Unveiling Perceptions of Rural People regarding NRHM in Haryana: A Social Category-Centric Sociological Approach

Dr. Kuldeep Singh Associate Professor, Govt. P.G College Sector-1, Panchkula

Dr. Brijesh Sharma Lecturer, GSSS, Panipat

Prof. Prem Kumar Professor, Dept. of Sociology, K.U. Kurukshetra

Abstract

The present study was conducted in the rural areas of Haryana to explore the perceptions of rural people regarding National Rural Health Mission (NRHM) services, with a particular focus on variations across social categories. The study employed exploratory and descriptive research design methods, selecting 528 respondents through a Multi-Stage Stratified Random Sampling Method. While no significant disparities were observed in perceptions of doctor and staff behavior in government hospitals, the majority of respondents expressed satisfaction, indicating a generally positive view of healthcare providers. Notably, Scheduled Caste (SC) respondents reported complete satisfaction with NRHM services, contrasting with Other Backward Class (OBC) and General Category respondents, who were either partially satisfied or dissatisfied, implying greater benefits for SC individuals. SC respondents also exhibited noticeable lifestyle changes post-NRHM, suggesting a more significant impact on this group. Although the null hypothesis of no relationship between social category and motivation for utilizing NRHM services was supported, most respondents still reported feeling motivated by these services. Furthermore, SC respondents demonstrated greater awareness of various healthcare aspects, including ASHA workers, 24x7 health services, and government schemes like the Ladli Yojna, compared to General and OBC respondents. However, a significant portion of respondents did not benefit from any government health program, underscoring the need for broader outreach and education efforts.

Keywords: Income, Education, NRHM, Health, SCs, OBCs, General Category, Occupation

Introduction

Health is a complex and multifaceted concept that has been defined in various ways over the years. The World Health Organization (WHO) defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (**WHO, 1946; Kuhn & Rieger, 2017**). Maintaining physical health entails ensuring your body operates optimally both internally and externally. This encompasses the proper functioning of vital organs such as the heart, lungs, stomach, and brain. Consuming nutritious foods, engaging in regular physical activity, and prioritizing adequate rest are crucial for sustaining good health. Physical wellness serves as a shield against illnesses and aids in managing weight effectively. Consistent physical exercise enhances cardiovascular health, fortifies muscles, and boosts overall vitality. Adopting a well-rounded diet rich in fruits, vegetables, lean proteins, and whole grains supplies the body with essential nutrients, while limiting intake of unhealthy foods high in sugar and saturated fats. Emotional and psychological wellness pertains to an individual's innermost feelings and mental state. This encompasses coping with stress, nurturing healthy relationships, and processing emotions in a constructive manner. Prioritizing mental well-being is paramount for overall contentment and correlates with reduced risk of chronic health conditions, enhanced physical well-being, and increased life satisfaction. According to the American Psychological Association (APA), mental well-being is characterized by "a state of mind characterized by emotional well-being, good behavioral adjustment, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stresses of life." (**APA, 2019**). Therefore, social health revolves around the quality of one's interpersonal connections. Establishing robust support systems, nurturing positive relationships, and actively participating in social engagements are pivotal for overall wellness. Practicing empathy, fostering effective communication, and actively engaging in community initiatives are effective strategies for enhancing social health.

In summary, health encompasses providing individuals with the opportunity to lead fulfilling and productive lives. Attaining good health necessitates maintaining a well-rounded lifestyle, which entails regular exercise, nutritious eating habits, sufficient sleep, and effective

stress management. Fostering health involves considering the holistic perspective—recognizing the interconnectedness of physical, mental, and social well-being. By prioritizing these aspects and making informed health-conscious decisions, individuals can optimize their well-being and experience fulfillment.

The National Health Policy (NHP) 2017, issued by the Ministry of Health and Family Welfare, Government of India, provides a comprehensive framework guiding the nation's health priorities and strategies. Central to this policy is the goal of achieving Universal Health Coverage, ensuring accessible and high-quality healthcare services for all citizens, with a focus on marginalized groups. It emphasizes strengthening primary healthcare infrastructure to meet community-level health needs and advocates for Health Systems Strengthening, including enhancing human resources, infrastructure, and healthcare financing to improve service delivery and health outcomes. **(Gupta & Kumari, 2017; Sundararaman, 2017)**.The policy also highlights Health Security and Emergency Preparedness, promotes Wellness and Preventive Healthcare initiatives, and emphasizes Quality of Care standards across healthcare tiers. Collaboration with stakeholders is encouraged to address challenges and strive for equitable, affordable healthcare nationwide. In rural areas, health indicators encompass a wide range of factors influencing population well-being. These indicators include mortality rates, life expectancy, healthcare access, disease burden, environmental conditions, health behaviors, socioeconomic circumstances, mental health, health disparities, health literacy, environmental exposures, medication access, healthcare utilization, and availability of health technology. For instance, infant and maternal mortality rates reflect healthcare effectiveness and maternal care access. **(Annis et al., 2004)** Socioeconomic factors such as poverty and education levels significantly impact healthcare access and outcomes. **(Yusoff, et al., 2021).** Access to clean water and sanitation facilities plays a crucial role in preventing diseases, while mental health indicators indicate the prevalence of mental disorders and access to services in rural communities. **(Annis et al., 2004)**

Review of Literatures: -

Marriott (1955) in their study "Western Medicine in a Village of Northern India" examined the social and cultural obstacles that physicians and the medical profession encounter. The study discovered that the healer's deity-derived spiritual strength was more significant than their technical reputation. The study emphasizes how important human connections are in the medical industry. In a study titled "Medicine and Faith in Rural Rajasthan," **Carstairs (1955)** looked at the villages of Sujarupa and Delwara in the state of Rajasthan. The study discovered that there was a miscommunication between the villagers and the doctors because of their divergent perspectives about etiology theories, treatment methods, and the doctor's position. It stated that there are three ways to get people to accept modern scientific medicine: by educating them about infection and sepsis over time, by better understanding what they expect when they see a doctor, and by introducing new methods that meet their expectations. **Dhillon and Srivastav (1972)** undertook a sociological study titled "How People Perceive Illness and What They Do When They Fall Sick." The study discovered that people perceive disease as an episode, especially in minor cases or when the sufferer is unable to care for themselves. It also demonstrated a greater concern for the health of family members who work, as well as the fact that people's views of sickness drive curative behavior. Except for major and urgent illnesses, there is normally a time lag between recognizing the onset of illness and seeking medical attention. In the early stages of disease, people generally adjust their diets or use home treatments. **Punekar and Golwalkar (1973)** explored the topic of "Rural Change in Maharashtra: An Analytical Study of Change in Six Villages of Konkan." The study discovered that, in rural Maharashtra, there were fewer doctors, nurses, and hospital beds available despite an increase in patients, which led to subpar healthcare facilities. **Matthews (1979)** performed a sociological study "Health and Culture in a South Indian Village." The study sought to comprehend the origins and cures of various diseases, types of healers, maternal and child health, and family planning practices. It discovered that the villagers held their own ideas about the origins of disease, which were not arbitrary superstitions but rather part of a methodical approach. The locals strongly believed in indigenous medical systems such as Ayurvedic, Siddha, and Unani. Despite their poor knowledge of allopathic
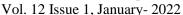
medicine, many villages continued to use it. They also had a strong belief in traditional and spiritual healers, preferring remedies based on the nature of ailment. Traditional healers were recommended for a variety of pediatric and adult disorders. **Simon (1981)** in their study "The Ultimate Resource" identified the elements influencing family planning performance at the primary health care level. The study noted that the frequency of visits by the "change agent" and villagers' views toward family planning had a direct impact on the Primary Health Centre's performance. **Doyal (1983)** conducted a study titled "Women's Health and the Sexual Division of Labor: A Case Study of the Women's Health Movement in Britain." and noted a scarcity of "feminist epidemiology" regarding the social production of women's health. The study found a relationship between women's health and their paid and unpaid work roles. It concluded that there is a complex relationship between work and health, with paid work being associated with better health and well-being among women. However, it also emphasized the hazards of paid work, such as the impact of the social organization of work, toxic substances, and other workplace hazards that women face. **Mosley and Chen (1984)** conducted a study titled "An Analytical Framework for the Study of Child Survival in Developing Countries," identifying factors such as maternal influences, environmental pollution, nutrient deficiency, injury, and personal illness control. It found that maternal factors and environmental pollution affect both genders equally, while nutrient deficiency, personal illness control, and injury may differ by gender. It also noted that the allocation of food and medicine varies by gender. **Khan et al. (1986)** conducted a study titled "Nutrition and Health Practices among Rural Women: A Case Study in Uttar Pradesh" The study revealed poor nutritional status among women during pregnancy, which led to adverse outcomes. It identified poverty and the burden of labor due to family responsibilities as the primary causes of malnutrition. To address such issues, the National Health Policy of the Government of India set forth key objectives to be achieved by the year 2000. **Singh et al. (1987)** conducted a research titled "The Myth of the Healthy Tribal" on tribal people in two rural blocks of Ranchi district, Jharkhand. The study examined health and maternity in terms of scientifically correct knowledge, attitudes, and behaviors about physical and mental health, family planning and child care, personal hygiene, and environmental sanitation. The health of tribal people was
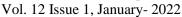
assessed using factors such as living conditions, eating habits, women's marriage age, fertility and family size, immunization, malnutrition, infant mortality, and disability. It discovered common difficulties in the research area, such as unsanitary living conditions, overcrowding, poor contraceptive use, a high frequency of sickness, and pervasive beliefs and misinformation about physical and mental health, diet and nutrition, and family planning and child care. **Sinha and Rajeshwari's (1993)** study on the "Social structure and utilization of health care facilities in rural Haryana" revealed that higher castes accessed healthcare facilities more frequently and experienced a lower incidence of diseases than lower castes. **Patel et al. (1996)** study on the " Reproductive Health Problems of Women in Rural Uttar Pradesh: Observations from a Community Survey" highlighted the necessity for gender-sensitive approaches to address the reproductive health needs of both men and women. The study, conducted in Agra district, found that many rural women experienced reproductive health issues but sought treatment infrequently. According to ANMs (Auxiliary Nurse Midwives), common reasons for seeking treatment included discharge, menstrual irregularities, infertility, prolapse, abortion, and infertility-related prolapsed problems. **Patel and Capoor's (1996)** study, "Listening and Talking with Women on Health", aimed to understand women's health issues within the context of social and cultural conditions in India. It highlighted that many Indian women suffer silently due to these factors. The study sought to create a forum where women and young girls could openly discuss their health concerns and gain knowledge. Treatment for gynecological illnesses was provided in a supportive and non-threatening environment. The study also found out that women often lacked the courage and confidence to voice their health problems openly. **Bajaj's (1999)** study, "Knowledge and Utilization of Maternal and Child Health Services in Delhi slums," revealed low utilization of public healthcare services for maternal and child health. The primary reason identified was a lack of awareness among residents. Most deliveries occurred at home with assistance from traditional birth attendants (dais). Additionally, immunization rates in these areas fell below the universal target. It concluded that there was a critical need for increased awareness among women in the slums about the free maternal and child health services offered by the government to improve utilization rates. **Ansari's (2005)** work on "The Spatial Organization of

Healthcare Facilities in Haryana," revealed several key findings. The construction of Primary Health Centers was slow between 1991 and 2001, with only 19 new centers, 6 Sub-Health Centers, and one district hospital added. There were significant disparities in the distribution of healthcare facilities among different districts, with Jind having the lowest number of facilities per capita and Bhiwani the highest. The study highlighted that the distribution of healthcare facilities, including hospitals, doctors, beds, and medical assistants, was uneven across the four divisions of Haryana. Interestingly, the degree of urbanization did not significantly affect the availability of healthcare facilities, according to the findings. It emphasized the need for better planning and allocation of healthcare resources to ensure more equitable access to healthcare services across Haryana. **Ashtekar (2008),** in "The National Rural Health Mission: A Stocktaking," highlighted several challenges faced by the National Rural Health Mission (NRHM). The study found delays and inefficiencies in the utilization of NRHM funds in certain states, as well as a lack of comprehensive understanding of some schemes. Additionally, poor working conditions and low salaries deter doctors from working in rural centres, contributing to many nurse positions remaining vacant. Despite some increase in institutional deliveries, it concluded that the NRHM had limited impact on the health system in its initial three years. The study emphasized the potential of Accredited Social Health Activists (ASHAs) within the NRHM but underscored the need for improvement in their training, accreditation processes, and payment mechanisms. The research pointed to systemic issues hindering the effective implementation and outcomes of the NRHM in improving rural healthcare delivery. **Das and Srivastava (2009)** in their study titled "Maternal Health Care Utilization among the Tribals of Madhya Pradesh: Constraints, Prospects, and Ramifications for Well-Being," focused on antenatal care and delivery care, drawing from the Reproductive and Child Health project conducted from 2002 to 2004. It revealed that Muslims exhibited better adherence to antenatal care compared to other groups, highlighting significant disparities in utilization between rural and urban women. Additionally, the study found that the Scheduled Tribe (ST) population showed lower awareness and utilization of antenatal care compared to non-ST populations. Furthermore, it identified 13 districts that were inadequately equipped to provide satisfactory delivery care services. **Kumar and Khan (2010)** conducted a

study on the health status of women in India, emphasizing maternal mortality as a significant concern. They reported a maternal mortality rate of 450 deaths per 100,000 live births in India, with variations across states. Socio-economic conditions and access to healthcare services were identified as key factors influencing maternal mortality rates among different states. Malnutrition was highlighted as another critical issue affecting Indian women, contributing to obstructed deliveries. The study also noted that the unequal treatment of women compared to men was a contributing factor to the poor health outcomes observed among Indian women. **Gohel et al. (2015)** conducted a study titled "Problems Faced by ASHA Workers for Malarial Services Under NVBDCP: A Cross-Sectional Study," which revealed several key findings. The majority of ASHA workers had less than one year of work experience in sub-centre villages with poor performance. Approximately 13.79% of ASHA workers faced challenges in receiving incentives for their work, primarily due to remote locations and high population densities in their service areas. The study identified a vacancy for an ASHA worker position in one of the low-performing sub-centre villages under study.

Methodology: -

The present study aims to unveil perceptions of rural people regarding NRHM services in Haryana, particularly focusing on variations across social categories, in six villages of Haryana. These villages were selected through a Multi-Stage Stratified Random Sampling Method. The study employed exploratory and descriptive research design methods. A total of 528 respondents were selected for the study, with 10% sampled from each caste in each village. Of these, 206 respondents were drawn from three villages with higher literacy rates: Basai (74), Ramgarh (91), and Adhohai (41). The remaining 322 respondents came from Dabwali (137), Harolli (119), and Pema Khera (66), which are characterized by lower literacy rates. Primary data were collected through interviews and observations, whereas secondary data were obtained from government reports, census records, village documents, and other relevant literature.

Perceptions of rural people regarding National Rural Health Mission Services -

Table No. 1
Responses on Doctor and Staff Behavior Across Respondent Categories

Category	Are you satisfied with the behavior of dr. and other working staff in your Govt health center?			
	Totally	Sometimes	Never	Total
General	81(E-85.8) 57.0%	54(E-52.2) 38.0%	7(E-4.0)4.9%	142(100%)
Other Backward Class	106(E-105.1) 60.9%	65(E-63.9) 37.4%	3(E-4.9)1.7%	174(100%)
Schedule Caste	132(E-128.1) 62.3%	75(E-77.9) 35.4%	5(E-6.0)2.4%	212(100%)
Total	319(E-319.0) 60.4%	194(E-194.0) 36.7%	15(E-15.0) 2.8%	528(100%)
Calculated value	Df	Asymp. Sig. (2-sided)	At 0.05	Null hypothesis
5.397	4	.448	9.49	Accepted

The table above shows that the chi-square value (χ^2= 5.397, df=4, p>0.05) is not significant. As a result, there is no significant difference between the respondents' knowledge of the level of satisfaction with the behaviour of doctors and working staff at the government health facility and their category. As a result, the null hypothesis is accepted, indicating that the difference between theory and observation is not substantial. However, the study's findings show that the majority of respondents are satisfied with the behaviour of the doctors and personnel.

Table No. 2
Respondents' Categories and Their Satisfaction Levels with NRHM Services

Category	Are you satisfied with NRHM Services?			
	Totally	Sometimes	Not Satisfied	Total
General	89(E-94.7) 62.7%	**48(E-37.9) 33.8%**	5(E-9.4)3.5%	142(100%)
Other Backward Class	96(E-116.0) 55.2%	**50(E-46.5) 28.7%**	**28(E-11.5) 16.1%**	174(100%)
Schedule Caste	**167(E-141.3) 78.8%**	43(E-56.6) 20.3%	2(E-14.1).9%	212(100%)
Total	352(E-352.0) 66.7%	141(E-141.0) 26.7%	35(E-35.0) 6.6%	528(100%)
Calculated value	Df	Asymp. Sig. (2-sided)	At 0.05	Null hypothesis
50.583	4	.000	9.49	Rejected

The table shows that the resulting chi-square value is significant at the 0.05 level of significance, as the calculated value (50.583) exceeds the table value for 4 degrees of freedom (9.49) at the 0.05 level of significance. Thus, the null hypothesis is rejected, and there is a substantial difference across respondent categories in terms of satisfaction with government services,

specifically NRHM. According to the study, respondents from the Scheduled Caste category were completely satisfied with the program, whereas respondents from other backward and general categories were only moderately or not satisfied. It may be inferred that Scheduled Caste people have profited more from the program than those from other castes, namely General Category and Other Backward Classes Respondents.

Table No. 3

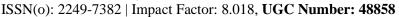### Perceived Lifestyle Changes Across Categories Post-NRHM Implementation

Category	Responses about the change in lifestyle after execution of NRHM Services		
	Yes	No	Total
General	95(E-95.2)66.9%	**47(E-46.8)33.1%**	142(100%)
Other Backward Class	100(E-116.7)57.5%	**74(E-57.3)42.5%**	174(100%)
Schedule Caste	**159(E-142.1)75.0%**	53(E-69.9)25.0%	212(100%)
Total	354(E-354.0)57.0%	174(E-174.0)33.0%	528(100%)
Calculated value	Df	Asymp. Sig. (2-sided)	At 0.05	Null hypothesis
13.291	2	.001	5.99	Rejected

The table indicates that the chi-square value ($\chi^2 = 13.291$, df = 2, p < 0.05) is significant, suggesting a notable difference among respondents from different caste categories regarding their perception of the change in lifestyle after the implementation of NRHM services. Consequently, the null hypothesis is rejected, leading to the conclusion that the respondents' perception of the change in lifestyle post-NRHM service execution is significant. The results indicate that respondents from the Scheduled Caste category were more inclined to agree that they experienced a change in lifestyle, while others were more likely to disagree. This suggests that Scheduled Caste individuals are more likely to have benefited from these facilities compared to others.

Table No. 4
Respondents' Categories and Their Motivations for Utilizing NRHM Services

Category	Responses of Respondents about NRHM motivating them to utilize the Services		Total
	Yes	Don't know	
General	141(E-140.1)99.3%	1(E-1.9)0.7%	142(100%)
Other Backward Class	169(E-171.7)97.1%	5(E-2.3)2.9%	174(100%)
Schedule Caste	211(E-209.2)%	1(E-2.8)0.5%	212(100%)
Total	521(98.67%)	7(100%)	528(1.33%)
Calculated Value	Df	Asymp. Sig. (2-sided)	At 0.05	Null Hypothesis
4.788	2	.091	5.99	Accepted

The results from the table above indicate that the calculated chi-square value ($\chi^2 = 4.788$, with 2 degrees of freedom, and a p-value greater than 0.05) is not statistically significant. This suggests that there is no significant relationship between the respondents' category and their perception regarding NRHM Services motivating them to utilize these services. Consequently, the null hypothesis is supported, and the difference between prediction and observation is considered statistically insignificant. However, a majority of respondents reported that NRHM motivates them to utilize the health services of NRHM.

Table No. 5
Respondents' Categories and Their Responses on ANM/ASHA Workers Advising Private Hospital Services

Category	Responses on ANM/ASHA worker advising them about private hospital services		Total
	Yes	No	
General	26(E-40.3)18.3%	**116(E-101.7)81.7%**	142(100%)
Other Backward Class	**70(E-49.4)40.2%**	104(E-124.6)59.8%	174(100%)
Schedule Caste	54(E-60.2)25.5%	**158(E-151.8)74.5%**	212(100%)
Total	150(E-150.0)28.4%	378(E-378.0)71.6%	528(100%)
Calculated value	Df	Asymp. Sig. (2-sided)	At 0.05	Null hypothesis
19.975	2	.000	5.99	Rejected

The table above indicates that the calculated chi-square value ($\chi^2 = 19.975$), with 2 degrees of freedom, and a p-value less than 0.05, exceeds the critical value of chi-square for 2 degrees of freedom at the 0.05 level of significance (5.99). This suggests a statistically significant difference between the categories of the respondents and their experiences of being advised by government health workers to seek private hospital services. Consequently, the null hypothesis is rejected. It can be concluded that, compared to the general and Scheduled Caste respondents, Other Backward Class respondents reported receiving advice from ANM/ASHA workers to seek private medical treatment.

Table No .6
Respondents' Categories and Their Opinions on NRHM Scheme Upgrading Health Services

Category	Responses about health services upgrade after NRHM execution			
	Yes	No	Don't know	Total
General	89(E-100.3)62.7%	1(E-1.3)0.7%	**52(E-40.3)36.6%**	142(100%)
Other Backward Class	113(E-122.9)64.9%	**2(E-1.6)1.1%**	**59(E-49.7)33.9%**	174(100%)
Schedule Caste	**171(E-149.8)%**	**2(E-2.0)0.9%**	39(E-60.2)18.4%	212(100%)
Total	373(100%)	5(100%)	150(100%)	528(100%)
Calculated Value	Df	Asymp. Sig. (2-sided)	At 0.05	Null Hypothesis
17.955	4	.001	9.49	Rejected

The above table illustrates that the chi-square value (χ^2 = calculated value, df = degree of freedom, $p < 0.05$) is significant. The null hypothesis is rejected, indicating a significant difference between the theoretical expectation and the observed data. The result of the study shows that most respondents believe that health services have improved after the implementation of NRHM. Notably, only respondents from the Scheduled Caste category demonstrated statistical significance in favor of this improvement.

Table No. 7
Respondents' Categories and Their Perceptions of 24x7 Health Services and the 102 Service

Category	Responses of Respondents			
	Yes	No	Not going in Govt hospital	Total
General	59(E-79.6) 41.5%	**80(E-61.6) 56.3%**	**3(E-.8)2.1%**	142(100%)
Other Backward Class	82(E-97.5) 47.1%	**92(E-75.5) 52.9%**	0(E-1.0).0%	174(100%)
Schedule Caste	**155(E-118.8) 73.1%**	57(E-91.9) 26.9%	0(E-1.2).0%	212(100%)
Total	296(E-296.0) 56.1%	229(E-229.0) 43.4%	3(E-3.0).6%	528(100%)
Calculated value	Df	Asymp. Sig. (2-sided)	At 0.05	Null hypothesis
49.373	4	.000	9.49	Rejected

The calculated chi-square value of 49.373 is found to be statistically significant, as it exceeds the table value of 9.49 at a 0.05 level of significance. This indicates a significant difference in the knowledge of the 24x7 health service and the 102 ambulance service among the respondents. The findings suggest that only respondents from the Scheduled Caste category have knowledge of these services, whereas those from the General and Other Backward Class categories do not. It can therefore be concluded that only Scheduled Caste respondents are aware of the 24x7 health service and the 102 ambulance service.

Table No. 8
Respondents' Categories and Awareness of Primary Health Kits at Home for Child Illnesses

Category	Responses of the respondents about the availability of primary health kit in their home when their child is sick.		
	Yes	No	Total
General	**73(E-62.9)51.4%**	69(E-79.1)48.6%	142(100%)
Other Backward Class	**81(E-77.1)46.6%**	93(E-96.9)53.4%	174(100%)
Schedule Caste	80(E-94.0)37.7%	**132(E-118.0)62.3%**	212(100%)
Total	234(E-234.0)44.3%	294(E-294.0)55.7%	528(100%)

Calculated value	df	Asymp. Sig. (2-sided)	At 0.05	Null hypothesis
6.967	2	.031	5.99	Rejected

The examination of the data indicates that the calculated chi-square value (6.967) exceeds the table value (5.99) at a significance level of 0.05, with 2 degrees of freedom. This result suggests a significant difference in the knowledge of having necessary tablets or a primary health kit in

the house when a child is ill among the respondents' categories. The study reveals that General and Other Backward Class respondents possess knowledge of having a primary health kit, while Scheduled Caste respondents do not. It can be concluded that only Scheduled Caste individuals lack a primary health kit in their homes, while the rest of the respondents have one.

Table No. 9
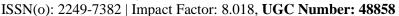**Respondents' Categories and Their Knowledge about the ASHA Workers**

Category	Do you know about ASHA workers?		Total
	Yes	No	Total
General	88(E-99.5)62.0%	**54(E-42.5)38.0%**	142(100%)
Other Backward Class	110(E-121.9)63.2%	**64(E-52.1)36.8%**	174(100%)
Schedule Caste	**172(E-148.6)81.1%**	40(E-63.4)18.9%	212(100%)
Total	370(E-37.0)70.1%	158(E-158.0) 29.9%	528(100%)
Calculated value	df	Asymp. Sig. (2-sided)	At 0.05	Null hypothesis
20.708	2	.000	5.99	Rejected

The calculated chi-square value of 20.708 exceeds the table value of 5.99 for df 2 at a significance level of 0.05. This indicates a significant difference between the categories of the respondents and their knowledge about the ASHA worker. Consequently, the null hypothesis is rejected, confirming a notable deviation between the expected and observed frequencies, though not uniformly across all responses. The study findings suggest that respondents from the Scheduled Caste category have a statistically significant level of knowledge about the ASHA worker, while other categories of respondents i.e. General and Other Backward Classes Category do not.

Table No. 10
Respondents' Categories and Regularity of ASHA/ANM Worker Check-ups for Infants

Category	Did the ASHA/ANM worker check-up regularly for infants?				
	Forever	Sometimes	Never	N.A.	Total
General	84(E-94.9)59.2%	3(E-3.8)2.1%	**1(E-0.8)0.7%**	**54(E-42.5)38%**	142(100%)
Other Backward Class	107(E-116.3)61.5%	2(E-4.6)1.1%	**1(E-1.0)0.6%**	**64(E-52.1)36.8%**	174(100%)
Schedule Caste	**162(E-141.7)76.4%**	**9(E-5.6)4.2%**	1(E-1.2)0.5%	40(E-63.4)18.9%	212(100%)
Total	353(100%)	14(100%)	3(100%)	158(100%)	528(100%)
Calculated Value	Df	Asymp. Sig. (2-sided)		At 0.05	Null Hypothesis
23.165	6	.001		12.59	Rejected

The calculated chi-square value of 20.708 is found to be greater than the table value of 12.59 at a significance level of 0.05 and with the appropriate degrees of freedom. This result demonstrates a significant difference in the regularity of ASHA/ANM workers for infant check-ups among the categories of respondents. The study results indicate that the relationship between the categories of respondents and the regularity of ASHA/ANM workers for infant check-ups is significant.

Table No. 11
Respondents' Categories and Advice Given by ASHA Workers during Pregnancy

Category	Did the ASHA worker give any advice during pregnancy?				
	Forever	Sometimes	Never	N.A.	Total
General	84(E-94.4)59.2%	3(E-3.5)2.1%	1(E-1.6)0.7%	**54(E-42.5)38%**	142(100%)
Other Backward Class	108(E-115.7)62.1%	0(E-4.3)0%	**2(E-2.0)1.1%**	**64(E-52.1)36.8%**	174(100%)
Schedule Caste	**159(E-140.9)75%**	**10(E-5.2)4.7%**	**3(E-2.4)1.4%**	40(E-63.4)18.9%	212(100%)
Total	351(100%)	13(100%)	6(100%)	158(100%)	528(100%)
Calculated Value	Df	Asymp. Sig. (2-sided)		At 0.05	Null Hypothesis
27.592	6	.000		12.59	Rejected

The rejection of the null hypothesis implies that the categories of respondents have a significant impact on their experiences with receiving advice from an ASHA worker during pregnancy. This finding suggests that there is a difference in the experiences of the respondents based on their category, with some groups more likely to have received advice from an ASHA worker during pregnancy than others. Understanding these differences can help in tailoring healthcare interventions and support services to better meet the needs of specific demographic groups.

Table No. 12
Respondents' Categories and Health Workers Providing Knowledge About Health Programs

Category	Has any health workers provided you with knowledge about health programs/planning?		Total
	Yes	No	Total
General	80(E-96.3)56.3%	**62(E-45.7)43.7%**	142(100%)
Other Backward Class	107(E-118.0)61.5%	**67(E-56.0)38.5%**	174(100%)
Schedule Caste	**171(E-143.7)80.7%**	41(E-68.3)19.3%	212(100%)
Total	358(E-358.0)67.8%	170(E-170.0)32.2%	528(100%)
Calculated value	df	Asymp. Sig. (2-sided)	At 0.05	Null hypothesis
27.776	2	.000	5.99	Rejected

The calculated chi-square value of 27.776, which exceeds the table value of 5.99 at a significance level of 0.05 with 2 degrees of freedom, indicates a significant difference between the categories of respondents and their awareness of whether any health worker was given knowledge about a health program or planning. The results indicate that those belonging to the Scheduled Caste category are knowledgeable about any health worker being given knowledge about a health program, while others are not. Consequently, it can be concluded that Scheduled Caste individuals are more aware of this knowledge compared to other castes.

Table No. 13
Respondents' Categories and Knowledge Regarding the Reproductive Child Health Program

Category	Do you know about the RCH program?		Total
	Yes	No	Total
General	41(E-64.0)28.9%	**101(E-78.0)71.1%**	142(100%)
Other Backward Class	65(E-78.4)37.4%	**109(E-95.6)62.6%**	174(100%)
Schedule Caste	**132(E-95.6)62.3%**	80(E-116.4)37.7%	212(100%)
Total	238(E-238.0)45.1%	290(E-290.0) 54.9%	528(100%)
Calculated value	df	Asymp. Sig. (2-sided)	At 0.05	Null hypothesis
44.544	2	.000	5.99	Rejected

The calculated chi-square value being greater than the table value of 5.99 for a 5% level of significance and df 2 indicates a significant difference between the categories of respondents and their knowledge about the Reproductive Child Health (RCH) program. This rejection of the null hypothesis suggests that deviations between the expected and observed frequencies were notable, although not consistent across all responses. The observation that only respondents from the Scheduled Caste category answered positively suggests that only individuals from this category possess knowledge about the RCH program compared to other castes.

Table No. 14
Respondents' Categories and Their Knowledge Regarding the Ladli Yojna Program

Category	Do you know about Ladli Yojna?		
	Yes	No	Total
General	26(E-48.7) 18.3%	**116(E-93.3) 81.7%**	142(100%)
Other Backward Class	49(E-59.6) 28.2%	**125(E-114.4) 71.8%**	174(100%)
Schedule Caste	**106(E-72.7) 50%**	106(E-139.3) 50%	212(100%)
Total	181(34.3%)	347(65.7%)	528(100%)
Calculated value	df	Asymp. Sig. (2-sided)	At 0.05	Null hypothesis
42.222	2	.000	5.99	Rejected

The chi-square test results indicate a significant difference in knowledge about Ladli Yojna among the categories of respondents. The calculated chi-square value of 42.222, exceeding the table value of 5.99 at a significance level of 0.05, supports this conclusion. Ladli Yojna is a government scheme aimed at promoting the welfare of girl children, providing financial assistance and incentives for their education and well-being. It appears that respondents in the Scheduled Caste category are more knowledgeable about Ladli Yojna compared to those in the General and Other Backward Class categories.

Table No. 15
Respondents' Categories and Their Benefits from Government Programs

Category	Do you receive any Govt benefit from any program/plan?		Total
	Yes	No	
General	3(E-36.0)2.1%	**139(E-106.0)97.7%**	142(100%)
Other Backward Class	34(E-44.2)19.5%	**140(E-129.8)80.5%**	174(100%)
Schedule Caste	**97(E-53.8)45.8%**	115(E-158.2)54.2%	212(100%)
Total	134(E-134.0) 25.4%	394(E-394.0)74.6%	528(100%)
Calculated Value	Df	Asymp. Sig. (2-sided)	At 0.05	Null hypothesis
90.197	2	.000	5.99	Rejected

The examination of the data supports the conclusion that there is a significant difference between the categories of respondents and their knowledge about the benefits of government programs. The rejection of the null hypothesis suggests that the deviation between expected and observed frequencies is high, although not consistent across all responses. Specifically, it is apparent that Scheduled Caste respondents have more knowledge about the benefits of government programs, while the General and Other Backward Class categories have less knowledge in this area. Additionally, the data shows that the majority of respondents, 74.6 percent, did not benefit from any government health program.

Conclusion:

Despite the lack of statistical significance between the categories of respondents and their perceptions regarding the behavior of doctors and working staff in government hospitals, the majority of respondents expressed satisfaction with the behavior of both doctors and other staff. These findings suggest a generally positive perception of healthcare providers among the surveyed population. The study showed that respondents from the Scheduled Caste category were fully satisfied with the program, whereas Other Backward Class and General Category respondents were only partially satisfied or not satisfied with NRHM. It can be concluded that Scheduled Caste individuals have benefited more from the program compared to those from other castes, i.e., General Category and Other Backward Classes respondents. The results indicate that

respondents from the Scheduled Caste category were more inclined to agree that they experienced a change in lifestyle after the execution of NRHM services, while others were more likely to disagree. This suggests that Scheduled Caste individuals are more likely to have benefited from these facilities compared to others. There is no significant relationship between the respondents' category and their perception of NRHM services motivating them to utilize these services. Consequently, the null hypothesis is supported, indicating that the difference between prediction and observation is statistically insignificant. However, the majority of respondents reported that NRHM motivates them to utilize its health services. There is a statistically significant difference between the categories of respondents and their experiences of being advised by government health workers to seek private hospital services. Consequently, the null hypothesis is rejected. It can be concluded that, compared to General and Scheduled Caste respondents, Other Backward Class respondents reported more frequently receiving advice from ANM/ASHA workers to seek private medical treatment. The results of the study show that most respondents believe health services have improved after the implementation of NRHM. Notably, only respondents from the Scheduled Caste category demonstrated statistical significance in favor of this improvement.

The findings suggest that only respondents from the Scheduled Caste category have knowledge of these services, whereas those from the General and Other Backward Class categories do not. It can therefore be concluded that only Scheduled Caste respondents are aware of the 24x7 health service and the 102ambulance service, while others are not. This result indicates a significant difference in the knowledge of having necessary tablets or a primary health kit at home when a child is ill among the different respondent categories. Consequently, the null hypothesis is rejected, confirming a notable deviation between the expected and observed frequencies. The study reveals that General and Other Backward Class respondents possess knowledge of having a primary health kit, while Scheduled Caste respondents do not. It can be concluded that only Scheduled Caste individuals lack a primary health kit in their homes, whereas the rest of the respondents have one. The study findings suggest that respondents from the Scheduled Caste category have a statistically significant level of knowledge about the ASHA worker, while respondents from the General and Other Backward Classes categories do not.

Hence, the null hypothesis is rejected, indicating a substantial discrepancy between the expected and observed frequencies, though not for all responses. The study results also indicate that the relationship between the categories of respondents and the regularity of ASHA/ANM worker visits for infant check-ups is significant. These findings suggest that there is a difference in the experiences of respondents based on their category, with some groups more likely to have received advice from an ASHA worker during pregnancy than others. Understanding these differences can help in tailoring healthcare interventions and support services to better meet the needs of specific demographic groups. The results indicate that those belonging to the Scheduled Caste category are more knowledgeable about health workers providing information on health programs, while others are not. Consequently, it can be concluded that Scheduled Caste individuals, are more aware of this information compared to other castes.

There is a significant difference between the categories of respondents and their knowledge about the Reproductive Child Health (RCH) program. This rejection of the null hypothesis suggests notable deviations between the expected and observed frequencies, although not consistent across all responses. The observation that only respondents from the Scheduled Caste category answered positively indicates that individuals from this category possess more knowledge about the RCH program compared to other castes. Ladli Yojna is a government scheme aimed at promoting the welfare of girl children by providing financial assistance and incentives for their education and well-being. It appears that respondents in the Scheduled Caste category are more knowledgeable about Ladli Yojna compared to those in the General and Other Backward Class categories. Specifically, Scheduled Caste respondents have more knowledge about the benefits of government programs, while respondents in the General and Other Backward Class categories have less knowledge in this area. Additionally, the data shows that the majority of respondents, 74.6 percent, did not benefit from any government health program.

References:

1. **American Psychological Association.** (2019). *What is mental health?* Retrieved from https://www.apa.org/topics/mental-health

2. **Annis, R. C., Racher, F., & Beattie, M.** (2004). *Rural community health and well-being: A guide to action.* Rural Development Institute.

3. **Ashtekar, S.** (2008). The national rural health mission: A stocktaking. *Economic and Political Weekly,* 23-26.

4. **Ansari, S. H.** (2005). Spatial organization of health care facilities in Haryana. *National Geographical Journal of India, 51*(3-4), 51-62.

5. **Bajaj, J.** (1999). Knowledge and utilisation of maternal and child health services in Delhi slums. *Journal of Family Welfare, 45,* 44-52.

6. **Carstairs, G. M.** (1955). Medicine and faith in rural Rajasthan. In *Health, culture and community* (pp. 107-134).

7. **Das, A., & Srivastava, H. C.** (2009). Maternal health care utilization among the tribals of Madhya Pradesh: Constraints, prospects, and ramification for well-being. *Man in India, 89*(3), 239-250.

8. **Dhillon, H. S., & Srivastava, V. P.** (1986). How people perceive illness and what they do when they fall sick. *Research in Health Practices,* 287-300.

9. **Doyal, L.** (1983). Women, health and the sexual division of labour: A case study of the women's health movement in Britain. *Critical Social Policy, 3*(7), 21-32.

10. **Gohel, A., Makwana, N., Rathod, M., Sarkar, A., & Parmar, D.** (2015). Problems faced by ASHA workers for malarial services under NVBDCP: A cross-sectional study. *International Journal of Research in Medical Sciences, 3*(12), 3510-3513.

11. **Gupta, R. K., & Kumari, R.** (2017). National health policy 2017: An overview. *JK Science, 19*(3), 135-136.

12. **Khan, M. E., Dastidar, S. G., & Singh, R.** (1986). Nutrition and health practices among rural women: A case-study of Uttar Pradesh, India. *Journal of Family Welfare, 33*(1), 3-20.

International Journal of Research in Economics & Social Sciences

Email:- editorijrim@gmail.com, http://www.euroasiapub.org

(An open access scholarly, peer-reviewed, interdisciplinary, monthly, and fully refereed journal.)

270

13. **Kumar, A., & Khan, M. E.** (2010). Health status of women in India: Evidences from National Family Health Survey-3 (2005-06) and future outlook. *Research and Practice in Social Sciences, 6*(2), 1-21.

14. **Kühn, S., & Rieger, U. M.** (2017). Health is a state of complete physical, mental and social well-being and not merely absence of disease or infirmity. *Surgery for Obesity and Related Diseases, 13*(5), 887.

15. **Marriott, M.** (1987). Western medicine in a village of northern India. In *Health, culture and community* (pp. 239-268). Russell Sage Foundation.

16. **Matthews, C. M. E.** (1979). *Health and culture in a South Indian village.* Sterling. Retrieved from https://cir.nii.ac.jp/crid/1130000794300974336

17. **Mosley, W. H., & Chen, L. C.** (1984). An analytical framework for the study of child survival in developing countries. *Population and Development Review, 10,* 25-45.

18. **Patel, P., & Capoor, I.** (1996). Listening and talking with women on health. *Social Change, 26*(3-4), 125-136.

19. **Punekar, S. D., & Golwalkar, A. R.** (1973). *Rural change in Maharashtra: An analytical study of change in six villages in Konkan.* Popular Prakashan. Retrieved from https://cir.nii.ac.jp/crid/1130282272644949504

20. **Singh, A. K., Sinha, S. K., Singh, S. N., Jayaswal, M., & Jabbi, M. K.** (1987). The myth of the healthy tribal. *Social Change, 17*(1), 3-23.

21. **Sundararaman, T.** (2017). National health policy 2017: A cautious welcome. *Indian Journal of Medical Ethics, 2*(2), 69-71.

22. **World Health Organization.** (1946). *Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June 1946.* Retrieved March 21, 2017, from https://apps.who.int/gb/bd/pdf/bd47/en/constitution-en.pdf

23. **Yusoff, N. S., Rashid, M. F., & Abd Halim, N.** (2021). The indicators of socioeconomic well-being of rural community. *Management, 6*(26), 253-261.

International Journal of Research in Economics & Social Sciences

Email:- editorijrim@gmail.com, http://www.euroasiapub.org

(An open access scholarly, peer-reviewed, interdisciplinary, monthly, and fully refereed journal.)

271