Chapter - 7
Summary and Conclusion

Introduction

1.1 The Problem of Research:

Despite the introduction of modern health care system, the traditional institutions continue to play an important role in the rural areas and there does not seem to be any apparent sign of their disappearance either from the health scene in the near future. One such live example from traditional institution is the Traditional Birth Attendants (TBA) locally known as a "Dai". An institution of "Dai" got established when one woman, a female obstetrician assisted the other woman, in child-birth. TBAs (Dais) conduct deliveries in the homes of their clients in different socio-cultural environment. They provide psycho-social support to women during ante-natal and post-natal stages. TBAs stay in the villages where they work and enjoy a unique position of trust and responsibility among the village community. They continue to play an important role as more than three-fourths of the deliveries in the villages are conducted by them. In order to provide scientific training to TBAs and wider health care services to the rural folk especially mothers and children the government has established a centre of Health functionaries (female) in post-independence period at the village level.
With the introduction of ANMs' role, various changes have occurred in TBAs' role. New scientific approach brings consciousness among them. More and more TBAs got formal training in midwifery from the ANMs. In this interaction both have shared their skills and methods of conducting the delivery at home. In this process, ANMs got experience of working with TBAs, and TBAs got scientific training from ANMs. The role of both TBAs and ANMs in maternity practices are considered important as both try to maintain the community members' health, especially of mothers and children.

At the initial stages, ANMs were responsible for maternity and child-health care only. Later on, they were re-designated as multi-purpose health workers and made responsible for total health care of about 10,000 rural population. With this, the entire burden of implementing the health care programmes falls on them. The performance of such an enormous range of services with efficiency to the members of the village community makes their position ambiguous in the rural as well as occupational hierarchy. This intervention brought new expectations as also apprehensions, doubts and misgivings regarding some of the health services provided by them. Some TBAs inspite of getting formal training in midwifery still lack scientific temperament and are following the traditional methods in conducting the deliveries. On the
part of ANMs they lack experience and some of the scientific practices providing health care to mother and children which are not yet followed by them.

The health care services at the village level brought consciousness among the community members. They have started evaluating both the set of roles (TBAs and ANMs) separately. Certain segments of people think that ANMs provide more scientific health care to the mothers and children, whereas others consider the experience and traditional skills of TBAs more important and significant. This indicates that social set up of a village is still unchanged and people still uphold their traditional character. The community members prefer to call a TBA to get the delivery conducted at home, one of the important factors associated with the availing of services of TBAs (Dais) or ANMs is the perception of the community about them. This can be viewed in two contexts. First, what does the community expect from TBAs (Dais) and ANMs and second, their level of knowledge regarding services provided by TBAs and ANMs. The role performance of TBAs is affected by a different set of role expectations of community members as well as ANMs. On the other hand, the role performance of ANMs is affected by a different set of role expectations of immediate supervisors (LHV's) and supervisor (Medical Officer) and above all that of community members (where they work), in addition to their own role perception. This is precisely what forms the base of this study.
1.2 Objectives of the Study:

The main objectives of the study are:

1. To delineate the socio-economic and cultural characteristics of TBAs, ANMs and community members (housewives).

2. To analyse the perception and expectations of TBAs (Dais) and ANMs towards each other and relate these to some of their socio-cultural characteristics.

3. To analyse the expectations and response of the community members (housewives) towards their role performance.

1.3 Hypothesis of the Study:

The study largely being descriptive of the general hypotheses pertaining to it, are:

1. Differences in emphasis on various functions of ANMs by supervisors (LHVs and Medical Officers) as perceived by ANMs may create structural inconsistency and make their role dysfunctional.

2. Lack of association between the role prescription (demands), role perception and expectations as perceived by ANMs, may affect their performance and make their role dysfunctional, while this may be less among TBAs (Dais).
3. Because of the multiple role sets to be performed, ANMs may not perform adequately due to organizational constraints (targets of family planning and lack of medicines), whereas TBAs (Dais) as a single role-performer may prove better.

4. Lack of requisite role facilities and role rewards for ANMs may affect their performance and may also result in making their role dysfunctional.

5. ANMs may expect TBAs (Dais), being members of village social set-up, to work as their subordinates whereas TBAs (Dais) being independent workers may expect ANMs only to provide guidance in their tasks.

6. TBAs (Dais) by having an occupational autonomy of conducting deliveries in villages may for the protection of their self-interest, hinder the functioning of ANMs in the same village.

7. Community members, from the lower socio-economic status, may prefer to get the deliveries conducted at home by TBAs whereas the members belonging to the higher status may avail the services of ANMs or private nursing homes.
8. TBAs (Dais) may have a better acceptance among the community members than ANMs because of their willing participation in the culturally accepted norms or practices such as washing clothes, giving massage to baby and the mother etc. which ANMs' do not consider to be the part of their duties.

1.4 Methods of Study:

The study was carried out in the rural areas of Batala sub-division in Gurdaspur district in the State of Punjab.

After having necessary discussions with different district level officers, the universe of the study was selected as suggested by the District Panchayat Officer. All the ANMs associated with primary health centres in the sub-division were interviewed. A small number of ANMs available at PHCs was the only rationale behind selecting all the ANMs. The main focus was an eliciting their responses pertaining to their socio-economic background, occupational background, their expectations from LHV's and Medical Officers, TBAs and community members, their perception of their own and TBAs' role, their perception of the expectations of their supervisors (LHV's and Medical Officers), TBAs and community members about their role, their role performance (Working pattern in the Health Centre and field) and their own satisfaction with the role they performed, their role relationship with TBAs, problems and suggestions to make their own as well as TBAs' role more effective.
In order to have comparative analysis, it was thought appropriate to have an equal proportion of TBAs to ANMs (100). Since the comparative number of TBAs' was much larger, a selection became necessary. Accordingly, a list of TBAs from each block was prepared. Out of the list prepared from each block, after determining the first number through lottery method, every sixth TBA on the list was selected for the interview purposes, by following systematic random sampling technique. The main focus was on eliciting their responses pertaining to socio-economic background, occupational background, their expectations from ANMs, LHVs, Medical Officers and community members, their perception of the expectations of ANMs, LHVs, and Medical Officers and community members from them, their role performance (working pattern), satisfaction with the role they performed, their role relationship with ANMs and suggestions for making this role more effective.

For community members (Housewives) again a selection had to be made and accordingly five villages from each block were identified. The lists of householders in these villages were obtained. Ten respondents were selected from big villages and five from small villages, where TBAs (Dais) and ANMs in the sample provided their services. The unit of the study was the wife of the head of the households and in the event of her non-availability, the next elderly woman was taken for interview purposes.
Community members were interviewed with the help of interview schedule consisting of questions pertaining to their socio-economic background, their general health, their expectations of TBAs and ANMs role and their evaluation of the role performance of TBAs and ANMs and their level of satisfaction with the services rendered by TBAs and ANMs.

Non-participant observations were also recorded in different situations to supplement the data thus obtained.

The data collected were analysed through ratios, proportions, measures of central tendency and correlation, wherever found feasible.

1.5 Limitations of the Study

Some of the main limitations in carrying out this study are as follows:

1. The study has been conducted in the rural areas of the sub-division of a border district, the study may not be fully representative of the other districts or states in India. Since such findings may be different in other cultural and or geographical regions, it is necessary to test the validity of these findings in those areas before further generalizations with regard to the role of TBAs (Dais) and ANMs in the health care delivery system may be deduced.

2. Though the number of villages affiliated to each PHC varies, only five nearest villages from each development block were chosen due to the terrorist activities as well as imposition
of curfew after 4.00 p.m. It was assumed that 5 to 10 households of these selected villages from each block will reflect over all accurate performance of TBAs (Dais) and ANMs, and their relationship with the TBAs (Dais) and ANMs in general.

3. In order to group the community members into lower, middle and high status groups, family social status index was build up of variables like education, occupation and per annum family income. It has been assumed that each variable contributes equally towards socio-economic status, though this may not be true. In regard to TBAs, since the majority of them come from poor economic strata, this index was not considered necessary. In regard to ANMs, since some of them are drawn from urban areas, in order to keep the analysis uniform with these ANMs are from the rural background, the individual variables such as family income, occupation and education were treated as independent variables. In regard to community members, since the community members were from the same background (rural), an effort was made to construct family social status index for them of the variables like education, occupation and family income. However, it is a methodological attempt to group the community members into different socio-economic strata, and this has a significant influence in establishing community members relationship with TBAs (Dais) and ANMs for getting their services.
4. The data were obtained through subjective reporting. All intrinsic limitations of this method, (Festinger and Katz, 1965; and Seltz, 1976), therefore, would be valid for this study.

5. In view of the total universe of ANMs in the selected blocks, the test of significance could not be applied. In order to apply the test of significance in the case of TBAs and community members, the data in certain categories had to be combined due to small number of respondents. However, statistical measures were employed, wherever found suitable.

2. Socio-Economic and Cultural Profile of Traditional Birth Attendants (TBAs), Auxiliary Nurse Midwives and Community Members:

A. Traditional Birth Attendants (TBAs) (Dais):

2.1 Nearly three-fourth (70.00 per cent) proportion of the TBAs (Dais) were in the age categories of 41 to 70 years.

2.2 More than fifty per cent of TBAs (Dais) were Sikhs, followed by Christians (27.00 per cent) and Hindus (21.00 per cent).

2.3 The sample of TBAs (Dais) was dominated by scheduled castes viz., Majhbes 41.09 per cent; Mahasha (Dooms) and Sansi 16.44 per cent and 15.07 per cent respectively. Balmikies and Chamars were equally represented (2.74 per cent), Jats (12.33 per cent) were fairly
Backward Classes were represented marginally but their percentage varies between 1.11 per cent (Jalasahar) to 1.37 per cent (Jhevar and Luhar).

More than three-fourth (86 per cent) were illiterate, literate up to primary were eleven per cent, very few were educated up to middle (2 per cent) and only one TPA (Dai) was matriculate.

Two third of TPAs were married whereas thirty seven per cent were widows. Unmarried was marginally represented (one).

Nearly one-fourth of TPAs had maximum number of living children (7) whereas three had no living child.

The data regarding TPAs' (Dais) husbands revealed that eighty per cent were illiterate. A large proportion of them was engaged in lower prestige occupations like industrial workers, agricultural labourers, non-agricultural labourers, watchmen, etc. More than fifty per cent of TPAs (Dais) had two earning members in the family. An overwhelming majority (86 per cent) of TPAs (Dais) had annual gross family income upto ₹. 6,000/- only. Those who had more than ₹. 6,000/- annual gross income were marginally represented.
2.8 In a nutshell, the analysis of socio-economic background of TBAs (Dais) reveals that they are mainly drawn from lower socio-economic strata, however, a significant representation of TBAs (Dais) from medium socio-economic strata, shows that midwifery has a good social status in village social set-up.

B. Auxiliary Nurse Midwives (ANMs):

2.9 The majority of the ANMs (40 per cent) were upto 25 years of age. Thirty three per cent were within the age of 26 to 35 years and twenty seven per cent were within the age of 36 to 45 years.

2.10 Two-thirds were Sikhs, one-fourths were Hindus and Christians were marginally represented (10 per cent).

2.11 The sample of ANMs was dominated by higher castes and especially Jats (53.33 per cent), Brahmins and Khatri were fairly represented, whereas 15.55 per cent were Backward Classes and Scheduled Castes were marginally represented.

2.12 There was a preponderance (66 per cent) of ANMs were from rural areas.

2.13 Previously, the minimum academic qualification for the ANMs was middle but now it is matriculate/higher secondary. ANMs educated upto middle and above matric were marginally represented, their percentage being
six and eight respectively. Those who were above matric had completed their respective education before taking up an Auxiliary Nurse Midwifery as a job.

2.14 Two-thirds of ANMs were married and the rest were unmarried.

2.15 With regard to number of living children, two-thirds of the married ANMs had one or two living children. Very few (2.89 per cent) had four living children.

2.16 Majority of ANMs were getting the salary between Rs. 700/- to Rs. 1,300/- monthly.

2.17 With regard to ANMs' parents' education, occupation, and income, a majority of the ANMs' fathers educated up to school level, most of them were engaged in cultivation, shopkeeping or government jobs (clerical) and were earning up to Rs. 1,000/- per month from all sources. The mothers of the majority of the ANMs were illiterate (66 per cent) and housewives (95 per cent).

2.18 The data regarding ANMs' husbands' revealed that more than fifty per cent were educated up to matric. While a significant proportion of them (43 per cent) were college/university educated, a large proportion was engaged in government jobs; and majority of them were earning between Rs. 1,000/- to Rs. 1,500/- per
month though those earning above Rs. 1,500/- were also well represented. As compared to parents, the husbands of ANMs were better placed in life.

2.19 The analysis of socio-economic background of ANMs shows that majority of them were from medium socio-economic background. A significant proportion of ANMs was from higher socio-economic strata. It seems, some change for the better has occurred in the attitude of society regarding Auxiliary Nursing Midwifery occupation.

2.20 Community Members

The majority of the respondents (75.33 per cent) were within the age of 31 to 60 years.

2.21 The majority of the respondents were Sikhs (65.33 per cent), Hindus were fairly represented (24.67 per cent). Christians were marginally represented (10.00 per cent).

2.22 The sample of respondents was dominated by Jats (38.52 per cent), Brahmins and Khatri castes were marginally represented (5.18 per cent and 2.96 per cent). In backward classes, the majority were Tarkhan (11.11 per cent) and Jhivar (8.89 per cent). Whereas among scheduled castes respondents, the majority (7.41 per cent) were Mahashas (Doom).
With regard to the educational status of respondents, a large majority of the respondents (78.00 per cent) were illiterate whereas among educated respondents the majority (12.60 per cent) were educated upto primary level. Very few respondents (3.3 per cent and 6.00 per cent) were educated up to middle standard and matric respectively.

More than fifty per cent had joint families.

More than three-fourths of the respondents had maximum number of living children. The number varies between 3 to 7.

With regard to respondents' husbands' education, occupational status, more than fifty per cent were illiterate. Whereas nearly an equal proportion of them (16.00 per cent and 16.67 per cent) were educated upto primary and matriculation respectively, most of them were engaged in agriculture and casual labour. As compared to respondents' own educational status, the husbands of the respondents were better educated.

More than fifty percent respondents' children were educated upto primary level, whereas thirty seven per cent respondents' children were educated upto matric, and nearly seven per cent educated upto graduation level and only one respondent's child was post-graduate.
2.28 With regard to respondents' sons occupation most of them were engaged in agriculture, in lower administrative jobs (clerks and accountants etc.) and in agricultural labour.

2.29 Fifty per cent had only one earning member in the family. Nearly nine per cent respondents had maximum number of earning members (4).

2.30 In regard to the family income of respondents nearly two-thirds (64.67 per cent) have an income upto Rs. 6,000/- per annum from all sources, nearly one fourth (24.67 per cent) have an income between Rs. 6000/- to Rs. 18,000/- and nearly eleven per cent have an income between Rs. 18,000/- to Rs. 30,000/- annually.

2.31 With regard to the family social status index of the community members, two-thirds had lower socio-economic status. More than one-fourths had medium and the rest (12 per cent) had higher socio-economic status.

2.32 In short, the analysis of socio-economic background of the respondents (community members) who availed the services of TBAs and ANMs revealed that they were mainly from the lower and medium socio-economic strata. However, a significant representation of the respondents from the higher socio-economic strata,
shows that it is not only the people from the lower and the medium socio-economic strata but from the higher socio-economic strata also, preferred to get the delivery conducted at home by TBA and ANM.

3. Occupational Socialization of Traditional Birth Attendants (Dais) and Auxiliary Nurse Midwives (ANMs)

A. Traditional Birth Attendants (TBAs)

3.1 The mean age at which the TBAs (Dais) in the sample entered the occupation of midwifery was 27.89 years, they range varying between 10 to 45 years. Forty three per cent started learning this occupation by being apprentice to some family members.

3.2 Forty four per cent TBAs (Dais) were motivated for this occupation by health functionaries (Auxiliary Nurse Midwives or Lady Health Visitors) in their villages. Thirteen per cent had self-motivation and learnt the skill through their own experience. Rest were motivated by close female relatives (mothers-in-law, mother, sister, etc.).

3.3 The influence of ANMs/LHVs in motivating the TBAs (Dais) for midwifery occupation, had been much higher among higher caste while in the case of lower castes TBAs (Dais) the family kinship ties had an overriding influence. Self motivation was found much higher among backward class castes.
3.4 Various sources of motivation for the midwifery occupation appears to be decreasing with the increase in the economic status of TBAs (Dais). Traditional kinship ties was found to be operating significantly in respect of TBAs (Dais) belonging to lower income group (upto Rs. 6,000/- per annum) as compared to TBAs (Dais) belonging to medium income group (Rs. 6001/- to Rs. 12,000/-).

3.5 With the increase in educational level, the source of motivation for midwifery occupation got changed. In respect of illiterate TBAs (Dais), the traditional family kinship complex found exercising more influence in decision making, whereas in literate category health functionaries (ANM/LHV) appeared to be more significant.

3.6 As many as forty three per cent adopted midwifery as a hereditary occupation. With regard to their source of induction into this occupation, the data revealed that majority of these TBAs (67.44 per cent) had it in their in-laws family and were inducted into this occupation by their mothers-in-law, husband's aunt or grand-mother-in-law.

3.7 The prime motivating reasons or factors to adopt midwifery as an occupation for the majority of the TBAs (Dais) were: (1) economic reasons, and (2) recognition of the occupation in the community.
Two-third of TBAs (Dais) in the sample were formally trained and out of them more than fifty per cent got 1 to 2 months formal midwifery training at various health centres. Thirty six per cent did not get formal training but learnt their skills by being apprentice to other trained TBAs (Dais).

More than fifty per cent TBAs (Dais) irrespective of their age got 1 to 2 months midwifery training at various health centres. In the youngest age category (20 to 30 years), nearly two-thirds got nearly one year training in midwifery.

The analysis in regard to period of training and their length of experience as a Dai showed no significant association between these two factors. As many as forty four TBAs (Dais) 68.75 per cent who had 20 years working experience as a Dai, adopted midwifery as an occupation after getting formal training in midwifery. Whereas twenty (31.25 per cent) senior TBAs (Dais), that is those who had more than twenty years working experience got formal training in midwifery after adopting it as an occupation.

Irrespective of the training status, more than three-fourth of TBAs (Dais) had worked in association with various health agents and out of them 48.27 per cent had worked with senior trained TBAs (Dais), and 43.68 per cent worked with Auxiliary Nurse Midwives and learnt all the essential skills required for midwifery occupation.
B. Auxiliary Nurse Midwives (ANMs)

3.12 The mean age at which the ANMs entered the occupation was 20.6 years, the range varying between 18 to 32 years.

3.13 As many as eighty six per cent joined the job of an ANM as their first employment, whereas fourteen joined it as their second employment.

3.14 Out of fourteen ANMs 35.71 per cent had a maximum length of their previous services from 8 to 11 months.

3.15 A large majority of the married ANMs (88.41 per cent) had joined ANMs' job before their marriage.

3.16 Fifty per cent ANMs were motivated for the Auxiliary Nursing Midwifery as an occupation, by the traditional family kinship complex. Thirty per cent were self motivated to take up this occupation. Twenty per cent were motivated by friends.

3.17 As compared to married ANMs, a higher proportion of unmarried ANMs (23) were motivated by close relatives. Eight married ANMs were motivated for ANMs occupation by their husbands.

3.18 Father's educational background affected ANMs choice for Auxiliary Nursing Midwifery occupation. Apart from nearly nineteen per cent ANMs whose fathers were educated upto matric level, more than fifty per cent ANMs
fathers were educated upto graduate level, had motivated their daughters to take up this occupation.

Father's occupational status has also influenced their choice of this occupation. Out of fifteen ANMs who have their fathers in Government services, the majority (46.67 per cent) of the ANMs were motivated by their parents. Whereas overall majority of ANMs (32.61 per cent) irrespective of their father's occupation were self motivated and had monthly income upto Rs. 1,000/-. Friends and relatives played a significant role in providing them information about this occupation.

3.19 The main motivating reasons to join Auxiliary Nursing Midwifery for the majority of the ANMs were (1) economic reasons, (2) family member in the same occupation, and (3) easy availability of the job.

3.20 The analysis in regard to motivating reasons and per month family income revealed that an equal proportion of ANMs (28.79 per cent) having family income upto Rs. 1,000/- per month joined this occupation mainly due to economic hardship and a family member being already in this occupation, whereas an equal proportion (29.63 per cent) of ANMs having family
income between Rs. 1001/- to Rs. 2000/- per month adopted this occupation mainly because of the economic reasons and easy availability of the job respectively. Again, among ANMs having family income between Rs. 2001/- to Rs. 3000/- per month, an equal proportion (42.86 per cent) of ANMs joined this occupation because of the economic consideration and the easy availability of the job. The analysis further revealed that majority of the ANMs had adopted this occupation due to economic hardship, whereas liking for the job developed due to easy availability of the job. The family member already in this occupation, served as a "reference group" for them.

3.21 As ANMs have to work in association with Medical Officers, LHV's and Senior Trained TBAs. From them they learnt various skills, like from Medical Officers, they learnt to examine patients and especially female patients, from LHV's, to insert loops etc. and from senior trained TBAs; to respect the family and community customs.

3.22 It was observed that the values, attitudes and knowledge which TBAs and ANMs acquired at home, during training and with the assistance of their senior colleagues, influenced their later practices and behaviour.
Role Analysis of Traditional Birth Attendants (Dais) and Auxiliary Nurse Midwives (ANMs)

This section contains following four perspectives of the role concept:

(A) Role expectations of TBAs (Dais) and ANMs from each other and those of LHVs, Medical Officers and the community members.

(B) Role perceptions of TBAs (Dais) and ANMs regarding their own duties and functions, TBAs and ANMs perception of the expectations of each other, ANMs' supervisors (LHVs and Medical Officer) and the community members. Perceptions of the community members regarding the duties and functions of TBAs and ANMs.

(C) Role performance and working patterns of TBAs and ANMs.

(D) Suggestions given by TBAs and ANMs for making their role more effective.

Role Expectations:

TBAs had different expectations from different personnel but so far as their expectations from ANMs, were concerned, they mainly expected help in conducting complicated deliveries, follow-up of family planning acceptors and medicines for minor ailments for distribution. Further, in regard to
expectations from LHVs, very few (10) TBAs reported their expectations and these were of the follow up of family planning acceptors and medicines. From Medical Officers, they have general expectations like: equal treatment to all the patients irrespective of their socio-economic status and regular visit at the dispensary. From community members they expected co-operation and payment of rewards in time and no insistence on twice a day visit during the whole post-natal period.

In short, except help from ANMs in conducting the complicated delivery and no insistence from community members on twice a day visit during post-natal period, none of the reported expectations of TBAs do match with their role demands.

4.2 ANMs come into intimate contact with TBAs during the course of their duties. They have more expectations from TBAs. An overwhelming majority (94.66 per cent) expected TBAs to motivate more and more eligible couples for family planning techniques and all kinds of help in their other functions as well. From LHVs (Lady Health Visitors), they expected co-operation in family planning work and arrangement of medicines for minor ailments from PHCs, whereas from Medical Officers, they expected less stress on the targets of family planning and supply of medicines for distribution for minor ailments. From community members, they expected mainly to call a trained TBA for conducting the delivery at home and to consult the nearest
doctor immediately in case of complication in conducting the delivery and co-operation at the time of home visiting in the village.

In short, ANMs' expectations from TBAs, LHV$s, Medical Officers and community members are centred around family planning and medicine supply. In a way, reported expectations of ANMs, have shown the short coming in ANMs' occupation which may further affect their role performance.

4.3 LHV$s and Medical Officers expected TBAs to do motivational work for family planning along with their role demands whereas from ANMs they expected to perform duty-oriented role and especially to bring more and more cases of family planning at PHC.

4.4 Community members have more expectations from TBAs. In their expectations they emphasised more on the instrumental as well as expressive roles of TBAs. Twenty five (16.67 per cent) did not have specific expectations from ANMs. The remaining one hundred twenty five expected mainly the technical care and stay or regular visit at the village headquarter. From LHV$s, the community members have no specific expectations whereas from Medical Officers, they expected mainly their (M.O.'s) regular visit at the dispensary, medicines for all the patients visiting at the dispensary and at least two hours stay in the clinic. One fourths expected them to check ANMs' work.
4.5 A comparison among TBAs, ANMs, LHVs and Medical Officers and community members expectations showed that, although their expectations from all these categories were more or less the same but there was difference in their emphasis on various functions. TBAs were concerned more about the instrumental role of ANMs. While ANMs expectations from TBAs were concerned with their (TBAs) expressive role. The community members' expectations from TBAs and ANMs were concerned with maternal and child health care, whereas from Medical Officers, they expected complete health care.

Role Perception:

4.6 The perception of TBAs regarding their own duties and functions were the same as that of their expected (prescribed) duties. Regarding ANMs' duties and functions, TBAs were found aware of their two main duties only, that is, family planning work and immunization.

4.7 In regard to TBAs' perception of the expectations, of ANMs from them (TBAs), more than fifty per cent TBAs perceived that ANMs expected them to work for family planning motivation whereas this is basically ANMs' duty. This indicated that ANMs treated TBAs as their subordinates. Rest of the perceived expectations of ANMs especially related with maternity services did match with TBAs' role demands. Three-fourths perceived that like ANMs the LHVs and Medical Officers also
expected them to motivate eligible couples for family planning techniques. Further, with regard to their perception of community members, the majority (43.16 per cent and 37.89 per cent) of the TBAs reported that the community members expected them to visit twice a day throughout the post-natal days and to provide follow up services to those family planning acceptors whom they themselves motivated respectively.

The analysis of TBAs' perception of the expectations of health personnel (ANMs, LHV's, Medical Officers) and community members have shown that the expectations of health personnel and community members regarding motivation for family planning and later follow up of its acceptors created structural inconsistency in TBAs role structure, as this is not prescribed in their role demands. This structural inconsistency has made their role dysfunctional to some extent.

4.8 The perception of ANMs regarding their own duties and functions was fairly good. They treated family planning work, immunization, maternal and child health, record maintenance and home visiting and conducting surveys as their main duties. Further, their perception of the duties and functions of TBAs were the same as that of their (TBAs') role demands.

4.9 In regard to ANMs' perception of the expectations of TBAs depicted that they (TBAs) expected monetary incentives in return of doing motivation for family planning techniques
for ANMs. Besides this, ANMs perceived that TBAs expected medicines for distribution for minor ailments and help in conducting complicated deliveries. Further, the analysis of ANMs perceived expectations of LHV and Medical Officers revealed the difference in their emphasis on various functions. As the LHV expected ANMs to perform all the prescribed functions, equally whereas the Medical Officers stressed on the target-oriented duties (family planning work and immunization). They expected mainly family planning work which is one of the many functions of ANMs. However, these types of differences in emphasis created inconsistency in ANMs' role structure. This structural inconsistency later affected their role performance and made it dysfunctional. The analysis fully supported our hypothesis, "Differences in emphasis on various functions of ANMs by supervisors (LHV and Medical Officers) as perceived by ANMs may create structural inconsistency and make their role dysfunctional".

4.10 In regard to their perception of the expectations of community members, it was found that community members mainly expected technical care from them.

4.11 The perception of community members regarding the duties and functions of TBAs was similar to their role demands. Whereas with regard to their perception of ANMs' duties and functions a significant proportion (16.67 per cent) of respondents
did not know the duties and functions of ANMs. In rest, of the respondents level of awareness of ANMs' functions was found fairly high.

4.12 A comparison of TBAs' perception of their own duties and functions and their perception of the expectations of the community members bring out that the community members have more expectations from them. They not only expect a TBA to perform midwife's role but have other expectations as well, particularly follow-up of family planning acceptors, whom they had motivated.

4.13 Similarly, a comparison of ANMs perception of their duties and functions and their perceptions of the expectations of community members bring out that the community members have limited expectations from ANMs as compared to TBAs. The comparison shows some difference in the perception of their own duties and that of community members' expectations. Against the first main duty of family planning work which includes motivation for family planning methods, service and follow-up of the acceptors, the ANMs, perceived that the community members expect, follow up of family planning acceptors and medicines for minor ailments. An overwhelming majority of community members (95.00 per cent) expect them to stay at the village headquarters.
4.14 As compared to community members' perception of ANMs' duties and their expectations from ANMs' role shows some difference between their perception and their expectations. A significant finding was that sixty-four percent community members contrary to their perception of ANMs' duties expected ANMs to provide free services to people.

4.15 In short, no gap was found between TBAs' role-demands and their perception of these demands. In regard to their perception of ANM, LHV's and Medical Officers' expectations, less association was found between their role demands (prescriptions), perception and expectations. No association was found between the perception of TBAs' own role and their perception of the expectations of ANMs and LHV's/Medical Officers regarding education and motivation for family planning methods. Since this (family planning work etc.) is not a part of TBAs' role demands and having no official liaison with ANMs, they cannot be compelled to perform these functions. On the other hand, the analysis of role prescription, perception and expectations (perceived) of community members from TBAs revealed that there was a good deal of agreement. TBAs had perceived that community members had more expectations from them but that were not restricted to their role as a 'midwife' only. A complete association was found between their role demands and expectations of the community members. This may be so because of their being independent practitioners and members of a village social set up.
Like TBAs, ANMs also perceived their prescribed duties. They put more emphasis on three main duties, such as family planning work, immunization and maternal and child health care services. Variation was found in their perception of the rest of the role-demands (record maintenance, home visiting and survey and symptomatic diagnosis etc.). Differences were found in supervisors' (LHV and Medical Officer) emphasis on various functions of ANMs. ANMs perceived that LHVs expected them to concentrate on all the prescribed duties and functions, and on the other hand, Medical Officers expected more and more family planning work. Whereas community members despite their expectations of follow-up of family planning acceptors and medicines for minor ailments, expected them to stay at the village headquarters. The analysis of ANMs' role prescription, perception and expectations (perceived) of supervisors (LHVs and Medical Officers) and community members revealed that there is a gap between ANMs' role prescription, perception and expectations and this creates structural inconsistency and affects their role performance and make their role dysfunctional. This supported two of our hypotheses: (i) lack of association between role prescription (demands), role perception and expectations as perceived by ANMs; may affect their role performance and make their role dysfunctional, while this may be less among TBAs (Dais); (ii) "Differences in emphasis on various functions of ANMs by supervisors (LHVs and Medical Officers) as perceived by ANMs
may create structural inconsistency and make their role dysfunctional.

(C) Role Performance:

The performance of TBAs (Dais) and ANMs was studied into two ways. In this part, we had discussed their working pattern, whereas the services provided by them to the community members was discussed in the last chapter.

4.16 On an average level during last one year (prior to the interview), a TBA (Dai) conducted 16.04 deliveries.

4.17 The analysis of the age of TBA and her working hours in a day reveals that it does not show any significant relationship. It is evident from the value of chi-Square $\chi^2 = 10.48$; df = 6; $P > .05$). On an average and the TBAs between the age of 41 to 60 years spent 9.91 hours in performing midwifery practices. The mean working hours of a TBA (Dai) in a day was 7.43 ranging 5 hours to 11 hours a day.

4.18 As many as sixty six per cent TBAs conducted deliveries within the village of their residence.

4.19 The extent of TBAs' communication with expectant mothers depended upon the place of their (TBAs) residence and it is statistically significant ($\chi^2 = 7.54$; df = 2; $P < .05$). As many as 60.61 per cent TBAs oftenly communicated with the expectant mothers of the villages of their residence as compared to 44.12 per cent TBAs who did midwifery practice in both the places (village of their residence and the other).
4.20 During natal stage, three fourth proportion of TBAs came into the contact of expectant mothers through message whereas one fourths through their prior personal contacts with the concerned family.

4.21 The majority (80 per cent) of the TBAs irrespective of their occupational status and length of experience as a TBA were found aware of antiseptic precautions. The length of experience as a TBA was found significantly related with awareness of antiseptic precautions at the time of delivery ($\chi^2 = 8.63$; df = 2; $P < .05$). A significant thing that has been found, is that out of twenty TBAs who did not adopt these precautions at the time of delivery, fifty per cent were formally trained by ANMs. This may be attributed to the ineffectiveness of their training or lack of proper care on their part.

4.22 As many as eighty nine per cent TBAs cut the cord with domestic scissors. Forty six per cent cut the cord with a razor blade. A negligible number of TBAs (2.00 per cent and 1.00 per cent respectively) used crudest implements like knife and Ramba (trowel) for cutting the umbilical cord.

4.23 More than fifty per cent used butter and one fifths used ghee/oil to cover the cord and to ensure it's proper healing. A significant thing of this study was that all the TBAs were aware of tetanus and septic of the cord.
During the post-natal period an overwhelming majority of the TBAs (98.00 per cent) communicated with mothers mainly on personal hygiene and cleanliness of the baby and on immunization of the new born baby.

So far as the advice on diet to the mother during post-natal period is concerned, one-fourth of TBAs in the sample did not give any advice. Among the remaining (75.00 per cent) who advised on diet as many as 85.33 per cent advised light diet to the mothers.

The payment to TBAs (Dais) were made both in cash and kind. TBAs did not have a fixed rate of their services. Irrespective of the complexity of delivery TBAs' rewards were same as of normal delivery. The cash payment depended upon the socio-economic status of the family, sex and value of the child, in the family (on the birth of female child, the TBA got minimum Rs. 11/- in cash while on a male-birth she got minimum of Rs. 21/-, whereas the payment in kind depended upon the rate set by the community members.

Nearly three-fourths of the TBAs' expressed satisfaction with the payments made to them by the community members.

Three-fourths of the TBAs were found to be experts in the treatment of minor ailments with domestic medicines.
This treatment mainly centred around the intake of 'hot' and 'cold' items.

4.29 As many as seventy three per cent TBAs also motivated their clients for family planning methods. The higher proportion of motivation (96.15 per cent) was found in the TBAs between the age of 20 to 40 years. This proportion of motivation decreased (50.00 per cent) with the increase in age and experience. These TBAs (Dais) might have stopped motivating mothers for family planning practices, as it directly affects their own earning. A significant relationship was found between TBAs' motivation for family planning and their experience as a TBA ($\chi^2 = 7.21; df = 2; P < .05$).

The occupational status of TBAs' was found significantly related with family planning motivation ($\chi^2 = 11.67; df = 1, P < .05$). A significant thing has been found is that out of thirty six untrained TBAs as many as 52.78 per cent motivated their clients for family-planning methods. TBAs were found motivating mainly for permanent methods of family planning (Tubectomy and Vasectomy).

More than fifty per cent TBAs could be able to prepare some of their clients for family planning.

4.30 Majority of TBAs (73.00 per cent) did not approve abortion. No link was found in twenty seven per cent TBAs'
approval of abortion and their religious background. ($\chi^2 = 0.21; df = 2, P > .05$). A significant relationship had been found between TBAs (Dais) approval of abortion and their annual gross family income ($\chi^2 = 7.50; df = 1; P < .05$).

Majority of the TBAs (77.91 per cent) in the present study belong to the lower (upto Rs. 6,000/- per annum) income category. They did not approve abortion and believe in before hand precautions and believed in "more children more the family income".

4.31 After analysing the working pattern of TBAs an effort was made to compare their actual role performance with their role perception, with regard to their performance in functions like conducting the normal deliveries, reference of complicated delivery to ANM or doctor in time, sterilization of instruments and use of antiseptic techniques were concerned, a complete association was found between their role perception and role performance. A little variation in providing post-natal care had, however, been seen. Although the majority of the TBAs wash the clothes of the mother and the child during post-natal days, yet the other post-natal services are provided as per the family's specific requirements.
4.32 Further, the performance of TBAs was compared with their perception of the expectations of ANMs. A complete association was found between most of the perceived expectations of ANMs and regarding referring the complicated delivery cases to ANM or doctor in time, to notify new births to ANM of the village and proper utilization of midwifery training and their actual performance. As compared to perceived expectations regarding co-operation with ANM, an overwhelming majority (96.00 per cent) of TBAs were found co-operating ANMs during household survey in the village. Few gaps were found between perceived expectations of ANMs regarding motivation for family planning methods and calling an ANM for conducting the delivery and bringing children in sub centre for vaccination and TBAs' actual performance. For removing these gaps, TBAs can not be compelled to work as per the expectations of ANMs, because all the TBAs in the present study are the independent practitioners.

4.33 In regard to the extent of satisfaction of TBAs with their role performance an average TBA was found most satisfied with their performance. Satisfaction level was found increased with age and experience.

4.34 A significant relationship was found between the age of ANMs and their dealing with multiple responsibilities. It was found that age affected ANMs' role performance as the senior in age ANMs found it difficult to cope-up with the
work-load assigned to them. While it was not so, in the case of younger ones.

Unmarried ANMs felt difficult to visit far off villages alone whereas ANMs senior in age felt tiredness in performing all the functions due to lack of stamina associated with their advancing age. It was further revealed that as compared to unmarried ANMs, married ANMs could not cope with their work load (or to perform all the prescribed duties as well due to some familial problems. Again ANMs' ability to deal with multiple responsibilities found decreasing with an increase in their service. As compared to senior ANMs, juniors were found coping up well with the work load. Seniors had lesser interest in their work and considered their job as a routine, while the juniors show initiative and desire to learn.

4.35 As regards the usefulness of Auxiliary Nurse Midwifery training, it is found that it has increased with a rise in the educational level of the ANMs, as ANMs are educated upto matric/higher secondary level as many as 66.28 per cent reported the usefulness of their training, whereas in the category of above matric seventy five per cent reported its usefulness.

4.36 With regard to the social adjustment of ANMs in the villages, it was found that as compared to junior ANMs (in age), the senior succeeded in making social adjustments,
which has increased with the age. Married ANMs have adjusted themselves better than unmarried ANMs. Further, rural/urban background had no significant relationship with their social adjustment in villages as compared to 67.65 per cent ANMs from urban background 65.15 per cent from rural background were socially adjusted.

4.37 In regard to analysis on communication of ANMs with expectant mothers, it was found that on an average (mean, score value 1.37). ANM rarely communicated with expectant mothers in the remote villages other than the village of their posting. Whereas 42.39 per cent of the ANMs reported that due to multiple responsibilities they could not get time for regular visits to the villages to communicate with expectant mothers.

4.38 More than three-fourth of ANMs did not conduct deliveries. As many as eighteen ANMs reported that they conducted deliveries manually and used scissors, only for cutting the umbilical cord of the baby. Further, cut of eighteen ANMs, as many as fifteen (83.33 per cent) did not use any cord-care measures.

4.39 As compared to ANMs communication in neo-natal stage, the majority (92.00 per cent) irrespective of marital status, rural/urban background and length of experience, were found communicating with new mothers during post-natal stage.
4.40 During the last one year prior to interview an ANM, on an average, had persuaded 18.5 cases for tubectomy, 3.68 per cent for vasectomy, 15.29 per cent for IUD, 13.64 for practising condom contraceptives and 9.56 individuals for oral pills.

4.41 During the last one year, the mean TBAs (Dais) trained by ANMs was 1.71 the range varying between 0 to 12. By relating the number of TBAs trained by ANMs with their urban/rural background, it was found that ANMs with urban background on an average trained 2.29 TBAs as compared to 1.41 by ANMs from rural background.

4.42 As regards to constraints in job operations, it was found that individual family-planning target system and shortage of drug supply (75.00 per cent) and lack of incentives and promotional avenues (70.00 per cent) conflict with the Medical Officers (40.00 per cent). Constraints in personal life such as: prolonged illness and sexual harassment etc. were among the main reasons responsible for the inadequate role performance by ANMs. This provides support to our hypotheses: (1) "Because of the multiple role sets to be performed, ANMs may not perform adequately due to organizational constraints (targets of family planning and lack of medicines), whereas TBAs (Dais) as a single role performer may prove better", and (2) "Lack of requisite role facilities and role rewards for ANMs may affect their performance and may also result in making their role dysfunctional."
4.43 As far as conflict between occupational and familial role is concerned, as many as thirty four per cent considered family life a hindrance in their role performance. Out of thirty four as many as twenty nine (85.29 per cent) reported that their spouses did not approve of this occupation. Main reasons of disapproval: (i) criticism levelled against motivating people to accept family planning, and (ii) the field work duty. Nine unmarried ANMs stated that their low status and general notion that "ANMs are suitable for any odd work", make it difficult for them to find good matches.

4.44 A deviation was found between perception and performance (in the Health Centre as well as in the field) of ANMs. Except doing motivational work for family planning, gap was found in the actual performance of rest of the functions. ANMs' more stress on two duties (family planning and immunization) affected their other functions. The analysis further indicated that ANMs have organizational constraints in performing their role effectively. On the one hand, they have to work as per their role demands, whereas on the other hand, they have to work as per their supervisors. ANMs' role performance is evaluated on the basis of their achievement of the target set by the Health Department while as compared to ANMs, TBAs have no organizational constraint. The analysis support our hypothesis, "Because of the multiple role sets to be performed, ANMs may not perform adequately due to organizational constraints (targets of family planning and lack of medicines)."
whereas TBAs as a single role performer may prove better".

4.45 Some association was found between the perceived expectations of LHV's and actual performance of ANMs. As compared to perceived expectations regarding motivation for family planning, MCH care (ante-natal care), immunization, all the ANMs reported the performance of these functions. The performance was found based on the emphasis placed by the supervisor on different jobs. As many as forty (68.96 per cent) ANMs had distributed contraceptives as compared to fifty eight ANMs perceived expectation of LHV's. In comparison to twenty four ANMs' perceived expectations of the LHV's regarding ANMs daily visit in the field, thirteen (54.17 per cent) had been visiting their field regularly.

4.46 A few deviations were observed between the role perception, expectations (perceived) and actual performance of ANMs, which had made their role dysfunctional to a certain extent. Perception of prescribed duties and functions and their performance varies due to the target pressure and priorities set by the government from time to time on various health programmes. A uniformity between role perception, expectations (perceived) and actual performance in the field as well as at the Health Centre, was found only in two main activities of ANMs, viz., motivation for family planning and immunization. The above comparative analysis and observations
made by the researcher about the multiple roles (role demands) depicted gaps in the expected and performed jobs lend support to our hypothesis "Lack of association between role prescription (demands), role perception and expectation as perceived by ANMs, may affect their performance and make their role dysfunctional while this may be less among TBAs (Dais)".

4.47 A comparison between role perception and working pattern (performance) in villages near to PHC or sub-centre and in remote villages shows deviation. It was found that although in nearby as well as in far off villages, ANMs concentrated more on two main duties, viz., persuading people for family planning as well as in the immunization programme, yet ANMs first tried to complete their tasks from the nearby (periphery) villages. It was observed that ANMs rarely visited all the remote villages. The analysis further brought out that too much emphasis on certain duties and functions (family planning and immunization) due to pressure by their supervisors had made their role dysfunctional in certain other aspects, which were equally important for providing comprehensive health care to the community.

4.48 A comparison between perceived expectations of LHV's and performance of ANMs in periphery and remote village revealed that there was a fair agreement in the expectations and performance as far as instrumental role (motivation for
family planning services, immunization work and symptomatic diagnosis) and expressive role (co-operation with the supervisor) was concerned. A wide gap was however, found between perceived expectations and actual performance as regard to certain functions, such as, follow up of family planning acceptors, ante-natal care, record maintenance, distribution of contraceptives among eligible couples and daily visit in the field. A significant thing which is observed is that none of the ANM perceived LHVs expectation regarding natal and post-natal services. It depicts that LHVs do not lay emphasis on these two functions under Maternal and Child Care Services. This has led to structural inconsistencies and made ANM's role dysfunctional in many ways. Pressure of achievement of targets and time limits set for that, did not allow them to schedule their activities properly and they therefore, find it difficult to fully internalise their other tasks. Consequently, they were notable to effectively perform these to the advantage of the intended beneficiaries of health care services. The above findings do lend support our hypothesis: "Differences in emphasis on various functions of ANMs by supervisors (LHVs and Medical Officers) as perceived by ANMs may create structural inconsistency and make their role dysfunctional".

As compared to ANMs, a part of modern institutions for health care, the TBAs (Dais) are the members of old
traditional institutions. As analysed earlier, the TBAs (Dais) have only one single role to play and that is, of providing midwifery services to the people of the area they are living in. Being an independent practitioner, they have absolutely no organizational constraints like ANMs. A complete uniformity was, therefore, found in their perception and actual performance.

So far as the expectations (perception) of LHVs and Auxiliary Nurse Midwives are concerned, they expected TBAs (Dais) also to motivate couples for family planning. TBAs (Dais) not being bound to fulfil the expectations of LHVs or doctor or ANMs, acted on their own, hence whenever they felt like, they would advise the new mothers for family planning otherwise remained indifferent to expectations of the health functionaries.

4.49 The analysis in regard to the satisfaction of ANMs with their own role performance showed that despite the burden of multiple responsibilities, on an average, ANMs were found to be satisfied with their role performance. It was observed that ANMs evaluated their satisfaction level on the basis of the achievement of their individual targets.

4.50 A comparative analysis of role prescription (demands) expectations and performance of TBAs (Dais) and ANMs depict no structural inconsistency between TBAs' role demands, perception (perceived) and performance. It was observed that TBAs
by having a single role to perform and being an independent practitioner, are still in a position to satisfy the expectations of the community members to a large extent. On the other hand, ANMs have multiple roles to play, that is of co-ordinator, communicator, trainer and supervisor of TBAs (Dais). By analysing their role it is visualised that they are performing some of the duties and functions expected of them but the expectations appeared to be well above their capacity. The fact that their formal performance is determined mainly by organizational given demands (family planning target and immunization etc.) for which they are accountable to the health authorities, influence their role perception. This leads to certain structural inconsistencies which render their role, dysfunctional in some of the areas of their job.

Role Effectiveness:

4.51 TBAs revealed the demand for co-ordination between TBA and ANM. They suggested to restrict the work of ANMs and TBAs to their respective fields (Auxiliary Nursing and Midwifery). TBAs further reported that by avoiding interference in each other's (ANMs and TBAs) works, they would rather help in making the Primary Health Care services to be more smooth and functional.
4.52 Main problem encountered by TBAs was of poor rewards or incentives after conducting the delivery.

4.53 The main reasons reported for the maintenance of the social status of TBAs were: (i) ANMs cannot perform the functions of a Dai; (ii) Lack of facilities for ANM in the village; (iii) Lack of accommodation for ANMs to stay in the village; (iv) Inability to conduct a delivery alone; (v) Lesser fee demanded by a TBA and (vi) TBAs' intimate familiarity with the village culture.

4.54 With regard to TBAs' suggestions an overwhelming majority (98.00 per cent) of TBAs suggested that minimum monetary incentives should be given to TBAs, more than one fourth of TBAs suggested that untrained TBAs be motivated to take up midwifery training.

4.55 In order to establish better rapport with the community members, ANMs suggested to abolish target system and to make regular supply of drugs so that their services could be proved more functional and socially accepted.

4.56 For making TBAs' (Dais) role more effective, the striking majority of the ANMs also suggested that the health department should provide a minimum monthly monetary incentive to TBAs (Dais). More than fifty per cent suggested that a TBA should be attached as a helper to each of the ANMs.
All the ANMs suggested that in order to bring more effectiveness in their (ANMs') role performance: (i) the Health Department should not lay more emphasis on achieving family planning targets; (ii) Promotional avenues should be made available; and (iii) frequent transfer of junior ANMs should be avoided.

Role Relationship between Traditional Birth Attendants (Dais) and Auxiliary Nurse Midwives (ANMs)

5.1 With regard to TBAs (Dais) relationship it was found that as many as forty two per cent TBAs (Dais) sought help from ANMs. Main approach for seeking ANMs help was in conducting complicated deliveries at home and for giving injection for an easy delivery.

5.2 About the main reasons for not seeking ANMs it was found that (i) sixty per cent TBAs reported non-availability of an ANM at the time of need; (ii) more than fifty per cent did not feel the need; and (iii) fifty per cent avoided it as ANMs' behaviour towards TBAs would be that of a superior which they cannot resist. This lends support to our hypothesis that "ANMs may expect TBAs, being member of village social set-up, to work as their subordinates whereas TBAs being independent workers may expect ANMs only to provide guidance in their tasks".
5.3 The analysis further revealed that as many as forty five TBAs (Dais) rendered their co-operation to ANMs firstly by motivating their clients for accepting the family planning methods and secondly by accompanying them during their surveys and home visits.

5.4 Main reasons of TBAs for not rendering their services to ANMs were: (i) due to vast area of operation (conducting deliveries in their own as well as in other villages), they do not have time for rendering their help to ANMs. And (ii) ANMs already have TBAs (helpers) with them and they should therefore take help from them.

5.5 As regard to willingness of TBAs (Dais) to work with ANMs, as many as twenty-one expressed their willingness.

5.6 Main reasons for TBAs (Dais) refusal to work with ANMs were that they have no time as they have to do their own work related with midwifery, and for this they have vast area to cover. Secondly, since they had joined the present occupation, they were working independently and they cannot tolerate anyone's interference or dominance. They feel that if they work under ANMs supervision, they will definitely be treated like subordinates and may be pressurised by them for doing any work, which in the process may post threat to their own occupation. As analysed earlier, TBAs expected ANMs to provide only guidance (whenever ask for) in their tasks.
The above finding again lend support to our hypothesis, "ANM may expect TBAs (Dais) being members of village social set-up, to work as their subordinates whereas TBAs (Dais) being independent workers may expect ANMs only to provide guidance in their tasks".

5.7 TBAs have limited contacts with ANMs. As many as forty two TBAs were found having working relations with ANMs. As regard to their satisfactory working relations with ANMs, it was found that the mean score value (2.57 per cent) fell between satisfactory and less satisfactory categories and more towards satisfied responses, suggesting that an average TBA had satisfactory working relations with ANMs. Further, as compared to junior (in age and experience), TBAs, senior TBAs had more satisfactory working relations with ANMs. As compared to formally trained TBAs, un-trained (informally trained) TBAs had more satisfactory working relations with ANMs.

5.8 The main reasons for TBAs' least satisfactory working relations with ANMs was that ANMs did not fulfil their promises of providing monetary incentives to TBAs for motivating their clients for family planning techniques. And ANMs did not provide them medicines for minor ailments for distribution. Irregular visits of ANMs in the village was the main reason of TBAs for having no working relationship with ANMs. They preferred to establish working relations with RMP, the only available medical practitioner in the village.
5.9 As regards hinderances of ANMs in TBAs functioning, as many as thirty per cent TBAs reported that the problems created by ANMs were concerned with the family-planning work, whereas seventy TBAs reported that sometimes ANMs helped them in their main activity, that is, of midwifery. The majority (92.86 per cent) reported that the ANMs helped them in a way to educate them about better midwifery skills. As many as 85.71 per cent reported that ANMs educated them about the use of antiseptic measures while conducting the delivery and 41.42 per cent reported that sometimes ANMs helped them in conducting complicated deliveries.

5.10 In regard to ANMs relationship with TBAs, it was reported by ANMs that TBAs (Dais) sought their guidance in dealing with the problems related with pregnancy and in complicated deliveries. A significant proportion of ANMs (70.00 per cent and 63.33 per cent) reported that TBAs (Dais) sought their guidance in motivating eligible couples for family planning methods and in immunization respectively. This was likely that TBAs be their own trainees and while providing help on guidance to them they themselves might have asked TBAs to motivate their clients for family planning methods and immunization etc. So that they could fulfil their individual target of family planning. The analysis in a way indicated that ANMs expect TBAs to work as their subordinates.
and this again lend support to our hypothesis, "ANMs may expect TBAs (Dais), being members of village social set-up, to work as their subordinates whereas TBAs (Dais) being independent workers may expect ANMs only to provide guidance in their tasks".

5.11 With regard to reasons of not seeking ANMs' help, as many as 86 per cent ANMs reported that at the time of same complication in conducting the delivery, the TBAs (Dais) preferred to call a Registered Medical Practitioner or a private nurse. TBAs (Dais) being experts in conducting the delivery and unmarried status of an ANM were also one amongst the reasons of their not seeking ANMs help.

5.12 Three-fourth of ANMs were found to be supervising TBAs' work. The majority of the ANMs who were educated above matric (87.5 per cent) were found supervising TBAs regularly while ANMs educated only upto Middle or matriculation level did not supervise regularly. By relating supervision with ANMs length of service an inverse relationship was found to exist as with an increase in the length of service, the regular supervision of TBAs (Dais) work was found to be decreasing. As compared to senior (in service) ANMs, better role commitment was found among junior ANMs.

5.13 No specific reason as such was reported by ANMs for irregular supervision of TBAs (Dais) work. However, this can
be attributed to organizational constraints, such as pressure of individual family planning target, multiple roles to perform in a vast area or busy schedule of work.

5.14 With regard to the extent of satisfactory working relations of ANMs with TBAs, it was noticed that the mean score value (2.69) fell between satisfactory and less satisfactory categories, and more towards satisfied responses, suggesting that an average ANM had satisfactory working relationship with TBAs (Dais). It was further revealed that as compared to junior (in age) ANMs, senior ANMs had more satisfied working relations with TBAs (Dais) and those educated above matric had a more satisfactory working relationship than those educated up to matric or middle standard. As compared to married ANMs, unmarried ANMs had more satisfactory relations with TBAs (Dais). By relating relationship with ANMs' length of service, a significant link was found as ANMs with a longer period of working experience had more satisfactory working relationship with TBAs (Dais) than those with shorter experience.

5.15 The major reason for less satisfactory working relationship with TBAs (Dais) as stated by ANMs was due to their inability to provide them sufficient medicines for minor ailments. TBAs (Dais) did not co-operate with them.

5.16 As regards hinderances of TBAs (Dais) in ANMs functioning, as many as twenty eight per cent ANMs reported the
problems created by TBAs (Dais) in their functioning. The major problem was found to be concerned with the family planning work, which is one of the main duties of an ANM.

5.17 Nearly three fourth of ANMs reported that TBAs (Dais) helped them in their main activities such as maternity care, family-planning, immunization and in field visits. Three fourths reported that TBAs (Dais) helped them in a way to motivate the eligible couples of their respective areas for the family-planning. Two thirds reported that TBAs (Dais) accompanied them during their home visits in the village. Fifty per cent reported that TBAs (Dais) educated mothers for immunization etc. The above findings do not support our hypothesis "TBAs by having an occupational autonomy of conducting deliveries in villages for the protection of their self interests, hinder the functioning of ANMs in the same village."

TBAs might be helping ANMs due to these facts: (i) trained by these ANMs, (ii) in order to learn more and improve their own performance; and (iii) by making it clear that ANMs won't interfere in their autonomy in conducting the deliveries in villages and ANMs might have accepted this condition.

6. **Role Relationships of Traditional Birth Attendants (Dais) and Auxiliary Nurse Midwives with the Community Members:**

This section contains three parts: The first part deals with the community members' evaluation of the health care in general. The second deals with community members' evaluation
of the services provided to them by the TBAs (Dais) and ANMs while the third part deals with their satisfaction with the performance of the TBAs (Dais) and ANMs.

1. Community Members' Evaluation of Health Care in General:

6.1 Three fourth of community members consulted TBAs (Dais) for the confirmation of pregnancy. The analysis further revealed that as compared to lower and medium socio-economic group, the higher socio-economic group was found to be consulting gynaecologist. Illiterate community members were also found to be aware of the availability of gynaecologist for the confirmation of pregnancy.

6.2 An overwhelming majority (93.00 per cent) of the community members irrespective of their family's social status, were found depending upon the nature of delivery to be preferring deliveries at home. In the event of any complication arising while conducting delivery at home, the respondents from the lower and medium socio-economic strata preferred to go to the PHC or the Civil Hospital. A significant finding of the study was, that three fourth of even the higher socio-economic strata respondents preferred to get the delivery conducted at home. In case of some complication, as many as 16.67 per cent preferred to go to private nursing home than the PHC or Civil Hospital. The above findings do not
lend support to our hypothesis that "Community Members, from the lower socio-economic status, may prefer to get the deliveries conducted at home by TBAs (Dais), whereas the members belonging to the higher status avail the services of ANMs and private nursing homes. The community members from higher socio-economic group might have preferred to get the delivery conducted at home by TBAs because of the facts: (i) non-availability of ANM at the time of delivery and equal distance between the nursing home and place of residence; (ii) easy availability of TBA; (iii) Faith in TBA and (iv) longer experience of conducting successful deliveries by TBAs.

6.3 A striking majority of the community members (90.00 per cent) reported that the last delivery in their families was conducted by a TBA (Dai).

6.4 Mother/Mother-in-law emerged as a main decision maker for the selection of a person to get the delivery conducted. Almost all the respondents reported that their mother/mother-in-law had called the TBA (Dai) to conduct the delivery at home. In the absence of the mother/mother-in-law, it was the expectant mother herself or her spouse who called TBA (Dai) to conduct the delivery.

6.5 It was found that in the majority of the emergency cases the doctor in the nearby rural dispensary would not be
available. As many as ninety per cent respondents had to take the patient to the nearest private medical practitioner.

6.6 For minor ailments, nearly forty seven per cent community members preferred to avail the services of a private physician, whereas 26.67 per cent preferred to get the treatment at the rural dispensary.

6.7 Three fourths of community members' reason of not availing the services at the PHC or the Rural Dispensary was the irregular visit of the doctor at the health centre. As many as 51.61 per cent reported about lack of supply of drugs or other necessary equipments. An important finding of the study was the partial behaviour of few doctors towards their patients.

6.8 Community members were found visiting the health centres mainly for immunization and ante-natal care services.

II. Community Members Evaluation of Traditional Birth Attendants (Dais) and Auxiliary Nurse Midwives (ANMs) Services:

6.9 "Easy availability" and "post-natal care" were considered as the two major reasons contributing to the maintenance and importance of TBAs' (Dais) role. Faith in TBAs' (Dais) services, her long experience of conducting safe deliveries and less fee being charged were the other reasons which contributed to the importance of TBAs (Dais) role.
Almost all the community members were found to be availing the services of the TBAs' (Dais) for conducting the delivery and for giving after-birth care to both the mother and the child. An overwhelming majority (96.00 per cent and 89.00 per cent) were found availing TBAs (Dais) services for female's and children's minor ailments, and for the confirmation of pregnancy or ante-natal problems respectively.

With regard to reasons for calling TBA (Dai) it was found that better post-natal care by TBA (Dai), her taking care of beliefs and customs, of the community at the time of delivery, previous deliveries successfully conducted by her; non-availability of an ANM at the time of delivery, ANM not conducting the delivery etc. were the main reasons for calling a TBA (Dai). It was significant to note that TBAs (Dais) were called even to conduct the still-births and breach deliveries.

It was found that where the TBAs (Dais) were not well aware of the antiseptic precautions, the community members themselves asked them to follow the same before conducting the delivery. These precautions were in the nature of washing of hands with soap, boiling of the equipment and cutting of TBAs' nails etc. The analysis further revealed, that the community members, irrespective of their level of
education were found to be aware of the importance of hygiene and antiseptic precautions due to their socialization with educated residents or health workers or mass-media exposure.

6.13 With regard to their payments to TBAs (Dais) for their services, it was found that there was no set pattern of payment in cash. It, by and large, depended upon the economic condition of the family, as well as on the sex and value of the newly-born child in the family. A discrimination was found in the payments being made to the TBA (Dai) on the birth of female child (minimum Rs. 11/-) and male child in the family (minimum of Rs. 21/-). Community members reported that TBAs (Dais) provided even free services to the very poor.

The payments in kind were decided by the panchayat and were generally uniform.

6.14 A comparison of community members' expectations from TBAs (Dais) and their evaluation of TBAs (Dais) performance (role commitment) was found corresponding fairly well with each other, and the activities which the TBAs (Dais) performed were found relevant to the village social set up. Besides, social and cultural factors, a good personal rapport of TBAs (Dais) with the community members was another reason for community members giving preference to her services.
6.15 As regard to ANMs regular visits to the villages, the majority of the community members (78.00 per cent) were found aware of ANMs regular visits in their villages. As many as twenty two per cent community members were unaware of the regularity of ANMs' visits. However, it was reported that the ANMs after recording field-visits in their visiting register usually went back to their homes. By relating community members' awareness of ANMs regular visit with their family social status index, it was found that as compared to the community members from the lower socio-economic group the community members from the medium and higher socio-economic group were more aware of ANMs' visits.

6.16 In regard to ANMs' availability in the event of emergency as many as 53.33 per cent community members did not have any emergency as such, while 46.67 per cent had complications during pregnancy or delivery and tried to avail ANMs services. On an average (0.86 per cent) Community members could not avail ANMs' services in the event of emergency. The analysis further revealed that irrespective of the family social status of the community members, the availability of an ANM, depended upon the time of the emergency.

6.17 In the absence of an ANM, two third of community members preferred to call a Registered Medical Practitioner. However 34.67 per cent did avail of ANMs services at the time of delivery.
6.18 It was found that ANMs performed their role related to the conducting of a delivery inadequately. The community members reported that except giving an injection to a woman in labour they did nothing and would not bother about the expectations of the community members who called her for conducting the delivery. She considered conducting the delivery as "Ganda-kaam" (dirty task) which only a TBA (Dai) is supposed to do. As compared to ANMs the TBAs (Dais) had performed their role more adequately, ninety per cent deliveries were reported to be conducted by the TBAs (Dais). The community members expressed that after attending the delivery, an ANM hardly visited that family. The above analysis lends support to our hypothesis, "TBAs (Dais) may have better acceptance among the community members than ANMs because of their willing participation in culturally accepted norms or practices such as washing clothes, giving massage to the baby and the mother etc. which ANMs do not consider to be the part of their duties".

6.19 It was found that ANMs had minimum fixed rates for attending a delivery. The actual fee depended upon the sex and value of the child in the family. In the case of a female birth, she charged a minimum of ₹. 21/- and on the birth of a male child ₹. 31/- . The analysis further revealed that the payment to ANMs also depended upon the socio-economic position of the concerned family.
6.20 An regards the requirement of immediate payment to ANM for attending the delivery, two-third of the community members having upto ₹ 6,000/- income per annum reported that ANM insisted on an immediate payment and they did pay her immediately inspite of some hardship.

6.21 The study in regard to community members reaction to family planning practices showed that more than three fourth of the community members irrespective of their family social status approved of family planning practices. The analysis further revealed the proportion of approval of family planning being higher among those educated upto middle standard or matric. The approval was subject to the birth of atleast one male child or two male children. This is based on various socio-cultural, economic and religious factors such as: to carry family name, old age security of the parents, to help the father in his work, to perform the last rites of the parents etc. The main reasons reported for non-approval were: (i) fear of later complications; (ii) prolonged illness like backache, abdomen pain and (iii) irregular menstrual period etc.

6.22 A comparison between the expectations of the community members and their evaluation of the performance of ANMs showed that the community members felt that ANMs performance was not in keeping with their expectations. The three main
reasons cited by the community members for this assessment were: (i) lack of aptitude; (ii) lack of effective communication with community members, and (iii) lack of drug supply.

More than fifty per cent considered the village Panchayat (for not providing necessary facilities) and thirty eight per cent considered lack of communication with indigenous Dai, to be equally responsible for their inadequate performance.

III. Satisfaction of the Community Members with the Services Rendered by TBAs (Dais) and ANMs:

6.23 On an average (2.41 per cent) the community members were found fairly satisfied with the services of TBAs (Dais). The analysis further revealed that illiterate community members were found to be more satisfied with the services of TBAs as compared to the educated respondents. By relating it with the community members' family social status index, it was found that as compared to the satisfaction of higher social strata an average community member from medium and lower socio-economic background, was fairly satisfied with the services rendered to them by the TBAs (Dais).

6.24 The analysis in regard to the extent of satisfaction of the community members with the services rendered by ANMs revealed that on an average (1.23 per cent) the community
members were less satisfied with the services of an ANM. It was further revealed that as compared to illiterate and less literate (upto primary level) community members, better educated (upto middle and matriculation level) community members were more satisfied and also those with relatively high socio-economic background showed satisfaction with ANMs services.

An overall view of relationship of TBAs (Dais) and ANMs with the community members brings out that despite the various developments made at the village level, the village social set up is still maintaining its traditional character. Most of the community members rely on Traditional Birth Attendant (Dai) to get the delivery conducted at home. The reason appears to be the relationship between TBA (Dai) and the community members which was observed to be more personal, informal, holistic and supportive, as compared to the ANMs personal and formal behaviour and segmented characteristics of their services. As compared to TBAs (Dais) who are concerned not only with the biological aspects of the birth process but also with the woman's emotional life and family relations, the relationship between ANM and the community members appear to be essentially 'functionally specific'.
Conclusion and Suggestions for Improving the Role of TBA and ANM

The modern health care institutions of which an ANM is a member, employ only formally trained persons who work only on a professional basis. There is no doubt that modern health care institution is very competent from technical point of view, but it lacks some of the very basic emotional, psychological and social advantages of the traditional system. Since the community at large is still entrenched in traditions and not completely come out of emotional world to scientific and objective world. The need for such traditional agencies is still being felt. The traditional health care institutions are thus thriving along with modern health care institutions and are still quite popular. These are headed by the Traditional Birth Attendants. Traditional Birth Attendants have a relatively permanent and continuous linkage with a large number of families of the neighbourhood in which she works and it is here that she also lives. They naturally have better social rapport with the villagers as compared to the outsider health functionaries.

Traditional Birth Attendant has a single role to play and that is of a maternity specialist. Being a member of village social set-up, she provides services to her clients which are culturally determined and continue to have social approval of the community. TBA (Dai) is an independent practitioner. On the other side, an Auxiliary Nurse Midwife,
being a member of an organised health sector has multiple roles to play in the rural health care system.

It is important to note that irrespective of the availability of the medically trained persons, ninety percent deliveries in the present study were found to have been conducted by TBAs (Dais). The community members were found visiting health centres for immunization, ante-natal care and family planning advice mainly. This indicates that their knowledge of the availability of health services did not influence their preference to call a Traditional Birth Attendant for conducting the delivery. The community members were found fairly satisfied with the services rendered by TBAs (Dais).

Easy availability of TBA (Dai) and comprehensive postnatal care services by her has been often mentioned by the community members as important considerations while entrusting a delivery case. Non-availability of an ANM at the headquarters and her inability to conduct the delivery alone has also been mentioned by the community members for not entrusting the cases to ANMs. By and large TBAs (Dais) have been performing their role of a maternity expert in an accepted manner and thus held a significant 'social position' in the community.

On the other hand, the study brings to surface many weak points of inadequate role performance of ANMs.
Under Multipurpose Health Worker Scheme, ANMs have multiple roles to play. ANMs had given a varied account of their functions and duties, which in a way, were found affecting their role performance. They were found concentrating more on two duties that is, family planning motivation and immunization programmes for fulfilling their individual targets. Their efficiency is evaluated on the basis of the achievement of their individual targets set by the Health Department. On the basis of the fulfilment of their respective targets, ANMs themselves also evaluated their performance. Over emphasis on the family planning programme by the health department and inadequate drug supply to ANMs were found to be responsible for creating structural inconsistency making their role dysfunctional.

A difference was observed in the perception of the community members regarding their duties and functions. They have a general view regarding ANMs functions in the village sub-centre such as: visiting the sub-centre regularly, or to stay at the headquarter, motivating people for the family planning, immunizing the new born children and providing medicine for the minor ailments etc. Nearly thirty five per cent community members had availed ANMs services for conducting the delivery. It was evaluated that ANMs did not carry out all the functions in a planned way but did perform some of their duties like motivating eligible couples for family planning and immunization regularly.
Lack of orientation among ANMs to perform multiple roles, lack of promotional avenues and other incentives over emphasis on family planning target achievement and inadequate supply of medicines to ANMs, were the main obstacles responsible for making their role dysfunctional. Auxiliary Nurse Midwives are considered as the bridge via which the advantage of medical services can reach the people.

The findings of the study about the role of TBA (Dai) suggested some modifications in the role-performance of TBAs. The TBA's approach has to take a turn in favour of the community approach. TBAs have to be made aware of the training programmes and benefits of such a programme. Minimum educational qualification should be fixed for TBAs. During the training of TBAs, greater emphasis should be made on antiseptic operations. There is a need to remove fears, doubts and misapprehensions of family planning while training the TBAs, so that they could be motivated to persuade the mothers to adopt family planning methods. TBAs' skills should be made equal to ANMs.

Like ANMs, the community members has to be made aware of the training programme of TBAs and benefits of calling a trained TBA for the delivery. Since the delivery is considered to be most vital event in the life cycle of a family, any demonstration of conceivable improvement in its system may be warmly accepted by the community.
A mother/mother-in-law plays a major role in decision-making for calling a particular person for conducting the delivery in the family. Special efforts need to be made to educate mother/mother-in-law about the importance of the person called for conducting the delivery in the family. Spouses are also being emerged as major decision makers in calling a person for the delivery. Therefore, the entire community needs to be educated.

As our study shows that the TBA, being member of village social set up, have been providing culturally determined services to her clients and continue to have social approval of the rural community, their services can be utilized in an extremely beneficial way. Thus, if properly trained in scientific techniques of conducting the deliveries in the rural areas, she can certainly become more useful to the community. She can act as a positive change agent for applying modern ideas about the health care in the village where she works.

The findings of the study regarding the role of Auxiliary Nurse Midwife suggest a need for modification in making the role of an ANM more effective, so that she can truly belong to the people.

ANM, being a Multipurpose Health Worker, has to attend all the health problems of her area single handedly.
Therefore, an aptitude test should be taken at the time of their admission in Auxiliary Nurse Midwifery training schools, so that later on they do not take it as just another job but a kind of commitment. High officials should set an example for ANMs. They should demonstrate that the work entrusted to them can be accomplished with average intelligence and efforts.

The performance of an ANM should not be evaluated only on the basis of family planning cases motivated by her. For an overall improvement in the rural health care delivery system, an equal importance should be given to all the prescribed duties of ANM.

A regular supply of medicines for minor ailments and other necessary equipments should be given to ANMs, so that, they can establish a good rapport with the community members. During the course of present study, irregular medicines supply to ANMs, was found - as one of the main obstacles in their work for establishing rapport with the community.

Due to multiple roles, ANMs find it difficult to perform all the prescribed duties effectively. They could not get time to perform all the duties alone in periphery as well as in the remote villages. That is why they attend cases of remote villages only on request. Generally, they do not communicate with expectant mothers in the remote villages. Sometimes from personal security angle, they do not prefer to
go to remote villages. Therefore, there is a need to improve the working conditions for ANMs.

Due to various organizational constraints, the overall performance and their rapport with the community members was found weak and too loose. Most of the community members were found relying on TBAs to get the delivery conducted by them. The relationship between TBA and community members appeared to be more impersonal, informal, holistic and supportive as compared to ANMs' personal and formal behaviour and segmented characteristics of their services. The indifference on the part of ANMs should be discouraged and they should be made compatible with the socio-cultural framework of the village community. It is assumed that changes can be introduced from within the community and TBAs be attached with the health functionaries by issuing them license for midwifery practices with ANMs. Therefore, there is a need to establish a system whereby the emotional support of TBA is utilized along with new techniques for child-birth and family-planning. If TBAs would be paid (more than what she gets out of delivery cases), for family-planning work, then, the health care services could be more useful and it would be much more lasting, easier and inexpensive.