Negotiating conflicting roles: Female community health workers in rural Rajasthan

- A perspective on the Indian ASHA-programme

Dagrun Kyte Gjøstein

Thesis submitted for
Master of Arts
Department of Social Anthropology
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http://www.duo.uio.no/
SUMMARY

The “ASHA”, a female community health worker, is the newest addition to India’s frontline government health workers. This community health worker programme is embedded in the state health services, with a focus on maternal and child health, and family planning. They are named the “Accredited Social Health Activists” (ASHAs). Through the guidelines for selection of ASHAs and the North Indian kinship system, the ASHAs are young women, married into the village community they serve. The ASHAs are to facilitate the use of state health services in pregnancy, delivery, family planning and children’s health care and to bring awareness to their community about the state’s health advices and health schemes through mobilisation, counselling and creating awareness. The thesis is based on 6,5 months of field work in North India, including five months of living in the village household of an ASHA in Rajasthan.

The aim of the thesis is to explore the social interface between ASHAs and their village community and the public health system, how they negotiate between their various social roles. In order to do so, I contextualise and describe the dynamic social structures within which they manoeuvre and I explore the agency available for them.

Various aspects of the ASHAs’ position and agency is explored, mainly through the lens of a family planning campaign and the events that unfolded in the promotion, and execution of the campaign. This case-story illustrates that ASHAs meet conflicting pressures, and have to manage conflicting roles and duties—to health superiors, to their own household and to the rest of the village. I argue that they occupy an ambiguous and vulnerable position at the frontline and examine how they, skilfully, manage and navigate their role and work in order to perform well with regards to government criteria and, yet, also maintain good relations within the village.

The ASHA-programme, moreover, represents a current governing “technology” of the Indian state to induce behavioural change in the rural population’s health practices. Thus the thesis is also a local study of the changing interface between the State and its citizens—of ongoing governing technologies and modernity and citizenship discourses—through the lens of government health work.
“Gāv kī ASHA!
Desh kī ASHA!
Swastha kī raksha kaun karega?”
“Ham karēnge! Ham karēnge!” *

“We will do it! We will do it!”

“ASHA(s) of our village(s)!
ASHA(s) of our country!
Who will protect our health[care]?”

“Challi, challi re ASHA challi re
leke ANM kā sāth,
leke sārpanch kā hāth
leke challi re.
Leke man mē vishwās,
leke gāv kā sāth;
leke challi re..” **

“ASHA is on the move,
together with ANM,
hand-in-hand with Sarpanch,
along she marches on.
With confidence at heart,
together with [her] village community,
along she marches on”

* “Ham karēnge! Ham karēnge!”
** “Challi, challi re ASHA challi re
leke ANM kā sāth,
leke sārpanch kā hāth
leke challi re.
Leke man mē vishwās,
leke gāv kā sāth;
leke challi re..”

The “Accredited Social Health Activist (ASHA)” to the right, in uniform jacket.
Slogan and **song performed at a huge rally with thousands of ASHAs from all over Rajasthan gathered in connection with a huge health event in Jaipur, India, July 17th 2010. The event were a combined marking of the yearly “Population Day” and the celebration that Rajasthan was selected as the number one state with best “NRHM progress” in India. The event’s programme centred around the success of the ASHA-programme.

The drawn illustrations are taken from an official training material booklet (NRHM GoR 2010).

Envisaged ASHA in action: Counselling a pregnant woman, taking a birthing woman to hospital, distributing medicine for minor ailments, conducting a health awareness meeting.
ACKNOWLEDGMENTS

For the opportunity to conduct this fieldwork I am indebted to the generosity of many people in India and Norway.

First and foremost I want to express my sincere gratitude to Anya, the women who has become the main character in my thesis. Though Anya only knew a few English words, and I knew only basic Hindi, the two of us quickly found ways of communicating with each other. Mainly due to her patience, pedagogic approach and creative interpretations. In such everyday situations trying to communicate with her and others, I experienced a common willingness to understand one another, perhaps best captured in the term resonance, “the crucial— and charitable—orientation that allows us to go beyond the words to engage people's compelling concerns” (Wikan 1992:460). I am forever grateful to your generosity, willingness to discuss and share your concerns; For your patience to explain, persistent to make me understand, with laughter and warm-heartedness; for your charitable ability to understand and take me seriously in spite of my child-like language. I cherished our conversations, your original perspectives and the knowledge that you shared with me.

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NOTE ON LANGUAGE AND TRANSLITERATION

The villagers, spoke a local Rajasthani dialect, that lie relatively close to Hindi, which my regular field assistant Beena also spoke. The village interviews and conversations were conducted in this dialect or standard Hindi, or a combination. The majority of villagers understood simple Hindi, which I also master the basics of. I have in some instances used Hindi terms, or added the Hindi word next to the English translations. I have used Hindi-terms because the vernacular terms cover more complex and precise meaning than the English translations. Other Hindi terms that appear are names of local food, clothes or customs that has no English equivalent. If the local word had an obvious Hindi equivalent I have given the Hindi variant. (I have for instance given Hindi bura nazar for “the evil eye” rather than local bura najar.) I have for these terms in most aspects followed the transliteration schema used in Snell (2003). Long “a” is marked as “ā”, long “i” as “ī” and long “u” as “ū”. I have not consistently marked the nasalized vowels and the different retroflex an dental consonants, such as “t”, “ṭ”, “d” and “ḍ” sounds. Terms uses repeatedly, like bahū, are italicized and defined on first appearance. For Hind words conventionally used in English such as wallah (transliterated vālā), purdah (pārdah), chula (cūlā) I have given the words as conventionally written. Hindi terms that appear is listed in the glossary in the appendix.

NOTE ON KINSHIP TERMINOLOGY

Kin terms used in the area of the fieldwork conform to the North Indian kinship structure outlined by Vatuk (1969). I occasionally use the below notations following Vatuk (1969) to distinguish the exact kinship relation, as the English terminological distinctions between kin, and their associated roles, do not always adequately cover the kin relation:

M=Mother, F=Father, W=Wife, H=Husband, Z= Sister, B=brother, D=daughter, S=Son
s=elder, y=younger

Take for instance the English term “brother-in-law”: A woman has vitally different associated role relations towards her devar (Husband’s younger Brother, HyB) and her jeth (Husband’s elder Brother, HeB). In a similar manner, in a kinship system that distinguish between wife givers and wife takers, a man’s role relation towards his sister’s husband, (ZH) jiāji’s is differentiated from the role relation he has towards his wife’s brother (WB) sālā.
LIST OF ABBREVIATIONS

ANM: Auxiliary Nurse Midwife (DoMHFW)
ASHA: Accredited Social Health Activist
ASHA-Sahyogini: Rajasthan-specific ASHA-title of a combined DoMHFW and DoWCD worker
ASNI: Assessing and Supporting NIPI Interventions
AWC: Anganwadi-Centre (Pre-School Centre)
AWW: Anganwadi-Worker (under ICDS)
AYUSH: Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (under the DoMHFW)
BCG: Bacillus Calmette-Guerin / Tuberculosis Vaccine
BCMO: Block Chief Medical Officer
BPL: Below Poverty Line
CDPO: Child Development Programme Officer (Head of block level in the DoWCD)
CHC: Community Health Centre
CHW: Community Health Worker
DOTS: Directly Observed Treatment Support
DoMHFW: Department of Medical, Health &Family Welfare (“Health Department”)
DoWCD : Department of Women & Child Development (“Anganwadi-department”)
DPT: Combination vaccine against Diphtheria, Pertussis (whooping cough) and Tetanus
GNM: General Nurse Midwife(DoMHFW)
Gol: Government of India (Central Gov.)
GoR: Government of Rajasthan (State Gov.)
ICDS: Integrated Child Development Services (under the DoWCD, run the AWCs)
IUD: Intra-Uterine Contraceptive Device (Copper-T)
IMR: Infant Mortality Rate (per 1000)
JSY: Janani Suraksha Yojna, Safe Motherhood Scheme (Gol Scheme)
LHV: Lady Health Visitor (Supervisor at PHC-level under DoMHFW)
LS: Lady Supervisor (under ICDS/DoWCD)
MCH: Mother- and Child Health
MCHN: Mother Child Health and Nutrition-day
MDGs: The UN’s Millennium Development Goals
MMR: Maternal Mortality Ratio (per 100 000)
MO: Medical Officer (doctor position, commonly head of PHC-sector)
MPW: Multi-Purpose Worker (DoMHFW)
NIPI: Norway-India Partnership Initiative
NREGA: (The Mahatma Gandhi) National Rural Employment Guarantee Act
NRHM : National Rural Health Mission (DoMHFW flagship-programme)
OBC: Other Backward Classes
OPV: Oral Polio Vaccine
PHC: Primary Health Centre
PHFI: Public Health Foundation of India
PNC: Post-Natal Care
PRI: Panchayati Raj Institution (GoI)
“Rule of Village Committee-system”
SC: Scheduled Caste
ST: Scheduled Tribe
SUM: Senter for Utvikling og Miljø / Centre for Development and the Environment
SUM-MEDIC: Multi-disciplinary approach to Explaining Differential Immunization Coverage
TT: Tetanus vaccine
VHSC: Village Health and Sanitation Committee
Prelude: The Accredited Social Health Activist (ASHA)

During the summer months family planning campaigns were the centerpiece of government health work in the area of Rajasthan in which my fieldwork took place. In July mobile camps that inserted Intra-Uterine contraceptive Devices (IUDs), commonly known as Copper-Ts, toured the rural health facilities in Dhargarh sector. The nearest health centre to the village I lived, Bajipur sub-centre, was run by an Auxiliary Nurse Midwife (ANM) named Nidhi. Nidhi told her six community health workers, called ASHAs, to each bring her five “cases” for the upcoming IUD-camp at her sub-centre. Nidhi said that if they did not, she would not sign the papers required to release their payment that month. She told her ASHAs to promote the IUD as “an IUD-injection1 preventing pregnancy for five years”, in their villages. She insisted they avoid the term “Copper-T”, since it had a bad reputation. Nidhi knew that stories thrived among elder village women about how harmful Copper-Ts had been to their health. She thus worried that calling it Copper-T would scare women from wanting it. Nidhi insisted to her ASHAs that the “IUD-injection”, contrary to the Copper-T, was not harmful to women’s health. She seemed deliberately vague about whether the “IUD-injection” was, in fact, a Copper-T or not. Several ASHAs, among them Anya, replied anxiously that they did not think enough women were ready for IUDs in their villages. Nevertheless, one week before the IUD-camp Anya, ASHA of Chotipur village, went dutifully from house to house to promote the “IUD-injection”.

A core strategy of the Indian Government’s health policies has since 2005 been the Accredited Social Health Activist (ASHA):

“She is the link between the community and the health care provider[s]. Department of Medical and Health at State and at Center is looking at ASHA as a change agent who will bring the reforms in improving the health status of oppressed community of India (...) She will play a vital role in improving the health indicators of the State, especially IMR [Infant Mortality Rate] and MMR [Maternal Mortality Rate].” (NRHM GoR N.d. emphasis added)

1 The English terms “IUD-injection” and “Copper-T” were the vernacular terms used.
**The Night Before the IUD-Camp**

It was the night before the IUD-camp, six days after Anya’s first promotion round in the village. Anita, my field assistant, and I reached my host family’s home at 7 pm. At home were Anya’s parents-in-law, Ammāji\(^2\) and Bāūjī\(^3\), the youngest daughter-in-law of the house, Sarita, and the four boy children. Bāūjī, the grandfather, sat in the TV room by himself and the children went about. We went to sit with Ammāji and Sarita in the kitchen. Sarita was preparing dinner by Anya and Kanya’s *chula* (stove), which was a marked exception. Anya and Kanya, both sisters-in-law and real sisters, shared a chula and ran their household together. Normally Kanya would have taken on pressing housework in Anya’s absence, but Kanya was away that week, leaving all the housework responsibilities to Anya. I asked Ammāji where Anya was. Ammāji, clearly offended, answered: “In the village? Perhaps! Who knows?” The unease was palpable.

Anya came home at 7.30 pm, and was met by Ammāji questioning her whereabouts: “You must tell us before you go anywhere!” Anya insisted she had told Bāūjī that she was going to remind people about tomorrow’s family planning camp. She maintained that her ASHA-work was important. Moreover her *madamji* [Nidhi, the ANM-nurse] had phoned and specifically told her to mobilise in the village today. Sarita joined the discussion. It was not her place to cook for Anya’s household. Bāūjī came to the doorway listening quietly to the women’s dispute, but quickly returned to the TV-room.

When the dust settled, Anya took over the cooking, and proudly told us she had been to many houses this evening. More than the previous week, when Anita and I accompanied her on the first promotion round. She had gone to all the homes where she knew women were not yet sterilised. Anita informed Anya that we had met Lakshmi Bairva today in Sitapur. Lakshmi was a woman from Anya’s village, who got the “IUD-injection” previously at another family planning camp that month. We met Lakshmi at the hospital in Sitapur where she came to remove the IUD after lasting pain and bleeding. Startled by

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\(^2\) Common term for elder respected women (grandmothers) in the village.

\(^3\) Male equivalent to term explained above.
these news, Anya received a phone call from Nidhi-madam, the ANM and Anya’s supervisor. Nidhi called to ask how many cases Anya would bring for tomorrow’s camp. Anya listed the names of several women. She also informed Nidhi-madam about Lakshmi. Nidhi explained that the nurse who had inserted Lakshmi’s IUD was not very good, or experienced. That’s why it had happened. The doctor that was coming tomorrow, on the other hand, was very experienced.

Anya shared her anxiety for the upcoming event with the women in the kitchen. She worried that other women than Lakshmi would have problems from the IUD. She was anxious that they would blame her, accuse her of fooling them, if they found out the “injection” possibly was a type of Copper -T. Simultaneously, she kept reasoning that she had only told the women what Nidhi had told her to say: “What do I know? I am only ASHA. I told them: ‘just come to the camp and see, talk to the doctor yourselves, then decide.’” This way of promoting was the outcome of several days of pondering and discussions with Anita, myself and Ammājī. With a changed mood⁴, her mother-in-law now supported Anya, assuring her she had acted right. She said Anya had done her duty. Nothing more. Anya’s mother-in-law was constantly involved in how Anya performed her ASHA-work. Ammājī repeatedly told me that she wanted her daughter-in-law to do good and proper work. She claimed her family had a good reputation in the village, and that reputation seemed important for Ammājī to maintain.

After dinner Anya completed her evening household chores while the rest of her family watched TV. Anya had been tense about the upcoming IUD-camp and her role in promoting it all week. At night, in her room, she anxiously asked about my opinion. It had become regular for us to have personal conversations at bedtime, for Anya to confide in me or ask questions about my life in Norway. She reflected on her position vis-à-vis the ANM, which appeared more vulnerable:

“Nidhi-madam told me to call people for ‘injection’. Had I said it was a ‘Copper-T’, the women would not come, but many women will come for an ‘injection’. I am

⁴ Hearing that Nidhi-madam had ordered Anya to go around the village likely changed Ammājī’s opinion on Anya’s absence. She had great respect for Nidhi-madam.
afraid of telling lies. How could I lie? Nidhi is ANM [a nurse], right? (...) She comes to the village from time to time for a short while. We have to remain here always. When the villagers finds out, what will they think about me? How can I face them? Nidhi-madam only ever cares about getting more ‘cases’. Alright, let’s see what will happen”.

**THESIS’S OBJECTIVE**

The unfolding of this event, including some institutional antecedents and unfolding over the following days in Chotipur village will be a read thread of this thesis.

The event illustrates that the ASHA-position in certain aspects is experienced as ambiguous and vulnerable position for Anya and her colleagues. They are members of a new Indian cadre of frontline lay health workers. The episode thus far illustrates how ASHAs must negotiate cross-pressures: between their superiors’ demands, expectations and wants, and those of their family, and fellow villagers. It also illustrates how Anya capably tries to manage the conflicting loyalties and conflicting professional and personal roles in the complex and dynamic social landscapes in which she is entangled. Anya wanted to do her ASHA-work well and at the same time maintain her status and good relations in the community, and also to superiors. The scene further illustrates that her relations in the household and to superiors are hierarchical.

In this thesis I aim to elaborate on the social, cultural and institutional structures at work for the ASHA, in Anya’s case and more generally. I describe the context of village community and health system structures with in-depth knowledge of Anya’s work and life situation. This serves as my main example of an ASHA, but when pertinent, I draw on observations of other ASHAs. This, expectantly, grants my analysis a broader interest than of one single ASHA. The thesis is not an evaluation of the ASHA-programme, but give insight into the workings on the ground, and might inform the current “Community Health Worker”-debates in global health from an anthropological perspective.

The ASHA-programme, moreover, represents a current governing “technology” of the Indian state to induce behavioural change in the rural population’s health practices. Thus the thesis is also a local study of the changing interface between the State and its
citizens—of ongoing governing technologies and modernity and citizenship discourses—through the lens of government health work. My study, then, gives insight into how the state manifests locally, are experienced, negotiated and partly incorporated, through villagers’ embracing, or rejecting, its health advices and services. Accordingly, the thesis sheds light on aspects of ongoing societal change in contemporary rural Rajasthan. The thesis can be read as a contribution to anthropological studies of medicine and health; of changes and continuities in health practices and women’s reproductive health agency; and of local manifestations of national and global health trends, priorities and policy shifts. As such, the thesis is a study of processes of globalisation from the perspective of Rajasthani health services.
1 Introduction

The massive cadre of over 800,000 community health workers named ASHAs, are the newest addition to India’s rural[5] frontline health work. ASHAs are envisaged to bring awareness to their community about the state’s health advices, health schemes and facilitate the use of the public health system through mobilisation, motivation and counselling. Their work concerns chiefly mother- and child-health (MCH), thus pregnancy, delivery, newborn care, childhood and pregnancy vaccinations, and family planning. The ASHA-programme serves as a cornerstone under the “National Rural Health Mission (NRHM)”, an ambitious and comprehensive policy-programme the Indian government launched in 2005. The NRHM’s stated mission is to “carry out necessary architectural corrections” within the already established public health system—to improve “access to quality health care”—especially in rural areas and for the poor (GoI 2005a:2). The first stated component of the NRHM’s “plan of action”, is the village-based female Accredited Social Health Activist (ASHA) who is envisaged “to act as the interface between the community and the public health system and negotiate health care for poor women and children” (GoI 2005a:6). The ASHAs were selected by local village councils (panchayats) by criteria of being a literate female resident of the village, aged 21 to 45 years. She also “should have effective communication skills, leadership qualities and be able to reach out to the community”, and preferably be educated up to 8th grade or higher (NRHM GoR N.d.). The ASHA-training consisted of 23 days in several rounds over a year.

The ASHA is hence herself a community member sharing the worldviews of her village community, not medically trained like other frontline health staff. The position of ASHA is thus interesting because she represents a new mediating role between the Indian nation-state’s intentions to modify its population’s health practices, and the community which she works and, significantly also, lives in.

[5] The programme also includes urban ASHAs.
The Indian authorities want the population to adopt their “health messages”: comply to the small family norm; vaccinate their children; seek out health checkups during pregnancy; give birth in hospital; exclusively breastfeed children the first six months; use contraceptives and get sterilised after two children; construct toilets and so on. It is especially the poor, uneducated, and so-called “backward” rural population that is considered the problematic groups. Such messages are painted at the walls in villages and health centres, repeated in poster campaigns, TV and radio and from frontline health workers. Similar messages and strategies has been part of the government’s continuous communications since the 1960s (Singh and Bharadwa 2000). More recently, India’s commitment to reach the Millennium Development Goals (MDGs) in health has renewed its importance. The NRHM, under which the ASHA-programme is a cornerstone, “is essentially an initiative to meet some key health sector goals, where India seriously lags behind and was considered off-track in achieving the Millennium Development Goals” (Bajpai, et al. 2010:7).

The communication strategies attempts to produce responsible citizens who follow the official health advices, and play on notions of morality, modernity, progress and citizens responsibility (Singh and Bharadwa 2000). The ASHA-programme follows as one of the more recent governing techniques of Indian authorities to make the population self-manage and self-discipline, to “govern”, themselves according to its advised norms.

In North India, the selection criteria for the position together with the kinship system, results in most ASHAs being women married into her husband's village (sasurāl). The ASHA’s role as an “activist” may disconnect with common norms and values regarding young married women, who are not likely to have a visible or authoritative role. Living in her sasurāl, she has the role of a classificatory bahū, “daughter-in-law”, of the whole village. With that follows specific norms of respect towards elders, such as veiling, not raising her voice in public and general submissiveness. Daughters-in-law normally also have a heavy work load of farming and household duties, and a subordinated role in their household that restricts their scope of movement. These are some common aspects they must balance with their new role as the village's ASHA. The ASHA is envisioned in government guidelines as a community advocate, but also advocating the interests of the
authorities. These roles may, not surprisingly, always be consistent. The interests of the state do not necessarily coincide with those of the villagers; That is especially often the case in reproductive health, which represents a contested social field of various social values and ideals of kinship and gender, and maintenance of society (cf.Ginsburg and Rapp 1995; Patel 2006; Unnithan-Kumar 2004). The ASHAs’ role, then, is conceptually ambiguous; I argue that the ASHAs so experience their roles.

My objective for the thesis is to explore the position the ASHAs have at the social interface between their community and the health system, how they negotiate between, or play out, their various social roles. In order to do so I describe the dynamic social structures they manoeuvre within and explore what kind of agency is available for them.

The above mentioned social structures, e.g. of kinship and gender, that the ASHAs manoeuvre within are however not static, but dynamic and also changing. The ASHA-position in itself may represent individual changes in the ASHA’s bahū-role, changing their scope of agency in their household or village, but also represent changing opportunities for women’ position and agency, as part of wider societal changes in India. Before presenting my theoretical approach I first elaborate on the ASHA-role, and background for the ASHA-programme.

THE ASHA: CHANGE AGENT OR LACKEY?

The ASHA is by design what the WHO define as a “Community Health Worker” (CHW) (Lehmann and Sanders 2007:3). CHWs were advocated in the 1978 Alma-Ata declaration of “Health for All by the Year 2000” as a strategy for comprehensive health care and securing community participation (cf.WHO 1978). The benefits of CHW-programmes to improve health outcomes has since then remained a debated topic in global health, and employment of CHW-programmes has been abandoned and revived

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6 Also called e.g. Lay Health Worker (LHW) (cf.Lewin, et al. 2010) or Village Health Worker (VHW) (cf.Werner 1978). WHO use the term CHW.
periodically (cf. Lehmann and Sanders 2007; Lewin, et al. 2010). Werner (1977;1978) early on raised a still relevant question: of whether a CHW potentially can be a liberator, or if the CHW-role is simply that of a lackey? In the liberator role the CHW would take on a role as a change agent. The CHW would be a lackey if regarded primarily as an auxiliary to the physician, "a worker on the bottom", and given minimal (medical) responsibility (Werner 1977;1978). The design of the ASHA-programme incorporates aspects of both the liberator and the lackey, and whether also in practice, the thesis explore.

The acronym ASHA plays on the Hindi word *asha* (आशा) which means hope or expectation. The NRHM-policy quote in the prelude illustrates that the government has huge expectations to ASHA’s role of improving rural health. She is presented as a “change agent” who will facilitate less maternal and infant deaths and general use of the government health services. Lower maternal and infant mortality rates (MMR and IMR) are health indicators that reassure the success of the Millennium Development Goals (MDGs) for health. In global health CHWs has recently received new attention (cf.Walley, et al. 2008) as they are considered to play an important role in achieving the Millennium Development Goals for health (Lewin, et al. 2010:6). India’s social progress has since the UN Millennium Declaration in 2000 been monitored, internationally and in the Indian English press, in terms of whether the MDGs are likely to be met by 2015 (Jeffery and Jeffery 2010). Due to India’s large population, its continued high rates of infant and maternal deaths contribute heavily to the global indicators—which adds pressure on India to achieve lower IMR and MMR to be “on-track” to reach the MDGs. Thus high hopes rest on the shoulders of the AHSAs to contribute to significant improvements in national (and global) health indicators. Anya, and I presume most

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7 See NHSRC (2011:16-17) for a summary of earlier Indian CHW initiatives (between 1940 and 2011).

8 *आशा* is also a common female name


ASHAs, had not heard about the MDGs, nor did she know much about these larger contexts. At the frontline the work appeared as concrete, routinely tasks, some tedious, other enjoyable or chaotic; attending concrete health events and meetings, visiting people’s homes to counsel or inform, filling out reports and records. The ASHA’s various responsibilities and work tasks are quite comprehensive (see figure opposite).

Some of the ASHA-work is regular every month, and they are paid fixed monthly incentives (see table 1.0). That is for mobilising for village Mother Child Health Nutrition (MCHN)-days, attend monthly review-meeting with their superiors and convene health awareness-meetings in the village. Other work tasks are irregular, and the ASHA are paid incentives per “case”. For instance for each woman they accompany to hospital to give birth, and for each sterilisation they “motivate” (see table 1.1). Throughout the year they work on many health campaigns, such as Polio and Family planning. ASHAs are not permanent government employees of the Department of Medical, Health and Family Welfare (DoMHFW). Rather, they are compensated “volunteer workers”. They are supposedly free to work according to their capacity and then paid-for-performance. However, in chapter three I question whether the ASHAs’ superiors keep them accountable to achieve targets, and the ASHA thus experience themselves as regular government workers.

In Rajasthan the ASHAs have an additional role as Sahayogini, an outreach person hired at the government pre-school centres (Anganwadi-Centres) placed in most villages. The sahyogini-programme was running before the ASHA-programme, and since the role and tasks of the workers were considered very similar, the state decided to modify the design of the ASHA to the “ASHA-Sahyogini” (NRHM GoR N.d.). I will however in the following refer to them simply as ASHAs. The ASHA of Rajasthan is thus hired by two departments; the health department and the Integrated Child Development Services (ICDS) which run the anganwadi-centres. The ICDS give a fixed monthly

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10 Sahyogini can be translated as associate or assistant (of the anganwadi-centre).

11 The Sahyogini-programme had run for a few years before the ASHA-programme, and those who were earlier Sahyoginis, such as Anya, were given extra training for the new tasks for the Health Department.

12 ICDS come under the Department of Woman and Child Development (DoWCD)
Roles and Responsibilities of ASHA-Sahyogini

- **Create awareness**
  Health, Nutrition, basic sanitation, hygienic practices, healthy living and working conditions, information on existing health services and need for timely utilization of health, nutrition and family welfare services

- **Counseling**
  Birth preparedness, importance of safe and institutional delivery, breast-feeding, immunization, contraception, prevention of RTI/STI. Nutrition and other health issues.

- **Mobilization**
  Facilitate to access and avail the health services available in the public health system at Anganwadi Centers, Sub-Center, PHC, CHC and district hospitals.

- **Village health plan**
  Work with the village Health and sanitation Committee

- **Escort / Accompany**
  Escorts the needy patients to the institution for care and treatment. She will accompany the woman in labor to the institution and promote institutional delivery

- **Provision of Primary Medical Health Care**
  Minor ailments such as fever, first aid for minor injuries, diarrhea.
  - Provider for DOTS
  - Depot Holder of ORS, IFA, DDK, chloroquine, oral pills and condoms
  - Care of newborn and management of a range of common ailments
  - Inform Births, deaths and unusual health problem or disease outbreak
  - Promote Construction of household toilets

(Source: NRHM GoR N.d.)

### Table 1.0. Monthly "Integrated Compensation"

<table>
<thead>
<tr>
<th>Department</th>
<th>Activity (&quot;paid-for-performance-work&quot;)</th>
<th>Rs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Department</td>
<td>Monthly Sector/PHC meeting</td>
<td>100</td>
</tr>
<tr>
<td>NRHM/DoMHW</td>
<td>Mother Child Health Nutrition-day</td>
<td>150</td>
</tr>
<tr>
<td>&quot;ASHA-work&quot;</td>
<td>Village Health and Sanitation Committee Meeting</td>
<td>100</td>
</tr>
<tr>
<td>Anganwadi Department</td>
<td>Two Monthly Adolescent Girls Meetings</td>
<td>100</td>
</tr>
<tr>
<td>ICDS/DoWCD</td>
<td><strong>Total Regular Monthly Incentives Health Department</strong></td>
<td>450</td>
</tr>
<tr>
<td>&quot;Sahyogini-work&quot;</td>
<td><strong>Fixed honorarium</strong> (10 daily household-visits, update &quot;daily diary&quot; - record, monthly meeting with LS, help AVWW with village Survey &amp; Registers (e.g. pregnant &amp; lactating women, vaccinations, weight of children under 5 years, undernourished children etc.)</td>
<td>500</td>
</tr>
<tr>
<td>DoMHW/DoWCD</td>
<td><strong>Total Regular Monthly Payment</strong></td>
<td>950</td>
</tr>
</tbody>
</table>

### Table 1.1. Other "Performance-based Compensations"

<table>
<thead>
<tr>
<th>Department</th>
<th>Activity (&quot;paid-for-performance-work&quot;)</th>
<th>Rs per case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Department</td>
<td>Accompany woman to Hospital Delivery (+ Transportation)</td>
<td>200 (+400)</td>
</tr>
<tr>
<td>NRHM/DoMHW</td>
<td>PNC/NPII-Card (6 home-visits: Day 0, 3, 7, 14, 28 and 42)</td>
<td>200</td>
</tr>
<tr>
<td>&quot;ASHA-work&quot;</td>
<td>Pulse Polio Campaign (for 3 days work)</td>
<td>150</td>
</tr>
<tr>
<td></td>
<td>Motivator Sterilisation: tubeectomy / vasectomy</td>
<td>150 / 200</td>
</tr>
<tr>
<td></td>
<td>Motivator IUD</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>DOTS (Tuberculosis: registration &amp; follow up)</td>
<td>250</td>
</tr>
<tr>
<td></td>
<td>Cataract (detection &amp; referral)</td>
<td>175</td>
</tr>
<tr>
<td></td>
<td>Toilet construction (motivator)</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>Provide Radical Treatment to Malaria Cases</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>Leprosy case (detection &amp; referral + complete treatment(PB/MB)</td>
<td>100+ 2-400</td>
</tr>
</tbody>
</table>
honorarium that compensates all tasks, instead of the per-case, per-event payment model the health department use. Although their practical work in both departments mostly overlapped, the Rajasthan ASHAs thus had two sets of superiors, payment structure and bureaucracies to manage. They attended separate monthly meetings with superiors in the two departments. This aspect of their position I discuss further in chapter three. Below follow the conceptual framework, before I describe where and how I conducted the fieldwork.

CONCEPTUAL FRAMEWORK

I approach the various levels, actors, encounters and meetings I encountered during my fieldwork through a social interface-perspective, also called an actor-perspective (Long 1989; 2001; 2004a). Further, I use a structure and agency-perspective as developed by Ortner (1996;2006) to examine the position of the ASHA in the village community and the health department.

SOCIAL INTERFACES: SITES OF CULTURAL BORDERLANDS, FRICTION AND NEGOTIATIONS OF POWER

Long (2004a:16) describes social interfaces as “critical points of intersection between different fields or levels of social organization” where “discrepancies and discontinuities of value, interest, knowledge and power are clearly revealed”. The approach has “a focus on the lifeworlds and interlocking ‘projects’\(^\text{13}\) of actors” that encounters, and allows for “the elucidation of social meanings, purposes and powers”(Long 2004a:15). The NRHM-policy document envisage ASHA not only to negotiate health care between the social fields of her community and the health system, but “to act as the interface” between these fields (GoI 2005a:6 emphasis added). In some respects the ASHA-position in itself represents a social interface: not as a critical point, but a constant intersection of various social fields with different values, interests, knowledge and power. In certain situations these are revealed to the researcher through critical events or encounters. The social

\(^\text{13}\) I understand Long’s use of “project” as compatible to Ortner’s use of the concept, elaborated in the next section.
interface-perspective’s conceptual framework is then useful to analyse what intersects and what is negotiated. I thus see the social interface-perspective primarily as an instrument for the researcher to identify and examine critical points as concrete social interfaces.

I analytically distinguish between two spheres of the ASHAs life, “the village community” and “the local health department” as different fields of social organisation. The ASHAs and other actors likely do not experience these as distinct fields. They have personal relations with other actors who are also part of both social fields. Also the interests of the actors in both fields are likely often conflicting within these fields, as well as in agreement for some actors across the fields. Both social fields that I describe are certainly themselves dynamic and complex interfaces of various competing social fields of values and knowledge. In a way any ASHA’s lifeworld, as for anyone, is a constant interface between various social fields.

The social interface approach are criticized for conceptualising actors as mere representatives of one social field, and not recognising that actors are *Janus-faced* (von Benda, et al. 1989). Long (2004b:29) recognises that although particular persons represent a specific group or institution in encounters, one cannot assume that the actor therefore acts in the interests of his or her fellows. Also, groups and institutions likely has multiple internal interests. The prelude illustrates, that whose interests the ASHA acts on behalf of, and of which social field she is a representative, she continuously negotiates. I suggest that this balancing of interests is crucial for her working performance. My observations imply that the ASHAs experience conflicts, and so they continuously negotiate, between the social fields’ interest and values—for themselves, their community members, and their superiors. They recurrently negotiates cross-pressures between demands and expectations from various actors of these two social fields.

Ortner’s borderland-perspective resonates well with the social interface-perspective, and add meaning to how I understand interface. Ortner (1996:181-182) say a borderland-perspective attends to
“sites of social friction\textsuperscript{14} and cultural encounter where culture is (...) constantly under challenge and construction (...) the terrain of cultural encounters, of border crossings, is never neutral and never level (...) it is almost always a space of unequal power.”

An interface, the way I see it, is exactly a \textit{cultural borderland} where various social values, interests and knowledge intersect. Furtherer, Ortner’s (1996:181) concept adds movement and a global outlook:

“borderland work emphasize the movements of, and encounters between people, images, and so forth across cultural and political spaces (...) while always potentially (...) global, in scope, it is— ideally—at the same time local and ethnographic, looking at real places and asking what kind of things happen on the ground”.

Though, when I in the following use the term “social interface” I use it in a way that incorporates the borderland insight. I am chiefly concerned with the negotiations of the ASHSA-position and ASHA’s agency at the social interfaces between the state health system and the community she engages in.

\textbf{Agency as a serious game: power and projects}

Commonly agency is understood as an individual’s ability to act, or, more precisely, the scope of possible actions available to an agent. Agency is a debated concept in the social sciences (cf. Ahearn 2001; Ortner 2006a). It relates to the core debate of relative analytical emphasis on structure or agency of the actor in explaining human behaviour. The interface-approach’s focus on the actors and encounters may incline for a description of the social fields beyond as rigid structures, and not as dynamic social landscapes where changes are ongoing. In this regard Ortner (1996:19-20) notes that

“If we take the methodological unit of practice as the game, rather than the ‘agent’ we can never lose sight of the mutual determination(s) of agents and structures: of

\textsuperscript{14}Tsing (2005:4) promotes \textit{friction} which she defines similarly to a social interface as “the interactions (...) of interconnections across difference”. While Long emphasises the importance of insight in the lifeworlds and interests of the actors that encounter, Ortner and Tsing emphasises the creative and transformative, as well as unequal and awkward interaction in the “sticky engagement” (Tsing 2005:6) of the encounters.
the fact that players are ‘agents’, skilled and intense strategizes who constantly stretch the game even as they enact it, and the simultaneous fact that players are defined and constructed (though never wholly constrained) by the game.”

This perspective on the actor-structure relation is part of Ortner’s “serious game perspective” on social life: “seen as something that is actively played, oriented towards culturally constituted goals and projects, and involving both routine practices and intentionalized action” (Ortner 2006a: 129). Thus, in a circular argument: neither in the village communities nor the local health system are the structures inflexible, or the actors able to act unrestricted by the structures of the social field. Ortner (1996:19) highlight the “necessity of retaining an active intentional subject without falling into some form of free agency and voluntarism”. Although I describe the ASHAs and other actors’ active strategies, I emphasise that these are conditioned by the power relations of the social fields they are involved within. Thus actors “can never act outside of, the multiplicity of social relations in which they are enmeshed (Ortner 2006:130).

Ortner (2006b:152-153) distinguishes between “agency as a form of power”, which includes “empowerment of the subject, the domination of others, the resistance to domination and so forth” and “agency as a form of intention and desire, as the pursuit of goals and the enactment of projects”. However, agency “is never merely one or the other. Its two ‘faces’ (...) bleed into one another”(Ortner 2006b:139). Regarding agency as pursuit of projects, Ortner (2001:80) describe actors’ projects as what they “seek to accomplish (...) within a framework of (...) their own categories of value”. Their projects “infuse life with meaning and purpose” (Ortner 2001:80). The actor’s projects can range from individual "simple ‘goals’“ to “projects that are full-blown ‘serious games’, involving the intense play of multiply positioned subjects pursuing cultural goals within a matrix of local inequalities and power differentials”(Ortner 2006b:144).

Thus, with agency of power I mean agency to influence others actions, and decide on own actions. Agency of pursuing projects covers more subtle, yet intent, actions, or strategies of maneuver towards personal goal(s) or project(s) (without necessarily succeeding).
The “serious game”-metaphor is a valuable framework for my observations. Anya seemed to pursue projects of being a “good” worker and simultaneously a “good” bahū, family- and community member. The ASHA’s position is thus for Anya a “serious game”-project. She must measure her steps and strategies carefully to maintain good relations with neighbours, mother-in-law and demanding superiors in the enactment of her role as a community health worker. All the while she operates within social fields of hierarchal power-relations.

How to conceptualise power remains contested; power can be obvious and concrete, or subtle and difficult to seize. I explore power in relation to actor’s agency, played out in relations between actors, and in terms of governing techniques of the state’s technologies and health worker’s strategies. Long approaches power in a way compatible with both Ortner’s serious games and agency of power and projects. Following Long (2004:30) power must be explored through negotiation and struggle “over meanings and strategic relationships”. The struggles are founded on actor’s perceptions of themselves as “capable of manoeuvring within particular situations and developing effective strategies for doing so” (Long 2004:30). Moreover,

“room for manoeuvre implies, a degree of power (...), as manifested in the possibility of exerting some control, prerogative, authority and capacity for action, (...) for brief moments or for more sustained periods” (Long 2004a:30).

Anya’s scope of agency and power comes precisely through available manoeuvring strategies, not constantly, but fleeting and context-specific. Some actors (e.g. bahūs) have a subordinate position and a limited scope of exercising authority, e.g. over their own time and health choices. Still, I assume they actively play the game, by pursuing personal projects and try out various available strategies. Such power struggles and negotiations within households, between bahūs, husbands and mothers-in-law were especially apparent in use of contraceptives and sterilisations.

Foucault’s governmentality-concept refer to “the array of knowledges and techniques that are concerned with the systematic and pragmatic guidance and regulations of
everyday conduct” (Ong 2006:4) In short, through governing techniques the authority (in our case the nation-state—or health workers) try to make the population, an individual citizens self-manage, “govern”, themselves according to the norms the authority prefer. Building on governmentality, Ong (2006:6) identifies two kinds of “optimizing technologies” that enlightens how the connection between government and citizenship is changing within neoliberal reasoning and governing. A biopolitical mode of governing “centres on the capacity and potential of individuals and the populations as living resources that may be harnessed and managed by governing regimes” (Ong 2006:6). The first, technologies of subjectivity, induce self-government so citizens optimise their choices and efficiency through “an array of knowledge and expert systems” (Ong 2006:6). The second, technology of subjection, regulate populations “for optimal productivity” through amongst others political strategies and regulations (Ong 2006:6). These technologies Ong argues produce conditions that change both administrative strategies and citizens practices. I explore whether the ASHA-worker can represent such optimising technologies; and also how actors of the social interface deploy such technologies to manage and govern their subordinates.

**METHODOLOGY**

**CULTURAL TRANSLATION AND REPRESENTATION**

Anthropological data results from the ethnographer’s selective perception, inter-subjectivity and productive efforts (Stoller 1989:156). All observations involve interpretation and is produced from certain positions of “situated knowledges” recognising “the embodied nature of all vision” (Haraway 1988:581). Our way of presenting data, through narrative, observation and experience are necessarily representations of reality (Stoller 1989:39) and our representation is inevitably partial (Clifford 1986). The content of this thesis alike must be read as my partial representation of the village, actors, and events that unfolded. It is therefore important to consider some aspects of my position in the field and how I gained information and data. Before some methodological reflections I under present some key actors and arenas of the ASHAs’ work and my fieldwork.
KEY ACTORS AND ARENAS

ANYA’S HOUSEHOLD

Anya’s family consisted of three generations and two separately organised households in one house. Ammājī and Bāūjī, the grandparents and parents-in-law, were in their upper-sixties. Anya, the eldest daughter-in-law, was in her thirty-one and had a son aged five. Her husband, Ashok, was ten years older than her and worked and lived in a temple away from the village. Anya’s younger sister Kanya was married to Ashok’s younger brother Tej. The two couples had married in a double ceremony twelve years earlier. Kanya had two sons, aged eleven and nine. The third brother, Nishok, was married to Sarita, and they had one son aged seven. All of the three daughter-in-laws lived in their mother-in-law and father-in-law’s house, although Nishok and Sarita had separated their household. The organisation of the household, and its internal power struggles, is elaborated in chapter two.

ANYA’S VILLAGE

Chotipur, a village in Alwar district, in northeast Rajasthan, was not particularly remote; young girls and boys went to secondary school or college in nearby towns; and many men travelled daily to work in Alwar or Sitapur. Chotipur was located only 20 minutes by motorbike from Sitapur, the administrative centre of the block\textsuperscript{15}. There were frequent buses to Alwar city, the district centre. The trip was shorter than an hour and cost 20-25 rupees. Delhi and Jaipur was both about four hours from Alwar by train. The nearest bus stop was 15 minutes away from Chotipur by motorbike. Most households owned a motorbike, but none had cars. Most households had mobile phones, TV and radio. The standard of living and consumption was still way below the nearby cities, though, slightly higher than nearby villages (cf.Knivestøen 2012). The climate is dry, with harsh summers. The yearly monsoon starts gradually in June-July and ends in September. The winter is chilly, but the temperatures never fall below freezing point.

Chotipur was a small village of 850 inhabitants, composed of a few castes, all of which identified themselves as Hindus. The majority of the village was Sharmas, a Brahmin high caste, counting roughly hundred households. The minority counted ten Bairva

\textsuperscript{15} A block, also called \textit{thasil}, is a sub-district administrative and political body unit.
households, with official status as a “Scheduled Caste” (SC), a so-called “untouchable” caste-group due to hereditarily association with (pollute) leather work. There were also ten Meena households, an official “Scheduled Tribe”, and four Saini households, officially known as an “Other Backward Class”. The Sanis, vegetable farmers, lived isolated in an outskirt hamlet and had relatively low status in the village. They were not “untouchable” though. The village’s caste-composition with Brahmnic majority was remarkable in the area and in Rajasthan as such. About seventy percent of Rajasthan’s population is SC and twelve percent ST (Census 2011). SC, ST and OBC are official public categories that give right to quota government employment and education, prioritised over the “General Castes”.

The first time I visited Chotipur, I was introduced at the village school. A School Master\(^{16}\), Chotipur resident, and Sharma, greeted us with enthusiasm. He proudly presented his village by saying that here people believed in family planning, and had only two children. He also emphasised that they vaccinated their children. I was puzzled why this was the first he said, and on his own initiative. Obviously, that I was accompanied by District and Block Health Officers played a role, but a fuller significance of the teacher’s presentation became clearer after I had lived there a while. The Chotipur villagers identified their village as a particularly educated and progressive one. In the same manner as how people think, talk and practice vaccination can be said to express much about what people values, whom they are and identify with (Leach and Fairhead 2007), the same can be said about family planning (Ginsburg and Rapp 1995). People link their attitudes and health practices to the state policies’ discourses of modernity, backwardness and family norms (Anagnost 1995). The teacher likely presented his village in this manner to counter the established image of “backward” rural people who refuse family planning measures and vaccination, by ensuring us that his village adhered to “modern” health practices.

\(^{16}\text{Vernacular term}\)
Chotipur village:
Located in Alwar
district, Eastern
Rajasthan
CHOTIPUR ANGANWADI-CENTRE AND THE ANGANWADI-STAFF

The Anganwadi-Centres (AWCs) are government pre-schools or crèches, often located near village school buildings. The Hindi-word *anganwadi* means courtyard or playground. The Anganwadi-Centres are managed by the Integrated Child Development Services (ICDS), a Department of Women and Child Development (DoWCD)-programme. The centre monitors and promotes the nutrition and development of village children, adolescent girls, pregnant women and breastfeeding mothers. The centre employs three people. One Anganwadi-worker, the manager, who administrates and updates the many records. One Anganwadi-helper [*sahika*], who mainly cooks cleans. Finally one ASHA-Sahyogini, mainly an outreach assistant who give door-to-door-counselling, mobilise the village for events, and assists the manager with records and surveys. Anganwadi-workers earn 1800 rupees, the helper 900 and ASHA-Sahyogini 500. Any additional income to the ASHA is paid directly by the health department.

During opening hours, Monday-Saturday 10 am to 4 pm, pre-school children could come to play and get a hot meal for lunch. Every Thursday, the anganwadi-centre distributed nutrition supplements, one-kilo bags of flour\(^{17}\), to children under five, and to pregnant and lactating women. One Thursday monthly\(^{18}\) the anganwadi-centre was the locale of "Mother Child Health and Nutrition (MCHN)"-days, when the ANM arrived to give vaccinations and other MCH-services. Chotipur anganwadi-centre was located next to the government primary school. The largest room displayed a variety of posters containing colourful drawings and advices for diet, child care, hygiene and so on. Another room stored piles of government records, some equipment\(^{19}\) and medicines

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\(^{17}\) Mixed of rice, soy, wheat, fat and sugar. Commonly people said they did not know how to prepare it, that it tasted bad and thus gave it to their animals.

\(^{18}\) Since Chotipur was a village of less than 1000 inhabitants, MCHN-days was initially held only every second month. The policy changed in April-June 2010 to one monthly MCHN-day in every village, regardless of population size.
against minor ailments. The entrance porch functioned as the main space of activity in the centre. Here the centre’s staff spent most of the opening hours and the children played. The arrangements of Chotipur anganwadi-centre was typical of the area. Though some centres were smaller, and cramped on busy days such as the monthly MCHN-days.

Vaneesha Sharma had been anganwadi-worker in Chotipur for 25 years. The centre itself had been open for 27. Vaneesha was an authoritative and outspoken Brahmin woman. She was a grandmother of six, mother of two well-employed and married sons that lived in a joint household with her, and one recently out-married daughter.

THE SUB-CENTRE AND THE ANM

Nidhi Meena was an Auxiliary Nurse Midwife(ANM) at Bajipur sub-centre, the health post nearest to Chotipur. ANMs are female, full-time, salaried, government health workers. They are trained to provide immunisation, contraception advice, midwifery and antenatal and postpartum care. They are also tasked with sanitation and infectious diseases prevention(c.f.Mavalankar, et al. 2010). Employment as an ANM requires an 18-month training program. To be admitted one needs 10 years school education. They are the lowest level medically trained professional staff in the rural public health system. The ANMs are mobile auxiliaries, based in sub-centres. Each sub-centre serves a population of 3000-5000, matching the population of the Gram Panchyats20, self governing village-councils. Anya’s village belonged to Bajipur panchyat that consisted of six villages; Bajipur, Chotipur, Indoli, Kishpur, Bhakpur and Gholpur. Each village had a population of 500–900.Nidhi supervised the six ASHAs working in these villages. Among other tasks, Nidhi monitored and reported various health indicators in her area, performed various field visits and attended meetings. One important task was to give vaccination and MCH-services at monthly MCHN-days in each village. Nidhi was given yearly and monthly targets: numbers of children to vaccinate and women and men to sterilise. Together with her ASHAs she was responsible for “motivating” eligible

20 Gram Panchyats are the smallest political divisions (of PRI): Local-councils elected for five years, headed by the Sarpanch as chairman.
individuals to meet these targets. Nidhi held the MCHN-day at the sub-centre the last Thursday each month. Only then could the villagers surly find the ANM at the sub-centre. Due to Nidhi’s commitments in the field the centre was often closed.

Nidhi commuted daily from Alwar. She had a scooter that she used to move about between the sub-centre and various field responsibilities. Nidhi was in her forties and usually wore a colourful sari, golden jewellery and glasses to work; as did many of her ANM colleagues. She was friendly and generally wellliked. The villagers commented especially that she knew “village language” and related to them on a more equal foot. She also spoke less technically than other health personnel. By the end of my stay, one additional ANM, Sunanda Bairva, was posted at the sub-centre. Sundana was 19-years-old, and right out of nursing college. She was hired on a temporary NRHM-contract, not permanently positioned.

I was introduced to Anya and Nidhi through District and Block Health Officers. They were apparently chosen to be introduced to me because they were seen as well-performing, and active workers from the health administration perspective. The area was also well-performing; with relatively good indicators of vaccination coverage, family planning coverage, institutional deliveries and so on. I had asked to be introduced to “active” ASHAs, as district health administrators told me that not all ASHAs actually worked. It saw it as an advantage to observe “well-performing” active health workers, presuming they were more personally engaged, had reflected more on their challenges and come up with better strategies to manage their position compared to those less involved.
FIGURE 1.0. RURAL PUBLIC HEALTH LEVELS AND FACILITIES

**DH District Level Adm.**
- **Alwar District Hospital**
  - Travel time from Chotipur and Sitapur: 1 hour by car.
  - Opposite direction of CHC from Chotipur
  - Covers district population: 3,67 millions
  - Open 24/7; Second referral unit, Labour room & Labour wards, Operation Theatre. Offers C-sections for complicated deliveries. New Sick Newborn Care Unit (NICU-project). Various specialists.

**CHC Block Level Adm.**
- **Per GoR Guidelines**
  - Cover population: 80,000 - 120,000
  - First referral unit for 4 PHCs.
  - 30 patient beds
  - OT, X ray, laboratory and labour facilities
  - Open: 24/7
  - Staff: 4 Specialists; Surgeon, Physician, Gynaecologist and Paediatrician
  - 21 various medical and other staff

- **Sitapur CHC**
  - Travel time from Chotipur: 20 min by motorbike
  - Covered block population: 200,000 +
  - 2 Hospitals: Open 24/7
  - Jannana (women's) unit: Staff:
    - 4 GNM's (General Nurse Midwife) 3 yrs training
    - 4 ANMs, 1 LHV, 2 paediatricians, 1 gynaecologist, 1 MO, 8 Yashodos, 2 ward-boys, 3 sweepers
    - 2 labour tables, 2 labour wards w/ 20 beds

**PHC Sector Level Adm.**
- **Per GoR Guidelines**
  - Covering population of 20,000 - 30,000.
  - Referral unit for 6 Sub-Centers.
  - 4-6 patient beds preferably labour facilities
  - Open: 9am-1pm & 3-6pm (Sunday: 9-11am)
  - Staff: 1 MO and 14 various staff, including 1 Lady Health Visitor (LHV) per 6 sub-centers for supervision, 1 ASHA-supervisor, AYUSH-practitioner

- **Dhargar PHC**
  - Travel time from Chotipur: 15 min by motorbike
  - Opposite direction of CHC from Chotipur
  - Cover sector population: 45,000 (8 sub-centers)
  - Temporary building; no beds or labour room
  - Staff: 1 allopathic doctor (the MO), 1 Ayurvedic doctor, 1 Ayurvedic Compounding, 2 GNM's, 1 ANM, 2 compounders, 1 ASHA-Supervisor, 1 peon 1 accountant, LHV post vacant

**S-C Sub-Center Level Adm.**
- **Per GoR Guidelines**
  - Covering population of 3000-5000
  - First peripheral contact point between community and health care delivery system
  - Open: Mon-Sat: 10 am-5 pm (closed Sunday)
  - Staff: 1 Female Health Worker (ANM) and 1 Male Health Worker (MPW)
  - "Model Sub-Centers" may include labour room and 1-2 patients beds

- **Bajipur Sub-Centre:** Constructed in 2004
  - From Chotipur: 20 min walking (5 by motorbike)
  - Cover Bajipur Panchyat popul: 5000 (6 villages)
  - Staff: Nidhi Meena (ANM) posted in 2001
  - Sundara Bairwa (ANM) posted June 2010 on temporary NRHM contract
  - (Sweeper paid privately by Nidhi)
  - MCHN-day: 4th Thursday monthly
  - "Daily" consultation with ANM, free medicines

**AWC* Village Level Adm.**
- **Per GoR Guidelines**
  - 1 per village (or per 1000 population)
  - The Integrated Child Development Services:
    - Supplementary nutrition (children under 6 years, pregnant
      women and lactating women)
    - Health check-up
    - Referral services
    - Pre-school non-formal education
    - Nutrition & health education (women 15-45)

- **Chotipur Anganwadi-Centre**
  - Cover population: 850
  - Open: Mon-Sat: 10 am-4 pm (closed Sunday)
  - Staff: AWW: Vaneezha Sharma, AW-helper: Gita Sharma, ASHA-Sahyogini: Anya Sharma
  - Main health activities:
    - MCHN-day: the 3rd Thursday monthly
    - Nutrition supplement: every Thursday
    - Village Surveys & Monitoring
THE PRIMARY HEALTH CENTRE AND THE MO

The Primary Health Centres (PHC) are rural health centres administratively headed by a Medical Officer (MO) overseeing the population of a sector unit area. Dhargar PHC, headed by Dr. Rajul, was run from a temporary building. There was a dispute over the land allocated to build the planned PHC. Dhargarh PHC had no running water, no proper toilet facilities, no proper patients beds and no labour room. Villagers from Chotipur and the Bajipur-area did not use the PHC. They preferred to go to equally distanced Sitapur, where there was a government hospital (CHC) of higher standard, many pharmacies and a range of private practitioners and hospitals. Dhargar sector served a population of 45,000, and had eight sub-centres with field staff, including 36 ASHA-Sahyoginis. Anya and her ASHA-colleagues went to Dhargarh PHC only for their regular meetings lead by Dr. Rajul on the last Friday every month.

THE COMMUNITY HEALTH CENTRE (CHC) AND THE BCMO

Anya and fellow ASHAs frequently travelled to Sitapur CHC. They took birthing mothers to the hospital and engaged with nurses, doctors, as well as bureaucrats to secure their own incentives and the birthing women’s entitled incentives. Since 2005 the government Janani Suraksha Yojana (JSY), the safe motherhood scheme, paid women to give birth in hospital and AHSAs who accompanied them. The ANMs and other medical field staff came to the block health administration office near the CHC for their monthly block review meetings lead by the Block Chief Medical Officer (BCMO). The BCMO administratively headed the CHC hospital as well as the health staff and facilities of the block.

Sitapur CHC consisted of two separate buildings open 24 hours: one general hospital and one “mother-and-child” unit with a labour room, two labour wards, a vaccination room

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21 A block in health administration corresponds to a thesil in the PRI-administration. Sitapur CHC covered 7 PHC-sectors and 27 sub-centers. Umri CHC covered only 4 sub-centers, without any mediating PHC levels. See level map in appendix.
and a unit for undernourished children. The hospital had electricity and running water, but did not offer major surgeries. Such patients had to be referred to the district hospital in Alwar, as was the case with deliveries expected to be complicated. Most women from Chotipur and Bajipur-area came here to give birth. It was mostly nurses, aided by Yahodas, unskilled ward boys and ASHAs that attended the deliveries. Female family members of the mother-to-be often attended too, though not in a professional capacity. The doctors and staff nurses lived in quarters close by, and could be called on in emergencies.

“THE STATE”

If I specifically refer to the state of Rajasthan, as the sub-nation government organ, it is clarified. Otherwise, by “the state” I refer to the “authorities”—as “both an illusory as well as a set of concrete institutions; as both distant and impersonal ideas as well as localised and personified institutions; as both violent and productive” (Hansen and Stepputat 2001:5). A question to have in mind, in the local village- and health department-level, who were taken to personify “the state”? While the Medical Officer and, to some degree, the ANM represented the state’s faces to the villagers, how about the ASHA, or the anganwadi-worker? Many Chotipur villagers were also government employees, in education, police and lower-level administration. Were they representing “the state”?

The above presented were the important arenas and actor of Anya’s ASHA-work and also institutional context for the events that unfolded during the IUD-campaign. Under I consider aspects of my data production and my position in the field.

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22 Yashodas are hospital-based lay women trained to take care of and council the birthing mothers in newborn care, breastfeeding, vaccination and family planning—not designed to provide any technical medical procedures. They were part of a Norway-India Partnership Initiative-sponsored project placed in a few CHCs in three Rajasthan districts. "Yashoda" is thus not a common government position.
BEHIND MANY MASKS?

The people the anthropologist interacts with in the field are not the only subjects of interpretation, the anthropologist herself is also interpreted by the people with which she interacts (cf. Berreman 1962; Briggs 1986). The importance of placing people in a certain category might be more important in a stratified society like India, where one’s belonging to certain groups, determined by caste, class, age, gender, profession, and so on prescribe the appropriate rank and interaction patterns. Berreman (1962) did fieldwork in a stratified North Indian village, and claims that people, especially on top of the caste hierarchy, presented a should-be version, a mask. The villagers intentionally performed impression management in their representation to “keep up appearances”. Berreman discovered that the mask presented to him changed when his Brahmin assistant was replaced with a Muslim.

Following Berreman (1962) I could not always take at face value what people told me about their practices and values. I tried to understand the “mask” they presented. I myself also employed “masks” in order to manage people’s impression of me, to be someone people could relate to. I strived to enact an appropriate, married woman. I dressed in local outfits and tried to de-associate myself from common the negative prejudices against western women. I imagined that women would talk more freely with another married woman about issues such as life with their in-laws and husbands, pregnancies, bodies and births. As a female in my mid-twenties, most of the village women my age already had children and lived in shared households, working together with mother- and sisters-in-laws. I was frequently questioned about me coming of age and still childless—they thought it high time that I became a mother. Conceptualised in their kinship terms as a daughter of the household and village, staying in my natal village (pihar) I was given a role where I had more freedom of movement, fewer rules of concealment and respective behaviour than a bahū of the village had.

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23 Impression management, a psychology term, associated with Goffman (1969), involves that in interactions with others, one more or less consciously play out roles, convey certain sorts of information etc. that create particular effects among the other partners of interaction.
In many chaotic situations involving many actors there was no opportunity to inform everybody about who I was, and in many situations people did not have the option to resist interaction with me. I then had little control over what my assistant explained about us and our purpose. In initial encounters people often assumed I was working for an NGO or UNICEF, the most familiar presence of foreign people they related to. When we denied this they thought I was working for the government of India or my country. I tried to convey that I was a student of social science, doing research on health issues and services, in particular the work of the ASHA. I also said I was interested in learning about their culture and language. I felt I was soon accepted as an odd, but friendly foreigner both in the household and the village, and among the health workers I was frequently in contact with. However, I found out that some health workers tried to keep some events secret from me and sometimes directly lied about their practices. They might have been threatened by my presence, fearing I would report their potential (mal)practices.

My assistants’ castes and positions were important for people’s way of relating to us, as Berreman (1962) noted. Beena, my regular field assistant, was a young, unmarried woman, of twenty-two with a B.A. in English from a local college. She had a friendly, empathic, curious, naïve and un-authoritative approach that seemed to come across as unthreatening both to villagers and health workers. Accordingly, people appeared to readily share their thoughts and concerns with us. Beena had not done similar work before, but we gradually learned to work together, and established a well-functioning team. Beena was a Saini, not a high caste nor “untouchable”. I experienced this to make it easier for us to relate with both the high caste members and low castes of the village. However, Beena’s personality, and knowledge of “village way of relating to people” was equally important. Though Beena came from a middle class family in Alwar city, she was familiar with “village language”. She had stayed much with family in rural Alwar growing up. It was valuable for our relations with the villagers that she could approach the community in a “native manner”. Though Beena was my regular fieldwork partner, it was Anita who stayed with me the two crucial last weeks of July, when several of the events leading up to the IUD-camp and village uproar unfolded. Anita, a confident woman in her late thirties, was more mature and had extensive training in working with
anthropologists, my supervisor included. Through her empathic approach she astonishingly made people feel at ease, through she frequently informed and advised people about their conduct. She sometimes instructed people to educate their girls and vaccinate their children. Anita was herself a Brahmin, unmarried, and held a M.A. degree. Anita related well also with the “untouchable” and lower castes villagers.

LANGUAGE AND TRANSLATIONS

The reproduced quotes in the thesis come either from translated recordings, or a combination of my assistant’s translations and my own, as I wrote them down in my field notes. They are not exact translations, but I include them to represent the peoples voices (as I perceived them), and give a more vivid rendering of their characters and the episodes they were a part of. I promote the importance of “going beyond the words” of the people one engages with during fieldwork: “to attend to what people say and the intent they are trying to convey, rather than groping for some ‘larger’ answers within the particulars of their spoken words” Wikan (1992:466).

In the rural area I stayed most people understood standard Hindi, but very few knew English. I had attended an introductory Hindi-course at the University of Oslo, and understood some of the language. My mastery of Hindi improved throughout and I could gradually follow colloquial conversations. I gained a relatively good vocabulary regarding household activities, health and MCH-practices. Though, normally, Beena or Anita lived with me full-time and translated for me. Their knowledge, skills and contributions were indispensable and not limited to translation. Conversations with them became a good source of how interpret situations and conversations we had witnessed. They supplied a respondent validation reconciling insider and outsider perspectives (Stewart 1998:37) and helped me understand and adjust my own role in the field.

24I had some recordings translated by university students in Delhi.

25Beena and Anya proved to be excellent language teachers. Beena knew the local dialect, standard Hindi, and English. Her translations across these three tongues were valuable for my language-learning process.
THE DATA PRODUCED

This work is based on six months of participant observation fieldwork in North India, from mid-January until end of July 2010. I lived five months, March-July, in Chotipur, also exploring the neighbouring villages and health facilities. The data accumulated throughout the fieldwork was produced in numerous ways, encounters, places and contexts.26

My master’s project was undertaken in affiliation with two research projects based at the Centre for Development and the Environment (SUM) at University of Oslo.27 This affiliation and the projects’ research permits, agreements and contacts gave me a unique opportunity to straightforwardly and legitimately access different levels in the health system’s offices, people, reports, documents, ASHA-training materials and meetings. I talked to various positioned Health Officials at Block (“Sitapur”), District (Alwar) and State (Rajasthan) levels about their thoughts concerning the role of the ASHA-programme in the rural health work28. I also attend a few state-level ASHA-related conferences and health events in Jaipur. These periodic encounters provided a degree of insight into how ASHA was talked about and what moved about at various levels in the Health Department.

The data in the thesis is primarily based on my time living in Chotipur village and Sitapur block. I participated in the daily activities of Anya and her sisters-in-law, and went with Anya for ASHA-work in the village. Whenever she went outside the village for

26 I re-visited Chotipur one week in September 2010 to attend the yearly touring health awareness campaign (“Swasthya Chetna Yatra”), and for some days in March 2011, after attending (module 5) ASHA-training in another block in Alwar.


*Regarding “Norway India Partnership Initiative”(NIPI)—a supportive, flexible and catalytic State to State Initiative giving support and working within the existing Indian health system—See http://www.norwayemb.org.in/News_and_events/Development-Cooperation/-NIPI/NIPI_Fact_Sheet/

28 Some of these interviews I conducted with Cecilie Nordfeldt or other SUM-MEDIC team members.
meetings, or to accompany villagers to hospital, I went with her. Sometimes her other sister-in-law would take me and Beena around the village for errands and visit homes of relatives and friends. In this manner I eased into the life of villagers who gradually became used to my presence. Soon everybody had heard about the odd foreigner living in Anya's home, and many were eager to be visited. People were curious about how I adopted to village life, how I liked their food and whether I participated in various house and farm work. Patel (2006:11) points out that to experience daily village life gives information about natural interactions, reaction patterns, facial expressions, body language and displays of emotions. This provides supportive data through the researcher’s sensitivity to situational factors. I gained detailed insight into a normal day in the AHSAs life, what kind of work they do in the household and in the village and how ASHAs interacted with their fellow-villagers.

I and Beena frequently visited different homes in the village, especially to talk to new mothers, and to cover different caste-households with small children. We became more frequent guests in some homes. My host Brahmin family was concerned with our visits to the low-caste an “untouchable” houses. They directly asked us if we had been given anything to drink or eat. Sarita once questioned us, with expressed repulsion, how we could accept food or drinks “from the hands of such people”. Ammājī had preferred me to stay home under her protection at all times. She usually blamed and pestered Anya when she was worried or upset with my behaviour. This situation did not make it easy to develop close connections to the lower-castes as I felt a duty not to insult, or pollute, my host family who opened their home to me.

Furthermore I came to realise that my actions came to reflect not just upon the honour and social standing of the household in the village, but especially upon Anya. She received the complaints about and blame for my actions, sometimes also from superiors in the health system. I was assured of this when by the end of my fieldwork, the Medical Officer ordered Anya not to bring me to or tell me about one event. Dr. Raju further insulted Anya for “keeping that foreigner in her house”. He had grown annoyed and impatient with my presence, my difficult questions and my poking around—and often
avoided me. “He does not want you to know the reality, how things really are”, Beena explained.

I quickly developed a close relationship with Nidhi, and gained an open invitation to accompany her in most of her ANM-work. Staying near Anya and Nidhi gave insight into their interactions and performances across various situations. I attended most health activities in the sub-centre area that Nidhi and “her” six ASHAs participated in. Among these were the weekly arranged Mother Child Health and Nutrition (MCHN)-days, and reoccurring Family Planning and Polio Campaigns, ASHAs’ monthly sector-meetings, and ANM’s monthly block meetings. I visited various health facilities when joining Anya to accompany people for deliveries, or sought out staff for interviews. I visited the five other ASHAs of Bajipur Sub-centre area in their homes and spoke to them about their work, relations to superiors, life situation, household, and village. I had, though, less chance to seek out disconfirming observations there (Stewart 1998:21-22).

My supervisor visited me in the Chotipur two times and we attended meetings, MCHN-days and did some household interviews together. A fellow student also affiliated with SUM-MEDIC, Synnøve Knivestøen, stayed in Meopur village in the same district. We visited each other a few times which opened our eyes to the great cultural and social variations only an hour apart by car. The village where Synnøve stayed was quite different, with regard to caste-composition, the ASHA’s position, and the villagers health practices, norms and knowledge (Knivestøen 2012).

**GENDERED LIFEWORLDS**

Regarding partial representations, I spent most of my time with women. Strikingly, the categories of frontline workers I frequently engaged with—ASHAs, anganwadi-workers and ANMs—are per job description women. Their gender is apparently understood.

29 I attended over 20 MCHN-days; three in Chotipur; 17 other with Nidhi or Sundana in the other five sub-centre villages; one in Meopur (Knivestøen’s village); and a few during “field visits” together with district health officials in different blocks of Alwar district.

30 Due to her role in the SUM-MEDIC-team.
indispensable to effectively access the mainly female spheres with their mother-and-child-health services. The villagers daily lives (including ASHAs) were characterized of rather gendered divisions. I naturally got better admittance in the female spheres and networks in the household, village and health system. We talked with men during home visits and interviews, and I observed inter-gendered interactions privately in my host household and publicly in the village (and health department)—but I did not have natural access to “hang around” in the male spheres and networks.

ETHICAL CONSIDERATIONS

I experienced situations that gave me information about health workers’ practices that they probably would prefer that I did not have. For instance I experienced health workers intentionally misleading villagers about health services, presumably doing so motivated to reaching their targets. After lengthy considerations I decided to use material from such episodes. The situations I describe, though ethically questionable, did not seem uncommon or unknown among health administrators. I have included such material here, not to “expose” individual health workers. Rather to enhance the description and understanding of the actual health services available in rural areas, and to illustrate how health workers under pressure negotiate policies and priorities in their everyday work. I strive to portray the actors within the established context of hierarchical relations and expected behaviour without “exoticifying” or “blaming” individual actors. Names of informants and places below district level are pseudonyms.

OVERVIEW

In chapter two I describe the social field of Anya’s village and household through the lenses of a MCHN-day. The description also illustrate Anya’s role as an ASHA, how regular ASHA-work proceeds, and ASHAs’ regular interactions with their immediate

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31 In these situations it was difficult to consider where my ethical responsibility should be; whether to betray the trust of my informants (the health workers) or the people who were misled. If I intervened the health workers could have lost their job, and I would not be able to observe the reality of how the health workers really treat and interact villagers, which was in interest of the research.
superiors, the ANM and the anganwadi-worker. Further, power, kinship, caste and gender structures and relations within households and within a village context is elaborated on—the social context most ASHAs must manoeuvre within. Also, Anya’s and her household’s position in the village in relation to caste, class, education is depicted—as well as Anya’s social relations with various other community members.

After looking at an ASHA’s position and relations in her community I move on to looking at what kind of position and relations the ASHAs have in the local health system in chapter three. Here I describe one of the ASHAs’ most frequent interfaces with health system and superiors: the monthly sector meetings. Through the meeting I show how the expectations of her role and work is communicated to the ASHAs by the MO: largely through extending the longstanding target-mentality to the AHSAs. Further I discuss how the ASHAs negotiate their roles in the health system and manage the social relations with their superiors, and what kind of strategies and scope of agency is available.

In chapter four I describe the unfolding of the IUD-events in the village and health department. Through this lenses I disuses crucial aspects with ASHA’s position as a frontline health workers and simultaneously community member, as well as Anya’s agency of (percieved) power and agency of pursuing projects, in light of the social structures and conflicting relations she negotiates her role. Lastly in the conclusion I summarise, and discuss ASHA’s position conceptually out from the practical empirical material and cases presented.
2 The ASHA in her community

To understand ASHA’s position it is crucial that the ASHA is a member of the community in which she works. She is socialised in this community, and follows its rules and norms of acceptable behaviour. She lives and works within the social hierarchy of caste, gender, age and kinship typical of rural North India. Each ASHA’s position and degree of authority is unique, but normally shaped by these general characteristics. In the following, I describe Anya’s village community and outline important social aspects regarding household concerns, current health practices and norms, and social structures of women’s positions and agency. Also portrayed are Anya’s different roles: as a household member and as a bahū of the village. Through describing an ordinary health day in the village, I portray aspects of her “professional” role as an ASHA. I also aim to describe dynamics of the everyday village life.

Though I often refer to “the village community”, which appears to imply a sense of unity, solidarity and common interest, this implication is sometimes misleading. Other aspects of intimate village communities, such as hierarchical thinking, competition, jealousy, suspicion, accusations, gossip and blame-giving—both inter and intra-caste are also prevalent.

A MCHN-DAY IN MARCH

Below follows a description of a MCHN-day in Chotipur, that highlights how Anya, as an ASHA and as a village bahū, move about in the village, and how she relates to her superiors, the ANM and the anganwadi-worker. We see some everyday social relations that a bahū has with different positioned members of the village—some freely, straightforward while others are silent and avoiding. The MCHN-day description is illustrative of ordinary rural frontline health work in practice. It illustrates Anya’s

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32 This MCHN-day description has previously figured in a SUM MEDIC workshop paper (Gjøstein, Knivestøen and Nordfeldt 2011). The text is largely adjusted.
normal relations with her immediate superiors in action. It shows how an ANM may relate to the community members, how she talks about, and tries to motivate for family planning with those bahūs coming to the vaccination day. This regular work and everyday situations of the ASHA contrasts the events of the relatively extraordinary IUD-affair that features the thesis.

**MORNING HOUSEHOLD ROUTINES**

By seven o’clock, the village was usually bustling with activity. Most women were up before sunrise. Young housewives began the day by sweeping their floors, and feeding and milking buffalos. They then made food for the whole family, and helped husbands and children prepare for work and school. Today was Mother and Child Health and Nutrition-day at the Anganwadi-Centre. Being an ASHA does not free one from one’s household duties, so Anya started the day by sweeping the floors together with Kanya and Sarita. Then she made tea for the extended family. Ammāji usually sat at a string-bed on the patio in front of the house, supervising the housework of her daughters-in-law, giving orders and instructions. She sometimes engaged in light work when needed.

Anya fetched firewood for the chula, chopped vegetables for a casserole stew, kneaded dough and baked bread for the family. Together with Kanya and the children she filled all the water containers in the house. Most houses were connected to a pipe system powered by an electric pump, usually pumping water for no more than an hour in the morning. The village had electricity for eight hours a day, but when was always uncertain. Anya had no animals to tend, had only one son, below school age, and no agricultural work in March. She had thus less urgent work to tend to in the morning than some of her fellow ASHAs and other village women. Ramita, the ASHA in neighbouring village Bajipur—and Anya’s declared best friend, ran her household independently. She had an 18-monthold son, still being breast fed, three daughters in primary school, a husband, and two buffalos to feed and care for. She had no sister- or mother-in-law to help her. She was also expected to be at the anganwadi-centre at 10 am for the MCHN-day.
Village Landscape and Sociality

Chotipur had a village centre, with closely placed houses where the majority of the inhabitants lived. Additionally many houses were scattered along the roads leading out of the village centre, and alongside the myriad of paths leading through the surrounding fields. Most of the households in the village centre had some bighā\(^{33}\) land in the surrounding areas. Houses were painted cement and brick-buildings. Besides five Bairva houses, lumped together behind the school, the rest of the houses in the village centre were Brahmin.

My host family lived in a large house\(^{34}\) with a patio facing the road leading to the village centre. The house had four separate rooms surrounding a concrete courtyard. Each room was occupied by one of the four married couples of the family. Kanya’s room was the TV-room, where guests were usually entertained. Anya’s room was used for storage of both sisters’ clothes and properties. Ammājī and Baūji’s bedroom featured both the home temple, the fridge and pantry. This was occasionally a source of tension, as Baūji was particular about who could enter the room because of the temple. At one side of the courtyard, was Anya and Kanya’s kitchen, with their chula, two plated gas-cooker and kitchen supply. Opposite, Sarita had her chūlā, though she cooked mostly inside her own room where she kept a gas-cooker. The house had a roof terrace used for storage, but also for cooking in the summer season, when the open inner-courtyard became too hot. Most families had joint households organised roughly as Anya’s family’s, thus one room per nuclear unit of conjugal couple with children.

Walking around the central village took less than ten minutes, though it took more to reach the houses on the outskirts. Thus not all houses were equally convenient for the ASHA to visit. The location of Anya’s house was private compared to the village centre, removed from the hustle and bustle. The house location might have given less contact with neighbours, but it gave the family good view of people coming and going to the village. Ammājī and Bāūji spent much of their time, temperature allowing, sitting at the patio observing life and people passing. Both had friends visiting regular every week.

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\(^{33}\) Indian unit of land. About 2500m\(^2\) in Rajasthan

\(^{34}\) Drawing in appendix
Above: The front side of the house of my host family seen from the road.

Under: Anya and Kanya’s kitchen: two plated gas cooker, chula and utensils.
They spoke to those who stopped by and exchanged gossip. News spread quickly despite the distance.

Ammājī spoke proudly of their hospitality to travellers, and pointed out that since they were a Brahmin household, anyone of any caste could drink their water. Two sweepers came daily from Bajipur to sweep the streets of Chotipur in exchange for a couple of rotī. The village “untouchables”, the Bairvas, did not perform polluting tasks such as sweeping. Many cattle herding men came by regularly from the nearby villages, with goats, buffalos, cows or camels.

This particular morning I, Anya and Beena stepped outside Anya’s house just before 10 am, after Anya had finished her chores and hastily eaten a meagre breakfast. She veiled her face by pulling the lose end of her sari, her costume, from her hair down over her face. The fabric of her sari was thin, so her face was completely concealed though her view was not completely obstructed. To veil in front of elders was the proper behaviour for all women married into the village. They are bahūs not only in their household, but also of the village.

During the five-minute walk to the anganwadi-centre, Anya exchanged quiet greetings and hushed messages from behind the veil to people we encountered. She stopped briefly to exchange a few quiet words with a young veiling bahū, carrying a small scythe in her hand. The woman had her back against the village and swiftly lifted the sari-fabric up from her face and smiled at us while she gave a quick reply. Anya did not lift her veil, as she was facing some elders who were gathered at the veranda of one of the village temples. The young woman, Neelam, had given birth to her firstborn, a daughter, six weeks earlier at Sitapur CHC, attended by Anya. When we continued walking, Anya commented, clearly annoyed, that Neelam had no business going to the fields so soon after delivery, and that she had told this to both Neelam’s husband and mother-in-law. “Do they, or anyone else, ever listen to me?”, she sighed. Much of her motivation and counselling tasks were done in similar casual encounters.

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35 Unleavened griddle-baked bread, the main staple food.
The village was bustling with activity. Elders, on the way to or from worship in the temples; married men, grandfathers and grandmothers with toddlers on their arms; young men, and young unmarried women would all gather on people’s patios or outside the various temples in morning and evening. Children ran around playing. The veiled bahūs carried cattle fodder and buckets of water. When bahūs had time to relax between their housework and agricultural work they would stay at home or visit their neighbours, not gather outside in public. The village had many temples, some large ones occupying concrete buildings and small shrines and statues placed outside under trees on concrete elevations. The different jātis usually gathered separately, on the patios of members of their same jāti, and had seemingly separate social spaces. The gatherings outside the village temples were mostly of Brahmins, seeing that both the Sainis and the Meenas houses were not located in the village centre, and they were not known to worship as often. The Barivas were anyhow not welcome to sit by or enter their temples. They were considered ritually impure by the higher castes.

MOBILISING THE VILLAGE

At the anganwadi-centre we met the anganwadi-helper sweeping the floors alone. Anya phoned Nidhi, who said she was waiting at the Sub-Centre for the vaccines to be delivered, and Anya should start collecting women and children. Going out to mobilise, we stopped by the local shop to buy biscuits for the Village Health and Sanitation Committee (VHSC)-meeting later on. The ASHA was typically expected to perform the petty tasks for the ANM. In the village centre, three shops sold sundries. They kept basics, but most people went regularly to the larger market in Sitapur to shop.

On the road we met veiled women balancing large bundles of buffalo fodder on their head, and a few young men out running errands. Other women were up at their roofs top terraces, still cooking food, doing the dishes or other housework. Anya shouted from the street: “Today is vaccination day!”, and “Remember to bring your vaccine-cards!” People around raised their heads to see what was going on, greeted her or gave brief replies, and continued working. Anya also informed young men about the vaccination day and asked them to spread the word. We also stopped by a few houses were Anya knew infants or pregnant women that could be eligible for vaccines and checkups.

MOBILISING IN PEOPLE’S HOMES
Before we entered the first house, Anya signalled that this was the house I had heard people gossip about. Presumably, the mother-in-law did not care properly for her daughter-in-law after delivery. She did not wash her daughter-in-law’s clothes, nor cooked the appropriate food for a new mother’s diet. The mother-in-law was also accused for sitting outside the hospital while her daughter-in-law gave birth, when she should have been inside for support.

We entered the front door and came into an open inside courtyard. The mother-in-law was busy with housework. She told us that her daughter-in-law was in the bathroom. Anya lifted her veil half way, and insisted that the old woman must come for vaccination today at the anganwadi-centre. She said that her grandchild could fall ill otherwise. The woman confirmed with a nod. A man appeared on the second floor. Anya made sure that the veil covered her face. We left the house, without having seen either the new mother or her child.

We stopped by a second house. There we met an elderly woman squatting and washing dishes. She and Anya greeted colloquially as Anya pulled the veil off her face. A young man appeared with a chubby toddler on his hip. I noticed Anya did not cover her face, as he was in the devar (HyB)-category to her. The child wore only briefs, his eyes were marked with black kajal, and in his forehead a round, black mark had been made. He had black threads with silver pendants around his neck, silver bracelets with small bells and around each ankle, and a black thread was tied around his wrist and waist. This kind of adornment and make-up was considered to protect the child from curses caused by the unwitting gaze (burā nazar), “evil-eye”, of jealousy, or from any capricious, roaming spirits. Both were believed to cause illness, or worse, death (cf.Lambert 1992:1074; Nordfeldt and Roalkvam 2010:355).

Anya complimented the child for being chubby (moṭī)36 and tickled him. The grandmother brought Anya the child’s vaccine card. Anya examined the card and concluded that the child was due for measles vaccine. The grandmother invited us for tea, but Anya declined explaining that her “madam” (Nidhi) waited at the centre.

36 Can also mean healthy
At the neighbouring house, also a Brahmin household like the previous ones, Anya briefly stopped outside the outer yard. A grandmother sat there, washing utensils. Anya lifted her veil half-way and told the woman to bring her grandson for vaccination. The grandmother nodded and continued working. We continued along the village road and stopped by a few more houses.

The round of vaccine mobilisation revealed that Anya related differently to various families, not only due to structural kinship—and age relations; the relations also depend on the personal and family relations to Anya and her household. In some houses Anya stayed longer and had a friendlier relation, in others the conversations were brief and matter-of-factly.

THE MCHN-DAY SET UP AND SOCIAL RELATIONS AT THE CENTRE

Within an hour, we were back at the centre. Nidhi’s scooter was parked outside. Some small children were playing inside the centre. On the porch, the ANM had set up her equipment and supplies on the floor around her: Iron-Folic-Acid tablets, medicines, contraceptives, a bathroom weight, unused vaccine cards, unused disposable syringes, test slides for malaria, a box for used syringe needles and her MCHN-day-record. In the record she noted the name and birth date of village infants, and the dates they were vaccinated. She also recorded the names and weight of pregnant women, the dates for their checkups and vaccines, and how many iron tablets they were given. She greeted us, as she usually did, as old friends.

Next to her, the anganwadi-worker, Vaneesha, had also set up her equipment and records: one register people signed when receiving their weekly ration of nutrition supplement, and her MCHN-day records. Vaneesha was Anya’s classificatory mother-in-law, and friend of the family. As we arrived, Nidhi and Vaneesha were chatting with the anganwadi-helper and some village women visiting the centre.

For a few of hours the small porch bustled with activity. The anganwadi-worker, assisted by the ASHA, weighed and noted in a register the weight of each child at the centre that day. The helper and ASHA both handed out nutrition supplements while Vaneesha oversaw people signing her register. Simultaneously, Nidhi vaccinated other children and pregnant women, while people were chatting, and squatting where they
could find some room. Grandmothers and unmarried paternal aunts escorted pregnant bahūs due for checkups, brought children for vaccination, or came to collect packets of nutrition supplements. Some left right after finishing their work, others sat down for a while to chat. Some came to ask the ANM for advice about infected wounds or other minor ailments, or to get medicine for fever.

**DISPUTE AND ACCUSATIONS BY A DISSATISFIED FAMILY**

We had not been back at the anganwadi-centre for long when with a man and his mother approached the centre. I recognised the woman, the grandmother washing utensils outside the third house during mobilisation. She held her grandson wrapped in a shawl. Her son accused Nidhi of not coming regularly to duty and Anya for not coming regularly to their house to inform about vaccination. A teacher from the nearby school came by to mediate. Nidhi told the man: “How can you say that I do not come on time? Ask any of the responsible teachers here”. The teacher supported her. Anya and the man started yelling loudly and pointing fingers at each other. The teacher intervened saying that “Anya informs one person in every household. She cannot inform each and every person from every household. It will be very difficult. Do not be so agitated.” Swayed by the teacher argument calmed, and the man and his mother left after vaccinating the child.

Anya sat silent, shivering with anger.

After they left, the health workers and some village women—mostly grandmothers—discussed the incident. They agreed that the man was a troublemaker. Anya attributed the man’s anger with to another reasons: once he was refused to borrow a gas cylinder from her family for a festival arrangement. Someone commented that the man’s house was dirty. It was not uncommon that the Brahmins talked about lower-caste families’ houses as dirty. The angry man was, however, a Brahmin, which made the accusation remarkable. Having a “dirty” house could be a strong moral judgment.

**ANGANWADI-CENTRE ROUTINES: VACCINATION, PREGNANCY CHECKUPS AND FAMILY PLANNING COUNSELLING**

A young mother we met in the morning, Neelam, was among the first to arrive. Her baby girl was wrapped in a shawl in her arms. She kept a knife under the baby’s head, inside the shawl, a common practice to ward off evil spirits from approaching an infant. Neelam was escorted by her husband’s younger unmarried sister (nanad). Neelam
veiled during the whole consultation and she did not speak much; her young nanad spoke on her behalf. She was still a fresh daughter-in-law of the village and this behaviour was expected. Neelam sat down at a rug next to Nidhi with the child on her lap. Nidhi took the vaccination card from Neelam’s nanad, and documented the vaccination in her register. Nidhi asked whether the baby was born in a hospital, and what date it was born. The nanad said that the girl was born in a hospital on sixth February. Nidhi efficiently gave the child two polio drops and injected the DPT-vaccine in the child’s buttocks. “Next month she’ll get another injection.” She checked the upper arm for a BCG-mark\(^{37}\), but found none: “Was the injection given to her at the time of birth?” Neelam said no. Nidhi continued irritated: “Why is it not given nowadays in the hospital? There’s no mark on the arm. The hospital is supposed to give BCG vaccine. I’ll get her another BCG-vaccine. Here, take contraceptive pills until your child is older. There are no people to take care of all these children! How many children do you have?” Neelam answered: “This daughter only.” Nidhi asked her: “What if you have another daughter, then...?” One of the mothers-in-law present interrupted: “That is in God’s hands only”. Nidhi gave Neelam a quarter of a paracetamol tablet and told her to crush it with a spoon and mix it with water, then giving it to the baby at home; that would prevent fever. The nanad signed for and received a nutrition packet, then they left.

The above conversation, and the following pregnancy check-up, illustrate how Nidhi usually spoke to the village women, explained about vaccines and side-effects, and “motivated” for family planning. She instructed, but did not ask women about their needs. One of the first questions when villager were in contact with health workers were how many children they had. If it was more than two, they were instructed to get sterilised. The ANM’s “counselling” and people’s intimate information was shared in front of the other (female) villagers. \(^{38}\) Further, proper bahū-behaviour of being invisible

\(^{37}\) Per Indian vaccine schedule the BCG should be set before the child leave hospital after birth. The next childhood routine-vaccines (DPT, OPV, measles) should be administered from the child is 1,5 months onwards by the ANM at the village MCHN-days.

\(^{38}\) Privacy between patients and health providers is not usual at the MCHN-days, nor at other rural public health facilities. At the PHC and CHC people stood lined up before the doctor, and was consulted, asked all intimate questions, within hearing range of the others in the line.
and mute in front of elders did not encourage the young women to ask the ANM questions about family planning. Also, a bahū’s demeanour should not imply she is sexually active, which is a shameful matter (cf. Jeffery et al. 1989).

Nidhi examined the next woman’s stomach, registered her as pregnant, and turned to Anya: “I told her several times: do not have another child”. Then Nidhi told the woman: “You already have two sons and one daughter. I have told you to get sterilised. There are so many contraceptives now, like condoms and oral pills. In which month did your period stop?” The woman answered quietly: “It’s been four months.” Nidhi replied: “If you do not want a baby, get it aborted.” The woman was made to lay down on the floor, between medicines, papers, registers, women and children. Nidhi gave her a tetanus shot, and told her to eat green vegetables and take iron-pills.

Most village women did not like to take iron-pills, they said they did not agree with their bodies, and were considered to have a “heating” effect on the body (cf. Nordfeldt and Roalkvam 2010:336). In local notions pregnancy was considered a heated state, and pregnant women generally avoided heating substances. Excessive heat were believed to may cause miscarriage and premature labour (c.f. Knivestøen 2012; Jeffery and Jeffery 1996).

CREATIVE MOBILISATION-METHODS

Anya headed out again, to the Saini families in a small hamlet on the outskirts of Chotipur. We reached two houses surrounded by cultivated fields, without close neighbours. Their houses looked poorer than those in the village centre, partly consisting of straw-roofed adobe buildings. Outside the houses we met four mothers: three biological sisters and all sisters-in-law. One of the sisters had suffered from polio, her feet was as small as child’s, and they were tied up in front of her. She walked about the courtyard on her hands. She seemed happy to have visitors. The other women were

39 Beena did not want to come when she heard she would have to walk for 20 minutes, hence I went with Anya alone. I wondered if her (general) aversion to come with me to visit the Sanis was related to her being a Saini and an identity as middle-class and educated. The Sainis in Chotipur had a low status in the local hierarchy, and was talked about as “dirty” and “ignorant”.

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busy with different tasks and caring for the ten children. Anya sat talking with them for a long time, before they agreed to bring the children to the centre.

When we returned to the anganwadi-centre the women discussed that the Saini family did not regularly come for vaccination, thus breaking a village norm. They all voiced strong opinions on the issue. Looking to me for confirmation, Anya said: “You saw I told her so many things, only then they she agree to come”. Beena asked why they did not vaccinate their children. Anya said it was because their grandfather did not like the children crying, or having a fever, which is common after a vaccination. “Oh God, they are afraid of fever”, one of the village women proclaimed, shaking her head. Nidhi commented that that family knows nothing, does not understand anything, and is uneducated. That is why they refuse vaccines. She added that the handicapped woman should know to vaccinate her children, having suffered from polio herself. Anya defended her: “No, she is very intelligent, but she can’t walk, so she is unable to come. She says that the family is ready to beat her if she says anything [about giving the children vaccines].” Anya continued: “I always get them here by using different tactics. Today I told them that many children were dying in Jaipur because of diseases now.” The anganwadi-worker and the other women at the porch laughed on hearing this.

The lively conversation ended as two of the Saini women approached the centre each with a small child in their arms and four children walking beside them. The Saini women sat down among the others at the centre. Nidhi took a look at their vaccine cards and injected the two youngest children. The Sainis left directly after the vaccination. Nidhi had asked Vaneesha not to give the Sainis nutrition supplements, until they started coming regularly to be vaccinated.

**HEALTH DISCOURSE AND MORALITY**

It was not unusual that people openly talked about, criticised and ridiculed other families in their absence. Especially when the family in question was not following the “village elite’s” conventions. Villagers noticed and discussed whether people vaccinated their children, gave birth in hospital, how many children they had, and whether they got sterilised. More than health outcome, it seemed a question of morality and expression of identity whether to conform to the village norms of reproductive- and child- health
practices (cf. Leach and Fairhead 2007:2) Van Hollen (2003:2010) similarly argues that “choosing” hospital delivery, like “choosing” to have few children “was a way of indentifying oneself and/or one’s family as modern and ‘developed’”. Recall how the ANM reasoned that the Sainis did not come to be vaccinated because they were uneducated and ignorant. Van Hollen (2003:210) likewise notes that “people equated education with the use of modern maternal health-care services and family planning”. People and their health practices were commonly talked about within a discourse that contrasted people as educated, enlightened and modern—considered “the good”—vis-à-vis the ignorant, uneducated and backward—considered “the bad” (Nordfeldt and Roalkvam 2010; Van Hollen 2003). The discourse of modernity, education and “choosing” the “good” health practices also relates to the notion of “good citizenship” (Nordfeldt and Roalkvam 2010; Van Hollen 2003). The good citizens would be those who choose to follow the state’s “health messages”.

Such lines of reasoning—that “good” health practices was influenced by people’s education and social status were presented not only by health workers, health officials (cf. Nordfeldt and Roalkvam 2010) and the village “elite” in Chotipur. Those who did not conform to the “good” practices used similar reasons in their explanations. On a later visit to the Saini hamlet, the bahūs and their mother-in-law reasoned that the children’s grandfather’s disliked vaccines because he was illiterate and old-fashioned. Similarly, when we talked to the women in one of the poorer Bairva families about vaccines, they said that they had not vaccinated their children. When asked why not, they said “we are uneducated, poor, unknowledgeable, eh?” and “nobody ever called us for vaccination, we were busy working in the fields”.

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40 The relatively high value given to vaccines (and other mother- and child-health services) in Chotipur, I suggest relate to the relatively higher education levels and higher portion of government employment in Chotipur, see later this chapter.

41 At the time of their children’s vaccinations the ASHA-programme had not sarted. ASHAs have only been doing vaccine-mobilisation for a few years. The ANM previous to Nidhi was said to be lazy and not doing good work. Few of the Brahmin children more than five-ten years had gotten all their vaccines either.
Village Health Meeting, Filing Reports and Wrapping Up the Day

In the afternoon, less people came to the Centre. Nidhi started the Village Health and Sanitation Committee-meeting with seemingly randomly present women, and told them: “Motivate people to be sterilized”. Anya and Vaneesha listed some women that had been sterilised. Nidhi told them: “See, now malaria is spreading because of stagnant water. I have medicine against it. You must go to people to spread awareness, not to leave stagnant water. Keep the village and homes clean. Clean your house every day, don’t just sweep the floors.” Anya gave biscuits and tea—that she had been sent home to make—to the women attending at the meeting. Vaneesha complained that the door from the centre’s toilet had been stolen. She accused the Bairvas living behind the school of “dirtying” the toilets now that the door was gone. Nidhi decided they would propose to the sarpanch (the village council’s political head) to buy a new door. Nidhi explained that the committee had a fund for such projects. Anya had all the women present sign the VHSC-meeting minute, including me and Beena. Then Nidhi dictated what she should write in the VHSC-minute form.

After the meeting and snack break was over, the three women were busy filling their records and reports. Anya copied today’s new entries of pregnant women and vaccinated children from the anganwadi-worker’s record into her own anganwadi-record: the “ASHA-Sahyogini Daily Routine Diary”. Nidhi, Vaneesha and Anya then checked each other’s records to see whether they had the same numbers. All three keep individual records from the MCHN-days with detailed data. These records may be controlled by superiors at surprise inspections, which will be discussed in next chapter. In addition to their records, all three fill out report forms of each month’s new pregnancies, check-ups, vaccinations and so on to give their superiors.

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42 Beyond brief orientations to the workers at meetings by superiors, training had not been given to the Committee about its purpose and activities. The VHSC-meetings were likely elaborated more than usually because of my presence. ASHA was appointed as the convenor of the VHSC-meetings in official NRHM guidelines, and received 100 rupees monthly for this (when handing in the VHSC-meeting minute signed by the ANM, sārpanch and other members).
Over: The ANM with the cooler bag with vaccines, medicines, new syringes and MCHN-register, about to set a vaccine at Indoli AWC. The children are sitting on and playing with the scale.

Under: Village Health and Sanitaion Comitee meeting
After finishing the records, the three women passed the rest of the time by gossiping, speaking of weddings they would attend this summer and other personal news. In light of the complaints earlier, they considered it wise not to close up early. When the time was up Nidhi collected her things and put them under the seat of her scooter. Vaneesha collected her records; Anya and the anganwadi-helper folded the rugs and cleaned up. Nidhi put the vaccine-cooler bag between her feet in the scooter, tied a scarf tightly around her hair and face, put on her sunglasses and long-sleeved gloves to protect her against the harsh sunlight. She waived goodbye as she drove away.

ASHA as a mediator of Nidhi’s health services

The same night Pradeep, Neelam’s husband, visited Anya’s home. Pradeep, a part-time high school teacher, farmer and close relative of her in-laws, visited Anya’s house nearly every day. Anya, while cooking dinner, asked him why his wife was working in the fields so soon after his daughter’s birth. He replied that it was no big deal, and that it was not her business. He complained that his daughter had high fever after receiving two vaccines from Nidhi-madam that day, and wondered if she really needed to give her both. Anya defended her madam’s actions with an engaged, raised voice. She told him it was his fault that his daughter got both the BCG- and DPT-injections at once. He should have made sure she was given the first vaccine before leaving the hospital after birth. Besides, Nidhi-madam had given her medicine for the fever. Both used grand gestures and clicked their tongues as they were challenging each other in the heated, yet friendly, discussion. Pradeep was a classificatory devar (HyB) of Anya, which allowed them to speak freely, joke and mock insult each other (cf. Vatuk 1969)

Some issues of the MCHN-Day

Nidhi’s performance and the villagers use of her services seemed dependent on the social relationship and good reputation she had built with them over many years. She knew most families in the village, and engaged with them on an equal foot in chitchat about resent events. Likewise, several events illustrated that the village sociality and

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43 Village women usually did not wear sunglasses, nor did they drive or own motor vehicles; they noticed that Nidhi did—conceived as part of her urban lifestyle, and having a “madam” title and salary.
structures, including caste-relations, and relations between families, affects Anya’s ASHA position and work. For instance, she related differently with various families during mobilisation. The incident with the angry man demonstrates that Anya’s position include negotiations of thorny family relations. Though most disagreements are suppressed in the village community, such heated disputes occur regularly.

As we have seen, the ASHA is included in multiplex kinship-proscribed, gender-proscribed, caste-proscribed role-relations with people, included the other frontline health workers. How this affected her agency in relation to Nidhi and Vaneesha I describe in the next chapter. In the reminding of this chapter I elaborate on some aspects of the social and structural relations in the village community and how these are important for ASHA’s position and scope of agency, as for any bahū of a village community.

**ECONOMY, CASTE, CLASS AND HOUSEHOLD**

It was not easy for the untrained to see the differences between the high castes, low castes and tribals. Their houses were similar. They all farmed their own fields with crops of predominantly wheat, though some also grew other grains (e.g. millet, barley, corn), different pulses, mustard\(^\text{44}\) and vegetables. Women spent much time in farming and housework, which was done by hand and fairly time-consuming. The women of the village worked physically hard most of the day. The division of labour generally corresponded to the household hierarchy. The youngest bahūs did the most and heaviest work, while the mothers-in-law policed and delegated, like Ammājī. Food was made from scratch, ideally large batches of rotī was baked twice a day. Women made their own dairy products. Most of the families grew enough wheat to supply flour for their rotī; the main staple food of each meal.

The agricultural work had a yearly cycle with different crops growing in different seasons, and variations in workload. By early April the main harvest of wheat had started. Some families harvested their crops on their own, others also hired hands to

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\(^{44}\) Mustard oil was a considerable cash-crop industry.
help them. Many villagers, including the Brahmins, worked as hired help. A day's work, from nine in morning to five in the evening, paid between 100-150 rupees—enough for four litres of milk or five kilos of seasonal fruit. My host family harvested their four *bigha* fields of wheat in about a week of intensive work. For half the week they hired two Meena labourers. The families owned varying amounts of land, some had only one or two *bigha*, others had between ten and fifteen. A Beirva widow told me: “Brahmins have ancestral land and have the most. Bairvas were given five bigha of land by Indira Gandhi\(^{45}\) free of charge, as we did not have any. My husband sold four bigha of our land, which the Brahmins purchased (...) The Meenas came from outside and purchased their land sold by the villagers here”.

**THE VILLAGE HIERARCHY**

A village's caste configuration is significant for the village sociality, the ASHA’s context, it conditions the ASHA’s position within her village. Inter-caste relations were also a source of power struggle between groups and individuals in Chotipur. This struggle was related to “traditional” ritual status and dominance/subordination and “modern” emerging social stratification markers of class such as education and government employment. The “traditional” and “modern” stratification markers existed side by side, and their relative importance for the villagers’ hierarchical position was expressed in different contexts.

**NOTIONS OF CASTE AND HIERARCHY**

How to analytically conceptualise caste remains debated (cf.Berreman 1971; Béteille 1990; Dumont 1980; Khare 2006; Marriott 1976; Raheja 1988). The Portuguese word caste means “race” or “breed” and can refer either to the vernacular term *varṇa* or *jāti*. *Jāti*, translates to “of the same kind”; it refers to birth ascribed endogamous group-belonging. In Chotipur people referred to different endogamous groups as different jātis, including tribal groups and Muslims. I use *caste* in the sense of jāti. One’s jāti is not only

\(^{45}\) Land reforms under former Prime minister Indira Ghandi’s 1960's and 70's programme to “eradicate poverty” included re-distribution of land.
Busy wheat harvest in April. Above: Threshing was done with tractors. Only one (Meena) family in Chotipur owned a tractor. Under: The crops were cut by hand. Here on Vaneesha's field with rented labourers.
considered a social group-identity, but provides the very nature, or “transmittable substance” of a person (cf. Marriott 1976).

The hereditary status of the varṇas (the four basic caste-group divisions) correspond to their point of bodily origin, according to a prominent Sanskrit myth of the primordial man. The Brahmins (priests) who taught, rose from the mouth of the primordial man. From his shoulders rose the Kṣatrya (warriors/kings), who defended the land. From his thighs rose the Vaisna (merchants and farmers), who sustained the social body with farming and trade. And from his feet rose the Shudra (servants), who served under the other groups (Snodgrass 2004:261). The varṇas, and their innumerable local sub-castes (jāti) were ranked by relative ritual status ascribed by their hereditary occupations, along the axis of purity and pollution (Dumont 1980). Jātis with hereditary associations to the most polluted occupational specialties, such as sweeping and handling corpses, are considered impure, even “untouchable”. The so-called “untouchables”, had the lowest status and was not categorised in the four varṇas. Today discrimination against persons of so-called untouchable castes and practicing “untouchability” is a criminal offence. Still, people from these hereditary castes, especially in rural areas, are disadvantaged because of their hereditary caste. (Snodgrass 2004:273).

On a social and practical level inter-caste behaviour is intricately prescribed in relation to fear of transactions of pollution through substances and contact. The fear is manifested in rules about who can marry each other, eat together, exchange raw and cooked food and visit each other’s houses and so on (cf. Marriott 1976; Mayer 1986). In Chotipur inter-caste relations were talked about in such terms. The other castes would not take cooked food or water from, visit the house of or go to the weddings of the Bairvas. Brahmins invited all castes to their wedding feasts, but the Bairvas were seated on a separate row to eat. Bairvas were not allowed to enter the village temples, and so had built their own. Anya humorously commented that the sarpanch, who was Bairva, had to sit on the floor of the veranda outside her home if he came to visit. Though he held political office and his signature were required on papers for her ASHA-work, the

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46 Combining ritual purity, karma (action) and dharma (moral) in ones “coded substance”.

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caste hierarchy still subordinated his ritual position to hers in many practical social contexts in the village.

The social hierarchy in Chotipur also had other foundations and aspects besides caste. In line with Dumont (1980), it has been claimed that Indian thinking is fundamentally hierarchical\textsuperscript{47}, also beyond caste: “Hierarchies are organized around any possible social markers: age, gender, caste, ethnic tribe, class, education, religion, title, occupation, place of origin, and kinship ties and structures. Authority is often ascribed through position in hierarchies, and traditionally legitimized through ideas of fortune or merited destiny” (Nordfeldt and Roalkvam 2010:341).

CASTE RELATIONS AND RIVALRY: COMPETING FOR GOVERNMENT EMPLOYMENT AND PRESTIGE

Though the village as a whole was economically well-off compared to the average rural village in North India, there were distinct social inequalities between the families. Manual labourers earned 3000-5000 a month while government and private employees earned 20 000 and more. Nowadays many village men, across caste divisions, held government jobs and commuted daily to the nearby administrative centres Alwar and Sitapur. Among the older generation several of the Brahmin men were retired from government jobs. Many men also across caste divisions, were work migrants, employed in factories or companies in Jaipur or Delhi. These men usually came home only at weekends or if they were needed during harvest. Other, and mainly the elder, village men worked only with farming.

\textsuperscript{47} Related Ramanujan (1990) argue for a "context-sensitive" mode of "Indian" thought and behaviour, related to \textit{dharma}, prescribing morally right behaviour, which has \textit{relational}, not universal, values, "tied to place, time, personal character and social role" (Ramanujan 1990:54). He proposes "context-sensitive" in contrast to an Western or "modern", "context-free", (cf. the notion "all men are created equal") mode of thought.
TABLE 2.0 CASTE COMPOSITION OF CHOTIPUR

<table>
<thead>
<tr>
<th>Jat</th>
<th>Also called</th>
<th>Varna Category</th>
<th>Official Caste Status</th>
<th>Hereditary occupational association</th>
<th>Contemporary occupations in Chotipur</th>
<th>Hereditary vegetarian</th>
<th>Allowed in Brahmin temple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharma: Sarma</td>
<td>100 households</td>
<td>Pandit Brahman</td>
<td>Brahmin General Caste</td>
<td>Priests: performing rituals, versed in the Scriptures</td>
<td>Landowners Farmers Government employees Manual/Factory labour Some few: Priests (in temple or private 'popular' consultants)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Mina: Mina</td>
<td>10 households</td>
<td>“ST”</td>
<td>Scheduled Tribe (ST)</td>
<td>Cauldars: Protective guardians serving landowners also portrayed as thieves and fierce desperados</td>
<td>Landowners Farmers Goat/sheep herders Manual/Construction labour</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Saini: 4 households</td>
<td>Mali</td>
<td>Vaishnav</td>
<td>Other Backward Classes (OBC)</td>
<td>Gardeners Vegetable-farmers</td>
<td>Farmers Landowners Manual/Construction labour</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Left: Anya’s “ASHA” corner in her room: uniform, ID card and poster.
Right: “ASHA-Sahyogini’s Daily routine Diary”
Social and economic inequalities, noticeable in education level, living standards, consume and so on, cut across the caste hierarchy and are perhaps better described by class divisions. Some of the Brahmin families where poorer than the Bairva and Meenas, and worked on the fields of other families to make ends meet. A couple of the Bairvas had the most prestigious, newest and most decorated houses of the village. They had large living rooms including sofas and sofa-table to receive guests. Few Brahmin families had equally nice furniture and houses. Moreover these Bairva households had men in government jobs and sons pursuing master degrees in college. The Brahmins explained that the reason for the (caste-class) discrepancy was the governmental quota system in education and employment; a person from a scheduled caste or tribe could get a good government job with less education and experience at the expense of a Brahmin better suited for the job. Thus, these days the Brahmins said, it was difficult for them to get government jobs. Employment in government positions were prestigious and highly sought. They gave high regular salary, job security, and benefits such as pensions. A common attitude was that once secured, it was very unlikely to lose a government job\textsuperscript{48}, and one thus did not have to work hard. Such attitude and reasoning has been referred to as “government service\textsuperscript{49}-mentality” (Aase 2006). I encountered such attitudes from higher government officials, local government teachers, doctors, nurses and non-government-employed villagers alike. The accusations from the angry family (regardless of their accuracy) at the MCHN-day, appears representative of such sentiments.

Supporting my observations Aase (2006:58) notes that “absenteeism and lack of fulfilment of duties were common accusations put towards AWWs, teachers and other service-givers” in the area of her fieldwork. Absenteeism is a widespread problem in India. Rural people commonly do not expect government employees (i.e. in school and health) to show up daily, nor deliver quality work, at least not without bribes (cf.Corbridge, et al. 2005; Gupta 1995).

Several families, including Brahmin, in the village were Below Poverty Line (BPL) families. Holding a BPL-card gave access to subsidised commodities, such as gas,

\textsuperscript{48} Threats and transfers were the main disciplinary measures.

\textsuperscript{49} [sarkari naukri-mentality]
kerosene, and various food. They also gave access to special health schemes. BPL-cards were seen more as objects of desire rather than stigma, families who did not hold one were jealous of those who did.

**WOMEN AND MEN’S ECONOMIC HOUSEHOLD CONTRIBUTIONS**

Sarita in my host family held a BPL-card. On specific days each month she went to buy her subsidised goods. The other couples of the household were planning to apply for BPL-cards. Anya explained she could not get one as she had a government job, though they were applying for one for her husband. Ashok worked in a temple and his salary was not regular, he earned about 2000 rupees or less most months. He could earn more during big festivals. Tej, Kanya’s husband, worked as an electrician, sometimes working various construction jobs away from the village. At other times he took odd jobs and set up light-systems for nearby village weddings. His income was therefore not regular, and he earned much less than husbands in government jobs. He told me proudly that he was offered work in Dubai with a very good salary, but the contract committed him for several years without home-leave. He asked rhetorically who would look after the family if he went away for so long? He was the dependable man of the family who took care of his parents, own wife and children, and his brother’s wife Anya and her child. Ashok was mostly away, did not earn much, and some of his income went to support his opium addiction. The third son, Nitesh and his wife Sarita, had separated his economy from his brothers and father. Nitesh worked at a tea-factory outside Jaipur, as did many other Brahmin men from the village. These men lived together in apartments near Jaipur during the week, and returned to Chotipur only on the weekends. Nitesh earned 5000 rupees a month.

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50 BPL-holders were to have all costs, also for medicine, for free in government facilities. However, in practice they also paid health workers under the table and often purchased equipment and medicine outside like others did. BPL-categorised women received five kilo of highly demanded and expensive *ghee* after each birth, vernacularly considered a highly strengthening and healthy substance. Ghee featured much of the traditional food made for new mothers, also expected to be distributed to the whole village in various rituals following birth.

51 Not as priest, but as a self-learned electrician and other odd jobs. He had barely finished his lower primary schooling.
Anya’s salary varied, depending on ASHA-related work activities. Reliably she earned 950 rupees in months with an MCHN-day, and months without such a day she earned 750. Some months she earned 150 rupees extra for polio-campaigns, and if she attended many deliveries and handed in home visit-cards for new mothers and infants, she could earn as much as 2000 rupees. Both Kanya and Sarita worked in government NREGA projects. The NREGA-scheme guarantee 100 days of wage-labour in one year (GoI 2005b). Sarita also frequently worked in other people’s fields on per-day-wage basis. Kanya explained to me that her husband did not approve of her working fields that were not hers. When women did such work it signalled to others that her husband did not earn enough to support his family. However, many, also Brahmin women, were wage-earners at other’s fields or employed in the NREGA-projects in the village. Mainly men were employed outside the house, with regular salary income. A few women worked as teachers, and three as anganwadi-workers, in Chotipur and nearby Dabbli and Indoli. Sarpanch’s wife did tailoring work for village women of all castes, and similar small-scale industry of other women may have subsisted without my notice.

Women would insist that men were the family heads, though I observed that mothers-in-law made most household decisions, and had most to say in relation to their bahūs (regarding e.g. housework and reproductive health decisions) as is also noted by e.g. Førsund (2005) and Jeffery, et al. (1989) I got the impression that Ammājī, as many women of her generation, was the de facto, though not de jure, head of the family, as the behaviour of Ammājī and Bāūjī scene in the prelude story illustrated. Ammājī seemed to control much of Tej and Ashoks’s salary, and managed the daily household expenses. Bāūjī was a retired Indian railways employee. He received a monthly government pension, which he kept to himself and did not contribute to the regular household expenses. He “invested” his pension in different economic activities of his sons and grandchildren. He also held a separate storage of biscuits and other items that he sometimes demonstratively shared with other family members. According to his bahūs

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52 Unskilled manual construction/development-projects to improve the village, and governed through the local panchayats.

53 Women (bahūs without own wages) and children had generally no control over or access to money or goods accept through other household members, (young) bahūs should anyway not go alone to markets.
he also spoiled his married daughter. Though the family were included in the village’s “Brahmin elite”, they were not wealthy, or scoring high on a “class-scale” of living standard. They struggled to make ends meet.

**Structures of Kinship, Gender and Household**

Anya’s demeanour as she moved about in the village, conformed to the conventions of avoidance and veiling in prescribed bahū behavior, related to the “North Indian kinship system” and women’s associated kinship role relation to their in-laws. After marriage, men of the village continued to live in their natal village. Daughters of the village, on the other hand, moved to their husbands’ villages (*sasurāl*). The wives, mothers and grandmothers living in Chotipur thus came from outside, from nearby villages or other states. The female villagers were categorised either a “daughter of the village” or a “bahū of the village”. Daughters can move about and talk rather freely. The bahūs have to observe *purdaha*, rules prescribing veiling, avoidance of eye contact and talking in front of her husband and affinal kin, and other ways to show respect, modesty and submissiveness (Jeffery, et al. 1989; Unnithan-Kumar 1997). As fictive kinship transcends caste groups (Lambert 2002), the bahū role relation classificatory extends to all members of the village in a woman’s sasurāl. Villagers usually address each other in kinship terms, and Anya had various kinship relations towards all the villagers.

Gender, like kinship, is a fundamental social category, that partly prescribes, in most societies, position, scope of agency, and proper and expected behaviour. The structural subordination of women is based not only on male-female configurations. Female

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Commonly used consume items such as *bindi, sindūr*-makeup, hair oil, tobacco etc. were usually brought by men of the family (or elder sisters-in-law). The ASHA-salary thus potentially gave greater agency to personal purchases, or freedom to travel, without permission from the in-laws that other women did not enjoy.

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54 Alwar district lies close to Rajasthan’s boarders to Haryana, Uttar Pradesh and Madhya Pradesh.

55 Translates veil, or curtain.

56 I will not review social construction of gender against biological premises, or favour essentialist or constructionist gender theories—one may argue both perspective are reductive (cf. Fürst 1995).
gender is also constructed and constituted in relation to other women, in rural North India largely based on perpetuated age and kinship hierarchies within a household and village society. The tension and power-struggle between the bahū, the in-married woman to her sās, her mother-in-law, is a widely explored anthropological topic. The female positions as wife and mother conflicts in their relation to the bahū's husband and sās's son. (cf. Jacobson and Wadley 1995; Jeffery and Jeffery 1996; Raheja and Gold 1994).

The bahūs' purdah restrictions made mothers-in-law mediators between a bahū and her husband in many matters, at least in the early years of marriage (c.f. Jeffery and Jeffery 1996; Patel 2006). Mothers-in-law had considerable authority in decisions on their bahūs reproductive health and child care. Jacobsen (1995) argues that the bahūs' veiling aid harmonic lining in joint families, emphasising the subordinate relationship of the bahū to those with authority positions in the family as well as deemphasise the bahū's ties to her husband. The purdah gradually decrease as women become of age and birth sons, when they themselves become mothers-in-law and grandmothers. They are then relatively free to move about, talk in public and gain power in their household.

The relation between a younger sister-in-law and her elder brother-in-law (HeB-yBW) is one of avoidance and strict purdah. In comparison the relationship between an elder sister-in-law to her younger brother-in-law (HyB-eBW) is less restricted. That relationship allows for jokes and mutual teasing (Vatuk 1969).

The MCHN-day I described illustrates how Anya veiled and spoke mutely to show respect in front of men older than her husband (HeB), while she lifted her veil and spoke openly with men younger than her husband (HyB), as she did with Pradeep and the

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57 In strict purdah women maintain a cool distance from her husband, cannot talk to him in front of others, and the conjugal couple spend very little time together (cf. Jeffery et. al 1989:28-30). A bahū's demeanour should not imply she is sexually active, a shameful matter, although it is expected and enjoined that she is (to produce children).

58 Also, most of their elder in-law-generation has passed away.
father with the chubby boy. Anya was not a new bahū anymore, already mother of a son, and was less restricted by purdah than the younger mothers and newlywed women. Neelam, still a young bahū, she veiled and spoke only when directly questioned by the ANM at the anganwadi-centre. She did not ask questions and let her nanand speak on her behalf, in front of the elder village women present.

Aside from the structural conventions, individual family practices, ideas and education, and bahūs’ and in-law’s personalities influence the extent of women’s purdah. Anya and her sister Kanya observed purdah only when they moved about in the village, not at home. Their in-laws held liberal attitudes, and significantly the sisters came from a big city. Anya proclaimed she was not raised a village-girl. Sarita, however, veiled at home. She noticeably quickly drew a veil over her face and stopped talking mid-sentence when her father-in-law entered the room. Anya explained that Sarita did so because she was raised in a nearby village and was illiterate.

MARRIAGE

Marriage and weddings were a frequent conversation topic, both as pleasurable festive events and widespread worry. Families worried about their daughters’ marriages—both about the cost of the wedding and dowry and for her wellbeing in the new household.

Though largely adhering to the North Indian characteristics, of village exogamy, caste endogamy, virilocality, dowry and patrilineage (Dyson and Moore 1983; Vatuk 1969), the region had an exceptional regional twist. Two sisters frequently married two brothers, in full sibling-set, (i.e. real siblings) or collateral-set (i.e. cousin-sister, cousin-brother or other close kin-set) marriages (Kolenda 1978; 1987; 1989; 1993). This was not the case in every household in Chotipur, but it was very common. Some even married in triple sibling-sets, like the Saini family we visited in the hamlet. The sibling-set custom was commonly attributed to the economic relief for the bride’s family: only one set of wedding ceremonies was needed and they shared the dowry (cf. Kolenda 1989), so costs were cut. A standard wedding included many intricate rituals and gift-exchange-ceremonies—including several elaborate feasts—with invitation to the whole village. One wedding had ceremonies and feasts ongoing for two-three weeks. A much discussed wedding that summer from a nearby village had elaborate ceremonies costing 300 000 rupees. The size of dowries in North India has increased with the higher living
standards over the last decades (cf. Jeffery and Jeffery 1996). Nowadays a dowry was expected to consist of a motorbike, jewelleries, a full set of appliances and furniture for the house, as well as gifts and cash for the groom’s family. A Bairva grandmother said the size of her daughter’s dowry some years ago had been considerably less: “My oldest daughter I simply gave a golden nose ring and brass utensils, because we were very poor [then].”

HOUSEHOLD HIERARCHY AND RIVALRY

In my host household, I observed frequent rivalry between the sisters: quarrels about who did most of the work, disagreement about child upbringing, and whether they unfairly disciplined (slapped) each other’s children. At other times the sisters collaborated and helped each other in relations to the in-laws.

In times of tussles, Ammājī tended to side with Kanya and make Anya the scapegoat. She blamed Anya whenever she complained that her bahūs always quarrelled. I observed many times that when Ammājī was aggravated with Anya, she refused to take any food that Anya had prepared and gave her the silent treatment. Anya regularly complained to me that her family only saw the work Kanya did, not her own. When Anya did not give Ammājī her full ASHA-salary, Ammājī often told her that she could separate her household from them. Anya said that when Ammājī complained that “Anya is lazy, do not work, sleep too much”, Tej would hit her. Tej seemingly took on Ashok’s disciplining role, since he was mostly away in the temple.

Mothers-in-law often seemed to favour one of her bahūs, and treated her bahūs differently. People commented that Vaneesha favoured her eldest bahū; she always praised her, and made the younger bahū work harder. According to the gossip this was because the eldest bahū had given her two grandsons, while the other had three girls. Her eldest son worked in a private company that sold veterinarian pharmaceuticals and had a good income; the younger son worked in the Jaipur tea-factory and earned considerably less. Common factors for favouring one bahū over the other, was personality, submissiveness, good behaviour and the number of grandchildren, particularly grandsons, they produced. Also a factor was the husband’s differentiated statuses: of income, and how much he helped and contributed to the household. Kanya did better than Anya on most of these factors. Anya was also strong-minded with an
uncontrollable temper at times. Kanya was more pleasing and avoided conflicts with her mother-in-law. Because of difficulties with her husband and adjusting to her in-laws Anya had stayed with her parents for several years of her early marriage, while Kanya began to live with her in-laws shortly after her wedding. Anya was aged 20 years and Kanya 15 when they married. Patel (2006) remarks that the custom of marrying daughters young aid their compliant and subordinate adjustment in the new home’s hierarchy.

A frequent suspicion and topic for gossip and jealousy was accusations of sexual relationships between (actual or) classificatory elder sister-in-laws and younger brother-in-laws (HyB-eBW). Sometimes in heated domestic arguments, Anya’s husband Ashok insulted Anya for being “Tej’s wife”. Though nothing actually sexual might be going on, the implied liaison between HyB-eBW, and their allowed open talking and joking relation seemed to be a common source of jealousy and gossip.

**Women’s Duties and Polluting Aspects**

Women had regular reoccurring ritual duties in relation to their husbands, brothers and in-laws. These were particularly important for the Brahmins. Most Brahmin bahūs fasted one weekday of every week, and they daily applied a long red mark (*sindūr*) along the parting of their hair. These were significant rituals signifying long and happy life for husbands or brothers. Different Hindu festivals came frequently, and not one week went by without large or small worship rituals in the home. These rituals were performed by fasting women.

I noticed my Brahmin household upheld strict eating practices, to daily bathe and clean the house, and distinct between pure and polluted house sections. One morning Beena and Kanya were sitting outside the house brushing their teeth before breakfast. They observed Sarita coming from behind the house with an empty water bottle and looked

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59 People normally brushed their teeth only in the morning, before they ingested food. The purpose was seemingly to purify the mouth before ingesting food rather than dental hygiene.
Above: Bauji’s daily morning worship in the home temple. Anya worship home made God statues under a central Rajasthan Hindu festival. Under: Ammaji prepare roti at the chula.
Above left: “Cooling” food to be offered to Shitala Mata, “Goddess of Smallpox” Above right: Walking along field paths to the Shitla Mata shrine in early March. The wheat crop was green and the air chilly in the morning.

Under: Worship at the Shitla Mata Shrine. Stray dogs took care of the food that was offered.
disapprovingly at each other. After she went inside they commented on the act. It was implied that she had gone to defecate late in the morning, after cooking for her husband. Ideally, Beena told me, women should defecate first, bathe second, and only then cook food. Sarita also cooked food for her husband while she had her period, of which the others disapproved. It was, however, difficult for Sarita to avoid, if she had asked her sisters-in-law to cook for her during her period they would likely also frown on that. In my household upholding menstrual prohibitions was considered very important. The menstruating woman should not enter the kitchen, not touch any of the clean kitchen utensils, nor touch any of the water sources of the house. She should not enter any temples, including the house-temple. Preferably, menstruating women should stay inside the house, and do little. In Anya’s case this restricted her work as an ASHA. After three days the women washed their hair in a ritual bath and the prohibitions were lifted.

“WE ARE AN EDUCATED VILLAGE”
The villagers took great pride in telling me that their village was educated, compared to neighbouring villages. When they talked about being an “educated” village, I inferred that they with that they also implied enlightened, or modern. As we saw in the conversations at the anganwadi-centre, villagers as well as health workers seemed to relate to a discourse of the “educated” and “modern” in opposition to “uneducated” and “ignorant”—reasoning that those who were educated also adopted the state’s (modern) health messages.

60 Though the house had a toilet, Sarita was not allowed to use it, as she run her household separately. People anyhow used their toilets sparingly even though most houses in Chotipur had one. Instead they went behind the house or in some bushes in the field with brought along water-jugs at early morning or after dusk.

61 See Førsund (2005) on the ambivalent ideal of womanhood in Rajasthan, and how it can be analysed in relation to the different and ambivalent aspects of the different characters of Hindu Goddesses. The ambivalence lie especially in the ideal of the life-giving, fertile and sexual woman (who can be fierce and powerful and must be controlled) and the ideal of the ascetic fasting, subordinated, dutiful wife and self-sacrificing mother. Though women have auspicious qualities as life-giving and fertile her body is simultaneously in these matters considered polluting, especially during menstruation and child birth.
Over: Sās help hahū to place a bundle of twigs for the chula on her head to carry home

Under: Children walking to the government school in Chpotipur in the morning
Anya said she had followed school until 10th grade, though only completed 9th grade exams. She explained she was interested and devoted to school while her sister, Kanya, had not paid much interest and had quit after the 8th grade. Sarita was illiterate and had never attended school regularly. She had been the only daughter in her natal home. Her mother died when she was very young, and she had to work hard and contribute to the household chores. Her older sisters-in-law sometimes they made fun of her for being ignorant, but other times said so with pity, recognising the hardship of her life. She had lost three sons who died before turning a year old.

The government school in the village covered 1st–8th grade. All the village children attended primary school. Most also sent adolescent girls and boys to attended 9th-12th class in nearby towns. Some unmarried daughters and young men read for undergraduate degrees from Sitapur or Alwar. Among the 113 married couples between 15 and 45 years residing in Chotipur, surveyed by the ANM62, eighteen percent of the bahūs and six percent of the men were illiterate, while sixty percent of the bahūs and more than seventy percent of their husbands had education beyond six years. Of these 113 married couples, 11 women (9.7 percent) and 28 (24.78 percent) men had also attended college. On the average for Bajipur-panchayat area of the married couples younger than 45, about one third of the bahūs were illiterate, and seven percent had college education. Of their husbands about ten per cent were illiterate and 26.5 percent had attended college.

Fathers and grandfathers as well as mothers and grandmothers explained that they considered education, especially for the girls very important. Their wanted to send off their daughters to marriage educated. Educating daughters seemed to enhance a family’s rank, influencing their cultural and social capital (Bourdieu 1986). A daughter with good education required their match to an educated son-in-law expected to secure a well-paid job. However, such marriage-matches also meant expectations of a larger dowry. The value of high education of girls seemed to thrive mostly in the Brahmin and Meena “elite” families. The Brahmins, their varṇa supposedly originating from the head

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62 Numbers from Nidhi’s yearly “Eligible* couple survey” of 2009-2010, surveying all reproductive couples (i.e. married couples aged 15-45) in the sub-centre-area. *for family planning.
of the primordial human (Snodgrass 2004) has always been associated with literacy and wisdom. They to read the holy scriptures to work as priests. The Bairvas and Sainis in Chotipur had not sent daughters to school beyond 12th class, but agreed about the importance of education. Several of the young Bairva men, however, were pursuing college degrees. Being educated until 12th class was likely a task to please, and avoid n achievement in itself, compared to general education standards in rural Rajasthan and of the previous female generations. In the Bariva family we visited most, the mother-in-law (Tanupa) was proud that her daughter-in-law (Lakshmi) was educated until 12th class, as she herself had never been sent to school.

It was clear that men of older generations had much more schooling than their wives, but some grandfathers were also illiterate. Not all of the elder women were illiterate though. Vaneesha had to read and write to secure the Anganwadi-job. She jokingly commented that her husband was “nothing more than an illiterate farmer, working only in the [agricultural] fields”. Ammājī was also proud that she could read and had attended school until 8th class.

CONCLUSION

This chapter has portrayed one ASHA, Anya, in the social field of her village community. Importantly she, as a woman and bahū belonging to a specific caste, has many ideals and rules of behaviour to adhere to. As a bahū, she should be submissive, invisible, and have little authority on how to use time, make decisions, and must hence have permission to work outside to household. For the ASHA and her family, the job as ASHA is only one aspect of her everyday life. In the household, chores take precedence. Male family members often have higher incomes, and so their household contributions are valued more than the modest income the ASHA-job gives. Although Anya had a particular engaged and supportive mother-in-law, she also had to continuously juggle her work as ASHA with her household duties, negotiate the importance of the work and legitimate her absence with her in-laws.

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63 Rajasthan: male literacy 80.51%, female 50.66%, per Census 2011 (GoI 2011).
The ASHA must manage the village hierarchies, organised around many social markers; age, gender, caste-purity, class, education, title, occupation and kinship ties. Ramita, the Bajipur-ASHA, explained she felt shy and shamed in her village due to her low status. According to the ASHA’s specific caste membership, she would be expected to adhere to the village’s common inter-caste rules of conduct. If Anya had been of low caste, perhaps she would have had other problems. She might not be allowed to enter the home of high-castes, nor attend them in delivery (as a touch is believed to transfer pollution). She must also manage thorny family relations, jealousy and fear of accusations. The angry man incidence shows how aspects of the sociality in the village put Anya in an exposed position. Her “professional” behaviour was challenged, though, as she explained, the cause of the anger and dissatisfaction was the man’s tense relations with her household. The incident was caused by interactions that she was not directly involved in.

The way Anya negotiated Pradeep’s concern about fever and the competence and intent of the ANM, illustrate how ASHAs has a “mediator” function between actors at the social interface between the village and state health system. Though, such a role was more salient in other villages, where the majority had not already embraced and taken up the state’s health messages. In Chotipur, following the state’s recommended MCH-practices seemed to part of the village-elite’s identity as modern and educated, “good” citizens.

This chapter give some basic description of the village community, the sociality and structures Anya, as an ASHA, is included in. In the next chapter I describe the structures and sociality she engages in within the local health system.
This chapter centre on ASHA’s position, and engagement in social interfaces with the local health system structures and superiors outside the village and sub-centre; concrete relations and interactions with various superiors she manage in the government superiors-interface.

The target-oriented approach to health and family welfare in the Indian health hierarchy is longstanding. Targets were introduced in 1966, initially as family-planning targets (Van Hollen 2003:143). Every month each health worker were—and still are—expected to convince a certain number of people to insert an IUD, undergo sterilisation or accept contraceptive pills or condoms. During my fieldwork in 2010 the ANM’s targets were not confined to family-planning, but included most of their MCH-work. If the targets are met, they are rewarded (by praise, economically or advancement), if not they may be punished by superiors whom for instance withhold salary (Coutinho, et al. 2000; Van Hollen 2003). The disciplinary practices from superiors to withhold payment or benefits when subordinated do not work “properly”—achieve targets—are well-known and pervasive (cf.Coutinho, et al. 2000; Van Hollen 2003). Coutinho, et al. (2000) examined the priorities and practices of frontline health workers and concluded these were shaped by the pressure of meeting targets. According to Coutinho, et al. (2000) the “numerical narratives”, to be precise the frontline worker’s reports and records, gain primacy over the actual events (such as vaccination days) when the system judges the success of the public health programme or individual worker’s performance. Ten years has passed since the studies I’ve refereed to, and the ANMs were then the lowest frontline position in the public health system. Is the target-mentality continued, and is the insight of these previous studies relevant for the position of ASHA, in regards to her documentary practices and target-pressure?

Dr. Rajul, the ASHA’s superior at sector-level, explained “the basic role of ASHA is to reduce maternal mortality rate and infant mortality rate.” His conceptualising of their role thus resembles the NRHM-policy definitions, and relates to their role in achievements on basis of the MDGs of health numerical indicators. However, in practice,
how did the MO, and the ASHAs immediate superiors, the ANM and the anganwadi-worker, treat the ASHAs in practical interactions? Are the ASHAs becoming an extension, lackey, to the ANMs? What kind of role and agency do the ASHAs have in practice in relations to their superiors in the health department?

First follows an empirical description from a monthly PHC-sector meeting. The monthly sector-meetings were one of the significant recurring social interfaces the ASHAs engaged in with superiors and the health department bureaucracy. They interacted with the Medical Officer, as well as ANM- and ASHA-colleagues of the sector, and through exchange of information, orders and documents in the meetings, negotiations and discrepancies of knowledge, interest, values and power relations played out between the actors. I have selected excerpts from two monthly meetings. The meeting in March was important because was the last meeting of the year: a week before the workers had to complete their yearly targets. In the health department the administratively year do not follow a calendar year. It starts April 1st and end March 31st. The excerpts from the July meeting is included as it relates to the mobile IUD-camp Anya promoted in the prelude; the meeting was held four days before the IUD-camp at Nidhi’s sub-centre.

THE MONTHLY SECTOR-MEETINGS

Anya, Ramita, Beena and I had reached the meeting locale after a forty-minutes’ walk along the narrow paths crossing the agriculture fields between Chotipur and Dhargarh. Many ASHAs and ANMs had arrived. The bright colours of the women’s clothes and the energetic, lively conversations of the women welcomed us into the room. The ANMs sat typically in the front of the ASHAs. All of them sat on a large rug on the floor. The rank difference between the women on the floor and the MO, however, was marked. The Medical Officer, Dr. Rajul, sat elevated on a chair behind a desk. The room had no fan. When the heat during April-July escalated it resembled a sauna. The women used their various documents as hand-fans giving a modest breeze to cope with the heat.

Many ASHAs filled their report sheets at the last minute. The monthly report and various documents they handed in were copied sheets that they filled in with details—
Scenes before Dr. Rajul arriva at the sector-meeting at Dharagr PHC.
mostly numbers, dates and yes/no statements⁶⁴. All the ASHA’s documents required authorising signatures from an ANM. The time before and after the meeting was a welcomed opportunity for the women to meet friends, exchange work related information and gossip. The room filled completely up, and the Medical Officer and his administrative PHC-staff arrived last. Dr. Rajul requested silence and dived right into the first issue. Dr. Rajul conducted the meeting with a, to me, curious “old classroom rhetoric’s”. He asked questions to the “pupils” on the floor and expected them to give answers in chorus. He never achieved completely control over whispering.

The meetings had the following content: information on upcoming health campaigns and planned events and “training”-sections where the MO lectured and quizzed his audience on health topics or how to fill reports correctly. Dr. Rajul frequently complained that the ASHAs filled their various document incorrectly—the dates were incorrect, also they neglected some details. He emphasised the importance of correctly filled records and reports for monitoring purposes. Another focus was on the ASHAs’ progress and achievements of cases. Dr. Rajul did random checks if the ASHAs could stand up and tell how many “cases” they had “given” for family planning methods or institutional deliveries that month. He also talked frequently of the importance of well-maintained records and encouraged them to keep the survey-registers they shared with the anganwadi-worker updated. He often threatened them that he, or other PHC-staff, would come unannounced to control that they did their work properly and kept the records updated.

“What is the role of ASHA?”

The “training”-element of the March-meeting was about different stages and health issues of pregnancies, and ASHA’s related duties. Sometimes Dr. Rajul singled out a few ASHAs and requested them stand up to answer his questions. They were not taking any

⁶⁴ Number of ..: “hospital deliveries attended”, “new registered pregnancies”, etc. See example of sheets in appendix.
Dr. Rajul lecture to his ASHAs and ANMs
notes from the “training”, and were more or less attentive and involved audience. The MO started with his usual rhetoric of posing a question:

MO: Now tell me, what if a pregnant woman is anaemic? In India 75 percent of women are. What will the condition for an anaemic pregnant woman be after three months? (...) You are the counsellor for them. What is the role of ASHA-sahayogini?

[He paused, looking at his audience. None answer]

MO: You have to first do the registration. Include all necessary details like name, family status and so on. Then what will you do?
ASHA: We take weight, BP of the patient, we give iron tablets.
MO: Well, first you make the vaccination card. You also give her some counselling of how to take care of herself (...) ASHA’s are expected to explain things to pregnant women systematically, to check mother and infant and ensure good health. What else is important? You have to give her proper counselling (...) Otherwise ASHA is of no help! Otherwise even people around can give the pregnant woman advice. (...) Also tell why it is important to take tetanus-injection. Tell her the ill effects of evading this injection and what tetanus is exactly. Agitate her a bit so that she understands its importance. Alright, tell me what all have I told you?

[Dr. Rajul had a usual pedagogic of posing a question and let some ASHAs answer. The then gave the “correct” answer and asked the ASHAs to repeat what he had explained]

Anyadiscreetely to Ramita]: He is making us learn like a parrot!
[Both burst into unvoiced laughs and hid behind their veils]

The MO went through the details of three home visits ASHA is scheduled to do during pregnancy, what ASHA should inform about and check about the woman’s health at the different stages. Afterwards he went on to delivery and about subjects such as keeping the umbilicus cord clean, breastfeeding and not bathing the child the first days because the child could get hypothermia. He continued to ask them before giving the “correct” answers. He was not completely happy with the answers:

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65 I recorded most monthly meetings, which I got translated from students at Delhi university. The excerpts which follows are from these.
MO: You all need to know all this, otherwise what is the point of hiring ASHAs? You have to do reporting properly. Do your work well.

FAMILY PLANNING EMPHASISED; “WE ALL HAVE CASES, BUT FALLING SHORT OF TARGET”

Dr. Rajul also lectured on matters such as their different “targets”, of giving one case of sterilisation per month, achieve eighty percent vaccination coverage and so on. Officially the ASHAs’ “targets” were rather recommendations of how many “cases” they were expected to achieve. The ASHAs were not accountable to reach specific calculated targets in the same manner as the ANMs. Nidhi for instance had the targets of exactly 36 sterilisations, 22 IUDs, 117 fully vaccinated children and 138 institutional deliveries for the year 2009-2010. Yet, Dr. Rajul seemed to make his ASHAs accountable to him and the health system to complete their “targets”, and help the ANMs achieve theirs. This was the final meeting of the year. For the year 2009-2010 to be successful the yearly targets had to be achieved before the 31st that month. Throughout the year every month’s achieved numbers are monitored against the yearly targets, at every level; sub-centre, thus, per individual ANM, sector, block, state and nation. Health workers and administrators at all levels felt the pressure to succeed. The MO explained to me how he was himself accountable to monitor and achieve yearly targets given to him from the government for his sector population, for institutional deliveries, vaccination and family planning. The meeting in March continued after the MCH-training:

MO: I have told you about maternal care, now, I’ll tell about family planning. (...) Who all have not completed their target?
MO [He singled out one ASHA to stand up]: How many cases have you done?
ASHA: Three
MO: How many were you suppose to do?
ASHA: At least five, up to twelve
MO: Till this program of family planning is successfully carried out there is no point of carrying forward any other program. Who has family planning cases? (...) Tell us why you are not involved? What is the point of having ASHA-Sahayogini?

[The ASHA sat down again. None answered, but question seemed rhetorical]
MO: You have to complete the targets. Why are you not able to complete the target? Do you have a record of how many people have more than two-three children? I will now visit those villages where ASHA’s performance is the worst. I will get such families verified through the village head. You have to complete your targets before the 31st. You should at least be able to complete 70-80 percent of your targets. As of now, none of you have even a single case.
ASHA: We all have cases at this time, but we are falling short of target.
MO: Whoever will get most cases will be paid 600 extra. Now, who will get cases?

[The ASHAs murmured amongst themselves.]

MO: See, money makes people work, that I have seen.

After this meeting the first held family planning camp at Nidhi’s sub-centre was an mobile IUD-camp June 8th. Under follows what was said in the July meeting, subsequent to the camp held in June, regarding the upcoming IUD-campaign of July that Anya had promoted in the prelude.

MO: Alright, those centres who is having the IUD-camp, it is on Tuesday 27th. We have received good response for IUD so far done in other villages. It is really the best[contraceptive] of all—can somebody tell me why? See, for instance, if any women come and take the IUD. How much time does it takes to give it?
ASHA: Five minutes
MO: Yes, it takes five minutes. (...) And it covers five years. And if at any time, she wants to conceive, one can remove it also. There is not problem. Ok, Golakapura68-lady? How many “cases” do you have?
ASHA: Five
MO: So you have five. There have been three cases in which side effect has been noted. One with stomach-ache problem, which was cured within six days by giving a medicine. One had a bleeding problem, even that was solved. There are some who have a lot of bleeding also, it takes time to settle down—See, there are possibilities of lot of bleeding to persist for one or two months. If it is a lot, then ask them to remove it.

68 [village name]
Dr. Rajul rounded up by putting pressure on the ASHAs to all “give” five “cases” for IUD at the camp, and he added “just bring five cases each—how I don’t know, just bring them”.

The summer months of June and July were heavily devoted to family planning campaigns in the whole district. It was a main topic at the ANMs’ monthly block-level meeting with the Block Chief Medical Officer (BCMO) in June and July as well. The BCMO then encouraged the ANMs to especially note all “motivated” family planning measures during July—oral pills, IUDs, sterilisations. It seemed to be a goal in itself to achieve high numbers during the campaign-period. In July was the yearly all-Indian observed “Population Day”. The Population Day was celebrated in a large event in Jaipur, July 17th. Perhaps the district, block and sector level felt extra pressure to achieve high numbers from higher levels, due to the prestige in relation this event. It was anyway a NGO sponsored campaign, which gave the opportunity to achieve good results with minimum economic public spending. Also, according to Nidhi, the IUDs used in the mobile campaign were a better type than the government’s IUD-stock.

**DOCUMENTARY PRACTICES; BUREAUCRATIC PROCEDURES**

Dr. Rajul always stressed that without the ANMs’ signature on the various documents the ASHAs handed in, they would not receive payment. We jump back to the March meeting, when Dr. Rajul rounded off the meeting by summarising what was the ASHAs most important work:

*MO: See, all of you have two big things on your plate throughout the year which you have to do nicely—vaccination- and family planning-programme. You just need to finish that work properly. (...) Get your papers signed from ANM. Without ANM’s signature the payment will be stopped.*

Dr. Rajul left. The clerk and the accountant stayed behind to collect and control the ASHAs documents. Before writing out the pay checks, they scrutinised the ASHAs’ monthly report sheet, voucher, VHSC-meeting minute and PNC-cards to check that all

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69 Copies of these sheets in appendix.

70 Detailing that months regular activities (See table 1.0 in introduction).
signatures were in place and all columns were filled with details. Dr. Rajul instructed the ANMs at several meetings to carefully control that the six scheduled dates were correct before signing the PNC-cards. The PNC-cards were part of a new scheme \(^{71}\) that started in July 2009 in Dhargar. \(^{72}\) In a sector-meeting one ANM was made an example of, for signing off a PNC-card where the first visit dated two months before the PNC-card scheme had started. Dr. Rajul ridiculed the ANM in front of the others for not noticing that fact.

The ASHAs queued up to hand in their papers to the clerks. The remaining sat in groups, waiting for their turn in the queue, sub-centre wise. Some of the ANMs stayed back to chat with the other ANMs, to discuss work with their ASHAs, or sign off ASHAs’ documents. The ASHAs preferred to ask their ANMs rather than the MO if they didn’t understand an issue. The atmosphere after the MO had left was similar to before he came, chatting and cheerful.

A DIFFERENT HIERARCHY

The ASHAs were paid an incentive of 100 rupees to attend the sector-meeting, and it was here they received their payment checks. Also, it was a interface where they continuously learned about their expected roles, duties and responsibilities—mediated through the MO’s view. The meeting description illustrate how the rank and power relations between the superior representing the larger health system and the women at the floor played out. Sitting among them uncomfortably crowdedly in the heat, the two-hour-meetings could be painfully long. During the meetings some quietly chatted, others yawned or seemed restless.

The ASHAs did not veil in these meetings, they were outside their sasurāl without in-laws present. They were thus not required to observe the muted bahū-role. Relating to superiors and colleagues in the health system, were a more “modern” way of relating, and behaving. This hierarchy thus had other rules than those of affinal-kinship and

\(^{71}\) A Norway-India Partnership Initiative (NIPI)-sponsored initiative.

\(^{72}\) See details in appendix.
ASHAs of all jātis had tea together at the sector-meetings. The MO's caste was not an element of his authority. His rank was based on his achieved status; his education, curative skills, medical knowledge, power of the signature, and the practised authority over the ASHAs' continuous employment. The relations between health workers and health administrators were hierarchical expressed, in ways of showing respect upwards. Superiors were addressed as “madam” or “sir”, while subordinates were called by their name, position, or “lady of .” the place they were posted It was noticeable between the ANM and ASHA, exemplified during the MCHN-day; Nidhi, was the chief and Anya was her assistant performing petty tasks; Nidhi addressed Anya by her name, Anya addressed her as “madam”. Nidhi was addressed as “Bajipur-lady” by the BCMO — whereas the ASHAs and villagers addressed her “madam.” The local health department was thus also a hierarchy, though its basis and workings were different than the village hierarchy. This hierarchy had other ways of showing respect, and superiority was ranked principally on basis of achieved rather than ascribed statues. The ASHAs had a low ranked subordinated (and gendered) position in both hierarchies.

THE BLOCK-LEVEL-MEETINGS
At block level the monthly review-meeting had similar structure and content to the sector-meetings. The BCMO, the administrative Chief of the block, lead the meeting from a desk in front of his field staff: the ANMs, Lady Health Visitors (LHV) and Medical Officers. The women sat on the floor, crowded, warm and uncomfortable, while the MOs were seated in chairs. The Chief quizzed the ANMs about their number of cases that month, for vaccination, sterilisation or hospital delivery or any other indicator. The ANMs had to raise up and tell the whole room their number, and were teasingly scolded if they could not answer. The Block Chief and the MOs sat with the Block’s “progress report”73 that detailed each individual ANM's achieved numbers that month in relation to their yearly targets, and the overall monthly achievements. The Chief also went through the mistakes and wrongly filled reports of the month and scolded the ANMs who had done serious mistakes.

73 See example in appendix.
ENJOYABLE OPPORTUNITIES

Anya told me many times that she liked the monthly meetings in the health department and the anganwadi-department, although, signalling she was bored while the MO lectured. After the meetings she went to the town market with ASHA friends to “enjoy” as she expressed it. They would enjoy a 10-rupees restaurant-stall meal, threaded their eyebrows in a street-beauty-parlour for 7 rupees or bought cheap decoration items. It seemed like a blessed time to escape duties, demanding families and purdah-restrictions. The ASHA-salary thus potentially gave greater agency to smaller personal purchases, or freedom to travel, without permission from the in-laws that other women did not enjoy. The ASHA-role also gave a legitimate reason to absence from the home and to travel without family members to Sitapur or Dhargarh for meetings or hospital delivery “cases”. Thus, also freer agency of movement than other bahūs enjoyed.

ASHA’S RELATIONS WITH THE MO: NEGOTIATING KNOWLEDGE, POWER AND WORK-PRIORITIES

These monthly meetings dominated the ASHAs interactions with the MO. Though, sporadically he came to monitoring their work “in the field”. In my impression, he was for them an authority figure that represented the state or “the above” with its orders and purpose for their work (cf. Gupta and Ferguson 2002). Normally ASHAs did not engage with superiors at higher levels—though they are aware of block, district, state and national levels.74

As we saw from the meeting, the MO asked the ASHAs “What is the role of ASHA?”. The answers he seemed to give them throughout the described meeting were assorted. On one hand he emphasised they had to counsel women properly, and focused on what knowledge they had about stages, symptoms and advices they should give. On the other hand he also focused a lot on bureaucratic and documenting task of reporting and record keeping. He also stressed the importance of them producing “cases” and reaching

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74 An exception is higher level Officials’ occasional “field inspections” or when the Block or District Officials accompany “teams” of outsiders and foreigners, showing their well-performing ASHAs off.
targets. He emphasised, if they did not, then what was the point of the health department of having ASHAs? He spent much time on discussing and “training” them in their work tasks regarding pregnancy, delivery and post-natal care in the meeting. Yet, he plainly spelled out that family planning, thus motivating “IUD-cases” and “sterilisations-cases”, and achieving high vaccination coverage was the most important health work, also for them, throughout the year. When I came back to Chotipur in February 2011, I was told by Anya that Dr. Rajul had stopped giving long, elaborate meetings. He came briefly to list new information, and the clerks took their report. I had heard from ASHAs in other sectors, and states (cf.Hasija 2011), that their monthly meetings had similar a format as Anya now described. With shorter meetings and withdrawal of the “training” section, the focus on documentation practices, “cases” and targets are likely more emphasised.

TRAINING AND KNOWLEDGE

Dr. Rajul seemed proud of “his” well-trained ASHAs:

“Our ASHAs are far superior to ASHAs of any other region (...) Though they are not technical persons, they try to answer the questions. Even if they give 20-25 percent knowledge to the people of their village then our purpose is solved (...) I make them aware of various issues of public importance. They know everything that the Government wants to communicate.”

He thus judged the ASHAs of his area to have better knowledge than other ASHAs elsewhere. Dr. Rajul explained about his training methods in the meetings, that he made them participate actively by posing question and asking them to share answers because “it helps to develop a two-way communication. If we keep lecturing they sleep during the meeting.” Given that his ASHAs pass on to the knowledge, and that the knowledge alters the villager’s health choices, as Dr. Rajul seem to imply, he apparently seeks to employ the ASHAs as a form of \textit{technology of subjectivity}: making his villagers optimise their health choices, through providing knowledge.

DISCIPLINARY MEASURES; THE SURPRISE VISITS

Regarding his responsibilities to the ASHAs Dr Rajul said: “ASHAs are basically volunteer workers so my key responsibility is to \textit{motivate} them.” He portrayed to me that he motivated them by giving knowledge and discussing with them in a two-way
communicative manner. However, from my observations, and evident in the previously described sector-meeting, other sides of his “motivating” approach appeared authoritative and disciplinary. He ridiculed his subordinates, for not knowing how to perform their work properly or correctly fill the various sheets; unkindly teased or criticised their abilities; and pressured them to produce cases. He seemed to think the main motivation for the ASHAs themselves to work (properly) was monetary or if they feared their work could be controlled. Dr. Rajul, hence, explained about another motivating technique; to pay unannounced inspection visits to his field staff:

“They have a fear that the boss can come anytime. If I inform them then they will be prepared. Monitoring should be random and not planned. I do not penalise them, but want to motivate them to continue working properly. (...) There is a quote from our holy scripture Ramayan, that without fear there can be no favourable response. So your staff should now that they can be cross-checked.”

The intended effects of his disciplinary technique resonates with the effects of Foucault’s (1977; Redfield 2005:52-53) Panopticon prison-metaphor of modern discipline and surveillance; With constant fear of being observed, never knowing when you are actually watched, you act as though you were constantly observed. Similar surprise inspections by superiors are analysed by Gupta and Ferguson (2002) in terms of Focault’s concepts of disciplining power and governmentality. Gupta and Ferguson (2002:985) see the surprise visits as techniques of the state bureaucracy “in which the ritual surveillance and regulation” serves as an “instrument of control”. Gupta and Ferguson (2002) argue that the routinized surprise inspection makes the lower-level workers experience their position, relation to superiors and the State as the bottom of the pyramid-shaped bureaucratic hierarchy. The state is experienced as an institution that is vertical and encompassing, somehow “above” the society (Gupta and Ferguson 2002).

In the interactions between Dr. Rajul and the ASHAs, their differentiated power positions were evident. Dr. Rajul was to them an authority figure, and the relation was institutional and formal. He sought to regulate his subordinates to do better work with his own technologies of subjection: the surprise inspections and his motivation-techniques.
The interactions the ASHAs had with the MO were usually only once monthly, at the sector-meetings. The ASHA’s relations with their immediate superiors, the ANM and the anganwadi-worker were much more frequent, and of a different nature.

ASHA’S RELATIONS WITH ANM: LOYALTY AND DEPENDENCE

INVESTING IN PERSONAL RELATIONS TO ACHIEVE SUCCESS?

Most of the ASHAs under Bajipur sub-centre had known Nidhi for many years and related to her in various ways beyond as their supervisor. They organised the MCHN-days and various health events together, and Nidhi frequently phoned them, visited their villages or called them for meetings at the sub-centre. Nidhi also invested time in building relations with her ASHAs outside of prescribed work.

Nidhi seemed to be generally well-liked by villagers and had established friendly relations in her sub-centre area. She was sociable with the villagers and ASHAs, engaged in village gossip and shared personal stories, like we saw from the MCHN-day. Villagers commented that she knew the local tongue and ways of relating. Building good relations seemed to being a winning technique for being a “successful” health worker.

Nidhi had completed her yearly target the last three years, and twice won a prize for best performing ANM of the block. The fact that she was a bahū of a neighbouring village, where she lived jointly with her in-laws the first years she was posted in Bajipur probably gave her an “insider” status. However, she also asserted her current urban life, and talked often about her lifestyle, husband and the success of her two children and husband. She was thus in other respects an “outsider” to the villagers.

When we talked to Nidhi’s ASHAs about their relation, and how Nidhi treated them, they described her as friendly and “good” [acchi]. Vamita, ASHA of Indoli said that Nidhi “is really good. I like her way of explaining things. If I make any mistake or can’t understand anything at one go, she explains me twice, thrice and does not complain about it.” Ramita told me that Nidhi-madam was “like family” to her. Ramita’s home where only

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75 gāv bhasa [village language]

76 For nuanced picture of Nidhi’s behaviour with Vamita, see chapter four.
two minutes of walk from the sub-centre. Whenever Nidhi was at the sub-centre, Ramita stopped by to bring water or tea. Ramita’s two first children’s deliveries were attended by Nidhi at Ramita’s home. The births of them happened before Ramita became ASHA and before hospital delivery became the norm.77

Nidhi often stopped by Anya’s home on occasions when she came to the village to see the Sarpanch with work.78 The visits seemed more of a social nature, and Nidhi accepted water, food and tea. Ammāji seemed very pleased and proud to host Nidhi. She was highly respected and talked about well in Anya’s household. Anya and Ramita on several occasions sought Nidhi’s advice about household troubles, husbands, and own health. Nidhi invited the ASHAs and the anganwadi-workers to the wedding of her devar.

**Authoritative Loyalty**

Since Nidhi interacted with her ASHAs less formally, she had a different authority over them than the MO. She exercised subtle, but yet occasionally more coercive and effective forms of powers over the ASHAs. Nidhi had been instrumental in the ASHA’s selection. It was my impression that they felt indebted to Nidhi in many ways—for receiving the position, for the help and guidance she rendered, and perhaps also for being kind and friendly with them. Dr. Rajul was an authority figure, representing the wider health system management, whom the ASHAs were dependent on to release their payment. They were dependent on Nidhi for various reasons. She helped, guided and explained many things for them. She also supported them in frequent conflicts with the anganwadi-workers and the Lady Supervisor from the other department.

The ANMs also depend on their ASHAs. To achieve their targets, they needed the ASHAs to mobilise for the MCHN-days, family planning camps and so on. The ASHAs were good source for information about what went on in the villages. Nidhi relied on the ASHAs, and anganwadi-workers, on information about who were pregnant, if home deliveries

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77 Earlier, before the NRHM and the JSY-scheme, ANMs performed home deliveries. Earlier Nidhi lived with the in-laws in a neighbouring village of Bajipur. Nowadays most went to hospital and if people planned to deliver at home, they kept it secret from the ANM.

78 The sarpanch of Bajipur sub-centre area resided in Chotipur. Nidhi-madam needed his signatures for diverse approvals by the panchyat.
happened in the village and so on. Though ANMs and ASHAs cooperated, it was always clear that Nidhi had more authority than her ASHAs. Nidhi held the power card of her signature—they needed her signature for any of their documents to be approved and thus to receive any of the incentive-payment from the health department. Nidhi proudly told me that hers were “good [acchi] ASHAs” and that they did good work—often by comparing them to ASHAs elsewhere that she had heard did poor work.

**Muted Conflicts**

Though the ASHAs expressed mostly positive characteristic of Nidhi, I had a few peaks behind the mask that suggested some muted conflicts. As I will get back to in chapter four, Nidhi had a reputation of deviously “taking cases” off other frontline volunteers who worked with family planning, without giving them the “motivator”-money. Nidhi, however, insisted that she always gave the incentive money to her subordinates when she got their cases in her name as the “motivator”.

Anya said she usually gave her “sterilisation-cases” to Nidhi. When I asked her why, did she not want the money herself, Anya said: “Nidhi-madam is a very good woman. She always helps us [her ASHAs]. So, what is 150 rupees?” Anya reasoned that maintaining good relations with Nidhi was more valuable than the money. Thus, Anya here acts as an agent who with intent, “play the game”.

The reality of the family planning “motivator” accrediting, and the cases’ incentives remained unclear to me. Nonetheless it was a source of ongoing grudges, and a social play of accusations and speculations. Similar suspicion and accusations regarding money and cases were frequent everywhere in the community and the health system. Anya speculated if the nurses or Yashodas at Sitapur CHC scammed the ASHA’s escorting incentives when families came without ASHA. The nurses at the hospital recommended families to come without ASHA: she was of no need at the hospital, and coming without ASHA the family would receive a higher institutional delivery- incentive.79 It was rather

79 Women who delivered in hospital got an incentive of 1800 rupees if she came without ASHA, and 1400 rupees if she was attended by ASHA. In policy these additional 400 were earmarked transportation, which was given to ASHA to arrange for transportation. It was however conceived by the families and the hospital staff as the family losing some of the incentive if they brought ASHA.
difficult to judge who were mistaken or deliberately made up accusations for their own agenda.

The relation between the ASHAs and their superior Nidhi was one of mutual friendship, embedded in mutual dependence; the ASHAs needed signatures, help to fill reports and support; the ANM needed help to mobilise and “motivate” people and achieving targets—the power balance was in the ANM’s favour.

ASHA’S RELATIONS WITH AWW: MULTIPLEX RELATIONS

The ASHAs interacted with their anganwadi-workers on a daily basis. As part of their work for the ICDS, the ASHAs are to do ten daily house-to-house visits. To document this work they must daily go to the anganwadi-centre to sign off their "monthly attendance report, which the anganwadi-worker keep, first. ASHAs and anganwadi-workers are usually both community members in the same village and have multiplex relations vis-à-vis one other, of classificatory kinship, the village’s inter-caste relations, family relations and so on. The sum of all these relations inevitably affected the work relationship between ASHAs and anganwadi-workers. I often heard Ammajī instruct Anya to treat Vaneesha as her own mother-in-law when their working relation was discussed in Anya’s home. Vaneesha had an authoritative position towards Anya both in the capacity as her superior and the role of a classificatory mother-in-law. Anya addressed Vaneesha as cāci (FyBW), a respectful term for their fictive kinship-relations. The reverse relation did not require respectful address, ASHAs were called by their name. However, not all anganwadi-worker had the same type of affinal authority as Vaneesha, In other villages, in Gohlpur, Indoli and Kishpur, the anganwadi-worker and ASHA were from the same generation and had a more equal social role relation, they were elder- and younger-sisters-in-law. They were also posted simultaneously, when the anganwadi-centres there were established only four years ago. In Gohlpur both ASHA and anganwadi-worker were Saini, in Indoli both were Meena. Both Bhakpur and Indoli aganwadi-worker came from outside the village they worked, and their classificatory kinship were therefore not significant.

80 The Indoli anganwadi-worker, in her twenties, lived in Chotipur.
INDEBTEDNESS, JEALOUSY AND DISAGREEMENTS

Though Anya’s and Vaneesha’s families had a seemingly close relation, I witnessed a substantial quarrel between their families during that summer. Anya’s household was constructing two new rooms in their home; including a new kitchen on the roof terrace. The conflict centred around whether the wastewater from the kitchen ran unto the agricultural piece of land owned by Vaneesha’s family. Tej claimed the wastewater terminated within their piece of land. Vaneesha’s husband claimed otherwise. In relation with the quarrel, Ammajī recounted some of the families’ prehistory. When Vaneesha had undergone her anganwadi-training, she had to live away from the village for several weeks. Ammajī had then taken on her small children—one still breastfeeding—and “raised them as her own”. Vaneesha’s household had then been really poor and Ammājī had reached out. Ammajī cynically added: “But now look at her. Now our family is poor and she is better-off. Still, they don’t help us, or grudge us anything”.

Anya felt the consequences of the conflict in her work-relation with Vaneesha. At the height of the conflict Anya was scolded by Vaneesha for her family’s actions several mornings when she went to sign her attendance register. I was asked by Anya not to go with her these days. Beena escorted her one day, and reported Vaneesha had insulted Anya, as well as Ashok and Tej with sexually abuses. One day Vaneesha’s husband went around the village saying he would gather a crowd of men to go to Tej to put him in his place. It never came to this, though, how the argument was settled I do not know. The following weeks Vaneesha talked friendly, as normal, to me and Beena. Anya she did not look at or speak to. She did however authorise Anya’s attendance report with her signature, so Anya got her monthly ICDS-salary. Before the IUD-camp in July they had barely started talking again.

Several anganwadi-workers claimed the credit for procuring their ASHA the job. The ASHAs thus, also felt indebted to their anganwadi-worker for being selected ASHA. Vaneesha said she was the one to suggested Anya to Nidhi and the panchyat for her

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81 Funded partly from my monthly rent.

82 The selections of Sahyoginis, and later selections of ASHA-sahyogini was formally done through the panchyat, with the ANM and anganwadi-worker as committee-members.
sahyogini-position five years earlier. Ramita’s anganwadi-worker told us she had gone to measures to secure Ramita the position, through a family relation to the previous sarpanch. She explained she felt pity for Ramita who was poor, her husband had low wages as a carpenter, and thus thought Ramita needed some income. Ramita had only finished 5th grade. According to the Bajipur anganwadi-worker, others with more education had been surpassed when Ramita was selected. Ramita and her anganwadi-worker had a tense relation. She frequently teased Ramita about not taking care of her many children, and pointed the finger at Ramita for coming late in the day to sign the attendance register, and also not doing proper work. These accusations she also gave in front of their common (ICDS-sector-level) Lady Supervisor, Yashi, and Nidhi. Ramita said about the reason her anganwadi-worker’s put her down: “It’s because of our difference in jāti”. The anganwadi-worker was Brahmin, she was low caste. She continued: “Anya is a Brahmin, yet I get along very well with her (...) But in ones village [sāsural] caste is incredibly important.” Nidhi offered an alternative explanation: “Ramita’s anganwadi-worker does not have children and thus always comes on time, but Ramita has children and that is why she comes late.” That she was childless, and now pass expected reproductive age, was a sore point for the anganwadi-worker.

Also Anya said that Vaneesha tried to put her in a bad light in front of Yashi—for any alleged reason—at the monthly ICDS-sector-meetings. Anya suggested it was because Vaneesha was jealous of her, and the money she received. Vaneesha suspected Anya to earn a lot of her AHSA-work, while working less than she did. Anya, on the other hand, felt she worked unjustly much in relation to Vaneesha, for less income.

**Ambiguous expectations of ASHA-Sahyoginis work**

Generally, the anganwadi-workers wanted the ASHAs to help at the anganwadi-centre; weigh children; distribute nutrition supplements every Thursday; and help update various village-surveys and registers. The ASHAs on their side argued that these tasks were not their work (anymore). The ASHAs, with support from Nidhi, contrary claimed

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83 Several of the ASHAs was “Sahyoginis”, assistants, at the anganwadi-centre before the ASHA programme started.
that the ASHAs' ICDS work was outside the centre—only to do ten household survey-visits every day. Only on the MCHN-day were they required to help out on the anganwadi-centre. In practice it was not as easy to resist. Yashi encouraged the ASHAs to help with the anganwadi-records. Recall also that Dr. Rajul did the same in his meetings. The official guidelines are unclear what exactly is imperative of the ASHAs to do for the fixed monthly ICDS-amount.

When the comprehensive village-survey with details of all the household’s members, were to be copied over to a new record, Vaneesha requested Anya to do for her. Anya copied by hand from the old survey-register into the new survey-register. She sat with this repetitive task for hours several nights after finishing the housework. She recurrently did the same with other anganwadi-records that needed update. Anya would not receive more than the fixed 500 rupees from ICDS regardless if she helped Vaneesha with it or not. She said she did such petty tasks to please, and avoid arguing, with Vaneesha. That, however, did not stop Anya to reflect on the unfair division of work between them: "Anganwadi-workers gets 1800. My salary at the Anganwadi is only 500 rupee. Tell me why? They just sit at the centre every day. We [ASHAs] do as much work as they do!" Anya Remember how Anya’s mother-in-law also instructed Anya to treat Vaneesha as her own mother-in-law; ideally bahūs do the work they are told from their mother-in-laws without questions.

The ASHAs benefitted from cooperation and, occasionally support in conflicts with superiors, with their anganwadi-workers. However, they often also engaged in power struggles in both "professional" and personal conflicts with them. The anganwadi-workers, like the ANM, had the power over the ASHA’s required signatures.

**Anya’s Creative Strategies of Charm**

Anya boldly told me that many of her other ASHA-colleagues were afraid of Yashi-madam, but she was not. Even when Vaneesha put her down in front of Yashi, she did not worry. She said she knew how to charm Yashi. She got her to listen to her side of the story, not always believing Vaneesha. She explained that other ASHAs, came to her when they had something to inquire from Yashi. They asked Anya to call her on their behalf. Yashi occasionally withheld the whole, or parts of the 500-ruppes monthly ICDS-salary
of her ASHAs. If she was not satisfied with their work, or she listen to reports form anganwadi-workers that they had been absent or working inadequately, she used this as a disciplinary measure. However, although exercising worse disciplinary measures then the MO, Yashi also interacted with her ASHAs in less formal ways than the MO. After the official business of the ASHA’s monthly meetings in the ICDS-department, Yashi similarly to Nidhi engaged with them in village gossip and private matters.

Anya let me in on her strategy; to maintain good relations with Yashi-madam she charmed her by giving her small gifts. She had given Yashi-madam framed pictures of the Hanumanjī-statue in the temple her husband worked, and she sometimes brought her prasad (blessed food and items) Ashok took home from the temple. Such gifts had high religious and social value, but were free for Anya to give away. It seemed to be a common charming offence from Anya; the first time I visited Anya’s home in the company of District and Block Health Officers, she also charmed them by giving Hanumnajī-pictures from the temple.

She went together with Ramita to Yashi-madam’s new house-puja, that she invited all her 36 ASHAs to, and they each her gave 51 rupees for good luck. On top of the money they gave, came additional costs for Ana and Ramita; the travel fares from the village and taking the day away from home was together rather costly in their restricted economy. It seemed thus as also an investment in building personal relations with Yashi. Both Nidhi and Yashi called the ASHAs “my staff” when introducing them to others at their parties, seemingly proud to show off having their “own staff” coming to their functions.

It seemed Anya frequently manipulated the professional role relation to superiors to social and friendly one, by engaging in social- and gifts- exchanges, a well-known strategy in anthropological analysis, based on the power of the gift. Friendly relations were important, as conflicts with and accusations from other frontline workers actors at the frontline interface commonly occurred. The best measure (to uphold one ones position) was to have alliances with persons of some authority to support one’s side.

**TARGET-MENTALITY AND NUMERICAL NARRATIVES**

Though the study of Coutinho, et al. (2000) over ten year ago, and concerned ANMs, it seemed that also for the ASHA’s what the health department demanded was “numerical narratives” to meet the “bureaucratic imagination”. The practical, “actual events” the
ASHAs attend and “actual work” they do; the home visits, counseling, various meeting they are supposed to hold, accompanying birthing women to hospital, their presence in the labour room, the actual advices they give and so on are not (directly) seen by their superior Health Officials. What they see are the records and reports documenting the events, echoed by the emphasis Dr. Rajul put on importance of reporting and documentary practices in every sector-meeting. What is counted, what is visible, and what is the basis to judge the “well-performing” ASHAs is how good they master to fill reports and record correctly—the numerical narratives—and their results: number of cases they produce. Scott and Shanker (2010), note the dynamics of how there is no feedback loop for the knowledge accumulated by ASHAs, or other frontline personnel—due to the hierarchical relations and structure of the bureaucracy nothing but numbers are reported upwards (Coutinho, et al. 2000). Scott and Shanker (2010) also notes, resonating with my observations, that this system dynamic contribute to a lack of benefitting from the ASHAs greater insight into the reasons behind people’s health choices and practices, than superior health managers cover.

Following Scott (1998) and his argument that the state (bureaucracy) see only certain things, it is clear that what is seen, or recognised from above, is still target-achievements and productions of cases. What travels upward of information about the ASHAs work are reports with numerical achievements. The many hours spent by an ASHA at a hospital, supporting a anxious birthing woman, arranging transport, escorting, and staying until afterwards is not differentiated, seen differently, from that of an ASHA meeting the mother at hospital and leaving half an hour later. The incentives, and praise from superiors are given per case the ASHA can record, document, indiscriminately of the quality of care and investment of time. The work of hours spent visiting newborn and mothers by one ASHA is not separated, rewarded more, visible, or seen than the work of an ASHA just filling out the format, without actually going for the visits.

The visible ASHA-tasks, was that which was countable and reportable, and mostly recognised upwards in the system. Also, from my observations it seemed the tasks and events the ASHAs engaged in that were most visible to the members in the community concurred with producing “visible” numbers in the reporting structure, and also with
the paid ASHA-work. Thus, also which would easily be the most prioritised work. Then, what about “the health activist” role of the ASHA? The tasks which were most “social health activist”-like, were also often the tasks which were invisible, time-consuming, not countable and thus not paid- for-performance nor emphasised in the sector-meetings. The idea that money and reports are the driving force—“what makes people[i.e. ASHAs] work”—was recurring both at grassroots level and all levels of management, and enforced through discipline and monitoring practices from superiors.

**CONCLUSION**

The health system is another gendered hierarchy were ASHA have a subordinated position. As we saw from the monthly meeting-descriptions, the MO frequently told the ASHAs things such as they had made no progress, they neither worked properly nor filled forms correctly. He questioned what was the point of hiring them. The MO thus interacted with them as thought they were assistant health worker, having a “lackey”-role with very limited agency of power. Through the focus on records, reports, cases and targets, he made them accountable to achieve “cases” and targets, similarly to the other frontline workers. Although the ASHAs supposedly represents a new role among the frontline health workers, they are thus socialised into the target-mentality of the rest of the health system. In relation to payment, the NRHM-policies define the ASHA as a “volunteer worker”, paid “honorarium”-incentives, thus not hired as regular government workers. Yet, my observations of the interactions with their superiors suggest that they are treated and experience themselves as such: lower level workers. Also in concrete health work, such as the MCHN-day, they acted as the assistants of the ANMs.

The ASHA-Sahyoginis in Rajasthan are a double worker for two departments. As the chapter has revealed it is communicated rather ambiguously to the ASHA from her different superiors what “anganwadi-work” is required of her. This makes a room for negotiations between the ASHAs, the anganwadi-workers, and the LS. However, it leaves the ASHAs exposed for being taken advantage of from the various interests of her various superiors. The anganwadi-workers tried to uphold authority over their ASHAs and make them lackeys whom could do tedious work tasks, such as updating records.
Thought ASHA’s superiors formally have authority over them— their individual relations, affecting the ASHA’s agency, between different ASHAs and their anganwadi-workers and ANMs are individual and nuanced, based also on personality, familiarity and the ASHA’s creative strategies to play on the agency they have to manoeuvre. As revealed, Anya’s “well-performing” ASHA-work in the health department was funded on various strategies to build friendly relations and alliances with superiors.

The chapter has discussed an interface between ASHAs and their superiors, and how the various positioned actors through interactions negotiate how the ASHAs play out their concrete ASHA-role. It has also depicted how Anya related differently to her different authority figures in the local health system. The MO held authority, agency of power, over the ASHAs in a formal and fiscally manner. He exercised obvious disciplinary techniques to pursue his interests: He were also accountable upwards in the system to achieve the targets of his sector. The ASHA’s relations with the ANM and the anganwadi-worker were more ambiguous, and thus represents room for greater manoeuvres and agency.

On the other hand, that the ANM and ASHAs engaged in personal relations outside of work, predisposed that the ANM could play on indebtedness and loyalty to exercise power over the ASHAs. The interactions, and strategies of power and of pursuing interest, of this interface, should be kept in mind, when the next chapter seek to unfold the events of IUD-campaign.
4 The IUD-campaign unfolded

In the prelude we met Anya on the night before a mobile IUD-camp in July. In this chapter I present some important events that happened before and after that evening. The case of the IUD-camp highlights certain aspects of the ASHA’s position; for instance, the significance of it being a frontline position, and that the ASHAs also live in the community they serve contribute to why, and how, this position is vulnerable in cross-pressure situations, such as Anya were in regarding the IUD-promotion. In such dilemmas, it is hard to maintain balance the act of maintaining good relations with both superiors and the village community. In this context I will discuss how the ASHA’s perceived agency of their own, and other actor’s agency in various ways affected their “choice” to promote the IUD as an “injection”. However, I will first provide a short background of the role of family planning in India.

In India, when health workers say “family planning” they mean “contraception”, and they mean “population control”. India’s large population and its population growth, has been conceived of nationally, and international as a problem poverty and hinder for development. India was the first independent country to pursue reduction of population through a government sponsored family planning programme, and the programme has since 1966 been target-oriented (Engh 2001). In the 1990s staff of some government hospitals routinely inserted Copper-T in (poor) women who had given birth without informing them about the procedure (Van Hollen 2003). More dramatic were the events that unfolded during the 1975-1977 declared state of “emergency” in India, when family-planning became a priority at top-level. Severe coercive techniques were then used to sterilise people, which was still remembered by the elder population. Stories persist that busloads of poor were taken to sterilisation camps without consent, and that old men and women, out of reproductive age, were sterilised for the sake of getting required documents as “motivators” (Chadney 1988; Connelly 2011; Tarlo 2003).
TIME TABLE FOR THE IUD-CASE EVENTS

Whole July: Family planning campsite outside Sitapur CHC
The field staff of the block (ANMs and doctors) worked on to man the campsite outside Sitapur CHC, to receive and inform people several days during July. The camp offered sterilisations and IUD-insertions. Family planning, especially IUD, was also subject of monthly meetings at:
Block level: the BCMO motivated his ANMs and MOs to achieve many cases of family planning (IUD+ sterilisations) during July month
Sector level: the MO (Dr. Rajul) motvated his ASHAs and ANMs to bring many cases to the mobile IUD-camps.

June 8th: The first mobile IUD-camp at Bajipur Sub-centre No women from Chotipur get IUD inserted, but a few from the other Bajipur sub-centre villages

June 11th: Block review meeting: The BCMO praised the first mobile IUD-camp as a success to the ANMs and MOs. He announced it will be a second in July, and that the government stock of condoms is empty.

July 3rd: Block review meeting: The BCMO motivated his ANMs and MOs to achieve many cases of family planning (IUD+ sterilisations) during July month

July 15th: MCHN-day in Chotipur: Anya was already informed about the "IUD-injection" by Nidhi. The "IUD-injection" was discussed at the AWC during the MCHN-session. Lakshmi Bairava told Anya she got the IUD-injection in Sitapur, and has had no harm from it.

July 17th: Jaipur function of "Population day" & "NRHM- progress" celebration: Anita, Anya and I attended together with the Alwar delegation of 20 selected ASHAs and various District Health Officials.

July 20th: Anya’s first Promotion of IUD injection in village: Joined by me and Anita Anya motivated four women for IUD-injection ("stop the children"-injection)

July 21st: I and Anita visited Lakshmi and talked with Lakshmi and her mother-in-law about the "IUD-injection".

July 22nd: MCHN-day at the Sub-Centre: Nidhi had told her ASHAs to come there to get signatures as usual, but informed them she would not sign before each of them have brought her five cases to the IUD-Camp at Bajipur five days later.

July 23rd: ASHA’s Sector meeting: The MO informed about the upcoming mobile IUD-camp, and encouraged all ASHAs to bring five cases each when the camp stop in their sub-centre.

*July 26th: The day before the IUD-camp: Anya did a new round of the village to mobilise for the mobile camp. I and Anita met Lakshmi Bairava at Sitapur CHC, when she came to remove the IUD because of health problems. (*See prelude for details)

July: 27th: The mobile IUD camp come to Bajipur Sub-Centre: Five Chotipur bahis inserts IUD (Also women from the other five Bajipur sub-centre villages).

July 28th: Village uproar: Mothers-in-law of some of the bahis who got the IUD the day before confront Anya about the "IUD-injection" being Copper-T, and demand they are removed.

July 29th: Undoing "the injection": Nidhi and two ANM colleges arrive to Chotipur to remove the IUDs.

(I was present at the listed events except from Anya’s last promotion round July 26th)


**Preceding Meetings**

**Planning the event at Sector & Block-levels**

In the first meeting after the previous IUD-campaign in June, the Block Chief announced he was very pleased with the success of that campaign, and figures. He said, therefore, that he wanted to repeat the success in July. The Chief argued that IUDs, or Copper Ts, were the “most excellent contraceptive method” as it was safer than oral pills and condoms. He also informed them that the government stock of condoms was empty in all Rajasthan. The condom supplies the sub-centres had now would expire by the end of the month. The timing of the IUD-campaign was therefore perfect. At the next block meeting in July, before the new campaign, he asked the ANMs one by one how many cases they had ready for the campaign. He explained that for July there was an ongoing large and state-wide Family Planning Campaign, and that it was important to show progress in number of IUDs, oral pills, and sterilisation cases this month. As we saw in the previous chapter, Dr. Rajul also argued for the excellence of IUDs to the ASHAs at the July sector-meeting. He told them to bring five cases each when the mobile IUD-camp came to their sub-centres.

**The ANM gathers her troops**

Last Thursday each month Nidhi arranged the MCHN-day at the Sub-Centre. She usually requested all her ASHAs to come to the sub-centre that day to see if they had filled their reports, vouchers and cards correctly. If they had not, she corrected the paperwork before signing it. The ASHAs needed Nidhi's authorization to receive their payment. The last Thursday in July she told them to come as usual, and she checked their papers. She did however not sign any. She rather told them that they all had to bring five cases each for the upcoming IUD-camp at her centre before she would sign. Nidhi had already told her ASHAs promote the object of the campaign as an “IUD-injection” that lasted for five years, but now put extra pressure to promote it as such by the threat of withholding her signature.

The evening before the camp Anya went one last round in the village to promote the camp. Afterwards she heard that Lakshmi’s success story was untrue, as she had the IUD removed. She was afraid that if any of the other women had side effects or found out the
“IUD-injection” was a Copper-T—she would have to deal with the angry women and the ensuing social consequences. She reflected that her position was different from that of the ANM, the ANM did not live in Chotipur; she went home to another village in the evening. Nidhi only cared about her professional reputation, about achieving more cases.

THE DAY OF THE IUD-CAMP

The sub-centre was made ready for visitors. Chairs and a rug were laid out to sit on. Most of the ASHAs had brought a few women each and told Nidhi that more might be coming. The atmosphere was friendly and the women were chatting. Vamita, ASHA of Indoli, a remote village to the sub-centre, had come without any cases. She was there to get Nidhi’s signature on her documents for that month, because she could not come at the MCHN-day as usual. Nidhi told her to go back to her village and return with five “cases” for IUD before she would give her the signature. The mobile camp-team arrived in a jeep: two ANMs posted in Sitapur block, and two men representing the NGO who sponsored the campaign. The team was the same as the previous month.

One of the men wrote the names of “the cases” and “the motivators” in a book. The ASHAs were promised 50 rupees per case they had motivated in the previous sector-meeting. The ANMs had set up their “operation room” inside the sub-centre. Marsha, one of the ANMs, examined and inserted IUDs, while the other ANM assisted her.

Outside Nidhi-madam was trying to convince the women outside to get the “IUD-injection”. She argued that “these are very good [bahut accha ciz hai]—they are given to you for free by an NGO, today only, and it would be costly to get privately”. Nidhi did not explain what the “IUD-injection” really was, nor did she inform about side effects. She told the women that “this is the Freedom-sort [Freedom-wallah]85, the NGO-sort [NGO-wallah]. It is the superior type! [Bahūt baḍhia hai]”. She continued: “Sterilisation [nasbandi] and Copper-T is terrible [kharab] in comparison. You can choose to prevent

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85 Around in Alwar city, where Nidi lived, it was advertising boards promoting the “Freedom 5”, a popular brand of Copper-T. I looked at the packets that the mobile team had with them. They were different than the government supplied Copper-Ts, but the Freedom-logo was not on them.
children for two, three or five years, as you wish. Just try it, see if it agrees [suits] with your body, otherwise it can be removed!” Nidhi rushed the women: “Now, hurry, come on, get into the room. Others are waiting!” She pressured the women to decide quickly.

Several of the women were visibly scared. Some were taken into the room with Nidhi holding their hand and telling them it would be fine. Nidhi intervened if a woman seemed reluctant or nervous, and encouraged her to go on. The women did not question the handful of antibiotics and painkillers they were given by Nidhi after the procedure, or that they had been told to come back in three years to remove the “injection”. If they had any problems they were told to give notice to the ASHA of their village. Most of the women, bahūs, came alone, without a nanad or mother-in-law to ask questions.

Anya brought six “cases”, one Saini and five Brahmin women. It was more than any of the other ASHAs. One of the Brahmin women came back out after being examined when she realised the “injection” would be given in her uterus [bacche dahn]. She asked Nidhi why the injection could not be given in the arm. Nidhi explained that if the injection was to prevent pregnancy, then of course it had to be intrauterine and not in the arm. The hesitant woman ultimately backed out. She had come together with her sister-in-law Uma, a bahū of Chotipur, who did get the IUD. So too did Rekha, Vaneeisha’s two bahūs and a bahū from the Saini hamlet.

Later on Vamita, the ASHA who was sent back to her village returned with three women. She had told Anita then, that it took about an hour to walk each way between the centre and Indoli. Though Vamita had returned with cases, Nidhi still would not sign her papers. She was not happy with the numbers of vaccines given at the previous MCHN-day in Indoli. She showed Vamita the Indoli MCHN-day register and said too few names was recorded on the last date. She said could not sign her papers when she was not doing her job properly. Vamita, in despair replied that it had to be the new ANM who had failed to fill in all names in the register. She had taken many women and children for vaccines. According to Anita, Vamita kept pleading for signatures while Nidhi kept refusing. When we left in the afternoon, Vamita was still waiting back to get the signature from Nidhi-madam. Anya had gotten the signatures she needed before she left.
Nidhi, thus, also used forms of discipline to “motivate” her subordinates, like the MO did. Anya explained that Nidhi would give Vamita the signature in the end, but only after worrying her to work better.

**UPROAR IN CHOTIPUR**

The morning after the IUD-camp, Anya was verbally attacked and publicly scolded at the anganwadi-centre, when she showed up in the morning to sign the daily attendance register. Vaneesha’s own two daughters-in-law had gotten the IUD, and she aggressively confronted Anya along with two equally angry mothers-in-law. They complained that their daughters-in-law were poorly *kharab* after they came home from the camp, and not able to work. Vaneesha claimed her bahūs suffered from dizziness *shaker*, the others complained about bleeding and [vaginal] discharge *laal pani, safed pani*. They were furious, and said they were not fooled; the “injections” must have been “Copper-Ts”. None of the three mother-in-laws had been at the camp, but they said they recognised that it had to be Copper-T when they talked to their bahūs.86 Their anger was directed at Anya. She defended herself by saying that Nidhi-madam had told her that it was an “injection”, so had Sunanda-madam, the new ANM. Dr. Rajul also called it an injection at the meeting in Dhargarh. How could she know better? She asked them to talk directly with Nidhi-madam, called her up, and handed Vaneesha the phone. The phone was sent around among the three of them. They bawled out at her, and threatened that they would get her fired, and they would no longer let her vaccinate their [grand]children. Nidhi said she would come tomorrow to remove the IUDs and sort things out with them. Mira, who was cooking the school lunch, listened to the uproar as she made chapattis on the stove just outside the anganwadi-centre. The anganwadi-helper, and a few other women were also there. Some of the teachers came by to see

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86 However, they could just as well have heard it from somewhere, many people were involved in the campaign, that knew it was Copper-T inserted by the mobile team.
what the row was about. Mira, smugly, seemed to find the situation amusing. She laughed out loud, as she said things such as “they all thought they got an ‘injection’, and then it was a ‘Copper-T’!”. She eagerly explained this to the teachers. Even they chuckled.

That day the rest of Anya’s family was working in their fields, harvesting the crop. Anya was still alone to do housework. Kanya was getting an ear-operation in a hospital in Jaipur and stayed with relatives there. Anya rested for a while after coming back from the anganwadi-centre. Tej was angry with her for not helping with the harvest in the fields. In the afternoon there was a heavy shower of rain. Several women who had been working in the nearby fields found shelter in our house. The tale of the “IUD-injection” was by then the talk of the town. The elder women trapped in the rain shared stories of their experiences with Copper-Ts when they were younger. The elder women all agreed that the Copper-T had given them nothing but grief and ill health.

WHY AN UPROAR?

In Chotipur five women had the IUD Inserted; Rekha Sharma, Sita and Prita Sharma (Vaneesha’s bahūs), Uma Sharma and Neela Saini, from the Saini-hamlet. Anya also brought Uma’s married nanand visiting her pihar, who backed out of it. The three mothers-in-law who demanded their daughters-in-law’s Copper-Ts were removed were all Brahmin. The woman from the Saini hamlet might not have heard about the uproar, or was content with having a Copper-T inserted. There was no uproar and no similar complaints from Nidhi’s other villages. Ramita said she had told the women she motivated that it was Copper-T—against Nidhi’s orders. Nidhi’s other ASHAs might have done like Ramita, or the bahūs who got the IUDs from their villages remained unaware of the deception. They likely had not high-caste mothers-in-law that easily stood up to authorities, and who were not afraid to speak their mind. As noted previously, Chotipur villagers had more education and a higher number of government employees than neighbouring villages. My impression was that Chotipur-villagers were, in general, more

87 I wondered if Mira laughed of the women who had been fooled, if she laughed at Anya’s situation, or perhaps mostly self-righteously because Nidhi was in quite a mess, as her relation with Nidhi-madam was not good, and Mira, though having the position as janmangal, herself had not been part of the scheme.
confident in dealing with authorities, perhaps because they had more practice, with so doing.

The women were angry with Nidhi, but they were also equally, or more, angry with Anya. They might have expected deception from Nidhi, but felt personally betrayed by Anya, one of their own. None of them had been at the camp site and witnessed what had happened, nor had they spoken to Nidhi, as Anya suggested—only their bahūs had. Nidhi had also rushed them.

THE FACED POSITION AT THE FRONTLINE

The direct relations of the frontline interactions are crucially significant for the vulnerability of the frontline position. Frontline workers are those who try to perform welfare in practice, according to Vike, et al. (2002) in an analysis based on lower level health workers in Norway. They describe a permanent feeling of insufficiency of the frontline health workers, related to one distinctive feature: the experience of not being able to accommodate the overwhelming expectations and demands from those who seek their services and those who specify the conditions the services shall be given under (Vike, et al. 2002). Upwards in the government health system, actors can protect themselves by formulating complex problems as economic or administrative. Further down in the organisation, at the frontline, the same problems appear as concrete dilemmas. The frontline worker has to deal with real people, not abstract problems. In part the ANM, and certainly Anya’s superiors saw the achievement of targets, and producing cases, as administrative and impersonal work tasks. To Anya the “cases” were her neighbors and friends that she would also continue to see on a regular basis in private social contexts.

Anya’s anxiety about the IUD-camp, suggests that she struggled with balancing her personal and professional requirements. Her duty to her friends was not easily reconcilable with her duties to her job. She was not comfortable with the motivation strategy nor with the services she was motivating for. She had for a week repeatedly sought the advice from her mother-in-law, Anita and me about how to go about the
Anya's situation was clearly a dilemma: a situation where moral and practical demands cannot easily be reconciled, (Vike, et al. 2002:13). The frontline workers experience their feelings of insufficiency as a personal strain, which Vike, et al. (2002) make out to represent an internalisation of an organisational problem. The frontline health worker carries the limitations of the organisation in her body. To her the situation appear as an identity problem and as a loyalty problem between the organisation and ethics (Vike, et al. 2002:14). Similarly, Anya struggled with her actions to promote the IUD-camp through deceit as a dilemma between sustained loyalty to her superior, Nidhi, and her fellow village women.

For the ASHAs the frontline position is more intense and personal, as they continuously live at the frontline, among the people they serve. Vike et al. (2002) argues that the lack of limits, or boundaries makes the frontline position difficult. In the case of the ASHA, there are indeed no, or unclear limits between her role as a health worker and her role as a community member. There is no escape from being a friend or neighbour when doing ASHA tasks, and no escape from consequences of actions done in capacity of being an ASHA afterwards. In a way, the ASHAs are constantly at work in their private life and constantly a private person when at work in the village. This is what seems to be thought to be the advantage of a CHW, and how they can access their community through their personal relations. It does, however, also make the position vulnerable and psychologically tiresome, especially when work becomes a source of personal moral struggles. The frontline health workers in Vike et al.’s empiric descriptions constantly cope with moral dilemmas, but at least they escape their struggles when their shifts end.

Anya was clearly distressed after the uproar and the accusations of deception directed at her. The vulnerability of the ASHAs transcend the feelings of insufficiency Vike et al. describe, in that they have multiple personal relations in the communities, and can never escape. Their position at the frontline is not just a face-to-face relation, but a position of multiple relations (e.g. kinship, community and friendship) to the people

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88 For the Norwegian frontline workers it is the expectations to the service performance["ytelser"] of the welfare state that are without limitations.
she was pressured to deceive. She has no possibility of escape when unpleasant episodes such as the uproar occur.

What happened at the IUD-campaign was exceptional; still, similar events, and enforced orders and instructions to produce cases, to achieve targets, happen regularly. If something goes wrong, or the villagers are not content, Anya is the one caught in the cross-pressure. She does not have the ANM’s and her superiors’ possibility of escape. This we saw in chapter two, when Pradeep hassled Anya because Nidhi, in his opinion, had given his daughter too many vaccines. Also, the aggravated man at the MCHN-day directed blame and anger towards Anya, though his real issue seemed to be with Nidhi’s, or in general health workers’, alleged absenteeism. All these exceptional events make commonplace issues and dilemmas more visible.

UNDOING THE INJECTION

The day after the uproar, Nidhi, together with her ANM-colleagues, Hetal, from Dabbi sub-centre and Marsha, the ANM who inserted the IUDs, arrived in Chotipur on their scooters to calm down the furious women. The small patio of the Anganwadi-centre was crowded, as the deceived bahūs and their mothers-in-law along with other village women had gathered there.

Nidhi-madam arrived last, in a theatrical manner. She jumped off her scooter outside the anganwadi-centre and reached out for a small packet under her scooter-seat. “This is a copper-T!” she bellowed. She held up an individually wrapped Copper-T from the government supply for dramatic effect, while she continued to talk loud. She argued that what the women had gotten yesterday was “Freedom-wallah”, “an excellent type”, and maintained her claim that it was not Copper-T. She explained that the “freedom-wallah-injection” they received yesterday was very expensive. If they removed it they would waste a lot of money, but if they insisted, they would be removed. She sent the Copper-T around for the women to see. The mother-in-laws were still angry, and were not convinced by Nidhi. They again threatened to tell her superiors and have her discharged.

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89 She did not bring an example of the type inserted in the camp. She was probably not in possession of one, and if she were it would have defeated her purpose, as those also looked like Copper Ts.
from service. Nidhi nonchalantly answered that it would not make a difference, she had already talked to her chief, the BCMO, yesterday, and he was on her side. Nidhi-madam sat down on one of the few chairs at the patio and asked what problems the bahūs had from the “injection”. The conversation that followed was calmer than earlier. The mothers-in-law answered on their bahūs’ behalf, and listed the same nuisances as yesterday: they were poorly, needed to lie down, could not work, felt dizzy, some bleeding and discharge. At that point, Nidhi’s “show” was over, and women chatted amongst themselves. Hetal and Marsha also held that the IUDs from yesterday were not Copper-Ts.

The bahūs mostly kept quiet and lingered in the background of their expressive mothers-in-laws. Nidhi asked the bahūs if they were sure they wanted to take it out. All of them nodded and confirmed silently from behind their veil. Marsha took the four bahūs into the small room at the anganwadi-centre to take out the IUDs in private. The mothers-in-law waited outside and continued to discuss with Nidhi. When I left the centre, I could see a couple of the small, bloody Copper-Ts lying in the grass under the window of the room where Marsha removed them.

THE AFTERMATH

I left the village just a few hours after, as my time to do fieldwork was over. When I called her a few days later—Anyā told me that many villagers did not speak to her. Two months later, when I returned to Chotipur for five days, she was not shunned any longer, but Vaneesha still did not speak to her. It was, however, not uncommon for Vaneesha to act like this after conflicts with Anya. She also gave Anya the silent treatment for weeks after the conflict about the waste water spilled in Vaneesha’s family’s field.

AUTHORITY AND AGENCY: PLAYING THE GAME

My assistant Beena thought, that Nidhi was lying and had not notified her boss. In Beena’s opinion, she did not have to fear that the village women (“uneducated”, “unknowledgeable” as she put it) would actually go through with their threats of complaint.

To attend Swastha Chetana Yatra (yearly health awareness campaign)
Nidhi did not seem afraid of what the women could do to intimidate her position. Though the Chotipur women were conceivably more resourceful, more used to and less afraid to deal with government bureaucracy than average village women she dealt with, Nidhi did not believe they would follow up on their threats. She seemed confident about her position’s authority and her own cleverness. Also, Nidhi knew she was well-liked and respected in the villages, presumably a status gained from years of building relations and behaving respectfully towards people. She was nevertheless, like Anya reflected on in the prelude, just there to do concrete work and would leave straight thereafter. She had less to lose than Anya. In the worst case, she would be transferred to another sector. For Anya the event had social consequences on a daily basis. Her social life, not just her job was at stake. She could not leave the village without leaving her son, and where would she go? Her parents were poor and in ill health, and her brother’s household struggled economically. It was also considered to bring shame on a woman’s natal family if she abandoned her-in-laws. A daughter’s general behaviour in her sāsural reflects upon her natal family’s honour and reputation (cf. Jeffery and Jeffery 1996).

The consequences of the event clearly show the difference between the position of the ANM and the ASHA, the hierarchy of ranks and the difference in power, available strategies and scope of agency. The pressure from the superiors, the MO and BCMO, to produce cases illustrated the cross-pressures of ASHAs next to the ANMs, related to the fact that the ASHAs are community members as well as health workers.

A HISTORY OF COERCIVE FAMILY PLANNING STRATEGIES

Rural, and poor citizens in India have historically been offered substandard services and bad treatment by health personnel; they are likely not surprised to be deceived. In the state’s quest to control the growth of its population, health workers are known to go further in their strategies than Nidhi’s twist of the truth. Under the Emergency the target-approach was prominent: not only health workers, but all types of government and public officials were directed to fulfil family-planning targets, mainly sterilisations, and they were penalised if they failed to meet these targets. (Connelly 2011; Van Hollen 2003). Villagers in Alwar district were also affected by the politics during the Emergency. Bāūji explained that when his children were small he had to get sterilised.
for them to be allowed to attend school. He was unclear if this was due to a state policy, or merely a result of rules made by the government school’s teachers that had been given their own targets to fill.

I went to Nidhi’s home in Alwar with Anita after I left Chotipur. Anita talked to her about the “IUD-injection” and the uproar in Chotipur. Nidhi argued that it was after all better for the women to get the IUDs, as most didn’t remember to take oral pills daily, and condom use was dependent on the will of their husbands. The women kept getting pregnant and continuously went for abortions, which was bad for their health. She talked in a detached manner about the issues. It even seemed to me she found the whole circus after the camp to be a bit amusing. She argued that these rural women, especially the elder who had bad memories of earlier use of Copper-T, did not understand that these new Copper-Ts were not like before. She said it was of no use to try to convince such stubborn and unknowledgeable women with this information. She said both herself and her good ANM-friend Hetal had the same type of IUD inserted. She did not express any reflection about any potentially damaging consequences of this method of deception for her ASHAs’ position in their communities, or the villagers’ trust towards them. Vike, et al. (2002) suggest that the ability of actors to exert power (pressure) does not necessarily rest on their sovereign knowledge about which interests they promote—or about its effects and consequences. In the complex field of large organisations—such as the health department—we deal with actors who define their own interests without necessarily knowing much about the comprehensive universe of connections they are included in. (Vike, et al. 2002:12-13). The health department, characterised by hierarchal structures and sharp divisions of work, contributes to actors with very different experiences and understandings (Vike, et al. 2002). Especially when handling complex problems, or dilemmas. Only some, in this case, the ASHA (and partly the ANM) experience the dilemmas directly. Here, the dilemma seemed to be, understood to various degrees by differently positioned actors. The health workers know people do not trust or want Copper-Ts, but at all levels the health workers are measured against their IUD-targets, and so are incentivised to meet these targets. Most cannot afford not to do their utmost to reach them. Moreover, other non-permanent contraceptives are not perceived to be as efficient as the IUDs; and also medical concerns of women going through repeated abortions against the side-effects of hormonal contraceptives. Health
workers appear thus to be motivated to have IUDs inserted a procedure that the general population is not too fond of. This is, again, an illustration of how the pressure of best reaching the population control targets and that of following the will of the people clash.

One might ask why the actors resorted to deception strategies only to produce “cases”. Anya, and her fellow ASHAs seemed partly motivated to go along with the scheme to remain good relations and show Nidhi that they are loyal. The ASHAs also fear that if they do not follow her orders they can lose their job, or their payments could be cut or withheld, which had happened before. The Lady Supervisor in the other (ICDS)-department, regularly withheld payment as a means of inducing discipline. For the ASHAs there was not much prestige in having many cases as for the ANMs. The monetary gains were also low, 50 rupees per case. Nidhi had quite a rumour of stealing the motivator-credit of other’s cases. Both janmagal Mira and the trained (inactive) dai of the village accused her of previously taking their cases. Ramita and Anya were also unsure if their name or Nidhi was listed as motivator for their IUD-cases in the mobile camp. Anita told Anya that her name was listed only twice in the book as motivator, the rest of Chotipur-cases was listen in Nidhi’s name. Anya did not seem surprised. She continued that Nidhi-madam had taken her and other ASHA’s cases in her own name before. She had previously fallen out with Kavita, ASHA of Bhakpur for doing just that.

**PERCEPTION OF OWN AGENCY AND STRUCTURAL CONSTRAINTS OF PERCEIVED AGENCY**

Long (2004a:33) notes that all actors operate, more implicitly than explicitly, with beliefs about the agency of “relevant acting units and the kinds of knowledgeability and capability they have vis-à-vis other social entities.” These perceptions of the agency of others, Long argues, shape the behaviour of actors. Related, Vike, et al. (2002:12) with regard to dilemmas see power as the ability to exert influence on other’s possibilities to imagine and undertake choices. This relates to the actor’s own perception of having agency—or the lack thereof.

With this analytical frame Anya’s belief about the agency of power of the variously positioned subjects, all pursuing various projects of their own, likely influenced her
“choices” of action within the IUD-dilemma. Presumably the MO and the ANM were in possession of strategies that could make Anya’s ASHA-work difficult in the future, by avoiding to support her, or withholding payment. Nidhi indirectly threatened to do so by withholding her signature. The families in the village held within their agency power to socially shun her, ridicule her. They also had power over her future ASHA-work by not calling her in times of deliveries or choosing someone else as “motivator” for their family planning measures.

Because of the MO’s and ANM’s threats and disciplinary techniques, the ASHAs are constantly in fear that if they do not follow orders they could lose their job, or temporarily be denied the income, that for some, their household depends on. Their fear is strengthened at the monthly sector-meetings where they are constantly reminded about their responsibilities for and the importance of achieving targets. There their superiors also threaten to withhold their payment.

Was Nidhi concerned with the government’s interest of getting reproductive women to use safe prevention, to ultimately ensure a decrease in children born? Or, was she mainly encouraged by the opportunity to shine in the eyes of superiors and colleges when she reaches her targets? At least it seems reasonable to suppose that she, like Anya, was driven by a desire to do her job well and achieve results. This is speculations, of course; Nidhi might be driven all these reasons or more. In any case, it remains, that the structures of the system facilitates rewarding a high quantity of care, not a high quality of care. It is important to achieve the numbers, how the numbers are reached is less important. This also suggests an explanation for the deception at the IUD camp: there is a systemic focus on targets to be reached at any cost. The quality of care remains lower on the list of priorities, and the system is set up so that quantity ranks over quality (cf. Gjellestad 2010).

Recall how the MO encouraged the ASHAs to “agitate” women, exaggerate, to make them use their services in the monthly meeting. The BCMO explained, that if he “motivated”, thus demanded, his subordinates to manage ten cases, perhaps they managed five. It was seemingly a pervasive attitude in the various health management levels that the frontline workers were motivated by money, pressure, discipline and fear that their work could be controlled.
The vulnerability of the ASHA position: a lack of perceived agency of power?

In the case of the IUD-chain of events; the ASHA’s (Anya’s) position is vulnerable because she has modest agency (of power), while her superiors use their agency of power to pressurise her: to put her in her place and show that she is subordinated. The ANM formally has the power of the signature in her power, to do that. She also has a register of personal relations, indebtedness, friendship and loyalty to play on. The ASHAs negotiate strong structural constraints in both social fields of the health department and the village. In relation to agency of intention, of pursuing projects: I here assume the project Anya was pursuing was to be a “good” worker\(^{92}\) and simultaneously a “good” community member—she desired to maintain good relations with her superiors and fellow villagers. Pursuing this project was strengthened by Ammājī desiring the same end for her bahū. I have illustrated throughout the thesis how Anya negotiated and manoeuvred the scope of agency she had available in a culturally appropriate way, to pursue this comprehensive project. A main strategy, seemed to be to maintain good relations with her superiors through diverse actions, gestures, use of charm and sociability. She engaged in exchanges, gave gifts and attended private social events of Nidhi and Yashi, the Lady Supervisor. She also occasionally did work for Vaneesha, like updating the village surveys and copy information from old registers to new ones, which her job did not require her to do.

On occasions when the cross-pressure are difficult to balance, as with the IUD-promotion, it was difficult to pursue the project of being both a good worker (produce cases) and a good community member (not contribute to deception). Anya faced the dilemma of who to be loyal to. In a context of “serious games”,

> “the pursuit of projects for some [agents]often entails necessarily, the subordination of others. Yet those others, never fully drained of agency have both powers and projects of their own, and resistance (from the most subtle to the most overt) is always a possibility. Both domination and resistance then are (...) in the service of projects, of being allowed or empowered to pursue culturally meaningful goals and ends, whether for good or ill” (Ortner 2006b:153).

\(^{92}\)Though using the word “good”, this (sub-)project related to numerical achievements, not ethical concerns.
Anya seemingly “chose” to subordinate her pursuit of being a good community member to the pursuit of Nidhi’s project to achieve many cases in the mobile IUD-camp. Ramita’s strategy to call the IUDs Copper-Ts, can be seen as an acting of agency of resistance to the subordination to Nidhi. Both calls involved risks, and calculations of the other actors’ agency to punish them, as noted by Long. Also, as noted by Vike et al, the exercise of power from Nidhi, might have affected the ASHAs possibility to imagine if it was a real “choice” to be made. Ramita in several occasions expressed that she did not like her ASHA-work much, and that she did not want to do it anymore. She was thus likely less motivated to pursue the project of being a well-performing ASHA-worker than Anya. She had no mother-in-law in her household who interfered or expressed an own desire for her bahù to be a “good” ASHA-worker, neither.

CONCLUDING REMARKS

The IUD-case story show how easily the accredited activist may fall into discredit in her community, and how vulnerable her position can be, as it is based on relations of trust and loyalty; that is, the ASHA’s social and family-bonds in the village. Her position is not based on a “natural” authority, like the ANM or doctor, who hold prestigious education. Anya and her ASHA-colleagues were put in an awkward and unpleasant position brought about by Nidhi, and amplified by Dr. Rajul, by pressure to achieve cases. However, the “choice” to play along with the deceit might have been differently interpreted by Nidhi’s ASHAs, within a framework of how they differently perceived their own agency, and the agency of superiors versus community members to hold power over and exercise punishment.

Ortner’s serious-game framework can add perspective and understanding to the agency and pursuit of projects for actors in relation to the IUD-campaign. The goal of Anya’s superiors appear simply to insert many IUDs, and so count the family planning campaign as successful, Anya’s project, on the other hand, involved a full-blown serious game. At stake was her position and continued good relationship with her superiors, her neighbours and family; her status as a “good” worker and loyal subordinate assistant; her status as a trustworthy and dependable community member, and lose the good relations she had built. Yet, she “choose” to play along with the deception. It was
however because it was important for her, personally to pursue being a “good” health worker that she did. Ramita, who did not, did not hold her ASHA-position so important, and would care less if she ended up in Nidhi’s disfavour.
5 Conclusions

Revisited: Does ASHA represent a frontline change agent or bottom-level lackey?

By her title the ASHA is a “health activist”, and talked about in the policy as a change agent, thus resembling Werner’s (1978) liberator-role. In practice, though, by Werner’s (1978) classification, their role-relation in many aspects resembled that of a lackey in relations to their superiors. Lofty and ambitious health policies are perhaps a start of change, but it is though, as Long (2004: 33) notes, as practiced by frontline actors and their day-to-day decisions and routines that make or break policy. He argues that it is precisely at implementation interfaces that de facto policy is created. In a social field organised as a hierarchy, and a sociability preoccupied with rank and titles, it is not strange that the ASHA is incorporated in the health department as a lower-level assistant to her supervisors.

Also, in the other social field, her village community, the role as an “health activist” challenges the common social organisation. The selection guidelines and the kinship system in Rajasthan make the ASHAs young, married women, in a subordinated bahū-role, thus women who observe purdah; striving to appearing invisible and mute in public. However, these social structures are also flexible and changing. Anya did not veil at home for instance, in front of her “real” in-laws. She did when moving about the village, because that was the norm. To the individual ASHAs the ASHA-position also represented new opportunities and changing roles, from that of subordinated, rural women. Through their “professional” role they had more possibilities than other bahūs of their community to move about independently. Frequently accompanying women to hospital, and going alone or with colleagues to monthly meetings, without being escorted by her own family members, may gradually lead to a general freedom of movement. Thus, not having to always legitimise absence from the household to mothers-in-law, perhaps even acceptance of her having to be a “free” agent to leave on short notice to accompany other women to hospital deliveries and so on. After the
monthly meetings, for instance, Anya and her colleagues could enjoy small spaces of enjoying life outside their sasurāl, together with fiends and unrestricted by purdah-observations. The ASHA-position had also given Anya great knowledge of, and confidence to deal with bureaucracy, and multifaceted structures outside the village community. Though the ASHA-incentives do not correspond to high sums of money, it represents a possibility of income, to contribute to the household economy, or agency for own, independent purchases or saving up to pursue a larger project. Thus, holding the position in some aspect lead to ASHAs being a change agent in their own life, for instance by expanding their agency in the household.

**GLOBAL HEALTH AGENT?**

The MO, and the Health Officials above his level, related the role and work of ASHA to improving health indicators such as maternal and infant mortality rates. The MO was aware of the chain of reporting in these indicators, and other indicators such as vaccination coverage and percentage of institutional deliveries. He knew these numbers were compiling to India’s success or failure to deliver good results in relation to the global levels. The MO exercised strategies to hold the ASHAs accountable to achieve cases, and help the ANMs achieve their, targets. Yet, although he focused on continuous training of his ASHAs, he did not teach them about abstract concept such as the MDGs or Human Rights. Anya had barely heard about IMR and MMR from the MO, who was probably more invested in teaching his ASHAs concepts than superiors in other less well-performing sectors. At the level of the ASHAs the health work consisted of concrete duties, managing various relations, and filling reports and records without much awareness of their importance in national or global health context of the “race” to reach the MDGs by 2015. Although incorporated as and treated as a “lackey”-assistant, that does not mean that their concrete tasks, informal counselling with villagers and their mobilisations for health events and so on do not contribute, statistically, to improve health, even save lives, thus improve the health indicators that is measured in the MDGs. If the over 800 000 ASHAs in India all contribute a little to improve the health statistics, that is a considerable contribution taken together.
DO ASHA REGULATE POPULATIONS OR CONTRIBUTE TO ITS SELF-GOVERNING?

The ASHA-programme undoubtedly represent what Ong (2006) call “optimising technologies”, and whether the ASHA-position is best understood as a technology of subjection or technology of subjectivity, I think is not the valid question. In various ways the ASHA-position can represent both. The ASHA-programme as a whole is a technology of subjection, as a political strategy of the state to regulate the population’s health choices. The individual ASHA can also serve as such when she mobilise for vaccination and collect children and mothers in their homes to take them along.

In Anya’s case, the villagers in her community were more or less self-governing themselves, according to following the state health messages. The ASHA-training is not technically or detailed. The “array of knowledge and expert system” (Ong 2006:6) the ASHAs are to provide is more of the type “it is healthy to wait two years between each child” and “vaccines protects the child against diseases”, as they are not taught what hormones or antibodies are or how they work in the body. Anya did not have much more knowledge, for instance on how vaccines or contraceptives work inside the body, than the other villagers. Anya, thus did not negotiate health knowledge as much, or represented a technology of subjectivity as clearly as other ASHAs, in villages were people were more sceptical to, or not aware of the content of the state “health messages”.

NEGOTIATING ROLES AND RELATIONS

However, concretely for the ASHAs to successfully “play the game” of being an ASHA, they must apply to the rules of the game and learn how to manoeuvre. In my impression the “successful” ASHAs, as well as ANMs were actors who were good at handling negotiating various relations, and, sometimes conflicting, roles skillfully. To achieve targets means producing many “cases”, which again, is dependent on the villagers needs of or acceptance of their services. Because families got more incentives themselves if they came alone for institutional deliveries, many ASHAs told me people had stopped calling them, and preferred to go alone (see also Knivestøen 2012). Thus a paradox-situation was the case for several ASHAs: instead of being needed to help attend deliveries, they had to convince the families to take them along. Else the ASHA would not produce “cases”, not be well-performing, and also get less income. The 100 rupees-
incentive they were getting for three scheduled counselling home-visits during pregnancy were included in the incentive –sum they got for accompanying the women to hospital. If they were not called for when the woman then went to hospital to deliver, they were also cheated for that incentive, even if they had gone for the visits. Though, in Anya’s village, people did not generally need her help to arrange transportation, or deal with the hospital bureaucracy, she only lost out on a couple of all her possible hospital delivery-cases the year of my fieldwork. She drew on bonds of loyalty and social duty for the families to take her along.

So, although Anya had limited agency of power, she were considerably skilled in strategies to pursue her serious game-project of enacting a good health worker—both in the eyes of superiors (producing cases, reporting correctly) and in relation to the community (building good social relations). Thus, by looking not only for agency of power—(yes, Anya was treated as an lower level assistant, and had very little agency of authority)—but also agency of pursuing projects with intent, we can discover the real source of Anya’s, and presuming other ASHAs, agency as “well-performing” health workers: to manage, and negotiate roles and relations.
6 List of references

Aase, Maren

2006 Public Action and the Outcast: A study of poverty and malnutrition among indigenous women and children in India, Department of Political Science, University of Oslo.

Ahearn, Laura M.


Anagnost, Anna


Bajpai, Nirupam, Jeffrey D. Sachs, and Ravindra H. Dholakia


Berreman, Gerald D.


—


Béteille, André


Briggs, Jean


Census, India Online Pages


Chadney, James G.


Clifford, James

Connelly, Matthew (Programme Host)

2011 Controlling People (3 episodes). In The Documentary: BBC.

Corbridge, Stuart, et al.

2005 Seeing the state: governance and governmentality in India Cambridge: Cambridge University Press.

Coutinho, Lester, Suman Bisht, and Gauri Raje


Dumont, Louis


Engh, Sunniva


Foucault, Michel


Fürst, Elisabeth L’orange


Førsund, Laila


Ginsburg, Faye D., and Rayna Rapp, eds.


Gjellestad, Marianne

2010 Child birth in rural India: from home births to incentive-based institutional deliveries. A qualitative study on experiences and perspectives in Uttar Pradesh, Institute of Health and Society, Department of General Practice and Community Medicine, University of Oslo.

GoI, Ministry of Health and Family Welfare


GoI, Ministry of Rural Development


Gupta, Akhil


Gupta, Akhil, and James Ferguson


Hansen, Thomas Blom, and Finn Stepputat


Haraway, Donna J.


Hasija, Shefali


Jacobson, Doranne, and Susan S. Wadley


Jeffery, Patricia, and Roger Jeffery


—


Jeffery, Patricia, Roger Jeffery, and Andrew Lyon


Khare, R. S.

Knivestøen, Synnøve Nesdal


Lambert, Helen


Leach, Melissa, and James Fairhead


Lehmann, Uta, and David Sanders

2007 Community health workers: What do we know about them? The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers. World Health Organization, Evidence and Information for Policy, Department of Human Resources for Health.

Lewin, Simon, et al.

2010 Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases (Review). The Cochrane Library (3).

Long, Norman, ed.

1989 Encounters at the interface: a perspective on social discontinuities in rural development. Wageningen: Agricultural University.


Marriott, McKim

1976 Hindu Transactions: Diversity Without Dualism. In Transaction and meaning: directions in the anthropology of exchange and symbolic behavior. 1 edition. B. Kapferer,
Mavalankar, Dileep, Kranti Vora, and Bharati Sharma

Mayer, Adrian C.

NHSRC, National Health Systems Resource Centre

Nordfeldt, Cecilie, and Sidsel Roalkvam

NRHM GoR, (National Rural Health Mission) DoMHFW, Government of Rajasthan
2010 स्वस्थ गाँव की ओर ... ग्राम एवं स्वच्छता समिति के लिए पुस्तिका [Svasth gāv kī or.. grām svāsthyā ev sacchatā samiti ke lie pustikā] M.H.F.W.D. NRHM, ed. Rajasthan: NRHM.

NRHM GoR, National Rural Health Mission Medical, Health & Family Welfare Department Government of Rajasthan

Ong, Aihwa

Ortner, Sherry
2001 SPECIFYING AGENCY The Comaroffs and Their Critics. Interventions 3(1):76-84.

Ortner, Sherry B.

—

—
Patel, Tulsi


Raheja, Gloria Goodwin


Raheja, Gloria Goodwin, and Ann Grodzins Gold


Redfield, Peter


Scott, James C.


Scott, Kerry, and Shobhit Shanker

2010 Tying their hands? Institutional obstacles to the success of the ASHA community health worker programme in rural North India. AIDS Care 22:1606 - 1612.

Singh, Mani Shekhar, and Aditya Bharadwa


Snell, Rupert


Snodgrass, Jeffrey G.


Stewart, Alex


Stoller, Paul


Tarlo, Emma


Tsing, Anna Lowenhaupt

Unnithan-Kumar, Maya, ed.


Van Hollen, Cecilia


Vatuk, Sylvia


Vike, Halvard, et al.


von Benda, Beckmann, et al.


Walley, John, et al.


Werner, David

1977  The Village Health Worker - Lackey or Liberator? In International Hospital Federation Congress Sessions on Health Auxiliaries and the Health Team Tokyo, Japan.

WHO


Wikan, Unni

7 Appendix

List of Named Mentioned Informants (Pseudonyms)

Villagers of Chotipur:

My host household

Ammâji Sharma: Anya's mother-in-law

Anya Sharma: ASHA-Sahyogini of Chotipur. Lives in a joint household with her son Sajan, her sister Kanya, Āmmajî, Bāūjî, Tej, Kanyas's two boys and occasionally her husband, Ashok, who lives and work in a temple. The main character and key informant in the thesis.

Ashok Sharma: Anya's husband. Mainly lived and worked in a popular Hanumanjî temple, some hours' drive from Chotipur.


Kanya Sharma: Anya's younger sister and sister-in-law. Housewife. Wage-worker in NREGA.

Nishok Sharma: Sarita's husband. Factory employee.

Sajan Sharma: Anya's son, aged 6 years.

Sarita Sharma: Anya's youngest sister-in-law. Live in the same house as Anya, but has a separate room and run her household separately with her one boy and husband. Housewife and wage-worker in NREGA and farming.

Tej Sharma: Kanya's husband and Anya’s devar (HyB). Working as a freelance (uncertified) electrician.

The Remaining

Lakshmi Bairva (SC): Young bahû of Chotipur, a one-year old son. Inserted IUD at family camp in Sitapur on her own. Later had to removed it due to health torments. Housewife.


Mira Sharma: Cook lunch at Chotipur government school. The married woman of Chotipur's Janmangal-couple. Has two adolescent children, one daughter and one son.
Pradeep Sharma: Close relative of Anya's husband's family. High school teacher in history, farmer and hobby-pandit (astrology, read hands, fortunes and set up marriage astrology). Visible, engaged village member, central person in Chotipur.

Rekha Sharma: Young bahū of Chotipur. Appeared in the IUD-story as one of women who inserted IUD at the mobile camp in July. Housewife.

Tanupa Bairva: Mother-in-law of Lakshmi Bairva.

Uma Bairva: Bahū of Chotipur. Appeared in the IUD-story as she inserted IUD at the mobile camp in July. Housewife.


Frontline Health workers:

The other ASHAs

Kavita Meena (ST): ASHA-Sahyogini in Bhakpur.

Madhu Saini (OBC): ASHA-Sahyogini in Gholpur.

Ramita Jangir: ASHA-Sahyogini in Bajipur.

Sunita Balai (SC): ASHA-Sahyogini in Kishpur

Vamita Meena (ST): ASHA-Sahyogini in Indoli

Medically trained personnel, other DoMHFW and DoWCD workers:

Nidhi Meena (ST) ("Nidhi-Madam"): The Auxiliary Nurse Midwife (ANM) and administrative head of health of the Bahjipur Sub-Centre area, including 6 villages; Bajipur, Chotipur, Indoli, Kishpur, Bhakpur and Gholpur. Also supervised the six ASHA-Sahyogini's of these villages.

Hetal Meena: The ANM of neighboring Sub-Centre in Dabbli.

Marsha: ANM posted at Dhargar PHC. Part of the mobile IUD-camp coming to Bajipur sub-centre in June and July

Dr. Rajul: Medical Officer and head of Dhargarh PHC and sector.
Sunanda Bairva (SC): New, young ANM posted on temporary NRHM-contract at Bajipur sub-Centre during the summer 2010. Her first job, directly from nursing collage.

Yashi-madam: Lady Supervisor (LS) in DoWCD, superior to ASHA-Sahyogini and anganwadi-workers of her sector. Positioned at level in the DoWCD corresponding to the MO's level in DoMHFW.
GLOSSARY

Accha/acchi: Good. Can also mean “alright” or “ok” as a reply in a conversation.

Anganwadi: 1) Courtyard, playground, 2) Pre-school centre, crèche

Angrezi: English, Foreign

Asha (aśa): hope, expectation. See list of abbreviation for meaning of the acronym “ASHA”

Bahū: a kinship term meaning wife. or daughter-in-law. Bahū is rarely used about “own wife”, (Vatuk 1969). It is usually prefixed by “our” bahū or husband’s name: Ashok ki bahū (Ashok’s wife). Though it translates wife, daughter-in-law might be a more meaningful translation when one speak of the affinal-kinrelation between the married woman to her parents-in-law and classificatory in-law relations to the entire village [sasurāl].

Bacche dahni: uterus (“child carrier”)

Bairva: So-called “untouchable” caste group, with official status as Scheduled Caste (SC)

Būra Nazar [Najar]: bad (unwittingly) glance, comparable to the anthropological term “the evil eye”.

Chula (cūḷā): Cooking heart. Made out of clay, fuelled by burning logs, twigs, dung-cakes (dried “cakes” of cow or buffalo faeces) and the household’s garbage.

Dai (dāi): local, lay midwife, or “traditional birth attendant”, without formal medical education. Traditionally learned from experience, though some have received a little training, due to recurring training courses by the state.

Gāv: Village

Ghee (Ghī): Clarified butter. Common in Indian cooking.

Gram Panchyat: Gram means rural, see “Panchyat”
Guđ: Jaggery: unrefined, concentrated product of sugarcane juice or date palm juice without separation of the molasses and crystals. Usually golden brown to dark brown chunks. Locally considered good and strengthening to health. Claimed by local people to be source of iron.

Janani Suraksha Yojana: safe motherhood scheme

Jāti: 1) “Of the same kind” (race, genus, species, nationality, tribe, community, family, lineage) 2) Position fixed by birth; community or caste group 3) Birth 4) Commonly translated to caste

-jē: 1) respect marker 2) (polite) yes

Kaccā: raw, impermanent, unbaked

Kharāb: Bad

Moṭi: 1) Fat, chubby 2) Healthy, rich

Nasbandī: Sterilisation, “closing the tubes”

Nazar: Glance, look

Naukri: Salaried job

Meena (Miṇā): Tribal group found throughout Rajasthan. Classified as “Scheduled Tribe”. Contested if previous desperados or protectors. Own traditions of costumes, known for own styles of custom singing, dancing etc.

Panchayat: Village level council under the PRI, literally translates “the council of five” (Panch=Five, Yat=Council)

Pīhar: Woman’s natal village/home, her father’s ancestral village, “of the father”, “father’s house”

Prasad: “Gift from God”. Blessed food. Often sweets, or food sacrificed to a Hindu God during puja, and later distributed among kin and neighbours.

Purdah (pardā): Literally meaning curtain. Term that describes custom of veiling and avoidance for women.

Roṭī: Unfermented flat bread made of flour, water and salt, usually griddle baked on open flames or at a gas oven. A main staple food of Rajasthan. Can also refer generally to “food” or “daily meal” (cf. “the daily bread”). Typically made of whole grain wheat flour (aṭa), but flour of other grains can be used. Also called chapatti.

Rupees: Indian currency. At time of fieldwork 1 NOK was about 7 rupees

Saini: Vegetable farmers, gardeners. Lower caste, official status as Other Backward Classes. (OBC)

Saṛī: Traditional Indian women’s costume, with blouse, petty coat and a 2-6 m fabric draped elegantly around body and head.

Sahayogini: associate, contributor

Sarkar, Sarkari: Government

Sarpanch: Literally translates “head of five”, head of the panchyat, village level political leader under the PRI

XXIII
Sasurāl: Conjugal village/home, literally “father-in-law’s village”
Sindūr: traditionally red powder (also in liquid form) applied at the beginning or completely along the parting-line of a woman’s hair (mang), and denotes that a woman is married
Thasil: Sub-district administrational unit under PRI. Parallel the units called “blocks” in the health system administration
Tīka karan: Vaccination

Tīka/Tike: 1) Vaccine 2) Mark on skin, same word used for scars from vaccines and religious act of giving someone a coloured spot (tike) on the forehead

Yashoda: 1) Female name. Name of Lord Krishna’s foster mother, a popular Hindu God. 2) Name of a new non-technical, non-medically trained institutional based frontline health worker under a NIPI-programme, envisaged to be a friendly face at the hospital, to take care of the mother and infant and help initiate breastfeeding

Kinship / Relative terms

Ammā: 1) Mother 2) Grandmother
Bahū: Wife or daughter-in-law
Cācā: Paternal uncle, father’s younger brother (FyB)
Cācī: Wife of father’s younger brother (FyBW)
Devar: Husband’s younger brother (HyB)
Devrani: Husband’s younger brother’s Wife (WHyB)
Jēṭh: Husband’s older brother (HeB)
Jēṭhani: Wife of husband’s older brother (HeBW)
Mātā: Mother
Nand: Husband’s sister (HZ)
Sās: Mother-in-law
Sāsur: Father-in-law
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XXIV
The black arrows represent the lines I worked along, with the heaviest focus towards lowest levels and bold-emphasised facilities.
## Table 2.0. Education of reproductive couples of Bajipur Sub-Centre area

<table>
<thead>
<tr>
<th>Name of Village</th>
<th>Illiterate</th>
<th>1-5th class</th>
<th>6-8th class</th>
<th>9-12th class</th>
<th>college</th>
<th>Total no. of couples</th>
<th>Total village population per 1.4.2009</th>
<th>per 2001 Census</th>
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</thead>
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<tr>
<td>Bajipur</td>
<td>53</td>
<td>13</td>
<td>35</td>
<td>28</td>
<td>16</td>
<td>46</td>
<td>8</td>
<td>150</td>
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<tr>
<td>Bandoli</td>
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<td>7</td>
<td>13</td>
<td>20</td>
<td>18</td>
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<td>22</td>
<td>32</td>
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<td>43</td>
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<td>16</td>
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<td>16</td>
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<tr>
<td>Total</td>
<td>246</td>
<td>76</td>
<td>126</td>
<td>127</td>
<td>142</td>
<td>133</td>
<td>172</td>
<td>191</td>
</tr>
</tbody>
</table>

Source: “Eligible couple survey 2009-2010” for Bajipur Sub-Centre Area.

The “eligible couples” are defined as the married (reproductive) couples between 15 and 45 years.

According to the survey there are 113 reproductive couples in Chotipur:

- Of these the married men 7 (6,1%) are illiterate, 23 has 1-5th class, 22 6-8th class, 33 has 9-12th class and 28 (24,78%) have college education.

- Of the wives /married women, 20 (17,7%) are illiterate, 23 has 1-5th class, 24 6-8th class, 35 has 9-12th class and 11 (9,7%) have college education.

According to the survey, the Bajipur sub-centre area has 739 married/reproductive age couples:

- Of these the men (husbands) 76 (10,3%) are illiterate, 133 has 1-5th class, 133 6-8th class, 201 has 9-12th class and 196 (26,5%) have college education

- Of the wives/women, 246 (33%) are illiterate, 126 has 1-5th class, 142 6-8th class, 172 has 9-12th class and 53 (7,2%) have college education.
## Progress Reports Up to Month of JAN. 10 (Provisional)

<table>
<thead>
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<th>S.No.</th>
<th>Activities</th>
<th>Block SITAPUR</th>
<th>CHC SITAPUR</th>
<th>CHC UMR1</th>
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<td>Target</td>
<td>Ach.</td>
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<td>2867</td>
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<td>CC Users</td>
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<td>Desi Ghee</td>
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<td>N.A</td>
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</table>
Monthly Progress Report (Block) Example 1

The example are from the condensed forms used at District and Block levels to summarise the progress of the whole block up to a certain month of the year. The example show the up to January achievement vis-à-vis the full yearly targets (of April 2009-March 2010), both in numbers and percentage, thus two months remain to achieve full targets. The administrative health system year starts April 1st and end March 31st.

Similar, but more detailed forms (with place and workers names in Hindi scripture) were used at the Block level monthly meetings. (see Example 2, next page) The BCMO and MOs in charge of the PHCs present (sitting at chairs) were handed out the progress reports in the meetings, but they were not handed out to the ANMs and other field staff that sat on the floor. On these more detailed forms the targets were divided on the sectors/PHCs of Sitapur of which each of the sector/PHC-targets were again divided on the sub-centres and onto each accountable individual ANM in charge of a sub-centre area. On the detailed form, the names of the individual ANMs in charge, such as Nidhi Meena for Bajipur sub-centre, Hetal Meena for Dabbli sub-centre and their five other ANM-colleagues were listed under Dhargarh PHC, each with their personal targets and achievement of their yearly targets until that meeting’ month of the year. (See map of structural levels)

The targets in the example are given in number of individual persons (in order of appearance) getting sterilised, women inserting IUDs, women using Oral contraceptive Pills (OP users), numbers of registered condom using couples (CC users), women registering their pregnancy by a health worker (ANC-registration), number of injections set of the various vaccines (BCG, OPV 3, DPT 3, measles, TT), number of women giving birth at hospital, families receiving the JSY-money, and lastly number of BPL-families receiving the five kilos of clarified butter (desi ghee) after giving birth.
<table>
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Monthly Progress Report (Block) Example 2:

The detailed, sub-centre specified report, which was used in the monthly block meetings. The example is only the first of several pages, and details the name of the different ANMs and their individual yearly targets of cases for the same indicator as in Example 1, vis-à-vis their number of achieved cases. Also in percent. The Example is from March 2010, and most targets of the year 2009-2010, are thus achieved.

MY HOST FAMILY’S HOUSE
ASHAs' various sheets for reporting in the DoMHFW

The Monthly Voucher

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<tr>
<th>No.</th>
<th>Description</th>
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<tr>
<td>1</td>
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<td>Adolescent girls counselling meeting</td>
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</tr>
<tr>
<td>3</td>
<td>Village health and sanitation meeting</td>
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</tr>
<tr>
<td>4</td>
<td>P.H.C. meeting of Ashas</td>
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<td>PHC meeting of Ashas of Ashas</td>
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Total: 450

For the regular ASHA-incentives: MCHN-day (Rs 150), VHSC-meeting (Rs 100), Adolescent girls counselling meeting (Rs 100) and Sector-PHC-meeting (Rs 100)
The ASHA’s Monthly Report (for the DoMHFW) Sheet

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<th>Item</th>
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<th>Action Taken APRIL 2023</th>
<th>Notes</th>
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<tr>
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<td>Name of pregnant woman</td>
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<td>Name of index case</td>
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<td>Number of still born</td>
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<td>6.</td>
<td>Number of death</td>
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<td>7.</td>
<td>Number of alive babies</td>
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<td>Number of weighing</td>
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22) Number of house who made late both in poor and rich

ASHA Supervisor's Signature: ____________________________

Date: ____________________________
For ASHA to fill out about the state of the new mother and child for 6 scheduled home visits: at day 0, 3, 7, 14, 28 and 42 after birth. Sheet lists various questions that ASHA should ask and conditions to check regarding mother, child, and also “suggestions” of care of the mother and child, breastfeeding and family planning.
The Mother Child Health and Nutrition day (MCHN-day)
Commonly referred to as *tika karaṇ*, “Vaccination day”, by villagers and health workers; it is a monthly village health day-arena for many events and services. The ANM arrive to the AWC to give routine childhood vaccines and tetanus for pregnant women, as well as pregnancy check-ups, iron-folic-tablets and “counsel” couples for family planning. ANM take random blood tests to check for Malaria occurrence and other various chores during the year in relation to different health campaigns (such as bi-yearly Vitamin A campaign). The Village Health and Sanitation Committee (VHSC)-meeting should be held during the MCHN-day. Organising the MCHN-day is a joint responsibility between ANM, AHSA-Sahyogini and Anganwadi-worker. The ASHA mobilises the village, collects infants, children and pregnant/mothers from their homes. The ANM give the medical health services. The anganwadi-worker distribute nutrition supplement and weigh children. All three workers have individual record to document the services given that day.

Janani Suraksha Yojana: The safe motherhood scheme
The Janani Suraksha Yojana (JSY) [safe motherhood scheme] was launched in 2005 under the NRHM, to promote institutional delivery among the poor pregnant women with the objective of reducing maternal and neo-natal mortality (GoI N.d.). The JSY-Scheme included a monetary incentives of 1800 rupees to give birth in hospital, or 1400 for families who came together with ASHA\(^{93}\). If families brought ASHA, she was given the 400 marked for transportation and 100 rupees for accompanying them. The 100 rupees also remunerated three counselling-visits during pregnancy. The current policy with the strong monetary incentives put pressure on the inadequate infrastructure and over-worked staff; Sitapur CHC was often crowded and birthing women queued in the labour wards and outside the labour room with two labour tables available.

\(^{93}\) In urban Rajasthan: 1000 with ASHA and 1200 without. Though JSY is a nation-wide programme, the amounts vary between states,
The ASHA-Sahyogini: Integrated and distinct work tasks between the Health- and ICDS-department
The ASHA’s task which is distinct for the ICDS-department is the daily house-visits and to attend a separate monthly sector-meetings, joined by the anganwadi-workers and lead by the LS. For all of the work for the ICDS, the ASHA-Sahyoginis are paid 5000 fixed monthly rupees, there are no paid-for-performance incentives. Their distinctive health-department-task was to accompany hospital deliveries. The home-counselling, meetings and MCHN-day overlapped for the responsibilities to both departments. The ICDS-department is namely an integrated programme with the health department. For instance, the pregnancy- and PNC- counselling (for health department) counted as part of their outreach-anganwadi work (for the ICDS). The ASHAs are supposed to sign the attendance register, before doing ten household visits in the village every day, except Sundays. In a whole year they are allowed to take about twenty days of personal leave.