AN ABSTRACT OF THE THESIS OF

Sara Price for the degree of Master of Arts in Applied Anthropology presented on April 25th, 2012

Title: (Re)-Conceiving Birthing Spaces in India: Exploring NGO Promotion of Institutional Delivery in Rajasthan, India

Abstract approved:

Melissa J. Cheyney

ABSTRACT:

In India, globalized flows of bio-medical discourse, practices and technologies are reshaping the field of reproductive healthcare, and the performance of childbirth more specifically. These projects aim to produce institutional delivery rooms that are "safe and modernized" by equating the utilization of westernized, obstetric techniques for managing delivery with better birth outcomes. Yet, these projects often evoke dynamic tensions between the imagined labor rooms NGOs seek to produce and the lived realties of labor in a local context. In this thesis, I examine the ways NGOs market and disseminate state and global discourses around safe, institutional delivers to local communities through a case study of one NGO working in rural southern Rajasthan. Drawing on data from participant observation and in-depth, semi-structured interviews with NGO staff and skilled-birth attendants employed by community health centers, I argue that at the interface of NGO, state, and global relations of power, a commodified discourse in the form of Evidenced-based Delivery (EBD) practices is emerging. This discourse is marketed through a political economy of hope that promotes EBDs as essential for safe delivery. In this system, NGOs function as conduits for transmitting idealized notions of the safe and modern delivery room, and thereby affect a shift in what skilled-birth attendants and communities come to expect from their childbirth experiences -- expectations that I argue are often difficult to meet given current training levels,

limited economic resources, and a diverse set of cultural values around childbirth. My findings indicate that while Evidence-based Delivery practices may improve birth outcomes in some contexts, in the delivery rooms of rural Rajasthan, they are functioning essentially as technologies that capitalize on the political economy of hope by evoking the medical imaginary.

(Re)-Conceiving Birthing Spaces in India: Exploring NGO Promotion of Institutional Delivery in Rajasthan, India

by
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A THESIS

submitted to

Oregon State University

in partial fulfillment of
the requirements for the
degree of

Master of Arts

Presented April 25th, 2012
Commencement June 2012

Master of Arts thesis of Sara Price presented on April 25th, 2012.

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I understand my thesis will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my thesis to any reader upon request.

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Sara Price, Author

ACKNOWLEDGEMENTS

I would like to take this opportunity to express my gratitude and appreciation to my major professor and advisor, Dr. Melissa Cheyney for her support of my graduate studies at Oregon State University, my fieldwork and growth as a scholar. I also wish to thank Dr. Sunil Khanna, the P.I for my study and the other members of my committee for their support and insight with the research and writing process.

The fieldwork that made this project come to fruition would not have been possible without the support of the NGO with whom I worked. Their support, innovation and passion for the women of Rajasthan is commendable and inspiring. I also wish to acknowledge my research assistants and support network in Udaipur. Ian Anand Forber-Pratt, Devashish Mishra, Shivani Gupta, Manvendra Singh and Vikas Bhatt, for your friendship, unwavering support of my scholarship, and my passion for this work, I am eternally grateful.

I would also like to extend my thanks to the Oregon State University Anthropology Department for their financial support of my Master's Degree and for the American Institute of Indian Studies for financing my Hindi education, without which this project would not have been possible.

None of this work would be possible without the unconditional support of my family: Steve, Helen and Molly Price. Your support and love is what drives me to do this work and follow my passion. I would also like to dedicate this work to my grandparents, Millard and Mildred Price and Richard and Sara Taylor.

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LIST OF ACRONYMS

ANM—Auxiliary Nurse Midwife

BHRC—Building Human Resource Capacity

CHC—Community Health Center

EBD—Evidence Based Delivery Practice

FRU—First-Referral Units

IGO—International Governmental Organization

NGO—Non-Governmental Organizations

NT—New Technologies

PHC—Primary Health Centers

RH—Reproductive Healthcare

SBA—Skilled Birth Attendant

SBC—Sub-centers

TBA—Traditional Birth Attendant

UNFPA—United Nations Population Fund

UNICEF—United Nations Children's Fund

WHO—World Health Organization

(Re)-Conceiving Birthing Spaces in India: Exploring NGO Promotion of Institutional Delivery in Rajasthan, India

Chapter 1: Introduction

> *I sit drinking chai with Maya as we prepare for our second day of SBA training. She discuses a major concern: after participating in her training, most SBAs do not use the practices they have learned. I ask her what she thinks prevents SBA trainees from using evidence based delivery practices in their labor rooms. She explains that SBAs should only take the training with RHAT, her NGO. "The government training isn't systematic," she states, "they hardly teach for four or five hours. And practical [training] is basically not monitored so many of the practices won't [be taught at the] government training site." "What about after the training?" I ask, "what do you think are some of the reasons SBAs have a hard time using what they learned here when they go back to their labor room." Maya perks up at this question. "One or two reasons" she replies. "If the thing comes to her mind then she does it, otherwise she leaves it. They learn laziness. If they feel that the old practices are good, because their hands have become accustomed to it [then they use them]. So those not trained keep following the old practices. Those that don't follow [the Evidence Based Delivery practices], we are trying to help. The practices must to be monitored and must be watched to see if people aren't following [them]. Slowly, if practices are monitored, people will start to follow" (Field note and interview excerpt: 09/24/2011).*

In India, globalized flows of bio-medical discourse, practices and technologies are reshaping the field of reproductive healthcare. In my interview with Maya, an NGO employee who trains skilled-birth attendants, she described how her NGO participates in a process of introducing SBAs to specific, obstetric discourses and practices, thus making SBAs distribution sites for a particular discursive product, Evidence-based Delivery practices (EBDs). In the case of maternal and neo-natal health outcomes, NGOs increasingly engage in the distribution of a globalized

rhetoric that equates modernized healthcare spaces and provider-care techniques with safety and improved outcomes, even where there is no evidence in support of this claim. The purpose of this project was to examine the ways in which NGOs play a role in constructing and managing reproductive health care spaces, as they engage in globalized discursive projects that seek to reshape both practitioner and community expectations about reproductive healthcare through the increased utilization of institutional deliveries.

To examine how NGOs engage with globalized projects that promote institutional deliveries, I conducted qualitative research with one NGO based in rural southern Rajasthan. Southern Rajasthan is unique in that, geographically, the population is dispersed over significant distance, and its tribal and schedule cast majorities have traditionally relied on locally trained, traditional birth attendants (TBAs) to conduct deliveries rather than seeking care at institutions. Beginning in the early 1990s, state and global policy started to identify institutional delivery as necessary for improving maternal and neo-natal mortality outcomes, and worked with NGOs to facilitate a transition toward encouraging the use of institutional delivery rooms. The NGO that served as the site for my ethnographic data collection, Research Health and Training in Rajasthan (RHAT) was involved in the dual project of training skilled birth attendants (SBAs) and monitoring their use of Evidence-based Delivery skills within institutional labor room.

Drawing on qualitative and ethnographic data, I argue that NGOs engage in the production and distribution of discursive commodities, like EBDs, as part of a larger project to convert skilled-birth attendants and their clinical spaces into sites for projects of modernity. In an effort to distribute these EBDs, NGOs are able to reify their necessity as brokers uniquely positioned to facilitate global and state directives and policies within their own communities of practice. To contextualize this argument, I will draw on evidence from participant observation and in-depth interviews with trained SBAs and NGO staff who evaluated SBA performance as part of the Building Human Resource Capacity Project (BHRC). Data reveals the

mechanisms by which RHAT markets and distributes EBDs within a political economy of hope (DelVecchio Good 2010), promoting these practices as systematic procedures for ensuring safe deliveries. Ultimately, I argue that this exchange contributes to the construction of medically imagined labor rooms, predicated on state and globally derived discourse that define institutional deliveries as unequivocally safe.

Background:

Overview of Maternal Mortality:

Reproductive health care has historically been a critical social and economic issue with serious direct and indirect costs to the Indian state. Current estimates show India's national maternal mortality rate (MMR) is approximately 250 deaths per 100,000 live births (UNICEF 2010), although regional variation among larger north Indian states likes Rajasthan results in a disproportionately high number of maternal deaths in the region. In Rajasthan, MMR is higher than the national average. Sample Registration System (SRS) reports that for Rajasthan MMR is 388 deaths per 100,000 and IMR is 65 deaths per 1,000, which is higher than the national average of 250 and 55 respectively (UNICEF 2010). Of these maternal and infant deaths, many occur in the immediate post-partum period, or within the 24 hours following delivery. The most current data from between 2001-2003, found that lifetime risk of pregnancy-related death ranged from 1.9% to 2.2%, with maternal death accounting for 29% of all deaths among women of reproductive age (Iyengar 2009, 273). In many instances, these deaths are preventable with appropriate medical monitoring and intervention during the antenatal, labor and post-delivery periods (Iyengar et al. 2009).

Over the last fifty years, both state and international non-governmental organizations (IGOs), have reviewed the prevalence and causes of maternal mortality in India through a series of larger studies: National Family Health Survey (NFHS-III), National Sample Surveys (NSSs), Sample Registration System RHIME) (Vora et al.

2009); these indicate some slow progress in the reduction of MMR. Furthermore, at the national governmental level, pressure from the international non-governmental sector, particularly the United Nations, has manifested in a fragmented combination of programs and initiatives aimed at incentivizing institutional deliveries. In order to address the slow improvement in MMR and IMR, Reproductive and Child Health Scheme (RCH)-II, in conjunction with programs like the Janani Suraksha Yojana (JSY), have set a goal of increasing the quantity and quality of institutional deliveries. This has proved somewhat successful with the number of institutional deliveries increasing from 26% to 39% nationally between 1992 and 2006 (Vora et al. 2009; World Health Organization 2008).

As part of its efforts to improve MMR and IMR globally, the World Health Organization has produced a set of Evidence-based Delivery practices (EBDs), that are based on a systematic review of research, collected mostly from health systems in Africa, which found that adherence to these practices directly improves maternal and infant health outcomes (World Health Organization 1997). These practices are organized into three stages of labor, as well as after delivery care, and include skills for conducting abdominal and pelvic examination, managing all stages of labor, intra-partum care, newborn resuscitation and management of post-natal complications (Ministry of Health and Family Welfare 2010). Table 1 provides a summary of these practices.

Table 1. Evidence Based Delivery Practices (Adapted from: Government of Rajasthan Department of Medical, Health and Family Welfare, Action Research and Training for Health, United Nations Population Fund and United Nations Children's Fund visual aids for NGOs)

First Stage Defined by World Health Organization (2003) as: *Inactive labor, when cervix dilated 0-3 cm and contractions are weak, less than 2 in 10 minutes through Active labor when cervix is 4-10cm dilated*	1. Encourage patient to move during labor. 2. Avoid providing routine enemas and saving of pubic region 3. If labor is conducted at a facility where caesarean section is not available, do not induce or augment labor. Never use IM oxytocin to augment labor. 4. Always monitor labor using a partograph 5. Restrict pelvic examinations to 1x in 4 hours, unless delivery is imminent
Second Stage: Defined by World Health Organization (2003) as: *Cervical dilation of 10 cm or bulging thin perineum and head visible*	6. Encourage upright positions such as sitting or squatting. 7. Avoid routine episiotomy for primigravidas 8. Do not apply abdominal (fundal) pressure to push the baby out. 9. If fetal heart sounds (FHS) are normal, do not rush to complete the 2nd stage. 10. Always wash hands before handling women or newborns.
Third Stage: Defined by World Health Organization (2003) as: *Directly following the birth of the baby and before/during the delivery of placenta*	11. Practice active management of third stage of labor: IM oxytocin injection, controlled cord traction, uterine massage 12. Cut the cord after it stops pulsing (*unless the mother is RH negative or the baby needs resuscitation) 13. Avoid packing the vagina 14. Dry and wrap the baby immediately after birth, cover and place it on the mother's abdomen 15. Avoid routine nasopharyngeal suction (* unless meconium inhalation has occurred or the baby is asphyxiated).
After Delivery	16. Monitor maternal bleeding and vital sings every 15 minutes in the 1st hour, every 1-hour from 1-4 hours and every 4 hours till 24 hours. 17. Initiate breastfeeding as early as possible 18. Wrap the baby and keep close to mother 19. Discharge only after 24-48 hours. If there are any complications, delay discharge until 72 hours.

These practices have been adapted by the Government of Rajasthan's Department of Medical, Health, & Family Welfare, UNFPA and UNICEF to form the primary curriculum RHAT and other NGOs uses in training skilled birth attendants (SBA).

'Skilled-birth attendant', as a professional designation, is distinct from other delivery-care provider categories in India. Iyengar et al. (2009) deploys a broad definition of delivery providers as "any persons who directly participated in examining, monitoring, handling, assisting and/or giving medication a woman or newborn during labor and till at least one hour after childbirth" (305-6). Iyengar et al. (2009) also makes a clear distinction between modern care providers, or individuals who have received western medical training and administer western medical care as skilled-birth attendants (SBAs), and defines providers who have received traditional or non-western training as traditional birth attendants (TBAs). The trainings that have been developed to incorporate EBDs then, function to bolster what SBAs receive during their vocational and/or higher education midwifery training.

State Response: Rajasthan's management of MMR

In states like Rajasthan, a unique geographic and socio-cultural configuration contextualizes not only its high MMR, but also the modality and organization of its public health response. Geographically, Rajasthan is the largest state in India, organized into thirty-three districts. More than 60% of the state is desert, characterized by extreme temperature variation, low annual rainfall and sparse habitation (Iyengar et al. 2009). State poverty levels of 15.28% are high compared to other northern states, and fertility rates are around 3.4 compared to the national average of 2.7 (Ministry of Health and Family Welfare 2007). Table 2 provides a comparison of key socio-economic and health indicators in Rajasthan with those for India as a whole.

Table 2: Demographic, Socio-Economic and Health Indicators of Rajasthan as compared to India

Census Item	Rajasthan	India
Total population (Census 2001) in millions	56.51	1028.61
Crude Birth Rate (SRS 2007)	28.41	21.54
Crude Death Rate (SRS 2007)	6.8	7.4
Total Fertility Rate (SRS 2007)	3.4	2.7
Infant Mortality Rate (SRS 2007)	65	55
Maternal Mortality Ratio (SRS 2004-2006)	388	254
Sex Ratio (Census 2001)	921	933
Population below poverty line (%)	15.28	26.10
Schedule Caste population (in millions)	9.69	166.64
Schedule Tribe population (in millions)	7.10	84.33
Female Literacy Rate (Census 2001) (%)	43.9	53.7

In Rajasthan, institutional deliveries include all births conducted within the state's tired system of healthcare and exclude those conducted at home, though domiciliary deliveries attended by government or NGO trained skilled-birth attendants are considered part of the larger healthcare infrastructure. Within Rajasthan's tiered system of care, facilities are organized into three levels: sub-centers (SBC), primary health centers (PHC) and community health centers (CHC). These three tiers vary in size, infrastructural capacity and the level of technology available at each site. Health centers are divided into a specific level based on the number of auxiliary nurse midwives (ANMs) and support staff employed at the facility, as well as the availability of specialists providing emergency medical services, primarily caesarian section and anesthesia. If a community level health

center (CHC) is unable to provide emergency medical services, the center will then refer patients to a higher level of care, usually at a government hospital or medical college. Table 3 illustrates health facility staffing norms, as well as the average population covered by each facility and mean distance (km) to each designation of healthcare facility.

Table 3. Health Facility Designations (Adapted from Iyengar et al. 2009, 279)

Health Facility:	Staffing Designations:	Average distance (km) to center(s) in Rajasthan:	Average population served by center (s) in Rajasthan (March 2007):
Sub-center (SBC)	One ANM	3.2	4,080
Primary Health Center (PHC)	One medial officer One facility staff One supervisor	8.5	28,881
Community Health Center (CHC)	Obstetrician Surgeon Pediatrician Midwife specialist	17.8	128,465

Recently, a number of governmental and independent assessments by United Nations (UN) organizations have found that the physical structure, equipment and emergency systems of institutions providing deliveries in Rajasthan are not adequately equipped to manage complicated deliveries, and staff is not trained to manage all stages of delivery (Campbell 2006). Hence, national and state government in cooperation with UN agencies have provided financial and auxiliary support for NGOs to audit the structural status of delivery institutions, train delivery room staff, and evaluate their performance post-training.

Exploring the role of NGOs: RHAT as a Case Study

Rajasthan is an ideal site for examining the ways NGOs interface with state and global discursive projects for a number of reasons. In Udaipur, the city where I lived during the data collection phase of this study, there are hundreds of NGOs working in the development, education and healthcare sectors. Many of these

organizations received some state support, and because of government regulations for officially registering NGOs, these organizations must be able to prove that they have community support and are fiscally stable (Government of Rajasthan 2012). I selected RHAT[1] and proposed a collaborative project primarily because this NGO was actively engaged with a number of projects in reproductive health research, training and advocacy. During my time with the organization, RHAT had just begun participating in a project with the Department of Medical Health and Family Welfare and UN agencies to improve human resource capacity in labor rooms of three tribal majority districts in rural southern Rajasthan. The Building Human Resource Capacity (BHRC) project utilized a three-pronged approach to improve institutional deliveries in southern Rajasthan that included: (1) the training of SBAs in Evidence-based Delivery practices, (2) auditing delivery institutions and (3) monitoring SBA use of Evidence-based Delivery practices in labor rooms post-training. For this assessment, state and UN partners assisting with the BHRC project divided delivery institutions into different levels based on the degree of obstetric and neonatal complication they are equipped to handle. In all three districts covered by BHRC, every institution in level 2 and level 3 were pre-selected for evaluation by RHAT. The characteristics of these facilities vary based on their structural ability to perform life saving procedures (such as c-section and blood transfusion) as summarized in Table 4. Note that PHC and CHCs were considered either level 2 or level 3 facilities depending on their resources.

[1] RHAT is a pseudonym for the NGO serving as a case study in this thesis.

Table 4. Definition of facility level (Adapted from: Ministry of Health and Family Welfare 2010).

Level 3: (Comprehensive Level)	• Capable of managing all complications, including c-section and blood transfusion • Has Comprehensive Emergency Obstetric and Newborn Care (CEmONC) capacity • Has neonatal stabilization unit and special newborn care unit (SNCU)
Level 2: (Basic Level)	• Delivery is conducted by a skilled birth attendant (SBA) in a PHC, CHC or private nursing home • Has a newborn corner and stabilization unit

In the first prong of RHAT's BHRC initiative, NGO staff conduct institutional assessments, review the physical quality of the CHC buildings and labor rooms, carry out close-ended quantitative surveys with staff about their adherence to Evidence-based Delivery practices, and administer quantitative surveys to newly delivered mothers, questioning them about how their deliveries were conducted. The second prong focused on training delivery room attendants who had received, at a minimum, their general nurse-midwife (GNM) credential, which requires at least a 10^{th} graded education. Both RHAT and the government offer a 21-day combined class- and delivery-room-based training, which has become mandatory for all GNM employees. This training is focused on providing GNMs with theoretical classroom knowledge as well as practical delivery room experiences using Evidence-based Delivery practices in their management of labor.

In the classroom, GNMs learn about how the EBDs should be deployed during all stages of labor along with maternal and fetal/newborn monitoring. During the practical sessions, participants are taken to level 2 and 3 facilities in close proximity to the training center. There, they conducted assessments of patients under supervision. At the end of this training, GNMs were bestowed the credential of skilled-birth attendant (SBA).

The final component of RHAT's facility assessment is an evaluation of SBAs, which takes place after they have completed this training. Built into the assessment procedure, RHAT also positioned researchers to observe trained SBAs managing deliveries in the labor room. During these observations, SBAs are judged relative to their protocol adherence. BHRC team members carry a list of all nineteen EBD procedures and move from center to center observing deliveries. In conjunction with this quantitative assessment, my role in this project was to conduct interviews with SBAs in order to examine barriers to their use of EBDs. Ultimately, this information was complied into a report that was shared with district health and state officials and used to leverage additional resources for the improvement of sites.

The connection between state and global attempts to modernize the management of childbirth becomes deeply interwoven with discursive projects that many NGOs, including RHAT, participate in. In this case study, Building Human Resource Capacity (BHRC) provides one example of how NGOs working within the reproductive health sector, engaging in the process of identifying sites, spaces and bodies where modernity is seen as absent, and re-configuring those arenas to reflect modern, biomedical and obstetric practice. A number of authors have analyzed how NGOs, as sites for shaping the performance of medicalized models of birth, have enhanced their positions as regulatory extensions of the state. As international streams of power, NGOs like RHAT engage with the field of maternal health and legitimize their presence as an extension of governmentality. In the chapter that follows, I explore the literature on the historical promotion of institutional delivery in India, the emerging role of NGOs in the reproductive health sector and development of skilled-birth attendants as a professional category in order to identify the gaps in past research and for the purpose of contextualizing the ways prior research shaped my study.

Chapter 2: Literature Review

The historical development of India's public health response to maternal and reproductive healthcare is vast and complex. In order to contextualize the ethnographic findings of this case study, I examine literature organized into three major categories. The first category explores the forces directing India's shift from domestic to institutional deliveries since the 1990s. The second category addresses the burgeoning role of NGOs in the field of reproductive health in India. Finally, I review the development of skilled birth attendants as a professional designation within the Indian public health network. I argue that while the socio-historical promotion of institutional delivery in India has been thoroughly examined, the micro-level dynamics of NGO participation in shaping and monitoring labor rooms requires a closer examination.

The Promotion of Institutional Deliveries in India

The global agenda for reducing maternal and infant mortality has been instrumental in directing the shift from home to institutional deliveries. Through a systematic review of the causes of maternal mortality in low-income nations, the World Health Organization (WHO) identified labor and the immediate postpartum periods as being most dangerous for women and has since encouraged nation states to adopt policies that increase the safety of deliveries and reduce maternal mortality rates (MMR) (Ronsmans et al. 2006). The Government of India has prioritized this goal in its National Population Policy (NPP) of 2000 and 2002, "calling for a dramatic reduction in maternal mortality rates to 100 from 540 maternal deaths per 100,000 live births" (Mistry et al. 2009, 1). To realize this goal, the primary thrust of India's national reproductive health policy and programmatic response has been to increase the rate of institutional deliveries by 80%, associating institutional deliveries with improved maternal and infant mortality rates (IMR) (Ronsmans et al. 2006)**.** Yet, since the early 1990s, numerous studies (Kesterton et al. 2010; Lim et al. 2010;

Iyengar et al. 2009; Mistry et al. 2009) have examined India's response to international calls for improvement in maternal and neonatal health outcomes, particularly the extent to which increased institutional delivery has improved MMR and IMR rates nationally.

Comprehensive reviews of both national (Vora et al. 2009) and state reproductive health policies (Iyengar et al. 2009) focus primarily on the historical development of initiatives that precipitated the on-going shift toward institutional deliveries. These studies found that, beginning with the Safe Motherhood Program (1992), birth-attendants or *dias*[2] became a major target for improving pre-/post-natal coverage, mainly through increasing their training in early detection and referral skills for high risk pregnancies. The Safe Motherhood Program was also concerned with the bolstering of First-Referral Units (FRUs), which incorporated specialist practitioners capable of providing emergency obstetric services, such as vacuum extraction and caesareans (Kesterton et al. 2010). However, many of these early FRU facilities were habitually defunct in both their infrastructural capacity and their ability to recruit and retain specialist staff, particularly in rural locales (Iyengar et al. 2009). The results of this program were mixed, and to strengthen the program, two key interventions, Reproductive and Child Health Initiative Phase I (RCH) (1997-2002) and Phase II (RCH-II) (2005) were initiated. While phase I of RCH essentially extended the central aims of the Safe Motherhood initiative, RCH-II was unique in its introduction of a cash-scheme to incentivize institutional deliveries. This scheme was called *Janai Suraksha Yojana* (JSY). In its guidelines, JSY policy calls for eligible women to receive approximately 600 rupess in urban areas and 700 rupees in rural areas (approximately $13-14 and $15-16 US, respectively) to assit with the costs incured from institional deliveries (Lim et al. 2010). JSY has been a major force in the increased utilization of institutions for labor and delivery (Lim et al. 2010; Kesterton et al. 2010).

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[2] *Dia(s)* is a Hindi term for traditional birth attendant, and is frequently used in place of TBA.

In Rajasthan, this approach significantly increased the number of delivers seen at PHCs and CHCs, (99% and 57% respectively) (Iyengar et al. 2009). Other programs including Averting Maternal Deaths and Disability Project (1999-2004), supported by the Bill and Melinda Gates Foundation, UNICEF and UNFPA, and the Rajasthan Health Systems Development Project, supported by the World Bank (2004-2009) also focused on encouraging institutional deliveries by supporting the training of physicians and midwives, improving the structural environment of the labor room (i.e. increasing the furniture, equipment and availability of essential drugs) all in order to produce a more "client friendly" environment (Iyengar et al. 2009, p. 283). The majority of studies (Iyengar et al. 2009; Ronsmans et al. 2006; Thind et al. 2008) also found that these measures have been successful in increasing the utilization of institutions for birth, while at the same time, arguing that there is still a vast, unmet need for quality assurance and improved accountability measures in these settings. There is also some indication that increased utilization by patients has impacted the adoption of contra-indicated practices by providers, such as early discharge and labor augmentation to speed up delivery and manage high case loads in delivery rooms (Iyengar et al. 2009, 286). These findings are significant in that they make more complicated the proposed correlation between increased frequency of institutional deliveries and improved safety and health outcomes.

Several studies that examine the impact of state and national efforts to increase institutional deliveries focus primarily on barriers to utilization and factors impacting choice regarding delivery location. In a study of factors contributing to community utilization of institutional labor rooms for delivery, Kesterton et al. (2010) found possitive associations between use of institutions for delivery and house-hold wealth, education and birth order, as well as major regional varriation between northern India's rates of instituitional delivery (16%) and those seen in the south (59%). However, Mistry et al. (2009) and Hoope-Bender, Liljestrad and MacDonagh (2006) found that women's decision making power did not impact the utilization of institutional delivery rooms, but that finaical autonomy played a key role in the

decision to seek institional care. While these studies have been valuble in producing an understanding about trends in careseeking behaviors, it is also important to examine the historical shift in the location of deliveries in India by examining the role health-care institutions play in promoting institutional birth. While the governmental healthcare sector has actively participated in the articulation of policy and programmatic initiatives, in many cases, non-governmental organizations (NGOs) have been pivotal in the implementation of these programs. In the next section, I review a second, vital body of literature that addresses the role of NGOs in the production and promotion of institutional delivery and their sculpting of the reproductive health landscape in India.

NGOs in the field of maternity reform:

NGOs have increasingly nestled into the gaps left by national healthcare safety nets and private fee-for-service centers. By extending the spaces offering reproductive and maternal healthcare, NGOs are often able to respond to community needs much more quickly by locating themselves directly in a community. In this way, they have become prominent actors in the shifting political spaces created by increased interdependencies among global economic forces (Fisher 1997, 440). Yet, while the practical role these organizations play in providing healthcare has been sufficiently examined (Chhabra et al. 2010; Parasuramalu, Shakila and Masthi 2011; Gottschang 2007; Gauri and Galef 2005) their composition, organizational ethos, and role(s) in negotiations between national, international and private actors has been, by and large, ignored (Markowitz 2001). Often, NGOs function as mediators between local needs and global initatives (Markowitz 2001; Gauri and Galef 2005); studying the ways NGOs understand and operationalize their roles as reproductive and maternal healthcare providers is a new and extremely important avenue of inquiry. Not only have these organizations become conduits for aid and resources (Markowitz 2001), they are instrumental in shaping healthcare institutions and standardized delivery room conduct (Pinto 2004).

In India, reproductive health initiatives developed at the state level are often implemented through the financial earmarking of funds, many of which are distributed to NGOs. Appadurai (1989) argues that, particularly in a post-colonial context, "a close examination of the discourse of the state and the discourses that are contained within the hyphen that links nation to state" is central to understanding the relationship between the international non-governmental organizations (IGO), state and NGO actors, particularly as the web of financial, policy and programmatic arenas become increasing intertwined and global in nature (158). Fisher (1997) argues that this complex relationship effectively, "obscures NGOs as a political category" though these organizations are becoming increasingly responsible for producing the results mandated in policy (1997, 442).

In Pandolfi's (2010) discussion of humanitarian intervention in Kosovo and Albania, she expands Fisher's (1997) argument by contending that:

> NGOs have increasingly positioned themselves as a challenge to governments and occupied roles left vacant by government institutions. At other times, they acted as counterpoints to government actors, being much more agile at opening channels of intervention. By means of their own networks, international NGOs have created a direct and independent form of non-governmental diplomacy, allowing them to act in parallel to state governments (497).

In the case of India's NGO sector, Pandolfi's (2010) point is exemplified in the identification and solicitation of these organizations by larger IGOs (particularly WHO, UNICEF, UNFPA, and the Bill and Melinda Gates Foundation) who provide them with financial support to implement programs that do not necessarily require NGOs to work directly with the state. As Pandolfi (2010, 498) points out, since the early 1990's, the frequency of state solicitation to NGOs "as ad hoc experts in procedures and development of international agreements has increased tremendously. Their economic and intellectual resources, and their ability to manage information, have allowed a number of NGOs to acquire an authority that has often superseded that of state administrative bodies". Building on this concept, Van Hollen (2003, 167)

argues that NGOs participate within a larger apparatus of development by maneuvering individuals and/or groups within the landscape of reproductive healthcare initiatives, soliciting them to adopt modern practices associated with development, essentially making them the targets of development.

In 1997, the World Health Organization canonized a series of "modern" procedures for the management of safe, normal delivery (WHO 1997). These Evidence-based Delivery practices include a number of procedures, from encouraging providers to monitor their patients' blood pressure and weight gain during the pre-natal period, to discouraging the administration of abdominal fundal pressure, intramuscular injections of oxytocin (during the second stage of labor), and routine episiotomy (Action Research and Training for Health 2010; Campbell 2006; Registar General of India 2006). In this way, evidence-based delivery practices (EBDs) represent a strategy articulated through academic studies conducted primarily in the global south into prescriptive initiatives supported by IGO forces and embraced by nation-states (Pinto 2004; VanHollen 2003). At the same time, they also represent a discursive extension between international ideology and lived realities of birth performance in local community labor rooms (Action Research and Training for Health 2010; DelVecchio Good 2010; Hoope-Bender, Lilijerstrad and MacDonagh 2006). EBDs are one of many examples of state and global attempts to modernize delivery in India. Birth-attendants serving in both traditional and institutional capacities have also been targeted by NGOs, primarily in the form of coordinated attempts to modernize and westernize their methods for managing labor and delivery. In the final section of this review, I examine birth-attendants and the evolution of their role in delivery management in India.

Professional development of skilled-birth attendants:

Birth attendants are at the center of both international and Indian national discourses on improving maternal mortality rates. Numerous studies (Kesterton et al. 2010; Lim et al. 2010; Ministry of Health and Family Welfare 2010; Pinto 2006;

Iyengar et al. 2009) have examined the development of the 'Skilled Birth Attendant' (SBA) as a professional designation, and the role of SBAs in deliveries both at home and institutionally. In the "Operational Guidelines on Maternal and Newborn Health" developed by the Ministry of Health and Family Welfare (2010,11) a skilled birth attendant is defined as, "a professionally qualified individual who can handle normal pregnancies and deliveries, identify obstetric and neonatal emergencies, manage complications as per their defined competencies, and undertake timely referral to a higher center where comprehensive obstetric care can be provided."

Hoope-Bender, Liljestrad and MacDonagh (2006) nuance this defination by articulating the difference between SBAs and tradtional-birth attendants (TBA), the latter refering to attendants working independently of the formal health system in a community setting. Hoope-Bender, Liljestrad and MacDonagh (2006:227) found that TBAs have often been targeted by state and NGO forces through "quick-fix" training programs aimed at improving community health outcomes. Many TBAs were tapped to participate in short training courses to improve their skills, and were then returned to their communities, often with a box of instruments and/or medical materials. Yet these programs were ultimatly not considered to be successful or sustainable, because they did not incorporate TBAs into the health system by allowing them to link their patients to higher levels of care through a referal system. In addition, the training programs were often too short to make much difference in improving TBA skills (Hoope-Bender, Liljestrad and MacDonagh 2006).

A number of studies have expanded on Hoope-Bender, Liljestrad and MacDonagh (2006) critique of TBA training programs by exploring how they are organized and executed (Pinto 2004; Sharan et al. 2005; Thind et al. 2008; Iyengar et al. 2008). In their study of child birth practices in rural Rajasthan, Iyengar, et. al (2008), found that birth attandant trainings were severely limited, particularily when SBAs were trained along side medical and nursing students, whose access to practical training was generally privilidged. They also found that these trainings tended to take

place in hypermedicalized environments that did not reflect the environments of primary-care clinics where mosts SBAs actually practice (Iyengar et al. 2008).

Several other studies have examined birth attendant management of deliveries, usually with reguard to their adherence to EBD practices (Sharan et al. 2005; Mistry et al. 2009; Iyengar et al. 2009; Iyengar et al. 2008). In their study of oxytocin use for augmention and acceleration of delivery for example, Sharan et al. (2005) found that SBAs actively engaged in providing oxytocin injections to women in labor. This practice has been given particular attention because while the adminstration of oxytocin during the third stage of labor can prevent postpartum hemorrage, adminstration during second stage can produce intense uterine contractions that can cause fetal distress and occasionally, uterine rupture (Iyengar et al. 2009; World Health Organization 1997). Yet this practice is common in both domicilliary and institional settings. Sharan et al. (2005) report that during qualitative interviews, birth attendants commonly discussed the risks of oxytocin use. Jeffery, Jeffery and Lyon (1989) suggests that birth attendants' use of oxytocin is mainly due to requests from women in labor that the medication be administered to accelerate delivery. Ultimately, oxytocin adminstration in India has been viewed as symptomatic of an increasing biomedicalization of birth and the embrace of techonological interventions during labour and delivery (DelVecchio Good 2010; Sharan et al. 2005). In a compraison between home and insitituional deliviers attended by birth attendants, Iyengar et al. (2009) found that despite prior experience with EBDs, many birth attendants contiune to use contra-indicated practices like oxytocin adminstration and/or the application of heavy fundal pressure during the pushing phase of labor. Their data suggests that this could be caused by birth attendents compromised ability to make fully autonomous decisions about how to montior delivery because of intra-clinic, heirarchal dynamics (Iyengar et al. 2009). They also suggest that familial pressure for a speady delivery may have contributed to how SBAs practice their skills during delivery (Iyengar et al. 2009).

A large and growing body of literature has focused on the historical articulations of policies promoting institutional deliveries (Action Research and Training for Health 2010; Campbell, 2006; Hoope-Bender et al. 2006; Iyengar et al. 2009a; Iyengar et al. 2009b; Sharan et al. 2005; Thind et al. 2008), evaluations of training programs for birth attendants (Pinto 2004; Vora et al. 2009; VanHollen 2003), and the role of NGOs in promoting development discourse (Markowitz 2001; Fisher 1997). However, the interconnectivity between NGOs as strategically positioned apparatuses of state and global power and their role in implementing specific programs at the community level remain under-examined. Exploring the micro-level dynamics between NGOs and their communities of practice can reveal how mechanisms of power operate in relation to individuals and communities identified as targets of development (Pinto 2004). While several landmark studies (VanHollen 2003; Pinto 2004) have examined how the shifting landscape of reproductive health in India has changed the experience of labor and delivery for both women and birth attendants, few studies have engaged in an analysis of how this shift impacts the performance and experience of labor within institutions themselves. Furthermore, there has been relatively little research on the role of NGOs in managing the development of these spaces and those who attend deliveries within them. This study seeks to address this lacuna via an examination of one NGO's role in promoting the deployment of IGO and state policy aimed at increasing community utilization of delivery rooms in rural, southern Rajasthan. In the following chapter, I describe the methods I used to theoretically frame and implement my research.

Chapter 3: Methods

For the purpose of this study, I used a modified grounded theory approach following the work of Charmaz (2000). This approach facilitates the identification and exploration of common or recurring themes within interview narratives (Bernard 2006) thus, "grounding" the researcher in participants' experiences and perspectives. In addition, because with grounded theory findings are often returned to communities for comments and critiques, this approach promotes reliability and validity in qualitative research because it allows participants the opportunity to counter or correct the ways their stories have been represented and interpreted (Barbour and Kitzinger 1999). Because of my unique position as an intern doing research for RHAT's Building Human Resource Capacity (BHRC) team, I secured IRB approval from both my home institution, as well as RHATs internal review board in order to use data from qualitative interviews with BHRC expert staff and SBAs as part of my thesis and for future articles.

After receiving IRB approval, I interviewed five skilled-birth attendants working in community health centers (CHCs) in Udaipur, asking them to discuss their experiences participating in RHAT's SBA trainings. After conducting these initial interviews, I worked with a translator to convert transcripts from Hindi to English. I then coded interview transcripts based on common, recurring themes. Given that most SBAs described a tension between the theoretical practicality of Evidence-based Delivery practices (EBDs) and their utility within the labor room, in keeping with grounded theory methodologies, I refined my research question to consider: How does RHAT promote and monitor the use of EBDs through training and within the labor room? Furthermore, how do SBAs understand, interpret and practice EBDs?

In order to address these questions, I began the second stage of my research. This stage required me to conduct additional interviews with SBAs, as well as with expert staff from RHAT. I also engaged in participant observation of SBA trainings and

RHAT's evaluations of SBA performance post-training. I interviewed eleven SBAs (total) and six experts working for RHAT between August 2011 and November 2011 and relied on concept saturation to guide my recruitment process (Glacer 2001). I attempted to recruit a representative sample of SBAs from diverse educational backgrounds, age and castes groups, as well as individuals who had varying years of employment history. I also included SBAs who worked in all three of the districts where RHAT's BHRC project was beginning implemented: Udaipur, Banswara and Pratapghar. I stopped interviewing when no new details relevant to the construction of my emerging theory were being provided by SBA respondents. Following data analysis, my findings were summarized and reviewed with RHAT's BHRC staff, allowing them to provide comments and critique about my interpretation of the relevant findings. This process was valuable in that it allowed participants to elaborate on, and in some cases, to critique my interpretations (Cheyney 2008). Following a critically applied public Anthropology model (Bourgois and Schonberg 2009), I returned the results of this study to RHAT for their use in a report for the Government of Rajasthan. This made the results relevant and useful for the community from which they were collected and also helped to deconstruct power differentials between the community of study and myself as researcher.

Figure 1. District Map of Rajasthan

Interviews and participant observation took place in Pratapghar, Banswara and Udaipur districts (See Figure 1. District Map of Rajasthan). RHAT also operates a birth attendant training center where it conducts many of its health education training programs (within Udaipur district), and this was also a site for participant observation and several

interviews. It is important to note that the three districts described in this case study, Banswara, Pratapghar and Udaipur, are primarily tribal and schedule caste majority communities, who generally exhibit high rates of migration for employment, higher rates of poverty, and tend to have poorer health outcomes (Iyengar et al. 2009).

Rajasthan was an ideal choice for conducting this study because the state has made marked progress in developing and supporting a network of NGOs that provide direct or auxiliary reproductive healthcare and support to a vast and broadly distributed population (Government of India 2009-10). This network is comprised of government hospitals, private hospitals and clinics, as well as small to mid-level NGOs (of which there are hundreds working in Rajasthan). As one of India's largest states, Rajasthan receives significant financial support from both national and international funding bodies (World Bank and IMF), which have been particularly financially supportive of small to mid-level NGOs (Government of India 2003). Because RHAT participates with IGOs and state actors as its primary funders, their programs, particularly BHRC are ideal for studying the role of NGOs in negotiating international streams of power impacting the lived realities of the local communities they serve.

Participant Observation:

My internship affiliation with RHAT allowed me to participate as a member of the BHRC project, which had been underway since April of 2009. The central aim of BHRC was to assess the infrastructural and human resource capacity of institutions providing labor and delivery services. Level 2 and level 3 community health centers (CHCs) in these three districts were preselected by the state and UN forces that provided logistical support to the BHRC project. In pre-assessments of health facilities at both the state and national level (Iyengar et al. 2009), many of these CHCs were found to be lacking basic resources, like telephone access, electricity and appropriate supplies, while at the same time suffering from staff shortages and high patient case-loads (Vora et al. 2009). In order to comprehensively assess the quality

of institutional deliveries, RHAT developed a quantitative evaluation for delivery institutions, SBA training institutions, curricular evaluations for SBA trainings and post-training performance review. Table 5. provides, a break down of the thematic areas for evaluation.

Table 5. Areas for Data Collection

Delivery Institutions	• Equipment present at site • Supplies at site • Staff situation • Case load (number of deliveries)
SBA training institutions	• Training center facility assessment • Training center human resources • Teaching materials/training aids • Practical training site materials
SBA performance	• Labor room performance observation • Client interview • SBA quantitative interview

Assessments were initiated in April 2009 and are on-going. For the facility assessment process, the project team used standard practice checklists to evaluate all L2 and L3 sites (see Appendix C1 and C2) in the three districts enrolled in the initiative. Delivery institution assessments involved auditing the availability of equipment present at each site, the staff numbers and the number of deliveries conducted monthly at each site, and the general infrastructural state of the center. For the assessment of SBA trainings, the project team examined facilities and equipment at training sites, and audited training resources available at sites where SBAs practice their skills. SBAs were required to take pre- and post-tests designed to evaluate their knowledge of EBDs. They were also given closed-ended surveys at their CHCs after completing RHAT's training. These data were evaluated and then summarized in report cards that were distributed to each district for internal review.

Sampling:

For qualitative interviews with SBA and BHRC experts, I choose two primary sampling techniques. Because RHAT's BHRC team members, who were involved with SBA trainings and CHCs evaluations, constituted a small and specialized expert

group, I used purposive sampling to identify participants (Bernard 2006, 190). The SBA population was sampled primarily using respondent-driven and convenience sampling techniques (Bernard 2006, 192). There were several dynamics and constraints with this population that made this sampling method most appropriate. First, because my role in the BHRC project was to determine whether a deficiency in training or other barriers in the labor room were impacting SBAs' abilities to implement Evidence-based Delivery practices, only SBAs who had completed at least one training could be enrolled in the study. Second, because the labor rooms were often chronically understaffed, employees who were not SBAs often step in to manage deliveries. These other staff include medical assistants (*yosadas*) and medical students. For the purpose of this study, individuals assisting in deliveries who were not SBAs were excluded from participation.

Qualitative Interviews:

In order to gain an understanding of how RHAT promotes and monitors the use of EBDs and at the same time explore SBA understanding, interpretation and practice of EBDs, I conducted open-ended, semi-structured interviews with RHAT's BHRC team members, as well as with SBAs who had completed SBA training. As Bernard argues (2009), semi-structured interviewing is especially appropriate when working with bureaucratic institutions and individuals with particularly regimented schedules because the use of a structured interview guide allows the researcher to cover a range of topics efficiently (210). In addition, the open-ended nature of the questions allows time for rich description offered by participants. Interviews with experts from both the SBA training and BHRC evaluation teams focused on their experiences working at different locations of the BHRC and SBA training projects. All expert participants were RHAT employees, and their experience ranged from six months of employment to nine years. Their minimum level of education was a Bachelors of Science and maximum level was Medical Doctor (MD). Two respondents had worked for NGOs prior to joining with RHAT, and all but one respondent, who had recently been

recruited from the state of Uttar Pradesh, were local residents of Udaipur. Table 6 provides a break down of RHAT interviewee demographics.

Table 6. RHAT Respondent Demographics

Gender	Male	Female	Female	Female	Female	Female
Age	25	42	30	27	24	25
Time employed with RHAT	45 days	9 years	7 years	1 year	30 days	30 days
Education Level	BS Mass Communication	BS General Studies	MS English/Ph.D Student	MPH/MD	MS Social Work	MD Student
Designation	Associate Researcher	SBA trainer	Associate Researcher	Associate Researcher	Associate Researcher	Medical Intern

As stated above, because of the nature of the project, SBA participants were recruited using convenience sampling. Interviews were conducted in comfortable and convenient locations for the participants, and verbal consent was obtained prior to the start of the interviews. I interviewed eleven SBAs total in all three districts as part of the BHRC project. Of the eleven SBAs interviewed, four worked for CHCs in Udaipur, four worked in Banswara and three were employed in Pratapghar. Four of the interviews took place in Dungrapur district hospital, where participants were in the process of taking an additional practical training. Two of those respondents were employed in Pratapghar and two in Banswara. Table 7 summarizes demographic information on the SBAs interviewed. Participants varied in experience and professional designation, with some SBAs being employed for no more than three months. At the high end, one had been working as an SBA for twenty-six years.

SBA interviews represented the central form of data collection. Expert interviews with BHRC staff and participant observation functioned to help nuance and contextualize the information collected during SBA interviews, and allowed for the triangulation of SBA responses with expert narratives and my own observations.

Table 7. SBA Respondent Demographics

Udaipur	Age	Gender	Years worked at hospital	Time since SBA training completed	Credential	Degree
	40	F	23y	6 months	Staff Nurse	BS.C Nursing
	42	F	12y	3 months	Nurse Midwife	10th Class pass
	24	M	3y	1 year	Male Nurse	GNM
	40	M	10y	1 year	Male Nurse	BS.C Nursing
Banswara	47	F	26y	Training in progress	GNM	10th Class pass
	30	M	7y	Training in progress	Male Nurse	NA
	35	F	12y	4 months	GNM	10th Class pass
	38	F		1.5 years	GNM	10th Class pass
Pratapghar	24	F	3 mo	21 days	Staff Nurse	BS. C Nursing
	24	F	1y	21 days	GNM	10th Class pass
	28	F	3y	Training in progress	GNM	10th Class pass

Positionality:

There were two crucial areas demanding the reconciliation of my subject position in the context of this study: one is my identity as non-native Anthropologist, and the second is my role as intern conducting research for an NGO that was also the subject of an ethnographic study.

The value of work produced by native versus non-native Anthropologists has been a question of critical debate within Anthropology for several decades (Gupta and Ferguson 1992; Abu-Lughod 2002; Ashcroft and Ahluwalia 1999). I would contend that in the framework of what Bunzl (2004) terms neo-Boasian anthropology, cultural difference should be configured not as the principle component enabling ethnography, but as the "very phenomenon in need of historical explanation" (440). Bunzl argues that neo-Boasian anthropology can function to address the dilemmas of

'native' versus 'non-native' status of the researcher and the subjects of research by offering an alternative epistemology for conducting fieldwork. In this configuration, 'insiders' and 'outsiders' become united in their investigation and contribution to examining a history of the present (440).

Bunzl further contends that neo-Boasian anthropology not only turns the analytic gaze onto the manifestation of cultural difference in the present, but also functions as the "explanatory telos of anthropological inquiry" (2004, 440). In essence, this move 'suspends the preformative naturalization of cultural difference as the constitutive element of ethnographic field work' (2004, 440). Within the context of my research, neo-Boasian anthropology functions in two ways. First, this perspective disrupts any essentalization of the validity of my work due to my 'non-native' status by drawing the focus away from a dichotomized discussion of 'native' and 'non-native' to a larger grounding in the examination of a history of the present. Second, and particularly in the case of rural Indian healthcare providers and their relationship to larger systems of power, it seems essential to focus on how cultural difference functions in the present context. Neo-Boasian anthropology allows for a historical examination of power through the process of cataloging ethnographically the cultural dynamics of the present.

Additionally, because the locations of our data collection sites were in tribal majority districts, there was a distinct difference between our BHRC team and the individuals enrolled in our study. Most of my team members came from traditionally privileged castes and/or from high-income, socio-economic positions, while many of the women who attend CHCs are lower caste, lower income, non-native Hindi speakers (although while most of the SBAs had attended schools where Hindi was the medium of instruction, many female patients spoke in local dialects that our project staff did not understand). I learned through antidotal reports from my team that very few individuals on our research team were functionally proficient in the primary tribal dialect of the region, *Melvari*, and struggled to communicate with individuals who were dialect-only speakers. What this point illustrates is that beyond issues of

language, our presence in the community was viewed as that of 'outsiders', which inevitably influenced how SBAs and CHC staff were able to relate to our project's goals and aims.

Ostrach (2010) evokes Jacobs-Huey's (2002) work, arguing that in a review of participants' contributions to research, participants are often subconsciously influenced by the perceived role or identity of researchers(s). Ostrach further contends that:

> This makes a strong case for the value of conducting research in arenas where we have enough expertise, or can participate in enough preliminary participant-observation, to ensure that the researcher is familiar with common en vivo codes, practices, and scenarios that may be encountered in the research site. Even researchers who are not native to the research community are likely to find it beneficial to be familiar with, and comfortable using, terms and definitions used by the research participants (2010, 11-12).

However, in the case of BHRC team, we were able to minimize our disruption within our community of study because the same members from the team had been consistently present throughout the duration of the project. Several of my team members were familiar with the SBAs from either the training, or from multiple meetings with them during CHC assessments. All of our checklists for both patients and SBAs had been modified to use terminology or phrases both groups were familiar with (See Appendix C1 and C2).

My positionality as Anthropologist doing research for the BHRC project as well as researcher studying RHAT also necessitated clear articulation. Participation within the BHRC project was complex for both myself and my fellow team members as we all struggled to situate ourselves within a different cultural context. While I consistently reiterated the difference between my own research, and that done for the NGO, the line inevitably blurred. Ultimately, my only recourse was to consistently provide my team with the information I collected and clearly verbalize when notes or data were being collected for my own ethnographic purposes. Because I was engaged in the dual role of interning for RHAT and examining the role RHAT plays in

reconfiguring birthing spaces and SBAs' practices, situating my positionality was extremely important. Before initiating interviews or collecting field notes, I attempted to clearly situate myself in the role of researcher. I did this by taking notes in the presence of participants after securing permission from them. Furthermore, because I was particularly interested in the beliefs and attitudes of RHAT employees around birthing sites and practices and the ways in which these are shaped by outside sources (i.e. funders), any notes collected that reflect those attitudes were shared with them. All of the data collected during this project have been organized into a report (as requested by RHAT) that will eventually be used in a larger presentation to the Government of Rajasthan on the status of SBA training and CHCs in the districts of study.

Limitations:

There are a number of limitations to this study that impact the generalizability of ethnographic findings. Because the fieldwork took place over a relatively short period of time and because SBA participants were working in health centers spread over a larger territory, it was not possible to return for follow-up interviews. Often the SBAs working in a clinical setting were the only staff present at the time of the interview and, as a result, they rarely had much time to spend giving an interview. Interviews were frequently interrupted so that SBAs could attend to patients. For the purposes of this research, data were only collected from SBAs who had participated in one of the EBD skills training and worked in a L2 or L3 CHC. However, many SBAs also work in L1 facilities and some attended births in rural, in-home settings. Unfortunately, gathering ethnographic data from these individuals was not possible during the short data collection period. However, it seems clear that this population could have provided a unique and informative perspective about the landscape of reproductive health and the role NGOs play in its shaping. Their voices are absent. Furthermore, because of time constraints, it was not possible to conduct interviews with the women who came to CHC seeking maternity care. Collecting ethnographic

data from these individuals would be a logical next step for further research, as their perspectives about CHCs, and the roles of NGOs and SBAs in the changing landscape of labor and delivery rooms could potentially provide interesting insights.

An additional concern is a function of the fact that RHAT made qualitative interviews with SBAs and expert staff a component of the BHRC project. As a result, the questions that were asked of SBAs tended to be heavily influenced by the goals and central issues of concern for the project staff. BHRC staffs were often familiar with SBAs and tended to assist with the recruitment of staff for interviews. BHRC staff also insisted on being present for interviews, which must, invariably, have influenced the depth and types of responses participants felt comfortable sharing. Future research examining this topic should articulate clear boundaries between the NGO of study and SBAs or clients/patients.

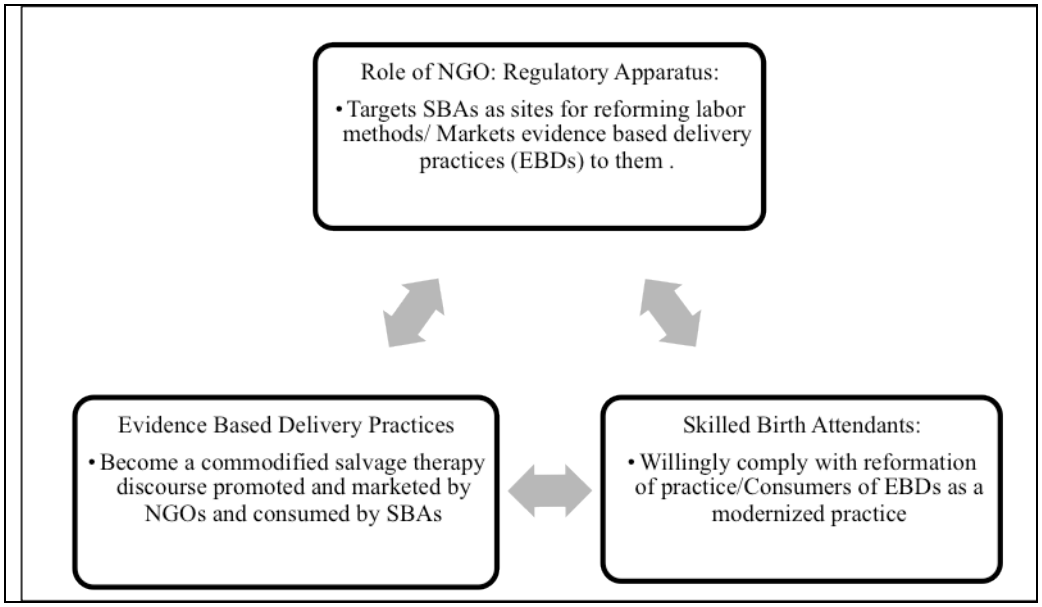
Finally, because RHAT served as the site for an in-depth case study, other NGOs doing similar work, or those doing training and evaluations of traditional birth attendants (TBAs) were not included in this study. Hence, the results of this case study are not generalizable beyond the community of study. I will argue that they do, however, provide important insights into how labor rooms are currently being re-configured and the tensions that emerge through this process.

Chapter 4: Results

Guided by grounded theory, I organized my results into three major thematic groups using qualitative coding software (TAMS analyzer). In keeping with the analytical methodology of grounded theory, I discuss my findings in conjunction with larger relevant theoretical notions in order to make sense of both the findings and their complex relationships to each other. I organized data from qualitative interviews with SBAs, providing additional supporting data from expert interviews with RHAT's BHRC staff and from participant observation field notes.

The first major theme addresses how SBAs described and related to the training RHAT provided, and the practices it promoted. In this theme, I describe how SBAs who participated in this compulsory training discussed a willingness to accept RHATs role as a training entity, and to consume the Evidence-based Delivery practices it promoted. In this way, I argue that RHAT was positioned as a regulatory apparatus that was able to distribute reproductive health discourses by training SBAs in EBD practices and the monitoring their use in the labor room. The second theme examines the ways in which SBAs articulated the use of EBDs as characteristic of what makes a "modern" care provider. In this theme, I draw on data that illustrates the way SBAs became sites for the consumption of EBDs and the ways in which labor rooms become spaces for establishing and distributing a political economy of hope. In the final theme, I examine findings that illustrate how EBDs, along with new technologies represented a kind of therapy that operated as a symbol of the *promise* of safer deliveries. I also explore how SBAs conceptualized the tensions between EBDs, new technologies, organizational hierarchies and community expectations within the labor room. Ultimately, I argue that the interaction between these forces culminates in the production of an imagined labor room space, which promotes the illusion that birth in the labor room can be universally synonymous with safe and speedy delivery. A relational model of these three themes is depicted below in Figure 2.

Figure 2. Thematic Relational Model: The Production of Imagined Delivery Rooms



Willingness to comply: Conceptualizing NGO authority:

RHAT provides intensive labor and delivery management trainings for staff who have already received some kind of formal medical education, usually culminating in their receipt of the designation(s): General Nurseidwife (GNM), Bachelor's of Science in Nursing (BS.c) or Male Nurse (MN). SBA participants all described how they were recruited by their superiors to participate in a compulsory, twenty-one day SBA training program offered by the government of Rajasthan and RHAT. Although all of the SBAs staffing community health centers (CHCs) had completed formal medical education, participants overwhelmingly discussed a willingness to reform their methods of managing deliveries in order to comply with the practices they encountered during their mandatory training. As Sunita Ji[3], an SBA from Udaipur, explained, "We did not choose RHAT. They choose us. They call us for training. Everyone is agreeing with using these practices. If you've been trained,

[3] Pseudonyms were used for all SBA respondents and NGO expert staff in order to humanize their words and experiences.

you can attend the patient. There should be no problem," (Interview 10/07/2011).[4]

A majority of participants described the practices they learned during training as "new" and expressed little to no resistance toward applying them in their work. When I asked SBA's to describe their trainings, respondents often stated that what they learned during training was "new" and modern compared to what they encountered during their medical education. Krishna Ji explained, "Actually [the EBD practices] were new for us. In school it was all theoretical, but this is all practical skills. Before training we were using fundal pressure, but now we never use. Before the training we were also using suction, but now we are not using this" (Interview 10/02/2011). Respondents often provided one or two examples of a practice they were instructed to modify post-training, or described how EBDs had re-shaped their work. One young SBA, Pile Ji, who had recently begun to manage deliveries on her own explained: "It's not so tough, it's easy [to use what we learned in training]. I have really already used them in my routine. I learned not to use centrol [oxytocin] before delivery, so now we are not using this in practical [setting]" (Interview 10/02/2011).

Despite the fact that staff attending deliveries in the labor room had been educated and certified, many SBAs stated that utilizing the practices were compulsory for managing deliveries and frequently stated that they had no issues with changing their standard practice completely to incorporate the EBDs. Anita Ji described it this way: "Everyone [in the labor room] is agreeing with using these practices. If you've trained, you can attend the patient. There is no problem" (Interview 10/07/2011).

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[4] Note on translation:
In translating quotations from Hindi to English, I have chosen to reflect the meaning SBAs were articulating rather then providing an exact re-iteration of their words. This was done both because translating from Hindi to English requires a certain degree of interpretation for the sake of clarity and as an act of representation, translations should also reflect the intelligibility of SBAs as they provide descriptions of their own lived experiences.

What was notably absent from my discussions with SBAs however, was any mention of how the adoption of the EBD practices displaced their prior strategies for managing delivery. There was also no explicit discussion of the role and/or the authority of the NGO conducting the training.

The central curricular crux of RHAT's training program is to re-train SBA staff to practice deliveries in accordance with 'Evidence-based Delivery practices', as well as to re-shape the ways they conceptualize delivery. In interviews with BHRC expert staff, one respondent explained that RHAT's training was split up into two sections, one that was lecture-based instruction in a classroom setting and a second section that was practical, which required participants' to practice evidence based skills in small health centers or with recently delivered women in local communities. I attended two of these trainings, one targeting GNMs who were early in their practice, and a second, which was a train-the-trainer program for SBAs who had completed the first 21-day program. The following field note excerpt is taken from the train-the-trainer program.

> *The women file in slowly, chatting and laughing as they position themselves along the perimeter of room. The instructors call for the women's attention. One explains how this training will run, while the other distributes pre-tests. The power goes out, and Dr. Uuchal curses. Now he will have to skip over the theoretical session and start modeling how the 'practicals' will work. He moves to the center of the room, sits cross-legged and demonstrates to the women how to correctly wrap the infant after birth. Women are then prompted to come to the front of the classroom and to practice on a doll. The first woman to come up walks confidently to the front of the classroom, takes the baby doll and wraps the towel around the body slightly haphazardly, finally presenting it to the audience beaming with satisfaction. Dr. Uuchal inspects her work, and asks the audience what was wrong. They reply that the head of the infant wasn't covered. He then invites another volunteer to come up to correct what the first women had done. The next woman to attempt to wrap the dolls is a young midwife. As she wraps the doll, Dr. Uuchal asks the class to list the causes of hypothermia in infants. The women provide standard answers: not wearing clothes, low maternal body temperature, cold labor room, etc. Dr. Uuchal discusses breast-feeding and mother-to-baby skin-to-skin contact as a way to prevent hypothermia. (Field Note: 10/06/2011).*

As this excerpt demonstrates, one of the primary functions of SBA training is to encourage participants to modify their labor room performance by implementing all of the EBDs described and practiced during training. After observing how these trainings were conducted, I began to ask SBAs to reflect on these experiences. Despite the perceived utility of the skills gained through the training, many SBAs still described barriers to their use. A common response is reflected in Lakshmi Ji, an older SBA's statement that, "[EBDs now are] part of the routine, but when there isn't time [we don't use them]. And that is a reason I am unable to use the practices. It's a time problem for me" (Interview10/13/2011). Another SBA, Ravi Ji, explained, "We can use these practices in the labor room whenever we want [and no one is stopping us]. In the morning time we have a lot of written work, so we are unable to do the practices and also because we are junior staff, we aren't doing the practices" (Interview10/12/2011).

"Training" is a key modality of many NGO-supported health programs to both reshape practitioners and distribute a hegemonic discourse about how birth can be best practiced. Historically, the state alongside NGOs, have trained local women to act as institutional agents with responsibilities such as encouraging sterilization and distributing contraception, and Pinto (2006) argues that similarly, TBA (traditional birth attendant) trainings are a staple of rural development. In these brief (usually six-day) encounters, village midwives are educated in safe delivery practices and made into representatives of institutions via symbolic objects such as kits and identity cards (Jordan 1993; Pinto 2006). Although in Rajasthan, both the state government and NGOs like RHAT offer trainings for SBAs, state forces are increasingly out-sourcing the responsibility for both monitoring and training SBA staff to non-governmental organizations. The explicit intension of these trainings is to reform the modalities for how deliveries are performed by attendants. They also function to redefine the *habitus* (Bourdieu 1990) of these same attendants into individuals elevated to a status of 'skilled-birth attendants' (SBA).

The Bourdieuian conceptualization of habitus argues that as individuals engage in processes of conditioning, which articulates a 'correctness' of practices deployed constantly over time, certain practices or behaviors generate a regularity that characterizes how individuals perform and engage in their fields of practice (1990, 53-4). Ultimately, the rational self-regulation performed during the practical trainings prompts the internalization of EBDs as both a set of behaviors and a hegemonic discourse about "appropriate" intrapartum care. As SBAs practice EBDs in the practical trainings and in their delivery rooms, they are shaped into the distributive agents of Evidence-based Delivery practices. This distribution is central to the re-shaping of the institutional delivery room environment, and the reification of NGOs like RHAT, as a kind of regulatory apparatus extending state control into the labor room.

In terms of reproductive health policy and programmatic implementation, RHAT was positioned at a unique intersection between international and state manifestations of governmentality. Pinto (2006) argues that NGOs, as an instrument for enforcing healthcare interventions aimed at improving maternal and neo-natal mortality outcomes, allow state and IGO forces to maintain a control over the labor room environment without needing to provide a direct physical presence there. As an extension of governmentatilty (Foucault 1984), one of RHAT's modalities for managing the labor room environment was visible in its exertion of hierarchal observation and the normalization of judgment that result in the standardization of practices for managing delivery. Deployed as a methodology for the control of medical spaces, Foucauldian notions of hierarchal observation, and normalizing judgment contend that within the paradigm of bio-power, bodies and spaces become sculpted through meticulous observation, producing internalized norms where power is exerted without the need for punitive punishment. Markowitz, (2001) contends that biomedicine, as a disciplinary extension of state control over the social body, is dispersed covertly through NGOs, making them particularly complex conduits of state power.

When I first joined the BHRC team, Dr. Jaya and I sat for almost two hours as she explained to me the structure of the project and to what degree it was organized and regulated by state and UN agencies, as well as what was considered "up to RHAT". As she explained, the relationship between UN and governmental forces were essentially a flow of financial support to RHAT in exchange for their service as a regulatory apparatus within CHC labor room environments. RHAT's primary responsibilities in this capacity included the hosting and conducting of SBA training programs, but also extended to the auditing of physical and infrastructural capacities of labor rooms (inspecting availability of supplies, the quality and cleanliness of the delivery room, etc.). Surveillance of staffs' use of Evidence-based Delivery practices (EBDs) in the labor rooms was also considered an essential responsibility. RHAT monitored and evaluated both the spatial quality and staff performance in the labor room, and augmented both of these elements through the promotion of high-tech newborn care technology and SBA performance trainings. Ultimately, the findings from RHAT's qualitative evaluations were presented at the district and state level.

I attended one of these meetings in Pratapghar, where district and state reproductive health officials, as well as the UN staff representative for the project met to discuss the most recent results collected from training and facility assessments. The following is a field note excerpt from that meeting:

> *Dr. Uuchal presents Pratapghar's assessment report card to the primary medical officer (PMO). He focuses on the three main issues, particularly that Pratapghar did not have 24-hour trained SBAs staffed at the hospital, that they were not using the Evidence-based Delivery practices consistently and that they did not use the partograph to monitor patients during labor. The PMO argues with Dr. Uuchal about one of his main suggestions that staff keep patients over 48 hours (one of the primary EBDs). He states that they don't have the beds or space to do that, and that it is therefore, not feasible. Dr. Uuchal does not fight him and continues with the presentation, mentioning the need for a doctors' orientation about EBDs at the end of the meeting. He also addresses the need for the district to increase the number of SBAs participating in training. Dr. Uuchal explains to the PMO that RHAT would like permission to enter all the L2 and L3 facilities in the district and shows him a UN and government endorsed document that describes RHATs*

> *authority to conduct these assessments. The PMO agrees to that, and then quickly left the meeting (Field Note: 10/11/2011).*

While this meeting's primary goal was to provide Pratapghar district with a summary of RHAT's findings during CHC audits, it also allowed RHAT to reify its position of authority within the project by displaying its state and globally approved authority to district representatives, ultimately allowing the organization to enter labor room spaces without interruption.

Perhaps one of the most interesting modalities for sculpting the labor room environment, however, was RHAT's role in the articulation and deployment of Evidence-based Delivery practices (EBDs). EBDs represent an example of regulatory discourse, produced by forces of governmentality and channeled through the NGO to the community level, via the training and surveillance of SBAs. It is not surprising that SBAs demonstrate a willingness to comply with EBD implementation in the labor room, particularly in the wake of RHAT's methods for promoting EBDs as normative practice. The next theme will explore how RHAT commodified EBDs as a standardized curriculum for the management of labor rooms and the ways in which this process correlated with SBAs' shifting professional identity.

Becoming "modern" healthcare providers: commodified EBDs, monitored performance and the political economy of hope

In every CHC we visited, nineteen Evidence-based Delivery practices were represented on posters, which displayed each stage of labor next to a picture of each recommended practice. During interviews with SBAs, they could easily name and explain many of the EBDs and were nearly universal in their iteration of these practices as easy and convenient to use. In almost all of my interviews with SBAs, respondents described EBDs as either "new" or "modern" practices. Saloni Ji described how her recently completed SBA training legitimized her status as a modern provider: "[EBDs] help with deliveries that have problems and it's good to

learn new, modern techniques so we can improve our weaknesses" (Interview 09/19/2011). Vidya Ji reiterated this sentiment, extending it by stating that it was SBA training that separates modern and traditional providers professionally. She stated: "We are modern providers, not like the *dias*. I will explain what I am doing to the family, and they come to accept it" (Interview 10/03/2011). A male SBA, Vikas Ji, provided one specific example of this distinction as he explained; "The Kalbelia (tribe) or village people sometimes come with their ladies [*dias*]. [These *dias*] question our use of the practices and try to tell us how to do deliveries. But we know best now after the training, and I am not allowing these ladies in my hospital or on my case" (Interview 10/07/2011).

SBAs also discussed how they frequently conceptualized the purpose of the EBDs as life saving measures for mothers and infants, illustrated in Selva Ji's comment; "Before training, post-partum hemorrhage cases were high. And after taking the training, I got help in managing them. So we don't need the doctor now to help us manage this" (Interview 10/10/2011). Several respondents also described how patients from tribal communities or their families would demand a speedy delivery, or request medical augmentation of labor. "They labor out in the village for days" Shilpa Ji, a young, pregnant SBA told me, "So when they come here, they want to deliver fast. And they want us to use medications to do this. We explain to them that the baby comes when it comes, but sometimes we do use the medications to help in an emergency" (Interview 09/16/2011).

DelVecchio Good (2007) has discussed the types of discourse that can arise in medical environments with a focus on the power of clinical narratives. Clinical narratives, like those that emerge around EBDs in this case study, she argues: "incorporate evidence-based medicine into clinical culture and introduce therapeutic meaning… through the aesthetics of statistics—how one conveys the odds and chances of particular treatments to patients—emerge as culturally shaped and institutionally sanctioned, taking on a centrality in the narrative discourse…" (276). I would argue that EBDs, in as far as they embody a new or "modern" clinical narrative

function to create a political economy of hope (DelVecchio Good 2007) for SBAs and their patients where the promise is one of safer deliveries. DelVecchio Good (2007) describes the political economy of hope as therapies or interventions that for doctors and patients spark a medical imaginary, promising new and innovative "regimes of truth in medical science" (273). I see the political economy of hope as including any discursive enterprise or practice that promotes the promise of an innovative scheme for improving medical practice and health outcomes. In the community health centers of southern Rajasthan, EBDs represent a regime of truth that produces a medically imagined labor room environment. SBA trainings elicits practitioner by-in to the practical shift in their management of deliveries through the conceptualization of EBDs as modern, innovative, and life-saving practices. Yet, despite the attempts to reshape SBA's management of delivery through a mandatory skills training, the application of Evidence-based Delivery practices in the labor room were, in practice, not universal and consistent. There are barriers to their implementation, and perhaps most importantly, little to no evidence that EBDs in their current application have done anything to improve the dismal maternal and infant health outcomes reported in southern Rajasthan.

What is significant here is the ways in which practitioners become the targets for and promoters of EBDs as a new brand of labor room therapy and practice. This point intersects with the role NGOs play in establishing authority within the labor room as they monitor SBA performance, ensuring the constant reproduction of EBDs. EBDs become products within this political economy of hope, capitalizing on a medical imaginary that utilizes SBAs as producers and reproducers of the (empty) promises EBDs symbolize.

RHAT not only participated in the commodification and distribution of EBDs, as a discursive product comprised of globally derived standards for conducting a normal delivery, but also monitored the consistent application of EBDs within delivery rooms. During one visit to a CHC, Anjali one of RHAT's field researchers, entered the labor room and explained that our work for the day would include

observing how SBAs manage deliveries and interviewing patients about their labor experiences, to confirm SBA use of Evidence-based Delivery practices. Rhodes (2004) argues that through the production of norms or values, articulated in this case through the observation and judgment of SBA labor room performance by RHAT staff, subjects participate in rational self-regulation, a force of habit that, once internalized, shapes the subject. In terms of the BHRC assessment, our interviews with SBA staff required a quantitative, self-report about their ability to perform EBDs after completing our training. Our role in conducting these assessments is demonstrated in the following field note excerpt:

> *As we began our work, Anjali turned and whispered to me: "If I wasn't here, they would never do it right. I have to stand here and watch all day so that they do the (EBD) practices." We returned to the staff room and she handed me a checklist that contained all the EBDs for 1st, 2nd and 3rd stages of delivery. "You can fill this out too and help us do our observations," she told me. "What do we do with this information?" I asked. Anjali sat cross-legged on the long bed that served as a bench in the staff room. "When we finish collecting this, it goes into a report card that we give to each district. You should watch the SBAs and mark when they do a practice, and when they don't. When they don't do the practices, I have to tell them that they must." When we shift back to the delivery room, one of the nurses is positioned beside the patient in the first bed, and starts to apply abdominal pressure on the woman's fundus from the side. The senior nurse notices us return and quickly snaps at the younger nurse, "Don't do that (Mut karo!)" The senior nurse has the patient layback into a fully reclined position and does not allow the SBA to touch her. (Field Note: 10/13/2011).*

The excerpt demonstrates the regulatory aspect of our assessments of SBAs. Rhodes (2004) argues that there is an element of malleability that plays out in a process like this, particularly as individuals begin to internalize norms established through hierarchal observation. As actors, SBAs in this case, engage in a kind of rational self-regulation as their performance of discursive norms becomes habitual (Rhodes 2004, 63).

While our presence in the labor room often seemed to impact SBA performance and application of EBDs, I argue that the dynamics of distributing and monitoring

SBAs' use of EBDs in conjunction with the promotion of reproductive technologies, like new-born care corners (discussed in more detail below), produced a number of tensions that SBAs often cited during interviews. In the third and final theme that emerged from SBA narratives, I discuss the ways SBAs related to and worked with new technologies (NT) dispensed within intra-clinical hierarchies, with a focus on the ways these NT functioned to re-configure labor rooms and, as a result, the community perception of these spaces.

Tensions in the delivery rooms: New technologies, hierarchies and community expectations of SBAs

In all fourteen interviews with SBAs in four districts, every respondent reported that therapies, such as EBDs and new technologies (NTs) like newborn care corners (NBCs) (As shown in Figure 3, NBCs are raised tables, where new born are often placed after delivery because these units omit heat and can regulate blood pressure, were easy to use). However, most SBA's also expressed concern or anxiety about their ability to consistently use EBDs or NT in the delivery room. While SBAs rarely questioned the utility or intelligibility of the EBDs, their use (or non-use) was often determined by a number of factors within the labor room environment. During interviews with four SBAs completing the practical portion of the advanced train-the-trainer EBD program, all interviewees described a plethora of issues that impeded their ability to use the protocols in their labor rooms. These issues ranged from a deficiency in staff available to handle high caseloads (which made supporting slower deliveries more difficult), doctor non-adherence to protocols, and pressure from staff and patient family members to speed up the pace of deliveries.

Figure 3. Newborn Care Corner (NBC)

A common response to questions about barriers SBA perceived as affecting their ability to use to discursive practices like EBD or the new medical

technologies like NBCs in the labor room included: anxiety with using new technologies, hierarchal constraints, particularly from senior staff and community expectations about how institutional deliveries should be conducted. Often, EBDs were predicated on the access and ability to use certain bio-medical technologies, for example, the newborn care corner (NBC), digital thermometers or suction machines. RHAT used these technologies throughout the training sessions. During one session, one of the SBA's in attendance raised the question as to how a skill like administering oxygen to a neonate suffering from asphyxia or recording temperature, could be implemented without ambu bags or thermometers, respectively. Maya, one of the instructors running the session snapped back at her, "All of your CHCs should have this equipment. If they don't, you must talk to someone about getting it." Yet, during one of our visits to a newer CHC, Anjali reviewed the equipment checklist with the male staff nurse. He showed us some of the equipment on the list, but much of it was missing. Anjali asked him if they had a working autoclave. "Yes, we do have, but we hardly ever use [it] because staff are not trained and do not know how" (Field Note: 10/13/2011). Saloni Ji commented: "We can use these practices in the labor room whenever we want. But sometimes the families don't want the patients to get the practices…and all we can do is try to refuse their request and try to explain the process" (Interview 09/19/2011). These quotes illustrate some of the tensions between how SBAs practice and interpret EBDs, and what the community expects from institutional delivery rooms.

Several SBAs also stated that the pressure from patients' families to perform quick deliveries acted as a barrier to their use of evidence-based skills. Ravi Ji described it this way: "When the village people come, they are (often) saying, 'Madam, *jaldi karo*! (Do it quickly!). They want us to give injections and make the delivery happen faster. That is why they come here" (Interview 10/12/2011). SBAs also described having to try to explain to these families how and why EBDs were used, primarily as a means to illicit community approval of these practices.

During our initial audit of one CHC, Dr. Uuchal boasted that, in terms of the number of trained SBAs, availability of technological equipment, and consistent use of EBDs throughout all stages of delivery, we were in "one of the highest performing centers in Banswara" (Field Note: 10/11/2012). However, as we conducted our CHC assessment and monitored the SBAs' use of EBDs, two major things became apparent. First, in terms of the reliance on new technologies, SBAs were not comfortable using things like new born care corners or administering oxygen to newly delivered infants. Second, the community expectation that deliveries be conducted quickly once they arrived at the CHC, was apparent, particularly because the family who came to the CHC during our audit, demanded quick medical augmentation that they believed was part of the healthcare experience at the CHC. These two points are also illustrated in the following excerpt from field notes:

> *The woman, her mother and TBA from her village enter the CHC quickly. "We need to do this delivery quickly," she tells the SBA, "She has already been in labor for days." Once the baby had been born, the SBA took the baby and placed it on a dirty rag that covered a stainless steal tray. This tray was located next to the NBC, which was covered in dust and not plugged in. Anjali had asked her about this earlier during our audit, but the woman responded that the power was out so often that the NBC never worked. Throughout the delivery, Dr. Uuchal would appear, yelling orders at the SBA to turn on the NBC, and to put the baby there, or use the oxygen. The* yoshoda *brought over the oxygen canister, but it was empty. (Field Note: 10/11/2011).*

The use of medical technology in CHCs provides one of the clearest examples of how a modern, westernized, bio-medical labor room was imagined. In both trainings and audits, BHRC staff iterated the importance of SBAs being able to use simple technologies, like a partograph, to more complex technologies such as automated suctioning equipment, autoclaves and new-born care corners. It is important to note that far more intricate equipment is needed to regulate infant heart rate and the purpose of NBCs becomes irrelevant when infrastructural issues like electricity access are compromised. Most of the NBC stations I observed had very limited capacity but more often then not, they were not operational, and had not been

for quite some time.

During all of our audits of CHCs, NBCs were one of the first spaces Dr. Jaya and Anjali would inspect. We often found them either not plugged in, or piled high with boxes or other medical waste. When we would question staff about why the NBCs were not in use, most SBAs stated that the labor room staff was not comfortable or trained to use the equipment. Some SBAs also stated that these technologies seemed complicated and difficult to use quickly. The following excerpt illustrates how these NBCs were treated in the labor room environment:

> *When I first entered one of the CHC delivery rooms, Dr. Jaya beamed as she pointed to the two newborn care corners (NBCs) positioned side by side in the neo-natal ward. These units were fitted with a warming tray that was capable of monitoring infant body temperature and blood pressure. "This room used to be a storage closet when we first started coming here," she explained, "But we advocated with this CHC to clean it out. It took so much work, a year's worth of work to get them to clear it out, and then to get the funds for the machines. But we kept on it, and now look. We have this beautiful new born care unit" (Field Note: 10/12/2011).*

The utilization of NBCs provides one interesting example of what DelVecchio-Good (2010) describes as the biotechnical embrace, which she argues situates the use of high-tech medical interventions as integral to legitimizing treatments that perpetuate the political economy of hope. These treatments and technologies, she asserts, become inextricable from patient expectations for care and physician standard practices (275). Bio-technical interventions that are seen as life-saving therapies are powerful because they spark the medical imagination of practitioners and patients, re-shaping their expectation of what medical intervention in a CHC can and should entail for both mother and infant. This happens regardless of the ability to deliver on these expectations and despite evidence that implementation will measurably improve birth outcomes. The point is that interventions like EBDs, and technologies like NBCs, are perpetuated, reified and hyper-valued, even in the absence of evidence of their worth (or even of their use, for that matter) because they are fueled by the *hope* that mothers and babies will be saved. The question is, who benefits from this political economy of hope?

The results of this study point to a significant juxtaposition between the imagined benefits of EBDs and the real barriers SBA associated with these practices and also demonstrate how NGOs become a regulatory apparatus, with the dual objective of: 1) marketing EBDs as a product that organizes, modernizes, and controls delivery rooms; and 2) regulating EBD use by SBAs. Ethnographic data collected from inside institutional delivery room spaces, shows the impact of EBDs and the ways in which they contribute to the production of an imagined labor room.

In the imagined labor room, the application and monitoring of EBDs by SBAs also produces a community expectation that CHCs offer a space for safe and speedy deliveries. Understanding EBDs as a kind of discursive product that offers the promise of a safe, modern delivery, a product that is distributed from a CHC network regulated by NGOs, produces a number of important implications. I explore the implications of these findings in the chapter that follows.

Chapter 5: Discussion

I have described three themes that emerged from SBAs narratives, and triangulated these accounts using participant observation and expert interviews to illustrate several key dynamics at play within these labor rooms. These include: a willingness to comply with NGO authority in the labor room, the association between the promise of a modern, 'safe' delivery rooms and the use of new-technologies and Evidence-based Delivery practices, and the subsequent tension between the imagined benefit of these interventions and the lived realties described by skilled-birth attendants. Ultimately, I argue that EBDs represent a unique product marketed from a globalized, political economy of hope. Yet the lack of empirical evidence that links their application to improved maternal and neo-natal health outcomes reveals them as primarily symbolic and part of a larger project of reifying NGOs as a regulatory apparatus.

In juxtaposing SBA's narratives with observations of their management of deliveries, a powerful inconsistency between the imagined utility of EBDs and the real barriers to their application within the labor room becomes visible. SBA's inconsistent use of EBDs demonstrates a certain degree of resistance to the total re-formation of their *habitus* by the NGO. While SBAs did not explicitly articulate any criticisms of EBDs, they did practice resistance at certain moments during management of labor. Often, SBAs expressed that during emergencies they would abandon the EBDs that took too much time or stalled speedy delivery. In my short time in the community health centers of rural southern Rajasthan, I found this to be true, particularly after observing the death of five infants, all of whom had been delivered with at least the partial application of EBDs and new-technologies like new-born care corners.

NGOs cannot simply be viewed as neutral actors that alleviate excessive demand on state resources by catering to the needs of communities. As the case of RHAT suggests, NGOs can be seen as representing a clear extension of

governmentality as they engage in the surveillance, management and control of labor rooms. A number of scholars (Fisher 1997; Markowitz 2001; Ebrahim 2001; Gauri and Galef 2005) have evoked a critical anaylsis that situates NGOs as representitives of unique loci of intersecting power relations that: a) shape indivudals who participate with these organizations and their programs; b) experience constant re-shaping by external state and internal forces; c) exercise this power onto their communities of praxis, while subsequently serving as sites of resistance. In her examination of birth attendant training in North India, Pinto (2006) examines the interplay between these dynamics. She argues that governmental and non-governmental health institutions are physically present in rural settings, particularly in rural North India, but states:

> The absence or uncertain presence of official institutions means that, for many, they exist primarily as points of imagination and longing, obscuring their functional purpose. This is all the more apparent in the context of globalization and…reliance on foreign donors and their agendas, and structural orientations toward profit and short-term interventions (337).

In terms of NGO presence in the reproductive health sector, Pinto (2006, 338) argues that while the "skeleton" of community health centers is visible, they are often chronically understaffed, medically unequipped spaces that provide inconsistent service to the community, despite the role NGOs seek to play in improving the capacity of these space. Pinto (2006) contends that:

> Government programs have, over the decades since independence, placed various figures (such as Assistant Nurse Midwives and Community Health Workers) in rural communities to provide care and educate the public. These workers operate in ever changing capacities (as policy, funding, and government organization fluctuate) alongside more permanent institutions and the stop-and-start workings of NGO and state "schemes." The line between governmental and nongovernmental agencies is often unclear, and the use of "sarkar" (government) for both calls into question the distinction between them (339).

As both Pinto (2009) and Van Hollen (2003) point out, Indian NGOs have a long history of implementing programs geared toward the training and re-shaping of birth attendants, who in Van Hollen's view are often some of the primary targets of

maneuvering development.

Pandolfi (2010) and Van Hollen (2003) argue that NGOs have become a unique site for both conducting and directing state power through a dissemination of projects that make local communities targets of development. Beginning in the 18th century, Foucault (1973) argued that state power began to shift from a punitive control of citizens to a management of populations through the new regime of bio-power. Bio-power channeled discursive norms, produced from a kind of normalized truth, to extend government control over citizens by coercing a shift in their performance toward behaviors prescribed through normative discourse (Foucault 1984). Van Hollen (2003) contends that within development discourse, bio-medicalized care, managed through healthcare institution, has become a central indicator for gauging the successful application of development projects. She further argues that in both governmental and NGO sectors, development projects target pregnant women as 'less developed' and attempt to transform their bodily practices by managing them in institutional settings (Van Hollen 2003, 168). A similar dynamic is at play with SBAs trained and monitored by RHAT. The promotion of bio-medicine as a form of discursive power targets labor room attendants, marking their practices and knowledge about the birthing body sites for the negotiation of development discourses.

Both the Government of Rajasthan and RHAT's trainings programs for SBAs serve as modalities for reforming how attendants manage deliveries, thereby redefining the *habitus* of SBAs themselves. In the Bourdieuian conceptualization of *habitus*, individuals engage in processes of conditioning, which articulate a 'correctness' of practices deployed consistently over time. Certain practices or behaviors generate a regularity that characterizes how individuals perform and engage in their fields of practice (1990, 53-4). The process of engaging in this regulation produces an SBA who will have a specific set of practices she has been taught and which to her become so 'natural' that their source is never questioned (Bourdieu 1990; Foucault 1979). Furthermore, the promotion of Evidence-based Delivery

practices (EBDs) in institutional labor rooms becomes significant in this process because, despite the fact that their effectiveness was rarely questioned, their discursive power manifested in a number of ways.

EBDs, as a scientifically legitimized strategy for managing labor and delivery, can also be understood as one component of global technoscapes (Appadurai 1996), particularly as they represent both a discourse about, and methodology for re-shaping understandings and epistemological practice for labor management. Janes and Corbett (2010), in their exploration of the landscape of global health, draw on Appadurai's (1996) discussion of technoscapes to illustrate how global technoscapes function at a macro-level. They argue that global technoscapes are comprised of a mix of things (e.g., medicines, medical devices, machines), techniques (e.g., medical procedures), and bundles of shared understandings and epistemological practices that together constitute normative science in the global north (409). Yet, despite the fact that EBDs have been promoted as a normative bio-medical approach for managing delivery, and were incorporated into SBA training curricula, there is no evidence that they have reduced maternal or infant mortality in southern Rajasthan. In fact, during my internship, I saw more term neonatal deaths in one day in one center, than a large, tertiary hospital in the U.S. might see in a one year.

The promotion of EBDs as scientifically legitimate becomes questionable then, particularly when little data supporting their effectiveness in an Indian context is available. Furthermore, EBDs are imported from a view of the labor process articulated through a combination of humanitarian initiatives and research supported by the global north, and fuelled into the global south. In the case of EBDs, most of the data supporting the utilization of these practices was carried out through western public health initiatives conducted almost exclusively in Africa. However, NGOs, like RHAT, receive directives from both state and/or IGO forces in the form of financial support and programmatic implementation support if they incorporate practices, like EBDs into their programs. This begs the question: Who benefits from these programs?

RHAT was intricately involved in, not only the re-production of SBA *habitus,* but also in the promotion of EBDs as a kind of biomedical product that was meant to restructure public *perception* about the quality and safety of institutional delivery. This was characterized by RHAT surveillance of SBAs use of new-technologies (NTs), and insistence that they incorporate these technologies in to practice. In this way, the biotechnical embrace can be seen as having been heavily promoted by the state and NGO advocacy efforts despite the utility of many of these. Furthermore, because EBDs are marketed through a political economy of hope, which ascribes the promise of better birth outcomes, they perpetuate a medically imagined set of health outcomes which continue to contrast with the reality of maternal and neo-natal lived experiences in Rajasthan.

The promotion of biomedical technologies and a westernized EBD discourse comes from a neo-colonial conceptualization of modernity and high-tech bio-medicine as intrinsically safer and inherently lacking in the global south. Numerous authors, including Witeford and Eden (2011) argue that globalization of health policies that promote a kind of modernized brand of healthcare are generally poor fits with culturally determined, local needs.

Chen (2011) takes this argument a step further. She argues that:

> Positioning rural subjects as efficient vis-à-vis the state's discourses of modernity…the state positions itself as invariably progressive, responsible, and promising in its quest to legitimize its hegemonic population policy and thereby discursively transform peasants—especially women—into docile instruments of its modernity project (39).

Whiteford and Eden (2011) and Chen (2011) argue that state and non-governmental actors also hyper-standardize care in order to target reproductive bodies as sites for modernization and development. However, in my experience, SBAs, CHC delivery rooms and the reproductive bodies of women birthing in those spaces also provide sites for state control, fuelled through NGOs. Furthermore, the use of SBA practitioners as sites for control, and targets of development, streamlines a specific flow of power from the global and state level into the reproductive body and birthing

space. Richey's (2010) terms "therapeutic citizenship" and "therapeutic state" provide a way to understand how global and state forces inscribe projects of modernity onto SBA practitioners. Richey asserts that the relationship between "therapeutic citizenship" and a "therapeutic state" is one where the citizen is characterized by a medical condition within a political or institutional framework, that allows the state to act as both a "performative apparatus and ethical project" (70-71).

In this sense, the therapeutic state is the cumulative project of state, international and non-governmental project of delivery reformation, framed as an ethical project. EBDs then, become a kind of ethical discourse promoting the safety of birth and requiring adherence to a specific discursive process. Failure to follow that process then, is seen as unethical because of the potential risks that non-adherence may produce for the mother and baby. Furthermore, because this project is framed as ethical, and requires a professionally specific performance in the labor room, the state is able to reify the extension of its authority within those spaces. Whether the EBDs deliver the promised safety is largely beside the point.

Janes and Corbett (2010) assert that this flow of discourse from the global north into operationalized practice in developing countries illustrates the "global circulation of expert knowledge [which] produces particular relations of power between policy makers and policy subjects, culminating into the establishment of epistemic communities. As these loose networks of actors develop frameworks of knowledge, values, and beliefs that culminate into particular configurations of public health policy and action…These communities become powerful representatives of a global capitalist class that can, "set agendas, frame issues, identify problems, and propose solutions" and as these networks extend, they form at the core of global health governance (Janes and Corbett 2010, 411). To bring this discussion full circle, conceptualizing NGOs as central components of these epistemic communities within the landscape of reproductive health makes explicit their status as conduits of power. If the practices and technologies NGOs promote are not being shown to assuage maternal and neo-natal mortality, yet, they are tied to enormous funding streams

sourced from state and international actors, again the question surfaces as to who benefits from the promotion of new-technologies and Evidence-based Delivery practices in Rajasthani labor rooms?

Chapter 6: Conclusions

In this thesis, I have argued that NGOs have engaged in the promotion, marketing and distribution of Evidence-based Delivery practices within a kind of political economy of hope (DelVecchio Good 2010). I contend that, in order to re-sculpt skilled-birth attendants into conduits for promoting global and state projects for modernizing community labor rooms, NGOs, like RHAT, have made SBAs the target of training programs and surveillance exercises, aimed at re-shaping these individuals into 'modernized' care providers. I demonstrated my argument by drawing on the lived experiences of SBAs who have participated in RHAT's training programs and been part of the NGO audits of community health centers. Ultimately, I have shown that the mechanisms RHAT uses to distribute EBDs within labor rooms contributes to the production of an imagined labor room, which deploys these practices as integral to insuring safer deliveries. However, despite the discourse that promotes EBDs as based in evidence -- a discourse that draws a causative relationship between their implementation and safer birth outcomes -- there is no data that clearly shows these practices to be effective in decreasing maternal and neo-natal mortality in southern Rajasthan. While this is not to say that EBDs have been completely ineffective in producing some positive delivery outcomes, their unquestioned implementation into the curriculum of skilled-birth attendant training is worthy of critical examination. Furthermore, the extent to which SBAs practice resistance to the total adoption of these practices into their process for managing labor hints at the impracticality of these practices within and Indian context.

There is no question that the status of maternal and neonatal health in Rajasthan is critical, and deserving of significant attention. While a number of prior studies have examined the role of international, state and NGO responses to issues of maternal healthcare, I have utilized this case study as a lens to examine how NGO responses to maternal healthcare is often multifaceted within a larger global ethnoscape of bio-medical healthcare. Nevertheless, there are some important

limitations to this study. At a macro-level it seems that a larger exploration into the shifting relationships between NGOs and their communities of practice is necessary. As Fisher (1997) points out, NGOs have only existed as a third sector since the early 1950's and their form, function, mission and relationship to global forces has never been stagnant. A deeper exploration of who NGOs work for, and the extent to which they should or can be viewed as representing their communities best interests demands further investigation as well. I would argue that further research should explore how SBAs are formally educated at the vocational level, and subsequently trained, or re-trained by NGOs as a lens for exploring how midwives becomes sites for the distribution of NGO authority and SBA expressions of resistance.

The applied significance and value of this work is multifaceted, and begs the larger question of how this kind of work can prove beneficial to the community. Bougeious and Schonberg (2009) contend that utilizing an approach they term "critically applied public anthropology" provides a strategy for making this kind of work relevant to communities, in this case to midwives impacted by NGO trainings. Bougeoius and Schonberg (2009) point out that, at its crux, critically applied public anthropology seeks to use ethnographic data for practical and policy level changes, and notes that this can run the risk of allowing political debates and policy discussion to revert to "discursive logics of power that propel governmentality, shape subjectivies, reinforce habitus-based inequalities, and extend the reach of biopower" (297). However, they further argue that in order to escape the paralysis catalyzed by post-modern critique of applied ethnography within the political sphere, "good-enough" ethnographies can infuse these debates by illustrating how the local, socio-cultural dimension of healthcare, which are often missing from larger political debates about reproductive healthcare in India. In the case of RHAT's work with SBAs and EBDs, particularly as global and state forces are pushing NGOs to increase the frequency of institutional deliveries, ethnographic work examining how NGOs are conceptualizing and operationalizing projects to reform labor rooms can have a tremendous impact in several ways.

First, by examining discursive products like EBDs and how they, in tandem with NGO-sponsored promotion of a biotechnical embrace, function within labor rooms, the realities of institutional deliveries can be teased out of those imagined, or promoted by NGOs. For example, by examining how SBAs relate to technologies like NBCs, this case study demonstrates that having those devices in labor rooms did not alter the safety of delivery or SBA confidence in their ability to manage newborn emergencies. Secondly, examining SBAs perception of NGOs and relationship to their community of practice, produces an understanding of how they understand their work, and what the community believes they will receive from an institutional delivery.

As state and global policy makers conflate institutional deliveries with safer deliveries and better maternal and neo-natal health outcomes, a critically applied public anthropology that can elicit ethnographic data on the local dynamics of these deliveries is imperative. Understanding the realties of institutional deliveries, and how they vary depending on local, socio-cultural circumstances provides a more dynamic picture of where improvements are need in the institutional system. While NGOs are most certainly involved in the promotion of a political economy of hope that markets EBDs as a discursive package that can produce a safer delivery room, the data presented in this case study illustrates that often, that delivery room is an imagined one. Yet, SBA midwives represent one site for resistance. Through the examination of the lived experiences of these providers, a more comprehensive picture of the community labor room is visible. In their understanding of the space, context and community expectation of delivery, there is also an opportunity for re-imagining a labor room that incorporates strategies for making birth safer in a way that becomes meaningful within the context of delivery in rural southern Rajasthan.

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Appendices

Appendix A1: Informed Consent (English Version)

Protocol Number: 4965
Title: THE ORGANIZATIONAL CULTURE OF NGOS: EXAMINING APPROACHES TO PROVIDING REPRODUCTIVE HEALTHCARE AND EDUCATION IN INDIA.
PRINCIPLE INVESTIGATOR: DR. SUNIL KHANNA

Oral Consent Form (English Version: Population 1 and 2)

What is the Purpose of this study?

This is Sara Price. She is a visiting student from the United States. You are being invited to take part in a research study she is helping with. This study is trying to learn about how ARTH works with this community. Sara also wants to know what you think about your work. Sara may use this information for her thesis and publication in academic journals. You may ask any questions about the research at any time. You can also ask about the possible risks and benefits, your rights as a volunteer, and anything else that is not clear. Participating in this study will not affect your work with ARTH and your name will not be used. When all of your questions have been answered, you can decide if you want to be in this study or not.

WHAT WILL HAPPEN DURING THIS STUDY AND HOW LONG WILL IT TAKE?

If you agree to take part in this study, your involvement will last for up to one-and-one-half hours. Sara will show you the findings from your interview and/or survey to see if you agree with it. You will also be asked to add your own interpretations of the findings. Sara plans to audio-record the interviews if it is ok with you; if it is not ok, Sara will take notes on your comments.

WHAT ARE THE RISKS OF THIS STUDY?

The possible risks and/or discomforts associated with this study include emotional discomfort that may come up when you talk about opinions and experiences. To minimize discomfort, you can choose not to answer any of the questions, or you can stop participating in the study at any time you choose.

WHAT ARE THE BENEFITS OF THIS STUDY?

There are no direct benefits from participating in this study.

WHO WILL SEE THE INFORMATION I GIVE?

Sara will do keep the information you provide confidential to the extent permitted by law. To help protect your confidentiality, Sara will use numbers and/or made up names to refer to you and other participants. Any materials that could be used to

connect your name with numbers or the fake name assigned to you will be stored in a locked and secure file box and/or using password protected computer files.
If the results of this project are published, your identity will not be made public.

DO I HAVE AN OPTION TO BE IN THE STUDY?

It is up to you if you want to be in this study. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering.

You will not be treated differently if you decide to stop taking part in the study. You are also free to skip any questions during the interview that you would prefer not to answer. You may withdraw your interview at any time with no penalty by contacting either of the researchers by calling or email.

WHAT IF I HAVE QUESTIONS?

If you have any questions about this research project, please contact: Dr. Sunil Khanna, at +01-541-737-3859, skhanna@oregonstate.edu and/or Sara Price, prices@onid.orst.edu.

If you have questions about your rights as a participant, please contact the Oregon State University Institutional Review Board (IRB) Human Protections Administrator, at +01-541-737-8008 or by email at IRB@oregonstate.edu

For the Researcher to complete:

Name of Participant: _____ Date: _____

Gender: Male ☐ Female ☐

Agree to Participate in study? Yes ☐ No ☐

Agree to be audiotape? Yes ☐ No ☐

Researcher's Signature: _____Date: _____

Appendix A2: Informed Consent (Hindi Version)

Protocol Number: 4965
Title: THE ORGANIZATIONAL CULTURE OF NGOS: EXAMINING APPROACHES TO PROVIDING REPRODUCTIVE HEALTHCARE AND EDUCATION IN INDIA.
PRINCIPLE INVESTIGATOR: DR. SUNIL KHANNA

Oral Consent Form (Hindi Version: Population 1 and 2)

मौखिक सहमति पत्र (अंग्रेजी संस्करण, 1 जनसंख्या और 2)

क यहइस अध्ययन का उद्देश्य क यहै?

यह सारा मूल्य है. वह संयुक्त राज्य अमेरिका से एक पर जाकर छात्र है. आप एक शोध अध्ययन के साथ वह मदद कर रहा है में भाग ले नेका रहा है आमंत्रित हैं. इस अध्ययन को जानने के बारे में कैसे अर्थ इस समुदाय के साथ काम करता रहा है. सारा भी पता है कि आप अपने काम के बारे में सोचना चाहता है. सारा उसे और अकादमिक पत्रिकाओं में शोध के प्रकाशन के लिए इस जानकारी का उपयोग कर सकते हैं. आप किसी भी समय अनुसंधान के बारे में कोई प्रश्न पूछ सकते हैं. आप यह भी संभव जोखिम और लाभ, एक स्वयंसेवक के रू प में अपने अधिकारों, और कुछ और है कि स्पष्ट नहीं है के बारे में पूछ सकते हैं. इस अर्थ और अपने नाम के साथ अपने काम को प्रभावित नहीं करेगा अध्ययन में भाग का प्रयोग नहीं किया जाएगा. जब आपके सभी सवालों का जवाब दे दिया गया है, तुम अगर तुम यह नहीं या अध्ययन में होना चाहता हू फैसला कर सकते हैं.

यह अध्ययन के दौरान क यहोगा और कब तक इसे ले जाएगा?
यदि आप इस अध्ययन में भाग ले नेके लिए सहमत हैं, या आप साक्षात्कार होगा करने के लिए एक सर्वेक्षण ले नेके लिए कहा. इस अप के लिए एक और एक आधे घंटे के लिए पिछले जाएगा. सारा आप अपने साक्षात्कार और / या सर्वेक्षण से निष्कर्ष को दे खनेके लिए शो अगर आप इसके साथ सहमत नहीं होगा. तुम भी अपने खुद के निष्कर्ष की व याख यजोड़ने के लिए कहा जाएगा. सारा ऑडियो रिकॉर्ड साक्षात्कार अगर यह तुम्हारे साथ ठीक है की योजना बना रहा है, अगर यह ठीक नहीं है, सारा अपनी टिप्पणी पर नोट ले जाएगा.

क यहइस अध्ययन के जोखिम हैं?

क यह इस अध्ययन के जोखिम हैं?

संभावित खतरों और / या इस अध्ययन से जुड़े असुविधाएँ भावनात्मक बेचैनी है कि ऊपर आ सकता है जब आप विचारों और अनुभवों के बारे में बात कर सकते हैं शामिल हैं. वहाँ भी जोखिम है कि गोपनीयता breeched हो सकता है. कि जोखिम को कम से कम, आप किसी भी सवाल का जवाब नहीं चुन सकते हैं या आप किसी भी समय आप चुन में अध्ययन में भाग ले नेहीं रोक सकता.

क यह इस अध्ययन के लाभ हैं?

इस अध्ययन में भाग ले ने कोई सीधा लाभ हैं.

जो जानकारी मुझे दे दे खे ?गा

सारा जानकारी आप कानून द्वारा अनुमत सीमा तक गोपनीय रखने के लिए प्रदान करेंगे. मदद करने के लिए आपकी गोपनीयता की रक्षा, सारा संख्या और / या नामों का उपयोग किया जाएगा करने के लिए आप और अन्य प्रतिभागियों को दे खेकिसी भी सामग्री है कि संख्या या नकली आपको असाइन नाम के साथ अपना नाम जोड़ने के लिए इस्तेमाल किया जा सकता है एक बंद और सुरक्षित फ़ाइल्सॉक्स में संग्रहित किया जाएगा और / या प्रयोग पासवर्ड संरक्षित कंप्यूटर फ़ाइलों अगर इस परियोजना के परिणाम प्रकाशित कर रहे हैं, अपनी पहचान सार्वजनिक नहीं किया जाएगा.

क यामैं एक के लिए अध्ययन में इ विकल्प है?

मौखिक सहमति पत्र (अंग्रेजी संस्करण, 1 जनसंख्या और 2)

क याइस अध्ययन का उद्देश्य क यहै?

यह सारा मूल्य है. वह संयुक्त राज्य अमेरिका से एक पर जाकर छात्र है. आप एक शोध अध्ययन के साथ वह मदद कर रहा है में भाग ले नेका रहा है आमंत्रित हैं. इस अध्ययन को जानने के बारे में कैसे अर्थ इस समुदाय के साथ काम करता रहा है. सारा भी पता है कि आप अपने काम के बारे में सोचना चाहता है. सारा उसे और अकादमिक पत्रिकाओं में शोध के प्रकाशन के लिए इस जानकारी का उपयोग कर सकते हैं. आप किसी भी समय अनुसंधान के बारे में कोई प्रश्न पूछ सकते हैं. आप यह भी संभव जोखिम और लाभ, एक स्वयंसेवक के रू प में अपने अधिकारों, और कुछ और है कि स्पष्ट नहीं है के बारे में पूछ सकते हैं. इस अर्थ और अपने नाम के साथ अपने काम को प्रभावित नहीं करेगा अध्ययन में भाग का प्रयोग नहीं किया जाएगा. जब आपके सभी सवालों का जवाब दे दिया गया है, तुम अगर तुम यह नहीं या अध्ययन में होना चाहता हू फैसला कर सकते हैं.

यह अध्ययन के दौरान क यहोगा और कब तक इसे ले जाएगा?

यदि आप इस अध्ययन में भाग ले नेके लिए सहमत हैं, या आप साक्षात्कार होगा करने के लिए एक सर्वेक्षण ले नेके लिए कहा. इस अप के लिए एक और एक आधे घंटे के लिए पिछले जाएगा. सारा आप अपने साक्षात्कार और / या सर्वेक्षण से निष्कर्ष को दे खनेके लिए शो अगर आप इसके साथ सहमत नहीं होगा. तुम भी अपने खुद के निष्कर्ष की व याख यजोड़ने के लिए कहा जाएगा. सारा ऑडियो रिकॉर्ड साक्षात्कार अगर यह तुम्हारे साथ ठीक है की योजना बना रहा है, अगर यह ठीक नहीं है, सारा अपनी टिप्पणी पर नोट ले जाएगा.

क याइस अध्ययन के जोखिम हैं?

यह आप पर निर्भर है अगर आप इस अध्ययन में होना चाहता हू.ँआप किसी भी लाभ या आप सामान्य रू पसे यदि आप स्वयंसेवक का चयन नहीं होता अधिकार नहीं खो देंगे. आप अध्ययन के दौरान किसी भी समय रोक सकते हैं और अभी भी लाभ और अधिकार आप स्व यंसे वसे पहले था रखने के लिए.

आप अलग तरह से इलाज नहीं किया अगर तुम अध्ययन में भाग ले नेको रोकने का फैसला करेगा. आप को भी साक्षात्कार के दौरान किसी भी सवाल है कि आप पसंद को छोड़ करने के लिए जवाब नहीं होगा मुफ्त. आप शोधकर्ताओं में से कोई एक फोन या ईमेल द्वारा संपर्क करके कोई जुर्माना के साथ किसी भी समय अपने साक्षात्कार वापस ले सकते हैं.

क यहोगा यदि मैं सवाल है?

यदि आप इस अनुसंधान परियोजना के बारे में कोई प्रश्न हैं, कृपया संपर्क करें: +91-294-2451033 डा. डॉ. डी. शरद अयंगर, अर्थ मुख्य कार्यकारी अधिकारी, arth.sac @ gmail.com, डॉ. सुनील खन्ना, 01-541 पर -737-3859, skhanna@oregonstate.edu और / या सारा मूल्य, prices@onid.orst.edu.

यदि आप एक भागीदार के रू पमें अपने अधिकारों के बारे में प्रश्न हैं, +01-541-737-8008 में ओरेगन स्ट े यूनिवर्सिटी संस्थागत समीक्षा बोर्ड (आईआरबी) मानव सुरक्षा प्रशासक से संपर्क करें या IRB@oregonstate.edu पर ईमेल द्वारा कृपया

Appendix B1: SBA interview guide (English Version)

Protocol Number: 4965
Title: THE ORGANIZATIONAL CULTURE OF NGOS: EXAMINING APPROACHES TO PROVIDING REPRODUCTIVE HEALTHCARE AND EDUCATION IN INDIA.
PRINCIPLE INVESTIGATOR: DR. SUNIL KHANNA

Subject ID # _____

Date: _____

Interview Guide for SBA Population: (English and Hindi)

Interview location: _____
Pseudonym: _____
Date: _____
*Start time:*_____
End time: _____

1. Gender: M _____ F_____
2. How old are you*?*_____

3. When did you attend the SBA training? _____

4. For how many days did you attend this training? _____

5. How long have you worked at this hospital?_____

6. What is your designation at this hospital? _____

7. What is your degree? _____

8. Why did you decided to participate in the SBA training?

9. Can you tell me what you learned in the training?

10. Where the skills you learned new for you?

11. Did you know about these skills before the training?

12. Is it hard or easy to use these protocols?

a. If yes, why:
b. If no, why:

Note: If SBA was observed not following protocols, probe about specific instance where non-adherence was observed. Probes:
13. When _X_ (thing observed), you did not follow protocols. Why didn't you use the protocols at that time? 14. _X_ (person) did not use the protocols. Why? 15. When protocols aren't followed, what do you do?

16. How often do you use the protocols from the training (on a scale of 1-5, 1=never; 5=always)?
    (Probe: Based on scale number ask "why?" for each of the following practices; Notes: Ask even if they give a 5)
    - IM Oxytocin
    - Fetal monitoring partograph
    - AMTSL
    - Newborn resuscitation
    - Fundal Pressure
    - Drying and wrapping new born

17. Think of a time when you wanted to use a protocol you had learned but you did not use it? What happened?

18. Tell me about the people you work with:
19. Do they use these skills?
20. What do they do when you do?
21. If you see someone doing something they shouldn't, what do you do?

Appendix B2: SBA interview guide (Hindi Version)

परिशिष्ट: एफ 2 जनसंख्या (अंग्रेजी और हिन्दी के लिए साक्षात्कार गाइड)

साक्षात्कार स्थान_____

छद्म नाम

तिथि

प्रारंभ समय

अंत समय

१. लिंग: म _____ फ_____

2. आपकी उम्र क्या है?_____

३. आप एसबीए प्रशिक्षण में जब कोम्प्लेते किया? _____

४. कितने दिनों के लिए आप इस प्रशिक्षण में आ गए? _____

५. आप कितनी समय इस अस्पताल में काम किया है?_____

६. इस अस्पताल में अपने पद क्या है? _____

७. अपने डिग्री क्या है? _____

८. आप को एसबीए प्रशिक्षण में भाग लेने के योंका फैसला किया था?

९. आप मुझे बता सकते हैं आप प्रशिक्षण में क्या सीखा?

१०. जहां कौशल आप आप के लिए नया सीखा?

११. क यक्षाप को ट्रेनिंग से पहले इन स्किल्स के बारे में पता है?

१२. आपको, ये प्रक्टिसस मुश्किल या आशानी लगते हैं? अगर "हा": फिर क यों?अगर "नहीं": फिर क यों

१६. आप कितनी बार प्रशिक्षण से प्रक्टिसस इस्तमाल करते हैं?, (५ से १ का सकाले में: ५ जसे हमेशा है और १ जसा नहीं है)

(प्रोब: पैमाने पर संख्या के आधार पर पूछओ "क यों?") निम्नलिखित प्रथाओं के प्रत्येक के लिए, नोट्स: पूछें यहाँ तक कि अगर वे एक 5 दे)

आईएम ओक्स्य्तोची (इम ऑक्सैटोसिन)

फेटल मोनिटरिंग पर्तोग्रफ से (फीटल मॉनिटरिंग वित परटोग्राफ)

अ.म.टी.स.ल.(अंतस्ल)

रेसुसितातिओं बीचो कई ले ईन्यूबोर्न रे ससिटे शन

फुन्दल प्रेस्सुरे दे ना(गिविंग फंडल प्रेशर)

दरी एंड वरप बच्चो (ड्राइ आंड रॅप न यूबोर्न)

१७. आप एक समय के बारे में सोचो जब आपनै जो सबा प्रसिसस सीखाके इस्तमाल करना चाहये, ले किन्आपनै इसे प्रक्टिस इस्तेमाल नहीं किया? क यहु आ

१८. मुझे आप लोगों के साथ काम के बारे में बताओ:

१९. वे इन स्किल्स करते हैं?

२०. जब आप स्किल्स करते हैं, तब वे क याकरते हैं?

२१. अगर आप दे खतेहैं किसी को कुछ चे इज़ाकर रही है, ले किन्हे नहीं करना चाहिए, फिर आप क याकरते हैं?

Appendix C1: CHC Evaluation Check list (English Version)**:**

Q. No.	Question:	Response:
1	Did the women have her pubic hair shaved?	Yes/No
2	Was the women given an enema?	Yes/No
3	Was the women's labor monitored with the partograph?	Yes/No
4	Was the woman sitting or was she lying down during labor?	Yes/No
5	During her labor pain was the baby's heart rate monitored?	Yes/No
6	Was the mother's blood pressure and pulse monitored during labor?	Yes/No
7	Did she have a vaginal examination?	Yes/No
8	Was the woman provided any injections, pills or gels to accelerate labor?	Yes/No
9	Was an episiotomy given to get the baby out?	Yes/No
10	Was fundal pressure used to get the baby out?	Yes/No
11	After labor was the umbilical cord cut within one minute or after pulsing stopped?	Yes/No
12	After the baby came out and it was checked that no twins were coming, was oxytocin administered?	Yes/No
13	Did the nurse give (uterine) message to the mother?	Yes/No
14	Did the women have (vaginal) packing done?	Yes/No

15	Was the baby given suction after delivery?	Yes/No
16	How was the suction done?	Yes/No
17	After delivery, was BP measured?	Yes/No
18	Was breastfeeding initiated within one hour?	Yes/No
19	Immediately after birth was the baby dried and dressed?	Yes/No
20	After delivery how often was the mother looked after? How many times was she monitored?	½ hr: Yes/No After one hrs: Yes/No After two hrs: Yes/No Etc.:
21	After delivery was the women's blood pressure measured?	Describe:
22	After delivery was the woman's pulse measured?	Describe:
23	After delivery was her vagina examined?	Describe:
24	After delivery was the infant monitored?	Yes/No

Appendix C2: CHC Evaluation Check list (Hindi Version)

संस्थान का नाम

प्रदाता का नाम व पद

क.सं.	प्रकियाएं	स्कोर
1	महिला की *Shaving of pubic hair* की गई	हॉ/ नही
2	क्या महिला को एनिमा लगाया गया ?	हॉ/ नही
3	पार्टोग्राफ पर महिला के प्रसव की प्रगति को अंकित किया गया ?	हॉ/ नही
4	क्या महिला का प्रसव अर्ध बैठी अवस्था या अन्य स्थिति जिसमें महिला चाहे में कराया गया	हॉ/ नही
5	क्या प्रसव के दर्द के दौरान महिला पेट पर बच्चे की धड़कन की जाँच (स्टेथोस्कोप द्वारा) की गई ?	हॉ/ नही
6	क्या महिला की रक्तचाप एवं नब्ज की जाँच की गई ?	हॉ/ नही
7	महिला की यौनी द्वारा जाँच की गई ?	हॉ/ नही
8	क्या महिला को प्रसव के दर्द बढ़ाने के लिये कोई सूई, गोली या जैल लगाई गई ?	हॉ/ नही
9	क्या बच्चा निकालने के लिए चीरा (एपिसियोटॉमी) लगाया गया था ?	हॉ/ नही
10	क्या बच्चे को बाहर निकालने के लिए धक्का लगाया गया था ?	हॉ/ नही
11	क्या प्रसव के बाद नाल काटने में 1 मिनिट या नाल में धडकन के बन्द होने का इतजार किया और बाद में काटी गई ?	हॉ/ नही
12	क्या बच्चा बाहर आने तथा यह सुनिश्चित हो जाने के बाद की दूसरा बच्चा नही है महिला को ऑक्सिटोसीन का इन्जेक्शन लगाया गया ?	हॉ/ नही
13	क्या प्रसव के बाद महिला के पेट पर जोर से मालिश की ?	हॉ/ नही
14	क्या प्रसव के बाद महिला के Packing की गई ?	हॉ/ नही
15	क्या प्रसव के बाद बच्चे के सक्शन किया गया ?	
16	सक्शन किससे किया गया ?	
17	क्या आपके प्रसव के बाद भी बीपी की जाँच की गई ?	हॉ/ नही
18	क्या प्रसव के बाद एक घन्टे के अन्दर दूध पिलाना शुरू कर दिया गया ?	हॉ/ नही
19	जन्म के तुरन्त बाद बच्चे को पोंछा, सुखाया व लपेटा गया?	हॉ/ नही
20	क्या प्रसव के बाद महिला की प्रसवोपरान्त देखभाल कितनी कितनी देर में की गई ?	आधे घन्टे से 1 घन्टे बाद 2 घन्टे बाद अन्य..... ...
21	क्या प्रसव के बाद महिला का बीपी नापा गया ?	
22	क्या प्रसव के बाद महिला का पल्स नापा गया ?	
23	क्या प्रसव के बाद महिला की पेट की जाँच की गई ?	
24	क्या प्रसव के बाद बच्चे की देखभाल की गई ?	हॉ/ नही