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# Perceptions of Rural Birthing Practices: A Glimpse into Maternal and Child Health for Women in Kangra District, Himachal Pradesh

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# I. Abstract

Over the past two decades birthing practices within India have drastically changed. This change is most visible in the shift from homebirths to hospital births following the implementation of the National Rural Health Mission. This study aims to understand and give voice to women's perceptions of birthing practices in the rural villages of Kangra District of Himachal Pradesh. A total of ten interviews were conducted with both mothers and healthcare practitioners in the surrounding villages of Kangra District in order to gain a thorough, qualitative understanding of birthing practices in the local communities. The healthcare practitioners' responses were divided according to their profession: Accredited Social Health Activists (ASHAs), Anganwadi Workers (AWWs), and Birth Attendants. The mother's responses were categorized according to five themes: Preparation for the Birth and Prenatal Care, Birthing Experience, Traditions and Cultural Norms Surrounding Birth, Changes in Birthing Practices over the Generations, and Hope for the Future: How to Improve Birthing Practices. Analysis of the interview responses indicated that the National Rural Health Mission has greatly influenced women's perceptions of birthing practices. When combined with a greater level of education and health literacy, these government schemes have fully changed the narrative surrounding birth. Women now view hospital births as the norm and homebirths are seen as backwards and too risky. The NRHM has also greatly altered how women interact with other aspects of birthing practices, such as prenatal and postnatal care. The incentivization of institutional births has created a large generational gap in perceptions of birthing practices. While childbirth in India has become much safer for both mothers and children through these government policies and schemes, all of the women interviewed agreed that there needs to be efforts made to achieve more comprehensive, women-centric maternal care.

# II. Introduction

Childbirth around the World

Childbirth is an incredible natural phenomenon that is influenced and governed by the interaction of many complex societal structures— culture, traditions, politics, economics, and science. It is also occurs very frequently with an average of 250 babies being born every minute.[1] This translates to approximately 140 million women giving birth annually.[2] Despite the frequency of childbirth around the globe, both women and newborns are still dying at alarming rates. Even as recent as 2017, 810 women died per day from preventable pregnancy and childbirth-related causes.[3] Furthermore, over 94% of these maternal deaths occur in low or lower-middle income countries.[4] Analyzing data from 2018, newborns are also dying at the alarming rate of 7,000 deaths per day.[5] Annually there are 2.5 million children dying within the first month of life around the world.[6] Despite these distressing statistics, there has been a lot of good progress made towards reducing maternal and infant mortality in the past few decades. However, the fight is not over and there is still much room for improvement. Childbirth should be seen as a beautiful phenomenon, and not a risk to the mother or child.

[1] Lucy Lamble, "With 250 babies born each minute, how many people can the Earth sustain?" The Guardian, last modified April 23, 2018, accessed December 5, 2019, https://www.theguardian.com/global-development/2018/apr/23/population-how-many-people-can-the-earth-sustain-lucy-lamble.
[2] World Health Organization, "Making childbirth a positive experience," Sexual and reproductive health, last modified February 15, 2018, accessed December 5, 2019, https://www.who.int/reproductivehealth/intrapartum-care/en/.
[3] World Health Organization, "Maternal mortality," last modified September 19, 2019, accessed December 5, 2019, https://www.who.int/news-room/fact-sheets/detail/maternal-mortality.
[4] Ibid.
[5] World Health Organization, "Newborns: reducing mortality," last modified September 19, 2019, accessed December 5, 2019, https://www.who.int/news-room/fact-sheets/detail/newborns-reducing-mortality.
[6] Ibid.

## Reasons for Researcher's Interest/Justification for Topic

Ever since the researcher was in high school and her love for travel and public health was ignited, she was always especially interested in global women's health. After reading *Half the Sky* by Nicholas Kristof and Sheryl WuDunn during her gap year, she began to look more closely at the intersection of gender and health. While studying public health at George Washington University, the researcher has opted to take classes that focus on women's global health. Furthermore, when given the option, she often focuses a lot of her research papers specifically on birthing practices both in the United States and abroad.

Even before the researcher came on SIT"s Public Health, Gender, and Community Action program she knew that she wanted to focus her Independent Study Project on maternal and child health. Throughout her time on this program, the researcher's eyes were opened even more to the complex issues of childbirth within the Indian context. During a class excursion to Satoli, Uttarakhand, there was the opportunity to sit down and talk to a group of women about their lives and health. The class was able to learn a lot about maternal and reproductive health from their stories, and how that differed greatly from a lot of the policies that are instituted by the Government of India. This field visit solidified the researcher's desire to study child birthing practices. Through further research she began to uncover more discrepancies between the official government documents and what they supposedly provided, and how it was interpreted and implemented in communities. She knew that there was a lot to be learned about maternal and child health within the context of India.

## Objectives and Research Question

This study is an attempt to understand the decision making process that women in rural Himachal Pradesh often face when it comes to birthing practices. A majority of the literature focuses more on governmental health policy changes. The literature is also concentrated on how structural, financial, and cultural barriers can alter birthing practices. The study aims to accurately capture how women navigate these policies and barriers themselves. It will focus less on the outcome of where they choose to give birth and more on the women's perspective of birth itself. There has been some secondary literature regarding women's perceptions on birth but most of it was in the earlier 2000s, only a few years after the implementation of the National Rural Health Mission (NRHM). The study is designed to capture how the NRHM has altered perceptions of birthing practices, as it has been over a decade since its implementation. Additionally, the study will hopefully give local women a forum in which they can openly discuss such a pivotal part of their life. It will focus more on their opinions, viewpoints, rationale, and perceptions rather than how the government or international bodies like the World Health Organization (WHO) or United Nations (UN) characterize childbirth in India. The primary research question for this study is: How do women in rural Himachal Pradesh perceive birthing practices and what are some of the factors that influence their birthing experience?

## Background Research

### *Himachal Pradesh*

Himachal Pradesh is nestled in the Western foothills of the Himalayas, sharing borders with Jammu and Kashmir to the north, Tibet to the east, Uttarakhand to the southeast, Haryana to

the south, and Punjab to the west.[7] It has a varied geography, with high snow-covered mountains, dense forests, deep lakes, and terraced fields. The climate is as varied as the land, with very hot summers in some locations and freezing winters in others. Himachal was once a union territory and became a state on January 25, 1971.[8] The capital of Himachal Pradesh is Shimla and it was once a favorite vacation spot for British officers before independence.[9] There are 12 districts in Himachal Pradesh.[10] Despite being well-liked by the British, Himachal Pradesh remains one of the least urbanized states in all of India. Most people in Himachal depend on agriculture, horticulture, and pastoralism as their main form of livelihood.[11] However, there has been a push from the state government to institute factories and make manufacturing a significant part of their economy.[12] Despite the slight industrialization, a vast majority of the state still lives in rural villages and their way of life reflects such living circumstances.

According to the 2011 census, Himachal Pradesh has a population of 6,864,602 people and the sex ratio is 972 females per every 1000 males, a ratio that is higher than the national average.[13] Despite remaining a very rural state, there is a robust education system. The education system has proven to be successful through the relatively high literacy rate of 82.8.[14] The literacy rate varies when stratified by gender, with a male literacy rate of 89.5 and a female literacy rate of 75.9. However, both of these rates still remain higher than the national literacy rate of 73.0.[15] Additionally, Himachal has a relatively small population that is considered below the poverty

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[7] Surinder M. Bhardwaj and Chakravarthi Raghavan, "Himachal Pradesh," Encyclopaedia Britannica, last modified May 24, 2019, accessed November 13, 2019, https://www.britannica.com/place/Himachal-Pradesh.
[8] Ibid.
[9] Ibid.
[10] Ibid.
[11] Ibid.
[12] Ibid.
[13] Government of India, "National Health Profile 2019," Central Bureau of Health Intelligence, New Delhi: 2019, 10.
[14] Ibid., 43.
[15] Ibid.

line (BPL). Using the Tendulkar methodology, the 2011 census showed that only 8.1% of the population in Himachal are considered BPL, which translates to roughly 560,000 people.[16] It may be considered a smaller state, but it still outperforms many of the larger or more established states in various census categories.

*Kangra District*

Kangra District is located in the north-western part of the state and it is the largest district in Himachal Pradesh. According to the 2011 census, it has a population of 1,510,075 people, which accounts for 22% of the entire population in Himachal Pradesh.[17] The sex ratio is 1012 females per every 1000 males, meaning there are actually more females than males in Kangra.[18] However, when delving deeper, the child sex ratio from ages zero to six is 876 girls for every 1000 boys.[19] This means there is a great discrepancy between how many girls are being born in Kangra versus how many migrate to Kangra. While originally it may appear that there is very little sex discrimination, it still remains a large problem. The literacy rates are also slightly higher in Kangra than the overall rate for Himachal Pradesh. The overall literacy rate for Kangra is 85.67, with a rate of 91.49 and 80.02 for males and females respectively. As far as religion goes, the region is very homogenous with 96.76% of the population identifying as Hindu. Additionally, the region is predominately rural in Kangra, mimicking the trend throughout all of Himachal Pradesh. Almost 95% (94.29%) of the population lives rurally, with the remaining portion living in urban localities. This by far has the greatest impact on the type of lifestyle in

[16] Ibid., 48.
[17] Census Organization of India, "Kangra District: Census 2011-2019 data," Census 2011, accessed November 12, 2019, https://www.census2011.co.in/census/district/230-kangra.html.
[18] Ibid.
[19] Ibid.

Kangra. Agriculture remains an incredibly important part in most people's lives, both as a source of livelihood and a source of food.

*Jagori Rural Charitable Trust*

Jagori is a nongovernmental organization that was founded in Rakkar, Himachal Pradesh in 2002 with the vision of creating a "just and equal society."[20] They address discrimination through tackling the issues of gender, caste, disability, class, and all other forms of exclusion. Their main focus group is women and girls, wanting to empower and elevate their voices. Jagori's mission is to empower the most marginalized groups of society through education and skill-centered trainings. Jagori has 4 main programs: Social Architects of Tomorrow in Himachal (SATH), Sustainable Agriculture, Forest and Land (SAFAL), Aware Girls Action for Justice (AGAJ), and Aware Woman's Action for Justice (AWAJ).[21] SATH is a program that helps students work together to increase community mobilization around pressing issues such as corruption or human rights.[22] SAFAL is a community farming program that aims to revitalize traditional knowledge about organic farming while fighting against the Green Revolution and its use of harmful pesticides and fertilizers.[23] AGAJ aims to create a generation of confident girls that are aware of their rights. They do this through a series of workshops, events, and life skills training.[24] Similarly, AWAJ is a formation of women's collectives that tackle a range of issues

[20] Jagori Rural Charitable Trust, "Our Vision," accessed November 12, 2019, https://www.jagorigrameen.org/our-vision.
[21] Ibid.
[22] Jagori Rural Charitable Trust, "Social Architects of Tomorrow in Himachal," accessed November 12, 2019, https://www.jagorigrameen.org/sath.
[23]Jagori Rural Charitable Trust, "Sustainable Agriculture, Forest and Land," accessed November 12, 2019, https://www.jagorigrameen.org/safal.
[24] Jagori Rural Charitable Trust, "Aware Girls Action for Justice," accessed November 12, 2019, https://www.jagorigrameen.org/agaj.

which all fall under the categories of violence, health, and leadership.[25] The health and reproductive wellbeing program within AWAJ takes a comprehensive approach, realizing that women's health cannot get better unless their overall status in society improves as well. Some of their work has included educating midwives, increasing and affirming the knowledge of traditional herbal remedies, and working with women to increase their body literacy.[26] They have conducted health surveys, taught reproductive and sexual health classes, and produced pamphlets on herbal healing remedies. Jagori's presence is widespread throughout Kangra district, with multiple different offices and specialized teams that work closely with the communities. The health program alone has reached over 5,000 students and over 1,200 women in nearby villages.[27] For over 15 years, Jagori has been on the forefront of changing women's lives in the rural villages of Kangra, Himachal Pradesh and their work continues to be pertinent even today.

*Maternal Health Practices and Policies in India*

Childbirth in India, as in many countries around the world, has a deep-rooted history in traditions and cultural norms. Pregnancy and childbirth are one of the rare life stages that affects everyone in one way or another. Everyone either is pregnant, helps conceive a child, raises a child, or was once a child themselves. It is also highly influenced by society, culture, economics, and politics. As Jordan eloquently puts it, "Childbirth is an intimate and complex transaction whose topic is physiological and whose language is culture."[28] By just viewing birth as a medical process, it completely ignores the socio-cultural qualities that often dictate the certain practices

[25] Jagori Rural Charitable Trust, "Aware Woman's Action for Justice," accessed November 12, 2019, https://www.jagorigrameen.org/what-is-awaj.
[26]Jagori Rural Charitable Trust, "AWAJ – Health and Reproductive Well Being," accessed November 12, 2019, https://www.jagorigrameen.org/awaj-health-and-reprductive-well-being.
[27] Ibid.
[28] B. Jordan, "Studying childbirth: The experience and methods of a woman anthropologist," in *Childbirth Alternatives to Medical Control*, ed. S. Romalis, (Austin, Texas: University of Texas, 1982), 182.

that occur leading up to birth, during birth, and after birth. Childbirth in India has a rich history of traditions and cultural practices.

Historically, births occurred at home. There were no hospitals or proper medical facilities so the birth was often unassisted or attended to by a Dai, a traditional birth attendant whose only knowledge had been passed down through generations.[29] As development occurred, especially with the rapid globalization in the past few decades, this tradition of homebirths has greatly disappeared. There has been a push for institutional deliveries— moving birth from a "community managed social event" to a "professionally managed medical event."[30] With the diminishment of homebirths comes a diminishment of traditional knowledge. Dai's roles have been redefined and the community has therefore had less ownership over childbirth. The responsibility has now been shifted to medical professionals. There has been an overall socialization of medicalized birthing practices in India. Homebirths have become something of past generations and the transition to institutional deliveries is now even seen as a way to show social status.[31] Those families that have enough financial stability opt for private hospitals over government hospitals.

Given that childbirth is such a complex phenomenon, it has been a very contentious topic in the field of politics. For centuries it has been debated, politicized, and the norms surrounding birth have drastically changed. From the 19th century to the early 21st century the discourse surrounding reproductive healthcare in India was primarily focused on population control.[32] Overpopulation was also often linked to underdevelopment and poverty. This rhetoric utilized

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[29] Satoli Village Visit Observations, observed by Mackenzie Burke, September 17, 2019.
[30] Bharati Sharma et al., "The transition of childbirth practices among tribal women in Gujarat, India – a grounded theory approach," *BMC International Health and Human Rights* 13, no. 41 (2013): 7, BioMed Central, doi: 10.1186/1472-698X-13-41.
[31] Ibid., 10.
[32] Ibid., 2.

neoliberal tactics to blame the most vulnerable populations for much of the country's issues. Beginning in the 21st century there was a shift in the discussion surrounding reproductive healthcare. It shifted from more quantitative measures of health to more qualitative measures of health. It was less about population control and seeing pregnant mothers as a burden to society, but more about providing these pregnant mothers with better overall healthcare. To have better health outcomes requires a holistic approach— seeing women as more than a number.

The rapid globalization of the early 2000s brought along the Millennium Development Goals (MDGs). Although they were not perfect and later on replaced by the Sustainable Development Goals (SDGs), they provided a starting point in addressing development on a global scale. There was a total of eight MDGs, with three specifically targeting health. MDG 4, MDG 5, and MDG 6 aimed to reduce child mortality, improve maternal health, and combat HIV/AIDs, malaria, and other diseases, respectively. Trying to make progress on the health-related MDGs, India implemented the National Health Mission (NHM) with the goal of increasing the availability of and access to quality health care for its citizens. On April 12th, 2005 the prime minister launched the National Rural Health Mission (NRHM) with the goal of providing "accessible, affordable and quality health care to the rural population, especially the vulnerable groups."[33] The mission covered all Indian states and territories, however, there was special focus given to the Empowered Action Group (EAG) States, as well as the North Eastern States, Jammu and Kashmir, and Himachal Pradesh.[34] These regions were targeted as the most vulnerable populations because they had some of the worst health outcomes.

[33] Government of India, "National Rural Health Mission," Ministry of Health and Family Welfare, last modified October 30, 2019, accessed November 1, 2019, https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=969&lid=49.
[34] Ibid.

One of the main components of the NRHM is the Reproductive, Maternal, Newborn, Child, and Adolescent Health program (RMNCH+A).[35] The RMNCH+A provides the framework and strategies for addressing the goals of the NRHM. Some of the NRHM's main objectives are to reduce maternal and infant mortality, as well as provide better comprehensive women's healthcare.[36] Because the MDGs heavily focused on Maternal Mortality Ratio (MMR) and Infant Mortality Rate (IMR), India rolled out many policies that aimed to reduce these two measurements of health. To complement the policy changes, India also created structural changes by revamping their healthcare system. There was an upscaling of the health infrastructures to ensure that there were functional subcenters at the village level, then primary health centers, community health centers, and finally district hospitals. Additionally, the NRHM also called for the creation of Accredited Social Health Activists (ASHAs). ASHAs are voluntary health workers within their own communities.[37] ASHAs were a position created to enhance the outreach of government health programs. This is the newest position added to the government health infrastructure, as Auxiliary Nurse Midwives (ANMs) and Anganwadi Workers (AWW) have been working in their respective communities since the 1960s and 1970s.[38] While all three of these positions have separate and defined roles, much of the responsibility becomes shared and they must work together in order to achieve the targets.

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[35] Government of India, "Reproductive, Maternal, Newborn, Child, and Adolescent Health program (RMNCH+A)," Ministry of Health and Family Welfare, last modified October 30, 2019, accessed November 1, 2019, https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=794&lid=168.

[36] Government of Himachal Pradesh, "Mission Objectives," Department of Health and Family Welfare, accessed November 1, 2019, http://www.nrhmhp.gov.in/content/mission-objectives.

[37] Government of India, *National Rural Health Mission: Framework for Implementation 2005-2012*, Ministry of Health and Family Welfare, New Delhi, 2005, https://nhm.gov.in/WriteReadData/l892s/nrhm-framework-latest.pdf, Kerry Scott et al., "India's Auxiliary Nurse-Midwife, Anganwadi Worker, Accredited Social Health Activist, Multipurpose Worker, and Lady Health Visitor Programs," Community Health Worker Central, accessed November 1, 2019, https://www.chwcentral.org/blog/indias-auxiliary-nurse-midwife-anganwadi-worker-accredited-social-health-activist-multipurpose.

[38] Scott et al., "India's Auxiliary Nurse-Midwife, Anganwadi Worker, Accredited Social Health Activist, Multipurpose Worker, and Lady Health Visitor Programs."

The largest and most robust policy that was implemented by the Indian government with the goal of tackling MMR and IMR is the program known as Janani Suraksha Yojana (JSY). It was launched on April 12, 2005.[39] This program is based on a conditional cash transfer (CCT) where the government provides poor pregnant mothers with monetary incentives to give birth in institutions.[40] The framework for JSY is the same throughout the country but there are different eligibility criteria and cash transfer sizes depending on the needs of the state and provinces.[41] More socioeconomically stable states have stricter eligibility requirements and a smaller cash transfer size. Similarly, many of the most vulnerable states do not have strict eligibility requirements. The cash transfer size can range anywhere from 600 rupees to 1400 rupees, depending on the woman's geographic location (rural versus urban) and her state's overall performance in achieving health standards (high performing or low performing).[42] Any poor woman disregarding her age or geographic location can qualify for the CCT under JSY as long as she gives birth in a government institution or an accredited facility. The other component of the JSY is cash entitlement given to ASHA workers. The entitlement usually ranges anywhere from 400 rupees to 600 rupees, again depending on the geographic location and the performance status of their state.[43] This incentive is for both facilitating institutional deliveries and providing prenatal care for the expecting mothers.

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[39] Government of India, "Janani Suraksha Yojana," Ministry of Health and Family Welfare, last modified December 5, 2019, accessed November 15, 2019, https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=841&lid=309.
[40] Bharat Randive et al., "India's Conditional Cash Transfer Programme (the JSY) to Promote Institutional Birth: Is There an Association between Institutional Birth Proportion and Maternal Mortality?," *PLOS ONE* 8, no. 6 (June 2013): 2, doi: 10.1371/journal.pone.0067452.
[41] Ibid., 3.
[42] Government of India, "Janani Suraksha Yojana."
[43] Ibid.

Each state is responsible for outlining their own eligibility criteria for JSY. In Himachal Pradesh, new mothers are given an incentive of 700 rupees for up to two live births.[44] The various eligibility requirements in Himachal are: BPL women above 19 years old, all scheduled caste (SC) or scheduled tribe (ST) women, and all slum dwellers.[45] This incentive will also only be dispensed to the mother if she has a Maternal and Child Health Card and has properly registered with her local health worker. On June 19th, 2019, the Himachal Pradesh State Cabinet decided to increase the incentive for SC, ST, and BPL mothers from 700 rupees per birth to 1100 rupees per birth.[46] This increase in the incentive amount has the main goal of attracting more mothers to deliver in hospitals, especially those most at-risk.

Noticing a shortcoming in the JSY policy, the Indian government launched the Janani Shishu Suraksha Karyakram (JSSK) in June 2011 with the hopes of eliminating out-of-pocket expenses for pregnant mothers and their children. Even though the JSY had substantially increased the number of institutional deliveries, over 25% of women still hesitated to access healthcare deliveries due to the high out-of-pocket expenses associated with hospital stays.[47] The JSSK entitles *all* pregnant women to a completely free delivery, both normal and cesarean section. [48] Previously, the JSY scheme covered *only* poor women. Each woman is guaranteed free food, free diagnostic tests, free drugs, and free blood tests. It also mimics the JSY scheme as

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[44] Government of Himachal Pradesh, "Revised guidelines for disbursement of cash benefit under Janani Suraksha Yojana in the State of H.P," National Rural Health Mission Himachal Pradesh, last modified April 26, 2013, accessed November 15, 2019. https://himachal.nic.in/showfile.php?lang=1&dpt_id=19&level=1&sublinkid=4827&lid=5163.
[45] Ibid.
[46] Government of Himachal Pradesh, "HP Cabinet decisions," Information and Public Relations, last modified June 19, 2019, accessed November 15, 2019, http://himachalpr.gov.in/OnePressRelease.aspx?Language=1&ID=13933.
[47] Government of India, "Janani-Shishu Suraksha Karyakram," Ministry of Health and Family Welfare, last modified November 14, 2019, accessed November 15, 2019. https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=842&lid=308.
[48] Ibid.

it provides free transport to and from the hospital in the case of referrals.[49] The JSSK also eliminates any barriers to accessing health institutions for sick infants as well. It entitles all sick newborns and infants, up to one year old, free healthcare services and medicines. In 2014 the scheme was also extended to cover the cost of all necessary prenatal and postnatal care required during complicated pregnancies.[50] All of these benefits are available to the women and children of Himachal Pradesh. Interestingly, the Chief Minister of Himachal Pradesh offered free care for infants up to one year of age in 2011, despite it not being offered nationally until 2014.[51] Himachal has been very proactive in breaking down the barriers that impede mothers from accessing institutional deliveries, prioritizing both maternal and child health within the state.

# III. Methodology

As aforementioned, the purpose of this study is to understand women's perceptions surrounding birthing practices in rural Himachal Pradesh. The study population includes lactating mothers that have just given birth within the past six months, and the healthcare professionals that help aid with childbirth. Using the help of Jagori's health team, the study population was further minimized by selecting mothers out of their partner villages located within Kangra district. Asha and other Jagori health team members were vital in helping locate these new mothers and healthcare practitioners. The field study was conducted using a combination of semi-structured interviews and observations made within the field.

[49] Ibid.
[50] Ibid.
[51] Government of Himachal Pradesh, "Instructions regarding 'Janani Shishu Suraksha Karyakram (JSSK)'," National Rural Health Mission Himachal Pradesh, last modified September 2, 2011, accessed November 15, 2019, https://himachal.nic.in/showfile.php?lang=1&dpt_id=19&level=1&sublinkid=4824&lid=5162.

A total of ten interviews were conducted, five with healthcare practitioners and five with lactating mothers. There were two mothers that did not fit the original criteria, Kaia and Sita. Although she had not given birth in the past six months, Kaia had delivered both of her children at home rather than in the hospital. Her interview was included because she brings forth a vital, and now less common, viewpoint in the assessment of women's perceptions on birthing practices. Sita was included in the research due to accessibility issues of finding a sufficient number of women that had given birth within the timeframe set by the original criteria. She had given birth only ten months ago, which was deemed recent enough since it was still within one year.

All of the mother's interviews were conducted in their homes, with the exception of Anjali who was interviewed at an Anganwadi center. Given that the interviews were conducted in the homes of these new mothers, there were many other people around at the time of the interview. Most often there were elder women, including the mother-in-law, and on some occasions there were also male family members. It would be remiss to not acknowledge the potential impact these family members had on the respondents answers. Given cultural norms, sometimes the older women or male family members would offer up answers instead of letting the woman speak herself. Similarly, Anjali was surrounded by ASHAs and AWWs during her interview so this possibly altered her responses as well. All of these interruptions and culturally-imposed silences were duly noted and used when analyzing the data. The healthcare practitioner interviews occurred in their respective workplaces, with the exception of the three birth attendants. One was conducted at their home, one was conducted at a Jagori district office, and another was conducted at a local trade fair. The rest of the interviews occurred at an Anganwadi center.

Each of the interviews were accompanied by at least one Jagori health team worker and a translator, with the exception of two interviews that occurred near the researcher's residence and were translated by a friend. A translator was an essential part of the process due to the researcher being a beginning Hindi speaker and the overall minimal use of English in the region. Due to the relative variability of field work, there were a variety of translators used. In total there were four different translators used throughout the course of the interviews. It should be noted that using a translator comes with the possibility of having information lost. While the translators all tried their best to accurately portray the mother's answers, there are sometimes things that cannot be fully translated or its full meaning is lost due to its identity within the sociocultural Indian context. Additionally, each translator had their own style of translation and this may have altered some of the data collection as well.

Following research ethics and norms, the interviewee was fully informed of the intent of the interview. The project and its purpose were duly explained, they were informed of their right to stop the interview at any time or skip any questions, and informed consent was obtained. Given the circumstances in the field, written informed consent was not feasible so verbal informed consent was used instead. The interviewees were also asked if the interview could be recorded solely for the purpose of a more accurate transcription later. All of them agreed to the recording. Additionally, all of the interviewees information has been altered or withheld to ensure their confidentiality. The villages have been labeled alphabetically and all of the names have been replaced with pseudo names.

The researcher and the perception of her also provided some limitations. She is a 21 year old, Caucasian student from the United States who has no ties to the local community in which she did her research. She speaks very little Hindi and relied heavily on the Jagori staff to help her

navigate life in the rural Himalayan villages. She comes from a background of high education and Western morals. These factors not only influence how she perceives the field study and the data collected, but it also influences how others perceive her. The way in which she is presented within the context of India, and more specifically in rural Himachal Pradesh, most likely influenced the answers of some women.

# IV. Results and Discussion

## Healthcare Practitioner's Perceptions on Birthing Practices

### *Accredited Social Health Activist (ASHA)*

The NRHM called for the creation of Accredited Social Health Activists (ASHAs). As outlined by the Ministry of Health and Family Welfare, one of the key components of the NRHM is to provide every village in the country with a trained village health activist who will "work as an interface between the community and public health system."[52] ASHAs are voluntary health workers within their own communities who receive an average of three to four weeks of training.[53] ASHAs were a position created to enhance the outreach of government health programs. ASHA's main role is to disseminate information regarding health to their local community and act as a link worker that connects the villagers to local health institutions.[54] Despite her undeniable importance to the success of the NRHM, the position is not salaried. ASHAs receive performance-based incentives according to a predetermined set of roles. Some of

[52] Government of India, "About Accredited Social Health Activist (ASHA)," Ministry of Health and Family Welfare, last modified December 2, 2019, accessed December 3, 2019, https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=150&lid=226.
[53] Government of India, *National Rural Health Mission: Framework for Implementation 2005-2012*., Scott, "India's Auxiliary Nurse-Midwife, Anganwadi Worker, Accredited Social Health Activist, Multipurpose Worker, and Lady Health Visitor Programs."
[54] Government of India, "About Accredited Social Health Activist (ASHA)."

these performance-based incentives include "promoting universal immunization, referral and escort services for Reproductive & Child Health (RCH) and other healthcare programmes, and [the] construction of household toilets."[55] The national maximum incentive an ASHA used to receive was 1000 rupees per month, granted that she fulfilled all of her requirements.[56] Beginning in October 2018, this national incentive was doubled from 1000 rupees to 2000 rupees.[57] However, it came with the caveat that states only have to institute this change if they desire. In the case of Himachal Pradesh, the state government did not decided to adopt this salary change. However, on June 19th, 2019, the State Cabinet voted to increase the ASHA incentive from 1250 rupees to 1500 rupees per month.[58] Again, these incentives are only guaranteed if the ASHA has fulfilled all of her roles as defined by the NRHM.

Shubha is an ASHA who has worked in her local village for the past five years since the implementation of ASHAs began in her area in 2015. She is 30 years old, finished +2 levels in school, and was pursuing her bachelor's degree when she got pregnant.[59] For health training, she reported having gone through five to seven initial days of training and then she also attends the mandatory ASHA training on the 27th of every month.[60] Some of her roles include helping increase health literacy for the villagers, helping connect mothers and children with healthcare facilities, and helping the disabled in her community. Shubha connects her village with government schemes and makes them aware of the different incentives for which they qualify. She also was trained to dispense tuberculosis medication and help those affected with the

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[55] Ibid.
[56] Government of India, "Manoj Jhalani Letter," Ministry of Health and Family Welfare, last modified October 8, 2018, accessed December 3, 2019, https://nhm.gov.in/New_Updates_2018/communization/Aasha/Orders_and_guidelines/Official_orders/ASHA_Incentives.pdf.
[57] Ibid.
[58] Government of Himachal Pradesh, "HP Cabinet decisions."
[59] Shubha Interview, interviewed by Mackenzie Burke, translated by Shabnam, November 20, 2019.
[60] Ibid.

stigma.[61] Maternal and childcare takes up a large portion of her activism. Shubha provides both prenatal and postnatal care for mothers. She conducts wellness checkups which include measuring sugar levels, weight, height, and temperature for expectant mothers.[62] She also helps teach women how to properly hold a baby, how to massage their breasts to produce an optimum amount of milk, and she will accompany the laboring mothers to the hospital.[63] Although ASHAs are not healthcare providers directly, they are equipped with a small medical bag. Some of the most utilized components of these health kits are the calcium and iron tablets they provide to pregnant mothers.[64] Additionally, she is one of the largest proponents of institutional births in the community.

Shubha adamantly believes that hospital births are far superior to homebirths. She said that hospitals have properly trained doctors, good staff, and more medicine available.[65] Hospitals also provide the newborn with necessary vaccinations like Hepatitis. It is believed by Shubha that these vaccinations are not accessible to women if they opt to have a homebirth. She believes the lack of supposed access to vaccinations is an unnecessary risk to the health of the baby. In reality these vaccinations are still available to women and their children, regardless of the location of birth. The Auxiliary Nurse Midwives (ANMs) are tasked with health outreach in the community using a fixed day, fixed time, fixed place approach. These days are known as Village Health and Nutrition Days (VHNDs), where all of the village health workers are supposed to be

[61] Ibid.
[62] Ibid.
[63] Ibid.
[64] Ibid.
[65] Ibid.

available for both spreading health information and providing basic health services.[66] These VNHDs are an opportunity for mothers that gave birth at home to get their children vaccinated.

Despite transportation potentially acting as a barrier, Shubha talked about the government schemes that make transportation to the hospital free for those that do not have their own private car. By calling either 102 or 108 the laboring mother can get an ambulance ride to the hospital for no charge.[67] From her point of view there are no barriers that affect her community when it comes to accessing hospitals for delivery. In her experience there was only one group during her five years as an ASHA that proved to be a little difficult to convince about the government deliveries. At one point a migrant group settled in her village. They were considered high risk because they preferred to deliver in their huts rather than go to the hospital.[68] Shubha was able to meet with them and educate them about the government schemes, ultimately convincing them to make the switch to institutional deliveries.

When it came to choosing a hospital, Shubha perceived the choice to be less about what the women preferred and more about what they could afford. Choosing between private and public institutions came down to if the family was financially stable and could afford the price of a private hospital. As she explained, everyone would prefer to deliver in a private institution, they just do not always have the privilege to make that choice.[69] Additionally, the choice between which government institution to go to is often made at the time of labor depending on how far the woman believes she can drive. If the mother is in extreme pain, or labor is progressing rapidly, she will choose the closest hospital.[70] Even though Shubha first described

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[66] Government of India, "Village Health Nutrition Day," Ministry of Health and Family Welfare, last modified December 6, 2019, accessed December 8, 2019, https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=152&lid=228.
[67] Shubha Interview, interviewed by Mackenzie Burke.
[68] Ibid.
[69] Ibid.
[70] Ibid.

the hospital as being a great option, towards the end of the interview she revealed that the government hospitals are not as good as she originally stated. Not only are they overcrowded, but there is no proper sanitation and medical students often do painful exams on women without the supervision of their teacher.[71] For some of the previously-mentioned reasons, Shubha said if the family has even the slightest bit of financial stability, the woman will choose to go to a private facility. However, despite some of the destitute conditions of the hospitals, Shubha still believes every woman should deliver in a hospital.

Although government schemes were one of the main reasons that homebirths have seen a major decline, Shubha believes that women these days are not able to endure a homebirth. She connects the strength of women in the past to their demanding field work and pure food. In her perception, the food in the past had no major additives and it was not genetically modified. She believes the purity of food was one of the main components attributing to women's strength in the past, allowing them to give birth at home with no intervention or complications.[72] Now the food is not as fresh nor pure so it leads to more complications for the pregnant mothers. Shubha thinks women these days are also less strong and incapable of enduring the pain of labor. Shubha believes these cultural changes also influenced the shift from homebirths to institutional births.

Hospital births are hardly perfect and there is much room for improvement, especially in government facilities. Shubha, despite being an advocate for institutional deliveries, recognizes the failures in the system. Along with everyone else that interacts with the government health infrastructure, she thinks overcrowding is one of the main issues plaguing hospitals around the country. Every woman deserves her own bed in the maternity ward, and there needs to be more

[71] Ibid.
[72] Ibid.

doctors so patients can get adequate time with the doctors.[73] However, the biggest issue she has with the government is how ASHAs are paid. Because they are not salaried positions they only receive incentives, which in her opinion are much too small. Furthermore, she disclosed that the government stopped paying ASHAs in her region about six or seven months ago.[74] ASHAs provide pivotal services to their communities and are the first point of contact for disseminating information into rural areas otherwise untouched by the government. She pleaded that ASHAs deserve to be properly compensated and should be given both job security and financial stability.[75] While the termination of incentives is not reflected in any official documents, it could be attributed to bureaucratic delays or corruption. As aforementioned, the Himachal Pradesh State Cabinet actually just voted to increase the ASHAs monthly incentive. Once again, there seems to be a discrepancy between the policies and their implementation.

*Anganwadi Worker (AWW)*

Anganwadi Workers (AWWs) were instituted into the Indian healthcare system in 1975 with the creation of the Integrated Child Development Services scheme (ICDS).[76] The ICDS aims to promote "child growth and development" while also providing services to pregnant and lactating mothers.[77] While AWWs have many roles, their primary ones are to provide informal preschool education and supplementary nutrition to the local village children. They mainly work with children from zero to six years of age. Another vital role of their job is keeping the health records of the community updated. To ensure they have all of the most up-to-date information

[73] Ibid.
[74] Ibid.
[75] Ibid.
[76] M.C. Sandhyarani and C. Usha Rao, "Role and Responsibilities of Anganwadi Workers, with Special Reference to Mysore District," *International Journal of Science: Environment and Technology* 2, no.6 (2013): 1277, http://www.ijset.net/journal/205.pdf.
[77] Ibid., 1278.

the AWWs must conduct home visits to all the houses within the community.[78] Most of their work heavily overlaps with the roles of the ASHAs. However, unlike ASHAs, AWWs are salaried workers that receive a monthly honorarium. In Himachal Pradesh, the honorarium for AWWs is 3450 rupees per month.[79] This stipend is not dependent upon referrals or completing their outlined roles. Nevertheless, it is still an incredibly small sum for all the work they do within their communities.

Sruthi is an AWW that has been working in her respective village for the past 25 years, creating great rapport and long-standing connections. She is 48 years old and completed through the 10th standard in school.[80] As for her health training, she underwent the initial AWW training and says she participates in refresher training courses about three to four times a year.[81] These refresher trainings are necessary for disseminating new government schemes and updating the AWWs knowledge. Much like the ASHA she provides both prenatal and postnatal care. For prenatal care Sruthi helps educate women about basic health practices and teaches them how to properly care for and clean their genitalia. Her role in postnatal care is much larger than that for prenatal care. She helps new mothers navigate the trials of breastfeeding, teaches women how to hold a baby properly, and goes on home visits to give the new mothers information about vaccinations for their newborns.[82] Sruthi doesn't personally give the vaccinations, just refers the mothers to a local dispensary. Dispensing vaccinations technically falls under the role of the ANM; however, this community does not seem to be utilizing this service. Healthcare workers

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[78] Ibid., 1279.
[79] Government of Himachal Pradesh, "Scheme/Guidelines for the engagement of Anganwadi Workers / Mini Anganwari Workers / Helpers on honorary basis under ICDS scheme run by Social Justice and Empowerment Department," Department of Social Justice and Empowerment, last modified February 26, 2016, accessed December 4, 2019, https://himachal.nic.in/WriteReadData/l892s/176_l892s/New%20Revised%20%20Guidelines,%20Feb-90761279.pdf.
[80] Sruthi Interview, interviewed by Mackenzie Burke, translated by Shabnam, November 20, 2019.
[81] Ibid.
[82] Ibid.

like Sruthi just refer the women to the local hospital and dispensaries. Another important role of Sruthi's is to manage the files of all the pregnant or lactating mothers in the village. Having been an AWW for over 25 years, she knows all of the women on a personal level and is able to have more meaningful connections.

Agreeing with Shubha, Sruthi thinks that hospital births are the only safe and viable option for women when it comes time to deliver. In her opinion hospitals are better equipped to take care of emergencies because every medicine and specialty is available. Originally she stated that homebirths should not be allowed, however, she later created the addendum that they are okay in tribal communities.[83] In these remote tribal areas, there are often no options other than to have a homebirth assisted by a Dai. While they do not provide the same level of care due to a lack of training, Sruthi believes that their years of experience in part makes up for the lack of formal training.[84] While it is still not a perfect solution, having an informally trained Dai is better than giving birth completely unassisted. However, Sruthi says the Dais are unequipped to deal with hemorrhaging, which can be life-threatening for the mother.[85] So while she is a proponent for institutional deliveries, she also recognizes that there needs to be other innovative approaches to reducing infant and maternal mortality in more remote areas.

While Sruthi said that there are no barriers impeding the women in her village from accessing hospitals, she also acknowledges there are transportation issues for those women that live in remote tribal areas. Improper roads, or no roads at all can stop women from utilizing the free ambulance provided by the government.[86] She said that there are sometimes even stretches of two to three kilometers at a time where there is no road, inhibiting women from efficiently

[83] Ibid.
[84] Ibid.
[85] Ibid.
[86] Ibid.

getting to hospitals during labor.[87] In Sruthi's point of view, lack of roads or reliable transportation is the only barrier stopping women from accessing institutional births. She said women are not afraid of hospitals. In fact, women are now more afraid of having a homebirth due to the associated risks.[88] Beginning with the NRHM, the Indian government has perpetuated the rhetoric that homebirths are inherently dangerous. Therefore, women have come to fear them. As for how women choose which hospital to give birth in, Sruthi perceives it as a decision guided solely by economic status. If the family is rich, they choose to go to a private institution. If they are poor, they choose to go to a government facility.[89] This trend can also be associated with the discourse of seeing hospital births as being progressive.[90] The location of birth is directly related to social class— a richer, more modern woman will choose a private institution to display her wealth.

Sruthi also confirmed the generational shift that has occurred. The primary proportion of births these days occur in a hospital, where even one generation ago, most of them occurred at home. In Sruthi's opinion, a lot of women in the past were not aware of their own health. Additionally, healthcare providers were not as extensively trained and often had no formal education at all.[91] Midwifery was dominated by Dais whose knowledge only stemmed from their own personal experience or that which was taught to them by other Dais. Now women have better body literacy and more awareness regarding their own health. There is also proper training of healthcare practitioners. These trends have contributed to a healthier and more educated generation of mothers and children— a generation who now prefers to seek healthcare from a

[87] Ibid.
[88] Ibid.
[89] Ibid.
[90] Sharma et al., "The transition of childbirth practices among tribal women in Gujarat, India – a grounded theory approach," 10.
[91] Sruthi Interview, interviewed by Mackenzie Burke.

hospital rather than a local healer. As for continuing to improve maternal and child health, Sruthi believes one of the best ways to do so is by continuing health education. She is a strong advocate for increasing awareness about family planning. Spacing children is a critical aspect to reproductive healthcare, as it ensures both the mother's health and the children's health. As someone that works so closely with the community, Sruthi just wants her villagers to be well informed and healthy.

*Birth Attendants*

Although there has not been a very clearly defined skilled birth attendant program founded in a government policy, India has a long history of Auxiliary Nurse Midwives (ANMs) dating back to the 1950s and 1960s.[92] While ANMs receive healthcare training that equips them to care for a variety of illnesses, a large portion of their 18 months of training revolve around maternal and child health.[93] However, upon their graduation from the ANM curriculum, they are still not considered skilled birth attendants. Even though their title includes the word midwife in it, they are still not considered midwives until they complete an additional skilled birth attendant training program.[94] ANMs are a critical part of the NRHM as they guide and help train ASHAs and AWWs. ANMs serve as the head village health worker, with ASHAs and AWWs working underneath them.[95] The NRHM also calls for the expansion of ANMs in the healthcare infrastructure, mandating a minimum of two ANMs per health subcenter.[96] While ANMs have

[92] Geeta Malik, "Role of Auxiliary Nurse Midwives in National Rural Health Mission," *Nursing Journal of India* 100, no. 4 (April 2009): 88, http://proxygw.wrlc.org/login?url=https://search-proquest-com.proxygw.wrlc.org/docview/214368994?accountid=11243.
[93] Ibid.
[94] Scott, "India's Auxiliary Nurse-Midwife, Anganwadi Worker, Accredited Social Health Activist, Multipurpose Worker, and Lady Health Visitor Programs."
[95] Malik, "Role of Auxiliary Nurse Midwives in National Rural Health Mission," 89.
[96] Ibid., 88.

been around since the 1950s, there are a lot of other less formally trained birth attendants that work in the communities. Their work is still just important as the formally trained ANMs and they often have better rapport with the local communities. These birth attendants, however, are not recognized by the Government of India because they did not complete the accredited ANM training program. Some have sought out training from local physicians, some have attended midwifery courses offered by non-governmental organizations (NGOs), and others have been trained by global governing bodies like the WHO or World Bank. Despite being trained on how to assist home deliveries, these birth attendants cannot be classified as skilled birth attendants. They have not gone through the same extensive health training as ANMs.

The role of birth attendants, both traditional and skilled, has seen a major decline in popularity due to the implementation of the NRHM. The incentivization of hospital births ultimately diminished the demand of skilled birth attendants because they could not compete with the benefits offered through JSY or JSSK. As the roles of Dais were undermined, a lot of the sociocultural aspects of childbirth were lost to the medicalization of pregnancy and delivery. These government policies and schemes have faced some scrutiny for providing more quantitative maternal healthcare rather than qualitative maternal healthcare. Recently, the Indian government has implemented a new midwifery addendum to the NRHM under the RMNCH+A program.[97] It began in 2018 with goal of moving away from the overmedicalization of childbirth and moving toward more "compassionate women-centric pregnancy care."[98] It is a fairly new addendum so the effects have not been fully realized. Hopefully, there will not be a failure in its implementation and skilled midwifery will find its niche once again.

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[97] Government of India, "Maternal Health: Strategies and Interventions – Other Programmes," Ministry of Health and Family Welfare, last modified October 30, 2019, accessed November 1, 2019, https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=822&lid=218.
[98] Ibid.

Out of the three birth attendants interviewed, only one completed the ANM training course. Komal was the only formally trained midwife and she later went on to become a nursing supervisor.[99] Samiya went through a midwifery training course that lasted roughly one week, and then a health training at a local NGO that lasted roughly 3 days.[100] Ragini was the midwife that had the least amount of training, lasting only 5 days at a local NGO.[101] All of the women reported providing both prenatal and postnatal care to their patients. A lot of this care mirrors services offered by ASHAs or AWWs. They all counseled women about the importance of proper nutrition, the necessity of vitamins and immunizations, and visited the women postpartum to help them transition into this new stage of motherhood.

Each of their prenatal and postnatal care routines differed slightly. Komal discussed visiting the new mothers the second and third day following the birth, as well as following up with them a month later to help with the referral process for immunizations.[102] Ragini also said an important part of her practice was massages.[103] She said this helps with relaxation for the mother and helps with muscle formation for the newborn. Following a vaginal birth, the child can look a little deformed, so Ragini would use massages to help reform body parts like the head.[104] Everyone except Ragini has experience actually delivering babies.[105] Komal has delivered countless babies, but she only aided in home deliveries when there were no complications with the pregnancy and the baby was in a good position.[106] Samiya has delivered roughly ten to twelve babies.[107] She described her experience as overall positive, but the

[99] Komal Interview, interviewed by Mackenzie Burke, translated by Nidhi, November 14, 2019.
[100] Samiya Interview, interviewed by Mackenzie Burke, translated by Asha, November 15, 2019.
[101] Ragini Interview, interviewed by Mackenzie Burke, translated by Neelam, November 17, 2019.
[102] Komal Interview, interviewed by Mackenzie Burke.
[103] Ragini Interview, interviewed by Mackenzie Burke.
[104] Ibid.
[105] Ibid.
[106] Komal Interview, interviewed by Mackenzie Burke.
[107] Samiya Interview, interviewed by Mackenzie Burke.

complicated cases she assisted were quite stressful. Ragini has been practicing for only five years, and given that the NRHM has heavily decreased the proportion of homebirths, her role has been to primarily aid in prenatal and postnatal care. Even though these birth attendants are trained to assist homebirths, they all still adamantly agree that homebirths should not occur anymore.

Even though the incentivization of hospital births undermine their own professions, all of the midwives interviewed are strong proponents for the NRHM. They perceive that hospitals are better equipped to deal with emergencies like postpartum hemorrhages. There are more systems in place to deal with emergencies and doctors have access to a surplus of medications.[108] All of the midwives believe that homebirths are associated with too many risks. These risks can be categorized into three categories: the women are not strong enough to deliver at home, there are no longer properly trained birth attendants that can assist with homebirths, and homebirths lead to complications with registration of the child with the government. Komal said that in the past women were strong enough to give birth at home and there were very few complications.[109] Presently, there are too many complications among pregnancies and she believes that women these days are not strong enough to deliver at home. Ragini views the main issue of homebirths these days as a lack of properly trained birth attendants. They no longer know how to recognize potential risks and do not have the ability to address complications that may arise, like a lack of oxygen for either the mother or baby.[110] Samiya sees one of the main issues with homebirths as the lack of proper registration with the government.[111] She said that should a child be born at home, they will not receive a birth certificate or be registered under the various government

[108] Ragini Interview, interviewed by Mackenzie Burke.
[109] Komal Interview, interviewed by Mackenzie Burke.
[110] Ragini Interview, interviewed by Mackenzie Burke.
[111] Samiya Interview, interviewed by Mackenzie Burke.

schemes. However, this is a misperception propagated by the government's push for institutional deliveries. Regardless of location of birth, the ANM and local government are responsible for issuing a birth certificate and ensuring the child receives all the necessary social benefits. A homebirth does not impede a child or mother from accessing government schemes, there is just a perception that it will.

Unlike other interviewees, all three midwives unanimously agreed that homebirths do still occur, even though it is uncommon. The common underlying factor of homebirths in Himachal Pradesh these days, as perceived by the midwives, is the geographic location of some women. Those that live in the very rural, interior villages with no proper roads have a higher likelihood of still having a homebirth.[112] This sentiment was also shared with some of the mothers. For these women that are located rurally, often transportation or lack of hospitals nearby are the main reasons for still choosing homebirths as the primary delivery option. Samiya also explained that even if these women seek out healthcare at a local health subcenter or community health center, often times there is no doctor present.[113] Doctors do not want to work in the most remote areas. This can be attributed to corruption and poor implementation. Poor staffing issues can lead to these already marginalized and at-risk communities becoming further marginalized because they cannot even access fundamental health care. Ragini also said that stereotypes, poverty, fear, and cultural traditions can sometimes encourage homebirths as well.[114] If women do not feel welcomed or safe in the hospital, they will be more inclined to revert to having a homebirth. Furthermore, if they will face discrimination on the basis of their caste, religion, or education level, sometimes it is just more comfortable to avoid the whole experience

[112] Komal Interview, Ragini Interview, and Samiya Interview, interviewed by Mackenzie Burke.
[113] Samiya Interview, interviewed by Mackenzie Burke.
[114] Ragini Interview, interviewed by Mackenzie Burke.

of giving birth at a hospital.[115] These women sometimes choose to face the risks of homebirths rather than feeling degraded in the hospitals.

While access to institutional deliveries still remains an issue for women in remote areas, government schemes make it both physically and financially accessible for all the women in the birth attendant's own villages. The midwives also unanimously agreed that the women who can afford to give birth in a private institution, will choose that route.[116] More women give birth in government hospitals, but the care at private hospitals is of a higher quality. There are fewer patients at private institutions, which means less crowds and more one-on-one time with the doctors. They also do not need to share a bed with anyone. According to Samiya, the government doctors do not treat the patients with respect and sometimes beat them.[117] She even experienced this side of abuse personally. When she was giving birth to her child, the doctor hit her.[118] She used this negative experience as her inspiration to pursue midwifery. While she turned her experience with physical abuse into a moment of empowerment, many other women do not have that privilege. So, while the government institutions are more accessible, the level of care is of lower quality.

As for the trends of birthing practices, all the midwives described homebirths being the norm in the past. With fewer hospitals, less education, and more financial instability, women almost always had homebirths. They also had a lot more children and they were often less healthy.[119] Women had more children for a variety of reasons. More children meant more hands to help with field work. More children also meant a higher percentage of them would survive

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[115] Sreeparna Chattopadhyay, "The shifting axes of marginalities: the politics of identities shaping women's experiences during childbirth in Northeast India," *Reproductive Health Matters* 26, no. 53 (2018): 66, Taylor & Francis, Ltd., https://www.jstor.org/stable/10.2307/26504900.
[116] Komal Interview, Ragini Interview, and Samiya Interview, interviewed by Mackenzie Burke.
[117] Samiya Interview, interviewed by Mackenzie Burke.
[118] Ibid.
[119] Komal Interview and Samiya Interview, interviewed by Mackenzie Burke.

childhood, especially during a time when surviving disease was not always a guaranteed. Finally, more children meant there was a higher likelihood of having a male child— a cultural norm that significantly defined birthing practices of the past. In the past there was also very little health education so women did not have access to contraceptives, did not understand the importance of having good nutrition, and had very little guidance through pregnancy.[120] As the decades passed, the general population gained a higher level of health literacy, more financial stability, and there was greater access to hospitals. These were some of the primary drivers of the generational shift toward institutional deliveries. Now women prefer to utilize hospitals. Ragini attributes this change in desires to education.[121] Women are more aware of the risks associated with homebirths and perceive hospital deliveries as the better option.

While there has been a generational shift from homebirths to hospital births, these birth attendants still believe there needs to be improvements made to the current system to expand the quality of care for these mothers and newborns. Other than the often reiterated issue of overcrowding, these midwives' unique perspectives brought forth problems that other healthcare practitioners failed to mention. While accessibility has increased for these women, Komal says women still bear the burden of accessing maternal healthcare.[122] While they are able to be seen at hospitals for free, they then have to travel to a different location in order to fill their prescriptions at dispensaries. This is a gap in the NRHM that should be amended. In Komal's opinion the burden of accessing medicines and healthcare outside the walls of a hospital should not fall on the women. Samiya believes the quality of care can be improved through increasing the number of female doctors and allowing family members into the labor room.[123] Birth has always been an

[120] Ibid.
[121] Ragini Interview, interviewed by Mackenzie Burke.
[122] Komal Interview, interviewed by Mackenzie Burke.
[123] Samiya Interview, interviewed by Mackenzie Burke.

intimate experience so women should be allowed to have select family members experience it with them. More female doctors will help some women feel more comfortable in the hospital, especially considering the gender divide in Indian culture. Finally, Ragini thinks ASHAs and AWWs need to have better training.[124] In her opinion they need to be more skillful in order to provide a higher quality of care to the villagers. While there have been great improvements in regard to the quality of maternal and child healthcare, these midwives think the government can still make strides toward creating a better system.

## Mother's Perception of Birthing Practices

Table 1. Information of Interviewed Mothers

| Name Of Woman (Changed for Confidentiality) | Village | Religion | Caste | Age | Year of School Completed | Age of Marriage | Age at Time of Birth of First Child | Age at Time of Birth of Most Recent Child | Number of Children & Gender |
|---|---|---|---|---|---|---|---|---|---|
| Kaia | A | Hindu | ST | 40 | 2nd Standard | 22 | 24 | 26 | 2 (1 girl & 1 boy) |
| Meera | B | Hindu | SC | 34 | 12th Standard | 21 | 23 | 34 | 2 (2 girls) |
| Sita | C | Hindu | SC | 23 | 10th Standard | 22 | 23 | 23 | 1 (boy) |
| Anjali | D | Hindu | SC | 23 | 8th Standard | 18 | 20 | 23 | 2 (1 boy & 1 girl) |
| Deepa | D | Hindu | General | 25 | Pursuing Masters | 20 | 23 | 25 | 2 (2 boys) |

[124] Ragini Interview, interviewed by Mackenzie Burke.

*Preparation for the Birth and Prenatal Care*

The preparation for birth varied greatly among the interviewed women. Although most of the women sought out some form of prenatal care and prepared for the birth of their children, there were some women that did not have the privilege of accessing prenatal care nor the financial stability to plan for their child's birth. All of the women except Kaia received prenatal care, although where they received it varied.[125] Kaia was the only one that did not seek out prenatal care but she did state that she was informed about the importance of the Polio vaccine and received that.[126] Additionally, Kaia was the only woman that had a homebirth. She delivered both of her children at home. Not seeking out prenatal care can be caused by many confounding factors. She was the only one from a Scheduled Tribe (ST) and also had the lowest level of formal education, only completing second standard.[127] In comparison to the other women she also had the least amount of financial stability and faced the most hardships during her life. Kaia was also the oldest woman out of the group, and when she was giving birth to her children the NRHM was not yet created. Therefore, institutional births were not as widely accessible. Additionally, there was no ASHA position created yet, which meant there was no community health activist educating the local community on the importance of prenatal care. She faced the cultural barrier of being classified as ST, she faced the structural barrier of no NRHM, and she faced the financial barrier of being unable to pay for prenatal care herself. All of these factors most likely confounded to inhibit Kaia from accessing prenatal care and ensuring she would have a healthy pregnancy.

[125] Kaia Interview, interviewed by Mackenzie Burke, translated by Nidhi, November 16, 2019.
[126] Ibid.
[127] Ibid.

The four other women received prenatal care in the form of vaccinations, iron tablets, calcium tablets, other various vitamins, and regular checkups with healthcare practitioners. Everyone except Anjali used the ASHAs and AWWs to aid in prenatal care.[128] Another repeated theme for accessing prenatal care was seeking out advice and guidelines from the local hospital and nursing staff. This seemed to be the more popular option for prenatal care, rather than using the ASHAs and AWWs. Out of the women that received prenatal care, many preferred to go to the local hospital and dispensary to receive their necessary vitamins. Anjali stated that she went to the hospital every month for her checkups and worked directly with a nurse.[129] Similarly, Sita explained that she went to the local hospital to regularly consult a gynecologist during her pregnancy.[130] Although Meera used the ASHA for her regular checkups, she also went to the local hospital for her vaccinations.[131] The relative easy accessibility of hospitals from their villages defined their prenatal care. There are two government hospitals nearby all of them. One of the hospitals is much smaller and is not equipped to help deliver babies, but offers vaccinations and prenatal care. The other is a very big, well-equipped teaching hospital that has all the necessary supplies to cater to complicated cases.

ASHAs and AWWs roles seemed less important in these women's pregnancies, as they often only helped with dispersing information about where the dispensary is located or telling them which vitamins were important to take. ASHAs also assisted with doing simple checkups like measuring weight, checking blood pressure, and checking hemoglobin levels. While interviewing Anjali in the Anganwadi Center, one ASHA interrupted the interview to explain that she does a good job at outreach and gives all the women the appropriate information. She

[128] Anjali Interview, interviewed by Mackenzie Burke, translated by Shabnam, November 20, 2019.
[129] Ibid.
[130] Sita Interview, interviewed by Mackenzie Burke, translated by Neelum, November 17, 2019.
[131] Meera Interview, interviewed by Mackenzie Burke, translated by Neelum, November 17, 2019.

lamented that some women choose not to accept the help or their labor occurs too quickly to inform the ASHA so she can accompany them to the hospital. While the ASHA was speaking, Anjali's body language changed significantly and she also said nothing about the ASHAs or AWWs.[132] Later on, it was revealed that she never contacted an ASHA or AWW at any point during her pregnancy or during the actual birth as well. Due to the location of the interview more information regarding the ASHAs roles in the community could not be collected. However, it seems that the ASHAs are not as well connected with the local community as they claim to be.

The preparation for the actual birth also varied for each woman. Some women made no plans as they relied heavily on the government schemes, knowing they automatically qualified for them. The JSY and JSSK essentially make the plans for the women, as they are guaranteed free transportation to the hospital, free services at the hospital and a free delivery. The government schemes almost strip the women of any ownership over their own birth preparation because everything is already organized for them. For example, Meera preferred to go to a government hospital but she made no plans prior to the onset of labor.[133] She knew she qualified for the incentives and thus waited until it was time to deliver to figure out the rest of the details. Consequently, she went to the smaller of the two local government hospitals but ended up being referred to the larger teaching hospital because there was no gynecologist at the first one. Sita experienced a very similar situation where she first went to the smaller of the local hospitals, but then was referred to the larger teaching hospital.[134] This can be attributed to the lack of planning for the time of birth.

[132] Anjali Interview, interviewed by Mackenzie Burke.
[133] Meera Interview, interviewed by Mackenzie Burke.
[134] Sita Interview, interviewed by Mackenzie Burke.

All of the other mothers had made some plans, whether that was choosing a location in which to give birth or talking about setting aside money for potential emergencies. Kaia, the mother who had two homebirths, originally planned to go to the government hospital for her first child.[135] Once she gave birth to her first child at home, she made no plans to birth her second at a hospital because the first one had occurred at home without any complications. Both Anjali and Deepa planned to deliver at the large teaching hospital, and that plan came to fruition.[136] Anjali even discussed finances with her family, setting aside a small amount of money for potential emergencies.[137] Even though they made some peripheral plans, none of the women expressed any form of extensive planning for the time of birth. Their preparation seemed more focused on prenatal care rather than preparing for the time of birth.

Coinciding with the seemingly low rates of preparation for birth, four out of the five women interviewed also had one unplanned pregnancy. Meera was the only one that planned for both pregnancies. Kaia and Sita did not plan their first pregnancies and said they were both accidental. Similarly, Deepa and Anjali did not plan their second child. Although the pregnancies were often a surprise it did not stop the women, aside from Kaia, from seeking out appropriate medical care. Additionally, everyone except Deepa was able to conceive on their own. Although her second child was a surprise, she and her husband sought out medical help from the doctors at the teaching hospital for their problems conceiving. They did not need help conceiving their second child. It is interesting that four out of the five women interviewed all experienced one unplanned pregnancy. They all come from different levels of education, different caste classifications, different financial situations, and overall different backgrounds, yet they still did

[135] Kaia Interview, interviewed by Mackenzie Burke.
[136] Deepa Interview, interviewed by Mackenzie Burke, translated by Neelum, November 25, 2019., Anjali Interview, Interviewed by Mackenzie Burke.
[137] Anjali Interview, interviewed by Mackenzie Burke.

not have access to or utilize proper family planning mechanisms in order to have total control over their reproductive health.

*Birthing Experience*

Despite all the women having varied backgrounds and different levels of prenatal care, their birth stories were all relatively similar. All the women that delivered in an institution went to the same government hospital, the larger teaching hospital that employs students from the local medical school. The women that delivered at the government hospital were all pleased with their experiences and had no negative opinions on the forefront of their mind. All of the women that delivered at the hospital used private transportation to get there, rather than opting to use the free ambulance ride.[138] They also did not bring the ASHA to the hospital. Even the women that used the help of the ASHA during prenatal care opted to not inform her during the onset of labor pains. Instead, the labor and delivery were kept within the nuclear family, involving only the immediate family members. Following Indian cultural norms, all of the mothers lived at the husband's house, so his family was more involved in the pregnancy and birth than the woman's own maternal side. Sita was the only one that had her own mother present for the time of birth.[139] The rest of the women always had their mother-in-law and husband. In Deepa and Anjali's case, their father-in-law also accompanied them to the hospital at delivery time.[140]

Once at the hospital, all of the women were attended to by both doctors and nurses. The nurses that attended to them were always female and more often than not the doctors were male, although there were a few female doctors. Sita, Deepa, Meera, and Anjali all explicitly expressed

[138] Anjali Interview, Deepa Interview, Meera Interview, and Sita Interview, interviewed by Mackenzie Burke.
[139] Sita Interview, interviewed by Mackenzie Burke.
[140] Anjali Interview and Deepa interview, interviewed by Mackenzie Burke.

that they had an overall great experience and the doctors were pleasant towards them. However, as they were asked more specific details about the birth they opened up more and shared some of the details that would be considered less than ideal.

Even though everyone said their experience was good, they all lamented about the extreme overcrowding in the hospital. All of the women had to share a bed with someone else, and Anjali even had to share a bed with two other women.[141] Meera and Sita explained that the extreme overcrowding added to their fear of the hospitals and made their experience much more stressful.[142] The overcrowding leads to an overall rush of processes, trying to deliver babies as fast as possible so they can tend to all the women going through labor. The large population in combination with the already constrained resources, including a lack of beds and doctors, is one of the main components to the overcrowding issue. Meera stated that the overcrowding increased her anxiety because everything was very rushed and none of the doctors properly explained to her what was occurring.[143] She was often left in the dark about her own labor. For Anjali, the overcrowding issue manifested in the form of fear for her newborn. She had to share the bed with two ladies, causing her to fear that her baby might fall off the bed or get an infection due to the close quarters everyone faces while living in the maternity ward.[144] The issue of overcrowding is not unique to these women's birth stories. It is a systemic issue across all government hospitals throughout India, and one that will most likely continue in the near future.

The facilities at the hospital were all up to the women's expectations. Given that it was a teaching hospital and had more resources and specialists than the other, smaller, local hospital, the women said that this hospital was more equipped to deal with difficulties or complications.

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[141] Anjali Interview, Deepa Interview, Meera Interview, and Sita Interview, interviewed by Mackenzie Burke.
[142] Meera Interview and Sita Interview, interviewed by Mackenzie Burke.
[143] Meera Interview, interviewed by Mackenzie Burke.
[144] Anjali Interview, interviewed by Mackenzie Burke.

The better resources and doctors brought them a peace of mind, and this sentiment was often repeated when they compared the tradition of homebirths with the new trend for institutional births. Among the women there is a shared perception that hospitals are equated with safer deliveries because they have more medicines and trained personnel to deal with major emergencies or even minor complications. Although the women agree that the hospitals have good medical resources, they had differing opinions about the overall comfort level of their hospital stay. Deepa repeatedly discussed her great experience at the hospital, stating that it was very hygienic and all the facilities were properly cleaned.[145] In contrast, Meera stated that the hospital was not hygienic, and the toilets were especially dirty.[146] This perception of uncleanliness attributed to Meera's fear of either her or her newborn contracting an infection.[147] It is interesting that Meera and Deepa had drastically different perceptions of the maternity ward, given that they delivered at the same hospital and both delivered within the last two months. One plausible reason for this difference in perceptions is that Meera had one of the more negative experiences with childbirth and Deepa had one of the more positive experiences with childbirth.

Abuse both in the maternity ward and the labor room has been a well-documented phenomenon throughout India's hospital systems. This disrespect and mistreatment also disproportionally effects women that are already marginalized, whether it is by caste, education level, or religion.[148] Although none of the interviewed mothers experienced abuse themselves, Deepa did affirm this practice of abusing mothers in government institutions. She explained that she had a good experience because she was a cooperative mother. Those women that do not

[145] Deepa Interview, interviewed by Mackenzie Burke.
[146] Meera Interview, interviewed by Mackenzie Burke.
[147] Ibid.
[148]Sreeparna Chattopadhyay, "The shifting axes of marginalities: the politics of identities shaping women's experiences during childbirth in Northeast India," *Reproductive Health Matters* 26, no. 53 (2018): 64, Taylor & Francis, Ltd., https://www.jstor.org/stable/10.2307/26504900.

follow the orders of doctors and staff are less fortunate. Deepa explained that women sometimes were hit or their legs were tied to the beds in order for them to become compliant.[149] She even witnessed this sort of abuse in the maternity ward during her time there. Her intonation and the way she described the situation implied that this abuse was okay in her eyes because the women were noncompliant. Instead of trying to understand why they would be reacting in a noncompliant way, Deepa seemed to accept the abuse as a norm within their government institutions. This dangerous way of thinking is called victim blaming, where the blame is placed on the individual rather than the system. Sometimes these women could be acting out due to fear or confusion, especially if they are illiterate and do not normally seek out healthcare in an institution. Abuse is never the answer. Instead, there should be cultural competency training that allows healthcare providers to better understand why these mothers might be acting in such a way.

Kaia had a completely different birth experience as she delivered at home. The NRHM, JSY, or JSSK had not yet been created when she was having children so she did not have the option of using an ASHA or having easy access to a free institutional delivery. For her first child she described having a great lack of knowledge. While the pregnancy was quite easy she did not understand the bad back pain or what kind of complications were possible.[150] With her first baby she had made plans to go to the hospital but she was persuaded by her family to wait out some of the labor pains at home. Before she knew it, she was too far into labor to go to the hospital so she prepared to give birth at home. The birth, although it occurred at home, was assisted by a trained nurse.[151] The actual birth went smoothly and there were no complications. For her second child,

[149] Deepa Interview, interviewed by Mackenzie Burke.
[150] Kaia Interview, interviewed by Mackenzie Burke.
[151] Ibid.

the pregnancy was much harder. She had a lot more pelvic pain and it was quite difficult for her to walk around.[152] She attributed this to the fact that her second child was heavier than the first. Kaia then did not plan to go to the hospital for the second birth because the first birth had occurred at home without any issues.[153] She was fortunate enough to have the same luck with her second child, delivering at home safely once again.

Despite giving birth at home, Kaia alluded to the fact that she thinks hospital births are still better. She said there are more benefits to delivering in a hospital, like receiving the incentive and having access to all the proper medical facilities should there be an emergency.[154] While she perceived homebirths safe enough for her own children, she is a proponent for the institutionalization of birthing practices. It is interesting to see how she navigated her second birth— having the option to go to the hospital, yet still choosing to give birth at home. At the time she perceived the risk to be low enough for her to choose a homebirth again, yet she now perceives the risk as too high for other women, believing they should choose a hospital birth over a homebirth. This change in perception can be associated with multiple societal trends— the socialization of medical births, an overall increase in access to modern medical care, and the deskilling of trained community health workers like skilled birth attendants.[155] Most of the women that delivered at home are now in the elder generation or those that live in very remote communities. This is reflected in Table 1 as Kaia is by far the oldest women. During all the interviews, at least one if not all of the aunties, mothers-in-law, and grandmothers gave birth at

[152] Ibid.
[153] Ibid.
[154] Ibid.
[155] Sharma et al., "The transition of childbirth practices among tribal women in Gujarat, India – a grounded theory approach," 1.

home. However, it is definitely a trend that is dying out as hospital births have replaced homebirths as the new norm.

*Traditions and Cultural Norms Surrounding Birth*

India is a country rich with tradition and cultural practices. When asked if they were subjected to any traditions or cultural practices, most of the women denied having experienced any rituals or superstitions. However, it was discovered through more questioning that these women often experienced cultural traditions, but they did not realize it because they cannot remove themselves from their own culture and take an introspective look. When explicitly asked about conforming to rituals or superstitions either during pregnancy or after the birth, only two out of the five women said they experienced some traditions. Meera said that she followed some traditions that forbid her from attending death ceremonies or eating meat.[156] Anjali also talked about her belief in superstitions and rituals. She said that after her baby was born she and her mother-in-law went to a local priest so the baby could be blessed.[157] The priest conducted various rituals to ensure the baby's health and prosperity. Additionally, Anjali spoke of a ceremony called Guntra that is performed 11 days after the birth.[158] These were the only two mothers that acknowledged any form of tradition that influenced their birth experience.

Even though the women did not see any cultural norms that influenced their pregnancy there were a few practices that stood out. All of them, whether consciously or unconsciously, abided by the deeply-rooted patriarchal norms within Indian society. As aforementioned, all of the women lived at their husband's houses. This definitely influenced their pregnancies and

[156] Meera Interview, interviewed by Mackenzie Burke.
[157] Anjali Interview, interviewed by Mackenzie Burke.
[158] Ibid.

postpartum experiences. Many of the decisions regarding their pregnancies were decided by the family, without any representation from the women's side of the family. Even though most of the women discussed having autonomy over their own bodies and being able to make their own decisions regarding their pregnancy, they still often deferred to their mother-in-law and her wishes. This norm was also present in the interview process as there was always family members present at the time of the interview, most commonly the mother-in-law. Sometimes the woman would be quiet as the mother-in-law interjected her own opinion, or a question could not be asked due to the presence of the husband's family. This was most apparent during the questions regarding autonomy over their own reproductive health and the pressure to have a male child.

Due to the stronghold of the patriarchy, there is a preference for male children. Although there are many factors that contribute to the preference for male children, one of the strongest influencing factors is the way in which inheritance works in India. Historically, women had no claim to the family's land or wealth because they were essentially merged into their husband's family upon marriage. Therefore, if the family wanted to continue their legacy, having a male child was a necessity. This preference for male children can be linked to a rise in female infanticide and sex-selective abortions. This practice can be seen in the sex ratio all throughout India. In Kangra District, where all of these interviews took place, the child sex ratio is 876 females per every 1000 males.[159] Out of the five mothers interviewed, Meera was the only one that reported experiencing external pressure from her family to have a male child.[160] She had her first daughter at 23 years old and just had another one at 34 years old. We had to discreetly ask her if she felt pressure to have another child in the hopes of having a male, and she quietly

[159] Census Organization of India, "Kangra District: Census 2011-2019 data."
[160] Meera Interview, interviewed by Mackenzie Burke.

nodded and said that her family was very unhappy with her for having another girl child.[161] There was more of a nonverbal communication of this pressure as the interview turned slightly somber with the acknowledgement that she was a disappointment to her family. She said they want to her have another child again soon, but she really does not want to and her body is very much not ready to have another child.[162] Meera kept lamenting the fact that there was already an eleven year age gap between her first child and her second. She also said that this second pregnancy and birth was much harder, both due to the gap between children and her own age. This societal pressure to have male children has drastically affected Meera's birthing experience and how she perceives motherhood and pregnancy.

None of the other women reported facing external pressure to have a male child. However, Kaia said that she personally wanted to have a son after her first child was a girl. The other women all reported not preferring male children over female children. Deepa stated that she actually wanted her second child to be a girl, but she gave birth to another boy.[163] Sita said that when the time comes and they decide to expand their family, her husband wants the second child to be a girl.[164] This lack of external pressure or internalized preference for male children for Deepa, Sita, and Anjali could possibly be attributed to the fact that their first child was male. This could have alleviated some of the societal pressure to have a male child and then they had the luxury to not have a preference for the gender of the following children. Additionally, this preference for a family that consists of one female child and one male child could be associated with the standard narrative pushed by the government that the perfect family only has two kids, one boy and one girl. The lack of pressure can also be attributed to an increase in the level of

[161] Ibid.
[162] Ibid.
[163] Deepa Interview, interviewed by Mackenzie Burke.
[164] Sita Interview, interviewed by Mackenzie Burke.

education across the region. As education level increases and globalization spreads, there is a pushback on cultural norms. One of these such norms that has been called into question is the preference for men. There have been large movements across India to promote women's empowerment. One of the outcomes of this shift in thinking is the abolition of sex-selective abortions and fight against female infanticide. There have been valiant efforts made to reconcile this preference of male children with the global trends of women's empowerment. However, it does take multiple generations for shifts in perspectives and values to be accepted within a culture. For now, these cultural practices do seem to still affect some of the women in rural Himachal Pradesh.

*Changes in Birthing Practices over the Generations*

Since the early 2000s with the introduction of the MDGs and the effects of mass globalization, childbirth in India has gone through drastic changes. Birthing practices have drastically changed over the generations, moving from less intervention-focused homebirths to more medicalized hospital births. This change has occurred relatively quickly since the creation of the NRHM. Following the standards created by the MDGs, the JSY was created under the assumption that hospital births are inherently better than homebirths.[165] Despite having good intentions, the JSY and its underlying assumptions have also done harm to some rural communities. It has contributed to not only the overmedicalization of the birthing process, but it has also began to delegitimize skilled birth attendants that have worked in the communities for generations. Additionally, the NRHM has attributed to the mystification of medicine because it

[165] Randive et al., "India's Conditional Cash Transfer Programme (the JSY) to Promote Institutional Birth: Is There an Association between Institutional Birth Proportion and Maternal Mortality?," 3.

has mandated a shift from home healthcare to institutional healthcare. Modern allopathic medicine has become idolized.

The women interviewed all echoed this belief, that modern allopathic medicine is better— thus hospital births are much better and homebirths should not be allowed. All five mothers agreed that hospital births are the best option, even Kaia who had two homebirths.[166] The most common benefits that institutional births provide as perceived by the women are: the money they qualify for through the incentive, the access to life-saving medications and medical care, pain management, and the proper governmental registration for their children.[167] Even the women that were present for the interviews and had delivered at home, agreed that hospital births are far superior than homebirths.[168] They agreed that homebirths just cannot compare with homebirths when assuring the mother's safety.

Homebirths are now perceived as extremely risky and it also does not provide all of the benefits of hospital births. In Deepa's experience, she received the incentive (albeit two years late) for her first child and then a newborn kit for her second child, which included soap, clothes, and a mosquito net. Although these incentives may seem minimal to an outsider from a more economically prosperous country, the incentive can be a large lump sum for these women. With an average per capita income of 86,637 rupees in Kangra District in 2016, the incentive can go a long way.[169] This per capita income is obviously skewed to represent those with more formal work, and often neglects to include those that do not have any job in the formal sector. With the Himachal Pradesh State Cabinet increasing the incentive to 1,100 rupees for the most

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[166] Anjali Interview, Deepa Interview, Kaia Interview, Meera Interview, and Sita Interview, interviewed by Mackenzie Burke.
[167] Ibid.
[168] Ibid.
[169] Government of Himachal Pradesh, "District Domestic Product of Himachal Pradesh 2011-12 to 2015-16," Economic and Statistics Department, last modified August 12, 2018, accessed December 3, 2019, https://himachalservices.nic.in/economics/pdf/distt_dp_2015-16.pdf, 31.

disadvantaged women, that lump sum can be the difference between a healthy and prosperous childhood for these newborns and one plagued by poverty and insufficiencies.[170] Where twenty minute bus rides still cost only ten rupees and an entire basket of fruits and veggies cost under 100 rupees, this 1,100 rupee incentive will stretch far.

Although all the women said that hospital births were better than homebirths, Meera's perception of birth slightly shifted throughout the interview. As the interview progressed and she lamented about her less than pleasant experience at the local government hospital, she came to the conclusion that homebirths aren't inherently bad. The older generation did not have a bad experience with homebirths and there are benefits to giving birth in your own home. Skilled and traditional birth attendants can provide additional services that are lost in the hospital. They have much better rapport with the women and provide not only clinical care, but also emotional and psychosocial support as well.[171] The birth attendants also provide follow-up care to ensure both the mother and baby remain healthy postpartum.[172] When compared to institutional births, homebirths often offer more comprehensive care. In Meera's experience, there was very poor rapport between the doctors and expectant mothers due to the rush caused by overcrowding. She also said the facilities were very dirty and she was she was afraid of her newborn catching an infection due to the overcrowding.[173] Despite seeing the positives in homebirths, she made a clear delineation between homebirths attended by a properly trained birth attendant and those attended by a traditional, informally trained Dai. Although she would prefer a homebirth for the sociocultural benefits, she still thinks that hospital births are better because there are not many

[170] Government of Himachal Pradesh, "HP Cabinet decisions."
[171] Lindsay Barnes, "Women's Experience of Childbirth in Rural Jharkhand," *Economic and Political Weekly* 42, no. 48 (December 1-7, 2007): 65, Economic and Political Weekly, https://www.jstor.org/stable/40276719.
[172] Ibid.
[173] Meera Interview, interviewed by Mackenzie Burke.

sufficiently trained birth attendants anymore. This decline in skilled birth attendants can be directly linked to the delegitimization of their skills through the implementation of the NRHM.

Even though the women did not experience homebirths, except for Kaia, they all described the practice as being the prominent form of childbirth in the past. However, it was not a practice of multiple generations past, as many of their own mothers and mothers-in-law gave birth at home. This time period in Indian history perfectly captures the changes in birthing practices, as within one generation the perception has shifted from homebirths being the norm to hospital births being the new norm. The generation that gave birth at home are not yet old enough to insinuate that this practice is something of the past, as these women are often in their 40s or 50s— still young enough to vividly remember their experiences and how they perceived birth at their peak reproductive years. Homebirths used to be the norm, and as some women reported, they still are the norm in very remote locations. As Deepa explained, the interior regions of Himachal can often be hard to reach as there are no roads. In these locations, traditional birth attendants and homebirths are still just as important for these women as they were in the past.

Historically, midwifery was a career that was passed down from mother to daughter and there was no formal training. The supplies used by the traditional Dais were often not sterile and they did not know how to properly address complications. In the past there were many cultural beliefs that influenced birthing practices, some that were ultimately harmful. Kaia said that during her mother's time, there was a commonplace practice to have women give birth on all four limbs.[174] She said that a Dai told her mother to deliver on all four limbs, a practice that has no medical benefits because gravity is no longer assisting the laboring mother. Although it may

[174] Kaia Interview, interviewed by Mackenzie Burke.

not be necessarily harmful, it is also not necessarily helpful. Times were also especially tough in the past and that greatly influenced how birth was perceived. Kaia provided the anecdote that her mother gave birth in the morning and had to go fetch water in the evening.[175] These women did not have the privilege of relaxing after having gone through such an exhausting and intense process. Giving birth was perceived as just another chore in the long list of services that women needed to provide for their families.

Changes to some of these traditional practices began as early as the 1970s and 1980s, when the WHO instituted training modules to teach these Dais the importance of the cleanliness when helping deliver babies.[176] However, beginning in the 1990s international donors for traditional birth attendant training began to rapidly decrease as training formally educated midwives became prioritized.[177] This trend continued into the 2000s when the MDGs pressured governments to combat infant and maternal mortality in a more direct and effective manner. Within less than 20 years there was a total shift from educating traditional birth attendants to their deskilling with the implementation of the NRHM. There was no value seen any more in training Dais, only in increasing the number of skilled birth attendants who undergo formal training. The direct manifestation of this is the disappearance of homebirths within areas like rural Kangra. All of the women said that homebirths have become an obsolete practice in their own villages.[178] The women all adamantly explained that no women in their villages have homebirths anymore because not only are hospital deliveries free but there is also free

[175] Ibid.
[176] Sharma et al., "The transition of childbirth practices among tribal women in Gujarat, India – a grounded theory approach," 2.
[177] Sheela Saravanan et. al., "Traditional birth attendant training and local birthing practices in India," *Evaluation and Program Planning* 34, no. 3 (February 2011): 254, doi: 10.1016/j.evalprogplan.2011.02.012
[178] Anjali Interview, Deepa Interview, Kaia Interview, Meera Interview, and Sita Interview, interviewed by Mackenzie Burke.

transportation.[179] They also attributed this shift to the lack of trained birth attendants.[180] During their mother's time, there were more skilled birth attendants that combined both the psychosocial support of traditional Dais and the modern maternal knowledge of allopathic doctors.

Now there are hardly any trained birth attendants that are willing to assist in homebirths. Most ANMs only attend births if they occur at the health subcenter. It is a profession that has been completely phased out and replaced by hospitals filled with physicians.[181] The women's perceptions of homebirths in their own villages matches the data found in the 2015-2016 Family Health Survey. According to National Health Profile 2019, 76.4% of the births in Himachal Pradesh were occurring in institutions.[182] While the interviewed mothers admit that homebirths do occur in some of the harder to reach areas, there is a much higher prevalence of institutional births in comparison. The move from homebirths to hospital births is a trend that will most likely not slow down or reverse, as the Indian government keeps trying to make modern allopathic care more accessible through different schemes. Before long, there will no longer be an entire generation that experienced homebirths as the norm.

*Hope for the Future: How to Improve Birthing Practices*

While there have been great strides made to improve maternal and infant health, there is still much room for improvement. The NRHM created a drastic shift in practices, basically changing the entire discourse surrounding birthing practices in less than 20 years. With rapid policy changes, often comes failures in implementation. The people that are most affected by

[179] Ibid.
[180] Ibid.
[181] Sharma et al., "The transition of childbirth practices among tribal women in Gujarat, India – a grounded theory approach," 2.
[182] Government of India, "National Health Profile 2019," 157.

these failures are the mothers for whom the policies are made. The NRHM aims to provide quality health care to Indian citizens yet it fails to do so on the micro scale. The healthcare infrastructure was not equipped to handle an enormous influx of patients delivering in hospitals. Therefore, there are limited resources for the ever-growing population. The hospitals remain incredibly overcrowded and there are not enough doctors to handle the increasing number of expectant mothers. When asked about how they would improve their own healthcare system with the goal of making birth better for both mother and child, the most common response was a need for more beds in the hospital.[183] Not only is there a minimum of two women per one bed, but if there is physically no more room for mothers in the maternity ward they are left for hours on stretchers in the hallways.[184] Kaia was the only one that believed the facilities are sufficient right now and no enhancements are necessary. This could partially be due to the fact she did not deliver in the hospital, thus having a less personal experience with its services.

Another issue confronted by the women interviewed was the lack of specialists at their local hospitals. Rural healthcare institutions often lack specialists or the proper machines to care for certain complications, forcing women to drive further to the larger hospitals. This was experienced by both Meera and Sita as they first went to their local hospital to deliver their children but were then referred to the larger government teaching hospital.[185] Meera said that the local hospital has more beds and a better patient to doctor ratio, but they lacked a gynecologist.[186] Due to the narrative pushed by the overmedicalization of childbirth, it is believed that a gynecologist must be present for every birth. Meera believes that there needs to

[183] Anjali Interview, Deepa Interview, Kaia Interview, Meera Interview, and Sita Interview, interviewed by Mackenzie Burke.
[184] Deepa Interview, interviewed by Mackenzie Burke.
[185] Meera Interview and Sita Interview, interviewed by Mackenzie Burke.
[186] Meera Interview, interviewed by Mackenzie Burke.

be more hospitals with the same number of specialists and resources as the large teaching hospital. This will not only make institutional births more accessible to women but it will also increase the quality of care by decreasing the crowds at the teaching hospital.

The final criticism raised about birthing practices in India is that there is hardly any privacy. Sita, a first-time mother, felt as though ensuring privacy throughout the delivery process is integral to maintaining human dignity for each mother.[187] As she described her experience in the maternity ward at the teaching hospital, she repeated that there is no privacy whatsoever. Even the labor room is quite open, allowing everyone to see everything at all times. She explained that this was quite difficult for her to come to terms with given that she was so exposed while giving birth to her first child.[188] Childbirth is an intimate process and it should be treated as such, giving expectant mothers sufficient privacy while they embark on this new journey of motherhood.

While no system is perfect, it is important to recognize the failures and try to appropriately address them. This final question was included in the interview to assess how women perceive the issues in their own healthcare system. It was also designed to give them the opportunity to prioritize the issues according their severity. Often times when policies are routinely inundated into society, it becomes hard to speak out against them. In order to properly address these issues, the women they affect need to have their voices be heard. Constructive criticism is an essential part to any evaluation. There truly have been great accomplishments achieved through the NRHM and all of its sub-policies. However, despite these accomplishments, there are still far too many women and infants that die due to lack of access to

[187] Sita Interview, interviewed by Mackenzie Burke.
[188] Ibid.

care or lack of access to quality care. The future of birthing practices in India should be addressed with as much fervor as it was in the early 2000s— there is still much work to be done.

# V. Conclusion

Since the creation of the National Rural Health Mission, birthing practices throughout rural India have drastically changed— shifting from intimate, family-managed homebirths to medicalized, intervention-based hospital births. This shift has occurred in under two decades, aligning itself with a reduction in both Maternal Mortality Ratio and Infant Mortality Rate. While these new government schemes were initially and abruptly imposed upon Indian citizens, its underlying belief system has fully been integrated into the lives of women in rural villages with Kangra District. The dominant discourse idolizing institutional births has overpowered any other narrative. The overmedicalization of birthing practices has also brought the idolization of formally trained healthcare practitioners. Every single one of the women interviewed perceived hospital births as being the only safe and viable option for pregnant mothers these days. Even those that had homebirths themselves believed that they should no longer be allowed. The benefits of institutional deliveries far outweighed the negative aspects of extreme overcrowding and occasional abuse. Similarly, the risks of homebirths far outweighed the benefits of delivering in a more comfortable environment with a more holistic level of care.

There appears to be a generational gap in perceptions of birthing practices, which can directly be seen through the location of birth. The elder generation gave birth at home and thus perceived birthing practices much differently than the current generation. With this change in the norms of where birth occurs also came a change in traditions. Many of the women interviewed discussed that their pregnancy and postpartum experience was not influenced by any traditions or

rituals. However, even when not apparent to the women themselves, there was still an evident theme of following deeply-rooted cultural norms, especially ones that were associated the patriarchy. This overall movement away from cultural traditions or rituals can be closely linked to the modernization of birthing practices.

Prenatal and postnatal care proved to be vital parts of these women's pregnancies and postpartum experiences. Prenatal and postnatal care also defined a lot of the healthcare practitioner's services, as they no longer assist in the actual delivery of babies. There seems to be a discrepancy between how the healthcare practitioners view their outreach, and how the mothers of these villages view them. The health workers, often employed under various government schemes, said they work very closely with the community and have great rapport with them. However, many of the mothers did not utilize their services and just bypassed these community health workers completely to seek out advice directly from the hospital staff.

Most of the women and healthcare practitioners reported that the government hospitals provided good care. However, upon further questioning, it was revealed that not all of the services, facilities, and healthcare providers were up to standard. The health infrastructure was not properly built up before implementing the NRHM. The hospitals and health system were not equipped for the enormous influx of women due to the incentivization of institutional births. This lack of proper planning for the increase in number of patients has placed enormous pressure on an already resource-constrained system. Both the mothers and healthcare providers concluded that some of these problems, like overcrowding and lack of privacy, impedes the healthcare system from delivery quality care to its patients. While the National Rural Health Mission and its subsequent schemes have increased the quantity of women giving birth in hospitals, there needs to be further efforts made to increase the quality of care received by these women. Overall, the

women interviewed have positive perceptions of birthing practices in rural Himachal Pradesh, but that does not mean they are completely happy with the quality and access of healthcare within Kangra District. The government should be striving to make even more improvements to maternal and child healthcare services, thus allowing more women to have positive experiences with birthing practices.

# VI. Recommendations for Further Studies

There has been much literature written about the implementation of the NRHM and all of its schemes. Now, almost 15 years after its implementation, a lot of the literature has focused on its effects on a quantitative scale. In order to understand how these policies have affected the women they are created for, there needs to be more qualitative studies performed. Women's voices and stories need to be elevated to the forefront of the research conducted about them—they should not be simplified solely to numbers. This study aimed to understand how women in the rural villages of Kangra District in Himachal Pradesh view birthing practices. In order to have a deeper understanding of women's perceptions of birthing practices, this study should be repeated with more interviews and during a longer period of time. One month is not a sufficient amount of time to truly understand the nuances of a region's culture.

Furthermore, to have a more holistic view of women's perceptions of birthing practices, it should be repeated on a larger scale both within one state and then expanding into different states within India. There needs to be a more varied set of women that are interviewed, spanning all socioeconomic levels, all caste classifications, all religions, all education levels, and more. Diversity of viewpoints is key to making this study successful. While the women in this study did come from varying backgrounds, their overall identity was too similar for the study to

generalize its findings for all of Himachal Pradesh. Once women's perceptions of birthing practices in Himachal are accurately captured and understood, it might be beneficial to focus on another state in a different geographic location to see how the results differ.

Finally, it is recommended to incorporate more stakeholders in the study. Due to the time and resource constraints, the criteria for this study had to remain finite. While there were five healthcare practitioners interviewed, there are many more that can be incorporated. These healthcare providers, especially if they are women, both are a part of the system as well as experience it. It is vital to capture their thoughts, feelings, and opinions regarding birthing practices in their region. Additionally, it would be beneficial to interview the elder generation of women, as their perceptions of birthing practices vary greatly as compared to those of the generation that is giving birth currently. In conclusion, further studies could be improved by working to elevate women's voices and expanding the study both geographically and through diversifying the population studied.

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# VIII. Appendices

Interview Questions for Healthcare Practitioners

1. What is your name?
2. What village are you from?
3. What religion are you?
4. What caste are you?
5. How old are you?
6. Did you go to school?
    a. If so, how many years of school did you complete?
7. What kind of health training have you completed?
8. What has your experience been like with childbirth as a healthcare practitioner?
    a. What is your role with the local community when it comes to maternal health?
9. Do you offer prenatal care or postnatal care?
10. What is your opinion on the government mandating hospital births?
11. How has your role changed since the government began mandating hospital births?
12. Do you think homebirths should still be allowed?
13. Are there still women who choose to have homebirths even if it is discouraged by the government?
14. What are some barriers that impede rural women from accessing institutional births?
    a. Can you easily access a hospital? / Will the ambulance come up to the villages?
    b. Are women afraid of giving birth in the hospitals?
15. How do women choose which hospitals to give birth in?
16. How have birthing practices changed through the generations?
17. How do you think birthing practices can change in the future for it to have the best outcomes?
18. Is there anything else you would like to add?

Interview Questions for Mothers

1. What is your name?
2. What village are you from?
3. What religion are you?
4. What caste are you?
5. How old are you?
6. Did you go to school?
    a. If so, how many years of school did you complete?
7. How old were you when you got married?
8. How old were you when you gave birth to your first child?
9. How many kids do you have?
10. How old were you when your last kid was born?
    a. How old is your last kid?
11. What was your personal experience with childbirth like?
    a. Where did you give birth?

        i. Did you go to a private, public, or NGO hospital?
    b. Was it a normal birth or a c-section?
    c. Who accompanied you during the birth?
    d. How did you get to the place you gave birth?
        i. Did you go by ambulance, private car?
    e. Who attended the birth?
        i. Was there a doctor, ASHA, Dai etc.?
    f. Did you make plans for the birth before it happened?
        i. Did you set aside any money or plan for where you wanted to give birth?
        ii. Did you plan at which hospital you would like to deliver?
12. Did you seek out medical care during your pregnancy before you gave birth (i.e. prenatal care)?
13. Who made decisions regarding your pregnancy?
14. Did you feel pressure to have a male child?
15. Are there any traditions that influenced your pregnancy or birthing experience?
16. Did your experience with pregnancy or childbirth change as you had more children?
17. Do homebirths still occur in your village?
18. What is your opinion on the government incentivizing institutional deliveries?
    a. Are they good or bad?
19. Do you feel comfortable delivering children in the hospitals?
20. Are there any barriers that stop you from accessing deliveries in the hospitals?
21. How have birthing practices changed through the generations?
22. How do you think birthing practices can change in the future for it to have the best outcomes?
23. Is there anything else you would like to add?