"DAILY UP-DOWN"

Why would an Auxiliary Nurse-Midwife (ANM) of Rajasthan prefer to reside within her work-area?

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PREFACE

The paper is the first in series of research reports from Action Research and Training for Health (ARTH), a non-governmental organisation that aims to help communities access and manage health care through services, research, technical assistance and advocacy. While working with communities in southern Rajasthan, we realized the importance of ANMs or auxiliary nurse midwives for meeting healthcare needs of the rural communities. While interacting with ANMs themselves and with others in the health system, we developed some insights into living and working conditions that affect their availability and performance. Impressions however, must be validated. This study was therefore conceived to methodically understand the underlying factors that affect ANMs' decision on where to reside -- a decision that is critical in determining their availability to communities. This paper describes the findings of this study and provides an agenda for action, based on the results and our assessment of existing opportunities. The paper is intended for all those who can make a difference -- non governmental organizations that work on the ground, policy makers and programme managers.

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Authors

Introduction

Rural communities in India receive primary healthcare from a range of formal and informal providers. For several key services that have a major impact on the health and survival of children and women, such as immunization, antenatal care, distribution of contraceptives, and skilled attendance at birth, they are largely dependent on Auxiliary Nurse-Midwives or ANMs, who are the frontline women workers of the government health system.

It is widely accepted that ensuring the attendance of a skilled provider at the time of childbirth is among the most important interventions for reducing maternal mortality. In view of the fact that most deliveries in India and in other developing countries occur in the absence of a skilled provider, the World Health Organization (WHO) has recently launched a campaign called "Global Action for Skilled Attendants for Pregnant Women". ANMs are key providers who could act as skilled attendants for rural communities in India.

Communities however tend to have limited access to ANMs for meeting their health needs. The reasons for an ANM's non-availability include the large population that she has to cover, her restricted mobility and the fact that she often does not stay within her work area. A study conducted in 23 districts of India revealed that only 57 per cent of all ANMs stayed at their place of posting, while the rest commuted to their place of work[1].

An ANM's place of residence is likely to significantly affect her performance, since some clinical services such as care during childbirth and treatment of childhood ailments require a presence round the clock. The non-resident status of an ANM might also act as a barrier to her building confidence and establishing rapport with the community.

ANMs of rural Karnataka who do not reside in their sub-center area have reported that they spend up to two hours each day, in commuting from their residence to the place of work. They have limited time for individual villages and are therefore unable to visit all priority households. They are also unavailable for attending to deliveries which not only begin at odd-hours, but also need considerable time investment until the baby and placenta are delivered [2].

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1. ICMR. 1997. Evaluation of Quality of Health Services at Primary health Center Level. An ICMR Task Force Study, Summary Report, Indian Council of Medical Research, New Delhi.
2. Bhatia JC. 1999. Constraints to Improving Quality of Primary Health Care Services in Rural Karnataka *In* Improving Quality of Care in India's Family Welfare Programme: The Challenge Ahead, ed Michael A. Koenig and ME Khan. The Population Council, pp. 183-209.

The lack of residential quarters has been cited as an important reason for ANMs not staying in their work area. Yet despite construction of residential facilities, many ANMs of Madhya Pradesh preferred not to reside in them[3]. By contrast, in one district of Gujarat, the absence of residential quarters did not deter ANMs from staying in the sub-center village. Those belonging to that area lived in their own house, while others rented accommodation for themselves[4] . Hence, the availability of government residential quarters may not be sufficient to ensure that ANMs do reside in the sub-center area.

Many ANMs refer to poor living conditions and threat to personal security as prime reasons for living in a town or a larger village.

> ANMs from Maharashtra and Gujarat, especially those who are unmarried, separated or living alone, express concern for their personal safety. Some prefer to live in neighbouring towns that have educational facilities for children. Others live in towns as they do not want to be separated from their husbands who work there [5].

While poor living conditions might deter ANMs from living in sub-center areas, the non-availability of ANMs could reflect the larger problems of lack of accountability within the public system, lack of awareness among clients and political protection to poor performers[6]. This view is echoed, though not openly, by several government health officers, and has led to a state of resignation and complacency among them about dealing with the phenomenon.

Action Research & Training for Health (ARTH) is a not-for-profit, non-governmental organization that uses research and training initiatives to help communities access health care. ARTH's current research priorities are in the areas of maternal health, contraception, safe abortion, neonatal care, child health and nutrition. During the course of our work in southern Rajasthan, we encountered a widespread impression in the community and among officials that

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3. DANIDA, MP. Evaluation Report. Health Care Project, MP, India. Main Report, Vol 1. Ministry of Foreign Affairs, DANIDA, 1996
4. Visaria L. 1999. The Quality of Reproductive Health Care in Gujarat: Perspectives of Female Health Workers and their Clients *In:* Improving Quality of Care in India's Family Welfare Programme: The Challenge Ahead, pp. 143-168.
5. Iyer & Jesani. Barriers to the quality of care: the experience of auxiliary nurse-midwives in rural Maharashtra. *In:* Improving Quality of Care in India's Family Welfare Programme: The Challenge Ahead, Ed. Michael A. Koenig and ME Khan. The Population Council, pp. 210-237
6. Mavlankar DV. Human Resource Management: Issues and Challenges *In:* Implementing a Reproductive Health Agenda in India: The Beginning.Ed. Saroj Pachouri.The Population Council, 1999.

most health workers do not reside within the work area, but instead "up-down"[7] daily or commute to their place of work.

This study represents an attempt to assess major determinants of the residential status of ANMs in Udaipur, a tribal-dominated district of southern Rajasthan, where conditions are typical of large parts of northern and central India. It then uses key findings to suggest ways to encourage more ANMs to live within their work areas and thereby increase the community's access to reproductive and child health services at village level. The study visualizes investments that might have to be made to improve the living and working conditions of a cadre of women health providers that has traditionally remained at the bottom of the decision-making hierarchy. In doing so, it explores the extent to which the community and its institutions could play a greater role in supporting the role of ANMs.

Objectives

1. To understand how auxiliary nurse-midwives (ANMs) of Rajasthan decide about residing within their work areas.
2. To suggest policy and programmatic changes to encourage ANMs to reside within their work areas.

Methodology

Four blocks, two each from among well developed and less developed blocks of Udaipur district, were selected randomly for the study. Study methods included collection of secondary information on each subcenter area, a written interview of all ANMs, and semi-structured, in-depth interviews with a sub-group. Administrative rules, policies and programmes that have a bearing on living and working conditions of the ANMs were also reviewed. The following account is based on secondary information on all 294 sub-centres of 4 selected blocks, written interviews with 231 ANMs that were able to participate, and in-depth interviews with 48 of them. Details of study methodology are available upon request.

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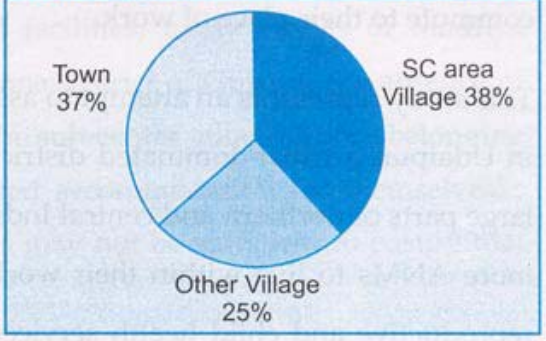
7. The term "up-down" is used colloquially both as a verb and as a noun, in referring to the daily commute from a city or town to a rural work area. "Up" refers to the outward journey, and "down" to the return journey, perhaps in an allusion to ease of traveling to and from rural areas. Even though the term "daily" is widely used, an employee might commute less frequently-- biweekly, weekly, or less often. The practice of daily up-down is not restricted to health workers but seems to be widespread among other government employees too, such as teachers posted in rural areas.

Results

Where do ANMs reside?

We assessed the residential status of 231 ANMs. Our results confirmed the widespread impression held by many, that most ANMs do not reside locally (figure 1). Only 38 per cent lived in a village of the subcentre area -- we termed these "resident ANMs". The remaining 62 per cent lived either in a town or distant village (termed "non-resident ANMs").

Figure-1: Place of Residence of ANMs



Homemakers, wives and mothers

Almost all the ANMs were married and had children; one-third had a child younger than 5 years. A large proportion of ANMs (39 per cent), irrespective of their place of residence, lived alone -- they managed their homes without family support. Several ANMs did not have adequate financial support from the family -- 16 per cent of ever-married ANMs acted as the sole breadwinner. Their husbands either did not work at all (9 per cent), had separated (6 per cent) or died (1 per cent).

Many also did not have adequate arrangements for taking care of children in their absence. The children of 45 ANMs did not stay with them - they stayed either with relatives (most often grandparents) or lived alone in the city to pursue their studies. The rest relied on different persons (including the husband in 16 per cent cases) for looking after young children. Ten per cent ANMs had no one to help.

Table-1: Who takes care of the Child when the ANM goes to work

Caretaker	Number
Husband	16%
Mother-in-law/other relative	17%
Neighbor	19%
Maid	4%
Older sib	7%
Children old enough can take care of themselves	5%
Child stays away	22%
No one	10%

ANMs had significant health care needs of their own, and of their children too. Given that a large proportion stayed alone, they had to look after themselves and sick children on their own.

Table-2 Health needs of the ANMs and their Children

Health need	Number of ANMs
Of the ANM herself over past 2 years (n=231)	
• Pregnancy	17%
• Abortion	3%
• Gynecological illness	8%
• Any other illness	32%
• No health need	40%
Of children over the past three months (n=204)	
• Pneumonia / ARI	9%
• Fever	31%
• Diarrhea	12%
• Other significant illness	6%
• No health need	42%

Inconvenience of residing locally

In almost all subcentre areas, at least one village was connected by a metalled road. In spite of this, it was not easy to commute to the town in times of need. In a third of villages, only one to two buses were available per day for going to the nearest town, which was often far, at a mean distance of 24 kilometers. This meant that commuting to or from the town was difficult and entailed significant investment in terms of time and money.

Though most subcentre areas had primary schools, less than a fourth (24 per cent) had a middle or secondary school. A middle or secondary school was more than 5 kilometers away from about half the sub-centers. This could impose significant stress on the ANM's children if they were to travel daily to their schools from the sub-center village.

While 188 (81 per cent) subcenters had their own buildings, 107 (46 per cent) lacked residential accommodation. Even those subcenters that had accommodation for ANMs lacked basic amenities -- 92 per cent did not have an electrical connection, while 96 per cent lacked piped

water within the premises. However, 52 per cent had a hand pump or well facility. By contrast, 99 per cent of subcentre *villages* had electricity and 25 per cent had piped water -- it should have been possible to extend facilities available in the village, to the subcenter building. Part of the reason may lie in the fact that half the subcentres were located away from habitation, where it would be expensive to extend electricity and water connections (table-3).

Table-3 Facilities available at sub-centers

Amenities	Proportion of sub-centers
• No electric connection	8%
• Electric connection available	92%
Water connection source	No water 44%
• Hand pump/well	52%
• Tap water	4%
Location	
• Middle of the village	49%
• Far from the village	51%

The availability of living accommodation in the sub-center building was not significantly associated with local residence (table-4) -- perhaps the poor quality of accommodation did not make living there any easier and hence, ANMs preferred to stay away.

Table-4 Residential status by presence of living quarters

Living quarters	Residents	Non-residents
Available (n= 140)	38.7%	61.3%
Not Available (n= 91)	37.4%	62.6%

OR: 1.06 (0.60-1.87), p-value=0.84

A larger proportion of ANMs stayed in the sub-center premises that were located in the center of the village, compared to those that were remotely located (table-5), thereby suggesting that the location of living quarters is an important determinant of their use by ANMs. This conclusion must however be interpreted with caution, since our analysis is based on the responses of 89 per cent ANMs who had been posted to subcentres having living quarters.

Table-5 Residential status by location of the sub-center building (110 responses out of 124 with living quarters)

Location of subcenter	Residents	Non residents
Center of the village (n=53)	51%	49%
Outside the village (n=57)	28%	72%

OR: 2.66 (1.13-6.35), p-value=0.0140274

Most ANMs, irrespective of residential status, referred to difficult living conditions such as poor quality of sub-center accommodation and non-availability of essential items and amenities. Many non-resident ANMs cited these among the reasons for not staying in the sub-center village. In the face of difficulties in staying alone, the ANM's relationship with the community and her husband's place of residence became important considerations in choosing where to stay.

"There is no electricity in the sub-center and water is a problem. Water stops flowing after few buckets are filled. Milk and vegetables are not available in the village. My husband works in another district and it is difficult to reside here alone." (***31 year old ANM, non-resident)***

"My area is very bad... people here fight a lot. The subcentre building is broken and there is constant fear of theft. There are no facilities.... there is only one bus to the nearest town. People drink and create trouble even in the daytime. That's why I am afraid to stay here alone. However, my husband stays with me." ***(24 year old ANM, resident)***

Physical and Sexual Harassment

Sixty seven per cent ANMs perceived their subcentres to be unsafe for living. This was a commoner response on part of those whose subcentres were located outside the village, away from habitation. While some ANMs, both resident and non-resident, reported that they themselves had been harassed or intimidated at least once during their professional life, the majority reported instances in which another ANM had suffered harassment.

The role of an ANM as frontline service provider demands that she be accessible to women and men of the community at all hours. Some men exploited this accessibility, more so in if she lived alone or appeared to be otherwise vulnerable. Among the situations in which ANMs reported

sexual harassment were their being called to attend a delivery, the offer of a lift by a man to help them reach the next village or town, and men seeking treatment late in the evening by feigning illness. The men in question used these opportunities to molest or rape the ANM.

These instances, whether experienced by ANMs themselves or by other ANMs, had inhibited them from going on house-calls to conduct deliveries. Whatever the reason, refusal on part of an ANM to visit a family for conducting a delivery often provoked hostility -- this became further pretext to make threats and inflict psychological trauma on her.

In 1997, an unmarried ANM residing in her subcenter rejected a proposal for marriage from a boy living in the vicinity. Some days later in the evening, a group of men came to call her to attend a delivery. They instead took her to a secluded spot where she was gang-raped and murdered. A police complaint was filed after considerable difficulty. As a group, ANMs of the district publicly applied pressure for bringing the culprits to book, but had to face intimidation from persons believed to be close to the accused. The case ultimately fell through for want of evidence and no one was convicted. After this incident, several resident ANMs stopped staying within the subcenter, while many others gave up the idea of staying in villages of their work area. ***(Eleven ANMs, both resident and non-resident).***

While the veracity and circumstances behind these incidents might be further investigated, it was clear that they had left a sharp imprint on ANMs' minds and had affected their decision to reside in the village. During their recall of these events in front of the investigator, some respondents appeared visibly shaken, and despite repeated assurances of confidentiality, were concerned about having disclosed them. Most of these incidents involved ANMs who were living alone in the sub-center area.

The ANM's response to physical or sexual harassment depended on her family and social support. In the absence of support, most ANMs shifted residence or managed a transfer out of their place of posting.

"Earlier when I was posted here, villagers (men) used to harass me. After drinking they would come to the sub-center and throw stones…….. At the time, my husband was staying with me. We sometimes got into physical fights with them. Now my husband is posted in Udaipur city and I do not stay here alone. Even if I were to lose my job, I would not reside here". ***(28 year old ANM, non-resident).***

Husbands of married ANMs had reprimanded and warned the offenders in some instances. A few ANMs who had a good relationship with the community had mobilized villagers in their favour, and they in turn had issued stern warnings to the errant men. However, none of the ANMs interviewed reported any significant support from supervisors or officers in dealing with such situations.

Personal background

We studied how an ANM's personal background might influence her preference for residing locally. We found that ANMs belonging to scheduled castes and tribes (SC/ST) were more likely to reside within the sub-center area, than those belonging to other castes.

Table-6: Residential status by caste

Caste	Residents	Non-residents
SC/ST (n= 68)	47%	53%
Others (n= 163)	35%	65%

OR=1.67 (0.90-3.09), p value=0.0794

We observed during field visits that an ANM's caste affiliation appeared to be related to her residential status in more than one way. For one, those belonging to SC/ST groups were more likely to be of rural background and therefore appeared to be better adjusted to a rural environment. Our analysis showed that ANMs that had grown up in villages were more likely to *reside locally, than their city bred counterparts (Table-7).*

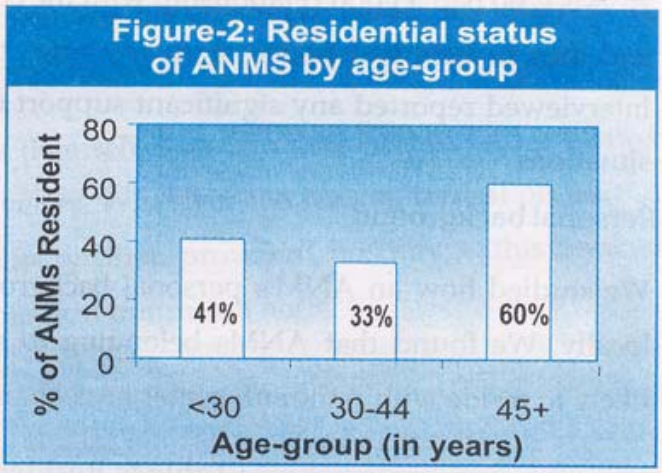
Table-7: ANM's background and residential status

Background	Residents	Non-residents
Rural (n= 157)	41.4 %	58.6%
Urban (n= 74)	31.1 %	68.9%

OR: 1.57 (0.84-2.94)

Dynamic Family Needs

Women aged below 30 or above 44 years were significantly more likely to reside within the work area as compared to those aged 30 to 44 years (Figure-2) Could this be because of certain needs during this period of their lives that could not be met residing in a village?



Most ANMs shared their concern about children's education. Many who had earlier lived in the subcentre village said that they had subsequently shifted to a larger village or town because facilities for education of older children were either not available locally, or were of poor quality. Under such circumstances, they traded their children's inconvenience of commuting to school with their own time and effort in commuting to the subcentre from a town. By contrast, ANMs with younger children that attended preschool or junior classes found it convenient to live in the subcentre area.

"I stayed in the sub-center village for 4 to 5 years. Because of my children's schooling I have recently shifted to the town. Previously, a lot of my children's time was being wasted in commuting from the (subcenter) village." *(38 year old ANM, non-resident).*

"Only if one stays at the sub-center can one give some time to the children. Even otherwise, my children are small and are not yet attending school. Hence I stay in the subcenter area " *(28 year old ANM, resident)*

ANMs posted to sub-center villages that had a middle or secondary school were significantly more likely to reside there -- this further confirms that children's education plays a significant role in influencing the decision of an ANM to reside in her work area (table-8)

Table-8 Residential status by presence of middle or secondary school

Presence of middle or secondary school	Residents	Non-residents
Yes (n=54)	50%	50%
No (n=177)	34.5%	65.5%

OR: 1.90 (0.98-3.69), p=0.0395

Supervisors' Support

Given difficult living and working conditions, one might expect that support from supervisors would help ANMs to cope better. However, most ANMs reported that supervisors did not attempt to solve problems related to their working conditions or place of stay. Those that we interviewed perceived their supervisors as being insensitive, and the relationship between them was evidently hierarchical. For fear of rebuke, many ANMs did not raise these problems with supervisors but instead tried to develop their own mechanisms for coping.

"My sub-center does not have a building and I live in rented accommodation. But the owner is asking me to vacate the house and often harasses me. I have reported this many times to my supervisors and panchayat members, but no one listens." *(33 year old ANM, resident)*

"I do not speak of my problems to anyone, because no one listens. If we tell our supervisors they say, do not talk of your problems." *(33 year old ANM, non-resident)*

"On sharing our problems with supervisors, they say, you will have to work despite all your problems. Sometimes on our not meeting targets, they ridicule us --some ANMs are often in tears because of this." *(32 year old resident)*

The convenience of residing locally

Despite all difficulties, staying within the subcenter area did offer the ANM some advantages. Most ANMs were appreciative of these -- they mentioned time and money saved on travel, lower living costs in the village and the benefit of better rapport with the community. Many non-resident ANMs acknowledged that by not residing locally, they had to forego these advantages. Conversely, resident ANMs reported that they saved time and energy by residing in the village that they gainfully spent with children. They also acknowledged that residing in the village provided them with an opportunity to supplement their income by conducting deliveries and giving injections.

"Expenses are higher in towns -- expenses on travel, stay and other costs. By staying in the subcentre one can work more easily, and one does not have to run around. " *36 year old ANM, resident.*

"Only by staying in the village, can one develop a friendly relationship with the community. There is good communication with the people and one can provide services 24 hours a day. Targets can also be achieved better, by staying at the subcenter." *38 year old ANM, resident.*

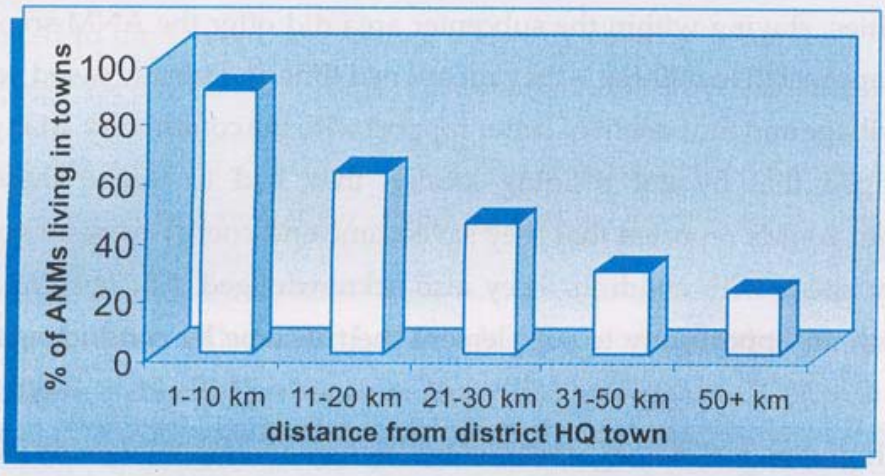
"I do not keep good health. If I were to *up-down* everyday, I would've had to walk 5 to 6 km. Hence I prefer to stay in the subcenter" *33 year old ANM, resident.*

Whether or not an ANM considered these advantages as significant, was influenced by the proximity of her subcentre to the town, especially the district headquarters. This factor determined whether it was worth the cost of commuting daily. Our analysis revealed that distance from the district headquarters significantly influenced an ANM's decision on where to reside -- the nearer a subcentre was to the district headquarters, the more likely was it that the ANM would reside in the city and *up-down* to the sub-center (figure 3)

"During my earlier posting, I used to reside at the subcenter because it was not possible to *up-down* from there. But now my subcenter is close to Udaipur, and also because of my children's studies, I do not reside in the subcenter. Wherever one may stay, work should be completed on time..." *(46 year old ANM, non-resident)*

"Before I moved here, my posting was in ## subcenter and I used to stay there. Then I got transferred to this place. There is no water or electricity, but it is much closer to the town and easy to commute. I have therefore stopped residing at the subcentre " *(33 year old ANM, non-resident.)*

Figure-3: Residential status by distance of the sub-center from district H.Q.



Accountability to the Health System

As mentioned earlier, the ANMs' supervisors did not appear supportive of their concerns regarding adverse working or living conditions. They also did not seem unduly concerned about whether or not ANMs reside within their work area, so long as they completed their "work". In most cases, achieving sterilization targets constituted priority work, and this in turn did not require the ANM to reside locally. Few ANMs mentioned that conducting deliveries was part of

the work expected of them by their supervisors. On occasion, written notices had been served to ANMs for not staying at their place of posting, but no follow-up action was taken. Administrators claim that the ANMs' political connections restrain them from taking action against those who do not reside within the sub-center area.

" No, they take action only if sterilization targets are not met, otherwise they just advise them (ANMs) to stay (in the sub-center area)" (*30 year old ANM, resident).*

"They take action on a case-to-case basis. Only if the ANM does not complete her work do they serve a written notice" (*28 year old ANM, resident)*

"Wherever you might stay, the work should be completed on time" (*46 year old, nonresident).*

Community Expectations

In absence of accountability to the system for residing within the work area, the community might be expected to assume a larger role in ensuring that ANMs provide access to care by residing locally. From the ANMs' responses it however appears that the community does not expect them to stay in the work area. This seems especially true of those ANMs that have established a good relationship with members of the community.

"I use a vehicle for commuting. I live nearby and therefore can commute easily. Villagers are completely satisfied with my work - I complete my work on time. They therefore do not object to my not staying here" (*35 year old ANM, non-resident.)*

"For the last 14 years, I stayed at the sub-center. Then because of certain problems, I stopped staying here. The villagers say that I may stay in the town nearby, but that I must not leave the village (get a transfer)" (*40 year old ANM, non-resident.)*

On occasion, members of the community accept poor living conditions in their village as valid reasons for non-residence on part of the local ANM.

" Earlier, an ANM had been raped in this village. She got herself transferred from here. The villagers themselves tell me, Sister, do not stay here at night because men get drunk and spoil the atmosphere" (*30 year old ANM, non-resident)*

"There is no sub-center (building) -- only one room belonging to the panchayat. That too is not electrified and is located away from the village. Sometimes they (people of the village) say, you must stay here, whereupon I say, you must give me a house to stay in. Then they have nothing to say because they know that facilities are inadequate" (*28 year old ANM, resident)*

In at least one case, villagers had complained to health department officials that the ANM did not reside at the subcentre headquarters. The ANM however continued to stay away.

Administrative Rules

A network of 27 ANM training schools provides pre-service training for ANMs in Rajasthan, with an annual capacity of 1620 ANMs. Any girl who has completed higher secondary school is eligible for admission. For the past several years, admission has been restricted to girls who are domiciled in the state. As part of the state's reservation policy for socio-economically marginalized groups, 50 percent of seats are reserved for girls belonging to scheduled castes, scheduled tribes and other backward castes.

An ANM passing out of the school might have to wait for months to years before securing government employment. While the state directorate appoints regular ANM's, in recent years district Chief Medical and Health Officers have also been authorized to additionally hire ANMs on contract to fill up vacant posts. Under contract appointment, ANMs are denied some of the benefits of a regular job.

There are no guidelines regarding the place of initial or subsequent posting. Similarly, there are no guidelines about the minimum or maximum duration of posting at a given sub-center or PHC, or at subsequent places of posting. There are anecdotal accounts of money changing hands or political connections being invoked, for getting comfortable postings initially or subsequently.

Transfers are usually centralized and carried out by the state directorate. The district health officials in turn, can carry out transfers within the district. Following on a government circular issued in 1999, local self-governments of the village (gram panchayats) have been empowered to make a binding recommendation regarding the transfer of a non-performing ANM out of their working area.

House rent allowance (HRA) as a proportion of basic salary is provided to ANMs where government accommodation is not available. Many ANMs however reported that they did not receive HRA even if the subcentre accommodation was not habitable. On the other hand, many ANMs who were posted close to the district headquarters and who commuted to their place of work continued to receive house rent allowance.

Administrative rules direct ANMs to stay in their sub-center village -- district officials are authorized to initiate appropriate disciplinary action including departmental inquiry and suspension of those who do not conform. Though written notices are often served on non-resident ANMs, they are usually not followed by inquiry or suspension.

Conclusions

Based on the results of this study, we conclude that an ANM in effect takes an "economic" decision about whether or not to reside within her work area. She takes this decision after having weighed the "*ease of staying*" and the "*inconvenience of not staying*" in the area. We have developed a framework to help identify strategies to encourage ANMs to become more accessible to communities by residing in their work area (Figure - 4).

Figure 4 - Conceptual framework to explain an ANM's decision to reside in her work area

Ease of staying within the work area	Inconvenience of not staying in the work area
Good living quarters and facilities (water, electricity, etc)	Cost and difficulty in commuting
Community support and appreciation	Rent and higher living costs in the town.
Quality schooling (especially middle and higher classes) for children	Time required for commuting daily
Other civic amenities	Accountability to the health system
Husband's job	Pressure from the community to reside locally.
Personal and household security	Difficulty in meeting work targets

Our study reveals that ease of staying is minimal because of uniformly poor living conditions that deter ANMs from residing in the work area. Occasionally however, the husband's job, family support and the convenience of living in a large village increase the ease. In absence of significant pressure from the community or health system to reside, the inconvenience of not staying ultimately depends on factors such as the difficulty, cost and time required for commuting. Where this inconvenience is substantial, the decision shifts in favor of residing locally.

Our framework suggests that efforts to encourage ANMs to reside in their work area should aim to enhance the ease of staying (i.e., making living more comfortable) while also enforcing accountability (i.e. increasing the inconvenience of not residing locally).

Besides this framework, supreme court ruling and a policy decision of the Government of Rajasthan form the basis of our recommendations.

Supreme court ruling on sexual harrassment at work place : Harassment of ANMs, when they are on duty in their field area, amounts to harassment at the work place. A historic ruling by Supreme Court of India (*Vishakha and others versus the state government of Rajasthan and others, August, 1997)* explicitly made employers (including the state) responsible for preventing sexual harassment of female employees at the work place. To redress the complaints of sexual harassment, the court directed the constitution of a Complaint Committee, and provided the following guidelines for the same:

- A woman should head the Complaint Committee and not less than half of its members should be women.
- The Complaint Committee should include an NGO or other organization that is familiar with the issue of sexual harassment.
- The Complaint procedure must be time bound.
- Confidentiality of the complaint procedure must be maintained.
- Complainants or witnesses should not be victimised or discriminated against, while dealing with complaints.
- The Committee should make an annual report to the government department concerned, of complaints and the action taken by them.

In pursuance of this order, a "Complaint Committee" has been constituted within the Ministry

of Health & Family Welfare, Government of India, to look into complaints of sexual harassment of women employees in the department. As per court directions, the committee is also working into matters relating to appropriate working conditions of women employees at the place of work. However, such a committee exists only at the national capital.

The constitution of Complaint Committees at the district level would provide the ANMs an accessible platform to voice their needs and grievances. The same or similar committee would also be well placed to recommend locally relevant actions for improving the living conditions of ANM's and other women employees .

Shift of administrative control over ANMs to panchayats :

In line with state government policy to devolve greater powers to Panchayati Raj institutions (PRIs), the department of Medical, Health and Family Welfare, Government of Rajasthan passed an order directing PRIs to assume responsibility for effective implementation of public health and family welfare programmes in the state, and handing over administrative control of primary health Centers and subcenters to Panchayati Raj institutions. It gives panchayats the authority to recommend transfers of ANMs who do not perform well or remain absent from duties[8]. However, while aiming to make frontline workers accountable to the community, this arrangement does not make panchayats or the community responsible for providing support or security to these workers, especially if they are women.

Recommendations : An Agenda For Action

1. Provide a common platform for panchayats and ANMs : Along with administrative control over ANMs, panchayats should be charged with the concurrent responsibility of ensuring personal safety and appropriate living conditions for them. These measures should be seen as a necessary investment by panchayats, in order to receive accessible and quality services. In a few instances where an intermediary non-governmental agency has provided the required support and community was responsive, this arrangement was found to be useful in meeting the needs of the ANMs, while also enforcing accountability on their part. The example in the accompanying box illustrates this point.

8. Order number Pan.6(58) Medical and Health/2/99, department of Medical and Health (group-2), dated 1 May 2000

2. Form Complaint Committees at district level for women health workers : Taking the cue from the Supreme Court ruling on formation of Complaint Committees by employers, we recommend that such committees be constituted at district level for women employees of the health department, including ANMs. Such a committee could have representatives from the health department, the district administration and civil society organizations. It should be mandated to redress cases pertaining to sexual and physical harassment. The same or a similar committee may additionally review and recommend actions for improving living and working conditions among ANMs. This approach may be applied to other women extension workers too, given that their situation is expected to be similar to that of ANMs.

Local self-governments and ANMs:
Ensuring comfort; enforcing accountability

An ANM posted in a sub-center in Jhadol block of Udaipur district did not reside in the sub-center area. The sub-center accommodation was in a dilapidated state. A local non-governmental organization motivated villagers to raise the issue in the gram sabha (general body meeting of all residents of villages covered by a gram panchayat). On being asked by the gram sabha as to why she did not reside in the work area, the ANM replied that it was impossible to live in a broken house. Villagers resolved to repair the accommodation and subsequently when the sub-center was repaired, she started residing there.

In a Gramsbaha in Dungarpur block of Udaipur district, an ANM voiced her concern about personal insecurity while going to conduct deliveries at night. Villagers resolved that those calling the ANM for conducting deliveries at the night would have to arrange for her transport and arrange for 2-3 female family members to accompany her.

3. Implementation of policy guidelines for ANMs : The public health sector does not have an explicit human resource policy, specially for front line workers. There is urgent need to develop and implement policy guidelines to address the following issues (this list is not intended to be comprehensive):

- *Recruitment and posting :* Since women hailing from a rural background are better able to adapt to working in the rural areas and are more likely to reside within their work area, the domicile criteria may be suitably modified to preferentially recruit them. An initiative along these lines would additionally tie in with giving panchayats a greater role in recruiting ANMs, a role that they currently do not have.

- *Matching transfers to changing needs :* Our findings reveal that ANMs have changing family support needs during different periods of their career. There are periods when the schooling of their children becomes a paramount consideration. The absence of a well-defined transfer policy means that while some ANMs remain posted in remote and difficult areas for many years, others manage to leverage comfortable postings closer to town from where it is easier to "up-down" daily.

  A transfer policy that takes into consideration the changing personal responsibilities and needs of ANMs over time, and posts them into progressively larger villages or towns, should be helpful in this regard. Quite obviously, the contours of a transfer policy may best be worked out in a participatory manner in consultation with the workers themselves.

- *Meeting personal needs :* While fulfilling some of the needs such as schooling of the children requires larger inputs, responsive supervisors can help ANMs to meet some others, provided they are equipped and made accountable for the same. For example, supervisors could help ANMs locate safe and convenient accommodation or refurbish the available subcentre premises. To achieve this, the health department would additionally need to institutionalize the ways to make supervision more humane and responsive.

- *Location of accommodation and amenities :* Quality of accommodation and safe location are important pre-requisites for residing in the area. In Barmer district for example, the District Health Society has installed solar lights in sub-centers that did not have electricity, in order

to improve ANM's living conditions. Sub-centers that are in unsafe locations or are uninhabitable should be identified and relocated. District health societies may be advised to carry out this job.

4. Encourage non-governmental organizations to support ANMs : Many field based NGOs working in rural Rajasthan have added a health component to their development portfolio. While several have launched direct service or communication initiatives, only few have attempted to strengthen the role of a government health workers for better service delivery. Apart from playing a role on district Complaint Committees, NGOs could work with government ANMs to bring them closer to marginalized communities and enhance their personal security, while increasing their accountability to local residents. To play a mediating role, NGOs would need to be able to work with and through frontline health workers and panchayati raj institutions.

An active effort by non-governmental and government organizations would enable ANMs to improve their living and working conditions, as also empower communities to hold them accountable for delivering reproductive and child health care. Such measures would be essential if the intractable problem of high infant and maternal mortality levels among the rural poor in states like Rajasthan, are to be meaningfully addressed. Hence we feel that investments in meeting the needs of frontline workers would make sense not only as a human resource management measure, but also as an important programme strategy.

ANNEXURE

SUPREME COURT JUDGEMENT ON SEXUAL HARASSMENT

(Vishakha & others Vs state of Rajasthan August 1997)

1. WHAT IS SEXUAL HARASSMENT?

The Supreme Court Judgement of 14 August 1997 contains guidelines prohibiting sexual harrassment. As defined in the guidelines: "Sexual harassment includes such unwelcome sexually determined behaviour such as :

a. Physical contact

b. A demand or request for sexual favours

c. Sexually coloured remarks

d. Showing pornography

e. Any other unwelcome physical, verbal or non-verbal conduct of a sexual nature."

2. WHO DO THESE GUIDELINES APPLY TO ?

It is the duty of the employer or other responsible persons in work places or other institutions to prevent sexual harassment and to provide procedures for resolution of complaints. Women who either draw a regular salary, receive an honorarium, or work in a voluntary capacity in the government; private sector or unorganized sector come under the purview of these guidelines.

3. PREVENTIVE STEPS

Preventive Steps must be undertaken by employers or other responsible authorities in public or private sectors as follows :

a. Express prohibition of sexual harassment should be notified and circulated.

b. Prohibition of sexual harassment should be included in the rules and regulations of government and public sector bodies.

c. Private employers should include prohibition of sexual harassment in the standing orders under the Industrial Employment (Standing Orders) Act 1946.

d. Appropriate work conditions should be provided for work, leisure, health, and hygiene to further ensure that there is no hostile environment towards women at workplaces and no woman employee should have reasonable grounds to believe that she is disadvantaged in connection with her employment.

1. COMPLAINTS PROCEDURE :

- Employers must provide a Complaint Committee headed by a woman and not less than half of its members should be women.
- The complaint Committee should include an NGO or other organization that is familiar with the issue of sexual harassment.
- The complaint procedure must be time bound.
- Confidentiality of the complaint procedure has to be maintained.
- Complainants or witnesses should not be victimized or discriminated against while dealing with complaints.
- The Committee should make an annual report to the government department concerned of the complaints and the action taken by them.

DISCIPLINARY ACTION :

- When the offence amounts to misconduct under service rules, appropriate disciplinary action should be initiated.
- When such conduct amounts to an offence under the Indian Penal Code, the employer shall initiate action by making a complaint with the appropriate authority.
- The victims of sexual harassment should have the option to seek transfer of the perpetrator or their own transfer.

OTHER PROVISIONS OF THE GUIDELINES :

- Sexual harassment should be affirmatively discussed at worker's meetings, employer employees meetings and other appropriate forums.
- Guidelines should be prominently notified to create awareness of the rights of female employees.
- The employees should assist persons affected in cases of sexual harassment by outsiders or third parties.
- Central and State governments are required to adopt measures including legislation to ensure that private employers also observe guidelines.

These Supreme Court Guidelines are legally binding and must be enforced.