Article: Understanding Cultural Sensitivity and Competence in Health Care: Reflections on Antenatal Care from Rural Lucknow

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Source: Explorations, ISS e-journal, Vol. 6 (1), April 2022, pp. 130-146

Published by: Indian Sociological Society
Understanding Cultural Sensitivity and Competence in Health Care: Reflections on Antenatal Care from Rural Lucknow

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Abstract

Time and again, the idea of cultural diversity has been stressed in healthcare delivery and management. While dealing with community health it becomes imperative to know about local culture and perception i.e. people’s knowledge and beliefs about health, disease and treatment, as it determines their behaviour related to it. The extent to which the relevance of these factors is recognised by healthcare workers and incorporated into practice determines the level of trust of the community in the institutional healthcare system resulting in positive health outcomes. Antenatal care is one such domain where the cultural sensitivity of healthcare professionals plays an important role as it directly influences the status of maternal and neonatal health. With the high rural population in India having a stronghold of traditions over it, the relevance of cultural sensitivity increases manifold.

Keywords: Cultural sensitivity, Cultural competence, Antenatal care, Maternal health, Public health

Introduction

Health is an important development concern as it entails in itself issues of social justice, equality and human rights besides primarily taking into account the complete physical, mental and social well-being of an individual. Not only is good health a basic right of every individual but appropriate, equality-based and dignified delivery of healthcare services is a requisite for enhancing the belief of the community in modern medical science.

The absence of good health is not only marked by its clinical manifestation i.e. disease rather ‘illness’ as well, the latter being a cultural construction of ill-health. Kleinman, Eisenberg & Good (1978) assert that the modern medical profession has in due course become ‘discordant with lay expectations’, wherein a higher focus of
medical practitioners remains on identifying the disease and its management, and less attention on managing illness. They further state that such an approach to health management reduces the faith of people in modern medical science or its health benefits, on the contrary, resulting in larger dependence on ‘popular’ and ‘folk’ sectors of healthcare. Thus, increased empathetic involvement of health service providers is essential to up-scale the outreach of the benefits of modern healthcare services even in communities and regions which are less privileged and/or those which have a higher inclination towards their traditional culture (Foster, 1962).

The Healthcare system predominantly involves both, the service providers and the stakeholders at large i.e. the community. However, while dealing with health it cannot be said that the onus of positive health outcomes lies solely on either the healthcare provider or on the care-seeker (as there is an array of socio-cultural, economic, psychological and other factors working) but, as noted earlier, definitely a more enhanced and empathetic involvement of the ‘provider’ eases the way for the ‘receiver’ or care-seeker, especially where the force of traditions is high.

Even in communities where modern healthcare practice has made in roads still the level at which they should be able to bring a positive change has not been possible. Foster (1962) has pointed out that any kind of technological advancement, be it in the field of health, does not at the outset ensure rapid and open acceptance in all instances. It is so because local culture and traditions, social institutions and various psychological factors bear an impact on health, and there is no dearth of evidence suggesting the same (Paul, 1955; Foster, 1962; Foster & Anderson, 1978; Napier et al., 2014). However, how a community at large is engaged in healthcare seeking is also determined by the factors e.g. what are the available healthcare resources at their disposal, who is the ‘provider’, and what kind of health needs of the people are being fulfilled etc.

Informal healthcare providers like shaman, medicine men, healers etc. enjoy local trust, draw respect and faith of the community, and have a wider acceptance by venturing into the social space of the individuals, than an ‘outsider’ physician treating patients in a formal setting like government or private hospital or clinic. Communities having a stronghold of traditional culture find it less easy to incorporate practices which do not hold an explicit sanction of their local customs or traditions as they remain divergent from their traditional knowledge. The most detrimental impact however can be observed in the form of non-compliance or lesser inclination towards the use of modern health services which affects a positive health outcome. Thus, to increase the level of acceptance for institutional services
in such communities the role of institutional healthcare workers becomes even more important and sensitive.

Antenatal care (ANC) in tradition-bound communities is one area where a greater reliance on traditional care can be witnessed (Manocha et al. 1992; Bloom et al., 1999; Chapman, 2003; Nelms & Gorski, 2006; Zamawe, 2013; Rout, 2016; Shewamene, Dune & Smith, 2017; Mawoza, Nhachi & Magwali, 2019), even when a complete absence of exposure to modern medicine cannot be claimed in them. In such a situation an effective reach of modern medical practice in the community depends upon healthcare professionals, i.e. to what extent the specialist understands the local culture and whether it seems to them essential or not to incorporate local perception for better treatment and health management, and how well they are able to deal with the perceptions of people regarding illness and disease. It is so because local beliefs and practices if not taken into account or disregarded are sure to create a lack of seriousness and belief from the side of care-seekers, ultimately affecting the health.

The present paper in its content tries to explore the significance of cultural sensitivity and competence among institutional healthcare workers (clinicians) with regard to antenatal health. The paper is based on intensive fieldwork done in four villages of Bakshi ka Talab (BKT) development block of district Lucknow, on antenatal care-seeking behaviour. In-depth interviews in the form of detailed case history were conducted with recently delivered women (RDW) currently pregnant women (CPW) and some special cases of miscarriage/intra-uterine death, and of physician advised medical termination of pregnancy. Healthcare workers in public health institutions present in the selected area and grassroots healthcare workers were also interviewed. Besides, Family members of some selected women (mother-in-law and husband), local traditional birth attendants (TBAs) and supernatural healers have also interacted. The observation was used for a better understanding of the phenomenon.

**Cultural diversity, sensitivity and cultural competence in healthcare**

Understanding of culture, cultural diversity, ideas of cultural relativism and cultural pluralism has been the focus of anthropological enquiry, which anthropologists have vehemently vouched for. These ideas extend a very important perspective that cultural plurality is an essential feature of human groups which brings forth its diversity. Each human group has its own specific culture which is valid in itself with no inherent superiority or inferiority of status. Having a dominance of tradition and customs in no way reduces the possibility of any culture or community not
having the best available healthcare resources at their disposal.

The idea of cultural diversity with inherent validity has a huge practical value. While dealing with human problems of practical nature an enhanced role of technological and scientific advancement has been increasingly noted. Traditional communities, as noted earlier, experience a challenge while adopting and adapting to fast paced scientific and technological changes. Health is one domain which has immense potential for marked improvement through scientific advancements in the field of medicine and health care. However, to what extent these advancements have been able to enter into the lives of those having a traditional culture has constantly attracted the attention of social scientists in general and anthropologists in particular.

The domain of health and healthcare has over time shown to have a dominating influence on social and cultural factors across the world. Terms like ‘social determinants’ (WHO, 2020) have been widely used while taking into account the socio-cultural context of health. However, what becomes essential is to know whether at the grass-root level social and cultural factors, cultural diversity and sensitivity are taken into consideration and brought into actual practice or not by the ‘providers’ in the delivery of healthcare services.

The need for cultural competence in healthcare has been time and again felt and reiterated in the field of medical practice, education and research. Cultural competence in health care according to Cross et al. (1989) takes into account the development and delivery of health care services ‘…in a culturally appropriate way in order to meet the needs of culturally and racially diverse groups. The word ‘competence’ as used by them implies ‘…having the capacity to function within the context of culturally-integrated patterns of human behaviour as defined by the group’. The cultural competence strategy takes into account that the cultural diversity of patients should be given due credence and be dealt with empathy so that any inequality or underutilization of health care services may be mitigated and better patient care and health outcomes may be achieved. It is an ability of health care professionals to develop a set of skills to interact with and provide effective high-quality care to patients from diverse cultural backgrounds, and to locate those socio-cultural factors that might affect the process of patient care and health management (Carrillo et al. 1999; Betancourt et al. 2010).

The relevance of cultural competence and cultural sensitivity in providing patient-centric care remains high. It is so because when cultural beliefs and value systems of the people are taken into consideration then their belief in the formal healthcare
system gets strengthened (Srivastava, 2019). However, Kleinman et al. (1978) assert that ‘…biomedicine has increasingly banished the illness experience as a legitimate object of clinical concern’. They assert that unless cultural meanings of the people, their idea about illness and disease will not be taken into account by clinicians or healthcare workers while treating, till that time belief in and adherence of patients/people with ‘formal’ treatment will continue to lack vigour. It will be ‘less satisfactory and less clinically effective’ to the people as the medical logic will not be able to find its way into their understanding and thus compliance with treatment will reduce resulting in a less effective outcome of the treatment (Kleinman et al. 1978). Thus, in order to improve the level of trust and interactions between the patients and healthcare workers and to improve healthcare utilization, it is essential that cultural sensitivity and competency should be effectively brought into practice (Thackrah & Thompson, 2013).

Recalling the Forgotten

As stated at the onset, there is an impressive ream of deliberations on the structural constraints in higher education in India. They highlight the delimiting impact of the academic bureaucracy, and stultified institutional and intellectual growth among other things. It aids in understanding and unreflective, and to a great extent anti-teacher and anti-student bureaucracy, and hence non-regenerative social science. The bureaucratic authorities, institutional structure, and governing bodies are key actors and driving factors. In such a scheme, we can easily decipher an allegedly disembodied category of the teacher as an unproductive or incompetent scholar. Also, there is a narrative of victimhood in which teachers are victims of the market, state, and bureaucracy and the students are victims of a bad system and bad teachers, as it were. It is, however, erroneous to mistake the pawns, the teachers and students, as docile bodies.

Likewise, there is a strong liturgy of lament about the practice of sociology in the region of South Asia. Emphasis is placed on the decline in the quality and standard in sociological research, teaching and learning. A glorified notion of ‘rigour’ underpins the two other attributes, quality and standard. Paradoxically, there has been a contemporary call for pluralising sociology, without a concrete plan or exemplars on ‘how to pluralise’. It thus is a mere hobby horse in intellectual deliberations detached from the practitioners, teachers and learners. There are many ways of doing sociology, intellectually as well as emotionally, vocationally as well as professionally, experientially as well as textually. This is where it is imperative to juxtapose the ‘diagnostic deliberations’ with ‘pedagogical pursuits’. In addition
to comprehending the issues of structural impediments, arguably, it is imperative to explore the micro-issues involved in teaching and learning. After all, sociological focus on inequalities out-there (social structure) cannot be separated from that on inequalities in-here (practices in the institutes of higher education). This divide between looking at self and the world is certainly as much a bottleneck as is the obsession with ‘buzzwords’⁴. This simple idea may not persuade the disciplinary orthodoxy, and hence the preponderance of perpetual divide between self and the other plagues the sociological attention to any issue, question, and idea on the anvil of sociological analyses.

Thinking of pedagogy in the time of pandemic requires steering clear of the dominant modes and means of analysis, and returning to the reasons why scholars resist the invitation to become pedagogues. This need not amount to falling back on the famous ‘call for indigenisation’. Much water has flown over the call for indigenisation. But behind such a call there was a significant intellectual-polemical stimulus that ought to be retrieved. One such insightful observation is about the ‘captive mind’ (Alatas, 1972) that was aimed at revealing the intellectual laziness of those who seldom question the content and methods of knowledge transaction. The calling out of the captive mind also aimed at incorporating the local-contextual social thoughts in the curricular and pedagogic practices of teaching and thus responded to ‘academic dependency’ (Alatas, 1993). This was not to debunk theories, which emerged in the European context; this was however to debunk the uncritical emulation of European theories. These issues, of epistemological significance, are crucial for a context-sensitive disciplinary scholarship (research, curriculum, knowledge-production and dissemination).

In this light, the backdrop of the pandemic compels for a rethinking of the course curriculum and pedagogy. Perhaps it has been much easier to talk about these and other such issues in a manner of intellectual deliberation than performing it through a curriculum, let alone pedagogy. The task becomes much more challenging when scepticism about the engagement with the contextual particularities is expressed through the phrase of ‘methodological nationalism’, an intellectual apprehension that sociology of particularities will be a compromise on the ‘universal-cosmopolitan’ characteristics of the discipline. It takes the notion of indigenous with a pinch of salt to suggest that it is a discursive product loaded with a colonial legacy, orientalist approach, and idealism of nation-building in post-independent countries ⁵. The students along with teachers spontaneously resort to the local/contextual while engaging with the textual, in a pedagogical plan to render
teaching and learning into a context-sensitive endeavour. A life-threatening situation of pandemic makes this endeavour even more like an existential necessity. And hence, the following section elucidates a possible phenomenology of pedagogic pursuits in the context of the pandemic. It is not merely about online education, instead, it is about how playfully teachers and students alter the given.

**Pregnancy and the local rationale for antenatal care**

In the selected area pregnancy is believed to be a special state and a highly vulnerable phase in a woman’s life. It is believed that proper care should be taken during this phase to avoid any complications. However, there remain some who believe that pregnancy becomes a special state requiring attention only when some health issue arises. Another commonly held belief in the area of pregnancy is that even though attention and care are required to avoid any complications still it is not a disease or a sick state as no matter how much care is taken each expectant woman faces some or the other problem at some or the other point of time in pregnancy because of associated vulnerability.

Any problem during pregnancy is either identified broadly as a physical problem or a supernatural affliction e.g. god’s fury, bad dreams, evil eye, spellbound air (*shaitani-saaya*), or any supernatural misery caused by an adversary etc. Accident cases are also resigned to supernatural causes on most occasions even if resorting to medical care. In the normal course, in order to avoid any adverse situation both medical and supernatural care are sought as a preventive measure.

Risks, threats and dangerous signs associated with pregnancy are not overlooked but which problem or condition is considered to be a risk or a danger sign is uniquely defined in the area which on several occasions is different from the medical perspective e.g. haemorrhage is one important locally identified danger sign but largely explained with a supernatural logic. Treatment sought by locals could either be only supernatural i.e. visiting a *naut* (indigenous/supernatural healer), or a combination of supernatural and medical care depending on how at the individual/household level the problem is interpreted. In very few instances the treatment sought is limited solely to medical care.

Local knowledge on pregnancy-related risks or danger signs is cumulative as it is based on traditional beliefs and practices passed down over generations as well as understanding gained from exposure to modern medical practices (over the years) focussing on institutional care at grassroots level, due to the role of the state. However, in the selected area the biggest source of information on danger signs or
risks or even general antenatal care is still a person’s family and informal social network and only secondarily any healthcare worker. It is here that traditional knowledge gains an edge.

Treatment or care sought for any problem depends upon the nature of the problem as understood. Preventive and curative care both form an important aspect of total pregnancy care in the area. For it, locals take the route of both formal as well as informal domains as what is most desired is the best possible care, according to one’s capacity, for the unborn and the expectant woman. Any compromise on the belief pattern is not preferred. Formal institutional care includes both public and private sectors but predominantly public health institutions. Informal pregnancy care includes folk and supernatural healers, traditional birth attendants (TBAs) along with an individual’s family, extended kinship and social network. As local culture is bound by traditions so the informal domain of care has a dominating influence over how pregnancy will altogether be managed. However, individual experiences, socio-economic conditions, and access to health care resources also influence the course of care-seeking.

Significance of sources of care during pregnancy besides bio-medical care e.g. local healer, herbalist, TBA etc. form the psycho-social support of the people. A supernatural or indigenous healer is able to describe a problem based on day to day events and the nature of social relations of individuals (at the levels of kinship, neighbourhood and community) with an inherent supernatural rationale about the problem being faced. Such explanations are contingent upon various human emotions of jealousy, hatred etc. (Horton, 1967). They treat any problem or provide preventive care during pregnancy by incorporating the total social life of the care-seeker which is mostly absent during a consultation with any medical specialist.

Thus, in the selected area the entire perspective surrounding pregnancy and antenatal care is holistic in nature considering it not only to be a physiological condition but also a bio-psycho-social reality, with a strong influence on the informal domain of care.
Understanding cultural competence in antenatal care: local view vis-à-vis medical view

In the selected development block, over the years, the extent of institutional healthcare services has increased. Over here public as well as private health institutions are present. Major public health institutions include six primary health centres (PHCs), three community health centres (CHCs) and one district combined hospital (DCH). Of them, CHCs and DCH are the main sources for seeking institutional ANC services. At the grassroots level, auxiliary nursing midwives (ANMs), anganwadi workers (AWWs) and accredited social health activists (ASHAs) form the main institutional healthcare force delivering services through anganwadi institutions.

Preference for public health institutions for ANC services remains high in the area as they are free and affordable. Thus, the majority of expectant women have a higher exposure to public health facilities and only on lesser occasions or during some emergency a private facility is sought. However, what is important to note here is that the experience at the former is considered less satisfying. This adds up to the need for the effort for understanding what factors are responsible for it.

Local women assert, as noted earlier, that most of the information regarding pregnancy and its associated care is received from some senior females either their own family or extended social network. However, information on TT vaccination or ANC visits, in general, is given to them by grassroots health care workers. At the village level, village health and nutrition days (VHNDs) are organised in which the expectant women have a chance of interacting with ANM besides ASHA and Anganwadi worker (the latter two being village-based) while making the antenatal visit, but visits made to CHC/DCH and interaction with doctors/physicians are always held in high esteem and given more importance. This remains so even though interactions on most occasions are considered not satisfactory. At local PHCs the level of ANC services is not up to the recommended level.

What is unique about these ANC visits made to CHC/DCH is that they are time-consuming but the time of interaction with the doctor for consultation is very short and impersonal. The doctor prescribes required tests, reports of which after being conducted are taken back to them for consultation. Although exposure to medical procedures has gained a wider acceptance in the area but the kind of interaction between an expectant woman and the doctor is believed to lack a sense of
familiarity and an association which women rather feel with grassroots healthcare workers or TBAs (or any local elderly lady providing such services with experience) or in alternative course with a local supernatural healer/herbalist. The reason for a high level of formality with a doctor is vividly explained by local women.

Except in a few cases, nearly on all visits, ASHA accompanies the expectant women for consultation with the doctor, as a part of her institutional duty. Explanation of the case is sometimes preferably taken from ASHAs by the doctor as the former is able to explain it in common medical terminology. During a consultation session, a doctor takes the medical and obstetric history of the expected woman, does physical examinations as required and asks about any problem or difficulty being faced, as a part of a routine examination. Enquiry about detailed medical and obstetric history as well as any problems being faced is the most important and sensitive aspect of the interaction between expectant women and their physician. It decides the nature of the interaction between the two and also the level of satisfaction of the former.

History taking, as noted in the field, even though an important step is the most affected aspect of the interaction between an expectant woman and the physician. Many local women reported (when details of obstetric history were collected by the researcher) that they skip giving the exact number or details about their past miscarriages or stillbirths which they believe happened due to some supernatural affliction or even fear or bad dreams. It is so because doctors do not buy their explanation and believe that such beliefs are ‘irrational’ and cannot be taken as an explanation for any adverse obstetric condition like miscarriage or stillbirth. On certain occasions, they are rudely dismissed. For locals, their beliefs hold immense value as they find them valid based on their traditional knowledge. Thus, in order to avoid any embarrassment, women prefer skipping the details at times.

Similar is the case with an enquiry about any problem being faced e.g. abdominal cramps or case of mild haemorrhage etc. In these events even though a doctor may be consulted but for some, the first resort is a local naut or a TBA in whom they instil strong faith as these illness episodes are on most occasions believed to have a supernatural etiology. If a consultation is made with a doctor and they ask about the perceived cause from the women e.g. whether any heavy labour done or weight lifted or improper food or medication is taken, many times the latter falter as some remain unclear and those who have a clear idea about the reason remain reticent at times because they believe that they would be verbally reprimanded by the doctor.
and be held responsible for negligence.

On the other hand, reasons for any problem being faced, if explained according to the traditional beliefs of the people (having supernatural explanations) offend the doctors. It is for this reason that doctors prefer an ASHA to be always present with an expectant woman during consultation. Bad dreams, which are locally considered to be an important cause of concern during pregnancy hold nearly no significance to a physician. Thus, any perceived problem related to pregnancy which is explained through a supernatural etiology with no apparent scientific explanation lack relevance to a physician. Locals believe that physicians show less sensitivity and understanding towards their traditional beliefs and cultural knowledge. This does not allow them to have increased familiarity with the latter. What a local healer does is, capture the social relations and life of the individuals, rest it upon psycho-social analysis and provide treatment with the use of some medicinal herbs, talismans, acts etc., which seems a ‘holistic’ treatment for the problem and holds value to locals.

Besides this, detailed institutional counselling on danger signs or general problems at large is not present. It is not so that counselling is not done at all but as the duration of the time of consultation with the doctor is short because of the high patient count so the information received is less and more general in nature. At the grassroots level also no serious initiative is taken to adequately counsel the expectant women beforehand. Thus, the total local view regarding pregnancy and antenatal care which is believed to be holistic is not catered to at public health facilities.

Doctors at the local public health institutions, on the other hand, provide their take on the scenario. They remain of the view that they are invested in providing proper medical attention to the women coming for antenatal visits. They assert that there remains a shortage of time for interaction with these women as the patient count in CHCs and DCH is very high. Giving extensive consultation time to a single patient/woman would affect the services to be given to other antenatal attendees who take out time, especially for these visits and come to the hospital. Their focus remains more on providing essential ANC components to the attending expectant women as making another visit soon is not easy for many. Doctors take a more diagnostic and practical approach where for them attending the expectant women with a proper medical diagnosis and treatment is important.

Interactions with expectant women, according to doctors, shows huge variation as they come across ANC attendees with varying level of educational qualification.
and socio-economic background. However, what remains a common point according to them is that the beliefs of locals are tradition-bound and not based on scientific laws.

For doctors, it is any physiological condition that has to be treated as that could affect the health of both mother and unborn. They do not delve deep into enquiring the social relations as a local healer or a village level dai (TBA) would do. This leads to a lack of proper handling of some important antenatal concerns at the institutional end e.g. dread and anxiety associated with pregnancy. Lack of proper counselling on it leads to a continuous interpretation of it as a supernatural concern for which care and support of local healer and informal social network is sought. Cases of dread or anxiety perceived due to bad dreams are not taken to any physician. It is commonly believed that a physician can do nothing about it, rather in certain instances they are taken to the naut. In this regard, Foster and Anderson (1978) opine that ‘alternate’ forms of medical care fill the gap of psycho-social support during pregnancy in the lack of proper institutional intervention in this domain. Thus, women are not able to take the advantage of modern medical practice during instances when proper institutional counselling could help in alleviating pregnancy-related anxiety. This can be done by clearing all the doubts through scientific explanations empathetically by a physician.

Not only cases of illness episodes but general counselling on diet etc. is also not considered very satisfactory by local women, who believe that doctors mechanically advise about diet and rest during pregnancy. They don’t ask about their family or social conditions, household (or other) responsibilities etc. They just prescribe a diet and if in the next visit the concerned marker/condition (e.g. Hb level) does not improve then they are scolded. Women lament the less empathetic antenatal consultations at public health facilities. They believe that the entire responsibility of their pregnancy health is put over them which is not at all in their hands as they are predominantly financially dependent besides having to bear the brunt of existing patriarchy.

In private health facilities, the patient care is believed to be better than at public health facilities still incorporation of local beliefs and values is lagging in these facilities also, the only difference being that ‘they are listened to’ i.e. women believe that women and their family have a still better chance of communicating their issue (than in public health facilities) but acceptance of their traditional beliefs is less in private facilities as well.

**Conclusion**
Sensitivity for and understanding of local cultural beliefs and practices is the key to providing quality healthcare. Lack of competition among physicians in incorporating cultural specificities of people during treatment not only results in reduced adherence to medical treatment by the latter but also lowers the level of their trust in institutional care.

Cultural competence increases the possibility of having a better understanding of the total condition a patient is in, the factors responsible, and how and to what extent local culture is influencing a patient’s health. This helps in providing patient-centric care to care-seekers and also helps in counteracting any locally held belief against the modern medical practice in a culturally sensitive way which may have the potential of adversely affecting a person’s health.

To be culturally competent, as Betancourt & Green (2010) emphasize, ‘a buy-in is critical’ from clinicians, meaning that only when they believe in the value of local culture and traditions and their impact on quality healthcare then only they will be able to incorporate it in their practice. It becomes essential that clinicians are made to understand ‘emic’ views about health, disease and illness in general and pregnancy in particular in the present case through advanced training so that locals do not attribute lesser weight to the significance of institutional care.
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Acknowledgement

Present paper is an outcome of study conducted as a part of Post-Doctoral research under University Grants Commission (UGC) sanctioned Dr. S. Radhakrishnan Post Doctoral Fellowship for Humanities and Social Sciences, from the dept. of Sociology, Lucknow University. Authors are immensely thankful to UGC for providing financial assistance. They are also thankful to all the respondents who participated in the study.

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