This study of Auxiliary Nurse Midwives (ANMs) was conducted between 1990 and 1992. It considers the complex network of roles that they play as health workers, wage earners, wives and mothers. The study also provides an understanding of the nature and spheres of subordination and empowerment in their lives. The profile of ANMs is built up using details about their age, religion, caste, education, native place and marital status.

Women in Health Care

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Auxiliary Nurse Midwives

Aditi Iyer
Amar Jesani
with
Audrey Fernandes
Seema Hirani
Sandeep Khanvilkar

The Foundation for Research in Community Health
Mumbai/Pune

First published in 1995 by
The Foundation for Research in Community Health

84-A, R. G. Thadani Marg
Worli
Mumbai 400 018

Publication Unit
3&4, Trimiti B Apts.,
Anand Park, Aundh
Pune 411 007

Computer Processing done at FRCH, Pune

Printed at Abhyankar's TypeServe
9, Brahma Mahal, Century Bazar Lane
Prabhadevi, Bombay 400 025

CONTENTS

ACKNOWLEDGEMENTS

Like so much social science research, the present book on Auxiliary Nurse Midwives (ANMs) is a product of collective enterprise. Our debts are considerable and our gratitude as deep to the individuals and agencies who have made it possible.

To begin with, we owe our special thanks to the **Danish International Development Agency** for funding this project.

This book also owes its existence to its protagonists - the ANMs - who gamely participated in a study that forms the basis of this piece of writing. Not only did they invite us into their homes but admitted us into their lives, dreams and confidences. For this privilege, we offer our heartfelt thanks. Our access route to ANMs was facilitated by the Joint Director, Directorate of Health Services in 1990, Dr. N.S. Wanere, and by the Medical Officers of the PHCs selected. We gratefully acknowledge the cooperation extended by them.

Our exchanges with ANMs began in the winter of 1990 and continued until the approaching weeks of summer, a physically gruelling period which took its toll on our colleague, Varsha Kulkarni and though she dropped out after six weeks, her interviews have remained and fed into the study. We are also lucky to have been received by the students, staff (including the Principal) and Director of a training school which offered an eye-opening and first hand experience of the training process.

Away from the field, we have greatly benefitted from our discussions with Dr.M.Prakasamma, then at the College of Nursing, Hyderabad. After concluding a most interesting Ph.D dissertation on ANMs, Dr.Prakasamma generously shared her insights and painstakingly reviewed our methodology and research tools. Mr.J.C.Sharma, at the Tata Institute of Social Sciences, Bombay, provided invaluable feedback about our statistical applications.

Closer to home, we were kept alive by every member of the wonderfully supportive group at FRCH and our gratitude to each one of them is immense.

Sonya Gill and Manisha Gupte, in particular, have helped us immeasurably with their sensitivity to issues from their vast experience. Shirish Kavadi also took a keen interest in the study for its entire length. Sheela Rangan and Ila Shah went through a first draft of the study and made suggestions that radically altered our approach to this book. Shubha Gadkari provided editorial support while Gauttam Jadhav, Anuradha Naik, Maria Pinto, Rajesh Ingle, Shashikant More and Pramod More provided the necessary administrative support.

Above all, Dr.N.H.Antia, Director, FRCH never stopped believing in the project and us despite the frustration of unrealised deadlines and many wild promises. His enthusiasm and support have kept us going and for this, he has not merely our thanks but the fullest measure of our gratitude.

FOREWORD

The one and a half year trained Auxiliary Nurse Midwife (ANM) though low in the public health heirarchy plays a highly significant role in rural health care. Unlike the doctor and nurse she comes from a cultural background similar to that of the rural women and hence is the only member of the Primary Health Centre (PHC) who identifies and in turn is identified with the village she serves. Despite `transfers' and ` target' pressures, bureaucratic harassment from her services at the PHC, and often subjected to sexual harassment as a young female who is not a part of the village community, she is the most effective member of the PHC and hence of the rural public health system. A major attraction is the salary of Rs. 3,000 per month much of which she remits to support her family elders or younger siblings.

This detailed study undertaken by well qualified researchers who visited ANMs at the subcentres and PHCs, and who stayed with them, provides a new insight to the crucial member of the rural health team.

Trained in an uban centre, often to provide a cheap pair of hands to serve the needs of the hospital, her chief role ends up in motivating and fulfilling the targets of the Family Planning Programme. This alleviates her from the very people she is meant to serve and leaves her little time to provide the curative services and even undertaking deliveries as indicated in her designation.

This study of Auxiliary Nurse Midwives was conducted between 1990 and 1992. It considers the complex network of roles that they play as health workers, wage earners, wives and mothers. This also provides an understanding of the nature and spheres of subordination and empowerment in their lives. The profile of ANMs is built up using details about their age, religion, caste, education, native place and marital status.

The study also foccuses on work and work related problems concerning time management , target reaching and intracacies of MCH work. The question of priorities in health care services is dealt with by considering pre- selected health against perspectives of the government and people. The study is a situational analysis and gains its credibility from its approach to the ANMS situation andfrom the broad sweep of its objectives.

As a member of the village accountable to the community, ANMs if suitably trained for specific tasks at the village level, without targets and transfers, could be the most useful health resource to the community under Panchayati Raj.

Dr N.H. Antia
Director, FRCH

GLOSSARY

ANM	Auxiliary Nurse Midwife
ANS	Auxiliary Nursing Service
BPNA	Bombay Presidency Nursing Association
CHV	Community Health Visitor
IUCD	Intra Uterine Contraceptive Device
LHV	Lady Health Visitor
MCH	Maternal and Child Health
MO	Medical Officer
OPD	Out Patient Department
PHC	Primary Health Centre
RH	Rural Hospital
TNAI	Trained Nurses Association of India

WOMEN IN HEALTH CARE : THE SEXUAL DIVISION OF LABOUR

The present day visibility of women in the health services is due to the presence of a large number of gynaecologists, anaesthetists, pathologists, nurses, midwives, ward *ayahs* and *dais*. These women are products of a gender based division of labour that has evolved over time in modern medicine. The present book focuses on yet another class of women health workers. These are Auxiliary Nurse Midwives (ANMs), the women who function as health workers in the state-run health services in rural areas. An understanding of their work and social position, as we hope to advance, requires us to situate them in the structural divisions that characterise modern medicine and nursing.

The history of nursing and its genderisation is not as old as the history of hospitals; what does stretch long into ancient history is the patriarchal character of the medical system. The genderisation of nursing in 19th century England only saw the development of a feminine work category subordinated to and controlled by (masculine) medicine. In this context, it is important to understand how modern nursing emerged in western Europe in general and in the Victorian hospitals of England in particular. How did a conservative society as the one that existed in the Victorian era accept the entry of respectable women into nursing, an occupation hitherto considered dirty and demeaning ? What made those mighty doctors relinquish part of their work territory to trained women? How has the history of nursing evolved since then? Above all, how has the role and status of auxiliary nurses evolved?

Division of Labour in Western Medicine

Nursing Before Nurses

The process of healing cannot begin without patients too sick to look after themselves. More so in the pre-scientific era when knowledge about the body and the causes of ill health as well as skills, drugs and equipment to diagnose and treat illness were abysmally low among medical practitioners. That is one of the reasons why medicine was regarded more as an art than a science. Medical history is replete with stories of medicine men tending to affluent and aristocratic patients in a manner not dissimilar to modern day nurses. It is not unusual to come across stories of renowned doctors who not only successfully operated on or administered medicines to ailing kings or

the nobility, but also stayed with them for long stretches of time providing gentle ministrations like soothing drinks, body massages, clean bed linen, a whiff of fresh air and so on.

There is no evidence to show that women were trained in the art of caring in the early days. What one finds instead is the dominance of an ideology that ascribed certain "natural" attributes to women; namely, submission, self sacrifice and, above all, maternal instincts enabling them to care, nurture and nurse. In the absence of hospitals as social institutions for the sick, these feminine qualities were harnessed for nursing in the household. Ironically, while this ideology glorified women's role as nurses in the household, it prohibited them from playing a similar role outside. In fact, patriarchal dominance was so entrenched in elitist medicine that there is no evidence from historical accounts to suggest that women worked as assistants to doctors. Instead, they had a strong presence among local folk as healers and midwives, undertaking many of the tasks of present day nurses, with one fundamental difference. These early healers were not subordinated, as their modern contemporaries are, to doctors. They had an independent existence in society as healers in their own right.

Outside the boundaries of the household, popular accounts of nursing recount the participation of only certain types of women in nursing. They were almost invariably priestesses, nuns of religious orders, penitent sinners, virgins, women of "doubtful virtue" or even criminals. Likewise, under war conditions, men and prostitutes were recruited - under duress or for a fee - to care for the wounded. Prior to the 19th century, training in care-taking - albeit informal - was conducted only in religious institutions. For instance, in Roman Catholic institutions, the individuals trained to care for the sick were nuns. It was also not uncommon to find men taking on such a role as part of their religious calling in these institutions. This appeared to be the case not only in Christianity but also in some of the other religions.

When sécular hospitals first came into being in Europe, they did not have trained and dedicated nurses. A narrative history of medicine first published in 1929 quotes the *London Times* of 1857 in its description of nurses in British hospitals : "Lectured by committees, preached at by chaplains, frowned upon by treasurers and stewards, scolded by matrons, sworn at by surgeons, bullied by dressers, grumbled at and abused by patients, insulted if old and ill-favoured, talked flippantly to if middle aged and good-humoured,

tempted and seduced if young and well-looking - they were what any woman might be in the same circumstances. They were, in fact, mostly dowdy-looking females of drunken and dubious habits" (Haggard 1959 : 175).

This is possibly an exaggerated description of the legendary Sairey Gamps. That this stereotype reigned at the time is countered by Dingwall and McIntosh (1978 : 36-37) who contend that there were some nurses who were in fact respectable widows. This mattered little in Victorian England, however, as the moral character of any woman who did not belong to the upper or middle class was automatically suspect. And yet, the media attention on nurses the likes of Sairey Gamps, is indicative of a general anxiety that held sway about the abysmally poor condition of hospitals. This is matched by progress in scientific medicine that was steadily making it possible to think in terms of improving the efficiency of hospitals in their treatment of the sick. As scientific concepts of antiseptic and asepsis gained ground and the use of anaesthesia met with increasing success, the need to improve the quality of hospital care became a matter of great importance. A problem area to be tackled was that of cleanliness and towards that end, the presence of trained nurses was seen as an essential pre-condition. Factors such as these created conditions conducive for the appearance of nurses and their acceptance in society.

Genderisation of Nursing

The name of Florence Nightingale is closely associated with the popularisation of nursing as an occupation for respectable, genteel and properly trained women of the middle classes. In an action defying Victorian expectations and morality, Nightingale along with forty other women, proceeded to provide nursing care to soldiers wounded during the Crimean wars in the late 1850s. Their back-breaking labour under meticulous and organised supervision, so different from the nursing care in evidence elsewhere, won them generous accolades and Nightingale soon became immortalised as a "lady with a lamp". Following her return in 1860, a nurse training school established at St. Thomas Hospital in London was named the Nightingale Fund School of Nursing and initially financed by a fund raised in her honour by an appreciative public. While acknowledging Florence Nightingale's immense contribution to the history of nursing, it should also be kept in mind that she was neither the first nurse nor was the commemorative school the first training institution. Historical accounts of nursing show the existence of at least three known schools: one at Kaiserwerth in Germany established in 1836, another

in Ireland established in 1816 and a third at Paris set up earlier (although the date of its establishment is not known.) Additionally, there were organisations in England like The Protestant Sisters of Charity inspired by Elizabeth Fry (Whittaker and Olesen 1978 : 35). In the words of Whittaker and Olesen (1978 : 25), "At the time of the Crimean War, the world of nursing in Europe was straining to evolve from the province of the sacred on the one hand and from the profane on the other." Its reputation now enriched by the "lady with a lamp" imagery helped to rescue it from the ignominy of Sairey Gamps. At the same time, it was gradually disentangled from the rigour of a religious order and thus presented a respectable secular employment alternative for middle class women.

Undoubtedly, the creation of nursing as an occupation for specially trained women and, indeed, of training as an essential component of health care cannot be attributed to the efforts of a lone individual. The identification of nursing with trained women was buttressed by two considerations. Firstly, in the complex society of the late Victorian age, the ideological perception of all women being "natural" nurses was undergoing a change. It was now believed that such "natural" attributes of good women remained innate until drawn out by proper education and training either at home or in other institutions. Hence came the notion that "all women could be taught to nurse". This notion was supported by religion. The second factor that contributed to the popularisation of nursing as a woman's job was the "surplus women" phenomenon. A large number of urban women from the middle and other strata were seeking respectable jobs in the non-industrial sector and nursing, now respectable and sanctioned by religion, fitted in perfectly with the need of the time (Maggs 1983 : 11-15).

Medical Response

The struggle for dominance in the matter of healing has manifested itself sporadically through the centuries. Skirmishes between lay women healers and male medicine men culminated in *witch hunts* which lasted from the 14th to the 17th century in Europe. These witch hunts served not only to physically eliminate women healers but also branded them as superstitious and possibly malevolent (Ehrenreich and English 1973:19). The fact that the hunted women were popular healers among the peasant class while male "professionals" were supported by the Church and the landed gentry only highlights the economic and social basis of the subjugation of women in the

medical system.

Two centuries later, women were inducted into the genderised occupation of nursing, albeit with a different role and status. A struggle for dominance appeared to take place between professionally qualified doctors and these trained nurses; except there were no obvious signs of a conflict at all and each party was content to settle down to an unquestioned hierarchical division of labour. Why and how did this come about ? Under what conditions did the medical profession accommodate women nurses into the process of healing ? What were the factors that contributed to the structural and ideological arrangement between medicine and nursing ?

One was the increasing demand for hospital care in England. Between 1861 and 1921, there was a 140% increase in the total provision of general hospital beds in the public, voluntary and Poor Laws sectors in England (Maggs 1983:7). This created demand for nurses, who as a result of their training, were expected to bring about a reduction in the average length of hospitalisation for patients and thus make medical care more cost efficient. As a result, while there were probably less than 1000 (religious and lay) hospital nurses before 1861, there were approximately 12,500 nurses working in general hospitals by the end of the century (ibid:8-9). The expansion of the hospital sector was, thus, both the cause of the increased demand for trained women as well as the result of the need for trained women nurses by society and the medical profession.

Secondly, knowledge of medicine and the tasks involved in the treatment process was growing increasingly complex. Issues discussed in medical journals during the 1840s and 1850s indicate that doctors were seeking to be alleviated from some of the more routine tasks under their domain. Katherine Williams (1978 : 41) illustrates this by tracing the career of the thermometer. "In the 19th century, when fever was an important criterion of disease, it (thermometer) was used only by a doctor. In the 20th century the thermometer may be used by a nursing auxiliary, for fever has long been supported for doctors by other criteria for illness, such as radiographic findings or the analysis of blood and urine chemistry." While the reading of temperature continued to be important in the 20th century, it was no longer central to the medical profession's activities. As a result, doctors were happy to surrender their control over it and busy themselves with more critical tasks. This transfer of responsibility automatically brought nurses into the picture and elevated their

occupational status from menial to skilled and remunerated workers.

The third factor is ideological. The social position is legitimised by the dominant ideology, just as changes in ideology serve to legitimise new roles for women. The ensuing conflict is minimised if these new roles and the ideologies surrounding them fit in with the culture of the time. In this context, nurses of the 19th century were able to create only such space for themselves as was socially permitted to all women of the time. Florence Nightingale played a crucial role in providing an ideology for nursing without seriously upsetting the patriarchal dominance of men, medicine and religious precepts. In justification of nursing and its interests, she proclaimed, "they call it a profession, but I say it is a calling." (Williams 1978 : 39). This rationalisation served to subjugate nursing to the power structures reigning in the work place while imbuing it with the lofty principles of altruism and self-sacrifice. This was consistent with the social position of women, the interests of the medical profession and the demands of religion. A further process of ideological legitimacy was achieved by finding similarities between the hospital and the patriarchal family with the doctor acting as the "father", the nurse as the "mother" and patients as "children needing care". Perhaps no other occupation makes as direct an ideological projection of the sexual division in the family to an occupational role division, as nursing.

It is no surprise, therefore, that in time nursing ceased to be viewed as an occupation reserved for missionaries or 'Nightingales' but as one of the many options that presented itself to the potential employee. In order to provide prospective probationers something in exchange for the long hours of work that they would have to endure, nursing offered status in the healing process that was denied to other workers and exclusivity through training (Maggs 1983). Nursing reforms in 19th century England aimed, firstly, to establish a single stratified occupation with responsibility for patient care and organisation and management of nursing and, secondly, to introduce this occupation into existing health care institutions (Gamarnikow 1978:103). Reforms also brought along an organisationally autonomous nursing hierarchy located in a separate department.

Medical and nursing functions were thus genderised - medicine as a dominant *masculine* function irrespective of biological sex of the doctor and nursing as a *feminine* function irrespective of biological sex of the nurse. This genderisation is ingrained in the health care services to such an extent

that its assumptions remain unquestioned even in countries which have a majority of women doctors.

Struggle for Registration

Unlike the manner in which women gained entry into the labour market as nurses, the movement for their registration was ridden with conflict. The reason for this is very simple. In the mid 19th century the entry of women as nurses was essentially a social need rooted in material conditions of the time. The valour of the early nurses was accommodated by a modified normative structure which provided the occupation with its legitimacy. However registration, which would have resulted in the legalisation of the role, status and scope of nursing and nurses within medical care, had an altogether different implication. For legalisation is a political process which brings into question the relative political and social power of contending groups. This makes conflict inevitable which is why it took nurses sixty years from the establishment of the Nightingale Fund School of Nursing (1860) to clinch the issue.

During that period, the medical profession won its battles with the state and the archaic royal societies and succeeded in establishing its legal monopoly over medical care via the Medical Registration Act of 1858 in England. Still, it was the group of general practitioners - a group which prided itself on its autonomy- that felt threatened by the competition posed by the growing hospital network and its newly founded staff. Consequently, they were the most vociferous opponents of state registration of nurses.

However, most of the nurses and their representatives were not hankering for equal status. They had already accepted the occupational hierarchy between nursing and medicine. Thus, much of the debate between nurses and doctors on the question of registration centred around the definition of the scope and limits of nursing and the manner in which this would be attained. This debate was ultimately resolved by the nursing profession deferring power to doctors. This was the foundation on which the 1919 Nurse Registration Act was instituted in England. It is in the context of such a hegemonic structure between medicine and nursing that much of the subsequent struggle for nursing autonomy has taken place.

Challenging Sexual Division

There can be no doubt that the specific historical conditions under which women were inducted into health care and the process of registration that legitimised the structural sexual division between medicine and nursing are there to exert a lasting influence upon the profession to this day. The subsequent history of nursing in the developed and in the underdeveloped world is characterised by tremendous changes in the way nursing is organised albeit within the framework of an unquestioned division of labour. With the introduction of new technologies and market driven changes in the work organisation of hospitals and community services, the medical profession has either passed on grudgingly more of its tasks or functions to nursing, or nurses have, through militant agitations, wrested some of the more refined and clinical tasks and functions from the profession. Yet, contemporary developments have not seriously contested the sexual division of labour in health care.

Despite their subordination, nurses have gained materially from developments through history. Indeed, the forms of intense exploitation and oppression of women in the health care services have not only undergone changes but also brought material benefits, confidence, a new image and an increasing voice in patient care for a sizeable section of nurses. Further, while nursing has remained predominantly an occupation for women, the 19th century ideological legitimisation has, to a substantial degree, erased the stigma attached to women working as nurses. Nurses have also been receiving relatively better incomes than other working women, reasonably positive social status too. Nevertheless, unlike medical professionals who can more easily set up autonomous practices (and thus escape being direct employees of the health care industry), nurses are almost always on the payroll of the services and are, thus, *workers*. Ironically while there is a historical and material basis for the nurses' drive towards professionalisation, this has also, to an extent, negatively affected their efforts to unify their ranks and struggles as workers.

There are two developments that have led to questioning of the sexual division of labour. Firstly, the functional division between "treating" and "caring" is objectively coming under some strain in the face of new medical and diagnostic technologies. These new technologies have not only produced new medical specialities, but have also brought about the creation of a cadre of nurses with better professional and technological qualifications to use such

technologies. This has qualitatively changed their role that was once restricted to merely "assisting" the doctor in diagnosis and treatment. Further, the medical profession has found it necessary to surrender more functions to nurses in order to cope with increasing complexity of medical work. This is due to attempts by hospital managements to reduce the working hours of junior doctors, to shift some tasks to nurses and due to the renewed professionalisation project of nurses seeking to upskill their occupation (Walby and Greenwell 1994 : 12).

The second development that has hit the sexual division is feminism. In the last three decades, modern feminist currents have generated critiques of medicine: of its inherent sexism (in its definition of concepts, diagnosis, treatment and care) and its sexual division of labour. When we view feminist critiques of medical care in conjunction with the critiques and practices of community health (its emphasis on demystification, deprofessionalisation, equity and humanisation), the functional gender based division in the process of healing looks phony, a tool to sustain the material interests of the dominant strata by creating a health care service of those and for only those who can afford it. The works of feminist writers like Carol Gilligan, Susan Sherwin, Alison Jaggar and many others have already brought into debate some of the reigning concepts in medical ethics. For instance, the feminist approach to medical ethics has resulted in "conceptual models for restructuring power associated with healing by distributing medical knowledge in ways that allow persons maximum control over their own health" (Sherwin 1992 : 28). While such works have posed a new body of feminist ethics against the conventional "justice theory", alternatives advanced by many are still in their formative stage. However, they do represent a great advance in questioning the sexual division by virtue of their attempt to change the very nature and purpose of medical care which opens up the great possibility of providing a theoretical and ideological basis for change.

Health and Nursing Services in India

Nurses in the Indian Systems of Medicine

The nursing profession as we know it in India today was grafted into the scene through the instrumentation of colonial power in the 19th century. It is true that the role of nurses in the treatment of illness was amply recognised in the Indian systems of medicine (especially ayurveda). Indeed, the Charaka and

Susruta-samhitas regarded successful medical practice to depend on four factors - the physician, the drugs, the nursing attendant and the patient (Chattopadhyay 1977 : 37). In fact, the presence of attendants tending to the sick in hospitals in ancient and medieval times has been documented by historians of Indian medicine (Jaggi 1979 : 128). Significant however is the fact that these nurses and attendants were invariably male (ibid). Given this pre-ponderance of males and the priestly class, the ayurvedic system of medicine precluded the participation of women as healers and carers of the sick, even as they played their part in the maintenance of health in the family. Therefore, the natural recognition of women as care takers and healers that led to the genderisation of nursing functions in the West did not take place in India. What happened instead was the accommodation of this Western ideal into the fabric of a Colonised society.

Nursing in Colonial India

Health services (and consequently nursing services) developed in India in response to the interests of British colonial rule. The earliest health institutions were established in the late 17th century to cater to the needs of the army of the East India Company. In 1664, a house was set up at Fort St. George in Madras with people appointed to look after men from the garrison and the company's ship (Wilkinson 1958 : 6). However, during the 19th century, the notion of health being a matter of individual responsibility, was slowly giving way to the recognition of the need for the state (in this case, the imperialists) to intervene in the health of its people while not incurring too great an expense on such an organisation (Arnold 1989:14). As a result, medical intervention was piecemeal and selective with resources being concentrated in areas vital to the operation of the colonial economic and administrative system. In this context, the workers in mines, plantations, barracks and main urban centres were favoured while rural areas and women and children were cast out of colonial benevolence. Given this background, it is not altogether surprising to note that when the first comprehensive health survey in British India was undertaken in 1946, the health facilities in terms of institutions as well as personnel were skewed in favour of urban areas which accounted for merely 20% of the total population. Health institutions in urban areas catered to an average of 16,912 persons while rural institutions catered to 45,965 people (Bhore Committee 1946 : 37). Similarly, the proportion of trained nurses employed in public medical institutions in rural areas was no more than 16% (in Bombay this was as low as 3.6%). While the province of Assam

boasted of a figure as high as 77.4%, this was more an exception than a rule. The distribution of health institutions and personnel were also skewed in favour of the old ports that had provided refuge to traders of the East India Company. As a result, Bombay, Bengal and Madras alone accounted for nearly half the total number of medical institutions (49.9%), nearly two thirds of the total number of registered medical practitioners (62.4%) and nurses in public health institutions (66.1%).

In comparison to medicine, nursing was relatively underdeveloped in numerical terms in British India. While there were 12,750 nurses, midwives and health visitors in the country around independence, there were 3.7 times as many doctors (i.e. 47,400). This can partly be explained by the fact that nursing made its appearance much after medicine was a well entrenched occupation in towns and the countryside. Secondly, a large proportion of the demand for nurses was determined by the development health care institutions like hospitals and clinics.

Since India lacked the tradition of female nurses, it took a great deal of time and energy to establish a nursing service on the lines of the western model (Jaggi 1979 : 130). The first attempts to develop nursing services by training women was started in the mid 19th century. The government sanctioned a training school for midwives in the Madras Presidency in 1854 (ibid). However, it was not until the 1870s that serious discussions took place about how the level of nursing could be improved. In western India, the J.J. Group of Hospitals was the first government hospital to train Indian women in the 1860s. Kashibai Ganpat became the first woman in western India to receive a certificate for General Nursing and Midwifery in the late 19th Century (Athavale and Sadgopal 1992 : 1, Jaggi 1979 : 133). A number of civilian hospitals started their own training programmes even as these early attempts were pitched against a general difficulty in attracting and retaining probationers and trained nurses. Between 1874 and 1894, 259 entered the Government General Hospital at Madras either as trained nurses or probationers and 244 left (Wilkinson 1958:16). Training courses in mission hospitals differed somewhat in that they were conducted in vernacular languages and thereby cleared the way for Indian women to join its ranks. However, the numbers were all too small and the general reliance on trained nurses from European (Some belonging to religious missions) and Anglo-Indian communities (some of the former belonging to religious missions) meant that nursing was far from becoming a popular occupation which was

taken advantage of by women. Training was not standardised (since it was conducted by the nurse(s)-in-charge of the institution who themselves had differing levels of training) and followed the apprenticeship system in hospital wards.

The early years of the 20th century saw the creation of the first professional organisations for nurses in the forms of the Trained Nurses' Association of India (TNAI) in 1908, the first quasi Nursing Councils viz. the Bombay Presidency Nursing Association (BPNA) in 1909 and the North of India United Board of Examiners for Mission Hospitals in the same year. The object of the BPNA was to coordinate the various attempts at training and to achieve a uniform system of training by inspecting schools and prescribing the curriculum. It also conducted examinations and registered successful trainees. Around this time, the first nursing journal called the Indian Journal of Nursing was published. This journal provided a forum through which nurses could exchange their views and experiences.

Nursing was beginning to show the first stirring of a profession. Nurses who served on the North of India United Board were staunch members of the TNAI. The members of the TNAI were convinced that state registration would bring along the status that nursing so badly needed. Members of the TNAI took up the issue in their respective provinces till their perseverance culminated in the passing of state registration acts. The first to be passed was the Madras Nurses and Midwives Act of 1926. This was followed up by Registration Acts in other parts as well. These pieces of legislation conferred some state recognition on nurses and nursing. However, in its composition, the Councils had very few nursing representatives. There were, for example, 14 seats on the Madras Council of which only six were allotted to nurses while the remaining were allotted to doctors and administrators.

Therefore, while the creation of provincial nursing councils served the interests of nursing at one level, it brought nurses under the control of medicine men. Secondly, these councils were vested with the authority of regulating training only within their respective provinces. However, there were by this time various grades of training for nurses, midwives and health visitors[1] and the efforts to standardise training by the councils in fact contrived to perpetuate these differing grades (INC undated:3). However, an Act to constitute an Indian Nursing Council was passed which received the assent of the Governor-General in 1947 and with it, the long standing wish of the TNAI to have a uniform system of nursing had as good a prospect as any of being fulfilled.

The status, conditions, emoluments etc. of the nursing profession were studied by the Bhore Committee (1946) and later, by the first Nursing Committee, also known as the Shetty Committee (1955). According to the Bhore Committee, nursing was characterised by lack of professional status, underpaid senior positions, deplorable living conditions, unbalanced diet, absence of recreational facilities and employee benefits. Hospitals were grossly understaffed and the few nurses who worked there were consequently overworked. Nursing education, too, was fairly in the doldrums with a total lack of uniformity.[2] Many schools did reach the "minimum standards" usually required for such training. In a majority of these schools, the services of students were used to "supplement the work of the nursing staff" and they were treated as "employees" of the hospital.

While taking stock of the situation, the Shetty Committee made recommendations for improving conditions of service and emoluments in various state and state aided institutions so as to attract women from "good families" to the profession. The committee was of the opinion that while training schools appeared to have no difficulty in filling seats, it was obvious that they were unable to attract "right women" for the job. Shortage in the number of trained nurses was evident in almost all states and hospitals due to the fact that posts were not created and nurses were expected to perform non-nursing duties. The main reason why women from good families kept away from nursing was because of unsatisfactory and crowded living conditions. Further there was a shortage of accommodation which compelled some hospitals to recruit fewer trainees/nurses than their finances would allow.

Auxiliary Nurses in the Health Services

Auxiliary workers are broadly understood as being technical workers in a particular field with less than full qualifications (WHO 1961). The second Five Year Plan described the task of auxiliary health workers as supplementing the contribution made by doctors and other highly trained personnel for promoting preventive and curative health activities in their various branches (GOI 1956:540). Finally, these two ideas are fused in a third description which sees auxiliaries as workers "trained for aspects of health care where responsibilities are defined by the tasks to be performed rather than by traditional professional roles; where training is primarily oriented to the responsibilities the particular worker will undertake rather than based upon a wide background of theoretical studies as in traditional medical and nursing

education; and whose authority is derived from the public or private health care organisation or team within which he or she works rather than from the traditional professional licensing bodies" (Hardie M. as quoted by Skeet and Elliott 1978).

Auxiliaries are products of specialisation in the division of labour. Their role is founded on the realisation that with increasing complexity in the labour process, auxiliaries are needed to relieve professionals from drudgery so as to allow them to tackle the more challenging aspects of work. While this rationale provided the early justification for the division of labour between medicine and nursing in the last century, it does the same for the division between professionals and auxiliaries in the 20th century. These auxiliaries support, not just the medical profession, but also the nursing profession in their capacity as technicians, vaccinators, assistant midwives etc. Logically, therefore, auxiliaries derive their legitimacy from professionals and the team in which their work is set. This pre-condition is important but problematic too as we shall later see.

Origins of Auxiliary Nurses : From Temporary to Permanent Cadre

The first official attempt to build a cadre of auxiliary nurses was made during the second World War in the face of severe shortages in the number of nursing personnel. The nurse to population ratio was in the order of 1 : 50-60,000 in 1942. What emerged was the Auxiliary Nursing Service (ANS) which was constituted of persons who, after some basic training, were sent to military hospitals in India and abroad to serve as Assistant Nurses (Jaggi 1979 : 137, INC undated:4). How long their courses were designed to last is also not immediately obvious. One source indicates that training lasted for three months followed by another eight to nine months (INC undated:4) and the others report that training lasted for six months (Wilkinson 1958:12, Jaggi 1979 : 137).

Under the circumstances of war, this scheme succeeded in fairly expanding the nursing ranks. During the period in question, 3344 persons were trained and 2737 were drawn into service. Recruitment for this service stopped in 1945. In the words of a nurse veteran, the ANS sought to "provide an adequate supply of nursing personnel for the Indian Army while safeguarding the rightful status of the nursing profession" (Wilkinson 1958 : 12). Thus, in this bid to enhance numbers quickly by lowering training standards, care was taken to separate them from other nurses trained in regular courses in the provinces.

These new recruits were called auxiliaries and, at the time, the term signified a temporary status in the health organisation of the country. After the war, there followed a process of demobilisation during which ANS members were allowed to complete the general nursing course in a shorter period. These concessions were withdrawn by the end of 1955.

The initial interest in auxiliaries in independent India was set against the objective of creating a more equitably distributed service delivery system and placing in the newly instituted health centres, trained personnel. In view of the shortage of professional nursesin rural health centres, planners and policy makers in India were eager to create a cadre of health workers quickly and with as little expenditure as possible. The first Five Year Plan stated, "The usual courses of training will take up considerable time and short term courses would, therefore, appear to be the only solution. Besides, persons with requisite, preliminary educational qualifications may not be coming up in sufficient numbers to meet the demand and the auxiliary courses where the preliminary educational qualification required is less than for the normal courses would facilitate recruitment of sufficient number of candidates" (GOI 1951 : 513). The Shetty Committee (1955) remarked that "auxiliary nurses and midwives who can be trained with less expense in a shorter time, would be very useful in supplementing the nursing services, providing they are assigned duties in keeping with their training and are required to work under supervision". By 1954, one dozen training centres running courses for ANMs was established.

By 1961, a comparison between the actual number of trained personnel and the numbers that were required to be attained by 1971 as also the personnel to population ratios suggested by Bhore Committee revealed a shortfall of 7,500 doctors, 17,500 health visitors and as many as 49,000 nurses and ANMs. In the essential struggle between expansion and consolidation, the Mudaliar Committee (1961) settled for the second. It argued that it was necessary/ desirable to "conserve the more highly trained personnel to jobs that they ought really to be doing and let the bulk of the work, which is of a routine nature, be done by those whose qualifications will be enough for that purpose, though they are not highly trained members of the medical, nursing or dental professions" (GOI 1961: 67). Thus it favoured continuance and extension of training programmes of ANMs. This recommendation sealed the fate of ANMs. No longer temporary staff filling for trained nurses, they were now permanent staff taking over from the absent nurses without ever becoming nurses.

Changing Roles : From Midwife to Birth Controller

From the start, ANMs were located in Maternal and Child Health (MCH) Centres and in the community projects. After one decade, they were no longer viewed as assistants to midwives but as replacements for the professional cadre of Nurse Midwives in Primary Health Centres (PHCs) and elsewhere (Mudaliar Committee, 1961). The 1960s saw a shift in their role in view of the changes contemplated in primary health care. This followed the fourth plan in which the desire to consolidate the gains of the various campaigns against communicable diseases (especially malaria) at the level of the general health services organisation by bringing the PHC back into focus was expressed. This was coupled with a growing emphasis on family planning within the health agenda, a programme, which the fourth plan proclaimed, to be of the "highest priority".

By the late 1960s, the family planning programme was backed by more extension work by health workers. Further, the introduction of IUCDs (the loop) made it possible for the government to think in terms of a mass programme. The earlier emphasis on popularising the condom was not successful. The committee appointed to review staffing pattern and financial provision under the Family Planning Programme (the Mukherjee Committee, 1966), recommended that such a mass programme be supported by better planning at all levels of the bureaucracy and financial allocations. The committee made many recommendations. One of these involved the system of targets to be fixed on a'scientific basis'. The system of giving incentives to women accepting the contraceptive also originated in this report. These incentives were also to be given to the Medical Officers (MOs) participating in the Family Planning Programme. The committee identified ANMs and other village level workers as agents for the popularisation of family planning and suggested that training courses for these workers be stepped up.

This system of family planning targets and the pressure on health workers to fulfill them thus took root in the late 1960s. When the fourth Five Year Plan was submitted, it called for an enhanced budgetary allocation for this centrally sponsored programme. The plan decided that family planning be integrated with the MCH programme and the general services. The logic was that such a programme would be more "effective and acceptable" . As a result, the scheme of immunisation of infants and pre-school children, immunisation of expectant mothers against tetanus, prophylaxis against nutritional anaemia

for mothers and children and nutritional programme for control of blindness caused by Vitamin A deficiency among children would now be implemented through family welfare planning centres (GOI 1968).

In response to the integration of family planning with MCH, ANMs and other para-medical workers were identified as crucial agents of the programme. Not only were training courses instituted for them but study manuals were also written up for trainers (GOI 1971), nurses (Russell 1968) and family planning staff (GOI undated & 1972). One of these titled *Guide for Integration of Family Planning for Auxiliary Nurse Midwife Training*, published in 1971 by the Department of Family Planning stated, in its foreword, that the "Auxiliary Nurse Midwife plays a very important role in implementing family planning programme at the periphery" (GOI 1971). A few pages later, the authors labelled ANMs as "crucial workers", "backbone" and "vital" (pp. 7).

The Family Planning Programme has been growing in strength ever since the late 1960s. Its integration with the general health services was emphasised in all subsequent Plans. Further, the initial discussions on integrating functions of the PHCs and of village level workers led to a full fledged committee in October 1972 at the initiative of the Executive Committee of the Central Family Planning Council (Kartar Singh Committee 1973). It was constituted to deliberate on the structure of integrated services at the peripheral and supervisory levels; the feasibility of having multi-purpose workers; the training requirements for such workers and the utilisation of mobile service units set up under the programme for integrated medical, public health and family planning services operating from the Taluka level. It resolved in its first meeting that the concept of multi-purpose workers at the periphery was both feasible as well as desirable. The committee may have seriously considered the operational research experience of the (Johns Hopkins) Project around Narangwal, the one at Gandhigram and of the National Institute of Health Administration and Education in reaching its decision (Giridhar et al 1985:94).

The committee suggested a reduction in the area and population assigned to these new health workers and an integration of their functions that were previously under the different (vertical) programmes. ANMs and the other workers affected by this new scheme of things were also awarded the labels of Health Workers (Male and Female). They were to be supervised by Health Assistants (Male and Female). The committee reasoned that the presence of only one health worker who would be in a position to deliver a range of services

(instead of just one) would increase their credibility in the villages. It would be "economical" and "effective". The committee believed that integration should be in rural areas since the main area of operation for the multi-purpose workers both in health and the Family Planning Programme was in the rural areas and there was a fair degree of uniformity of the staffing patterns of services for rural populations in the different states. In keeping with the requirements of this new cadre of workers, the Indian Nursing Council modified the earlier syllabus in 1978 and training was started in different states.

The fact that the integration of structure and function of PHCs and health workers were affected in the context of the rising importance of family planning has played a crucial role in turning the integrated scheme into a single minded family planning scheme. The priority awarded to this programme results in better facilities being made available for family planning and related activities to the detriment of other programmes and this has been amply demonstrated in a number of studies.

Status of Nurses and their Work

The entry of women in modern health care in India was a process initiated from above in response to the needs of colonial health care institutions. Unlike England, which experienced the surplus women phenomenon in the mid-19th century, there were no educated and respectable middle class women (which translates in the Indian context to mean upper and middle caste, and middle economic class) on the look out for wage labour . As reports of committees have pointed out time and again, the very fact that female literacy, let alone high school education, was low and slow to grow. So the first hurdle was to find women with sufficient education to qualify for training. A review of the standards set by the nursing council for training of various categories of nurses reveals that while councils began with women passing Std.7, they have increased this minimum requirement to Std.12 for general nursing and Std.10 for nurse-auxiliaries in the period of five decades. And through it all, complaints about not getting enough women with the "right" background have continued.

The greatest obstacle that Indian nursing has faced originates from the Indian cultural milieu with its notions of "purity and pollution". Pollution and defilement are identified with natural body functions like menstruation, sexual relations, body emissions, etc. Since some part of nursing involves the management of such body functions of patients, it does not fit into the

acceptable cultural definition of a good job. Sociologists have attempted to understand the relationship between the negative cultural image of an occupation and its effect on the self-worth and self-respect of its representatives (Nandi 1981). This situation is compounded by the fact that nurses work in close proximity with not only other male workers but with male patients too. Moreover, their relatively low status in the health care hierarchy , the visible dominance and even harassment by doctors and their modest income, has engendered a social stereotype of the women who work as nurses. This impacts negatively upon the status of the profession in India.

Nursing in India did not have a role model even remotely akin to Florence Nightingale. Efforts by reformers and nationalist leaders like Ranade, Agarkar and Deodhar in western India are commendable but have made no great difference to the profession since these efforts were part of a larger rehabilitation drive of orphans, ostracised and destitute women, termed *parityaktas* (Athavale and Sadgopal 1992:1). Another noteworthy effort was made by Mahatma Gandhi, who called nursing a "noble" profession. Along with co-workers, Gandhi personally nursed the sick and helped establish some nursing schools (ibid:1). While the importance of these efforts must not be underestimated in view of the cultural and social odds against which such pioneers worked, it is equally important to recognise that these efforts were vastly incapable of producing the kind of social stirring needed for the profession to achieve respectability. On the contrary, while *parityaktas* no longer dominate nursing in the government health institutions and big private hospitals (one does not know about those in the private nursing homes), nurses have nonetheless remained the *parityaktas* of Indian society.

Nurses and Auxiliaries in the Private Sector

The visibility of women in the health care services in India is due to their participation not only as nurses, but in menial capacities as ward *ayahs*, *dais*, etc. Almost no attention is paid to ward *ayahs* although they contribute towards maintaining cleanliness and hygiene in hospitals and nursing homes. In some cases (particularly in small nursing homes) they take on some of the duties associated with nursing like managing the bodily functions of bedridden patients etc. On the other hand, traditional *dais*, who have been the focus of much research and training efforts, play a limited role as traditional midwives in a traditional village system with no organic connection either to hospitals and clinics nor to the government PHC network. All of them are women and

though their numbers are significant[4], their contribution to the process of healing and caring is invisible when compared to doctors and even nurses. There are estimates, however, about the number of ward *ayahs*. Although the Bhore Committee (1946 : 402) had recommended that ward *ayahs* and nursing orderlies be trained in the "routine and non-nursing duties of the nurses", no information is available on the training given to them and their work is studied the least.

Nurses, on the other hand, appear only partially in official statistics of public and private institutions. While statistics about public institutions are more accurate, statistics of the private sector are grossly under-representative. Figures in 1992 indicated that at the national level, there were 6417 hospitals and 206,888 beds in the private health care sector (CBHI 1992). However, it is our considered opinion that the actual number of these may be at least three to four times higher. This is because private hospitals and nursing homes fall outside the ambit of the law since most states do not have legal provisions for their registration with local or governmental authorities. This affects reporting on the staff employed by these private health institutions too. If one is to go by what is reported in official statistics, it would appear as if almost all the 3,00,000 registered nurses in the country are employed by the public sector. Similarly, a majority of the 1,50,000 registered ANMs would appear to have been (ie: 1,21,765) employed by the government in PHCs and sub-centres. Does this mean that the private sector has done away with nursing care ? On the contrary. The only credible explanation is that private hospitals and nursing homes employ a large number of female workers, probably as many as the number of registered nurses. However, they are either untrained or partially trained and are unregistered. This illegitimacy only compounds their inferior position in the occupational hierarchy.

These partially trained and unregistered nurses in the private sector are the most exploited strata among nurses in India. Their condition is, in many ways, similar to the situation of nurses in the U.S. in the early years of the 20th century. Until 1930, the dominant method of training and recruiting women in hospitals in the market driven American health care system, was by the employment of unpaid nurse apprentices who exchanged their labour for room and board in the hospital and their eventual credentialisation as graduate nurses (later called registered nurses). After three years of unpaid nursing, graduates left hospital "schools" to work in what was called private duty nursing (a form of household domestic employment) because hospitals preferred to recruit new apprentices for unpaid labour instead of their own graduate nurses

(Brannon 1991 : 513).

Private non-recognised nursing schools are numerous in India although they have hardly been studied by scholars or even investigative journalists. These schools train women in a short course in nursing for a price and use their labour in the hospital in exchange for room and board. Such women do not get registered with the nursing council but are thrown into the labour market which has a fairly high demand for them thanks to the ever expanding private health sector and the incredibly low wages paid to such nurses. Some nurses are recruited without any training whatsoever and over the years pick up "nursing" from doctors and their seniors. It is not surprising, therefore, that when a small survey was conducted by a committee appointed by the High Court, it was discovered that private hospitals and nursing homes in Bombay city had a large majority of non-qualified nurses (Nandraj 1992).

These untrained or semi-trained nurses constitute a bulk of auxiliary nurses in India. They do not get counted in the official statistics. They belong neither to any of the nurses' association nor to the nurses' union. The registered nurses, who have their unions and associations , have barely paid any attention to them because they pose no serious challenge to their job prospects in the demand driven labour market of health care.

ANMs in the Public Sector : Issues at Stake

ANMs are not the only auxiliaries in the public health services. The (public) health delivery system also employs a host of technicians (including leprosy technicians) and male (multipurpose) workers. These male workers were previously uni-purpose workers employed under the vertically-run malaria eradication programme. The integration of their functions in the mid-1970s expanded the scope of their work roles and intensified their work load. They were now vested with the responsibility of conducting a host of activities under the national programmes against communicable, non communicable diseases as well as the family planning programme and supportive activities like record maintenance, team activities, etc. (Appendix 1 presents a detailed description of their responsibilities under the MPW scheme). With this intensified range of activities came smaller geographical and populations. As a result, these village level health workers have increasingly become visible health workers and also the main link between the larger public health organisation and the community. However, the enhanced scope of their responsibilities has not been matched by a rise in their status.

Male workers and ANMs share the same rung -the lowest, most subordinate- of the district health bureaucracy. They are, thus, subjugated to the district health administration in the capacity as workers. Male and female workers share some of the disadvantages inherent in their subordinate positions; however, female workers are far more disadvantaged and the reason for this is not hard to see.

The first fundamental difference stems from their affiliation to the nursing profession by virtue of their registration with the council. Since ANMs are only para- professionals by training they do not enjoy the same status as other nurses. This subjugates them not only to medicine but to full fledged nursing and nurses as well. Furthermore, unlike regular nursing which allows the participation of males, however marginal this might be, [3] the cadre of ANMs is constituted exclusively of women. The inequalities rooted in their gender now add another dimension to their situation and makes their subordination complete.

Their affiliation to nursing carries along a negative social image which is fine tuned in view of the specific requirements of their work and ANMs now carry the additional burden of a reputation -a stereotype- that portrays them as immoral women. Such a stereotype is found to be a big handicap in rural areas (Jesani 1990: 1103).

This is also manifested in a sexual division of labour between male and female workers and a close inspection of the health activities assigned to these two categories makes this abundantly clear. While male workers are expected to take on an active role in the control of malaria (through detection, slide collection and treatment), tuberculosis and other communicable diseases programmes, ANMs are principally responsible for MCH activities. Part of the reason for this must undoubtedly be the "carry-over effect" of their previous functions. However, the outcome of this division of labour (which draws its ultimate justification from the "natural functions" argument) is crucial. On the one hand, the sex of the male health worker and his use of slides and other "clinical" devices serve to project his image in the community as a malaria "doctor". This is in direct contrast with female workers who are simply looked upon as being "*nursebais*"(Jesani 1990:1099, Mavalankar et al 1992). The difference is not merely a matter of semantics; the associations are ideological wherein the male doctor is assumed to be a more competent worker than his female counterpart .

Additionally, unlike male workers, ANMs are expected to maintain the cleanliness of the sub-centre. In actual fact, the female worker's responsibility with regard to the sub-centre goes beyond hygiene. She is expected to stay there and to run it on a day-to-day basis. However, this responsibility (which is not entrusted to the male worker) is not matched with administrative authority at the level of the sub-centre. As a result, the male worker does not report his activities to the female worker or even necessarily feel accountable to the sub-centre.

At present, while a PHC ideally serves a population numbering 30,000, it has only one doctor for 15,000 people (assuming that each one has two doctors). These doctors are hardly in a position to provide constant support and supervision to ANMs and male health workers posted at sub-centres. Effectively therefore, there is no team (what with the doctor -the team leader- located at a distance in the PHC) and these workers carry out the day-to-day work of the sub-centre in an independent fashion. Thus, contrary to their status, ANMs become de facto independent workers -quasi doctors- with neither the recognition nor the wherewithal so necessary to live out such a role in the community and in the health services.

It is from such theoretical and practical concerns that the present study of ANMs in the public services derives its rationale. It focuses on ANMs, not as an operational category, but as women in the hierarchical structure of the health services and attempts to document the many ways in which the system (of which they are a part) impinges upon their lives and experiences. It broadly studies their status in the health services, the community and in their homes through an understanding of their social role and day-to-day problems as perceived and experienced by them.

Structure of the Book

The book attempts to recreate a story of the lives of ANMs through the findings of a qualitative study. The chapter that follows -Chapter 2- briefly recounts the methodology of the study from its basic research questions to its tools, design, logistics and limitations.

Chapter 3 titled **Social Backgrounds of Recruits** dwells on the class character of the cadre of ANMs in terms of their (and their family's) community, educational qualifications, occupational profile, agricultural land

holding pattern and income distribution. The discussion of socio-economic background provides broad pointers towards such an understanding although no attempt has been made to develop a socio-economic index.

Chapter 4 titled **Gearing up for Health Work: Professional Support Before and After** reviews trends in the professional preparation of ANMs through training and retraining programmes as well as on-going supervision and guidance on the job. At the heart of the problem lies the subordinate status that ANMs enjoy as women health auxiliaries; a position that calls for continuing professional support and yet, militates against access.

Chapter 5 titled **Health Work at the Village Level: The Living Reality** recreates the life and experience of village level health work. It surveys the content of village health and its meaning in the social context within which it is set. It also focusses on the adequacy of support mechanisms at PHCs and subcentres; misplaced work priorities; the target oriented family planning programme and general working conditions. It highlights aspects of work which are problematic at a cultural level and the implications of the inability to perform health work in the community and in the health services.

Chapter 6 titled **Access roads to the Health Services** provides information about the forces that guide women into a profession dominated by women and one discredited, even stigmatised by that token. Do ANMs seek employment out of choice or circumstance? Is their entry into the health services smooth or is it hindered by forces of opposition?

Chapter 7 titled **Social Context of an Economic Role** contemplates on the complex relationship between the role as wage labourers in the health services and its social ramifications at the household level and in the marriage market. How does the social prejudice that attends their work as ANMs affect their eligibility in the marriage market ? Is the marital relationship able to withstand their transferrable jobs and their unpredictable work schedules?

Chapter 8 titled `**Staying On**' reflects on the reasons why ANMs choose to stay on in a job that is so clearly overlaid with impediments. How do they look back on the time that they have spent in the delivery of health care services? This chapter will provide a finale to the saga of their lives and work, hopes and aspirations.

NOTES

[1].There were two grades for the course in General Nursing: Senior or A Grade Courses and Junior or B Grade Courses. The former were conducted for students with Junior Cambridge or who had completed secondary school Leaving certificates in English; while the latter were conducted for students completing schooling upto Std.VI or VII and in some cases even Std.III, in local languages. There were General Nursing Courses that were imparted in hospitals for women and children. The system of grading applied to this course as well to the courses in Midwifery. Courses in Midwifery for trained nurses lasted for six months to one year while it stretched over 18 months to two years for other. Some of the north Indian states conducted two year courses for Nurse-dais which combined nursing and midwifery. These were subsequently discontinued. Courses for Health Visitors also varied from 12 to 18 months, the certificate in midwifery being an essential pre-requisite.

[2].The Indian Nursing Council's attempt to standardise and consolidate nursing training led to the resolution that there should be only two standards of training in Nursing and Midwifery, one of these being the course for ANMs which would replace junior grade certificates and the course in midwifery (INC, undated:5). The minimum educational requirement for the course was seven years of schooling and the minimum age was 17 years (GOI, 1954).

[3].A mere 4.3% of all nurses registered with the Maharashtra Nursing Council on 31.12.90 were males.

[4] By 1992 the government had trained about 6,00,000 women *dais* in villages all over the country.

RESEARCH METHODOLOGY

The need to treat ANMs as a category of health functionaries worthy of research is neither new nor unusual. Studies with widely disparate objectives and methodologies have placed ANMs under the lens of scrutiny. As a result, there are studies that have evaluated their knowledge and performance in national programmes (Gupta and Murali . 1989, ICMR 1989, Khan and Dey 1988, Kumar et al (Eds) 1989, Nagi 1990) as well as in specific job aspects like curative care (Phadke 1994, Paul et al 1988) and family welfare. Other studies have assessed their work or evaluated their overall performance using different guidelines (Gupta and Gupta Undated, Prakasamma 1989, Reddy and Rao 1990, Virmani 1984). One of the studies makes an assessment of the training needs of different members of the PHC team, including ANMs (IIHMR 1991) and two others have studied the allocation of time on work activities by different members of the PHC team (Ghosh 1991, Satpathy et al 1988).

A second group covers the broader canvass of the rural health care delivery system through its network of PHCs and sub-centres and has examined the role that ANMs play in the day-to-day functioning of these village level health institutions (David 1985, Durgaprasad et al 1989, ICMR 1991, Sathyamala and Gokulamani 1986).

A third group has approached ANMs from the perspective of the community and considered their role in the context of utilisation of PHC facilities (Mavalankar et al 1993). Baseline surveys which take stock of health care provision in the villages that are to be placed under Area Projects have also featured ANMs (Gupta et al 1992, Jain and Talwar 1985, National Tuberculosis Institute 1988).

Lastly, ANMs have been studied in ethnographic and social studies. One focuses on role strains between different members of the PHC team (Nichter 1986), one explores the cultural implications of policy initiatives (Justice 1984) and, finally, one takes cognisance of the gender dimensions of employment in the health services (Jesani 1990). There is, thus, a rich precedent to the present study of ANMs in the government-run rural health delivery system.

The present study, which was conducted between 1990 and 1992,

is guided by a broad sweep of objectives that attempt to document the status of the women known as ANMs in view of their labour participation in the public health delivery system in rural areas. It considers the complex network of roles that they play as health workers, wage earners, wives (or potential wives) and mothers in order to better understand the nature and spheres of subordination and empowerment in their lives. If ANMs face problems, what is the nature and repercussions of these problems ? What are the motivations and aspirations that propel ANMs and what sense of gratification do they derive in the process ? These questions are put up for inquiry within the framework of a non-rigid research design.

Questions Asked and Answered

The first research area focuses on ANMs and their family and the questions posed cover the aspects of socio-economic background and marriage. What is the socio-economic background of ANMs and their family ? Has there been a shift in the class character of the cadre after the 1980s ? How does their role as wage earners affect their family and their future prospects ? How does their role as ANMs affect their marital relationship and their eligibility in the marriage market ?

The profile building information about the ANMs includes details about their age, religion, caste, sub-caste, educational qualifications, native place and marital status. This is followed by an understanding of their socio-economic background through comparative information on education, occupation, income and agricultural land holding of parents, in-laws and husbands (wherever applicable). For parents, this comparison is between the point at which ANMs are recruited and at which the interview is taken. However, for in-laws and husbands, this comparison is between the time of marriage and the present. The second set of information is about the highest and lowest educational levels attained by siblings (and siblings-in-law), the number of earners.

Information about their economic role comprises details about their first and present salary, loans taken and currently repaid, regular remittances and other non-monetary help that they may have rendered in the past. Information about marriage includes specifics about the date and type of marriage, reasons for breakdown of marriage (if any), living children (their education, residence, occupation and income, if applicable), ANM's residence,

people residing with her and frequency of their meetings (if ANMs and their husbands live separately).

Embedded in the reality of their households are the reasons why ANMs join the health services and the study asks why they prefer to make a career in the health services instead of continuing with their previous employment. To what extent is their decision supported or opposed ? Do ANMs find viable alternatives for wage employment elsewhere ? Why do opportunities for higher studies elude them ? A question asked but excluded from the analysis (due to the vague answers received) focuses on the reasons why members of their family or community may have valued (or not valued) the services rendered by another ANM in their area.

The second major area covered by the study focuses on work and related problems. The questions posed cover the area of time utilisation (on the last working day and during the last month), the extent to which ANMs are in a position to provide drugs to the people who approach them, the manner in which they motivate people to get sterilised (in general terms and in the instance of their last case), targets for Copper-T and sterilisation and achievement of these (during 1989-1990 and 1990-1991), their views about targets and its abolition, the number of high risk pregnancies identified and referred in the last year and the location and number of deliveries conducted. The question of priorities in health care services is also touched upon through the process of ranking pre-selected health activities from supposed perspectives of the government and people.

The study winds up with a brief attempt to understand why ANMs persist with an occupation that is so clearly overlaid with impediments. What are the yardsticks with which ANMs measure their satisfaction? Does dissatisfaction provide an impetus for change ? Are ANMs willing to recommend their jobs to younger friends or relatives ? Would ANMs contemplate a shift in employment ? If so, what jobs would they like to do ? A question asked but excluded from the analysis (due to its confusing construction) was the extent to which their abilities as health workers are utilised in the provision of health care.

Finally, eight close-ended questions designed to evoke ANMs' perceptions about how men and women in the community perceive their family planning motivation effort, their work in association with male workers and

the extent to which they receive cooperation from people failed to get off the ground altogether due to its convoluted structuring and inability to generate in-depth information.

Study Design and Tools

The study is located in the western Indian state of Maharashtra. Four districts representing four geographical regions were selected; thus Pune from western Maharashtra, Wardha from Vidarbha, Beed from Marathwada and Ratnagiri from Konkan were identified. These districts are representative of differing levels of socio-economic development as measured by the CMIE index of development.[1] Accordingly, Pune with an above average index of 175 was an industrially advanced district, Wardha with an index of 85 and Beed with an index of 50 were average districts and Ratnagiri with a below average index of 35 was a backward district (CMIE 1987).

Three talukas from each of the districts and two talukas in the tribal belt of Pune district were selected in a purposive manner and from each of these, two PHCs were selected randomly from a list provided by the Directorate of Health Services. Thus, information on 27 PHCs was brought to bear on the research process.

All the ANMs working in these PHCs at the headquarter or at sub-centres were interviewed once on a one-to-one basis by a woman researcher with the help of an open ended interview schedule. The schedule was designed to generate qualitative data and to provide respondents with space to express themselves. There should, ideally, have been 210 ANMs when you include the number of vacant positions. Of these, we could interview only 183 ANMs : 68 in Pune, 50 in Wardha, 36 in Beed and 29 in Ratnagiri - refer to Table 1(a). The 27 non-responders were either on leave (maternity or long leave), on training or were simply unavailable - refer to Table 1(b).

In addition, one ANM in each of the selected PHCs - or 27 ANMs - were singled out for in-depth interaction over a maximum period of three days and the researcher who stayed and accompanied them on their rounds was able to engage in lengthy discussions and witness some health activities undertaken at the village level. The researcher was aided by a interview guide which attempted to generate the same range of information as the interview schedule but in greater depth.

The qualitative data gathered at the end of six months of field work was then individually listed, categorised and quantified as evident in the tables towards the end of the book.

Approach Adopted by Researchers

The team assigned to the study was composed of urban-based researchers who brought with them abroad sensitivity to women's issues (although some had a better grounding in the women's movement than others), a certain degree of freshness and enthusiasm, and some measure of naivety.

We presented ourselves to prospective interviewees - the ANMs - as women who were interested in learning about their work and their problems. In an attempt to bridge the chasm of a rural-urban divide and the unequal relationship that we had with interviewees, we consciously subverted all visible signs of power : no ordering, lots of banter.

We lived at PHCs and sub-centres as unobtrusively as possible. Sometimes we inhabited unoccupied beds in the PHC ward. We made do with whatever facilities were available, with whatever food and transport came our way.

We relied heavily on our ability to build rapport. We took care to interview ANMs when they were alone in their sub-centre or residence, out of earshot of the motley group of hangers-on. We insisted on them being alone so that they could talk freely without fear of repercussions. We asked a range of private questions but respected their privacy and did not coerce them into giving us information against their will.

The present study, a situational analysis conducted at one point in time, gains its credibility from its approach to the situation of ANMs and, to some extent, from its broad sweep of objectives. By that very token, not all of these could be explored in depth due to considerations about feasibility. Although our interviews often went on for four hours, there was much ground to cover and certain questions posed by the study could not be explored in as much detail as we would have liked (eg.socio-economic background, work performance, etc.). Given the time-bound character of our interactions with ANMs, we have done little more than skim over the surface of an existence rich in experience and insight.

NOTES

[1] The CMIE Index of Socio- economic development, which is a rough proxy indicator of Gross National Product, is a weighted average of indicators pertaining to three sectors of the economy. Agricultural sector (per capita value of output of 26 major crops and per capita bank credit for agriculture); mining and manufacturing sector (number of mining and factory workers per lakh population, number of household manufacturing workers per lakh population and per capita bank credit for manufacturing sector); and Service sector (per capita bank deposit, per capita bank credit to services, percent literacy percent urbanisation.

SOCIAL BACKGROUND OF RECRUITS

This chapter briefly examines the class character of the cadre of ANMs who occupy the most subordinate rung of the district health bureaucracy. The status and prestige awarded to an occupation has a bearing on the socio-economic strata from which it attracts its members. However, in the case of ANMs, a number of extrinsic forces have played a mediatory role.

On the one hand is the Nursing Council which stipulates that ANMs cannot be younger than 16 years (nor older than 35 years) and should have successfully completed the 10th class. This automatically excludes non-matriculates and middle-aged employment seekers. On the other hand, is the health delivery system itself and its capacity to absorb recruits. This capacity was accentuated during the 1980s when an expansion of the infrastructure created conditions conducive to recruitment. The number of PHCs almost quadrupled from 454 (in 1981) to 1650 (in 1991) and the number of sub-centres more than doubled from 4041 (in 1981) to 9364 (in 1991). Correspondingly, the number of posts sanctioned for ANMs tripled to 11,397 in 1991 (CBHI, 1992). At the micro level of our study, this trend is reflected in the fact that not more than one fourth of the ANMs interviewed (ie.24.6%) were recruits of the pre-1980 period. Whether there was any change in the social background of these new recruits will also be briefly discussed.

Social Background

ANMs are accepted into training schools at a fairly young age. The average age at which the women in our sample joined was 20.5 years. By the time they passed out of training schools and were posted for the first time in PHCs and sub-centres, they were two years older (mean age being 22.7 years) which is no real gain when measured against the overwhelming challenge of work placed before them. To begin with, they are expected to establish a presence strong enough to withstand scepticism in the community. Since they are seldom posted in their native villages (although more than two thirds - 71.6% - were posted within their native districts), they are expected to build this rapport with a set of complete strangers.

Most ANMs are unmarried when they are first positioned in the rural health system (Refer table 2 and 41). This and the vulnerability of their age[1] and inexperience only redouble their overall challenge in a conservative and

male dominated social setting.

Despite the predominantly rural location of their jobs, not all ANMs have rural backgrounds. More than one third of the ANMs in our study (ie.63 or 34.4%) had urban backgrounds or were at least fairly conversant with urban life and living while completing high school (refer to Table 2).[2] Further, only 65% of these "urban" women were able to work in their native district as compared to 75% of the "rural" women. However, this finding is not statistically significant.

Interestingly, the representation of women with rural backgrounds went up perceptibly (from 55.6% to 68.8%) among recruits of the post-1980 period. Alongside, the proportion of women posted in their native districts went up to a significant degree (from 57.8% to 76.1%). Therefore,since 1980 the cadre has begun to be increasingly constituted of women rooted in the soil.

Education

The educational qualifications with which women approach the health services is determined by the minimum requirement laid down by the Indian Nursing Council. Accordingly, two thirds of all ANMs (ie.122 or 66.7%) were matriculates while 43 (ie.23.5%) having passed the Std.10 examination had gone on to study for an additional year or two in college (refer to Table 3) Only a small proportion of ANMs (ie.18 or 9.8%) had studied less than this present minimum. Nearly all of them (ie.17 out of 18) were recruited before 1980. Additionally, 57 (or 31%) had undergone vocational training[3] while 29 (ie.15.8%) continued to study through training and after[4]. ANMs achieved their education in a discriminatory familial set up which held more benefits for males than females. On the whole, they tended to be better educated than their sisters but less educated than their brothers. Four out of five of their brothers (ie.80.2%) either matched or outstripped their educational achievement unlike nine out of 10 (or 89%) of their sisters who studied less or were, at best, equally educated (refer to Table 6).

The tendency for recruits of the post-1980 period to have better education is evident from the significantly larger representation of matriculates and college educated women (an increase from 62.2% to 99.3% - refer to Table 3). The women with less than the currently stipulated educational requirement were accommodated prior to the 1980s when the

occupation was less visible, less accessible and academic preconditions were less stringent. During the 1980s, however, a demand-driven recruitment drive by the government created conditions for increased competition among aspiring recruits, each trying to nudge the others out of the reckoning with better educational records. This picture is brought into sharper focus when the educational qualifications of ANMs are viewed in the context of their communities. It is here that a peculiar pattern emerges for ANMs from scheduled castes and scheduled tribes. These were the castes that had the largest representation among pre-matriculates (ie:38.9% out of 18), all of whom were recruited before 1980 (refer to Table 4). They also had a substantial representation among post-matriculates who were recruited later. This shows that women from lower castes were more easily absorbed into the health services before 1980 despite their lower education. However, with more and more women from the upper and middle castes competing for employment, in the decade that followed these (lower caste) women were required to buttress their chances with superior educational qualifications. *Thus, while a deliberate gender-specific recruitment policy may appear to empower women, the usual disablement that women from lower socio-economic backgrounds face in the labour market afflicts their recruitment into the health services as well.*

Community

On the whole, two thirds of the ANMs belonged to middle (ie.69 or 37.7%) and upper castes (ie.62 or 33.9%)[5] (refer to Table 2). The lower castes comprising scheduled castes and tribes accounted for less than one fifth of the sample (ie.19.1%) which is not vastly different from the state average of 20.4% (according to the 1991 Census). On , disaggregation however, it becomes apparent that this comparability was achieved by an over representation of scheduled castes (ie.17.5% against 11.1% in the state) and the under representation of scheduled tribes (ie.1.6% against 9.3% in the state). Similarly, within the group of minorities, the under-representation of Muslims (ie.1.6% against the 1981 Census figure of 9.2%) was compensated for by an over-representation of Christians (ie.7.7% against the 1981 Census figure of 1.2%).

The caste composition also shows interesting variations in the context of the district to which ANMs are currently posted (refer to Table 7). In this context, 84% of the ANMs currently working in Wardha belonged to lower and middle castes (or 42% apiece) in contrast to their colleagues in Ratnagiri and Beed who predominantly belonged to middle and upper castes (96.5% and

80.5% respectively). The representation of minorities (mainly Christians) was uniformly low in all districts except Pune (which had a representation of 15.4% and 23.8% in tribal and non- tribal areas respectively). Further scheduled castes and tribes were entirely absent among the ANMs posted in Ratnagiri. A further analysis of these four groups in the context of their rural-urban backgrounds reveals that while over two thirds (ie.68%) of the ANMs from the first three community groups hailed from rural areas, the group of minorities had predominantly urban backgrounds (only 41.2% were rural based) - refer to Table 8.

After 1980, the representation of lower castes (chiefly scheduled castes) and upper castes has shown an increase but that of minorities (Christians and Muslims) and the middle castes has declined. If this trend is allowed to continue, it would only exacerbate the imbalance which would adversely affect the representation of scheduled tribes and Muslims. In view of the urban background of minorities, it must be cautioned that *any future policy decision to recruit women solely from rural areas may lead to a further lowering of the representation of women from religious minorities unless such a policy is also accompanied by specific affirmative measures to educate and induct them into the services.*

Economic Background

While ANMs are supported to a fair degree by their middle and upper caste composition, the same cannot be said about their economic status as evinced by the size of agricultural land holdings (among those with rural backgrounds) and the cash incomes being earned. At recruitment, 63.6% of the ANMs (or 75 out of 118) from rural areas belonged to landless and poor peasant families ; 43.2% being landless and 20.3% with not more than five acres (refer to Table 9). This proportion rose, but insignificantly, across the four community groups : 53.8% for upper castes, 67.3% for middle castes, 69.6% for lower castes and 71.4% for the group of minorities (refer to Table 8). Further, the average cash income being earned by their father was as low as Rs.737.6 with only insignificant variations across the four community groups (refer to Table 8).

To compound the precarious financial resources of the family were economic dependencies in the household so sharply defined at recruitment there were, on an average, three to four dependents per earner[6]. This is due to

the fact that one out of four of their fathers (ie.25.7% or 47 out of 183) were either dead or economically inactive at the time of recruitment.)

ANMs belonged to families that were still largely dependent on agriculture and allied occupations. Out of 149 ANMs whose fathers were alive, more than half (ie.81 or 54.4%) were engaged as cultivators, agricultural labourers or as artisans/petty traders while a smaller proportion worked as industrial workers (ie.52 or 34.9%), white collar workers (ie.20 or 13.4%) and in supervisory, managerial and professional capacities (ie.two or 1.3%). On the other hand, a majority of the 168 mothers who were currently alive (ie.103 or 61.3%) were non earners. The rest (ie.49 or 29.2%) assisted in cultivation, worked as agricultural labourers or as artisans/petty trader. A mere 9.6% worked as industrial workers and white collar workers (refer to Table 9). This and the finding that only 4.4% of their brothers and 5.5% of their sisters were engaged in tertiary sector activities like teaching and nursing, indicates that most ANMs were among the first women in the family to be employed in the modern sector.

They were better educated than their parents(refer table 5 and 6) and earned higher wages. Three fourths of their fathers (ie.75.6% or 65 out of 86) earned less than Rs.1000 per month which is comparable to 70.9% (or 61 out of 86)[7] of the ANMs whose first salaries fell in the same range. However, while the average monthly salary of ANMs in this category was Rs.778, their fathers' earned only Rs.507, a significantly lower sum.

At recruitment, a majority of the ANMs (ie.62.8% or 54 out of 86) earned more than their fathers; nearly two out of three of these ANMs earned twice or three times as much. On the other hand, difference in the salaries of the ANMs who earned less than their fathers did not exceed 75%. Thus, the entry into the health services resulted in virtually instantaneous upward financial mobility for a majority of ANMs. This was only augmented over time[8]. *It was this capacity to sharply alleviate the economic condition of the household that impinged upon the motivation of these women to join the services and to grit their teeth and stay on.*

NOTES

[1] The current age of all ANMs in our study was as low as 19 and as high as 57 years with 23.5 being the modal age, 27 the median and 29.3 (±6.6) the mean age. In this there were interesting variations between married and unmarried ANMs : the average current age of all those who were ever married was 30.7 years while that of unmarried ANMs was 24.1 years.

[2] Instead of using nativity (or place of birth) as the single criterion for determining their backgrounds, we sought information on the place(s) at which they studied in order to understand their exposure to rural or urban life.

[3]Two thirds of these 57 ANMs had acquired modern or urban skills in typing, stenography and telephone operating while one third had learnt traditional or rural skills- sewing, tailoring, anganwadi work, *dai's* work, CHV's work (refer to Table 3). 58% of those who assimilated so-called urban skills had rural backgrounds. Equally, 58% of those who learned so-called rural skills were from rural areas.

[4]Thirteen continued their studies even as they were being trained while 16 persisted with studies after getting jobs with the health department. Of these,five were trying to complete their matriculation, one was studying in Std.11 and an overwhelming group of 22 ANMs (which is 76% of those continuing studies) were working towards their graduation.

[5]Upper castes and communities are comprised of Brahmins (numbering 19 or 10.4%), ("96 Kuli") Marathas and Rajputs (numbering 38 or 20.8%), Jains, Sindhis and Lingayas. Middle castes and communities are comprised of Marathas (non "96 Kuli"), Kunbis and the occupational castes (numerically, the most dominant group in our sample with 58 members or 31.7%). The occupational hindu castes included are Gawlis, Salis, Koshtis (Devan, Halba), Telis (Tirale, "Dhon bail", Sav), Sonars (Panchal, Lad), Telgus, Vanjaris, Dhangars (Kutekar, Ladse, Hatkar), Tambhats (Twashakasar, Saraswat), Nhavis, Shimpis (Namdeo, Aher), Parits, Malis (Phulmali), Bhois, Gosavis, Bhandaris (Kite) and Sutars (Panchar).

[6]Dependency relationships in the households at the time of recruitment have been defined by calculating the number of non-earners for every earner in the household. Our inclusion of productive but non-wage earning workers in the ranks of earners (like small farmers who may cultivate for self consumption), makes our definition of 'earners' a liberal one. Despite this, dependencies were enormous; 81.9% of the households that had at least three to four dependents per earner. It was only a small proportion of households that had more earners than dependents (ie. 5.1%) or both in equal measure (ie. 4.3%).

[7] As we did not engage in a detailed socio- economic survey, we were forced to exclude agricultural incomes and non-cash incomes. Accordingly out of 182 ANMs (excluding the lone orphan), we were in a position to bring in information related to income for only 86 of their fathers at the time of their recruitment (ie:47.3%) and for a smaller number of 65 at present (ie:35,7%).

[8] The number of ANMs earning less than their fathers came down from 37.2% at recruitment to 23.1% at present and the magnitude of the wage differential reduced drastically. On the other hand, the magnitude of the wage differential for the second group of ANMs who earned more than their fathers was heightened. Overall the difference in the average monthly earnings at recruitment was 351.9 with ANMs earning, on the average,64% more than their fathers. At present, this difference was Rs 669.4, with ANMs earning, on an average, 69% more than their fathers.

GEARING UP FOR HEALTH WORK
Professional Support Before and After

Through four decades of planning, ANMs have been at the receiving end of more titles than many of their colleagues at the PHC. During the 1950s and for most of the 1960s, they were known as *Auxiliary Nurse Midwives* in acknowledgement of their role as assistants to midwives in the newly instituted health centres. During the late 1960s, they were referred to as *Multipurpose Health Workers* to distinguish them from the erstwhile unipurpose workers. And in the mid-1970s, they were awarded the designation of *Health Workers (Female)* to formally inaugurate the diverse set of responsibilities that were about to be handed over to them.

Each of these revisions have brought in additional responsibilities. As a consequence, ANMs have long ceased to play the peripheral role that was conceived for them at the turn of Independence.[1] Their heightened accountability and visibility in the community concur to transform them into key health workers at the interface of the (public) health services and the community. Underlying this metamorphosed role, however, lies an essentially unchanging subordinate status which mediates and circumscribes their terms of access to empowering inputs like comprehensive training, retraining, and on-going, on-the-job supervision and guidance. Their status limits their access to information and their "inferior" knowledge and submissiveness, in turn, reinforces their subordinate position in the team.

Adequacy of Training Programmes : A Quantitative Assessment

ANMs are first exposed to the requirements of their job through training and retraining programmes. Given their status as para-professional workers, training programmes attempt to equip them to handle specific tasks rather than philosophise about a range of theoretical subjects.

When they played the role of auxiliary midwives in the 1950s and1960s, training courses focused on midwifery and MCH with nine out of twenty four months earmarked for this subject. When the integration of the various functions of the health services received its endorsement

in the Kartar Singh Committee report , a change was effected in the ANMs' role. The Srivastav Committee constituted in the following year called for an expansion in training so as to adequately fortify them for multipurpose health work. In response, the Indian Nursing Council approved a new syllabus in one of its meetings in September 1977. The training course now covered subjects like Anatomy and Physiology, Sociology, Microbiology, Psychology, Hygiene, Nutrition, Fundamentals in Nursing, domiciliary midwifery, maternity nursing, family planning & welfare, environmental sanitation, health statistics, nutrition education, health education, communication skills and audio-visual education, basic medicine and pharmacology, health problems and plans, communicable diseases and mental diseases. With it came the decision to reduce the duration of training from 24 to 18 months, a time span which, in the opinion of some nurse trainers, is too short to acquaint students with all subjects in the course and prepare them adequately for work at the village level[2].

The sanctity of an optimum time period for training received another set back in Maharashtra in the 1980s when newly created vacancies in the rural government-run health delivery system generated an urgent demand for trained women. A frenzied attempt to recruit women for the job ensued. Nearly 90% of this recruitment took place between 1982 and 1988 and by the end of the decade, with 7471 additional ANMs pressed into service, the cadre had swelled to twice its capacity (refer to Tables 11 and 12).

This augmentation came about not by a redistribution of fully trained ANMs from the private sector, but by *expansions in the absorption capacity of training schools*[3]. The greatest spurt in annual admission capacity was during 1983 and 1984 followed by alternating periods of drastic reductions and stabilisation. Between 1980 and 1989, training schools had the capacity to absorb 13,427 ANMs (refer to Table 12) . How many of these students successfully completed their course? Here we are confronted with an absence of state level data of student turnout. If we are to work with an exxagerated failure rate of 10%, 12,084 ANMs can be supposed to have passed out of training schools during the decade. Of these, only 7,471 were absorbed by the government sector - more than 35% were still lost to the private sector. However, for the same time period (ie.1981 to 1990), the total number of registrations with the State Nursing Council was a mere 2,142 (refer to Table 12). Assuming that all these registered ANMs were recruited into the government-run health system, there remains

an astounding pool of 5,329 ANMs who were still unregistered. This works out to a substantial proportion of 71.3% of all recruits during the 1980s or 47.8% of all ever - recruited ANMs till 1990.*Therefore, the goal of making an expanded infrastructure of PHCs and sub-centres operable was achieved by the induction of large numbers of unregistered personnel.*

The chief architect who presided over this trend was the state government and it went about its job by tinkering with the training course This process began in February 1982 when it introduced a version of the MPW course - the Step Ladder Course - which further reduced the duration of training from the customary 18 months to 12 months and located nearly all its instruction in the *field* (instead of the training school). Trainees were thus expected to assimilate knowledge at PHCs and sub-centres and to subsequently occupy these vacant positions as "employees" of the district administration.

However owing to the liberties taken with the standards of nursing education, the course did not immediately win official approval of the Maharashtra Nursing Council. Still, the number of student-employees who were unwilling to accept their status as unregistered workers was large and it was only after these irate probationers filed a lawsuit that the Nursing Council and the state government worked on finding a way to co-opt them into the system. The Council agreed to register these probationers provided they were put through another six months of training and a round of examinations at the end of it. In deference to the Council's injunction, Step Ladder *Promotional* Courses were instituted in different training centres after August 1987 and ANMs, after working for two to three years, were deputed for them. Through all these shortcuts the government had succeeded in training over 8000 ANMs. This state level trend is borne out by our study. Nearly four out of five of the 138 ANMs who joined after 1981 were trained under the Step Ladder Course. Half of these workers had completed only 12 months of the course and were still unregistered. On the whole, 31.7% of all ANMs in our study were unregistered.

The revision in minimum educational standards and its subsequent legitimisation has had several far reaching implications. Firstly, dividing the course into two time slots without enough time for assimilation does little to build the confidence of the young and inexperienced women

who are selected. Although their words and yardsticks varied, most ANMs trained under the Step Ladder Course complained that they were inadequately prepared for their jobs. Too much information was imparted in too short a time.

Secondly, their registration is now controlled by too many agencies - the bureaucracy (which determines who is to be deputed for the second half of the course and when) and the council (which is guided by academic standards). For ANMs who are considered to be non-permanent workers until they get registered, the politics behind what now surrounds their formal acceptance only intensifies the insecurity already engendered by their deficient training. Their non-permanent status gets in the way of their receiving wages commensurate with their status as full time workers[4]. Further, their eligibility for basic employee benefits, which should be automatic, is now subjected to the whims of the district level administration.

This situation has brought on its share of problems which is demonstrated in the case of Shubha, an independent minded and proud spirited woman who took to nursing to protect herself from the uncertainties surrounding her unhappy marriage. Of the two options available to her, the ANM course was the more accessible as there were no fees to be paid and low marks in the Std.10 examination did not disqualify an applicant. She applied for the course and was admitted. This was in 1986 when all the trained women were put on an initial period of probation for eleven months prior to confirmation. Shubha's probation period should have ended at the end of the year and she should have been given a letter of confirmation. What came her way instead was a continuance of probation with a day's break in service. All of this ended in March when she was asked to resign. No reason was explicitly stated. Shubha, however, attributes this to her inability to complete her quota of sterilisation targets - she had motivated only one 'case' in 13 months.

Realising that it was upto her to fight, Shubha took the help of two lawyers, fought her case in court and succeeded in getting re-instated. However, she had to pay a price for she continues to get fresh letters of appointment every six months with a day's break. She cannot break free from this cycle of tension and insecurity unless she is made a permanent employee, but she cannot become a permanent employee until she is sent for the six months' Promotional course. What's more, Shubha believes

that she will never be sent for the six months' course given her antagonism with the bureaucracy. And while she continues to be an unregistered nurse, she cannot even hope to seek employment in the private sector. Shubha's is not a "freak case". Her insecurity is only an extreme version of what all non-permanent workers face.

Nature of Training - A Qualitative Review

How are students recruited ? How are training courses organised? What experiences are recruits exposed to and what professional values are inculcated in them ? In order to be informed about some of the more practical aspects of the training course for ANMs, we put in time at one of nine voluntary organisations that received government grants from the state government[5]. This was in 1990, the year by which time the Step Ladder course had long since ceased to be. All that remained was the six months' promotional course and the revised 18 months' course. We observed the latter for a total duration of one month[6]

Traditionally, nursing education has consisted not merely of training in the science and art of caring but of an orientation - both ideological and psychological - that serves to buttress the subordination of nursing to medicine. The inspiration for this comes from the moral code prescribed by Florence Nightingale who had turned a once discounted occupation in England into a respectable profession worthy enough for middle class women. Accordingly, nurses are expected to develop a character beyond reproach. The preferred attributes to be imbibed are strength, efficiency, self effacement, cheerfulness, sociability, politeness, tolerance, truthfulness, trustworthiness, sensitiveness, alertness, impartiality, diligence, obedience, humility and openness to constructive criticism. In short, a distillate of purity.

Given their affiliation to the nursing profession, this orientation underlies the training of ANMs too. However, in view of the changing caste and class character of the cadre in the post-1980 period (wherein non-Christians and rural based women have participated in greater numbers) and the shortened duration of training, the influence of the Nightingale role model may be assumed to be, at best, limited.

Recruitment Policies

The *Training College of Nursing for General Nursing and Revised ANM* as it was called, has been conducting courses for ANMs since 1959. At the time at which we visited it, the school was recruiting only those women between the ages of 17 and 30 who could produce their school leaving certificate, SSC mark-sheet, two *satisfactory references* and a certificate vouching for their physical fitness. Till 1988, it had a rigorous system of selection based on performance in Std 10 plus the results of aptitude tests. However, this procedure was time consuming and expensive and the authorities chose to dispense with it. They now relied solely on marks. They claimed to give preference to students with a proven record of physical fitness from rural areas. They did not appear to have a separate quota for students from scheduled castes and tribes.

Statistics collected for four years preceding 1990 indicate that the school admitted, on an average, only 8.5% of all those who applied for the course. In August 1989, of the 387 application forms that were sold, 279 forms were received and 23 applicants chosen. The school was conducting two courses in a year and therefore, opened its doors to approximately five to six hundred applicants. Candidates were expected to purchase a form worth Rs.5 as well as a prospectus for the same amount. A number of conditionalities were listed in these which prospective trainees were expected to comply with.

Firstly, trainees were expected to pay Rs.1000 as bond money and enter into a formal agreement about a year's compulsory service. However, since opportunities for employment in the government-run health system had fairly dried up by then, trainees were ultimately bound for employment, not in the government but in the lower paying private sector. So in the matter of bonds, the organisation expected trainees to fulfill a year's service in the tertiary hospital to which the school was attached, thus contriving to assure itself of a steady stream of labour to manage its wards and OPDs at virtually no cost ! At present, however, there was no room for everyone who passed out of the school because some trainees from an earlier batch were put on the hospital's regular payrolls. This had relieved some the new recruits from their bond responsibilities. The Principal viewed this with some irritation because she felt that her students were being deprived of "jobs"!

Secondly, students were expected to incur an additional expenditure of Rs.1000 towards the cost of books, stationery, uniforms and miscellaneous items. Thirdly, parents and guardians were asked to give an undertaking that their wards would complete the course and not marry while under training. Students were also told that they could meet their friends and relatives only when off duty. The training school allowed them to meet only those persons whose names were mentioned in the application form. When students were in the village for domiciliary experience, visitors were not allowed except during emergencies. The school, thus, controlled not only the immediate futures of its trainees but their private affairs as well.

Organisation of Training

During 18 months of the course, trainees were oriented for the first three months at the hospital in the city. Subsequently, they were sent for six months to a PHC in the vicinity and then on to the Rural Hospital (RH) attached to the institution before being asked to return for the last three months to the city.

When students were posted at the PHC, they inhabited a four room house and were supervised by a home sister and an *ayah* both of whom were employees of the institution. Trainees were divided into three groups- one group worked in the PHC; the second went on home visits and the third organised mess activities for the day (this included the planning and cooking of meals as well the buying, cleaning and sorting of provisions and vegetables).

Classes took place four times a week and usually involved lectures with occasional demonstrations on dummies. Class timings were flexible to accommodate trainers who travelled each day from the city. The students said that if the trainers came early (ie. by 12.00 or 12.30 pm), they would feel motivated to pay attention to what they had to say. If they came later, they would feel bored. Trainees watched television whenever they could. They said that they did not have much work although they had fixed hours of duty which rotated every month. Even if they did have OPD duty in the evenings, the only persons who would come were family planning cases who stay in the PHC for eight days. They complained that they were not allowed to conduct deliveries although they would have liked to. They were not expected to assume any responsibility independently. Given this

undemanding work at the PHC, most of them spent their time completing their notes and registers.

On field visits, they had strict instructions to visit houses only in groups of three or four and never to accept tea even if it were offered to them. The school authorities said that they wished to enforce discipline. In practice, the students were being asked to keep a distance from people in the community. Further, since they lived in groups of at least 20, trainees were never actually exposed to the experience of being alone and managing sub-centres on their own. This is not true only of this institution, but of many training institutes. While talking later to the 183 women in our sample, we discovered that almost 99% of them had not lived in any of the sub-centres (with the ANM in - charge) for even one night although they did visit themduring the day with the ANM or the Health Supervisor.

When trainees finished almost half their course, they were posted for six months at the RH. Again, they were broken up into three groups: while the first group made home visits (within a radius of 3-4 km. from the RH), the second group assisted trained personnel in OPDs and wards and the third ran the mess. However, unlike the PHC, mess duty at the RH involved cooking meals not only for their classmates but for the other staff in the hospital as well. These consisted of doctors, staff nurses and even the students of the General Nursing Course who come along for a months field experience. The institution employed only one *ayah*. The bulk of the work was done by the trainees. If the *ayah* was absent or on leave, the trainees were expected to manage the mess on their own. In the process, the institution allowed itself to run their hospital mess without bothering to employ staff and the students who came for a rural experience actually ended up spending one third of their time cooking.

The school gave trainees a stipend of Rs.160 per month. When they were in the city, trainees received only Rs.65 since Rs.60 was deducted as mess expenses. While they were posted to the rural areas, trainees were given Rs.160 with which they were expected to run their own mess. The justification given for this was that trainees were being exposed to the notion of budgeting and organising their food expenses.

It was obvious that trainees more than supplemented the efforts of the four doctors and four staff nurses who were on the regular payroll

of the hospital. During our second visit to the RH, we noticed that some of the trainees had gone home on leave (they were awarded two weeks leave per semester). As a result, home visits were suspended and the trainees who remained on campus were asked to manage the wards. The institution was clearly subsidising its humanpower costs by utilising trainees in its routine activities. However, it is not alone in its exploitation. In other schools in other parts of the country, almost 75% of the nursing care activities of the hospitals attached to training schools are being routinely provided by trainees (Govt. of India 1955, Govt. of India 1989).

All in all, the young and vulnerable women who aspire to become ANMs get only an unauthentic preview of their future life and work in training schools. In shielding them from taking on and following through responsibilities, nursing schools fail to build the confidence of trainees, a quality so vital for unassisted health work and independent decision making. Moreover, their cloistered existence in the school does little to prepare them for work in unfamiliar, often uninviting, village communities[8]. Some of the older ANMs remember being shocked at the discovery that an ANM's work is located in the community (not in a hospital), so great was the institutional bias during their training. Therefore, while training students for village level work, it is not nearly enough to merely plant trainees in PHCs and sub-centres without radically reorienting the content and pedagogy of training courses. This reordering needs to be effected not only in the Step Ladder course but in the 18 month course as well.

The threat of sexual harassment and abuse dogs the careers of most ANMs; yet, trainees are not acquainted with their legal rights or with channels of redressal. Instead of being taught assertiveness, they are shown the virtues of docility. In the end, ANMs learn their lessons of village level health work not in training schools but while negotiating - and surviving - the numerous hurdles that greet them in the course of the day.

Professional and Interpersonal Support from the PHC team

Once ANMs are out of training schools, they need professional support to help them carry out the tasks assigned to them. This need is particularly acute in sub-centres where ANMs are deprived of the reassuring hustle and bustle of a health campus. ANMs need to be put through periodic

retraining programmes and on-going, continuous supervision.

In the PHC set-up, it is the MO and Health Assistants (Male and Female) who are assigned the responsibility of supervising workers like ANMs as well as male MPWs, *Dais* and Community Health Visitors. Health Assistants (F) also called Lady Health Visitors (LHVs)- are no more than experienced ANMs who are given additional training for six months. According to their job descriptions, they are expected to supervise and guide them in planning and organising their programme of activities; make weekly visits to sub centres to observe and guide them in day to day activities; carry out home visits in the area, to supervise their work under various National Health Programmes and suggest changes if necessary to suit the priority of work; hold monthly staff meetings for evaluating the progress of work and suggest steps to be taken for further improvements.

In view of the largely unclinical nature of their health work, on-the-job professional support should consist not merely of technical guidance but also of moral support and encouragement. Supervision takes place during occasional visits to sub-centres as well as in monthly meetings at the PHC. During these meetings, MOs convey feedback from their meetings with the District Health Officer, inform staff about campaigns/surveys proposed by the district level administration, monitor existing activities and outline work schedules for the next month. Sometimes, this is accompanied by a short lecture on any of the health activities. In one of the monthly meetings that we attended, we were treated to a technical lecture on Copper-T and on the way in which it ought to be inserted. In another, we witnessed a revision class on infant mortality.

The process of supervision, however, is mediated by inter-personal relationships which are, in turn, founded on unequal professional, gender, political and social assumptions. This creates widely differing conditions under which supervision takes place[8]. One outcome of this inequality is the differential treatment that ANMs receive : in one of the PHCs, ANMs belonging to the same caste as the MO were given preferential treatment; in another, the MO's wife who was an ANM got off lightly despite doing no work. Lata, an ANM in Wardha was convinced that she was being penalised for being assertive and vocal. She said that she was never assured of cooperation from the MO. In one instance he kept putting off a tubectomy of a women motivated by her. Another time when there were no empty

beds in the ward, he made Lata bring a cot for one of her 'cases' from home and did not allow her to take it back home in the jeep after the operation, thus making things very difficult for her.

The hierarchical relationship between MOs and ANMs also erects barriers between these two functionaries reducing whatever bargaining power ANMs might otherwise have mustered. An authoritarian MO in Wardha forcibly extracted respect from his staff by asking them to stand to attention while talking to him. He also discouraged staff unity by inviting tale - tattling which only succeeded in creating a self destructive atmosphere. At times, ANMs were expected to help the MO in his private practice or to manage OPDs with the compounder in the MO's absence (who conducted a private practice elsewhere). Another ANM (separated from her husband) reported receiving sexual advances from the MO who suggested that they "have fun" at a lodge in town. When she refused, he retaliated on the following day by issuing a memo. To counter these instances of harassment, however, were narratives in which ANMs gratefully acknowledged the MOs' interventions that helped resolve ugly confrontations with leaders in the community. One of the MOs even allowed an ANM to get off lightly despite doing little work since she was undergoing a personal crisis.

Secondly, in view of the rather narrow view of health programmes (and its implementation), supervision becomes a watered down activity that consists of little more than target monitoring and perfunctory inspections[9]. The haunting role of targets in the lives and psyches of ANMs becomes apparent even after the most preliminary of conversations. For targets are treated as the only indicators of performance and these are enforced zealously in individual interactions and in monthly meetings at the PHC. Indeed, monthly meetings were often turned into sites at which ANMs were court martialled and flayed for not completing targets assigned to them[10]. This pressure intensified towards the year-end (which is April). As a result, ANMs were sometimes driven to fudging records which they admitted without great difficulty. ANMs expected little from these meetings; in fact, not many looked forward to them at all and tended to set aside their routine health activities one or two days before these encounters to complete their records.

In terms of content, supervision ranged from active encouragement

to indifference, non-cooperation and even visible antagonism depending on the MO's attitude to nurses in general and individual ANMs in particular. In general, reprimands were more easily issued than praise. Sometimes supervision did not take place at all. ANMs in the more inaccessible or remote sub-centres complained that they were rarely visited by their supervisor who was put off by the prospect of walking long and lonely distances on their own. It is true to say that we did come across some instances where ANMs worked in close association with their supervisor; however, these were exceptional cases. On the whole, the intent, consistency and quality of supervision leaves a lot to be desired[11].

The spirit in which supervision is carried out may, perhaps, be summed up thus "inspection is often substituted for education, criticism for consultation and irritation for understanding" (Fendall 1984).

NOTES

[1] By 1991, ANMs in Maharashtra were covering an average population of 5168 which is half of what they were covering in 1981.

[2] Compomises in training affects the confidence with which ANMs are able to carry out their duties. An in-depth study on the factors affecting the performance of the ANMs proved that the performance of those trained under the two years' ANM course was significantly better than those trained under the 18 month MPW course (Prakasamma 1989). In the same study ANMs were asked to comment on the adequacy of training. A majority (ie.76.7%) felt that it was not entirely adequate - 30% felt it was only slightly adequate, while 46.7% felt that it was moderately adequate. The question on how well training prepared ANMs to perform their tasks showed that training with regard to MCH was far in advance of others in quality and quantity (ibid). Another study on training needs of 683 ANMs, a majority of whom had undergone the MPW training, suggested that while MCH was potentially weak, child health was decidedly a weak area in their current knowledge (IIHMR 1991).

[3] There is no basis to assume that the 3,797 ANMs employed in the private sector (including the private voluntary sector) at the start of the decade were absorbed into the expanding public sector. If there was indeed such a movement, then the staff strength would have increased with no appreciable alteration in the admission capacity of training schools. What we see instead is a rising trend in the number of institutions and their admission capacities.

[4]After completing the first rung of the "ladder", ANMs in 1990 were put on a salary scale of 950-20-1150-Efficiency Bar-25-1500 while they could hope to earn as much as their fully trained colleagues (ie. 1200-30-1440-Efficiency Bar-30-1800) only after their registration. Since more than half of the 109 ANMs who received Step Ladder training in our sample were unregistered, they were offering their labour at disadvantaged terms.

[5]Interestingly, although the state's Performance Budget report for the same year recorded the grant paid to this organisation, the database officially compiled by the Central Bureau of Health Information - Health Information of India - excluded the nine voluntary organisations from its list of training institutions in the state.

[6]Despite the criticism that training courses conducted for ANMs lack uniformity owing to the rather lax attitude towards monitoring by the Nursing Council (Deodhar 1994), the case study demonstrates in spirit, if not in detail, the inadequacies, biases and assumptions on which training courses are founded.

[7]This criticism was also levied in the instance of training in Nepal. A nursing consultant had observed that ANMs (Assistant Nurse Midwives) lack field training. At the ANM campuses, they are treated as if in a convent, which fits with cultural expectations, then they are sent out to work completely on their own, in total contrast to all cultural expectations (Justice 1984).

[8]One of the concluding observations of a study considering the ideology of primary health care from the vantage point of health centre field staff in South India and Sri Lanka was that the issue of a doctor's 'professional status' and the relative caste power of staff within the regional health bureaucracy influences team-work within local health centres (Nichter 1986).

[9]A study of training needs of System Health Functionaries in eight districts of Maharashtra included 173 MOs and 159 Health Assistants (Female) within the framework of its 2500-strong sample. Although the latter are entrusted with a host of duties, they perceived their main responsibilities to be supervision, implementation of health programmes and record keeping. Their view of supervision was limited to inspections. Similarly, implementation of health programmes was assumed to consist of achievement of targets.

The study noted that HAs(F) spent 54% of their time on field visits. However in planning these, they tended to be guided by the mandatory number of field visits that were expected of them rather than the needs of their workers or the community. Their role as coordinators was also assessed to be less than adequate. During field visits, they spent a major portion of their time checking records and stocks at the sub centre. They spent very little time on interaction with the community and training the worker. It was observed that they provided ANMs with technical guidance and helped them solve some of their work

related problems. However, a majority supervised ANMs by reviewing records and by asking questions rather than suggesting possible solutions. The main problems faced by this cadre of workers were inadequate transport facilities, inadequate physical facilities and unresponsive communities (IIHMR 1991).

In contrast to Health Assistants, majority of MOs perceived their responsibility as the provision of curative care, implementation of various health programmes and administration of PHC/ sub-centre. Only 34.4% took cognisance of their role as supervisors. Most MOs said that they would work towards greater involvement of the community and stricter supervision in order to fulfill targets allotted to them. Like Health Assistants, they made field visits and, like them, were guided by the number of mandatory visits and not programme performance, community problems or worker needs. During field visits, they generally spent their time either checking sub centre records or in a clinical activity or follow-up of family planning cases. Training of functionaries was a low priority task. In assessing worker performance, MOs usually went by the achievement of targets and record keeping ability. Less than 50% of them considered sound technical knowledge as one of the deciding criteria. On the whole, methods of supervision employed by MOs (Allopathic) were house visits (80%), target achievements (27.7%) and reports and records (18.5%). Only 10.9% assessed the MPWs' technical knowledge (Ibid).

[10]An anthropological study of two rural primary health centres intermittently studied over a six year period (1974 to 1980) in South Kanara also observed that a majority of the time at monthly health centre meetings was devoted to a review of case motivation by individual staff members (Nichter 1986).

[11]The report of the High Power Committee on Nursing and the Nursing Profession noted with concern the lack of supervision and guidance for nursing personnel at all levels. The committee observed that "the 8th passed ANM with a 6-month Promotional Course is not educationally and professionally competent to perform her supervisory role" (Government of India 1989:23). This sentiment was reflected once more in a micro study of four functioning subsidiary health centres conducted in 1985, in Madhya Pradesh (David 1985). The study notes that Health Assistants are not capable of functioning any differently from ANMs just because they have had a few months of LHV training, late in their career. Further, it observes that there is not much evidence of their guidance beyond explaining about the maintenance of records.

HEALTH WORK AT THE VILLAGE LEVEL : THE LIVING REALITY

ANMs are assigned the responsibility of providing round the clock health care to populations residing in villages[1] through periodic house-to-house visits and clinics. Their responsibilities cover a broad range of reproductive and child health services namely, maternal and child health, family planning, immunisation, nutrition and, to some small extent, medical termination of pregnancy; and primary curative care (Appendix 1 provides an elaborate list of their present job responsibilities). These health activities are conducted in PHCs and sub-centres; and ANMs are assigned to these for periods of time before being transferred and re-assigned to new, unfamiliar places[2].

ANMs are auxiliary workers; in conventional terms, workers like these cannot be expected to tackle tasks beyond their sphere of competence (even health complications that may arise unexpectedly in the normal course). Accordingly, they are expected to engage in a host of supportive activities like *education*, *motivation*, *identification* (of specific categories of people/patients/health conditions) and *referrals* while directly tackling only limited health care tasks.The health. care services that ANMs are expected to provide directly (or in conjunction with the MO or female supervisor) are antenatal and post natal care, uncomplicated deliveries, distribution of contraceptives, distribution of iron and folic tablets, to counter malnutrition, blood smears and presumptive treatment for malaria, administration of oral rehydration solution, finally, first aid and treatment for minor ailments. Auxiliaries derive their legitimacy from their membership in a health team and through their relationship with professionals. By that same token, their village level health work derives its meaning in the context of a society high on inequalities and low on distributive justice.

The *nature of relationships* between ANMs and the community, the *nature and location of health work* (PHC or sub-centre/developed or underdeveloped district/accessible or remote area) and the *nature of professional, infrastructural, and personal support mechanisms* are the hinges around which their experiences revolve. How these different elements concur or collide with one another and how they contribute to

their living reality forms the core of this chapter.

Working in the Community

The ANMs in our study reported to be providing curative services to 7.6% of all those who approached them (refer to Table 16), fulfilled 64% of their sterilisation targets and 65% of their Copper-T targets (refer to Table 18) and conducted an estimated 14.6% of all deliveries in their areas (refer to Table 19). However, statistics do not even begin to capture the spirit of their work and the tremendous odds against which it is conducted.Three fourths of all ANMs had more than one complaint about the conditions under which they were working (refer to Table 29). They cited the inadequacy of facilities, equipment and medicine stocks, as well as the feeling of being over-burdened. They also mentioned the lack of proper accommodation and inadequate transport facilities as being problematic.

The delivery of health care through house-to-house visits, for example, sounds easier than it really is. What it disguises are the hours of travel that go along, often under adverse conditions. One third of all ANMs spent an average of two hours commuting to and from their sub-centre and the village(s) under their charge on their last working day. (refer to Table 15) This aspect of work is more sharply defined for sub-centre ANMs 40.7% of whom spent nearly a third(ie: 30.8%) of their time on travel, as against 9.8% of the PHC ANMs. This should be added to the time that it takes ANMs to conduct House-to-house visits.On an average these last for four hours (or for three fifths of their day). Again, house-to-house visits were more clearly indicated for sub-centre ANMs, 77(or 55%) of whom were engaged in it on the last working day as against 10 (or 24.4%) of those posted at PHCs. In the near absence of transport facilities, this involved trudging on foot, sometimes through desolate fields (which resound with heinous stories of violence, rape or murder) under the blazing sun. Some villages and hamlets were so segregated that hills or (dam site) lakes needed to be crossed before they could be reached .

Further, as village level health workers, ANMs are exposed to community politics and it is at this juncture that their gender, age, marital status, social image, caste and political affiliations (if any) are crucial. The disadvantages already imposed on women by a patriarchal social fabric are compounded in the case of ANMs who are also encumbered with a reputation that precedes them in the community. This reputation has its roots in nursing. Here, the attributes of *pollution and disrepute* ascribed to the nursing

profession are fine tuned in view of their work that requires them to speak openly about contraceptives, to interact with men and women and to keep itinerant schedules. ANMs are viewed as women with loose characters[3]. This social image compounds their subordinate class character and ANMs become easy prey to wide ranging harassment, including sexual harassment.

Unmarried, separated, deserted, divorced and widowed women, who are believed to be *unspoken for* or who do not visibly display the protection of their families, were particularly vulnerable to sexual harassment. A number of unmarried ANMs, mostly in Wardha, remembered being treated very differently before and after marriage : the lewd propositions and taunts that came their way before stopped dramatically when they had the "protection" of a husband.

One of the ANMs in Pune district, a young divorcee, recalled a time when a man approached her late one evening for a medical certificate. She could not give him one herself but he hoped that she would use her good offices to secure one for him from the MO. He then asked her togive him dinner. He was standing in the doorway and being very persuasive. Prabha (the ANM) sensed his motivations and while pretending to accompany him to the doctor's house, cleared the doorway and slammed the door shut. While she was doing this, she noticed a male accomplice lurking in the shadows... She is convinced that had it not been for her quick wittedness, she would have been molested that day. The vulnerability of an existence outside marriage was also felt deeply by a 38 year old widow in Wardha who declared, "The happiness I had when my husband was alive and earning Rs.500, I do not get now despite earning Rs.2000". Sexual harassment was not limited to the community alone. ANMs cited instances of harassment by the MO or the male worker too.

Another kind of harassment emanates from appointed (and self appointed) village leaders who demand special services at home like immunisation. One of the sarpanchs kept a close eye on the ANM in the village, another insisted that he be allowed to inspect her records, a third badgered the ANM because she did not give vitamin tablets (how could she, when she had no supplies ?), a fourth made reportedly unjustified complaints to the District Health Officer and asked the ANM to get out of the village and never return !

A third pretext for maltreatment emanates from caste affiliations. In

this context, it is interesting that several of the ANMs belonging to the lower castes in Wardha with its 42% representation, explicitly mentioned being discriminated against. One of these, a 36 year old Neo-Buddhist reported that Deshmukhs and well off Kunbis gave her tea in broken cups, made her sit on a sack or on the floor, did not allow her to touch them and occasionally threw her medicines away before her very eyes. Conversely, a few of the ANMs belonging to the higher castes in Ratnagiri were visibly uncomfortable dealing with deliveries of women from lower castes.

Inadequate Support Systems at PHCs and Sub-centres

.More than three fourths of the ANMs in our study (ie.77.3%) were posted at sub-centres while the rest (ie.22.7%) were in PHCs[4]. PHCs tend to be located in more developed areas while sub-centres are located in remote villages or are remote within villages[5] . At PHCs, moreover, ANMs work within the reassuring hustle and bustle of the health campus or at least have a visible backdrop for their work in the community. This includes the perceptible presence of the health team (with the professionally trained doctor) and a health infrastructure with facilities for a daily OPD and in-patient care.

PHCs should ideally be posted with ANMs, one for handling work within the precincts of the health centre and the other for outreach activities in the community. However disguised vacancies exist the extent of which can be derived from state level statistics compiled by the DGHS. Accordingly in 1991,1650 PHCs in Maharashtra should have had 3300 ANMs when in actual fact they were positioned with only 1924 ANMs. The shortfall of 1376 ANMs at PHC headquarters calculated in this manner is more than 14 times the reported vacancies for non sub-centre ANMs for the same year. The ANMs who are saddled with the jobs of two individuals naturally feel burdened and over-stretched. Despite quantitative increases in the setting up of PHCs during the 1980s, buildings to house these came up very slowly. The number of PHCs in the state of Maharashtra tripled during the first five years of the decade. This increase came about as a result of a single spurt during 1983 (refer to Table 22). The process of accommodation of PHCs in government buildings came only later. By 1987, the time by which most of the expansion had taken place, less than half the PHCs had regular buildings. All this changed by 1989 when there was a near total provision of housing for PHCs.

PHCs are also inadequately fortified with equipment and supplies. This finding is borne out by the rich literature on primary health care and PHCs.

This affects the capacity of the system to respond to people's health needs and ANMs, being part of that system, fare no differently.

In contrast to PHCs, sub-centres are set in isolation at varying distances from PHCs. The ANMs posted in these ce.tres work in an unassisted fashion with only transient professional guidance from the MO or LHV who cares to visit them. Besides, they are placed in communities that are not only unfamiliar but may even, at first, be uninviting or openly hostile.

This experience rang true for ANMs in developed villages where a curative oriented private sector discounted the largely preventive and motivational work that they were doing as government health workers. This was also true of the early days when village communities were unused to seeing a health worker in their midst. One of the older ANMs in Ratnagiri recalled the teething problems she had in her first posting. People would get agitated over the onset of fever after immunisation. Further when she approached them with family planning information and contraceptives, they would say, why are you giving us your left overs, or why don't you use them yourself?

There was usually a period of testing to which many ANMs alluded during which they are accosted, teased or harassed by certain individuals in the village (usually village youth). One of the ANMs in Wardha vividly recalled the early days of her stay in the sub-centre village to which she is currently posted. People would stone her house in a bid to get the previous ANM to come back. Young boys would drive their cycles right up to the steps of the sub-centre. Her daughter, who was studying in the local school, was troubled by her classmates. This state of affairs lasted for nearly a year and a half.

In order to support an already precarious position at the sub-centre level, all ANMs should be provided with fully operational sub-centres namely, well constructed buildings replete with essential equipment and supplies and secure living quarters. What happens in actual fact is the opposite. More than half the sub-centres do not have specially constructed buildings. This is apparent not only at the state level[6] but at the micro-level of our study too.

Less than a fourth of all sub-centre ANMs in our study (ie.a mere 23.6%) were provided with buildings constructed and owned by the District Health Administration. Forty two (ie.30%) did not have separate structures from which they could function - 22 did not have a building at all while 20 were compelled

to conduct health activities from their homes - and 65 (or 46.4%) ran a sub-centre from either a rented room or from premises belonging to the local government or Panchayat (refer to Table 20).

While it is true that sub-centres constructed by the government were better than makeshift rental arrangements, these were usually located at the edge of villages or outside the protection of the main village cluster. ANMs naturally felt scared to live in these structures alone unless they had their families with them. The rented rooms which served as sub-centres, on the other hand, were located within the villages but were quite abysmal - dark, dingy, often offering no privacy.

Sub-centres also fared poorly in terms of amenities and instruments. Among the instruments and furniture that may or may not be available, one that is almost universally present is the stove, because it has many *non-health* uses as well. Yet, 30 ANMs (out of 140 or 21.4%) lacked even this basic amenity (refer to Table 21). Apart from the ubiquitous stove, the only other instruments that were found in a majority of sub-centres were fetoscopes as part or independent of the delivery kit (in 63.6%), weighing machines (in 63.6%), and chairs and stools (in 45%). Certain essential instruments for preventive and curative care were supplied only to a few sub-centres. These included the autoclave (in 35%), stethoscope (in 21.4%) and apparatus to measure Blood Pressure (in 16.4%) . Likewise certain essential items of furniture like cupboards (in 32.1%), delivery/examination table (in 30.7%) and a bench (in 29.3%) were only occasionally to be found. Further, out of 118 structures from which sub-centre activities were conducted in our study, one third were *kuccha* structures. Again, more than a quarter of these(118) structures did not have electricity and as many as 70% did not have pipe water supply[7].

These are gross inadequacies which impinge upon the ability of ANMs to work with any degree of confidence in the community. For instance, while they are expected to conduct at least 50% of the deliveries in their areas, the 140 women posted at sub-centres were able to conduct not more than an estimated 13% of these[8]. Their inability was founded on the pervasive sense of inadequacy and insecurity due to their deficient training[9], isolated functioning and the limited facilities reposed with them[10]. This is why, two thirds of these deliveries, limited as they were, were conducted in the homes of women[11] under far from ideal conditions.

This provided an avenue for sexual harassment which was greatly feared. Stories of the ANMs who were drawn out of their homes at night under false pretenses, only to be molested or raped, made their rounds and were lodged in the collective experience of this cadre. As a result, ANMs tended to either shun health work after 8.00 pm. Some ANMs refused to budge until they could verify with their attendant or CHV the authenticity of the requests that came their way after dark. And some simply lived elsewhere where they were not expected to make home visits at night.

Indeed the consideration that weighed on all sub-centre ANMs was the question of safety. This was particularly crucial for unmarried and separated women, the ones most vulnerable to sexual harassment. At the very least, all ANMs should be provided with secure living quarters. However, a distinct bias exists favouring those posted at PHCs. As many as 58.5% of all PHC ANMs but as few as 17.1% of all sub-centre ANMs were provided with government quarters (refer to Table 24). Despite the absence of living quarters, as many as 83 of all sub-centre ANMs (or 59.2%) were putting themselves out and staying in the villages to which they were posted (refer to Table 23). Three out of four of these 83 ANMs (ie.77.1%) were doing so without being provided with quarters.

Ideally work at the sub-centre should be distributed between the ANM and the male worker. In reality, this was not consistently done. Ideally too, sub-centres should be operational round the clock. However while ensuring that health workers put in a 24 hour presence, it is the ANM, not the male worker, who was pressured. This left them holding the baby, as it were, while male workers took on a more mobile and carefree role. They resided elsewhere and breezed in and out. *It is ironical that while ANMs have been awarded the responsibility of uninterrupted health work, they are not rewarded to the same degree with any measure of administrative authority.*

With a sub-centre to run without adequate backing, ANMs are in an unenviable position. Auxiliaries as far as the health bureaucracy is concerned, they were simply health workers from the community's point of view. When they were unable to cater to all the demands that came their way, they were badgered and asked to provide some rationalisation for their (government) salary. Given the non-ideal conditions under which they worked, most of the times ANMs relied on their wits and improvisation, rather than their training, to get along.

Misplaced Priorities

If ANMs are in a position to do all the work expected of them, they would indeed have been important workers at the village level. However, they were unable to do this. The reasons lie in the realm of priorities, the resulting utilisation of time and in the grossly insufficient network of support mechanisms.

The fact that the family planning programme has been rising in prominence since the 1960s is obvious enough. Since the 1980s, the approach to fertility reduction through child survival strategies has gained ground. These policy level changes affect ANMs who are the final agents through whom health activities and programmes are implemented at the village level. However, by virtue of that very position in the community, ANMs were also buffeted with demands for health services by people. These were not always the same and in trying to match the two, they ended up walking a tightrope that proved to be very unsettling indeed.

We asked ANMs to rank eight health activities including family planning, antenatal care, deliveries, immunisation, health education, curative care, water purification and medical termination of pregnancy from the perspective of the government and the people (refer to Table 14). Each activity could be given any rank ranging from 1 to 8. In order to arrive at aggregate figures, we computed median ranks against each of the eight activities. These were then arranged in the ascending order as shown in Columns 2 of Table 14. Their perception of priorities reveals a primary disagreement in the assessment of what should be the first priority in health care (although the subsequent ranks progressed in an identical fashion). Here, the demand for curative services by the people found no resonance in the government's preoccupation with population control. In the face of this glaring incongruence, the (rank) correlation shows a negligible figure of +0.14 which is statistically significant at 95% level of confidence. The significance of this value in the t-test indicates that this inappreciable association is not limited to our sample of 183 ANMs alone.

Government priorities guide and financial allocations which in turn affect the provision of equipment and supplies. As a result, PHCs may experience gross deficiencies in essential drugs[12], but are invariably well stocked with contraceptives ![13] This deficiency affects

not only the capacity of ANMs to provide tangible services at the point of contact with the community but upon their very credibility. "You don't give us medicines when we need it; why should we listen to you when you tell us about family planning ?" ANMs were obliged to hear this refrain over and over. In order to rectify this community level perception about their superfluous and self serving role, they placed great importance on their role as curative agents[14] and, to some small degree, on their function as midwives.

They tried tremendously hard to honour as many requests for medicines as possible[15] as a means to build up their reputation and acceptance in the community. This need was accentuated in the case of sub-centre ANMs who reported that they were able to provide curative care to (an average of) 69.1% of all those who approached them, nearly 7% more than the coverage reported by PHC ANMs (refer to Table 16). This was attained despite the dire inadequacy of drugs which was more acutely felt by sub-centre ANMs (refer to Table 17). In the absence of drugs, ANMs referred patients to the PHC, rationed their stocks by giving patients medicines in smaller doses than indicated or simply turned them down. A few were driven to dispensing innocuous drugs and placebos to palliate people. A few purchased and dispensed medicines in a private capacity. Therefore, inadequacies in training and drug provision sometimes distorted the curing process which impinged upon the rationality of care[16].

Government priorities also get translated into *more important* and *less important* targets to be achieved and it is no surprise that family planning (euphemistically called family welfare) wins by a long shot. One manifestation of this appears in the manner in which ANMs utilise whatever little time that they have at their disposal[17 18].

The predominance of to family planning over other programmes results in other activities and programmes being sidelined .This has been borne out by empirical studies over and over. In time, ANMs tended to conduct other health activities with the expectation that these would positively impact upon their family planning performance namely their ability to complete their quota of sterilisation ~cases~. They fed this philosophy into their motivational strategies (refer to Table 27). In order to build up their credibility, they took care of women through the entire period of pregnancy and after - they conducted antenatal care, deliveries, post natal care, immunisation (strategy adopted by

over 64.1% of all ANMs). And through all of this, they kept dinning in the benefits of having a small family in view of the economic benefits that it would bring their families (proposed by 52.5% of all ANMs) or the health benefits to them and their children (proposed by 38.7%). Accompanying the above strategies too were a host of monetary and material incentives which sub - centre ANMs (more than PHC ANMs) were offering.

Interestingly not more than 16% of all ANMs were willing to admit to their reliance on this tactic. It was only when they were pinned down to outlining their motivational strategy for their last family planning case that 95 ANMs (or 51.9%) admitted to a range of incentives. Nearly two thirds (ie.65.3%) provided meals ot the woman undergoing sterilisation and the relatives accompanying her. 56.8% supplied medicines and injections during and after the operation. 36.8% augmented the monetary incentive (of Rs130) offered by the government with a personal contribution (of approximately Rs200) and 30.5% provided reimbursements for travel (refer to Table 28). This approach was more clearly indicated in Wardha and Beed.

Problematic Family Planning Targets

The family planning scenario resembles a hunting expedition with targets (ie.married women younger than 45) and target chasers (none other than ANMs). At the heart of it lies the notion of targets which become not only oppressive but also oppressors in some ways.

Targets become yardsticks by which ANMs are judged and accordingly, rewarded or punished. Rewards consist of being commended in a meeting, getting a cash prize or a certificate from the District Health Officer. However, ANMs tend to be confronted more with the inability to complete targets and what follows is the sordid tale of withheld salaries (sometimes for three months at a stretch), being flayed in monthly meetings in full view of the entire staff, receiving memos, and, on the odd occasion, being asked to leave.

On the other hand, targets also worked wonders for some individuals in districts like Wardha and Ratnagiri. A case or two brought about a desired transfer or any other extraordinary favour from the district administration. This saw a whole lot of government servants like teachers, *gram sevaks* and *talathis* joining the fray. They now competed with ANMs for cases. However, since they were not expected to fulfill any quota, they could afford to be

extravagant and in pushing their deals through, they offered lucrative rewards to women. Some offered as much as Rs.400 for a tubectomy. This set up a market economy at the village level. Women were now demanding a proper price for their impending loss of fertility. When the ANM approached them, they asked them to state their price. This created a lot of problems since ANMs were now expected to make out-of-pocket payments. They offered travel expenses for women and their accompanying relatives in addition to food during their stay at the PHC. Some offered a six month course of B Complex injections following the operation. However, the most extraordinary request came from a woman's husband who asked the ANM to fill in for his wife while she was away at the PHC !

Targets tended to distort what could have become mutually empowering relationships between ANMs and women in the community. This was particularly acute in areas riddled with competition. Like the health system many ANMs did not have a perspective on women's health save the narrow view of their role as reproducers. Without them knowing it this tended to alienate them from the community.

People in the community - especially male leaders and youth - were quick to use the ANMs' over-anxiety with targets as leverage to establish political and sexual power over them. Some used this as a pretext for sexual harassment. A gram sevak promised to supply cases to one of the ANMs in Beed if she accompanied him to a lodge in town . In another instance, the Patil wanted her to insert a Copper-T into his sexual partner; in this case, an unmarried woman with no children. When she refused, he complained about her to the District Health Officer.

The programme affected the way the general community reacted to ANMs and the general demands that it made of them. The ANMs who faced the greatest harassment in the community were those who were unmarried. One of them narrated the instance of the village sarpanch approaching her for an injection that would enable his pregnant sexual partner to have an abortion. When she refused, he complained to her supervisor. The supervisor explained it away by saying that since she was unmarried, she did not know about such an injection ! She would administer it herself !! A much relieved sarpanch then decided that the village should henceforth have only a married ANM and promptly demanded that she be transferred.

Others were either not taken seriously (since they were presumed to know nothing) or were harassed for knowing too much (presumably from personal experience). This created and reinforced a negative social image that pronounced them as women with loose morals.This, in turn, led to importunate demands usually at night for condoms by cheeky men. Sometimes, though, ANMs were showered with lewd nicknames (like "Balloon Woman") in generous doses regardless of their marital status.

Despite all these experiences, ANMs were unwilling to denounce the system of targets. Nearly one third (ie.32.8%) believed that its removal would affect other aspects of their work negatively. An equal number, however, favoured the removal of targets and one fifth (ie.19.9%) argued that the presence or absence of targets made no difference whatsoever (refer to Table 26).

The reasons usually offered by those who took a negative view (refer to Table 25) were that they would be tempted to neglect non-family planning duties (43.6%) of the ANMs articulated this reason). This argument finds ideological resonance among the 30.4% who asserted that they would lose all direction. 17.1% were not just concerned about their performance and morale but remained convinced that the removal of targets would lead to large increases in the population.

Of those who took a positive view, one fifth (ie.21%) believed that the quality of their family planning work would improve. Almost an equal number (ie.19.9%)felt that the removal of targets would actually alleviate much of their current harassment and tension. 17.1% felt optimistic that their other work would actually get better. In the midst of all this, only 9.9% took the community into consideration and mentioned that their relationship would improve. A smaller ratio (ie.1.7%) sensed that their relationship with colleagues would get better.

Family planning was a bugbear programme for ANMs. However, not all of them are in a position to criticise the programme except the odd ANM like Renu who categorically stated, "I'll tell you the truth. Where I work, people have no demands from us. They work so hard that they have no time to think, let alone ask for health care. They have no time to be sick. What they need is to be released from poverty, not family planning". Nor were they willing to unanimously discard targets that brought on so many impediments

in their lives and work. Their induction (and subsequent re-socialisation) into the health services served to trammel their sights and it was generally with this narrow utilitarian vision that they approached their work in village communities.

The Mechanisms of Survival

ANMs are acknowledged as being key workers in the rural health delivery system by government committees (Government of Maharashtra 1975, Government of India 1989), evaluations of national programmes as well as micro studies (Reddy and Rao 1990). And yet, the disadvantages bestowed on them are tremendous.

Sexual harassment, or the prospect of it, rankles them throughout their careers and the women in our study clearly feared it. However, they were not always willing to talk about it[19] nor fully understand the cause of it. On numerous occasions, they'd relate gruesome stories about others but relatively palatable accounts of their own lives. Whenever they mentioned sexual harassment, these instances were usually in the distant past or were successfully negotiated. Similarly, while they readily admitted to the living presence of a "bad reputation", they were quick to mention that they had belied community level expectations arising out of it with their exemplary behaviour.

Many ANMs were indeed convinced that the main reason for harassment was linked to one's personal behaviour and not to unequal social relationships. Such a belief is encouraged at all levels, in the family and in training schools which teach ANMs to be morally upright and constantly on their guard. By thus reinforcing a patriarchal explanation for the problems that women face, ANMs believed that it was only one's virtue that could vindicate the negative social image of nursing. This perhaps explains why we heard them say time and again, "How people treat us depends on how we behave".

They consciously projected certain behaviour patterns in the community and took care to avoid certain others. They usually avoided talking to men unless absolutely necessary. Some relied on their ability to read people and gauge their motivations before entering into conversation. An ANM said, "I don't give people the excuse/opportunity". One went a step further and moulded her response patterns to suit the prevailing mood. And another said that she

maintained business like contacts in the village and did not unduly mingle with everyone.

ANMs generally tried to avert confrontations fearing repercussions (that is, increased harassment). They appealed to their harassers'good sense, used humour to dispel anger or even invoked the presence of "God". Occasionally, these tactics were not foolproof and they would become victims of conflicts and confrontations. These they tried to quell by drawing upon the support of persons in positions of authority (like the MO, LHV, village sarpanch, *police patil*) or local residents (like the CHV, attendant or neighbours).

ANMs have managed to cope by mustering resourses within easy reach. Despite the odd ANM who may be assertive or in possession of a world view, a majority are caught up with the daily battle of survival. Martyrs are easily found and the mentality of the latter is perhaps best exemplified by the remark of a 28 year old ANM in Beed, "If we undergo all the trouble and harassment then, after a long time, they will treat us better. They will realise the value of our services and know that we are needed".

NOTES

[1]The optimum population size specified is 5000 (3000 in tribal and hilly areas). At the beginning of this decade (in 1991), the average population coverage by ANMs in Maharashtra was 5,168. The average coverage for in our study (which was conducted at the same time) was reportedly 3,482 in non-tribal areas (1,832 in tribal areas) which is significantly lower.

[2]ANMs get transferred after every few years. These transfers are generally limited to the same district but not always within the same taluka and very rarely to the ANMs' native village. For the ANMs in our sample, these took place after an average (ie.modal) interval of four years. Given their relatively recent entry into the health services, 60 ANMs (ie.32.8%) were not transferred even once. Most ANMs were transferred only once since their first posting which was, on an average, five years ago (five being the median value).

[3]This finding was more clearly brought out in an in-depth qualitative study of two PHCs and one Rural Hospital in three districts of Maharashtra (Jesani 1990). Informal conversations over a period of time with male health workers and with groups of men in tea shops and other meeting places revealed a negative social image. When pointedly asked to state their reactions, a mere nine (out of 32 of the male workers) felt that ANMs were respected by people while 13 were

very sure that they were not. Thirty one maintained a discreet silence. The negative images stemmed from their gender and the belief that they had "bad" characters (ibid).

[4]In 1991, the corresponding averages for the State of Maharashtra were 82.3% and 17.7% respectively (DGHS,1992), which were significantly more.

[5]The study, which came up with this finding, measured development in terms of type of road, availability of bus services, media accessibility and electrification (ICMR, 1990).

[6]At the state level, sub-centres were established in the 1980s with a great deal of enthusiasm : by the end of the first five years of the decade, a two fold increase was in evidence (refer to Table 22). However, this enthusiasm was matched only belatedly - and feebly - by the provision of buildings. In 1987, less than 20% of the sub-centres were positioned in buildings constructed by the government or rented from other government agencies. And towards the end of 1993, this coverage had gone up to only a little less than half.

[7]This finding is reflected in the report of the High Power Committee on Nursing too. The committee remarked that many ANMs in most states were also found to be living in sub-centres that were dilapidated without water, light or toilet facilities (Government of India 1989).

[8]The role of midwives has been sidelined in time. This is borne out by the finding that only 11.1% of the deliveries in rural Maharashtra are conducted by trained persons like doctors, ANMs, trained dais, etc. while an overwhelming 60.2% of the deliveries continue to take place at the hands of untrained persons (Registrar General 1988).

[9]The time allotted for the study of midwifery in training programmes has been diminishing over time. From six months devoted entirely to midwifery under the two years' ANM Training Course, it is now covered with a host of other subjects during 18 months of MPW Training. Here, the subject suffers from a loss of emphasis. Some nurse trainers also contend that the stipulated number of 20 cases per trainee can hardly qualify them to handle all situations which may crop up (Deodhar S. 1994). Besides, it is difficult to ensure that all trainees get a change to conduct 20 deliveries during their stint in rural settings (ibid). The study of midwifery is placed at a further discount in the fragmented Step Ladder Course.

[10]A multicentric evaluation of facilities for family welfare services (ICMR 1991)

showed that in nearly half the sub-centres, facilities for normal delivery were absent. Facilities for routine ante-natal care were adequate in most PHCs but greatly deficient in sub-centres.

[11]This finding finds corroborative references, once more, in the NSS Results of Child and Maternity Care (for the period July 1886 to June 1987) where 77.8% of the births in rural Maharashtra were domiciliary in nature (32.5% of which were unattended by trained personnel while only 5.59% of them were conducted by government nurse/ midwives).

[12]A study of the supply and use of pharmaceuticals in an average district of Maharashtra covering nine PHCs, one Rural Hospital and one Cottage Hospital found that only 14 out of 149 essential formulations (ie.9.4%) were available for more than half the year (Phadke et al1995).

[13]A multicentric evaluation of facilities for family welfare services (ICMR 1991) showed that while 60% of the PHCs were inadequately stocked with antibiotics, 40% had no oxygen supply and while 30% had none of the supportive drugs required in emergencies, supplies of vaccines, contraceptives and nutritional supplements were sufficient.

[14]In keeping with their status as para-medical and para-professional workers, ANMs play a peripheral role in curative care. They are expected to do no more than provide treatment for minor ailments and first aid in cases of accidents. They are precluded from taking on an independent role in diagnosis and treatment. This also serves to preserve the sanctity of the professional's role in medicine.

[15]The urge to medicate is echoed in an observational assessment of curative care rendered by ANMs in their sub-centre villages, in clinics and in non-sub-centre villages on three working days. The study revealed that most of the morbidity service contacts (86.3%) at the centre and home involved the dispensing of drugs. ANMs discussed about nutrition and diet only occasionally (Paul et al, 1988).

[16]A study on the knowledge of 24 nurses (mostly ANMs) about 10 essential drugs (comprising five common drugs like aspirin, paracetamol, antacid, mebendazole, furazolidone; four 'medicines' supplied through the MCH programme like iron tablets, oral rehydration powder, an oral contraceptive and methergin and, finally, Copper-T) in nine PHCs and 15 sub-centres in a district of Maharashtra showed that their overall knowledge was unsatisfactory, although slightly better than the MOs. Their overall average scores for knowledge about drug indication and adult dose

per drug were satisfactory (68.2% and 75.2% respectively). However, their knowledge about precautions and side effects was alarmingly low (score of 29%) which dramatically brought down the composite average (Phadke 1994). Further a qualitative and quantitative assessment of the treatment of sick persons by 12 sub-centre ANMs in one PHC in a district of Uttar Pradesh revealed that ANMs administered correct treatment (correct drug in correct doses) in 56.9% of the cases. In 14.2% of the cases, they gave the correct drug in incorrect doses and in 20.7% of the cases, they simply failed to render any treatment. Most of the drugs distributed (43.2% of them) were antibiotics and anti-amoebics (Paul et al 1988).

[17]An analysis of the job profile and problems of 50 ANMs in five India Population Project Districts of Karnataka dramatised the utter inadequacy of time. The study calculates that ANMs have only 118 days for home visits per year (ie.32.3% of 365 days) after deducting holidays, meetings, travelling time, etc. and proposes that if ANMs are to perform all the duties assigned to them by the government, they would require 30 days per month, 360 days in the year which is twice as much time as they actually have (Virmani 1984). A study on the utilisation of time in one PHC in Karnataka over a period of three months revealed that a high proportion of 33-50% of all productive time in an average day was spent by Female Health Workers on family planning (Ghosh 1991).

[18]Interestingly, ANMs were generally not willing to admit to their relying on this tactic in their motivational strategy (a mere 15.9% did at first). It was only when they (95 or 51.9%) were pinned down to outlining the motivational strategy that they employed in their last case that they more freely admitted to having offered incentives to their last *case*. Nearly two thirds (ie.65.3%) supplied their last *case* with food, 56.8% bought medicines and injections, 36.8% topped up the regular motivation fee offered by the government (of Rs.130) with their own contributions of approximately Rs.200.00 and 30.5% reimbursed them for their travel expenses (refer to Table 28).

[19]. The tendency to deny sexual harassment is not limited to ANMs alone but to nurses too. A study of 720 nurses in central ans state government as well as private hospitals and nursing homes revealed that nurses were sitting targets for sexual harasmment/abuse by doctors and some patients but perceived no authentic channel of redressal. Further, although 61% could recall several instances of sexual abuse, only 10% confided in being victims themselves (Mohan 1985).

ACCESS ROADS TO THE HEALTH SERVICES

The chapter that you are about to read revisits the access roads that guide ANMs into the health services. Nursing has for long been dominated by women. By that very token, it is a subordinate and socially discounted occupation about which notions of *disrepute* and *pollution* hold sway. This negative social image gets compounded in the case of ANMs who occupy the fringes of both the nursing profession and the district health bureaucracy[1]. Their isolated work often without the familiar backdrop of a health centre, their status as outsiders in the village and their role in monitoring women's sexuality under the dictates of the family planning programme compound the vulnerability already induced by their gender, social class, age, occupational status and para-professional training. Ironically, it is to this very discredited occupation that women were drawn during the last decade. This is particularly true of the state of Maharashtra and the employment profile of the ANMs in our sample reflects this macro-level trend[2].

However, women do not participate in the labour market as free agents. Firstly, their capacity to compete is severely constrained by their (in)eligibility in view of their moderate formal education and technical training. Unlike men, women do not routinely enjoy access to formal education: their representation is already low at the primary school level and progressively gets worse as higher levels of schooling are reached. This is borne out by sex ratios (ie. number of females per 1000 males). Already low at the primary school level (viz.671), these plunge to 551 at the middle school level and 390 at the higher secondary level. Further, with the exception of teacher training courses (in which the sex ratio was 1085 in 1985), the representation of women in technical and vocational courses is negligible (Ministry of Human Resource Development, Department of Education, Selected Statistics, 1985-86 as quoted in Government of India 1988:23).

Secondly, even if women do receive education they are few employment guarantees at the end of their academic careers. To be effective, the planning of education should be tied up with opportunities created in the labour market. However, in India, there has been a mismatch between the output from educational institutions and the jobs created by the economy so that there are too few jobs and these are, most often, appropriated by men (Krishnaraj 1991).

Thirdly, women's access to job openings is confounded by geographical distances which they are seldom encouraged to traverse. Statistics indicate that women migrate more than men (141.8 million as against 59.9 million according to the 1981 census). However, this coincides more with their marriage than with the furtherance of education or employment[3].

Lastly, women are constrained by notions about the suitability of wage labour vis-a-vis their domestic responsibilities and by what are considered as socially *appropriate* occupations. These normative structures (and strictures), which are encountered in the family and in the community, are shaped by a number of determinants not the least of which is one's relative position vis-a-vis marriage. It is against this background that this chapter seeks to recapture the journey that brought ANMs to the health services. Was it a smooth one was it hotly contested ? Did these women respond to a choice or were they driven by circumstance ? What were the influences that motivated them to take up village level health work ?

Prior Participation in Wage Labour

On an average, it took ANMs almost four years after their matriculation to secure a berth in the health department. This time interval ranged quite widely from the three years and four months that it took unmarried women to the seven years that it took those who were married or separated and the 13 years that it took the lone widow. In all that time, nearly half the ANMs (ie.84 or 45.9%) had already worked elsewhere for wages (refer to Table 30). Their participation in wage labour increased with time. From an initial rate of 22.9%, this proportion rose steadily to 38%, 43.8% and 45.9% over five yearly intervals (refer to Table 30). This tendency appears natural enough when you consider their socio-economic background. It is obvious that not many ANMs could afford to remain unremunerated for long after they had been rendered eligible for some form of wage labour.

On the eve of their recruitment into the health services, these wage earners were employed in anganwadis or balwadis (by 23.8%, mostly married women) followed by agricultural labour (by 20.2%, mostly unmarried women) and self employment (by 17.9% ,mostly separated/ deserted/divorced/widowed women) - refer to Table 31. These "jobs" were

largely set in the *unorganised* sector, were *seasonal* in nature (especially agricultural labour) and characterised by low wages. The average reported wage was as low as Rs.166.85 per month; even the highest average income that was awarded to para-professional health work did not exceed Rs 315.00 per month. Therefore, although half the ANMs had established themselves as wage earners before their recruitment, their participation was limited to unviable, back-breaking and dead end jobs.

Perceived 'Options' Elsewhere

Were there concrete alternatives to the occupations that ANMs engaged in prior to their recruitment ? Did they try to find a foothold there or were they content to let them go by ? A finding of some significance concerns the *number* of options that ANMs could discern. More than a third (ie.36% or 66 out of 183) perceived only one option, slightly less than a third (ie.31% or 57) perceived two and a smaller proportion of 18% (or 33) sensed the presence of three options. In contrast, 27 (or 14.8%) could not fathom even one alternative avenue for gainful employment. We often heard them say regretfully that without the means, there was no point in talking about choices and options. They had merely grabbed what was placed within easy reach.

The three occupations most commonly perceived were teaching (by 70.5%), clerical work (namely, stenography, typing and telephone operating - cited by 42.3%) and self employment (including tailoring, tuition giving and running a small business - cited by 35.3%). These were set in and around the village or small town within an acceptable radius (refer to Table 33).

Teaching, which extends the nurturing role that is believed to come naturally to women, was particularly popular. With fixed hours of duty, attractive salaries, job permanence and a reassuringly large female representation, it is deemed to be an *appropriate* job for women. However, the investment in time (two years for the D.Ed Course without a stipend) and money (course fees and an incumbent donation) that preceeds employment is particularly hard for economically disadvantaged families to make. Further, not all teacher trainees are offered hostel facilities which makes it difficult for the women who need to leave their villages and make that journey to the city/town. As a result, teaching (as indeed the

other two occupations) was nothing more than a notional option that one out of two ANMs did nothing to concretise. There were hurdles which were difficult to cross and these deterred them[4].

On the other hand, the women who tried to make a go of clerical options and self employment discovered that these held few guarantees/ assurances. On the whole, a preference for the job of an ANM was rarely singled out for special mention[5]. Ironically, it was this profession that provided the greatest access amidst impracticable options and a previous job that made no material difference to families in need of an extra wage. And ANMs were driven by circumstance, not choice, into quietly accepting the employment that came their way.

Wage Labour Versus Higher Education

Four out of five (ie.153 out of 183) ANMs would have liked to have pursued higher studies but had to abstain in view of the fragile economies of their households. An ANM who remarked that "economic need crushes all dreams" was probably reflecting the disappointment felt by the entire group. However, it was only 48.6% of all ANMs (especially those wishing to study further) who explicitly blamed economic reasons for denying them access (refer to Table 32).

Against a background of deprivation, social conventions were called in to buttress family decisions about higher studies. One of these was a notion about their social role (portraying them as wives and mothers) which resulted in a diversion of resources to their male siblings. The underlying assumption was that the returns on investment in the academic careers of daughters was not long lasting (and therefore not worth it) since their marriages would eventually make them valuable to *another* family. As a result, perhaps, 27.9% of all ANMs were married off in accordance with prevailing social conventions. The other rationale stemmed from the principle of distributing resources equitably between all children, meagre as they were. In this context, ANMs believed that their continuing education would have denied younger siblings their share of the pie. They chose instead to support their families (18%).

The women who did not wish to study further were especially propelled by the drive to be independent (ie.8 out of 30 or 26.7%) so that the channels that they hoped to establish with the outside world could be sustained in the

long run even after marriage. Seven of them hoped to do this by working as nurses. It was only a small group (ie.27 out of 183 ANMs or 14.8%) who directly addressed the fact that higher education was inaccessible.

Decision Making

Thus, the decision to join the health services was embedded in the context of straitened financial circumstances in the household. Yet, not all ANMs stated this rationale in unequivocal terms - only half the group did (ie.92 ANMs or 50.3% - refer to Table 34).

Against this background, a third of the 126 women who were unmarried at recruitment were motivated by a desire to be self sufficient while doing "seva" or social work. More than half (ie.54%) took this decision on their own. They attempted to create some measure of autonomy for themselves by widening their circle of acquaintance with the outside world. They softened this motivation with the altruistic vocabulary of "seva" which served to effectively obfuscate and underplay their economic role and contribution to the family. The fact that training was free was another attraction (for 27%) for it succeeded in immediately throwing open access lines that other occupations were unable to. Unmarried women faced the least amount of opposition (ie.35.7% of all these women did) from their families and friends. The same is not true of the group of women discussed below.

The separated, deserted, divorced women and the lone widow most vehemently expressed a desire to be self sufficient (ie.58.5%). As many as two thirds took this decision entirely on their own (and three out of four of them were unopposed). However, this motivation was rooted in the context of their broken marriages which brought along economic and social vulnerability. They were offered no financial support from their parental household since there were already too many mouths to be fed by the few who earned.(four fifths of these households had an average , four to five non-earners for every earner.).

The desire to be self sufficient was also mentioned by (37.8% of the) married women. They also wished to do "seva" (cited by 35.6%) and to put their education to some use (cited by 24.4%). However, their entry into the health services was not smooth. Slightly more than half (ie.51.1%) took this decision on their own and nearly half (ie.47.8%) were opposed. The decision making process was of little consequence. Regardless of whether they precluded

others from their decision or whether they allowed them some say, there was opposition all the same. This indicates that a consensus on the suitability of wage labour (especially in the nursing profession) is nearly impossible for a majority of married women.

On the whole, 99 ANMs (or 54.1%) took the decision to join the health services by themselves (two fifths of whom faced opposition from at least one person). At the other end were 20 ANMs (ie.10.9%) whose decisions were taken for them by their families (interestingly, 25% of these women still faced some form of opposition). The third group consisting of 64 ANMs (35%) were amenable to some form of persuasion : 22.4% of them were influenced by family members and other relatives; 2.2% by outsiders and 9.8% by people already in the medical/nursing profession. Opposition was highest when the persuaders were people from the medical or nursing profession.

More than a third of all ANMs (ie.37.7%) were confronted with some form of opposition. Table 36 briefly looks at the relationship between the value assigned to the work of the ANMs by relatives and friends and the presence of opposition at the time of recruitment. It shows that the families which valued the work that ANMs did in the villages tended to show less opposition than those which did not value their services. However, the relationship between the two variables does not stand up to the test of statistics which indicates, obviously, that the presence of opposition is mediated by more than one consideration.

Relationships of economic dependence conspired with their positions in or outside marriage to define social sanction to their proposed employment in the health services. The married women could not compete as free agents but were constrained by their roles as *daughters-in-law* and *wives*. The number of barriers that they needed to cross were many and it was only when they could sufficiently negotiate and enlarge the boundaries of *acceptability* that they could break away and encounter some of the inherent complexities in the health services. In contrast, the women who were separated, deserted, divorced and widowed were relatively free to participate in wage labour.

The major argument that was placed before nearly half the ANMs related to the fact that as women, they were not expected to work outside the house : their contact with people of both sexes and of all castes and classes would ruin their reputation in the community (refer to Table 38). This argument was to

weigh more heavily on married (ie.55%) and unmarried (ie.48.9%) women than separated, deserted, divorced, or widowed women whose 'reputation' and status was already, in a sense, at a discount.

The second reservation that bore down on half the unmarried (ie.42.2%) and separated, deserted, divorced, widowed women(ie.50%) related to the specific nature of the ANM's job which popular perceptions labelled as being objectionable. Therefore, it was an inappropriate job for them to take up. The apprehensions which greeted unmarried women stemmed from the belief that their reputations and characters ('precious' possessions till their marriages), would be threatened by the negative connotations of their jobs. On the other hand, the sceptics who questioned the wisdom of separated/deserted/divorced/widowed women feared that their social positions,which was vulnerable enough, would only worsen due to their jobs.

The third argument located these women in the context of their families and focused on the neglect of their (non-wage) work in the house and farm. Not surprisingly, this argument was almost exclusively reserved for 11 of the 20 married women who faced opposition from their families. The objection, in a manner of speaking, echoed the fear that their participation in a lucrative job (compared to the unremunerative work that many were already doing) would somehow subvert the assumptions in the family about their social role. And it was precisely this unpreparedness to accommodate the heightened economic role that they would ultimately play that made the job seem all the more threatening to opinion makers in the family.

NOTES

[1]ANMs are neither professionals nor indeed are they nurses in a strict sense. However, they do constitute a derivative category whose legitimacy springs from an allegiance to nursing.

[2]Nearly two thirds of the ANMs currently in position at PHCs and sub-centres in the state were recruited in the 1980s. This trend is emphasised in our sample wherein three fourths (ie.75.4%) of the ANMs were recruited between 1981 and 1991. More than half of them joined in the initial years of the 1980s in response to the burst in vacant positions.

[3]As many as 77.4% of women migrants in 1981 cited marriage while a mere 1.6% quoted employment and an even smaller proportion of 0.7% pinpointed education as their major reason for migration. In contrast, 29.9% of male migrants were guided by employment prospects in their mobility and an equal number were directed by the shifting of their families (Census of India, 1981, Series-1, India, Part II Special, pp 250-251, quoted in GOI 1980:pg.24).

[4] More than half the women who actively sought employment as'teachers were ineligible in view of their inadequate marks, underage or late applications (cited by 54.5%), unable to pay donations (cited by 16.4%) and hindered by family opposition (cited by 19.1%). On the other hand, those who merely acknowledged the possibility without pursuing it found the D.Ed Course was unaffordable (30.9%), while 18.2% faced familial opposition and 12.7% were accepted into the training school for ANMs before they could give the D.Ed Course a chance.

[5]This preference for nursing and the ANMs' job was articulated more by persons who did not pursue job options. The number of ANMs in either case was inconsequential. For example, a mere 5.5% of the ANMs who considered and actively pursued the teaching option mentioned a preference for the course. This proportion went up to 14.6% in the case of those who did not actively pursue the teaching option. The corresponding proportions in the case of those considering clerical options were 8.6% and 19.6% respectively.

The social ramifications of the economic role played by ANMs in the household and in the marriage market are discussed in this chapter. How does the social prejudice that attends their wage labour in the health services affect their eligibility in the marriage market ? Is the marital relationship able to withstand their transferrable jobs and their unpredictable work schedules? To what extent are they in a position to translate their economic worth into some measure of social status ?

Eligibility in the marriage market

ANMs tended to join training schools as unmarried women[1] and to marry within a reasonably short time after the completion of their course. Four out of five of the 88 women who married after training did so after an average period of 3.3 years[2]. This speed was induced by their advancing marriage worthy years, no doubt, but also by apprehensions about their eligibility in view of their affiliation to a stigmatised occupation. This (inherited) social image caused a few of the ANMs (who were married after recruitment) to be turned down by the families of prospective grooms or for proposals to be hastily made - and accepted - before it was "too late". The ANMs who specifically mentioned this belonged to upper caste (mainly brahmins) families. On the other hand, their jobs also carried the promise of economic benefits which countered their social image and made them eminently eligible in the marriage market. A comparison between the profiles of husbands who made their appearance before training and those who came along later makes this abundantly clear.

ANMs tended to marry men as if not better educated than themselves. With the proportion of husbands with post-matriculation education rising sharply and significantly, such a conclusion is obvious. This trend is accentuated among the women marrying after passing out of training schools (refer table 44). Similarly, in the matter of occupation at the time of marriage, the largest number of ANMs were married to men with white collar jobs (ie.45 out of 145 or 31%) followed by industrial workers in the organised and unorganised sectors (ie.38 out of 145 or 26.2%)- refer to Table 45. The increasing tendency for ANMs to marry men better placed in supervisory, mafiagerial or professional positions is evident in a slight though significant way among those marrying after

training (an increase from 1.8% to 8%). Thus, two thirds of the 88 ANMs marrying after training (ie.65.9%) were in a position to attract men with comparable or better jobs than themselves; and far from thwarting their marital chances, their employment in the health services only heightened their eligibility in the marriage market. The remaining ANMs ended up marrying seasonal workers, non workers, or men with impermanent jobs on the look out for solvency through marriage. On the whole, spouse preference was related more to occupations and incomes than agricultural wealth. More than four out of five of their husbands (ie.88.3% or 128 out of 145) owned no agricultural land unlike 56.8% (or 67 out of 118) parental (rural) households which owned at least some land.

ANMs showed a willingness to marry for practical reasons rather than for grand notions of love and fulfillment. Once their weddings were *out of the way*, the family could get around to making arrangements for their younger siblings. Further, marriage somehow provided a facade of protection in the community even if this promise was not always lived out on a day-to-day basis in their homes. The ANMs who joined as unmarried women were only too aware of this. They reported being at the receiving end of perverse humour - or worse - from certain quarters. ANMs in Wardha and Beed particularly recalled the way they were teased and taunted, drawn out at odd hours with unwarranted requests for medicines and condoms. They recollected the way that drunks and unemployed youth threw stones at their houses while passing by. All of this tended to stop after they were married and thus "spoken for" in society. This absence of a visible family presence also weighed down on separated women who felt vulnerable because of it. This is why Shanta, a deserted woman, turned a blind eye to her traumatic marriage and deliberately created and sustained the myth of a husband whose invisibility she attributed to his being in the army.

ANMs seemed to depend a little less on their families to arrange marriages for them once they became wage earners in the health services. The incidence of self arranged marriages increased significantly from 3.5% to 33% as did that of inter-caste and inter-religious unions (from 3.5% to 17.3% - refer to Table 42). Five out of these 15 inter-community marriages (ie.33.3%) were, in fact, inter-religious and the remaining (ie.66.7%), inter-caste unions. This is partly due to the secularising influence of their (modern) occupation which ,drew them away from their homes, and liberated them, from its

conservatism to some extent.

Contrarily, not all the ANMs who arranged their own marriages were willing to admit to it. When they did, many made it a point to mention that these were not "love" marriages for there was a price to be paid for being so *bold* and *daring* as to marry out of choice. Pramila who married after a long and bitter battle against her family had earned herself a bad reputation in the village. Savita too defied her family and married a Muslim neighbour after becoming economically self sufficient. When she heard of it, her mother was so enraged that she doused Savita with kerosene and burnt her until her son-in-law came in and threatened to file a case with the police. The ever cautious Rajashree wanted to protect herself from this bad reputation when she decided to accept a proposal by a school teacher through the general practitioner in the village. So she invited her parent's participation in her decision making and while her husband would have liked their wedding to be registered with a minimum of fuss, she insisted on vedic rites to lend an air of *orthodoxy* and *respectability* to the occasion.

Fissured Families

ANMs are not always in a position to live with their families. One out of two of the unmarried ANMs in our study were living alone (refer to Table 54). Equally, one out of two of the ever married ANMs (ie.72 out of 145) were bearing the brunt of stressful or broken marriages : three ANMs were widows, 15 were separated or deserted and 54 were currently married to men who could not live with them on a daily basis. This is particularly true of ANMs who choose to live where they were posted (refer to Table 55). As many as 80 out of 127 currently married ANMs (or 63%) were doing so but more than two out of five (ie.45% or 36) were forced to contend with husbands who lived away. On the other hand, a small proportion of 16.5% (or 21 out of 127 ANMs) resided in towns and villages near (but outside) the village where it was possible for two out of three to live with their husbands.

In the first place, there were practical problems arising out of their transfers which came in four yearly intervals, on an average[4]. Every transfer set up a whole new process of reordering which affected not just ANMs but their families too. This disruption of existing arrangements is dramatised by the fact that ANMs could have as many as nine transfers in a career spanning over three decades. Understandably, all this created a considerable amount of tension and it was mainly to resolve this dilemma that half the ANMs (ie.87

out of 176 ANMs or 49.3%) wanted a transfer out of the normal course (refer to Table 59).

Transfers did not irreparably break down their marriages since 11 out of 15 (ie:73.3%) of theses marriages dissolved before training[5]. They did however severely test the resilience of existing relationships. In the first place, there were distances that physically kept 54 (out of 127 currently married ANMs) from their husbands and 22 (out of 118) ANMs from their children[6]. The predominant reason that kept at least four out of five of these (54) women was their job and the irreconcilable locations that it took them to[7]. On the other hand, the principal consideration that prompted ANMs to send their children to live with relatives was the lack of educational facilities in their villages. These enforced separations brought on the necessity of running two households and reduced family contacts to occasional visits[8]. This unnecessarily duplicated some of the expenditure and caused some friction when husbands were called upon to look after school-going children against their will. Separations from children were emotionally taxing too.

Secondly, there was the job itself and its description which stifled the marital relationship and family life in terms of the time that it released for work within the household. There were times when ANMs could not even get through a meal without being called out for medicines or a delivery. If they lived away from the villages to which they were posted, erratic transport and unanticipated work often made it impossible to make plans in advance. Savita remarked that a nurse's life is such that one cannot make much of marriage. If she and her husband planned to go for a movie, an emergency would crop up. The doctor would prolong the monthly meeting or she would miss the bus .... By the time she reached home every day, she was so tired that she could do no more than cook before falling off to sleep. She could not always wait up for her husband who returned late after making the rounds in his rickshaw.

ANMs, like other female wage earners, are doubly burdened with work responsibilities both inside and outside the home. It is true that there were a few husbands who supported their wives by accompanying them whenever they were called upon to conduct deliveries or to attend the monthly PHC meeting. Some did this on a continuing basis when they made household visits with them in the community. Obviously, this was possible only when husbands did not have a viable occupation that made demands on their time. However, a redistribution of responsibilities within the household was rarely attempted when ANMs lived with their spouses. Most often, ANMs were forced to wake

up early, finish cooking, wash the clothes and clean the house before setting out for a gruelling day in the sun.

Ironically, these time defying schedules also have the potential of subverting internal controls. These were resisted in varying degrees. The most stark dramatisation of this was played out in the life of Shashikala who said that because she went out whenever people called her for deliveries or other health work, her unemployed and alcoholic husband suspected her. He beat her up frequently. A few days before we spoke to her in Beed, he poured kerosene on her and threatened to burn her. The neighbours intervened when they heard her young children cry.The villagers asked her to return to her parent's house since this first-time incident would be a bad influence in the village. This lack of trust also affected another ANM in Wardha to such an extent that she tried to commit suicide thrice by pouring kerosene over herself.

Indeed, violence within the "protective" walls of the home was not unknown to ANMs. Some, like Shanta, lived through the brutality of it all until their separation while some, like Shashikala, bore the brunt of it with no support system worth its name. It is into families such as these that the economic benefit of their labour was ploughed.

The Valued Wage

Once ANMs began to receive wages through their participation in the health services, they instituted a process of economic stabilisation of their households. It is apparent that they contributed more than substantially to their family's betterment. At the time at which we spoke to them, 35 (or 19.1%) were sole earnersincluding 18 separated or deserted women, and 17 others whose husband father or brother did not earn a wage at all. Further 60 (or 32.8%) who commanded higher wages than their husband, father or brother (in the absence of the father), were main earners (refer to Tables 46 & 48).Although more than a third (ie.36.8%) earned less than the acclaimed providers of the family, the magnitude of this difference did not exceed 56.7%; on the contrary, the incomes of the main earners exceeded the male wage by 176.9%. The differences in the earnings of married ANMs and their husband was more sharply defined than unmarried ANMs. The married ANMs earning more than their husbands .showed a 182.6% differential as compared the differential of 158.1% that

unmarried ANMs earning more than their father displayed. Equally the differential for the married ANMs earning less than their husband was 49.2% as compared to the one showed by unmarried ANMs (ie.102.9%) - refer to Tables 46 and 48.

However, this economic role was embedded in social and gender based relations within the patriarchal family and it was here that the apportioning of the fruits of labour was taking place. It is to these structures that the emancipatory potential of wage labour was subjected. Discussions on the emancipatory potential of wages on existing forms of gender subordination in the household have taken on many hues. While there are those who believe that the actual presence of wages must have some impact on the situation of the earner since it is a source of (subjective and psychological) power (Omvedt 1980 as quoted by Standing 1985:.232); others argue that this mode of evaluation oversimplifies the issue and calls for a more integrated framework (than the one currently available) to study objective indices like the *control of income and decision making* (Krishnaraj 1991). However, writers like Standing (1985) believe that even "this cannot stand as a measure of increased *personal* autonomy in the sense of an enhanced capacity to determine the conditions of their lives" (pp.234). She, therefore, focuses on the changes that an entry into wage employment brings on the *amount* or the *terms of access* to resources and basic entitlements in the family (eg. education, health care, property inheritance, etc.)[9].

The role that ANMs played as wage earners was embedded in of households rife with relations of economic dependence. So far from empowering them in the fullest sense of the term, their wages did little more than keep alive its subsistence economy and support the futures of its members. No sooner did they start receiving regular wages than their responsibilities towards their siblings, parents, husband and in-laws began.

One hundred and nine ANMs (or 61% out of 179, four not responding) reported to have provided help towards the furtherance of their siblings' (husband's siblings') education after joining the health services : 66 of these (ie.60.6%) helped their parental households, 27 (ie.24.8%) helped their in-laws' family and 16 (ie.14.7%) helped both. On the whole, 84.1% of the ANMs who offered any kind of support assisted their siblings in their education while 65.9% funded their siblings-in-law.

In the matter of controlling their salaries, two scenarios presented

themselves. On the one hand were the main earners whose wages may have replaced the ones earned previously by the reigning patriarch, or whose wages may have helped them experience a sense of economic self sufficiency. (especially true of separated, deserted, divorced or widowed) However, given the limitations against which their employment was set, their earnings were entirely focused on keeping themselves and a motley group of dependents from sinking into total poverty. In this context, the question of control holds little meaning since it ceases to become the wage earner's prerogative.

On the other hand were those who felt compelled to hand over most, if not all, their salaries to an elder in the family or to the reigning patriarch (the husband or father) or the widowed mother. The ANMs who willingly handed over their salaries usually belonged to the older age group or had suffered a bereavement in the not so distant past (usually, the death of a father). Sometimes, unhappily married ANMs living away from their husbands bought their peace of mind by willingly sending money or hastily acceding to the most unjust monetary demand whenever it was made. Occasionally, one came across an ANM whose salary was prised away from her through deception or brute force. One of the ANMs in Wardha district had a no-good alcoholic husband who did not live with her but lived nonetheless off her earnings. He visited her only when he wanted money. Once he even forged her signature and drew her money from the bank without her consent.

ANMs were not always in a position to live with their entire family; so in addition to supporting the relations who stayed with them, they also sent money in periodic instalments. Table 50 indicates that 71 out of 183 ANMs (ie.38.8%) were sending out a quarter of their earnings to their families (25% being the mean and 27% the median value). Of those who sent money,(36 or 50.7%) sent out a quarter of their salaries while 31 (ie.43.7%) sent out between 25% to 50% of their salaries. Four ANMs were sending more than half of their salaries every month (refer to Table 53). The average (ie.mean) amount that was sent was Rs.390 per month (the median was Rs.400).

The proportion of women specially sending money increases among the unmarried (ie.16 out of 38 or 42.1%) but reduces among those currently married (ie.49 out of 127 or 38.6%) and those separated, deserted, divorced and widowed (ie.6 out of 18 or 33.3%). On the whole, half of the recipients were husbands and their families and the other were their parents and siblings (refer to Table 51). Of significance is the finding that 15 of the 49 currently married women making remittances (ie.30.6%) were actually sending money

to their parents and siblings. This indicates that for at least some ANMs, their economic responsibilities vis-a-vis their parental homes did not always cease after their marriages. This also indicates that at least some ANMs did have a measure of autonomy from their in-laws in deciding how to spend their money.

The economic responsibilitiesof ANMs did not cease, however, with remittances. They were also called on to take loans in view of their credibility/ credit worthiness with lending agencies. Accordingly, 63 of all ANMs (ie.34.4%) were presently repaying loans taken mostly from the Credit Society organised by district level workers or from banks and other agencies. Nearly three fourths of these loans (ie.42.9%+ 33.3% =76.2%) fell in the range of Rs.5001 to Rs.20,000 (refer to Table 52). They were taken to purchase or improve the value of assets owned by the family like houses, fields, shops etc; to assist family members in their job hunting expeditions; and to finance their own as well as the weddings of relatives.Two of the loans to the tune of Rs.80,000 were taken to build houses. The average amount borrowed was Rs.12,000 (median value) or Rs.12,230 [mean value].

The monthly instalments through which these were repaid varied widely from Rs.20 to Rs.10,000 (the average being Rs.500 - median value - to Rs.529 - mean value -per month). As Table 52 shows, half of these ANMs were repaying monthly instalments of up to Rs.500 and another 39.7% were paying between Rs.501 and Rs.1000. There were only three ANMs whose monthly loan payment was as high as Rs.1000 to Rs.2000. On the whole, loan repayment and remittances put together swallowed an average of 29.30% of the total wage earned (29.1% being the median and 30.7% being the mean) - refer to Table 53.

Thus, ANMs were so called upon to make large scale and long lasting contributions to their families. While their salaries succeeded in buttressing the well-being of others, it did not appear to drastically alter power relationships in the household. In the end, ANMs played a subordinate role in the health services only to be weighed down by the structures of dominance in the household.

NOTES

[1]Three fifths of all ever-married ANMs (ie.60.7% or 88 out of 145) did so after their training. As a result, over two thirds of the ANMs (ie.68.9% or 126 out of 183) joined the services as unmarried women (refer to Table 39). Less than one third (57 or 31.9%) had married : of these, 45 (79%) were currently married, 11

(19.3%) were S/D/D and one (1.8%) was widowed.

[2]Four out of five ANMs married within 3.3 years after their stint in the training school (refer to Table #). This brings down the overall average for all ANMs marrying after training to 4.3 years which is significantly different from the average period of 7.7 years that women marrying before training had to wait before they could seek wage labour in the health services.

[4]Given their relatively recent entry into the health services, one out of three of all ANMs (ie.60 out of 183 ANMs) had never been transferred before. In fact, most of them had been transferred only once since their first posting five years ago (one being the median and modal value and five being the median value0. The experience of being moved from one place to another was, therefore, fairly new to many of them.

[5]Since 11 out of 15 (ie.73.3%) of these marriages dissolved before training, the contention that it is the ANMs' job that causes breakups cannot be substantiated. Besides, only two ANMs blamed their jobs for their breakups. The reasons why seven women severed marital ties were their husband's waywardness (mentioned by three), dowry demands and its accompanying violence (mentioned by three) and lastly, their husband's impotency (mentioned by one). The others were deserted by their husbands due to their affairs with other women.

[6]Less than a quarter (35 or 24.1%) of the ever married ANMs (145) in our sample had three or more children; most of these women (30 out of 35) were married for more than ten years (refer to Table 57). On the other hand 27 or 18.6% had no children; most of them (20 out of 27) married for less than five years). The remaining 83 or 57.2% had one or two children. The average number of children that these ever married women had was only 1.65.

[7]While agricultural labourers, artisans or petty traders and unemployed or retired men were better able to accompany their wives, industrial workers, supervisors, managers or professionals who earned a viable wage were unable to go along to quite the same extent (refer to Table 56). Interestingly, men with white collar jobs like teachers, clerks, etc. were more often able to stay with their families at the time at which we spoke to them. This could be attributed to fortuitous transfers.

[8]Out of 54 ANMs who lived away from their husbands, five did not respond to our question. Of those who did, 25 (ie.46.3%) met once a week, 10 (ie.18.5%) met once a fortnight, 6 (ie.11.1%) once a month and 8 (ie.14.8%) met irregularly.

[9]While the present study does not benefit from a full fledged inquiry into the impact of wages on the lives of ANMs, it charts out a brief sketch of their role as wage earners in the context of their families.

STAYING ON : WHAT SATISFACTION HAS TO DO WITH IT

Why do ANMs stay on in an occupation that is clearly overlaid with impediments? What are the yardsticks with which they measure satisfaction? What is the relationship between discontentment and change ? An attempt to understand the answers to these questions is made in this chapter.

Explaining Job Satisfaction

Despite the numerous problems that they faced in the course of their careers in the health services, nearly three out of four ANMs (ie.72.7% or 133 out of 183) considered themselves to be satisfied with the work they were presently doing. The conditions under which they sought employment, namely, economic dependence in the family coupled with unfavourable terms of access to other options sharply contrast with the present economic security that their jobs were providing via their monthly wage (which works out, on an average, to Rs.1638.40). However, only 22 out of 133 ANMs (or 16.5%) recollected the economic interest that guided them into the health services in the first place (refer to Table 62). Instead, 49 (out of 133 or 36.8%) chose to couch their rationalisation in the altruistic vocabulary of social work (doing service, helping others, working towards the nation's development) which has traditionally been associated with voluntary and charitable efforts.

Sometimes, satisfaction was dependent on the work that they were able to do successfully at different points in time (cited by 48 out of 133 or 36.1%). These included their handling of difficult deliveries, their completion of family planning targets and immunisation. Conversely, when they were unable to fulfil to the targets assigned to them, they felt disappointed and dissatisfied. In addition, 20 (out of 133 or 15%) were gratified by their ability to utilise their training and skills. Accompanying these two groups of responses were occasional references to the community, namely, the cooperation and respect that emanated from there (cited by 18.8% of the satisfied ANMs).

Lastly, there were those ANMs whose satisfaction was founded on a spirit of simplicity and fatalism. These include 24 (or 18.1%) who expressed a liking for their work and 16 (or 12%) who said that they had settled down into a routine. Having *chosen* to work in the health department, having understood the challenges therein and settling down to a routine, they supposed

themselves to be satisfied with what they were doing.

In contrast to the satisfied ANMs, the 44 women who expressed dissatisfaction with their work outlined its more gruelling and problematic aspects. As many as 45.5% (or 20 out of 44) highlighted the more burdensome and tension generating aspects of the Family Planning Programme (refer to Table 63). They criticised the system's obsession with family planning which sidelined other more important health activities and which resulted in their being reproached during PHC meetings. Surprise checks were made sometimes by inspection teams and ANMs feared them. They also lamented the fact that they were sometimes driven to faking results in their registers.

Two out of five ANMs (ie.40.9% or 18 out of 44) cited the indifferent or negative community reactions that either marginalised them or brought about harassment. Less than a third (ie.31.8% or 14 out of 44) complained about the conditions under which they worked. Their long trudges in the absence of proper transport under the blazing sun or in the pouring rain, their visits from one household to another made them feel over-stretched and over-worked.

Being health workers at the lowest rung of the hierarchy, ANMs take orders from a host of superiors (including the District Health Officer's staff, the MO, the LHV, even the sanitary inspector). 29.5% registered their unhappiness with the negative approach of the superiors in their dealings with them while 15.9% regretted that they were working in a monotonous job with no promise of promotions and variations in their assumed responsibility.

Contemplating Change

Does dissatisfaction provide an impetus to change ? Do ANMs have the liberty to make drastic changes to their careers ? We looked at two aspects of change. The first - *recommending the job to other (female) members in the family or community* - refers to influencing a process of thought while the second - *shifting to another occupation* - refers to a radical change from one form of employment to another. In our study, 96 ANMs (or 52.5%) were willing to recommend the job to other women with whom they felt close while a substantially smaller number of 58 (or 32.2%) could think of the possibility of switching jobs. Therefore, unlike the question of recommendations, the motivation and *capacity* to make real changes - to recast their lives in some way - was articulated without the same confidence.

There appears to be a direct relationship between dissatisfaction and change (refer to Table 61) wherein disenchanted ANMs were inclined to refrain from recommending the job to others (ie.34 out of 44 or 77.3%) and to want to move on to some other form of wage labour (ie.23 out of 44 or 52.3%). However, the equation fails to stand up to the test of statistical significance. This suggests that the translation of discontentment into action for change is neither easy to contemplate nor achieve.

Recommending the Job to Others

The two themes that dominated the responses of the 96 ANMs who said that they would recommend their job to other women, revolved around the practical realisation that this was one avenue through which they could provide *social service* to people in the community (ie.46.9% or 45 out of 96 ANMs) and to simultaneously earn a decent livelihood (ie.37.5% or 36 out of 96 ANMs). The former rationale found more votaries among those satisfied, than the latter (refer to Table 64). Resonances of this theme were found once more in the logic that the job was relatively more accessible for women in villages (ie.20.8% or 20 out of 96). Significantly, only 13 ANMs (or 13.5%) mentioned respect and appreciation from the people as being a worthwhile reason for continuing to work and an even tinier number of four (or 4.2%) were convinced that they were actually taking care of the health needs of people.

As against the ANMs who were willing to advise other women to take up employment in the health services, the 86 ANMs (ie.47%) who were reluctant to do so pointed to the rather adverse circumstances under which work had to be done. They had apprehensions about how these younger women, presumably without the same tenacity as themselves, would be able to cope. As Table 65 indicates, 36 ANMs (or 41.9%) zeroed in on their overburdened work-schedule and constant commuting and the tensions accompanying their round-the-clock duty (this response was more forthcoming among those who were dissatisfied). Fourteen ANMs (or 16.3%) placed the blame squarely on the (tainted) reputations that nurses - especially village level nurses - were generally set up against in the community. However, since they had "redeemed" themselves with their competence, they had bypassed the damning reputation that *could have been* slapped on them. Twenty ANMs (or 23.3%) expressed anxiety about the personal safety of their friends if they were to take up this job (interestingly, this apprehension was voiced more by those who were satisfied).

Perhaps, it was after considering all these aspects of the job that 44.2%

of the ANMs said that they would advise these women to become engineers, doctors, staff nurses or teachers instead; in short, jobs which commanded a better status and which could be conducted under more agreeable conditions. The logic used was- "It doesn't matter any more whether I am dissatisfied or willing to change my job. My days are over but I would like my daughter/ niece/friend to do something else with her life. I don't want her to make the same mistake that I did".

Interestingly, this concern was articulated by ANMs regardless of their personal satisfaction with their work. This itself suggests that the yardsticks with which they used to judge their well-being differs from those employed to judge the wisdom of these younger women entering the profession.

In the end, it is not so much the question of satisfaction (or the lack of it) guiding the advice that they give younger women, but of their *relationship* with them and the social and material considerations which underpin it. Perhaps this is why they were more reluctant to persuade their daughter(s)/ relatives if they were *unmarried* than if they were *separated* or *deserted.*

Changing Occupations

In contrast to the changes suggested in the previous sections, the confidence with which women are able to shift from one field to another depends on several factors not least of which is the objective presence of avenues for change. In rural areas, these are very limited. This is borne out in Table 66 which indicates that 50% of the women who are considering other options for employment tended to return to the very options that had previously eluded them. This is particularly apparent in the case of those wishing to be employed as school teachers or in a clerical capacity (73.7% each).

Therefore, while the impetus for change emanates from motivation, its realisability is afforded only by the presence of real options. Even if these are authentic, the need to acquire new skills means that there must be sufficient training schools both in numbers and in their capacity to absorb female applicants. In India, however, institutions offering technical education at the post school level form barely 0.37% of all institutions and the student enrollment in these is a mere 2.0% of the total number in all institutions (Krishnaraj 1991). What is more, these facilities, scarce as they are, are taken advantage of by boys more than girls. This is because men are expected to participate in the labour market while this is not believed to be women's ultimate destination.

"The social process of selection and exclusion for systematic technical training is a self perpetuating cycle defined as it is by the notion of women's proper role" (ibid :119)[1].

Another important consideration which has a bearing on the issue of change is the one of timing. This encompasses the maximum amount of time for which ANMs can forgo their salary, a consideration which assumes great importance in view of their economic role in their families, and their age. Some of the older ANMs could not dream of moving on because they believed that it was too late for them to be contemplating it.

Table 68 provides some of the reasons that two thirds of the ANMs (ie:124 or 67.8%) offered for wishing to maintain a status quo. Taking stock of existing alternatives, nearly half the ANMs felt that they were better off with their present job. They had gained experience over the years cited by 61 out of 124 ANMs or 49.2% They believed that they were in a better position to get admissions for the course in General Nursing and Midwifery which would not only augment their basic training but their status within medicine as well (in short, they saw their present situation as being a transitory one). They liked what they were doing. Moreover, the job was better paying than others at the village level. This reasoning was particularly popular among those who were satisfied with their jobs.

Related to this line of reasoning was the assertion that any change would only negate all the accumulated experience and expertise of the seven years since training (seven being the median value) and, with it, all chances of promotion to the post of LHV. Not surprisingly, this line of reasoning was adopted by those who are dissatisfied but unwilling to switch jobs.

Interestingly, only 16.9% of the ANMs were encouraged by the social service that they were rendering to want to stay on. 12.9% believed that the transition and process of adjustment to another job would be difficult and 11.3% were contained by the sobering realisation that other options were unavailable.

In contrast, the major reasons offered by the 58 ANMs seeking to change occupations reflect the adversities that ANMs need to face and deal with on a day-to-day basis(refer to Table 67). The feeling of being hard pressed due to incessant travelling as well as the enforced separation from the family and the insecurities surrounding their status as 'outsiders' in the village (as articulated by 39.7%), the frustration surrounding the deficiencies in facilities and supplies that contributed to the underutilisation of their services and the devaluation of their

role (as voiced by 24.1%) engender not only a sense of dissatisfaction but also the motivation to make alternations to their work situations.

These are not just revelations but also indictments of the health services which contribute to making ANMs feel demoralised. The fact that they are eager to change their occupation in defiance of all odds indicates just how sharply this disappointment was felt.

NOTES

[1]. As many as 89.7% of the female workers in rural areas, having been excluded from formal training programmes, are unskilled (Sarvekshana Vol.V,Nos 1&2 quoted in GOI 1988) and with the possible exception of teaching and nursing, which are essentially `feminine' occupations, the participation of women in other training courses and occupations in the modern sector is negligible.

CONCLUSION

The status and experiences of the women who occupy the fringes of the public health delivery system in rural areas are moulded by the paradoxes that beleaguer them at every turn. Their participation in an occupational cadre constituted exclusively of women gains significance in rural areas where employment opportunities in the non-agricultural sector are hard to come by. Indeed, ANMs are usually among the first women in the family to get access to employment in the service sector. Further, most of their wages are considerably greater than the ones earned by their fathers or other reigning patriarchs in the household. And yet, their economic role does not get translated into social status nor does it lead to empowerment to the fullest extent possible.

A number of reasons account for this. Firstly, their wage labour is set in fragile household economies with marked relationships of dependency. In this context, their economic role serves merely to keep alive these subsistence economies, to support the futures of other members and to raise their eligibility in the marriage market without reordering any of power equations existing previously.

Secondly, ANMs enter the health services in a subordinate capacity as lower-rung workers and as para-professionals. Their administrative and professional subordination (to doctors and nurses) is compounded by their gender, youth, negative social image, disadvantaged socio-economic backgrounds and their status as outsiders in the community which not only adversely affect their assertiveness and bargaining power but also create material conditions conducive to harassment.

Thirdly, ANMs owe their allegiance to the nursing profession by virtue of their registration with the council and yet, their work role is far removed from the tasks conventionally associated with nursing. Further, unlike full fledged nurses, ANMs are located in a non-institutional setting at the interface of the health services and the community in relative isolation from their colleagues. This position makes them vulnerable and exposes them to the cross-fire of widely differing expectations by the government and the people. In trying to achieve a delicate balance between their role as family planning motivators (defined by the former) and as health care workers (demanded by the latter), ANMs encounter many

unpleasant experiences in the community ranging from indifference to open hostility.

They tend to accentuate the more tangible aspects of health care (like curative care and deliveries) so as to build a credible presence in the community. And yet, deficient and inappropriate training, notional professional supervision, grossly inadequate (or absent) facilities, equipment and infrastructure contrive to limit the scope and efficiency of their work as defined by conventional indicators. This affects their relationship with superiors in the district health bureaucracy as well as the community.

Fourthly, while ANMs are dogged with work related problems (including sexual harassment), they have few sure-fire channels of redress and virtually no support systems. They face the very real problem of safety, a problem which gets accentuated by the fact that they are outsiders in the villages to which they are posted; yet, this issue does not receive more than notional attention from the district bureaucracy. Further, support from the team leader at the PHC (the MO), LHVs, other health workers as well as neighbours and other people in the community is possible but not guaranteed.

ANMs willingly attest to the presence of problems emanating from their work but not many admit to dissatisfaction. Further, dissatisfaction does not readily bring on the capacity to make real changes in their lives in terms of conceiving of other employment alternatives or even accessing them. ANMs remain confined within a limited radius for most of their lives even as their jobs require them to cover the length and breadth of a 5000 population. In the end, their challenge centres around fighting - and overcoming - the daily battle of survival. ANMs do survive by achieving practical, down-to-earth solutions, by drawing on resources within easy reach and by conducting their lives with caution and circumspection.

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APPENDIX 1

JOB RESPONSIBILITIES OF HEALTH WORKERS (FEMALE)

1. Maternal and Child Health Care

To register and provide care to pregnant women throughout the period of pregnancy.

To test the albumen, sugar and haemoglobin levels among women during pregnancy in the course of home visits and at clinics.

To ensure that all pregnant women get VDRL test done.

To refer cases of abnormal pregnancy and cases with medical and gynaecological problems to Health Assistants (Female) at the PHC.

To conduct about 50% of total deliveries in the area.

To supervise the deliveries conducted by *dais.* To assist them whenever called in.

To refer women with difficult labour and newborns with abnormalities; help them to get institutional care and provide follow-up to the patients referred to or discharged from hospital.

To make at least three post-natal visits for each delivery conducted in the area. To render advice on care of the mother and care and feed of the newborn.

To monitor the growth and development of infants and take necessary action to rectify defects, if any.

To educate mothers individually and in groups about better family health including maternal and child health, family planning, nutrition,

immunisation, control of communicable diseases, personal and environmental hygiene.

To assist the MO and Health Assistants(Female) to conduct antenatal and postnatal clinics at the subcentre.

2. Family Planning

To utilise information from the 'Eligible Couple and Child Register' for the family planning programme. ANMs are squarely responsible for maintaining eligible couple registers and updating them at all times.

To spread the message of family planning to couples individually and in groups and motivate them to adopt family planning.

To distribute conventional contraceptives and oral contraceptives to couples. To provide facilities and help prospective acceptors to access family planning services; if necessary, by accompanying them or arranging for the *dai* to accompany them to hospital.

To provide follow-up services to female family planning acceptors. To identify side-effects, give on the spot treatment for side-effects and minor complaints and refer those cases that need attention by the physician to the PHC/Hospital.

To establish female depot holders. To help Health Assistant (Females) to train them and provide them with a continuous supply of conventional contraceptives.

To build rapport with family planning acceptors, village leaders, Health Guides, Dais and others and utilise their services for the promotion of family welfare.

To identify women leaders and help the Health Assistants to train them.

To participate in Mahila Mandal meetings and utilise such gatherings for educating women about the Family Welfare Programme.

3. Medical Termination of Pregnancy

To identify women requiring help for medical termination of pregnancy and refer them to nearest approved institution.

To educate the community about the consequences of septic abortion and inform them about the availability of services for medical termination of pregnancy.

4. Nutrition

To identify cases of malnutrition among infants and young children (upto five years), give the necessary treatment and advice and refer serious cases to the PHC.

To distribute Iron and Folic tablets as prescribed to pregnant and nursing mothers, infants and young children (upto five years) and family planning acceptors.

To administer Vitamin A solution in prescribed doses to children between the ages of 1 to 5 years.

To educate the community about nutritious diets for mothers and children.

5. Expanded Programme of Immunisation

To immunise pregnant women with tetanus toxoid.

To administer DPT, oral poliomyelitis, and measles vaccines (where available) and BCG vaccine to all infants and children.

6. Dai Training

To list *dais* in the area and involve them in promoting Family Welfare.

To help the Health Assistants (Female) in the training programme of *dais.*

7. Communicable Diseases

To notify the MO of the PHC about any abnormal increase in cases of diarrhoea, dysentery, fever with rigors, fever with rash, fever with jaundice

or fever with unconsciousness which one comes across during home visits, take the necessary measures to prevent their spread and inform the HW(M) to enable him to take further action.

To take blood smears from people suffering from fever, administer presumptive treatment for malaria during home visits and inform the Health Worker (Male) for further action.

To identify cases of skin patches, especially if accompanied by loss of sensation during home visits and bring them to the notice of the Health Worker (Male) for skin smears.

To assist the Health Worker (Male) in maintaining a record of tuberculosis and leprosy patients under treatment in the area and check on the regularity of their treatment. To motivate defaulters to take regular treatment and bring these cases to the notice of the Health Worker (Male) or Health Assistant(Male).

To give Oral Rehydration solution to all patients of diarrhoea/dysentery/ vomiting.

To identify and refer all people suffering from blindness (including suspected cases of catarract) to the MO.

8. Vital Events

To record births and deaths occuring in the area in the Births and Deaths Register and report them to the Health Worker (Male).

9. Record Keeping

To register (a) pregnant women after three months of pregnancy; (b) infants below 1 year of age; and (c) women between the ages of 15 to 44 years.
To maintain pre-natal, maternity and child health records.

To assist the Health Worker (Male) in preparing the Eligible Couples and Child Register and update them.

To maintain records about contraceptive distribution, IUD insertions, couples sterilised, clinics held at the subcentre and supplies received and issued.

To prepare and submit prescribed monthly reports in time to the Health Assistant(Female).

10. Primary Health Care

To provide treatment for minor ailments, first aid in case of accidents and emergencies and refer cases beyond her competence to the PHC or nearest hospital.

11. Team Activities

To attend and participate in staff meetings at the PHC/Community Development block or both.

To coordinate activities with the Health Worker(Male) and other health workers including Health Guides and *dais.*

To meet the Health Assistants(Female) each week and seek her advice and guidance whenever necessary.

To maintain cleanliness of the subcentre.

To participate as a member of the team in camps and campaigns.

Note : This is an edited version of the official description of the ANM's job

APPENDIX 2

TABLE 1 (a)
SAMPLE SELECTION

Geographical Zone	Districts Selected	CMIE Index (1987)	No. of PHCs selected	No. of ANMs interviewed	No. of non-respondens
Western Maharashtra	Pune				
	Non-tribal	175	6	42	9
	Tribal		3	26	8
Vidarbha	Wardha	85	6	50	4
Marathwada	Beed	50	6	36	-
Konkan	Ratnagiri	35	6	29	6

TABLE 1 (b)
NON RESPONDERS

Reasons	Frequency
On training	4 (14.8)
On Leave (long leave, maternity leave)	5 (18.5)
Vacant Post	11 (40.7)
ANM unavailable	3 (11.1)
Reason unstated	4 (14.8)
Total	**27 (100)**

TABLE 2
PROFILE OF ANMS - I

	Recruitment		
	Before 1980	After 1980	All ANMS
Age at Training			
Mean (±Standard Deviation)	19.8 (±4.3)	20.7 (±4.3)	20.5
Age at First Posting			
Mean (±Standard Deviation)	24.0 (±4.8)	22.3 (±4.2)	22.7
Marital Status at recruitment			
Unmarried	33 (73.3)	93 (67.4)	126 (68.9)
Married	9 (20.0)	36 (26.1)	45 (24.6)
Separated/Deserted/ Divorced	3 (6.7)	8 (5.8)	11 (6.0)
Widowed	---	1 (0.7)	1 (0.5)
Totals	**45 (100)**	**138 (100)**	**183 (100)**
Community			
Brahmins,Marathas,Rajputs, Lingayats	15 (33.3)	47 (34.1)	62 (33.9)
Kunbis,Other Marathas,OBCs	18 (40.0)	51 (37.0)	69 (37.7)
Scheduled castes and tribes	7 (15.6)	28 (20.3)	35 (19.1)
Christians and Muslims	5 (11.1)	12 (8.7)*	17 (9.3)
All Communities	**45 (100)**	**138 (100)**	**183 (100)**
Posting			
In Native District	26 (57.8)	105 (76.1)*	131 (71.6)
Outside Native District	19 (42.2)*	33 (23.9)	52 (28.4)
Totals	**45 (100)**	**138 (100)**	**183 (100)**
Native Place			
Rural	25 (55.6)	95 (68.8)	120 (65.5)
Semi-urban/urban	20 (44.4)	43 (31.2)	63 (34.4)
Totals	**45 (100)**	**138 (100)**	**183 (100)**

* Significant differences at 95% level of confidence

TABLE 3
PROFILE OF ANMS - II

	Recruitment		
	Before1980	After 1980	All ANMs
ANMs' Education			
Secondary/High School education	17 (37.8)	1 (0.7)*	18 (9.8)
Matriculation	25 (55.6)	97 (70.3)**	122 (66.7)
Inter/Junior College/Graduation	3 (6.6)	40 (29.0)*	43 (23.5)
Totals	**45 (100)**	**138 (100)**	**183 (100)**
Additional Technical Training			
Typing/Stenography/tele.operating/ banking	5 (41.7)	33 (73.3)*	38 (66.7)
Sewing/Embroidery/Tailoring	3 (25.0)	7 (15.6)	10 (17.5)
Anganwadi/CHV/Dai training	2 (16.7)	3 (6.7)	5 (8.8)
Other training	2 (16.7)	2 (4.4)	4 (7.0)
Totals	**12 (100)**	**45 (100)**	**57 (100)**

* Significant difference at 95% level of confidence

** Significant difference at 99% level of confidence

TABLE 4
SOCIAL ASPECTS OF EDUCATION

	Educational Achievement			
	Pre-Matric	Matric	College	Totals
Background				
Rural	10 (8.3)	78 (65.0)	32 (26.7)	120 (100)
Urban	8 (12.7)	44 (69.8)	11 (17.5)	63 (100)
Totals	**18 (9.8)**	**122 (66.7)**	**43 (23.5)**	**183 (100)**
Community				
Upper caste hindus	4 (22.2)	45 (36.9)	13 (30.2)	62 (33.9)
Middle caste hindus	6 (33.3)	49 (40.2)	14 (32.6)	69 (37.7)
Scheduled castes & tribes	7 (38.9)	15 (12.3)	13 (30.2)	35 (19.1)
Christians and Muslims	1 (5.6)	13 (10.7)	3 (7.0)	17 (9.3)
Totals	**18 (100)**	**122 (100)**	**43 (100)**	**183 (100)**

TABLE 5 (a)
EDUCATIONAL PROFILES OF PARENTS

	Recruitment		
	Before 1980	After 1980	All ANMs
Father's education at joining			
No Schooling/Primary	14 (31.1)*	62 (44.9)	76 (41.5)
Secondary/High School	15 (33.3)	45 (32.6)	60 (32.8)
Matriculation	9 (20.0)	17 (12.3)	26 (14.2)
Inter/Jr.College/ (Post) Graduation	3 (6.7)	7 (5.1)	10 (5.5)
Medicine/Nursing/ Non-health Profession	1 (2.2)	2 (1.5)	3 (1.6)
Total (excluding non responders)	**45 (100)**	**138 (100**	**175 (100)**
Mother's education at joining			
No Schooling/Primary*	28 (62.2)	112 (81.2)	140 (76.5)
Secondary/High School*	13 (28.9)	22 (15.9)	35 (12.1)
Matriculation	2 (4.4)	2 (1.4)	4 (2.2)
Total (excluding non responders)	**45 (100)**	**138 (100)**	**179 (100)**

TABLE 5 (b) (Contd.)
EDUCATIONAL PROFILES OF SIBLINGS

	Recruitment		
	Before 1980	After 1980	All ANMs
Highest educational level achieved among sisters			
Primary level	---	4 (6.0)	4 (4.9)
Secondary/high school level	7 (46.7)	24 (35.8)	31 (37.8)
Matriculation	7 (46.7)	31 (46.2)	38 (46.3)
Jr.College/(Post) graduation	1 (6.6)	6 (9.0)	7 (8.5)
Medicine/nursing/non-health profession	---	2 (3.0)	2 (2.4)
Total no. of sisters completing education	**15 (100)**	**67 (100)**	**82 (100)**
Highest educational level achieved among brothers			
No schooling/Primary level	1 (4.7)	2 (2.9)	3 (3.3)
Secondary/high school level	5 (23.8)	14 (20.0)	19 (20.8)
Matriculation	7 (33.3)	25 (35.7)	32 (35.2)
Jr.College/(Post) graduation	6 (28.6)	23 (32.9)	29 (31.9)
Medicine/nursing/non-health profession	2 (9.5)	6 (8.5)	8 (8.8)
Total no. of brothers completing education	**21 (100)**	**70 (100)**	**91 (100)**

Siblings still studying have been excluded

TABLE 6

EDUCATIONAL PROFILES OF PARENTS AND SIBLINGS - II

	Father	Mother	Brother	Sister
Less educated than ANM	142 (81.0)	175 (97.8)*	18 (19.8)	37 (45.1)*
As educated as ANM	19 (11.0)*	4 (2.2)	44 (48.4)	36 (43.9)
More educated than ANM	14 (8.0)*	-	29 (31.9)*	9 (11.0)
Totals	**175 (100)**	**179 (100)**	**91 (100)**	**82 (100)**

* Significant difference at 95% level of confidence

TABLE 7

COMMUNITY BY DISTRICT WHERE CURRENTLY POSTED

	Community			
District	Upper	Middle	Lower	Minorities
Pune (Tribal)	12 (46.1)	7 (26.9)	3 (11.5)	4 (15.4)
Pune (Non Tribal)	12 (28.6)	15 (35.7)	5 (11.9)	10 (23.8)*
Wardha	7 (14.0)*	21 (42.0)	21 (42.0)*	1 (2.0)
Beed	16 (44.4)	13 (36.1)	6 (16.7)	1 (2.8)
Ratnagiri	15 (51.7)**	13 (44.8)	---	1 (3.5)

* Significant difference at 95% level of confidence,

** Significant difference at 99% level of confidence

Figures in parenthesis are percentages over district totals

TABLE 8

COMMUNITY BY NATIVE PLACE, AGRICULTURAL LAND HOLDING AND FATHER'S OCCUPATION AT RECRUITMENT

	Community			
	Upper	Middle	Lower	Minorities
Native Place				
Urban	22 (35.5)	20 (29.0)	11 (31.4)	10 (58.8)*
Rural	40 (64.5)	49 (71.0)	24 (68.6)	7 (41.2)
Total	**62 (100)**	**69 (100)**	**35 (100)**	**17 (100)**
Agricultural Land Holding@				
No land	12 (30.8)	27 (55.1)	8 (34.8)	4 (57.1)
Less than 5 acres	9 (23.1)	6 (12.2)	8 (34.8)	1 (14.3)
6 to 10 acres	7 (17.9)	8 (16.3)	5 (21.7)	---
11 to 20 acres	7 (17.9)	4 (8.2)	2 (8.7)	1 (14.3)
More than 20 acres	4 (10.3)	4 (8.2)	---	1 (14.3)
Total	**39 (100)**	**49 (100)**	**23 (100)**	**7 (100)**
Average (±Standard Deviation)	**9.0 (±10.9)***	**5.5 (±9.1)**	**4.0 (±4.0)**	**6.4 (±9.5)**
Father's Occupation at recruitment				
Non earner	4 (7.7)	5 (8.9)	2 (6.7)	3 (23.1)
Cultivator	13 (25.0)	9 (16.1)	3 (10.0)	1 (7.7)
Agricultural Labour	3 (5.8)	8 (14.3)	10 (33.3)	-
Artisans, petty traders	11 (21.2)	18 (32.1)	5 (16.7)	-
Industrial Labourers	12 (23.1)	9 (16.1)	7 (23.3)	4 (30.8)
White collar workers	6 (11.5)	7 (12.5)	2 (6.7)	5 (38.4)
Professional careers	2 (3.8)	-	-	-
Total	**52 (100)***	**56 (100)**	**30 (100)****	**13 (100)**
Average Cash Income (Rs) (±Standard Deviation)	**757.5 (±522)**	**754.6 (±613.8)**	**578.9 (±504)**	**837.5 (±484)**

@ Excludes ANMs with urban backgrounds

* Significant difference at 95% level of confidence

TABLE 9
PROFILE OF PARENTS' OCCUPATION AND INCOME

	Recruitment		
	Before 1980	After 1980	All ANMs
Father's Occupation at recruitment			
Housework/retirement	3 (8.3)	11 (9.7)	14 (9.4)
Cultivators	5 (13.9)	21 (18.6)	26 (17.5)
Agricultural Labourers	3 (8.3)	18 (15.9)	21 (14.1)
Artisans, petty traders	8 (22.2)	26 (23.0)	34 (22.8)
Workers in organised/ unorganised sectors	10 (27.8)	22 (19.5)	32 (21.5)
White collar workers, school teachers	6 (16.7)	14 (12.4)	20 (13.4)
Professional careers	1 (2.8)	1 (0.9)	2 (1.3)
Total (excluding dead fathers)	**36 (100)**	**113 (100)**	**149 (100)**
Mother's Occupation at recruitment			
Housework/retirement	26 (63.4)	77 (60.6)	103 (61.3)
Cultivators	2 (4.9)	20 (15.7)*	22 (13.0)
Agricultural Labourers	3 (7.3)	18 (14.2)	21 (12.5)
Artisans, petty traders	2 (4.9)	4 (3.1)	6 (3.6)
Workers in organised/ unorganised sectors	6 (14.6)*	4 (3.1)	10 (6.0)
White collar workers, school teachers	2 (4.9)	4 (3.1)	6 (3.6)
Total (excluding dead mothers)	**41 (100)**	**127 (100)**	**168 (100)**
Agricultural Land Holding @			
No land	13 (54.2)	36 (38.7)	49 (42.0)
Upto 5 acres	3 (12.5)	22 (23.7)	25 (21.4)
6 to 10 acres	2 (8.3)	17 (18.3)	19 (16.2)
11 to 20 acres	3 (12.5)	12 (12.9)	15 (12.8)
More than 20 acres	3 (12.5)	6 (6.5)	9 (7.6)
Total	**24 (100)**	**93 (100)**	**117 (100)**
Average (±Standard Deviation)	**5.7 (±8.4)**	**6.8 (±10.9)**	**6.5**

@ Excludes ANMs with urban backgrounds

* Significant difference at 95% level of confidence

TABLE 10
DIFFERENCE IN INCOME BETWEEN ANMS AND THEIR FATHER

	Difference in income between ANMs and their father					
	0-25%	25-50%	50-75%	75-100%	100-200%	200%+
At Recruitment						
ANMs earning less (N=32)	10 (31.2)	14 (43.8)	8 (25.0)	---	---	---
ANMs earning more (N=54)	9 (16.7)	6 (11.1)	4 (7.4)	---	12 (22.2)	23 (42.6)
At Present						
ANMs earning less (N=15)	8 (53.4)	5 (33.3)	2 (13.3)	---	---	---
ANMs earning more (N=50)	1 (2.0)	2 (4.0)	6 (12.0)	5 (10.0)	13 (26.0)	23 (46.0)

TABLE 11
DECADAL TRENDS IN TRAINING, RECRUITMENT AND REGISTRATION IN MAHARASHTRA - I

Year	Number of ANMs Registered With Nursing Council	Number of ANMS In Govt. PHCS & SCs.	Number Of Training Schools	Annual Admission Capacity
1980	8468	4671	30	1094
1981	8719*	3671	30	1094
1982	9273	4614	25	743
1983	9668*	6004	24	1353
1984	9915	8755	31	1652
1985	10099	9339@	31	1563
1986	10247	10277	31	1563
1987	10352	10826	31	1563
1988	10469	11306	31	1563
1989	10588	11185	22	1239
1990	10861	11142	22	1289
1991	NA	10852	22	1289
1992	NA	11158	22	1248

Sources :'Health Information of India', CBHI, Government of India, respective years *'Maharashtra Nursing Council' data

@ Provisional figures

Notes : SC is an abbreviation for sub-centre

TABLE 12
DECADAL TRENDS IN TRAINING, RECRUITMENT AND REGISTRATION IN MAHARASHTRA - II

1980 - 1989	Total Admission Capacity in Training Schools	13,427
1981 - 1990	Total Number of Recruitments by the Government in Rural Areas	7,471
1981 - 1990	Total number Registered with Maharashtra Nursing Council	2,142
1982 - 1987	Total Admission Capacity in Training Schools	8,437
1983 - 1988	Total Number of Recruitments by the Government in Rural Areas	5,302
1983 - 1988	Total number Registered with Maharashtra Nursing Council	801

TABLE 13
RECRUITMENT AND TRAINING

Year Of Recruitment	Duration of Course: 24 Months	18 Months	12+6 Months	12 Months	All ANMs
1976	20 (100)	---	---	---	20 (100) [10.9]
1976	23 (92.0)	2 (8.0)	---	---	25 (100) [13.7]
1981	12 (13.8)	10 (11.5)	34 (39.1)	31 (35.6)	87 (100) [47.5]
1986	2 (3.9)	5 (9.8)	17 (33.3)	27 (52.9)	51 (100) [27.9]
Totals	**57 (31.1)**	**17 (9.3)**	**51 (27.9)**	**58 (31.7)**	**183 (100) [100]**

Notes : Figures in ( ) are percentages over row totals;

TABLE 14
PRIORITIES IN HEALTH CARE

HEALTH ACTIVITIES	People's Priorities: Median	Rank	Government's Priorities: Median	Rank
Curative Services	1.29	1	6.83	7
Mother and Child Care	2.97	2	2.00	2
Immunisation	3.27	3	2.65	3
Deliveries	3.48	4	3.61	4
Health Education	5.36	5	5.04	5
Water Purification	5.50	6	5.63	6
Family Planning	6.09	7	1.79	1
Abortion	7.87	8	7.87	8

Spearman's Rank Correlation = +0.14 statistically significant at 95% level of confidence

TABLE 15
TIME DISTRIBUTION ON THE LAST WORKING DAY

ACTIVITY	FREQUENCY	AVERAGE TIME*
PHC ANMs		
Home visits	10 (24.4)	3,47 [52.5]
Travel	4 (9.8)	1,49 [25.1]
OPDs/Clinics	30 (73.2)	4,56 [68.4]
Record Writing	9 (22.0)	1,40 [23.1]
UIP Camps	5 (12.2)	3,18 [45.7]
Deliveries	8 (19.5)	3,11 [44.2]
Meetings	3 (7.3)	4,50 [67.0]
Transporting family planning cases	---	-,--
Other activities	6 (14.6)	4,00 [55.4]
Not Applicable/on leave	1 (2.4)	-,--
Totals	**41**	**7,13**
SC ANMs		
Home visits	77 (55.0)	4,10 [62.5]
Travel	57 (40.7)	2,03 [30.8]
OPDs/Clinics	21 (15.0)	4,05 [61.2]
Record Writing	42 (30.0)	2,21 [35.2]
UIP Camps	22 (15.7)	3,58 [59.6]
Deliveries	8 (5.7)	4,09 [62.3]
Meetings	13 (9.3)	5,01 [75.2]
Transporting family planning cases	4 (2.9)	2,45 [41.2]
Other activities	24 (17.1)	2,34 [38.4]
Not Applicable/on leave	7 (5.0)	-,--
No Response	1 (0.7)	-,--
Totals	**140**	**6,40**

TIME DISTRIBUTION ON THE LAST WORKING DAY (contd.)		
ACTIVITY	FREQUENCY	AVERAGE TIME*
All ANMs (excluding ANMs on training)		
Home visits	87 (48.1)	4,08 [60.5]
Travel	61 (33.7)	2,02 [29.8]
OPDs/Clinics	51 (28.2)	4,35 [67.1]
Record Writing	51 (28.2)	2,17 [33.4]
UIP Camps	27 (14.9)	3,51 [56.4]
Deliveries	16 (8.8)	3,40 [53.7]
Meetings	16 (8.8)	4,59 [72.9]
Transporting family planning cases	4 (2.2)	2,45 [40.3]
Other activities	30 (16.6)	2,51 [41.7]
Not Applicable/on leave	8 (4.4)	-,--
No Response	1 (0.6)	-,--
Totals	**181**	**6,50**

Figures in ( ) are % over total numbers of ANMs,
SC is an abbreviation for sub-centre ANMs.
Figures in [ ] are % over average day
Time reported in hours,minutes

TABLE 16
COVERAGE OF CURATIVE SERVICES

	Coverage of Curative Services				
Posting	> 75%	50- 75%	25-50%	< 25%	Coverage Average
PHC ANMs	18 (43.9)	9 (22.0)	10 (24.4)	4 (9.8)	62.5%
SC ANMs	68 (48.6)	44 (31.4)	25 (17.9)	3 (2.1)	69.1%
All ANMs	**86 (47.5)**	**53 (29.3)**	**35 (19.3)**	**7 (3.7)**	**67.6%**

SC is an abbreviation for sub-centre
Percentages in parenthesis are over row totals - PHC (41), Sub-centre (140) and Total (181)

TABLE 17
ADEQUACY OF DRUG STOCKS VERSUS
EXTENT OF COVERAGE

	Coverage of Curative Service				
Adequecy of drug stock	> 75%	50% - 75%	25% - 50%	< 25%	All ANMs
PHC Posting					
Sufficient Stock	9 (50.0)	2 (22.2)	---	---	11 (26.8)
Insufficient Stock	7 (38.9)	4 (44.4)	8 (80.0)	---	19 (46.3)
Other reasons	2 (11.1)	2 (22.2)	1 (10.0)	2 (50.0)	7 (17.1)
No Response	---	1 (11.1)	1 (10.0)	2 (50.0)	4 (9.8)
Totals (%)	**18 (100)**	**9 (100)**	**10 (100)**	**4 (100)**	**41 (100)**
SC Posting					
Sufficient Stock	37 (54.4)	5 (11.4)	2 (8.0)		44 (31.4)
Insufficient Stock	27 (39.7)	34 (77.3)	18 (72.0)	1 (33.3)	80 (57.1)
Other reasons	3 (4.4)	2 (4.5)	5 (20.0)	1 (33.3)	11 (7.9)
No Response	1 (1.5)	3 (6.8)	---	1 (33.3)	5 (3.8)
Totals (%)	**68 (100)**	**44 (100)**	**25 (100)**	**3 (100)**	**140 (100)**
All ANMs					
Sufficient Stock	46 (53.5)	7 (13.2)	2 (5.7)	-	55 (30.4)
Insufficient Stock	34 (39.5)	38 (73.6)	26 (74.3)	1 (12.2)	99 (54.7)
Other reasons	5 (5.8)	4 (7.5)	6 (17.1)	3 (42.9)	18 (9.9)
No Response	1 (1.2)	4 (7.5)	1 (2.9)	3 (42.9)	9 (5.0)
Totals (%)	**86 (100)**	**53 (100)**	**35 (100)**	**7 (100)**	**181 (100)**

SC is an abbreviation for sub-centre
Figures in parenthesis are percentages calculated over column totals
Grand total excludes ANMs on training

TABLE 18

ACHIEVEMENT OF FAMILY PLANNING TARGETS

Target Completion Rate (%)	PHC Posting		SC Posting		All ANMs	
	1	2	1	2	1	2
00-20	2 (4.9)	2 (4.9)	2 (1.5)	8 (6.3)	4 (2.3)	10 (5.9)
20-40	5 (12.2)	6 (14.6)	31 (23.7)	19 (14.8)	36 (20.9)	25 (14.8)
40-60	8 (19.5)	6 (14.6)	34 (26.0)	32 (25.0)	42 (24.4)	38 (22.5)
60-80	7 (17.1)	9 (21.9)	29 (22.1)	24 (18.8)	36 (20.9)	33 (19.8)
80-100	9 (21.9)	9 (21.9)	21 (16.0)	33 (25.8)	30 (17.4)	42 (24.9)
100+	10 (24.4)	7 (17.1)	14 (10.7)	12 (9.4)	24 (14.0)	19 (11.2)
Totals	**41 (100)**	**39 (100)**	**131 (100)**	**128 (100)**	**172 (100)**	**167 (100)**
Averages	**72%**	**70%**	**62%**	**64%**	**64%**	**65%**

Notes : SC is an abbreviation for sub-centre

Achieved targets calculated as % of allocated targets for 1989-90

Column (1) presents information about the completion of sterilisation targets

Column (2) presents information about the completion of Copper-T targets

Missing responses or non respondents have been excluded

TABLE 19

ANMS' ROLE IN CONDUCTING DELIVERIES

No.	Categories of Information	REFERENCES/COMPUTATIONS	
1	Estimated Annual Live Birth Rate in Rural Maharashtra (1989)	SRS (1991)	30.6
2	Average population per sub-centre	Sample Data	3,723
3	Expected number of births in the sub-centres	(1) X (2) / 1000	113.9
4	Average Number of births conducted by ANMs in sub-centres	Sample Data	14.9
5	Percent share of deliveries conducted by ANMs in the sub-centres	(4) X 100 / (3)	13.0
6	Average population per PHC village	Sample Data	5,407
7	Expected number of births in PHC villages	(1) X (6) / 1000	165.5
8	Average No. of births conducted by ANMs in PHC villages	Sample Data	31.1
9	Percent share of deliveries conducted by ANMs in PHC villages	(8) X 100 / (7)	18.8
10	Average population per PHC	Sample Data	28,158
11	Expected number of births in the population covered by PHCs	(1) X (10) / 1000	861.6
12	Average No. of births conducted by all ANMs	Sample Data	125.4
13	Percent share of deliveries conducted by all ANMs	(12) X 100 / (11)	14.6

TABLE 20
EXISTENCE AND NATURE OF THE SUB-CENTRE

Existence & Nature of the sub-centre	FREQUENCY
Rented room/other government premises	65 (46.4)
Specially constructed building	33 (23.6)
No sub-centre space at all	22 (15.7)
No separate building run from ANM's house	20 (14.3)
Totals	**140 (100)**

Figures in parenthesis are percentages over the column total

TABLE 21
ESSENTIAL FURNITURE AND EQUIPMENT
AT SUB-CENTRES

Essential items of furniture with ANMs		Basic equipment with ANMs	
Chair/stools	63 (45.0)	Stove	110 (78.6)
Table	55 (39.3)	Fetoscope	89 (63.6)
Cupboard	45 (32.1)	Weighing Machine	89 (63.6)
Delivery/Examination Table	43 (30.7)	Autoclave	49 (35.0)
Bench	41 (29.3)	Stethoscope	30 (21.4)
		Blood Pressure Instrument	23 (16.4)
All sub-centre ANMs	**140**	**All sub-centre ANMs**	**140**

Figures in parenthesis are percentages over the total number of sub-centre ANMs

TABLE 22
PRIMARY HEALTH INFRASTRUCTURE IN MAHARASHTRA
HEALTH CENTRES AND THEIR COVERAGE

	Primary Health Centres		Sub-Centres	
Year	Number	Percent of PHCs built & run from Panchayat/ Govt. Bldgs	Number	Percent of SCs built & run from Panchayat/ Govt. Bldgs.
1980	441	NA	3775	NA
1981	454	NA	4041	NA
1982	476	NA	5041	NA
1983	1539	NA	5741@	NA
1984	1343	NA	6391	NA
1985	1343	NA	7711	NA
1986	1343	NA	8911	NA
1987	1539	42.0$	9238	19.8$
1988	1539	51.9	9238	23.5
1989	1646	93.3	9248	29.0
1990	1768	94.1	9364	47.6
1991	1650	99.8	9364	47.6
1992	1670	100.0	9377	47.6
1993$$	1683	99.6	9377	47.6

Sources :'Health Information of India', CBHI, Govt. of India, respective years
'Rural Health Statistics Bulletin', DGHS, Govt. of India, respective years
'Family Planning Year Book', Ministry of Health and Family Welfare, Govt. of India, respective years

Notes : @ - information from 'Health Information of India' based on discussions with state representatives (27.7.87); $ information as on 30.9.87; $$ information as on 30.9.93. **NA** information not available.
SC is an abbreviation for sub-centre.

TABLE 25

EFFECTS OF THE REMOVAL OF TARGETS ON HEALTH WORK

Effects of target removal on health work	PHC posting		SC posting	All ANMs
Other health activities will suffer	19 (46.3)	with	60 (42.9)	79 (43.6)
ANMs will suffer from a lack of direction/satisfaction	10 (24.4)		45 (32.1)	55 (30.4)
There will be no substantial difference	6 (14.6)		35 (25.0)	41 (22.7)
Quality of F.P work will improve (no fake cases)	12 (29.3)		26 (18.6)	38 (21.0)
Harassment, tension, expenses will go	9 (22.0)		27 (19.3)	36 (19.9)
Other health activities will improve	5 (12.2)		26 (18.6)	31 (17.1)
F.P work will suffer/population will increase	5 (12.2)		27 (19.3)	32 (17.7)
Relationship with community will improve	4 (9.8)		14 (10.0)	18 (9.9)
Relationship with colleagues will improve	1 (2.4)		2 (1.4)	3 (1.7)
Not applicable / No response	2 (4.9)		7 (5.0)	9 (5.0)
Total Number of ANMs	**41**		**140**	**181**

SC is an abbreviation for sub-centre.

Figures in parenthesis are percentages over the total number of ANMs, not over the total number of response.

Grand total excludes ANMs on training.

TABLE 23

LOCATION OF RESIDENCE VIS-A-VIS POSTING

Posting	ANM 'S Residence: Where posted	PHC Village	Elsewhere	Totals
SC ANMs	83 (59.2)	11 (7.9)	46 (32.9)	140 (100)
PHC ANMs	35 (85.4)*	----	6 (14.6)	41 (100)
NA/On training	1 (50.0)	1 (50.0)	----	2 (100)
TOTALS	**119 (65.0)**	**12 (6.6)**	**52 (28.4)**	**183 (100)**

SC is an abbreviation for sub-centre.

Figures in parenthesis are percentages over row totals

* Significant value at 95% level of confidence

TABLE 24

NATURE AND LOCATION OF THE ANMS' RESIDENCE

Accomodation	ANM 'S Residence: Where posted	PHC village	Elsewhere	Totals
Sub-centre ANMs				
Government Quarters	19 (22.9)	3 (27.3)	2 (4.3)	24 (17.1)
No Government Quarters	64 (77.1)	8 (72.7)	44 (95.7)	116 (82.9)
SUB-TOTAL	83 (100)	11 (100)	46 (100)	140 (100)
PHC ANMs				
Government Quarters	24 (68.6)	---	---	24 (58.5)
No Government Quarters	11 (31.4)	---	6 (100)	17 (41.5)
SUB-TOTAL	35 (100)	---	6 (100)	41 (100)
All ANMs *(excluding ANMs on training)*				
Government Quarters	43 (36.4)	3 (27.3)	2 (3.8)	48 (26.5)
No Government Quarters	75 (63.6)	8 (72.7)	50 (96.2)	133 (73.5)
TOTAL	**118 (100)**	**11 (100)**	**52 (100)**	**181 (100)**

Figures in parenthesis are percentages over (sub) totals

TABLE 26
NATURE OF THE EFFECT OF TARGET REMOVAL

Effect of target removal	PHC posting	SC posting	All ANMs
Positive Effect	14 (34.1)	46 (32.9)	60 (32.8)
Negative Effect	12 (29.3)	47 (33.6)	59 (32.2)
Positive & Negative	3 (7.3)	9 (6.4)	12 (6.6)
No Effect	10 (24.4)	26 (18.6)	36 (19.9)
Cannot Say	---	4 (2.9)	4 (2.2)
Others	---	1 (0.7)	1 (0.5)
NA / Targets not given	1 (2.4)	3 (2.1)	4 (2.2)
No Response	1 (2.1)	4 (2.9)	5 (2.7)
Total Number of ANMs	**41 (100)**	**140 (100)**	**181 (100)**

SC is an abbreviation for sub-centre.
Figures in parenthesis are percentages over column totals
Grand total excludes ANMs on training

TABLE 27
STRATEGIES EMPLOYED TO MOTIVATE WOMEN TO USE FAMILY PLANNING METHODS

Motivational Strategies	PHC posting	SC Posting	All ANMs
Building credibility through other tangible health services	26 (63.4)	90 (64.3)	116 (64.1)
Promoting the ideal of a small family for nation's devt.	19 (46.3)	76 (54.3)	95 (52.5)
Advising women to have few children to protect their health	15 (36.6)	55 (39.3)	70 (38.7)
Building rapport/explaining things in identifiable terms	17 (41.5)	47 (33.6)	64 (35.4)
Providing monetary and other material incentives	3 (7.3)	26 (18.6)	29 (16.0)
Promoting the ideal of gender equality	2 (4.9)	12 (8.6)	14 (7.7)
Excluding men and targetting only women for motivation	2 (4.9)	7 (5.0)	9 (5.0)
Other methods	1 (2.4)	1 (0.7)	2 (1.1)
Motivation not required	2 (4.9)	---	2 (1.1)
Not stated	3 (7.3)	---	3 (1.7)
Total Number of ANMs	**41**	**140**	**181**

SC is an abbreviation of Sub-Centre.
Figures in parenthesis are percentages over the total number of ANMs, not the total number of responses
Grand total excludes ANMs on training

TABLE 28
MATERIAL INCENTIVES FOR MOTIVATION

Incentives given	PHC posting	SC posting	All ANMs
Meals/snacks for patient & relative during	13 (61.9)	49 (66.2)	62 (65.3)
Medicines/tonics/injections before/during/after	12 (57.1)	42 (56.8)	54 (56.8)
Augmentation of incentive fee	6 (28.6)	29 (39.2)	35 (36.8)
Reimbursment of travelling expenses	7 (33.3)	22 (29.7)	29 (30.5)
Other incentives	2 (9.5)	5 (6.8)	7 (7.4)
Sub-total	**21**	**74**	**95**

SC is an abbreviation for sub-centre.
Figures in parenthesis indicate percentages over total ANMs in each category not over total number of responses.

TABLE 29
PROBLEMS AT WORK BEING FACE CURRENTLY

Source and nature of problems	No. of problems	No of ANMs
Working Conditions	**212**	**139 (76.0)**
Inadequate Facilities/Equipment		
Over burdened with work		
No proper accommodation		
No proper transport		
Non/Under-utilisation of her services		
Population coverage too large		
Colleagues	**69**	**61 (33.3)**
No attendent		
Too many vacancies/understaffed		
Troublesome male staff		
Family Planning Programme	**68**	**59 (32.2)**
Difficult family planning motivation		
Pressured by the MO/DHO		
Competition between workers		
No cooperation from MO		
Superiors	**61**	**51 (29.9)**
Non sanctioned TA/DA/Leave		
Harassment by the MO		
Harassment by other supervisors		
Community	**41**	**33 (18.0)**
Low status/no respect		
No security by health department		
Expectations of help at PHC not met		
Bossy village leaders		
Harassment by men		
Personal Reasons	**22**	**19 (10.4)**
Adverse effect on children's education		
Difficult managing work at home & outside		
Poor health		

Figures in parenthesis are percentages over the total number of ANMs (ie.183)

TABLE 30
PARTICIPATION IN WAGE LABOUR

	Participation in Wage Labour			
	Yes	No	NR	Totals
Gap between School & Training				
Less than 1 year	8 (22.9)	27 (77.1)	----	35
Less than 5 years	52 (38.0)	83 (60.6)	2 (1.4)	137
Less than 10 years	74 (43.8)	91 (53.8)	4 (2.4)	165
Less than 15 years	84 (45.9)	94 (51.4)	5 (2.7)	183
Marital Status at Training				
Unmarried	51 (40.5)	74 (58.7)	1 (0.8)	126
Married	26 (57.8)	16 (35.6)	3 (6.6)	45
Separated/Deserted/Divorced	6 (54.6)	4 (36.4)	1 (10.0)	11
Widowed	1 (100)	----	----	1
Totals	**84 (45.9)**	**94 (51.4)**	**5 (2.7)**	**183**

Figures in parenthesis indicate percentages calculated over row totals

TABLE 31
NATURE OF WORK DONE IMMEDIATELY BEFORE RECRUITMENT

Occupation Immedeately before training	Frequency	Average Duration	Average Income$
Wage Employment			
Work in an Anganwadi/balwadi	20 (23.8)	2 years	120.75
Agricultural Work	17 (20.2)	2 yrs,10 mths	83.60
Self Employment	15 (17.9)	3 yrs,1 mth	159.40
Para Professional Health Work	9 (10.7)	1 year	315.00
Clerical Work	8 (9.5)	1 yr, 9 mths	296.50
Industrial Work	6 (7.1)	1 yr, 6 mths	215.00
Others	9 (10.7)	2 yrs,5 mths	144.40
Sub total	**84 (100)**	**2 yrs,3 mths**	**166.85**
Non Wage Employment			
Studies (& housework)	50 (53.2)	N.A.	N.A.
Housework	44 (46.8)	N.A.	N.A.
Sub total	**94 (100)**	N.A.	N.A.

$ Refers to Average Monthly Income in Rupees

Figures in parenthesis indicate percentages calculated over sub-totals

TABLE 32

REASONS FOR NOT STUDYING BEYOND STD 10

Reasons for not studying further	Whether ANMs wished to study further: Yes	No	All ANMs
Socio-economic problems in the household	82 (53.6)	7 (23.3)	89 (48.6)
Social conventions and problems	44 (28.8)	7 (23.3)	51 (27.9)
Desire for independence to support the family	28 (18.3)	5 (16.7)	33 (18.0)
Desire to be self sufficient/independent	15 (9.8)	8 (26.7)	23 (12.6)
Higher education being inaccessible	23 (15.0)	4 (13.3)	27 (14.8)
Preference for nursing	6 (3.9)	7 (23.3)	13 (7.1)
Other reasons	21 (13.7)	6 (20.0)	27 (14.8)
No Response	2 (1.3)	---	2 (1.1)
Total	**153**	**30**	**183**

Figures in parenthesis indicate percentages calculated over total number of ANMs in each category

TABLE 33

NATURE OF JOB OPTIONS PERCEIVED

Type of options	Tried	Untried	All ANMs
Teaching	55 (50.0)	55 (50.0)	110 (100) [70.5]
Clerical Work	35 (53.0)	31 (47.0)	66 (100) [42.3]
Self Employment	26 (47.3)	29 (52.7)	55 (100) [35.3]
Health Work	10 (62.5)	6 (37.5)	16 (100) [10.3]
Agricultural Labour	5 (45.5)	6 (54.5)	11 (100) [7.1]
Anganwadi/balwadi	3 (37.5)	5 (62.5)	8 (100) [5.2]
Industrial Work	1 (25.0)	3 (75.0)	4 (100) [2.6]
Others	5 (55.6)	4 (44.4)	9 (100) [5.8]
Number of Options	**140**	**139**	**279**

Percentages in ( ) are calculated over 156, the number of ANMs perceiving options

TABLE 34

REASONS FOR JOINING THE SERVICES

Reasons for joining	Unmarried	Married	S/D/D/W*	All ANMs
Financial dire straits in the family	62 (49.2)	25 (55.6)	5 (41.6)	92 (50.3)
Desire to be self-sufficient/ independent	42 (33.3)	17 (37.8)	7 (58.5)	67 (36.1)
Desire to do social work/preference for nursing	42 (33.3)	16 (35.6)	1 (8.3)	59 (32.2)
Guarantee of job after free training	34 (27.0)	8 (17.8)	2 (16.7)	44 (24.0)
Desire to put a Std.10 education to some use	12 (9.5)	11 (24.4)	2 (16.7)	25 (13.7)
Unremunerative and inviable previous job	11 (8.7)	4 (8.9)	3 (25.0)	18 (9.8)
Knowledge would be personally beneficial	11 (8.7)	1 (2.2)	---	12 (6.6)
For other reasons	4 (3.2)	1 (2.2)	1 (8.3)	6 (3.3)
No Response	2 (1.6)	1 (2.2)	---	3 (1.6)
Totals	**126**	**45**	**12**	**183**

* S/D/D/W is an abbreviation for Separated/Deserted/Divorced/Widowed. Percentages in parenthesis are over total number of ANMs under each category

TABLE 35

OBSERVATION OR EXPECTATION OF JOB RESPONSIBILITIES BEFORE TRAINING

Nature of Health work	Obse-rvation	Expectation	Observation Or Expectation	Neither
Curative Work	52.5	10.4	51.9	37.2
Working without supervision	32.8	9.8	62.8	57.4
Hospital based activities	39.3	12.6	41.0	48.1
Conducting Immunisation/MCH	35.5	5.5	33.3	59.0
Wearing a uniform/Doing Seva	30.6	10.4	29.0	59.0
Conducting Deliveries	24.0	9.3	23.0	66.7
Doing Family Planning Work	21.9	7.1	52.5	71.0
Record Keeping	18.0	4.9	41.0	77.1

Figures indicate percentages over 183 against each category of work.

TABLE 36

VALUATION OF WORK VERSUS OPPOSITION

	Opposition	No opposition	Totals
Value Awarded to Work			
Work Valued	30 (29.1)	73 (70.9)	103 (100)
Work Not Valued	33 (49.3)	34 (50.3)	67 (100)
Valued & Not valued	2 (66.7)	1 (33.3)	3 (100)
Don't Know	4 (44.4)	5 (55.6)	9 (100)

Phi coefficient = +0.2, statistically insignificant

TABLE 37

CONTROL OVER DECISION MAKING VERSUS OPPOSITION

Decision Makers	Opposition	No Opposition	Total
Decision taken by Self	39 (39.4)	60 (60.6)	99 (100)
Influenced by Family Members	16 (39.0)	25 (61.0)	41 (100)
Influenced by Non-Family Members in Medical Profession	5 (45.5)	6 (54.5)	11 (100)
Influenced by Family Members in Medical Profession	3 (42.9)	4 (57.1)	7 (100)
Influenced by Non-Family Members	1 (25.0)	3 (75.0)	4 (100)
Influenced by Other People	----	1 (100)	1 (100)
Decision taken by family	5 (25.0)	15 (75.0)	20 (100)
Total	**69**	**114**	**183 (100)**

Figures in parenthesis refer to percentages calculated over row totals.

TABLE 38
REASONS FOR OPPOSING DECISION TO JOIN THE SERVICES

Reasons for Opposition	Unmarried	Married	S/D/D/W*	All ANMs
Women should not work outside the home	22 (48.9)	11 (55.0)	1 (25.0)	34 (49.3)
Objectionable job. So inappropriate to take up	19 (42.2)	4 (20.0)	2 (50.0)	25 (36.2)
Work will lead to neglect/ separation of family	1 (2.2)	11 (55.0)	---	12 (17.4)
Concern about ability to cope on ones own	5 (11.1)	---	---	5 (7.3)
Further studies preferrable before deciding	3 (6.7)	---	---	3 (4.4)
Other reasons	7 (15.6)	---	---	7 (10.1)
No response	---	---	1 (25.0)	1 (1.5)
Totals	**45**	**20**	**4**	**69**

S/D/D/W is an abbreviation for Separated/Deserted/Divorced/Widowed
Percentages in parenthesis are over the total number of ANMs in each category.

TABLE 39
MARITAL STATUS AT TRAINING AND AT PRESENT

Marital Status	At training	At present
Unmarried	126 (68.9)*	38 (20.8)
Married	45 (24.6)	127 (69.4)*
Separated/deserted/divorced	11 (6.0)	15 (8.2)
Widowed	1 (0.5)	3 (1.6)
All ANMs	**183 (100)**	**183 (100)**

Figures in parenthesis are percentages over 183
* Significant difference at 95% level of confidence

TABLE 40
AGE AT MARRIAGE BY MARITAL STATUS AT PRESENT

Age at Marriage	Married	S/D/D	Wlidowed	All ANMs
Below 18 years	25 (19.8)	8 (53.3)	1 (33.3)	34 (23.6)
18 to 20 years	30 (23.8)	4 (26.7)	1 (33.3)	35 (24.3)
21 to 25 years	52 (41.3)	2 (13.3)	1 (33.3)	55 (38.2)
Above 25 years	19 (15.1)	1 (6.7)	---	20 (13.9)
Totals	**126 (100)**	**15 (100)**	**3 (100)**	**144 (100)**
Average Age	21.2	17.9	19	20.8

S/D/D is an abbreviation for separated/deserted/divorced
Total excludes one currently married non-respondent

TABLE 41
MARRIAGE VIS-A-VIS TRAINING

	Marriage before training		Marriage after training	
	Frequency	Av.Duration	Frequency	Av.Duration
Less than 5 years	22 (38.6)	3.5	70 (79.5)	3.3
6 to 10 years	21 (36.8)	8.3	13 (14.8)	6.6
More than 10 years	14 (24.6)	13.4	5 (5.7)	15.0
Total	**57 (100)**	**7.7**	**88 (100)**	**4.3**

TABLE 42
TYPE OF MARRIAGE

Type of Marriage	ANMs Married Before Training	ANMs Married After Training	All ANMS
Self Arranged	1 (1.8)	23 (26.1)*	24 (16.6)
Arranged	56 (98.2)	65 (73.9)	121 (83.4)
All married ANMs	**57 (100)**	**88 (100)**	145 (100)
Inter-community/religious marriage	2 (3.5)	13 (17.3)*	15 (10.3)
Marriage within the same community	55 (96.5)	75 (82.7)	130 (89.7)
All married ANMs	**57 (100)**	**88 (100)**	145 (100)

Figures in parenthesis are percentages over 57 and 88

* Significant difference at 95% level of confidence

TABLE 43
COMMUNITY PROFILE OF HUSBANDS

Community Profile Of husbands at marriage	ANMs Married Before training	ANMs Married After training	Totals
Brahmins/Marathas/ Rajputs/Lingayats	16 (28.1)	32 (36.4)	48 (33.1)
Kunbis/Other Marathas/OBCs	29 (50.9)	27 (30.7)	56 (38.6)
Scheduled Castes & Tribes	10 (17.5)	21 (23.9)	31 (21.4)
Christians/Muslims	2 (3.5)	8 (9.1)	10 (6.9)
All married ANMs	**57 (100)**	**88 (100)**	**145 (100)**

Figures in parenthesis are percentages over 57 and 88

TABLE 44
EDUCATIONAL QUALIFICATIONS OF HUSBANDS

Educational Qualifications at marriage	ANMs married Before training	ANMs Married After Training	Totals
No schooling	1 (1.8)	---	1 (0.7)
Pre-matriculation	18 (31.5)*	12 (13.6)	30 (20.7)
Matriculation	20 (35.1)	23 (26.1)	43 (29.7)
Post-matriculation	17 (29.8)	53 (60.2)*	70 (48.2)
No Response	1 (1.8)	---	1 (0.7)
Totals	**57 (100)**	**88 (100)**	**145 (100)**
Husbands with no education	1 (1.7)	---	1 (0.7)
Husbands with less education	16 (28.1)	14 (15.9)	30 (20.7)
Husbands with equal education	22 (38.6)	18 (20.5)	40 (27.6)
Husbands with more education	17 (29.8)	56 (63.6)*	73 (50.3)
No Response	1	---	1 (0.7)
Totals	**57 (100)**	**88 (100)**	**145 (100)**

Figures in parenthesis indicate percentages over 57 and 88

* Significant difference at 95% level of confidence

TABLE 45

OCCUPATIONAL PROFILE OF HUSBANDS

	ANMs Married Before Training	ANMs Married After Training	Totals
Occupational Profiles at Marriage			
School teacher, white collared work	17 (29.8)	28 (31.8)	45 (31.0)
Workers - organised/ unorganised sector	15 (26.3)	23 (26.1)	38 (26.2)
Artisan, petty trader, self employed	10 (17.5)	12 (13.6)	22 (15.2)
Non worker, retired	6 (10.5)	9 (10.2)	15 (10.3)
Cultivator, agricultural labourer	6 (10.5)	9 (10.2)	15 (10.3)
Supervisors, managers, professionals	1 (1.8)	7 (8.0)*	8 (5.5)
No Response	2	---	2 (1.4)
Totals	**57 (100)**	**88 (100)**	**145 (100)**

Figures in parenthesis indicate percentages calculated over 57 and 88

* Significant difference at 95% level of confidence

TABLE 46

ECONOMIC ROLE OF ALL ANMS EVER MARRIED VIS-A-VIS HUSBAND AT PRESENT

		Frequency
ANMs as Sole Earners -	Non earning husband	14 (9.7)
	Absent husband (for S/D/D/W ANMs)	18 (12.4)
ANMs as one of two Earners -	ANM earning more than husband	46 (31.7)
	ANM earning as much as husband	10 (6.9)
	ANM earning less than husband	37 (25.5)
Not Applicable -	No knowledge about husband's income/ Cash income not earned	20 (13.8)
All ever married ANMs		**145 (100)**

S/D/D/W is an abbreviation for separated/ deserted/ divorced

TABLE 47

INCOMES EARNED BY ANMS CURRENTLY MARRIED AND THEIR HUSBAND - COMPARATIVE PROFILE

Differentials	**ANMS earning more**	**ANMS earning less**
Less than 25%	11 (23.9)	12 (32.2)
25% to 50%	9 (19.6)	13 (35.1)
50% to 75%	4 (8.7)	5 (13.5)
75% to 100%	3 (6.5)	3 (8.1)
100% to 200%	7 (15.2)	3 (8.1)
More than 200%	12 (26.1)	1 (2.7)
Total	**46 (100)**	**37 (100)**
Average Differential	182.6%	49.2%

Total excludes husbands who do not earn

TABLE 48

ECONOMIC ROLE OF UNMARRIED ANMs VIS-A-VIS FATHER/BROTHER AT PRESENT

		Frequency
ANMs as Sole Earners -	Non earning/dead father (and no other male earner)	3 (7.9)
ANMs as one of two Earners	-ANM earning more than father/brother	14 (36.8)
	ANM earning as much as father/brother	1 (2.6)
	ANM earning less than father/brother	6 (15.8)
Not Applicable -	No knowledge about father's/brother's income/ Cash income not earned/female earner(s)	14 (36.8)
All unmarried ANMs		**38 (100)**

Brother's income considered if father dead

TABLE 49

INCOMES EARNED BY UNMARRIED ANMS AND FATHER/BROTHER - COMPARATIVE PROFILE

Differentials	**ANMS earning more**	**ANMS earning less**
Less than 25%	1 (7.1)	1 (16.7)
25% to 50%	1 (7.1)	1 (16.7)
50% to 75%	2 (14.3)	---
75% to 100%	2 (14.3)	2 (33.2)
100% to 200%	4 (28.6)	1 (16.7)
More than 200%	4 (28.6)	1 (16.7)
Total	**14 (100)**	**6 (100)**
Average Differential	158.1%	102.9%

Excludes fathers who do not earn

TABLE 50

ANMS MAKING REMITTANCES

	Material Status of ANMs			
	Unmarried	Married	S/D/D/W	All ANMs
ANMs sending money	16 (42.1)	49 (38.5)	6 (33.3)	71 (38.8)
ANMs not sending money	22 (57.9)	78 (61.5)	12 (67.7)	112 (61.2)
Totals	**38 (100)**	**127 (100)**	**18 (100)**	**183 (100)**

S/D/D/W is an abbriviation for separated/ deserted/ divorced/ widowed

Figures in parenthesis are percentages over column totals

TABLE 51

PERSONS TO WHOM REMITTANCES ARE SENT

	Material Status of ANMS			
Recipients	Unmarried	Married	S/D/D/W	All ANMs
Parents	13 (81.3)	12 (24.5)	3 (50.0)	28 (39.4)
Brothers/Sisters	2 (12.5)	3 (6.1)	1 (16.7)	6 (8.5)
Parents-in-law	---	21 (42.9)	---	21 (29.6)
Husband &/or children	---	11 (22.4)	2 (33.3)	13 (18.3)
Brother/Sisters-in-law	---	1 (2.0)	---	1 (1.4)
Others	1 (6.3)	1 (2.0)	---	2 (2.8)
All ANMs sending money	**16 (100)**	**49 (100)**	**6 (100)**	**71 (100)**

S/D/D/W is an abbriviation for separated/ deserted/ divorced/ widowed

Figures in parenthesis are percentages over column totals

TABLE 52
AMOUNT BORROWED AND REPAID (EVERY MONTH)

Amount Borrowed	Frequency	Amount Repaid	Frequency
Upto Rs.5000	11 (17.5)	Upto Rs.500	31 (49.2)
Rs.5001 to Rs.10,000	27 (42.9)	Rs.501 to Rs.1000	25 (39.7)
Rs.10,000 to Rs.20,000	21 (33.3)	Rs.1001 to Rs.2000	3 (4.8)
Rs 20,001 and above	2 (3.2)	Over Rs.2000	2 (3.2)
No Response	2 (3.2)	No Response	2 (3.2)
Total	**61 (100)**	**Total**	**61 (100)**
Average (Mean)	12230		529

Figures in parenthesis are percentages over column totals

TABLE 53
PROPORTION OF SALARY SPENT EVERY MONTH AS REMITTANCES OR LOAN REPAYMENT

Proportion of salary sent	Loan Repayment	Remittances	Repayment &/ Or Remittances
Less than 25%	24 (38.1)	36 (50.7)	42 (35.0)
25 to 50%	32 (50.8)	31 (43.7)	63 (52.5)
50 to 75%	1 (1.6)	4 (5.6)	7 (5.8)
75 to 100%	2 (3.2)	---	4 (3.3)
No Response	4 (6.3)	---	4 (3.3)
Total	**59 (100)**	**71 (100)**	**116 (100)**
Averages - Mean (±SD)	28.1% (±87.7)	27.1% (±16.3)	30.7% (±30.7)
Median	27.0%	25.0%	29.1%

Figures in parenthesis are percentages over column totals

TABLE 54
PEOPLE RESIDING WITH ANMS

Other Residents	Unmarried	Married	S/D/D/W	All ANMs
None - Lives alone	19 (50.0)	22 (17.3)	7 (38.9)	48 (26.2)
Friend or colleague	3 (7.9)	7 (5.5)	1 (5.6)	11 (6.0)
Husband and/or children	---	51 (40.2)	6 (33.3)	57 (31.2)
Husband, children & relatives	---	38 (29.9)	---	38 (20.8)
Parents & relatives	16 (42.1)	9 (7.1)	4 (22.2)	29 (15.8)
Totals	**38 (100)**	**127 (100)**	**18 (100)**	**183 (100)**

S/D/D/W is an abbriviation for separated/ deserted/ divorced/ widowed
Figures in parenthesis are percentages over column totals

TABLE 55
ANMS RESIDENCE VIS-A-VIS HUSBAND'S RESIDENCE

ANM's Residence	With husband	Without Husband	All married ANMs
Stays where posted	44 (55.0)	36 (45.0)	80 (100)
PHC or nearby village	15 (60.0)	10 (40.0)	25 (100)
Nearby town outside PHC area	14 (66.7)	7 (33.3)	21 (100)
No Response	---	1 (100)	1 (100)
Total	**73 (57.5)**	**54 (42.5)**	**127 (100)**

Figures in parenthesis are percentages over column totals

TABLE 56

HUSBAND'S RESIDENCE BY OCCUPATION

Husband's Occupation	Stays with ANMs	Stays Away	Total
Cultivator, agricultural labourer	8 (72.7)	3 (27.3)	11 (100)
Non-worker, retired	10 (71.4)	4 (28.6)	14 (100)
School teacher, white collared work	26 (60.5)	17 (39.5)	43 (100)
Artisan, petty trader, self employed	12 (57.1)	9 (42.9)	21 (100)
Supervisors, managers, professionals	4 (50.0)	4 (50.0)	8 (100)
Workers - organised/ unorganised sector	13 (44.8)	16 (55.2)	29 (100)
Total	**73 (57.9)**	**53 (42.1)**	**126 (100)**

Figures in parenthesis are percentages over column totals

TABLE 57

MARRIAGE AND CHILDREN

Years of Marriage	Number of Living Children: None	One	Two	Three +	All ANMs With Children
Currently Married					
Less than 5 years	18	28	9	---	55
5 to 10 years	3	7	11	5	26
More than 10 years	---	6	14	26	46
Sub total	**21 (16.5)**	**41 (32.3)**	**34 (26.8)**	**31 (24.4)**	**127**
S/D/D/W					
Less than 5 years	2	---	---	---	2
5 to 10 years	1	---	---	---	1
More than 10 years	3	5	3	4	15
Subtotal	**6 (33.3)**	**5 (27.8)**	**3 (16.7)**	**4 (22.2)**	**18**
GRAND TOTAL	**27 (18.6)**	**46 (31.7)**	**37 (25.5)**	**35(24.1)**	**145 (100)**

Figures in parenthesis are percentages over row totals

S/D/D/W is an abbriviation for separated/ deserted/ divorced/ widowed

TABLE 58

CONTRACEPTIVES USED

Contraceptive Method	Number of Living Children: None	One	Two	Three +	All ANMs with Children
None	10 (62.5)	14 (43.8)	8 (25.0)	2 (7.1)	34 (31.5)
Sterilisation	---	2 (6.3)	9 (28.1)	22 (78.6)	33 (30.6)
Copper-T	---	10 (31.3)	11(34.4)	2 (7.1)	23 (21.3)
Condoms	5 (31.3)	4 (12.5)	2 (6.3)	---	11 (10.2)
Oral Pills	---	1 (3.1)	2 (6.3)	1 (3.6)	4 (3.7)
Rhythm Method	1 (6.2)	1 (3.1)	---	1 (3.6)	3 (2.8)
Currently Pregnant	4	7	1	2	14
Total	**16 (100)**	**32 (100)**	**32 (100)**	**28 (100)**	**108 (100)**

Figures in parenthesis are percentages over column totals

Totals exclude currently pregnant ANMs

TABLE 59

REASONS FOR WANTING OR (NOT WANTING) TRANSFERS

Reasons for/against Transfers	Whether ANMs want transfers: Yes	No	All ANMs
Managing work with family responsibilities	51 (58.6)	49 (55.1)	100
Due to working conditions and facilities being what they are	27 (31.0)	20 (22.5)	47
People's cooperation and reaction to her work	6 (6.9)	23 (25.8)	29
Personal reasons : health, children's education, etc.	16 (18.4)	12 (13.5)	28
Conditions influencing completion of targets	5 (5.8)	2 (2.3)	7
Timing : temporary/new posting, no experience, impending deputation	2 (2.3)	3 (3.4)	5
Other reasons	3 (3.5)	8 (9.0)	11
No response	---	3 (3.4)	3
Total Number of ANMs	**87**	**89**	**176**

Percentages in parenthesis are over the total number of ANMs (ie.87 & 89), not over total number of responses

TABLE 60
WORK IMAGE AT RECRUITMENT VERSUS SATISFACTION

SATISFACTION	ACCURACY OF WORK IMAGE: Below Average	Above Average	TOTALS
Satisfied	77 (67.5)	56 (81.2)	133 (72.7)
Dissatisfied	32 (28.1)	12 (17.4)	44 (24.0)
Cannot Say/NR	5 (4.4)	1 (1.5)	6 (3.3)
Total	**114 (100)**	**69 (100)**	**183 (100)**

Below average knowledge of work = (6-10); Above average knowledge of work = (10-18)
Phi Correlation Coefficient = 0.13, Statistically significant at 95% level of confidence

TABLE 61
SATISFACTION AND CHANGE

	Satisfied	Dissatisfied	Cannot Say
Recommending the Job to others			
Yes	83 (62.4)	10 (22.7)	3 (50.0)
No	49 (36.8)	34 (77.3)	3 (50.0)
Cannot Say	1 (0.8)	---	---
Total	**133 (100)**	**44 (100)**	**6 (100)**
Phi Correlation Coefficient = 0.35, statistically insignificant			
Contemplating a Job Switch			
Yes	31 (23.3)	23 (52.3)	2 (33.3)
No	102 (76.7)	21 (47.7)	1 (16.7)
Cannot Say	---	---	1 (16.7)
Total	**133 (100)**	**44 (100)**	**6 (100)**
Phi Correlation Coefficient = 0.27, statistically insignificant			

Figures in parenthesis indicate percentages over 133 or 44

TABLE 62
STATED REASONS FOR SATISFACTION

Reasons for Satisfaction	**Frequency**
Ability to serve people & contribute to overall development	49 (36.8)
Satisfaction comes with the ability to do work successfully	48 (36.1)
People trust/respect/cooperate with her. Enhanced social status	25 (18.8)
Liking for the work. Her choice of occupation	24 (18.1)
Gets economic benefits/independence and support from the family	22 (16.5)
Ability to use education/training to conduct deliveries/treat people	20 (15.0)
Settled down to the job/routine. Spent many years in service	16 (12.0)
Other reasons	9 (6.8)
Number of ANMs who are satisfied	**133**

Percentages in parenthesis are over the total number of ANMs (ie.133) and not over the total number of responses

TABLE 63
STATED REASONS FOR DISSATISFACTION

Reasons for Dissatisfaction	**Frequency**
Problems with family planning targets	20 (45.5)
Negative attitudes and harassment by community	18 (40.9)
Over work/tiring work, too much travelling	14 (31.8)
Negative attitude of superiors. Harassment by them	13 (29.5)
No promotion/work too monotonous/repeated transfers	7 (15.9)
Inadequate facilities at sub-centre/residence	6 (13.6)
Feeling inadequate due to nature of training	6 (13.6)
Conflicts between family responsibilities and work demands	5 (11.5)
Inability to meet people's health demands	2 (4.5)
Other reasons	6 (13.6)
Number of ANMs who are dissatisfied	**44**

Percentages in parenthesis are over the total number of dissatisfied ANMs (ie.44) and not over the total number of responses

TABLE 64

REASONS FOR RECOMMENDING THE JOB

Stated Reasons	Whether Satisfied		
	Satisfied	Dissatisfied	All ANMs
Ability to do Social Service	41 (49.4)	3 (30.0)	45 (46.9)
Job has economic benefits	29 (34.9)	6 (60.0)	36 (37.5)
Job is easily accessible	15 (18.1)	3 (30.0)	20 (20.8)
Job gets you respect and appreciation	12 (14.5)	---	13 (13.5)
Job allows flexibility of timings	6 (7.2)	---	6 (6.3)
Ability to take care of people's health	3 (3.6)	1 (10.0)	4 (4.2)
Other reasons	11 (13.3)	1 (10.0)	13 (13.5)
No response	1 (1.2)	---	1 (1.0)
Total Number of ANMs	**83**	**10**	**96**

Percentages in parenthesis are over the total number of ANMs willing to recommend the job (ie.96) and not over the total number of responses

Totals include the responses of ANMs who have not clearly mentioned whether they are satisfied or not

TABLE 65

REASONS FOR NOT RECOMMENDING THE JOB

Stated Reasons	Whether Satisfied		
	Satisfied	Dissatisfied	All ANMs
Other jobs are better- eg.engineer, doctor, teacher	22 (44.9)	15 (44.1)	38 (44.2)
Conditions of work are difficult	15 (30.6)	19 (55.9)	36 (41.9)
No safety while working / risky work	13 (26.5)	7 (20.6)	20 (23.3)
ANMs have a negative social image	7 (14.3)	6 (17.7)	14 (16.3)
Family Planning targets create problems	5 (10.2)	4 (11.8)	9 (10.5)
Recommendation only as a last resort	2 (4.1)	1 (2.9)	3 (3.5)
Training is inadequate / no use of abilities	---	2 (5.9)	2 (2.3)
Other reasons	---	1 (2.9)	1 (1.2)
No response	---	1 (2.9)	1 (1.2)
Total Number of ANMs	**49**	**34**	**86**

Percentages in parenthesis are over the total number of ANMs unwilling to recommend the job (ie.86) and not over the total number of responses.

Totals include the responses of ANMs who have not clearly mentioned whether they are satisfied or not

TABLE 66
NATURE OF EMPLOYMENT CONSIDERED BY ANMS DESIRING A JOB SWITCH

Nature of Employment	Whether considered /Tried before		
	Yes	No	Total
School Teacher	14 (73.7)	5 (26.3)	19 (100) [32.6]
Clerk/Typist	14 (73.7)	5 (26.3)	19 (100) [32.6]
Staff Nurse/LHV/Doctor	1 (7.1)	13 (92.9)	14 (100) [24.1]
Own Business	---	1 (100)	1 (100) [1.7]
Others	---	3 (100)	3 (100) [5.2]
No Response	---	---	2 (100) [3.4]
Total Number of ANM	**27 (50.0)**	**27 (50.0)**	**58 (100) [100]**

TABLE 67
REASONS FOR SEEKING A JOB SWITCH

Stated Reasons	W hether Satisfied		
	Satisfied	Dissatisfied	All ANMs
Over work/incessant travel /separation from family/ insecurity	10 (32.6)	11 (47.8)	23 (39.7)
Low status/underutilisation of services /inadequate medicines/facilities	4 (12.9)	9 (39.1)	14 (24.1)
Other jobs are better -(better paying ANMs more attuned to them)	8 (25.8)	3 (13.0)	12 (20.7)
Family Planning Programme and targets	6 (19.4)	5 (21.7)	11 (19.0)
No promotion, monotony, temporary work status, no challenge	2 (6.5)	3 (13.0)	6 (10.3)
Other Reasons	6 (19.4)	6 (26.1)	13 (22.4)
No Response	1 (3.2)	---	2 (3.5)
Total Number of ANMs	**31**	**23**	**58**

Percentages in parenthesis are over the total number of ANMs seeking a job switch (ie.58) and not over the total number of responses
Grand total includes the responses of ANMs who have not clearly mentioned whether they are satisfied or not

TABLE 68
REASONS FOR NOT SEEKING A JOB SWITCH

Stated Reasons	W hether Satisfied		
	Satisfied	Dissatisfied	All ANMs
Liking for job, accumulated experience, etc.	53 (52.0)	8 (38.1)	61 (49.2)
Experience will be wasted/loss of seniority /nearing retirement	29 (28.4)	11 (52.4)	41 (33.1)
ANMs get respected/social status /able to share people's problems	20 (19.6)	1 (4.8)	21 (16.9)
Difficult to adjust to other jobs/other jobs worse	15 (14.7)	1 (4.8)	16 (12.9)
Unavailability/difficulty getting other jobs	10 (9.8)	4 (19.1)	14 (11.3)
Other reasons	8 (7.8)	2 (9.5)	10 (8.1)
No Response	2 (2.0)	---	2 (1.6)
Total Number of ANMs	**102**	**21**	**124**

Percentages in parenthesis are over the total number of ANMs not seeking a job switch (ie.124) and not over the total number of responses
Grand total includes the responses of ANMs who have not clearly mentioned whether they are satisfied or not

INDEX