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AUXILIARY NURSE MIDWIFE

A Study in Institutionalized Change

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INTRODUCTION*

I. *How the present study arose*

It would not be wrong to say that one seminar or conference gives rise to another. Likewise it often happens that one study arises out of another. The present study arose out of the suggestions made at the Seminar on Categories and Functions of Nursing Personnel, organized by the Regional Office for South-East Asia of the World Health Organization, Delhi, India, 5-25 August, 1956. Amongst the many topics discussed the problem of the Auxiliary Nursing Personnel was discussed at some length. As a result of the discussion it was suggested that 'a regional study should be made to determine the specific functions and the administrative organization required to provide better nursing through the use of the auxiliaries and to set up criteria for judging the functions to be assigned to them'.[1] Concrete suggestions were made regarding the content of the study. 'The study might consist of: A survey of the actual situation in the hospital or public health field where Auxiliaries are working; a study of the feelings and attitude of professional nurses toward auxiliaries, and a study of the basis on which duties are assigned to various categories of nursing auxiliaries'.[2] In accordance with these suggestions the Regional Office for South-East Asia, World

*The present study was made by the author in his capacity as a Social Scientist Consultant to the World Health Organization for a Seminar on Auxiliary Nursing. The author wishes to record his deep sense of gratitude for the facilities made available to him to make the study as well as for the permission given to him to publish the study.

It needs hardly be said that this is only a working paper. The author intends to work on it at a later date.

1. F. N. Report of the seminar on categories and functions of Nursing personnel organized by the Regional Office for South East Asia, W.H.O., Delhi, India, SEA/NURS/13, p. 38.

2. *Ibid.* p. 22.

Health Organization, New Delhi, planned to have a Conference on Auxiliary Nursing for the South East Asia Region in 1958.[3] The suggestion regarding the study was accepted. In addition it was decided to make 'a special study of selected examples of auxiliary training and utilization (in hospital nursing and in public health)' with a view to determine what kind of information the preliminary studies (in the region) should seek and to prepare a guide for the preliminary studies. This is the background of the present study and constitutes what may be called terms of reference.

II. *The scope and Setting of the Present Study*

It was felt that a study of the following variables, viz., the programme, the personnel and the Community, i.e., the people for whom a given programme is intended and the inter-relationships between these three variables would adequately take care of the content of the study as suggested in the seminar on nursing already referred to. The relationship between these variables is described below. But it is important to note that these are sub-variables in the situation, which need to be stated in the first place and, in the second, their relationship to the variables and the sub-variables also need to be described. Starting with the first variable, viz., the programme, the sub-variables are the nature of the programme, whether it is service oriented or educative; the institutional set-up for the implementation of programme, involving different types of teams; area of coverage for the programme, etc. Under the variable personnel the important sub-variable to be discussed is the social background and the personality of the personnel. Apart from the technical competence of the personnel factors such as age, sex, position in the social hierarchy, etc., have a bearing on their acceptance or otherwise by the people. The third variable, viz., the people subsumes sub-variables such as the types of people, e.g., rural or urban, the system of stratification, the system of beliefs and prejudices upheld by the people for these affect the acceptance or otherwise of both the programme and the personnel.

Further, the sub-variables of each variable have definite implications for those of the other two variables. The following illustration will bear this out. Take for instance the nature of the programme—say it is primarily educative, then it necessitates the possession of a particular background on the part of the personnel such as the belonging to the 'right' stratum, 'right' age, marital status, etc., if the personnel is to be accepted

3. F. N. First Bulletin Relative to the Conference on Auxiliary Nursing for the South East Asia Region 1958. RCAN/Bull./1 of 25 July 1957, p. 1.

by all layers of the society to be served. The institutional set-up can also be shown to have similar implications. Thus, all the sub-variables have more or less precise implications for the effectiveness of a programme through the interaction of the main variables and the sub-variables. Certain changes had to be effected in the scope of the study due to the local setting described below. The variables mentioned above need some elaboration. By programme is meant the programme for health services and education. The programme is also usually given in the sense that a state determines its policies and targets in the field of health services and education and designs the programme accordingly. Mainly owing to the genesis of the programme, it is hardly amenable to change or at any rate to a quick enough change. Administrative factors are partly responsible for this lack of changeability of the programme. Second, the type of personnel that is available may also be responsible. Inertia and lethargy contribute their own share towards the relative unchangeability of programmes. Further a state has to make some arrangements to ensure a steady and unfailing supply of personnel to carry out the programmes. This introduces the arrangements for training of the personnel. In its train comes the problem of institutionalising of training so that standards be maintained. Any process or product of institutionalization means problems of structure and function. The structural framework ensures stability of relationships. The hierarchical structure of institutions — here we refer to the training institution as well as that which renders health services — enables smooth running and, therefore, smooth functioning too. In the absence of a structure it is likely to result in chaos. Thus the programme inevitably introduces the second variable, viz., the personnel. The personnel has to be thought of in its two stages: (1) those who are being trained so that they can, on successful completion of the training, effectively function as personnel for implementing a programme, and (2) the finished product, i.e., the personnel that can readily start functioning towards implementation of a programme. In the context of the present study these three variables can be and should be translated into programme planned for and organized by a state in India so as to carry to the rural people health services and education so as to improve standards of health and ultimately to ensure better living. The programme is linked up with other aspects of development and is thus an integral part of the same. In order that the programme reach the rural people an adequate supply of personnel is essential. In India there is a scarcity of doctors and nurses. And hence arose the fact of the dependence on auxiliary nurses for the implementation of the programme. As discussed below an auxiliary nurse is one whose training falls short of that required to qualify her for a full professional status. This raises several problems that are discussed below. Yet even she needs some amount of

training. Therefore, arrangements have been made for the training of auxiliary nurses. The problem in a country like India is to substitute auxiliary nurses for fully trained nurses. This aspect has or should have consequences for the training programme in the first place and for implementation of a given programme of health services and education, in the second. The question of qualifications for admission to the course of training for auxiliary nurses comes to the fore here. In addition there is the main problem of the acceptance of the programme by the community, i.e., the people. A host of problems are introduced hereby. The programme and the organizational set-up, the personnel, their personal and social background, qualifications, attitudes, etc., the people and their prejudices and prepossessions, systems of beliefs, previous experience, etc., act and react upon each other. And that is how we get a picture of the net result of this process of interaction. I must hasten to explain that the process of interaction is limited since, one, the programme is usually given and is relatively unchangeable due to factors already discussed and, two, the community, i.e., the people, with all their predilection and prejudices, cannot be easily brought to change. Thus amongst the three variables the first variable, i.e., the programme assumes a near status of an independent variable. The second variable, i.e., the personnel constitutes the link between the first and the second. The third variable, i.e., the community is acted upon by the first two and it is only over a period of time that it can act on them. The second variable is the most exposed variable to such interaction by virtue of its position.

The setting of the present study was in a state in India with reference to a particular institution for training a particular category of Auxiliary Nurse, viz., Auxiliary Nurse Midwives only. The programme as 'given' by the state, the personnel — both those under training and those who were already posted after training and the community, i.e., the people are described. The state envisaged carrying health-services and education to people in cities, towns, small towns and rural areas. Primary Health-Centres were started all over the state and in order to get adequate nursing personnel, training institutions were started in the year 1954 to train Auxiliary Nurse Midwives. The yearly capacity of the twenty training institutions developed for this purpose was 420. The present study is limited only to the study of one of these training institutions so as to analyse the problems of training and the preparation of the personnel for participation. This aspect of the problem has been studied from various angles: (A) the content of the training, (B) the trainees, (C) the relationships in the training institutions as between the staff and the trainees, amongst the trainees, etc. As regards *A* it has not been included in this paper. Only those who were trained in this institute were studied with reference to the implementation of the pro-

gramme. Only a few centres were studied towards this end. The personnel was observed in action in the community.

A: It needs to be mentioned here that my discussions with the Superintendent, the matron, the sister-tutor, who is in charge of the training programme and also with the medical officer in charge of the various centres studied and, of course, with the A.N.M.s already posted brought out a very vital fact pertaining to the disparity between the training programme and the field situation. In field situations demands for omnibus services are made on the A.N.M.s. In fact, even according to the programme as envisaged by the state, the A.N.M. is loaded with many kinds of functions, for which she is not equipped in terms of the training received by her. This situation is very likely to have consequences for the programme, the personnel and the community. The ramifications of such a situation are analysed in the section on community.

B: A full section is devoted to the discussion of the problems of trainees, in the light of the situation that exists in the training institutions.
C: In the same section are discussed the problems of relationships in the training institution.

Thus, the discussion of personnel is divided into two sections: (1) A.N.M. trainess, and (2) those already working in the Community, i.e., the potential personnel and the actual personnel operating in a field situation.

For a discussion of the latter, one has to describe the working of the different primary health centres and sub-centres. The section on community discusses that.

In terms of the programme as envisaged by the State, there are very specific limits put on the scope and functioning of the A.N.M.s Thus, in the first place, they are supposed to work under the guidance and supervision of a fully trained nurse. Second, they are supposed to do work which is more of a routine type. Then there are many suggestions made regarding the housing facilities (free residential quarters) for the A.N.M.s, as well as provision of female escorts for them. Mention is also made of a special allowance for medical officers for working in rural areas, where no amenities of any kind including schooling of children exist. Otherwise, the medical officers might resort to unfair practices of all kinds. With the best of intentions, at the operational level, as we shall see below, hardly any of these suggestions is implemented. As a consequence the personnel suffers and so does the programme and in its wake the community. Cases were reported where the A.N.M.s refused to work in certain places due to lack of accommodation. Then again the lack of necessary equipment in the various centres and sub-centres reduces the efficacy of the programme. The gap

between the idealized level of working out a programme with the implicit assumption that the necessary type of personnel is there to implement the programme and the various lacunnae that exist at an operational level in respect of the programme, the set-up and the personnel need to be analysed. An attempt is made to do the same in the present study.

Thus, in certain ways, a departure has been made from the scope as suggested (refer p. 1). The first part of the suggestion, viz., a survey of the actual situation in the hospital or public health field where auxiliaries are working, has been followed. The second part of the suggestion, viz., a study of the feelings and attitudes of the professional towards the auxiliaries has not been followed for the simple reason that in the present study there was no instance where the professional and the auxiliaries worked together. In reality, the auxiliary was left to work all by herself under the supervision of a medical officer or a health visitor or with hardly any day-to-day supervision. In fact, the very use of the term Auxiliary Nurse Midwife needs to be questioned. This again is another instance of the gap between the operational level and the idealized or structural level of a given institution. The third part of the suggestion, viz., study of the basis and criteria on which (functions can be assigned to the auxiliaries) has been touched on at various points, even though a detailed study of the same was not made Briefly it can be said that only such duties be assigned to them as are indicated by an urgent demand in the first place, second, which can be undertaken by them without raising complications and third, which cannot be performed otherwise by any other easliy available person. The scope in a way has been limited but in many other ways expanded.

The material collected, except in relation to the trainees, was of a qualitative type, based more on discussions— formal and informal and observation. Due attention was paid to factors such as stratification and hierarchy, typology of centres as revealed by types of set-ups, distance from cities, nature of the locale, etc., thus a city, a town, a small town and eight villages were selected to study the working of the programme in terms of (1) the programme, (2) the personnel, and (3) the community. The results obtained are not of a conclusive nature and lack finality of any kind. All that I strove to do was to sort out the variables and their interaction. Certain hypotheses do emerge from this study.

III. Methodologically speaking,, an integral approach to the problem was adopted. The working of the auxiliary nurses was sought to be studied in terms of different factors viz: their training, their social and personal background, the set-up in which they functioned, the programme and their

role in its implementation, the community and its reaction. The functioning of the programme at an operational level was viewed in terms of the structure of the programme i.e. a hypotheised relationship between the various factors on which hinges the efficacy of the programme viz., (1) the programme, (2) the personnel and (3) the community. Thus the various gaps that exist between the idealized picture and reality were brought out. This is in short what is called the structural-functional approach. Issues are raised as to why, given the best of intentions, partially backed by efforts, results simply cannot be obtained. The manifest functions of a particular arrangement or an institution may not be realized in practice and if so why? What are the structural constraints ? What are the hindrances to a change?

Schedules, interviews, free discussions, use of files and documents, observation — all these tools were employed in the present study.

IV. *Concepts and Definitions*

Since the concepts such as the programme, the personnel and the community have already been defined it merely remains for us to discuss the concept 'auxiliary nurse'. The seminar on nursing, earlier referred to, had accepted the following definition 'Auxiliary Nursing Personnel—those who give in comparison less comprehensive care, supplementing that given by nurses, or those whose duties are confined to some particular phase of the nursing care. Auxiliary personnel always work under the direction of a professional nurse and their functions include direct services to the patient'.[4] Operationally, this definition has been regarded as satisfactory because it both includes and excludes the fact of supervision and guidance. Yet on scrutiny it is found to be defective for the two are mutually exclusive and therefore inconsistent. At an operational level it is very difficult to conform to the last condition viz., that auxiliaries always work under the direction of a professional for the obvious reason that a professional may not exist within a few miles. In addition certain manifest functions e.g., that of auxiliary nurse midwife may be surpassed in practice when she has to perform duties of an omnibus nature ranging from the administrative to the treating of patients for minor ailments on her own. Under such conditions the use of the term Auxiliary is unwarranted for she is neither auxiliary to anyone — except to the medical officer — nor are her functions in any way defined. As for the present study the use of the term Auxiliary Nurse Midwife should be interpreted in the light of these limitations. What is really needed is an appraisal of

4. *Op.cit.* SEA/NURS/13 p. 5.

the concept and a definition operationally. This assumes all the greater significance when it is admitted that in the underdeveloped countries — at least for some years — the auxiliary will substitute the professional — that means in effect she will cease to be an auxiliary. This situation is full of implications for programme, personnel and community.

The Auxiliary Nurse Midwife Trainees

The trainees certainly constitute a very important part of the entire programme, for they are the potential personnel through whom the programme is to be implemented. Therefore, the social background of the trainees, their experience, views relating to the training programme, the training institution and relationship with the staff of the training institution, difficulties etc. need to be studied. To get a rounded picture the views or rather the estimation of the trainees and training programme by the staff-in-charge also need to be discussed. The present discussion has to be made keeping in mind the institutional background.

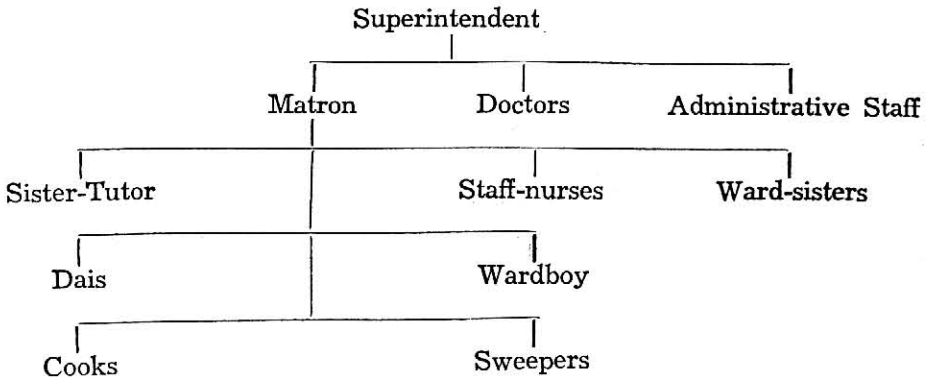
A. The *Institutional Set-up*

The training programme for the Auxiliary Nurse Midwives (as reported in the present study) is carried on in a hospital for women. This hospital is used for the training programme of medical students preparing for a degree. It is located in a city in India that is a capital of one of the States. Even though the hospital has been functioning for the last twenty years it was only four years ago that it became a part of the training programme for medical students. This institution concentrated on the training programme for the Auxiliary Nurse Midwives. It also conducts a training programme for the Dais. 'General' nursing students from a sister institution in the same city are sent here for gynaec experience. However, since only one cadre of Auxiliary Nurses is trained the set-up is relatively simple as it is free from all manner of complications arising out of differentials in training, staff, students and a host of inter-personal and inter-strata relationships.

The hierarchical structure of this Institution is as follows. It is headed by the superintendent of the hospital, a lady doctor, who also works as professor in the medical college in the city. There are a few doctors under her. Apart from the administrative assistants, there is a matron, who supervises the entire nursing staff of the hospital and is also in overall charge of the training programme for the Auxiliary Nurse Midwives, the Dais, the general nursing students, and the medical students too who come for gynaec experience. She has supervisory powers and is responsible for the training programme and the well-being, discipline etc. amongst the trainees,

A sister-tutor is immediately in charge of the training programme for the Auxiliary Nurse Midwives. She works under the general supervision of the Matron. As it happens, the Matron and the Sister-tutor in charge of the A.N.M. training programme are related to each other as sisters. And this brings about special relationships, as we will have occasion to mention later on. The teaching programme is primarily conducted by the sister-tutor, though doctors deliver lectures on certain topics e.g. anatomy, hygiene etc. and a staff nurse gives lectures on some aspects of nursing. Then there are staff nurses and ward-sisters. The staff nurses usually plan the work for the A.N.M. trainees in the wards. And the ward-sisters are expected to leave them alone. There are Dais, wardboys, cooks, sweepers etc.

Thus the hierarchical picture is relatively simple and quite clear so that no confusion or misunderstanding about the relative position of the staff need arise. The chart below clarifies the situation.



B. *The Training Programme*

The training programme is two-fold: (1) lectures, (2) demonstration in wards and clinics. The staff in charge of the training programme, including the doctors, impart training to the A.N.M.,s through these three methods. According to the time-table of the month in which the study was made there were eight lecture periods for both the first year and the second year A.N.M. trainees. The ward duty was eight hours a day for the trainees, of course with suitable breaks for lunch or dinner and rest. On Sundays too the period of duty was six hours. It was only on Sundays that the trainees got an evening off to go out. The time-table of lectures and daily programme of work for the A.N.M. trainees given in appendix A bears testimony to the busy programme.

In the light of such a training programme one can readily understand that since the inception of the programme i.e. November 1954, nine trainees

were discharged after three months[5] and fourteen resigned. So far twenty-two trainees had successfully completed the course. In the first batch all the fourteen who took the final examination were successful. In the second and the third batches the percentages of the successful candidates to the total number were 75 per cent and 92 per cent respectively. Most of these candidates were from the State in which the training institution is located. The religion-wise division of these successful candidates is — 14 Christians, 4 Hindus and 4 Muslims.

The minimum qualification for admission is the passing of seventh standard in vernacular. It is in very few cases that the minimum qualification is exceeded by the trainees. The superintendent of the hospital and the Matron were of the opinion that there was hardly any choice for them as amongst those seeking admission to the course. In many instances the minimum became the maximum. There were other types of difficulties too in respect of the up-bringing, the social background of the trainees which gave rise to complications of a serious nature. Likewise the religion-wise distribution of the trainees too is very likely to have consequence for acceptance by the community — in terms of system of stratification.

C. *The Present Trainees*

Material relating to the present trainees was obtained through (1) schedules for each trainee, (2) interviews and discussions with the trainees and (3) discussions with those in charge of the training programme.

The material from the schedules is discussed batch-wise. As for the material from the other two sources an overall idea about the situation is presented.

1. *Material from the Schedules*

The schedules furnish material about the personal and social background of the trainees, their views regarding the training programme and the Institution, difficulties, suggestions, the operation of certain forces like the caste-system etc.

A. *First-Year Trainees*

In all there were fourteen trainees. Excepting one Hindu (Rajput) all the trainees were Christians. Eight of the trainees were below twenty years in age, five between twenty and twenty-five; one was over thirty.

5. At the end of three months after joining the A.N.M. trainees have to appear for a preliminary examination and only those that are successful are continued.

Three trainees had passed their sixth[6] standard, six had passed their seventh standard, four had passed their eighth standard and only one had passed her ninth standard. Amongst these, eight were single and six were married. Amongst the latter only one had children, who were looked after by her parents. There were three who wanted to divorce their husbands, the grounds being drunkenness, refusal to support the wife and discord-pattern. All the trainees hailed from the same region. Barring one who had no sublings and another who had only a brother, all the rest of the trainees had at least a brother and a sister each. In one case there were as many as five brothers and five sisters. Barring the orphan and one more trainee who was seventh and last amongst the siblings all the rest were either first or second. Thus there was no relationship between the position in the family and the fact of taking to this career. Only three trainees belonged to joint families. All the rest excluding the orphan belonged to nuclear families. As regards the educational background of the family excepting the five following cases the level of education was restricted to vernacular education: (1) Father — Intermediate pass, (2) Father — Matric, Sister — Matric, Husband — Doctor (his education, though not given, can be guessed easily), (3) Brother — Intermediate, (4) Husband's Brother — Matric and (5) Brother — Matric. In all the cases the siblings are reported to have either studied or are studying. Occupational background of the family was as follows: (1) Father — Clerk, (2) Husband — Doctor, (3) Father — Retired Head Master of a primary school, (4) Father — Doctor, (5) Husband's Brother — Clerk — in the rest of the cases the occupation was either that of a farmer, or a labourer or a craftsman. In two cases sisters were A.N.M. trainees. In another case a sister was a teacher. Only in one case was the mother reported to be a primary school teacher. The economic status of most of the families was low. Four of the trainees decided to join the training course in consultation with parents, husband and a cousin sister (who was a midwife); two in consultation with friends and nine independently — by reading advertisement in newspapers. Only two of the trainees had some kind of background of social work — one was a matron in a mission school for 10 years and another had worked in a children's clinic for one year. In another case her father had worked in the field of Adult Education. In one case the Husband's sister had preached the Bible. Strictly speaking the concept of social work has been stretched to report all these cases. Excepting two all others felt that the training programme was not too busy. Asked to say if they were aware of the purpose of the training institution, the general consensus was that the main purpose was to

6. So even the minimum requirement about education has not been complied with.

help the sick people, serve the villagers and teach people about health and hygeine. Only one trainee also expressed that she felt happy by being kept busy. There was no response from anyone to the query as to how they felt the institution worked. Excepting five trainees, all the rest of the trainees were satisfied with the training received and the atmosphere in the institution. Three stated that they felt dissatisfied after strict rules pertaining to visits and visitors were enforced. One complained of inadequate stipend. Four of the trainees suggested that advanced training be given to them so that vertical mobility may be facilitated. One suggested that medical instruments be made available. Another suggested that better boarding facilities be made available to the trainees. Four suggested that restrictions on visits and visitors be relaxed. Only two asked for better facilities for house-visiting (of patients) e.g. transport. Two seemed to be apprehensive about their posting (one of them due to the reports from her friend who had already been posted in a village) and suggested that proper arrangements in respect of accommodation, transport and escort be made prior to their posting. Asked if there was any grouping on the bases of caste and religion amongst the trainees everyone said that there was no such thing. Further, everyone stated that they did not discriminate between the patients on the bases of caste and religion. Excepting one trainee, everyone replied that they did not feel that the patients discriminated between the trainees on the bases of caste or religion. This trainee (a Christian herself) mentioned that sometimes some Christian patients inquired about the caste of those nursing them, yet she was not certain that this necessarily meant discrimination. The trainees were asked if they had experienced any distinction made by the patients as between the A.N.M.s and the Nurses. Excepting two trainees, everyone felt that there was no such awareness on the part of the patients. One felt that the patients regarded the Nurses as superior to the A.N.M.s, while another said that generally no such distinction was made.

B. *Second-Year Trainees*

There were twelve trainees in the second (final) year. Of these, eight were Christians, three were Hindus (1 Brahmin, 1 Katia, 1 Nayar) and one was a Muslim. Nine of the trainees were below twenty years of age and three were between twenty and twenty-five. Two of the trainees had passed their seventh vernacular standard; four had passed eighth; five had passed ninth and one was a 'Matric-fail'. Ten were unmarried; one was a widow and the only married girl had strained relations with her husband, though she had not yet divorced him. Barring three of the trainees, all the rest hailed from the region where the training institution is established. Everyone had at least a brother and a sister each. In one case there were as many as four brothers and eight sisters. Only one of the trainees was the

first child, three were second children, and all the rest were fourth and beyond. Yet it is difficult to say that the position in the family determined the career. Excepting three cases, all the trainees were brought up in a nuclear family. In two cases sisters-in-law were staying with the parents of the trainees. In one case the paternal uncle, aunt and their children were staying. Amongst this batch too there was an orphan who was brought up in a Christian Mission. In one case illiteracy of the parents was reported. In four cases education of the parents and husband was not known. There were six cases in which at least one member of the family was a matric and above. (1) Brother — B.A., Brother — Inter, (2) Brother — F.Y., Brother — B.A., (3) Brother — Matric, (4) Sister — Matric, 2 Brothers Matric, (5) 2 Brothers — Matric, (6) Brother — Matric, (7) Brother — Matric, Sister — Matric, 2 Brothers — Intermediate. In the rest of the cases the family members had only vernacular education. In six cases the occupations of the family members were reported to be lower in the conventional sense. Only in six cases, white-collared occupations were reported viz. (1) Brother — Clerk, (2) Brothers — Clerks, (3) Sister — A.N.M. trainee, (4) Brother — Clerk, (5) Brother — Post Master, Sister — Matron, Mother — Health — Visitor in a big city, Sister-in-law — Staff-nurse, (6) Paternal uncle — Doctor, Aunt — Ward-sister. Four of the trainees decided to join the course in consultation with relatives; four in consultation with friends (one of these had also consulted a parent) and five independently. In one case, the parents supported the idea but the brothers objected, while in the other case the husband's relatives objected. In both these cases the objection did not flow from the factor of economic influence. As noted earlier the only girl who was married had strained relations with her husband and so the objection of her husband's people becomes readily comprehensible. There was no background of social work in the families of the trainees. The trainee who was bought up in a Christian Mission had worked for three months in the same. Another trainee had worked as a village-level-worker. Excepting the following three cases: (1) who found it interesting though busy, (2) who found it busy only sometimes, and (3) who thought it to be always busy — the first felt that the training programme was not too busy. According to all the trainees, the purpose of the training institution was to serve the sick, helpless villagers, educating people in principles of health and hygeine, raise standards of living etc. Three of them frankly said that they would be helped to earn their livelihood through the training programme. Only one of the trainees said that the institution functioned well, while all the rest did not respond to this part of the query. One trainee had worked as a teacher in a missionary school and had helped fellow-villagers in their illness; another had worked as a village-level-worker; still another had worked as a clerk in the present Hospital. All the rest had no experience

of work whatsoever. Excepting the following three trainees: (1) dissatisfied now due to restrictions on visits and visitors, lack of sick rooms for trainees, (2) dissatisfied due to inadequate stipend and worry about posting, and (3) though formally she said she was all right, she did not mean what she said for reasons stated below. All the rest (9) stated that they were satisfied. Seven suggested that stipend be increased. Three suggested that arrangements be made regarding accommodation, transport, escort etc., before they are posted. Five suggested that advanced training be given so that vertical mobility be possible for them. Only two suggested that restrictions on visits and visitors be removed. This is but natural, for all of them will soon be passing out, so they did not feel the urgency about the same. One — no, three above — was entirely silent. In fact, at the time of the first interview that took place in the presence of a staff-nurse — this trainee was most vocal in voicing complaints and making suggestions — but later on she refused to say a word — possibly due to some pressure brought to bear upon her by the authorities. Everyone said that there was no grouping amongst the trainees on the basis of caste and religion. Ten of the trainees also said that they were not conscious of distinctions of caste and religion while treating the patients. One (Muslim) said "naturally, I feel nearness when a patient of my own sect comes in". Another, who was a Brahmin, hesitated to reply to this query. She was also hesitant to answer the query if patients discriminated on the basis of caste and religion. Likewise the Muslim trainee answered in the affirmative. All others replied in the negative. Only one felt that the patients regarded the A.N.M.s to be inferior to Nurses. Another said that patients just were not aware of any distinction between the two.

2. *Material from my discussion with the trainees*

The discussion revolved round the following points: (a) occasions for social meets with the staff, (b) rewards and punishments for their performance both inside and outside the wards, classroom, etc., (c) treatment by the staff, (d) relations with the Matron, the Sister-tutor, etc., (e) facilities or lack of them in respect of housing, stipend, leave of absence to go out visiting, meeting visitors, (f) disciplinary measures and their reaction to such measures.

(a) A dinner party was given to meet the W. H. O. team by the nursing staff to which the trainees were also invited. It was said to be the first occasion of its kind. They had common sports on the last Republic Day due to the initiative of the Superintendent. On the occasion of the dinner-party to the W. H. O. team, cultural evening was held so that there were scores of music, dance, tableaus, etc. The performances were sepa-

rately given by the staff and the trainees. One little incident tended to mar the cordiality. Owing to a shortage of crockery evidently, the trainees were asked to get their own glasses. This was looked upon by the trainees as a deliberate attempt to differentiate and they took it as an insult. Thus the very first occasion of social meet was spoiled. The trainees further said that they were not even allowed to enter the staff-quarters. The Matron told me that some years ago a charge of pilfering was levelled at a trainee when something was found missing in the staff-quarters.

(b) The trainees felt that rewards were few and far between, if at all any, but punishment was amply given and that too publicly. Thus scolding was done even in front of patients. To cancel a day off or rather an evening off was the minimum punishment for any failing.

(c) They smarted under the feeling that they were being harshly treated by the staff, e.g., aloofness and superiority complex of the staff, condescending attitude, etc.

(d) They came in for a lot of scolding from the Matron, she being directly responsible for their doings, and hence they felt the relations were rather unhappy. The sister-tutor being the sister of the Matron, in addition to the fact that she was in charge of the training programme, also came in for transference of the Matron's image in the mind of the trainees.

(e) Stipend was both inadequate and irregular. Quarters lacked proper protection. There was no adequate leave of absence. The trainees felt particularly cut up when they were refused permission to see their relatives. The Matron held the view that all manner of bogus relations came in and created serious complications.

(f) They felt that discipline was too strict. They were not allowed to go even as far as the gate.

On the whole they felt that they were treated as 'dirt' and that even the Dais and the sweepers disregarded their orders. The Matron and the other members of the staff. however, contradicted this.

(g) Quite a few trainees were apprehensive about their posting in villages. Quite a few said that they would like to practise on their own after the bond period was over. This eventually means that the programme of training Auxiliary Nurse Midwives would be defeated. In addition to that an unspecified, undefined nursing cadre would be let loose on the public and the nursing world.

Some were keen on improving upon their prospects by matriculating, so that they could join the health-visitors' course. This aspiration certainly would not harm the programme.

In a way it was surprising to see that none of the trainees betrayed her social origins. All of them were well clad and seemed to be striving very hard to ascend in the social hierarchy. In itself there is nothing wrong in such efforts, provided socially approved methods were adhered to attain the end. Instead if there was an undue emphasis on technical efficiency to meet the goal, irrespectively of the means employed, it would result in deviant behaviour. If only the goals are accepted, but not the institutionalised procedures to meet such goals, then deviant practices will arise.

3. *Material from my discussion with the Matron, the sister-tutor, and the Superintendent*

The material pertains to two areas: (a) the training programme, the expectation of and actual practice of work done by the trainees and (b) problems of discipline, order and behaviour of the trainees.

(a) The superintendent of the Hospital very candidly said- that greater emphasis was placed on getting work done in the wards and clinics by the trainees. In addition there had to be a much greater emphasis on general nursing in view of the demands that would be made, and are in fact actually made, when the trainees are posted. The sister-tutor even suggested a change in the present training programme so that the trainees woud do medical nursing for fifteen months and midwifery nursing for nine months. In practice the A.N.M. is expected to be at least a 'Jack of All Trades'. Another important fact is that the trainees do not work as Auxiliary to professionally trained Nurses. Therefore, the very concept is misapplied. Then there is every possibility for the auxiliary nursing midwives to pass themselves off as fully trained professional nurses (a) in view of the functions they are called upon to perform and (b) the ignorance and helplessness of the people at large.

The sister-tutor said that the present syllabus was a little heavy going for the trainees. She had no means of ascertaining whether the Doctors who gave lectures to the trainees covered all the topics and also if the trainees had any difficulty in following them. Once, some years ago, she tried to ascertain the same by attending some of the lectures given by Doctors but the latter disapproved of her doing so. Since then she had to give up this method. Now she only tries to fill the gaps in the knowledge of the trainees by reviewing the courses given by the Doctors. Another source of difficulty was that the text-books available were written in high-flown Hindi and both she and the trainees found it difficult to comprehend and express what was contained in such books.

(b) *Problems of discipline and behaviour*

As per the Matron's and the sister-tutor's views the roots of indiscipline lie (1) "in the social background of the trainees, e.g., they belong to an unruly disorderly stratum, (2) their exposure to city life, (3) possibilities of social ascent, (4) inadequate and irregular stipend whereby the trainees are tempted to accept petty cash and presents from riff-raff such as the cooks, wardboys, chowkidars, sweepers, etc". The Matron added that "girls hailing from Christian Missions tended to be the worst culprits in respect of flirtations as they are suddenly released from an unduly, unnatural and rigid atmosphere of discipline". In support she cited the case of a Christian trainee who had become pregnant very recently. "This girl went out under the pretext of going to a Church and flirted with a young man of no social consequence". The problem of indiscipline had assumed, according to both of them, serious proportions and that they were hard put to stop flirtations. They reported that even married girls resorted to flirting. In one such case the trainee was asked to leave the course by her husband, on getting reports about his wife's activities from her fellow-trainees. Anonymous letters were written both to the authorities and family members. I actually saw three such letters. "Then there is no putting a stop to a spate of 'love-letter' some trainees receive and all types of complications". The Matron and Sister-tutor reported that they derived full support from the present head of the Institution, in any disciplinary measures taken by them. They reported that the previous head of the Institution sometimes failed to support them and hence it had a demoralising effect. The Matron said that only those trainees who had a good record of conduct, behaviour, performance of duty, etc., e.g., auxiliary nurse midwives from set-up A, C, D, E, kept in touch with the staff and the institution.

A record is kept of the conduct and behaviour, physical condition, capacity to learn, ability to get along with colleagues, superiors and patients, honesty and diligence, etc., of each trainee since 1956. However, there has been neither any follow-up study of the trainees once they have been posted nor any suitable action been taken to prevent the misfits from entering the field.

All the components of the situation pertaining to the training of the Auxiliary Nurse Midwives, viz., A, the Institutional set-up; B, the training programme; C, the present trainees, their social background, attitudes, difficulties and problems are bound to affect the implementation of the programme when the trainees are posted and become the key variable linking the programme and the people. To the extent that the trainees are indisciplined, the implementation of the programme is bound to suffer and in some

cases as in set-up B it might be completely jeopardised, as discussed below. The type of training, including practical experience is also very likely to have consequences for their performance in the field situation. Then the situational factor, viz., that in the field the duties are not only of an omnibus character, but in addition the Auxiliary Nurse Midwives have to work and actually work as Auxiliaries to Medical Officers rather than to the fully trained nurses also creates difficulties (1) due to the nature of the training and experience, (2) personal and social background of those so posted, and (3) people's reactions and responses to the entire programme as implemented by the A.N.M.s — here factors like prejudices, system of stratification, system of beliefs come into play. Even the mere fact of introducing an innovation is sometimes a disturbing factor. In view of all this greater care and thought should be given to the recruitment of the trainees. But then, as the Superintendent, the Matron and the Sister-tutor said, so far the training programme has not attracted 'very good material'. Then there are difficulties regarding the caste and religion-wise predilections and prejudices with reference to nursing as a career. In India, there exists in the first place a prejudice against the fact of women working for a living. It is felt that only those women work for a living who are economically badly off and that their people are not in a position to support them. Second, nursing as a career is a taboo since it involves close contact with strangers, leaving aside the concept of pollution. Thus, on the one hand, only those women who belong to the lower economic strata can work for a living, on the other, nursing as a career is largely a taboo for Hindu women, at least to the higher castes. The religion-wise distribution of all those who have been trained so far and those under training today in the present institution bears out the observation made here. Thus, there were five Muslims, eight Hindus and thirty-five Christians amongst the total number of forty-eight. It is all the more strange, when nursing is eulogised as a noble act — but primarily within the precincts of a family. Instances have not been wanting when ladies — more often than not widows hailing from families that were well-to-do and higher up in the social hierarchy took to nursing, in particular midwifery nursing, as a means of social service. This obviously is a case in point of the noblesse oblige attitude and behaviour. Therefore, it might be worth experimenting if a few girls from the 'right stratum' were persuaded to go in for the present type of training so that it might become more acceptable and reputable. On the other hand it might also perpetuate snobbery and create further problems for those hailing from the lower strata of society. But still it would be worth trying it out in a small set-up such as the present one.

The Community :

The Community is certainly one of the most important variables since the success, utility and acceptance of any programme depends upon it. It has also to be borne in mind that the reaction and response of the community are in no small measure guided by the programme on the one hand and the personnel on the other. The word community has been used to denote population of different types (1) urban, (2) town, (3) small towns and (4) villages. The urban population is served by institutions that are functioning directly under the supervision of the training institution for the A.N.M.s. The people from small towns are served by M.C.H. centres, which are usually staffed by a medical officer, A.N.M., compounder, dais, etc. The village population is sometimes served by these M.C.H. centres or in other cases by what are called sub-centres. These sub-centres may or may not have a full-time medical officer. In some cases, the medical officer pays a weekly visit, while for the rest of the week the A.N.B. and the compounder carry on the work of dispensing and treating patients for minor ailments. It hardly needs saying that thus there is not only a difference between the types of population that are served but also in the kinds of services that are rendered to them. The programme involves both quantitative and qualitative differences. This certainly complicates the question of acceptance or non-acceptance by the people of a programme. Two factors are simultaneously at work, viz., the kind of programme and the personnel that carry it out. It will be thus useful to describe the various arrangements for medical services that have been included in the present study. In all there are five different set-ups which render different types of services. Type A functions in a city and is directly amenable to supervision by Medical Officers. Certain special programmes are undertaken, e.g., maternity and child welfare with reference to a restricted portion of the population. Efforts are made to concentrate activities in the section surrounding the centre with a total coverage of about 10,000 people within a radius of half a mile. In view of the shortage of staff which consists of one health visitor, one A.N.M., and two dais it has not been possible to cater to the needs of the entire city. Type B functions in a small refugee township about five miles from the city and consists of a medical officer, one A.N.M., two dais and a compounder and has under its jurisdiction about twenty villages within a radius of six miles. Day-to-day treatment is given to out-patients. Arrangements exist for delivery cases, though difficult cases are referred to the hospital in the city. The A.N.M. is supposed to do house-visiting in the township as well as in the villages. Naturally enough it takes quite some time before each village gets its turn of house-visiting. In short, any intensive follow-up of cases is out of question, considerably reducing thereby the efficacy of any

health programme. Type C consists of a centre in a town with a medical officer, an A.N.M., a dai and a compounder. Beds are kept for delivery cases and emergency cases. This centre has under its wing two sub-centres. Local population is primarily catered for, though villagers nearby can avail themselves of the services offered at this centre. No house-visiting is done in villages. Therefore, there is neither creating of awareness regarding health services nor any follow-up of cases that might come from villages. Type D consists of a sub-centre in a small town, manned by an A.N.M. and a compounder, with weekly visits by the medical officer from type C. Here too services are, due to paucity of personnel, primarily restricted to the local population, yet the A.N.M. had attended on two delivery cases in villages which were situated a mile away and three miles away from the sub-centre. Type E consists of a sub-centre in a small town with a medical officer, an A.N.M., a compounder, a dai and a menial servant. This centre also covers ten villages in the vicinity within a radius of four miles. House-visiting is done by the A.N.M. The centre is very poorly equipped. In addition, however, there is a well-equipped hospital just about six miles from this place. To worsen matters, there have been partly substantiated rumours to the effect that the medical officer and the compounder charge heavy fees to the patients — particularly when visits are paid. Consequently, people simply refuse to come to this sub-centre. In one of the villages I came across a fairly advanced tubercular case that had not been referred at all to the sub-centre. There are in addition other factors at work, which will be analysed while discussing the reaction and response of the people to the A.N.M. and her work.

Description of the community set-up-wise will illuminate the problem of acceptance and non-acceptance. As regards set-up A it has already been noted how only a certain section of the city is covered. The total population covered is roughly 10,000. This includes both Muslims and Hindus, the former constitute about 95 per cent of the total. The level of education is very low. It was very difficult to get a lady in the sample who could as much read and write. The economic level is also very low. In the sample families interviewed, the average monthly income was less than Rs. 35. The degree of dependence of these people on this centre is revealed by two sets of facts — one the number of patients treated per year and two the persistent demand these people make for soap, milk, egg-powder, vitamin tablets, etc., and the fall in their attendance at the centre consequent upon the stoppage of such supplies.

The B set-up has two types of population to cater for — one the small refugee township and two the villages. There are both Hindus and Muslims staying in the refugee town-ship. Yet the refugees (Hindus) preponderate.

As amongst the refugees some are fairly well-to-do, while a majority of them are so poor that even ten years after their influx they have to be provided with free rations. Those who are well-to-do would hardly constitute 15 per cent of the population. The degree of education is also rather low. The villages consist predominantly Hindu population — comprising of various castes in the hierarchy — Brahmins and Rajputs, the craftsmen and the lower castes and the untouchables. In two villages there were a few Muslim families. All the villages studied under this set-up did not have a population exceeding 500. The major occupation was cultivation of land. Second, came field labourers. The level of education was quite low. In all the four villages there were about 90 persons who were literate in the approximate total population of 1,650. There were only 4 English literates, amongst whom one was a Punjabi Refugee and three were teachers posted in these villages. The level of income also was fairly low, judging from their living conditions and the reported inability to pay anything for medical treatment.

The C set-up served a town. The population includes both Hindus and Muslims. There was one primary school, a high school and a teachers' training school in this town. The major occupation of people was agriculture. Business stood next in importance. The level of education was fairly high, there being many literates. The economic level was also not very low.

In the D set-up the locale was a small town. It was a railway station and had a middle school. The total population was about 700. Hindus and Muslims were present. Caste-wise it displayed considerable variety — from Brahmins and Rajputs to Harijans. It was primarily a market town, and agriculture was relatively unimportant. The economic level seemed to be fairly satisfactory relatively to the others. The level of education was also fairly good, there being 140 students.

The locale of the E set-up was a small town, a railway station and villages, though from the viewpoint of the services the former did not matter. The entire railway staff obtained medical services from the railway hospital in a nearby town. The total population under this sub-centre was in the neighbourhood of 3,500. The level of education was low, there being only 45 literates amongst the four villages with a total population of 1,000. The economic level was also low. Agriculture was the main occupation. Field labourers were an important category. Amongst the villages studied only in one village there were a few Muslim families. In the rest of the villages there were Hindus only. The patels or the headmen of the villages were Rajputs. Castewise the majority comprised of Rajputs, though there were a house or two of Harijans in each of the villages. In one of the villages there was a sutar (carpenter) and a nai (barber).

Even though certain broad features of the areas served have been described, it will be useful to analyse unitwise the responses and reactions of the people. Thus set-up A serves only one unit primarily and we denote it by A1; set-up B serves five units and we denote them by B1, B2, B3, B4, B5; set-up C serves only one unit and we denote it by C1; set-up D serves only one unit and it is denoted by D1; set-up E serves four units and they are denoted by E1, E2, E3 and E4. As is evident from the above description, each set-up is manned by one A.N.M.; no matter what may be the number of the units subsumed under it. It may bear repetition to say that the greater the number of units that are served, the lesser the possibilities of an intensive programme. Possibly whatever might be gained in extent may be lost in intensity. This is not meant to be over-critical of a programme, but merely to point out the nature of the difficulties involved in carrying out such programmes. In fact, the extent of carrying a programme to wider areas seems to have a direct bearing on the quality of the programme in two ways. On the one hand, it mars the purpose by lessening the effectiveness of service and in some cases this might even lead to the people almost not availing themselves of whatever services that might exist as for instance is revealed in the present study. On the other hand, it has consequences for the morale and functioning of the team working on a given programme. It is very likely to give rise to (1) a feeling of helplessness and frustration, (2) development of the attitude of a shirker, (3) entrenchment of deceitful practices on the part of the members of the team. In the event of any of these possibilities, rejection of either the programme, or the personnel or of both the programme and the personnel is very likely to ensue. In such a case the entire scheme is undermined. This aspect of the problem was brought to light in the present study.

The reaction and response of the community is a function of three factors, viz., (a) the programme, (b) the personnel carrying out the programme and (c) pervious experience of the people in relation to a programme of a similar nature, prejudices and prepossessions of the people, needs, aspirations and capacity of the people to pay for a given programme or a part thereof. All these factors need further elaboration.

A. *The Programme*

Theoretically speaking the programme can be either medical and health services or health education or both. A good deal also depends on the personnel in charge of the programme. Thus some may be competent to render medical and health services, while others are more proficient in their role as educators. Of course, in practice there usually obtains an admixture of both. Another complicating factor is what is called the pro-

cess of image-building on the part of the people regarding the efficiency of the personnel in respect of the two roles mentioned above. Thus people look upon some of the personnel as cut out for one role rather than the other. And there may be fairly sound reasons for doing so. Take for instance the factors of age and social stratum of the personnel. Age is a great determinant of roles in all societies. Naturally enough, people simply cannot reconcile themselves to the situation where a young person — say an auxiliary nurse — midwife — tries to educate them in respect of health and hygiene. Then again the system of social stratification e.g. the caste system in India militates or is very likely to militate against both the effective rendering of services and imparting of the relevant education. Social stratification either opens out or shuts off avenues of work to people. In turn it gives rise to three possible types of reactions to the personnel concerned on the part of the people, viz (1) acceptance, (2) rejection and (3) indifference. In either of the events it affects the implementation of the programme, whether it be services or education or a combination of both. For no matter however good or desired and needed a programme might be, the instruments or the media through which it is implemented viz. the personnel is a key factor in its success or otherwise.

Then again the programme may or may not be amenable to modifications and change in the light of varying conditions and situations. Under the 'Conditions and Situations' are subsumed both the personnel and the people and their relationship with reference to a given programme. Theoretically it is possible to argue that all the three variables, viz. the programme, the personnel and the community can be changed in order to obtain the best of results. But in practice the last variable displays the greatest stability and resistance to change. In fact at any point of time it is the most stable factor. Therefore to assume that it is easily changeable amounts to begging the question. There are difficulties even with relation to effecting a quick change in the personnel arising out of a real shortage of the personnel, as for instance in the lesser developed countries, and administrative difficulties. Therefore, the programme seems to be relatively the most changeable variable. Yet, even here difficulties of attitudes on the part of the personnel and administrative problems might militate against any kind of modification. Structural changes in the programme hinge upon policy formulation and are, therefore, very difficult to attain in a short period. But even minor changes cannot sometimes be effected due to administrative arrangements and the consequent inability of the personnel directly in charge of implementing a programme in a field situation. This situation is particularly dangerous since it might engender a spirit of frustration and helplessness amongst those who are actually supposed to deliver the goods. It is not necessary to labour the point how very vital it is that the programme must

be meaningful to those who implement it. Otherwise there would be either a mechanical implementation of the programme or at worst a complete lack of co-operation in its implementation. The factor of deceitful practices arising out of this situation cannot be left out of account.

B. *The Personnel*

It is necessary to think both of the individuals and the team that is put in charge of a given programme. The present study has brought to light the immense importance of the team as well as that of what may be appropriately called the collective reputation. In one instance it was found that the efforts made by the A.N.M. came to naught owing to the bad reputation the medical officer and the compounder had earned by charging high fees. On the other hand, in cases where the collective reputation was good it had cumulative effect in rendering the programme successful. In cases where both the individual and collective reputation was bad the failure of the programme was certain as evidenced by one of the set-ups under study.

It is usual to speak of the 'personality' of the personnel — while analysing the success or otherwise of a programme. The 'personality' is a net result of complex interaction of factors such as the social background, qualifications, age, system of stratification, the set-up and the area. In many an instance there is hardly any scope for any modification either in the programme or in the set-up, let alone the community. At any rate the least that can happen in such a case is that the personnel is reduced in efficacy. There must be always some scope for initiative so that a 'situation' or at least some aspects of it can be changed. Detailed description of 'situation' in set-up E will clarify this point. The nature of the programme again necessitates that ceratin factors like age, system of stratification etc. be in favour of the personnel in order that the 'personality' may develop. For example, as the study has revealed, it is necessary for the A.N.M. to be mature in age, belong to a 'proper caste' in order to pursue effectively her functions in the field of maternity and child welfare services. Any type of activity where education which mainly involves changing peoples' attitudes, factors such as social background, age, qualifications, in addition of course to both individual and collective reputation assume special significance. It is not merely enough to be 'tolerated' by the people. In order to be effective it is necessary to be 'accepted' or rather 'wanted' by the people. For the former viz. being tolerated implies an attitude of condescension on the part of the people while the latter would probably imply the opposite. Of course, high and mighty attitude is not conducive to acceptance by the people. Likewise any act of discrimination also runs counter to acceptance. The case illustrations given below will amply prove these points.

The locale also affects the effectiveness of the personnel. Some are happier in smaller towns than in cities, while some feel happy in a rural set-up, notwithstanding the onerous conditions of work and living that obtain in villages. On the other hand, some feel stifled by rural conditions so much so that they develop attitudes of cynicism and fatalism. Naturally, this nullifies any chance of success of a programme.

C. *The People*

A good deal depends upon the previous experience of people in respect of any programme designed to enhance welfare and register improvement in living. The human mind is prone to draw comparisons and, therefore, the success or failure of any other programme tends to affect the fresh programme. A cumulative process is normally to be seen in operation, ensuring success where there has been any success in the past and likewise ensuring doom where there has been a failure. This is much more applicable in the case of relatively stable human organizations viz. in small towns and villages. Any programme that respects the needs and wishes of the people has a much greater chance of success than the one which flouts them. The latter situation might invoke a response ranging from indifference to hostility. A middle situation would be that where some of the needs and wishes are taken into account in the formulation of a programme. In such a case response is likely to be sectional. The local system of hierarchy is another factor in the peoples' response to a programme. There are three possible situations here. One, the programme has no bearing whatsoever on the local system of hierarchy so that the entire population remains indifferent — or two, the entire population reacts favourably or three, various strata are affceted differentially so that discrimination ensues with all its attendant consequences. In the last situation the programme may be functional for a few, but it may be either non-functional or largely disfunctional for the majority of the people. Either the system of hierarchy is left unaffected, or sharpened or new criteria and bases of hierarchy are introduced.

The prejudices and pre-possessions of the people in respect of health and medical services would also play a great part in the acceptance or otherwise of a programme. For instance, certain types of beliefs e.g. in witchcraft and black magic seem to be *prima facie* very inconsistent with modern system of medicine. On further scrutiny, however, it is found that people work out a very functional way of ranking maladies and remedies. The present study has revealed how even a priest-magician resorted to modern medicine beyond a particular limit. People are able to judge the utility of the seemingly irrational remedies and they also know at what

point they have to effect a departure in favour of modern system of medicine. Thus a peculiar position of equilibrium is arrived at by the people, which is by and large functional.

Of course there are other factors like prejudices based on sex, age, caste etc. which stand in the way of acceptance of a programme. More important still are the difficulties of the people in relation to payment for the programme or any part thereof. Partly this is due to the age-old tradition of dependence and partly due to lack of liquid money.

Special difficulties present themselves in the sphere of the educative aspect of a programme. Here the notions of hierarchy, concepts of pollution, lack of faith in any educative process and overemphasis on immediate curative results etc. on the part of the people come into their own. And it is very difficult to counterbalance the effect of these forces so that the possibility of health education is reduced to its very minimum if not to nullify altogether. It also needs to be added that the general living conditions put a premium on unhealthy practices.

The same analysis as above would logically apply in the case of the personnel in charge of implementation of a programme. In fact the first possibility viz. the indifference of the people to the personnel is relatively slender as evidenced by the present study. The second possibility is greater. And the third possibility viz. discrimination in favour of certain strata by the personnel is also to be seen in operation e.g. in favour of the relatively more educated people. The programme ultimately is that which is implemented by the personnel and so I have introduced the variable of the personnel along with the programme. Yet it would be wrong to think of this variable as neutral. In itself it gives rise to factors such as age, system of stratification, qualification, individual and collective reputation and complicates matters in relation to the acceptance or otherwise of a programme by introducing the problem of personnel or otherwise in between.

Thus the entire problem of acceptance or otherwise of a programme and its consequent success or failure has to be analysed structurally in terms of the relationship between the programme, the personnel and the people. I have purposefully adopted this order in listing the variables as the programmes become meaningful or rather even come into operation due to the instrumentality of the personnel. This way of putting things might smack of a linear relationship between the three variables. However, it rests on the assumption that a programme is always 'given' and thus not amenable or subject to change. And this is all very true in a short span of time. In the long run, however, there is every possibility that the programme can be modified and changed in view of the pressure of opinion of either the

personnel or the people or that of both. Hence in terms of analysis over a period of time we have to think of the interaction at work.

Now we proceed to describe reactions and responses of the people set-up-wise and unit-wise.

Set-up A, Unit A1

Following the mode of analysis mentioned above we describe in brief the programme, the personnel and the peoples' reactions and responses.

A—The Programme

The main work of the centre pertains to maternity and child-welfare services. Accordingly, ante-natal and post-natal 'clinics' are held in every week and there is also a clinic on children. Milk, foods and vitamin tablets are distributed every morning to expecting mothers and children in the centre. A sewing class has also been set up in order to enable women in the locality to take lessons in sewing, particuarly their children's clothes.

The centre is situated in the heart of the city and caters to a very congested locality; within a radius of half a mile there are about 10,000 persons living in shabby houses. The entire picture is one of poverty, want, suffering, lack of education, insanitary and unhygeinic conditions of living etc.—And the programme primarily caters to such people.

B—The Personnel

The health-visitor (who is a Refugee Hindu) is in charge of the centre. She is assisted by an A. N. M., Dais and an Ayah. The health-visitor is properly trained. The A. N. M. seemed to be a keen worker. The observations about these persons are based on house-visiting with them as well as on the interviews with the patients and finally on the discussions that I had with both of them.

From the point of view of the present study some details about the A. N. M. would worth recording. This A. N. M. has been working in this centre since December 1956 and has done a good deal of house visiting.

The following details would provide the requisite background:

Religion—Muslim, Age—27, Education—non-matric, Civil status—Divorced, Birthplace—A city capital of the State, Number of brothers and sisters—3 brothers, 1 sister, Position in the family—second, Nature of the family—Nuclear family, Educational background of family—Father—Sub-Inspector of Police, Brother—Sub-Inspector of Police, other Brothers—educated up to 8th class, Mother and sister read and write Urdu. How did she join the training course for the A. N. M.—In consultation with

Dr in charge of the Institution where the course is given and in spite of the objections raised by the parents and the husband, Background of social service in the family—nil, Her first experience with people in this centre—At first it was unhappy as people had suspected her to be working for the intelligence Branch, in view of her activity of house-visiting, but now they have realized the true nature of her work and so they have accepted her and she is happy. Suggestions made by the A. N. M.—She suggested that the stipend during the training period be enhanced, proper residential quarters be given, training period be extended so as to fit the trainees better for the various jobs they are expected to perform. In fact, she suggested that the minimum educational qualification for admission to the training programme for the A. N. M.s be matriculation.

All these details are given with a view to understand better the personality of the A. N. M. and the consequent response of the people to her work. Discussions with the person in charge of the centre, as well as the A. N. M. concerned and the people for whom she worked brought out the fact of the interest taken by her in her work.

C — *The People and their response to both the Programme and the Personnel*

The families were visited by me once with the health-visitor and the A.N.M. and next time independently. The families selected were nine in all of which eight were Muslims and one was a Hindu, thus taking note of the proportion of the population. Economic status of the families was very low, the average monthly income being less than Rs. 35. The educational level of the families was also very low, particularly amongst the females. The housing conditions and the sanitary arrangements were pretty bad. Except in two cases, where the husbands happened to be at home, women were interviewed.

In relation to the programme the consensus of opinion or rather unanimous opinion was in favour of demanding greater supplies of food-stuffs, soap, vitamins, etc., the primary cause being dire poverty. Even in respect of the personnel there was a unanimous good opinion of the work being done by the health-visitor and the A.N.M. Likewise the families were satisfied with the manner in which they were treated by these two. Both of them have established fair reputation.

In the case of unit A1 the programme, even though people asked for an expansion of the same, was successfully carried out owing to (a) the needs of the people being satisfied at least partially if not completely; (b) the harmonious relationship between the people and the personnel in charge of the programme; (c) the fair individual and collective reputation

of the personnel; (d) the absence of factors like prejudices, previous unhappy experience, etc., which go to impede the effective functioning of a programme — at any rate the presence of such factors, if any, was negligible since it didn't seem to affect the working of the programme; and (e) there was no attempt on the part of the personnel to overplay the role.

Set-up B

The set up, the programme and the personnel remain the same for set-up B though there is a change in the people along with a change in the units. Therefore, the set-up, the programme and the personnel would be described first and then the various units.

The centre caters to maternity, child and health services. It is directly under the Civil Surgeon and being near to the city should be more amenable to control and supervision. Yet in reality it is not, may be due to the personnel.

A *The Programme*

The programme consists of maternity, child-welfare and general services to the small township and twenty villages. A training programme for the Dais has also been organized and both the medical officer and the A. N. M. participate in the same. This programme is designed to prepare the Dais for undertaking deliveries in rural areas in a scientific and hygeinic way. The purpose is to reduce the burden of work on the A. N. M. ultimately. Even today normal cases of delivery are conducted by the local Dais who are untrained, and the A. N. M. is mainly called upon if a case is difficult. Ante-natal, post-natal and children's clinics are conducted in the centre. House visiting is done by the A. N. M. in the township and the various villages under the jurisdiction of the centre. The purpose is both that of rendering services and imparting health education, though in practice the latter is almost absent. This may be due to two reasons—one, the shortage of time, two, the lack of enthusiasm on the part of both the givers and the recipients of health education. The factors mentioned earlier also come into play. Anyway in practice the programme is entirely service oriented.

B *The Personnel*

The personnel consists of a medical officer, an A. N. M., two Dais, an Ayah and a chowkidar. The medical officer had been recently posted there. In fact there was some history to that. The medical officer concerned was transferred to this centre owing to the complaints made by the community in the previous place of his posting regards illegal gratification,

resorted to by him and pratices of favouritism and discrimination. In this contest it has already been noted how even to the date of this study patients continued to flow in from the place of his previous posting. To say the least that meant neglect of duty on his part in the place of his present posting. He protested too much regarding the fraternal attitude he had towards all the people under his charge. In fact, statements to the effect were made by him without any warrant. On scrutiny it was found that he was notorious as regards neglect of duty and illegal practices. In short, he has earned a bad reputation.

The following details about the A.N.M. are given so as to throw some light on her personality and reputation. She is 21 years of age and is Muslim by religion. She has studied upto 7th standard and has appeared for the highest examination in Hindi. She stated that she wanted to do her B.A. and get out of this career. She said her husband was living, while on corroboration I learnt that she had lost her husband prior to her joining the training course. She had 1 brother and six sisters. She had a baby. She was second in the family. She was brought up in a joint family. As regards the educational background of her family, her father had passed his 8th standard; her husband had very little education to speak of, obviously to her great embarrassment; her uncles were matric and her brother and sisters were schooling. Her father is a fruit-seller and so was her husband. She was all apologies for that and explained that they were whole-sale traders and were doing good business. She joined the training course much against the wishes of her parents and husband's people, in consultation with a friend who was a nurse. None in her family had done any social service. As regards her first experience with people, she was hesitant to say anything. As will be mentioned later on, her experiences both in the training institution and with the people were none too happy. In fact, she mentioned that she had a difficult time with the matron in the training institute and also met with resistance from some people. She narrated an incident of people hooting her out in one of the villages where she had been for a case of delivery. As I went house-visiting with her in the township as well as in the villages I found that she almost tried to persuade the people to report to me that she had been there house-visiting. And many people did not comply with her request. The matron, referred to earlier, told me that this A.N.M. was notorious for her neglect of duty and deceitful practices during her training and had been severely warned. It was further stated that she never dared to meet the persons in charge of the training institution even when she was near to the city. The A.N.M. was very complaining about the conditions of work and living, although some of the difficulties were genuine e.g. lack of adequate accommodation and hardships relating

to house-visiting in the villages. As mentioned earlier she wanted to do her B.A. anyhow and wanted to quit the present career. She struck me as a relatively ambitious person. The present post was evidently being used by her as a stepping stone to further advance in the social ladder and was very keen on changing the present career. Obviously for her, even this post meant social ascent in view of what she regarded as poor occupational background of her father's and husband's family. There was not the slightest possibility of her devotion to the career. She was wanting in even ordinary degree of integrity needed for doing any job well. It must be mentioned that she was terribly uneasy in our presence and somehow tried to ward off any possibility of scrutiny regarding her work and doings. The attitude of this A.N.M. towards the poorer sections of the people was one of condescension. An overbearing nature and a tendency to snub the Dais were evident. In short, her character can be summed up as a very ambitious person who had no scruples in respect of attaining the cherished goal viz. that of personal advancement. The reactions of the people clearly revealed her character in full measure.

The Dais had hardly any position or say in the whole set-up. Either they toed the line followed by the medical officer and the A.N.M. or they were snubbed by them.

Thus both the medical officer and the A.N.M. had both individual and collective bad reputation.

Unit B1

This unit comprised of a small refugee township. The majority of the people were very poor. A few well-to-do persons were interviewed and they seemed to be satisfied with the services rendered by the A.N.M. and the centre. However, all the poorer people interviewed said that neither the A.N.M. nor even the Dais had ever visited their homes, let alone the question of any services being rendered by these persons. These people further explained that the A.N.M. visited the well-to-do families since she received fees from them. As for themselves there was no possibility whatsoever of paying any fee and hence the neglect. The medical officer and the A.N.M. had vouch-safed that every single family in the township had been visited by the A.N.M. and the Dais. This was obviously not so and the poorer sections had been discriminated against. The negative response of the majority of the people was owing to the fact that the programme just had not reached them. The A.N.M. stated that in general higher caste people did not like being frequently visited and one of the plausible reasons was that pollution in view of their visiting the houses of lower caste people. Obviously enough, this was just a convenient excuse hit upon by the A.N.M.

Unit B2

The unit B2 was almost next door to the centre, being just a mile removed from it. There too a few persons of different castes and including the headman of the village were interviewed. There was a unanimous response that the A.N.M. would not treat the cases properly even after extracting high fees from them. The former A.N.M. and a Dai had made such demands. Of course the people didn't say anything as regards the present A.N.M. and the Dais as none of them had ever visited them. However, owing to the previous experience, the people had abandoned going to the centre i.e. for two reasons—heavy fees that were charged and the bad treatment meted out to them. Here again is an instance of the utter failure of the programme due to unscrupulous practices on the part of the personnel and their high and mighty attitude. In view of this the people preferred to be treated by untrained Dais from nearby villages.

Unit B3

This unit was situated about five miles away from the centre. There were both Muslims and Hindus in the population. Persons of different castes were interviewed. The headman of the village was the only person who said that he had received services from the A.N.M. at the time of his wife's delivery. Everyone else, including the headman, reported that even though the A.N.M. had once visited the village, she had never rendered any services to them. These people complained of the neglect by the centre and the utterly unsympathetic attitude towards them by the personnel. Here too the people resorted to the services of an untrained Dai from a nearby village. These people had stopped going to the centre for any medical aid. The net result was a complete failure of the programme.

Unit B4

This village is also situated about five miles away from the centre. There was a primary school in this village. In this village also persons of different castes including the headman were interviewed. In this village there seemed to be a very clear-cut cleavage on the basis of economic status. All those who were relatively well-to-do reported that the A.N.M. visited the village and that the entire community had benefited by her services. The poorer people, on the contrary, reported that they had neither been visited nor helped by the A.N.M. This unit furnishes a very clear illustration of discrimination by the personnel. The programme is effective only sectionally.

Unit B5

This village is situated about six miles away from the centre. In this instance too more or less similar experience was reported by the people.

On the whole this set-up and the various units subsumed under it present the picture of the failure of the programme, intended to do good to the people, owing to deceitful and discriminatory practices by the personnel, individual and collective bad reputation, of course in this case quite well earned, inability and helplessness of the people at large to do anything in respect of such malpractices excepting that of refraining from taking advantage themselves of the centre and its activities. All this becomes all the more curious in view of the nearness of the centre to the city, which is also the headquarters of the Civil Surgeon, under whose supervision and control the centre is supposed to be.

Set-up C and Unit C1

The set-up comprises of a dispensary and beds for maternity cases. General medical treatment, dispensing of medicine, treating out-door patients and ante-natal and post-natal cases are the major activities of the centre. As said above the centre has two sub-centres under it. There is a medical officer in only one sub-centre. The medical officer of set-up C visits the other sub-centre once a week. The set-up is established in a town.

A. *The Programme*

The programme has been already described. The A.N.M. is required to perform general nursing duties. The medical officer told me that no specialization was possible due to paucity of staff. The programme primarily caters to the residents of the town, though people from neighbouring villages also take advantage of the centre. Yet house-visiting by the A.N.M. is restricted to the town as she has no time to go to the villages after attending to her duties in the centre.

B. *The Personnel*

There is a medical officer, an A.N.M., a compounder, a Dai and a Chowkidar. The medical officer has established an excellent reputation by his work and the manner of treating people. The A.N.M. too has established good reputation by her work and good manners. Thus, in this instance, both the individual and the collective reputation are excellent. The medical officer is fully trained and has excellent experience of work. The following are the details about the A.N.M.'s background. She is 23 years old and is a Muslim by religion. She is married to a sub-inspector of police and has a child. She has five brothers and three sisters and her position amongst

the siblings is 4th. The family is nuclear, though she is a co-wife, who stays with her husband at the place of his posting. The educational background of her family can be easily inferred from the fact that her father too was a sub-inspector of police. Her brother was studying in a college. Her uncle worked as a professor in a college. The general background of the family was quite good, occupationally and socially. She had joined the training course in consultation with her husband. In fact she said that after serving for the bond period, i.e., three years, she would like to join her husband and start private practice. There had been no one in the family who had done any social service. Her first experience of work in the community was of a mixed type — both happy and unhappy. Some persons had tried to harrass her. So also a subordinate of her husband tried to harass her. She referred to the fact that some individuals referred to her in a derogatory manner. Therefore, she insisted that she would always be accompanied by a Dai or a Chowkidar, while house-visiting. Yet she felt that by and large her honour was respected by the people. Her deplorable quarters were her greatest affliction. Since she had to perform general nursing duties in the dispensary, she said, she couldn't devote as much time as she would like to maternity and child-welfare services. On scrutniy, I found that people were well satisfied with her work and manners. In fact, many of the people, I interviewed, made a strong plea that the A.N.M. be spared from general nursing duties so that she can be of much greater use in the field of maternity and childwelfare services. The poise, and self-assurance of the A.N.M. were remarkable.

C. *The people and their response to the programme and the personnel*

Persons belonging to different strata were interviewed. They included a head-master of the B. T. School, a village-level-worker, a peon, a police constable and so on. There was a unanimously good opinion about the work and activities of the centre. The matron in the training institution regarded her as an excellent worker and reported that this A.N.M. kept in touch with the training institutions. People were very well satisfied with the excellent work of the medical officer and the A.N.M..

The programme was effective due to the following factors: (A) excellent individual and collective reputation of the personnel and (B) people wanted the programme.

Set-up D and Unit D1

The set-up functions in a small town with 200 houses. This small town has a middle school with nine teachers and 140 pupils. It is a trading centre. This sub-centre of set-up C does not have a resident medical officer.

The medical officer from the set-up C pays a weekly visit. This sub-centre is staffed only by a compounder and an A.N.M. Both the compounder and the A.N.M. are very well thought of by the people for their work. Between them the A.N.M. and the compounder perform duties right from dispensing of medicines, giving injections, general nursing duties and maternity and child-welfare services. Every day about 30-40 patients come to the dispensary. Serious cases are taken to properly equipped hospitals.

A. *The Programme*

The programme is really of an omnibus nature. House-visiting is done by the A.N.M. Muslim women do not go to the centre due to the purdah-system and hence the A.N.M. has to visit their homes. The programme primarily caters to the local residents, though people from neighbouring villages come to the centre for medicines. House-visiting is of course restricted to the small town as the A.N.M. has neither time nor any help to go to villages. By so limiting the area of her operation the A.N.M. has been able to render intensive services, e.g., she visits a family even three times a day in the case of a serious patient.

B. *The Personnel*

The personnel have an excellent individual and collective reputation. I observed personally how the compounder and the A.N.M. did not stand on formalities of any kind in the discharge of their duties. The A.N.M. is 32 years of age and is a Christian. She had passed the 7th standard. She was a widow and had three children. Her husband was a motor-driver and then worked in the railway department. She had two brothers and a sister, her position in the family being the youngest. She was staying with her children. Her sister is a nurse. All members of her family have been educated upto the 7th standard. She joined the training course against her husband's wishes. As ill luck would have it, her husband died of a heart attack very soon after her joining the course. And she had a bad conscience about it, though she was quite certain about the correctness of her decision. Her father had done some social service in a religious association. She appeared satisfied with her experience of work with the people. She suggested that the stipend during the training period be enhanced and safe living accommodation be provided for. Her present quarters aren't safe as the windows had no bars. She also asked for the assistance of a Dai and a sweeper. No complaint was made by her that the work was too heavy. She was very well satisfied with the response of the people and felt that her honour was very well respected by them. Likewise there was no discrimination on the basis of caste, religion, economic status, etc.

C. *The people and their responses to the programme and the personnel*

A group of nine teachers, a shopkeeper, a police officer, a constable and a few labourers were interviewed. The opinion was unanimous, viz., the excellent work being done by the A.N.M. and the compounder. As regards the effectiveness of their services, the people said that they would stand only next to the medical officer. The genuineness of the A.N.M. was revealed by the incident where she took all the pains to drive away a cow that was eating the grain kept by a cultivator when he had been a little removed from the scene. Everyone greatly appreciated the genuine interest the A.N.M. took in the well-being of the people even in extra professional field. The matron in the training institution also made very appreciative remarks about her work and character.

The success of the programme hinged on A — the excellent individual and collective reputation of the personnel based of course on their excellent work and B — the demand of the people for the services that were offered.

Set-up E

The set-up E is located in a small town, but caters to surrounding villages only, as the small town is mainly inhabited by the railway staff, who have their own dispensary and hospital in a nearby place and never visit the sub-centre. This sub-centre is under set-up C. There is a medical officer, an A.N.M., a compounder, a Dai and a Chowkidar. The only activity of the sub-centre is that of dispensing medicines and house-visiting by the A.N.M. No facilities exist for maternity cases so that any difficult case has to be referred to a hospital in a nearby town. Neither milk nor foods of any kind are distributed to the people. Injections are not supplied free. Very few people come to this sub-centre.

A. *The Programme*

The programme has been already described. It is characterized by meagreness of activities. The natural corrolary to that being a very poor response at this sub-centre. Owing to a lack of activities the programme becomes mainly an educative activity. There are hardly any services. House-visiting is done by the A.N.M. in the villages. But in the absence of any actual services that can be rendered, the programme becomes purely educative. Therefore, the failure of the programme is implicit in its very nature.

B. *The Personnel*

The personnel consists of a medical officer, an A.N.M., a compounder, a Dai and a Chowkidar. As regards the various units under the set-up there was on the whole a non-availing of whatever services that were avail-

able in the sub-centre. And some part, if not the major part, of its explanation lay in the fact of the bad reputations of the medical officer and the compounder. In some units a very direct mention was made of the same, while in others there was a veiled suggestion to the effect. The net outcome of this sort of situation was the collective bad reputation of this sub-centre. In one of the units the A.N.M. too came in for a good deal of criticism. The process of rumour-mongering was at work. The reputation of the A.N.M. was sought to be spoilt by spreading the rumour that she had refused to do her duty in a particular case. In all the other units she had a fairly good reputation. Though of course her reputation was entirely nullified by the fact of the collective bad reputation as well as by the general ineffectiveness of the programme. The following details about the A.N.M. will explain the situation. She is only 19 years old and is a Christian. She is unmarried. She had 3 brothers and 3 sisters and is the youngest amongst her siblings. She was brought up in a nuclear family. Everyone in her family had some schooling. Her father was a manager of a small factory. One of her brothers is a carpenter, while the other is a driver. A sister is a teacher and it is at her instance that she joined the training course in spite of objections raised by the brothers. Another sister was married and didn't work for her living, since her husband would take her working for a living as an insult to his capacity. The implication was that married women should not work for a living unless compelled to do so by force of circumstances. There was no background of social service in her family. Her first experience of work with people was happy. She suggested that accommodation should be given as insecurity resulted from a lack of living place during the last four months of her posting. So also arrangements be made for proper escort while home-visiting in villages. The most important suggestion made by her pertained to a substantial increase in the activities of the sub-centre so that the people, being convinced of the utility of the set-up, would avail themselves of the centre. It was further remarked that the activities of the sub-centre at present were too few to benefit the people and gave rise to partial utilization of the staff. She would like, she said, to set up an independent practice after the bond period was over. This was said not with a view to giving up the career obviously. She had stood first amongst the batch. She was interested in public health. She felt she had benefited greatly by the training and experience she had received. She felt that her honour was respected by the people.

C. *People and their responses to the programme and the personnel unit-wise*

It must be mentioned that the response to the programme was more or less common to all the units, whatever the difference in the reasons

ascribed by the people for their reaction. The over-all picture was one of apathy and indifference, coupled with frustration. The programme was too watered down to evoke any positive response from the people. The people had to resort to medical help from hospitals and dispensaries situated in nearby towns. Or the other extreme was that they completely refrained from taking any medical aid whatsoever.

Unit E1

This village is hardly a mile away from the sub-centre and consists of twenty-five families, mainly Rajputs by caste with a few Harijans. The headman of the village, a few other Rajputs and a few Harijans were interviewed. The unanimous opinion was that the programme was quite inadequate to meet the needs of the people. As for the personnel, the people were satisfied with the behaviour of the A.N.M. and the services rendered by her in respect of maternity cases. They went to the sub-centre to get some medicines. No mention was made regarding the medical officer and the compounder.

Unit E2

This village was situated three miles away from the sub-centre. There were twenty-five families mostly Rajputs with the exception of two Harijans. The headman of the village and a few other persons, including Harijans were interviewed. The unanimous opinion was that the people were not at all satisfied with the services rendered by the sub-centre. The primary reason for this was that the medical officer and the compounder charged heavy fees — it was reported that the former had in one case demanded Rs. 16 as a visit fee. On scrutiny I was told by the medical officer that it was within his rights to charge fees for visits, though he never said how much. Actually a tariff exists for the fees. Only the Civil Surgeon can charge Rs. 16 while the medical officer could only charge Rs. 2. Next, they were not supplied with any medicine other than 'saltish mixture'. They were asked to buy their own medicines from the market. Hence they have stopped going to the dispensary altogether. An obvious case of a woman suffering from T. B. was never referred to the Dispensary. Yet the people were satisfied with the behaviour and the work of the A.N.M. But owing to A collective bad reputation of the personnel and B the ineffectiveness of the programme, the people refrained from taking advantage of the sub-centre. Mere individually good reputation is thus not adequate in the face of adverse collective reputation.

Unit E3

This village was situated a mile away from the sub-centre. There were fifty-one families — mainly Hindu, with a few Muslim families. The

headman of the village and a few other persons, including the priest-magician were interviewed. A priest-magician lived in this village and the people had faith in the efficacy of his powers. Yet they knew when it was necessary to consult medical men. The priest-magician did not mind if people consulted medical men in cases that were presumably beyond his control. In fact he himself resorted to the help of modern medicine in the case of his own relatives. Thus people had worked out a system of classification and ranking of maladies and remedies and there was no conflict between the traditional belief system and the modern system of medicine. The people felt that the programme was far from adequate to meet their needs. There was no dis-satisfaction against the personnel. As regards the A.N.M. the people were quite satisfied with her behaviour and the services she rendered to them. She also persuaded them to utilize facilities that were available at the sub-centre.

Unit E4

This village was situated about two miles from the sub-centre. The population was entirely composed of the Hindus, with various castes. The headman of the village and a few other persons were interviewed. It was in this village that the rumour-mongering against the A.N.M. was noted. One person reported that the A.N.M. had refused to visit a case in a neighbouring village and that therefore the people of this village had stopped going to the dispensary. On thrashing out the matter, it was found that the A.N.M. had refused to go on good grounds, viz., that the man who came to fetch her at midnight refused to say anything about the reason for calling her and secondly he also refused to get any transport for the A.N.M. even when she agreed to go with him. In spite of this thrashing out facts the villagers did not in any way feel sorry for having spread rumours.

The total impression one gets from the analysis of these units is that even where the A.N.M. was liked by the people, she was not completely accepted by them. As gathered from casual remarks made by people, the age, caste and the civil status of the A.N.M. hindered the process of acceptance. In the first place she was both very young in age and unmarried and hence failed to instil confidence in the people in respect of maternity cases. Second, her religion proved to be a bar against her acceptance. And yet due to her dignified and pleasing appearance, keen desire to help the people and genuine efforts made by her she earned a place for herself in the peoples' estimation. However, in terms of concrete effects she was mainly tolerated. The decisive reasons for this situation being: A — the basic inadequacy of the programme and B — the collective bad reputation. Under these circumstances her efforts could not be effective. The people were convinced

of her genuineness. The matron in the training institute had testified to the high degree of competence as well as the integrity of character and a right sense of service and the spirit of helpfulness of this A.N.M. It is all the more tragic that due to the factors mentioned above she could not be effective. It was heartening to note that the A.N.M. had neither lost courage nor hope.

The theoretical analysis made earlier relating to the responses of the people to programmes and personnel or rather through the personnel is borne out by the description of different set-up and units. The linear relationship, as it operates in the short run, between the three variables, viz., the programme, the personnel and the people's responses is also largely brought out, though there are hints to the effect that the dialectical process can set in at certain points, e.g., in the set-up E wherein the action and reaction of all the three variables was noticed.

Concluding Remarks

As stated in the introduction there are no conclusions to this study. Yet a few hypothesis have suggested themselves. The first suggestive anomaly is of a conceptional nature, viz., the use of the term Auxiliary Nurse in face of the fact that no guidance or supervision from professional nurses is usually available. Then if the A.N.M.s, have to be regarded as 'substitutes' for nurses they cannot legitimately be called Auxiliaries. This process of substitution, whether manifest or latent in the sense that it is both intended and acknowledged or it is neither intended nor acknowledged has consequences in the first place for professional standards, two, for the personnel, three, for the programme and four, for the community. The hypothesis arises that in the case it is intended, due safeguards have to be provided for to maintain standards of performance, to prevent encroachment on the professionals area of work, to draw a clear line between the professionals and the auxiliaries, to provide opportunities for the advancement of the auxiliaries so as to attain full professional status, to plan the programmes and training accordingly to prevent the 'substitutes' from outstepping their limits in view of their relatively inadequate training and finally planning of the entire programme in such a manner that there will be no unemployment amongst the auxiliaries who have been required to function as substitutes. The present study goes far towards supporting the hypothesis that such an integrated action-programme would be followed by favourable results. My discussions with the Matron, the sister-tutor and the brother-tutor in a sister institution brought forth the possibility of the feeling of insecurity on the part of the professional if the process of substitution were to be manifest. In the other event, viz., the process being latent, it is very difficult to plan ahead, for the

authorities concerned are just not aware of it. Nevertheless the consequences for standards of performance, encroachment on the professionals' field and all other possibilities listed already would be the same. Even today when the process of substitution was not manifest, quite a few auxiliaries — the trainees and the trained — expressed their desire to set up an independent practice after completing the bond period. Obviously enough this will give rise to a variety of situations ranging from undermining the entire scheme for providing auxiliary nurses to lowering of standards of performance, encroachment on professionals' field and the consequent insecurity, rivalry, undercutting, etc., thereupon. Besides, the dangerous consequences arising out of situational factors whereby the Auxiliary Nurse Midwife has to outstep her role have been already noted. In this case the programme and the people will suffer.

The effect of partial implementation of any scheme, viz., the preparation of the A.N.M.s is reflected in the training programme, the programme of health services and education, the manner of posting and all that goes with it or rather should go with it, e.g., safe and assured accommodation, provision of an escort, etc., has been forcefully brought out by the foregoing analysis of a relatively simple situation.

The foregoing study has vindicated the basic formulation of the problem, viz., in terms of the three main variables, i.e., the programme, the personnel and the people. Further, the sub-variables subsumed under each variable and their interrelations with and interaction on other sub-variables have vindicated the methodology employed, viz., the structure-functional. For it has been amply borne out by the findings that the social system has to be treated as an integrated whole in order to understand properly the ramifications of a measure intended to bring about change, in a desired direction. In the context of this study the desired change was in the spreading of medical and health services by providing for a special personnel. Thus change was sought to be institutionalised. However, it was found how the change would be or would not be functional for the people, depending on the congruence or otherwise between the prevailing social structure and the measure for change. The principle of structural unity and fact of structural constraints pari passu with that were reaffirmed. Thus on the one hand it was found that change in one area of social structure would not be operative unless other aspects of the same were taken into proper account. Secondly, that every social structure is beset with structural constraints, e.g., the relative shunning of nursing as a career by high caste Hindu women on the one hand and the relative non-acceptance of non-Hindu nursing personnel by the people.

APPENDIX A

Teaching Time-Table for the Month of March 1958

Days	8-30 a.m. to 9-30 a.m.	4 to 5 p.m.	4 to 6 p.m.	6 to 7 p.m.
Monday.	——	——	Midwifery 2nd year A.N.M.s	Revision classes 1st year A.N.M.s
Tuesday.	Anatomy and Physiology 1st year A.N.M.s	Midwifery 2nd year A.N.M.s Dr. Deshi.	——	do.
Wednesday.	——	——	Midwifery 2nd year A.N.M.s	do.
Thursday.	Anatomy and Physiology 1st year A.N.M.s	——	——	do.
Friday.	——	——	Midwifery 2nd year A.N.M.s	do.
Saturday.	Anatomy and Physiology 1st year A.N.M.s	Midwifery 2nd year A.N.M.s Dr. Deshi.	——	——

APPENDIX B

Daily Time-Table of A.N.M. Students

6 to 7 a.m.	Toilets.
7 to 7-20 a.m.	Breakfast.
7-25 a.m.	Roll call.
7-30 to 11-30 a.m.	Duty.
11-30 to 12 noon.	Lunch.
12 noon to 4 p.m.	Duty.
4-30 to 6-30 p.m.	Games (Badminton, basket ball, cycling, tennis etc.).
After 6-30 p.m.	Bath.

Evening duty

7-30 to 12 noon.	Duty.
12 noon to 1 p.m.	Lunch.
1 to 4 p.m.	Rest.
4 to 7-30 p.m.	Duty.
7-30 to 8 p.m.	Dinner.
8 to 10 p.m.	Study.
10 to 6 a.m.	Bed.

(Sunday) *Morning duty*

7-30 to 12 noon.	Duty.
12 to 12-30 p.m.	Lunch.
12-30 to 2 p.m.	Duty.
2 to 4 p.m.	Rest.
4 to 8 p.m.	Shopping or pictures.

Evening duty

2 to 4 p.m.	Duty.
4 to 4-30 p.m.	Tea.
4-30 to 7-30 p.m.	Duty.