यु का कारण 1. Eclampsia			
	2. ए.पी.एच.			
	3. पी.पी.एच			
	4. प्रसव संक्रमण			
	5. टिटनेस			
	6. अवरूद्ध प्रसव			
	7. एनीमिया			
	योग			

3.7.4	बच्चों, शिशुओं व मातृ मृत्यु दर में कमी लाने के लक्ष्य को प्राप्त करने हेतु वर्ष के दौरान आप द्वारा क्या कदम उठाऐ जायेंगे ?
	1.
	2.
	3.
	4.
	5.

4.1 वर्ष 1998-99 की परिवार कल्याण की वास्तविक उपलब्धियाँ एवं 1999-2000 के लक्ष्य

	साधन	वर्ष 1998-99 की वास्तविक उपलब्धि	1999-2000 के लिए लक्ष्य (तालिका 2.3 के अनुसार
1.	नसबन्दी		
2.	आई. यू. डी. निवेशन		
3.	ओरल पिल्स उपयोग कर्ता		
4.	निरोध उपयोग कर्ता		

4.2 क्या आपके उपकेन्द्र में निम्न संस्थान कार्य कर रहे हैं :

1.	गैर सरकारी संस्था (एन.जी.ओ.) जिसे परिवार कल्याण की कोई योजना स्वीकृत है ।	हाँ/नहीं
2.	आंगन बाड़ी केन्द्र	हाँ/नहीं यदि हाँ तो संख्या
3.	गर्भ निरोधक वितरण डिपो	हाँ/नहीं यदि हाँ तो संख्या
4.	जन मंगल जोड़े	हाँ/नहीं
5.	आयुर्वेद औषधालय	हाँ/नहीं
6.	दाईयों की संख्या 1. प्रशिक्षित 2. अप्रिशिक्षित	
7.	गांवों की संख्या जिनमें दाई कार्यरत नहीं है	

3.7 उपरोक्त संस्थानों से आप परिवार नियोजन व मातृ शिशु कल्याण कार्य में क्या सहयोग लेंगी व कैसे ? टिप्पणी अंकित करें ।

1. गैर-सरकारी संस्थाऐं (एन.जी.ओ.) .....
2. आयुर्वेद.....
3. दाई.....
4. आंगनबाड़ी.....

5.1 साधनों एवं सामान की आपूर्ति

क्र. सं.	सामान का विवरण	इकाई	1.4.99 को स्टॉक में उपलब्ध	अतिरिक्त आवश्यकता	कुल
1.	ओ. आर. एस. पैकेटस				
2	Metronidazole Tablets				
3	Co-trimoxazole Tablets				
4	पेरासिटामोल				
5	क्लोरोक्वीन				
6	एन्टी सेप्टिक घोल				
7	Uristix				
8	डिस्पोजिवल दाईकिट्स (ममता किट)				
9	खून की जांच के लिए सलाइड				
10	थर्मा मीटर				
11	दस्ताने				
12	IFA Tablet बड़ी				
13	IFA Tablet छोटी				
14	Vitamin - A Solution				
15	निरोध				
16	ओरल पिल्स				
17	आई. यू. डी.				
18	सिरिंज एवं निडिल्स				

6.1 उप स्वास्थ्य पर उपलब्ध उपकरण एवं सुविधाएं

क्र. सं.	विवरण	उपलब्धता/मात्रा (संख्या)		
		हाँ/ नहीं	सही हालत में (संख्या लिखें)	अतिरिक्त आवश्यकता (संख्या लिखें)
A.	**सुविधाएं**			
1.	उपकेन्द्र भवन			
2.	आवास भवन			
3.	पानी की व्यवस्था			
4.	बिजली			
B	**फर्निचर एवं उपकरण**			
1.	परीक्षण टेबल			
2.	मरीजों के बैठने की बेंच			
3.	दवाईयों के लिए आलमारी			
4.	स्टूल			
5.	पानी के लिए बर्तन			
6.	बेकार पानी के लिए बर्तन			
7.	सफाई के लिए उपकरण			
8.	स्टीम स्टरलाईजर			
9.	डिवलरी किट			
10.	टार्च लाइट			
11.	स्टोव			
12.	वजन लेने की मशीन			
13.	ब्लड प्रेशर उपकरण			
14.	हिमोग्लोबीनोमीटर			
15.	वेक्सीन केरियर			
16.	आई. यू. डी. किट			
17.	ममता किट्स			
C.	**आई. ई. सी. मेटेरियल**			
1.	पोस्टरर्स			
2.	माडलस्			
3.	फिलिप चार्ट			

7.1 आई. ई. सी. गतिविधियों के वार्षिक लक्ष्य

क्र. सं.	गतिविधियाँ	लक्ष्य	वर्ष 1998-99 की वास्तविक उपलब्धि	वर्ष 1998-99 की सम्भावित उपलब्धि
1.	महिला स्वास्थ्य संघ की बैठकें			
2.	माताओं की बैठकें (मदर मीटिंग सी. एस. एस. एम. जिलों में)			
3.	पंचायत की बैठकें जो आयोजित करानी हैं।			
4.	फिल्म शो जो आप द्वारा आयोजित कराना चाहेगी			
5.	ग्राम संपर्क अभियान जो वर्ष के दौरान आयोजित की जाएगी।			
6.	पैम्फलेट की संख्या जो बांटने हैं।			
7.	उपकेन्द्र स्वास्थ्य सलाहकार समितियों की बैठकें			
8.	नमूनिया व दस्त रोग हेतु लोगों को शिक्षित करने हेतु कितनी मिटिंग आयोजित की जायेगी।			

नाम व हस्ताक्षर (एम. पी. डब्लू)

नाम व हस्ताक्षर (ए. एन. एम.)

योजना का अनुमोदन

(चिकित्सा अधिकारी प्रभारी, पी. एच. सी. सरपंच, ग्राम पंचायत, अंध्यक्ष, ग्राम सलाहकार समिति, सैक्टर सुपरवाईजर/एल.एच.वी. द्वारा)

(क) मैने योजना का निरीक्षण कर लिया है। लक्ष्यों का निर्धारण सही किया है।
इस वर्ष इस उपकेन्द्र में उपरोक्त गतिविधियों द्वारा निम्न उपलब्धियां होगी

1. जन्म दर ..... (बच्चे प्रति हजार) से कम होकर ..... प्रति हजार सम्भावित हैं।
2. शिशु मृत्युदर ..... से कम होकर ..... होनी सम्भावित है
3. मातृ मृत्यु दर ..... से कम होकर .....होनी सम्भावित है।
4. वर्तमान दम्पत्ति संरक्षण दर ..... से बढ़कर .....होनी सम्भावित है।
5. इस योजना का नाम पंचायत की बैठक में अनुमोदन करवा लिया गया है / आगामी बैठक में करवा लिया जायेगा।

हस्ताक्षर	हस्ताक्षर	हस्ताक्षर	हस्ताक्षर
चिकित्सा अधिकारी प्रभारी	सरपंच ग्राम पंचायत	अध्यक्ष ग्राम सलाहकार समिति	एल. एच. वी./सैक्टर सुपरवाईजर

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