Improving maternal healthcare

A fieldwork-based research of a collaborative project between Sweden and India

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Abstract: The purpose of this thesis was to explore a collaborative project between Sweden and India, a project that is working with improving maternal health care in India. I focused on investigating how the project worked in practice, how they worked for improving the situation for Indian midwives and for pregnant women. This investigation was performed during a two month fieldwork in India where I got the opportunity to meet and interview several people connected to the project. The focus has been primarily on the “Master Trainers”, i.e. Indian midwives who have taken part in a training program in Sweden and in India, and who will function as teachers to other Indian midwives, regarding their perceptions about the project and its achievements.
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**Introduction**

India is divided into 28 states and 7 union territories, all of them with their own governments but united under the Indian constitution. (URL 1) According to the constitution, India is a secular state; however religion, including Hinduism, Islam, Christianity, Buddhism, etc., plays a major part in people’s lives. (URL 2) Despite officially having abolished discrimination based on caste belonging, caste is still an important social, economic and political marker in many fields of life, and may restrict people from taking certain jobs or in combination with economic factors getting access to good education and health care. This means that all people do not have the same possibilities and the social differences may be difficult to overcome.

However India has one of the world’s fastest growing economies and has considerable shares of the world market within such sectors as telecommunications, information technologies and pharmaceuticals. The rapid growth in parts of India together with persistent poverty in other areas contribute to great differences in the standard of living and to the possibilities for people to get access to medical assistance. (WHO, 2006: 1) India has the political instruments required to manage the health sector, and the constitution states that; equitable access to health care is every citizen’s right. In practice, however, dealing with the problems within the health care sector is an enormous task and many states in India cannot meet the needs of the citizens and provide adequate health care. (Peters, 2002: 82-83)

The health care in India is based on modern medicine but in addition a number of traditional forms of health care are in operation, including for instance the Ayurvedic traditions, but also homeopathy and other alternative health care methods. The state governments provide general and public health care, but there are also several private medical partitions and hospitals who treat people for higher fees, which effectively excludes poor people. (Karolinska institute & Indian Institute of Management Ahmedabad, 2005: 5) The private medical sector is large and nationally unregulated.

In September 2000 Sweden was one of 191 countries who signed an agreement about reducing poverty around the world. This means that every one of these countries should take their responsibility to help to achieve the eight goals that where agreed upon by the year 2015. The so called Millennium Development Goals include for instance eradicating extreme poverty and hunger, introducing obligatory primary education, improving gender equality and improving maternal healthcare. (URL 3) From the 2009 development aid budget, Sweden put in an extra 100 million SEK for reducing maternal mortality around the world. (URL 4)
Sweden and India have cooperated on development issues for many years and India has been one of the main recipients of Swedish aid. However in 2005 the Swedish government decided that the traditional form of development cooperation would be phased out and be replaced by a new form of partner-driven development projects. This means that Sweden will give financial and other forms of support to Swedish-Indian development projects of mutual interest, but based on India’s own development plans and priorities, and with long-term sustainable effects. (URL 5)

One important health problem in India is the maternal mortality. It is estimated that about 100,000 Indian mothers die each year while giving birth; this is 20% of all maternal mortality in the world. There are a number of factors to explain these high maternal mortality figures, including socio-cultural, economical, administrative and professional factors. There are not enough health clinics to provide adequate health care and many people have to travel great distances to get medical treatment. Many women, an estimated 65% of all women who give birth, have no choice but to give birth at home. Another problem is that there are not enough fully qualified specialized midwives and other medical professionals do not have the knowledge and training required. Historically, the development of midwifery services has been very limited in India, and there has not been any special training to become a midwife; all nurses are registered as both nurses and midwives. (Karolinska institute & Indian Institute of Management Ahmedabad, 2005: 1-7)

As described above, social differences in India are related to economic differences and persistent differences due to caste belonging, however gender differences are also important factors to explain the high mortality rates for women. Because many women in India are not as highly valued as men, and their needs, including health care, are not prioritized, women suffer from a great disadvantage. Women have restricted access to available health services due to their lack of independence, private means and decision making powers. (Karolinska institute & Indian Institute of Management Ahmedabad, 2005: 6-7)

There are several research collaborations between Swedish and Indian universities and institutions. One of them is the project that I will focus this research on. I first came across the subject of maternal health care when I visited SIDA:s website to look for suitable and interesting projects. This project in India is aiming to improve maternal health services and the status of midwives through better education and training. The Karolinska Institute, the Swedish Midwifery Association, Indian Institute of Management in Ahmedabad, Trained nurses association in India, White Ribbon Alliance of India and Academy of Nursing Studies are working together on the project “Developing Inter Institutional Collaboration between institutions in India and Sweden for Improving Midwifery and EmOC Services in India”. The goal for the project is to contribute to a national effort in India to
reduce maternal mortality. To achieve this goal the project is working to strengthen midwifery and EmOC (Emergency Obstetric Care) services in both the public and private health care system in India.

The project is carried out in four different states in India; Gujarat, Andhra Pradesh, West Bengal and Tamil Nadu.

**Purpose and research questions**

Training in midwifery skills has been chosen as a target area for cooperation between Indian and Swedish institutions. The project I will focus on is working with improving the education for midwives in India and I will focus on investigating how the project works in practice. One of the problems identified by the project is that the midwives do not have enough education and that their status is very low. What I want to study is how this project will work to improve the situation for Indian midwives, and I will focus on the “Master Trainers” of the project, i.e. Indian midwives who have taken part in a training program in Sweden and in India, and who will function as teachers to other Indian midwives.

My major research questions are: what do the Indian midwives learn, how do they learn and what impact will their new knowledge and skills have on their work and status? According to the Indian midwives, does the project provide adequate and useful knowledge and skills? What goals have been accomplished and what difficulties and problems occurred during the project according to their perceptions? To what extent are possible cultural differences between Swedish and Indian health care traditions and systems accounted for in the project, for instance with regards to gender issues?

**Methodological approach**

I have based this thesis on fieldwork carried out in India during February and March of 2010. This study took place in four different states in India where I gathered empirical data from in-depth interviews. My interviews focused on the midwives who received training through this project, these midwives are called “Master Trainers”. I have analyzed how they perceive of the education they have received and how they, in turn, are passing on that knowledge and those skills to other midwives. I was supposed to interview eight women but I ended up interviewing all the Master Trainers who were able to be interviewed at the time I spent in India, it ended up being 11 of the 15 Master Trainers.

The research data was collected through interviews with these relevant project participants as well as through literature studies. Because I only spent a certain amount of time in every state I did not have the possibility to meet and interview my informants on several occasions. For this reason I found semi-structural interviews, my method of choice, as my best option. I designed the questions
to be open to the informants’ own narratives around the different topics. I was, because of this, able to guide the interviewees towards certain central issues of interest to my study, but leave enough room for my interviewees to express themselves freely and add to the questions and topics, if I had left out aspects that were considered important to the interviewees. The possible differences between the narratives will enrich the study and hopefully provide a more complete picture of variations between the interviewees. The data collected was compared with the project plan in order to find out and discuss how the project is working, and what goals have been fulfilled, if any, and how.

With consent from the interviewee, I used a tape recorder, and I sometimes took notes during the interviews. In these interviews I did not need to use an interpreter, my interviewees were comfortable with English and could express themselves and understand my questions without translation. I think this helped to make the interviews more relaxed and flexible.

I carried out my research assignment through qualitative and semi-structured interviews in combination with observations in both the lecture theatre as well as in the clinics (when it was appropriate) to get a more thorough picture of the project. You can read more about this in the subchapter “Participant observation”.

My contact person or supervisor in field was Dr M. Prakasamma. She is working as a director at Academy for Nursing Studies (ANS) in India. Academy for Nursing Studies is a professional non-profit making organization. They are working with research, training, information and within nursing, midwifery, public health and women’s empowerment. ANS was one of the organizations involved in this project. Dr Prakasamma is one of the people responsible for this project and she helped me to contact my interviewees and to arrange for my stay in India.

The interviews took place in the CAMT (Centre for Advanced Midwifery Training) which is the place the interviewees worked during their time as Master Trainers. One of the goals in this project was to setup a CAMT were midwifery tutors could receive more education. You can read more about this under the chapter “The Project”. I found it to be positive to be able to interview them at the CAMT’s, partly because this gave me the possibility to visit all CAMT’s and partly because my interviewees are familiar to these places, I think this help them to feel calm during the interviews. Each interview were about 1-1,5 hour long, and sometimes divided in to two different sessions because of their working schedule. This amount of time made it possible for me to discuss the things I needed, as material, and at the same time was not to long that my informants felt worn out.
Because of the readability I have chosen to correct colloquial language to more resemble what is regarded as written language from my transcripts. I have chosen to do this because I am more interested in what my informants have to say and not how they express this, and because it will be easier for the reader to comprehend.

**Participant observation**

During my time in India, I traveled in four different states. For the duration of my travels I visited the CAMT’s, the centers of the project in the different states. Together with a group of research assistants from Academy of Nursing Studies I visited the CAMT’s, hospitals and nursing schools related to this project.

This method enriched my thesis and gave me a fuller picture of the situation in those places I visited. It is of importance to give yourself as a researcher time outside of the interviews to study what you are there to investigate; this gives an opening for unexpected things to occur. With enough of these occurrences you get an understanding about the situation. Things you experience during participant observations, peoples actions, certain objects can give you a foundation which you can develop during your interviews. (Agar, 2008: 31) It can also give you a better understanding of those things discussed during an interview as it did for me.

Participant observation means that you involve yourself in the community, talk to the people, observe and learn from them. (Agar, 2008: 163) In my time in India I lived mostly at MyTRI Institute, which is their Midwifery resource Center at Academy for Nursing studies. There they work with coordinating the CAMT’s, they conducted the Master Trainers training programmes, and are doing research and providing support for the CAMTs and to the Master Trainers. At this place I came in contact with a lot of different persons connected to the project I investigated, I got to be part of their meetings and conferences and make my own picture of how they were working. During my travels to the different states I lived with the research assistants, which also helped me understand how they worked and evaluated the project. We mostly lived at the nursing hostels that were connected to the CAMT’s and there I saw their everyday work with students and tutors. This helped me during my investigation and in my contact with people in this project.

To travel together with those connected to the project was of great value to me, with them I got access to the hospitals: something that would otherwise have been almost impossible. This was an experience that helped me to understand the situation in a better way. To be able to see it with my own eyes how the maternity wards were organized, how the patients were taken care of and what problems their seemed to be. This helped me to comprehend the situation better than I would by only hearing or reading about it.
Research ethics

Before my interviews I introduced myself to the Master Trainers, I told them my purpose of this study and that the data collected will be portrayed in my Master thesis. I wanted them to have a clear understanding of who I am, what I was doing in India and why I wanted their view and perceptions regarding the project. (cf. Agar, 2008: 105-107)

Because I was send to the CAMT’s by the director of Academy of Nursing studies, and because she arranged for my interviews, I felt that it was of great importance on repeated occasions to tell my informants that their participation in my study was voluntary, I told them when we organized the time of the interview, before we started the interview and I notified them that they anytime during the interview could decline their future participation. If I would ask a question they did not want to answer, they were free to decline to answer. (cf. Agar, 2008: 231)

The right of anonymity can only be received to a certain level. People connected to this project may be aware of who said what in this thesis, and this is not easy to avoid. However, to be able to give my informants the most amount of anonymity possible without losing their personal facts I gave them aliases. (cf. Agar, 2008: 231)

The interviewees

Within this project several Master Trainers were selected. These were persons with qualifications and experience within the maternal health care. They have received special midwifery training from this project, both in India and in Sweden. The training involved midwifery practice, leadership, management and teaching skills. After receiving this knowledge they in turn trained midwifery tutors.

A total of 15 Master Trainers were trained, and during my time in India I got the opportunity to meet and interview 11 of them. Two in Gujarat, three in West Bengal, four in Tamil Nadu and two in Andhra Pradesh. From these interviews I have made a selection to focus mostly on 8 interviews, but some of the information collected from the other three interviews will also be portrayed in my thesis. Therefore I will give a short introduction of my interviewees. As stated before, for their right to anonymity I have chosen to give my interviewees´ aliases.

Gujarat

**Aadhaya** has been working within this field for a total of 16 years, both as a teacher and in the clinical area. She is now working both as a teacher and supervisor for midwifery students as well as a principal at a nursing college.
Madhula has been a midwife since 1981. She has been working in the hospital in the maternity unit and in the labor rooms. Now she is working as a teacher at the CAMT in Gujarat.

West Bengal
Rabhya has been working in the nursing field since 1976. And she was selected by the government to be part of the Master Trainers in West Bengal.
Kajri did her Masters in obstetrics and obstetrics nursing, she has been working within the field since 1975, and nowadays she is retired.
Saachi has been working as a midwife since 1981. She was a part of the Second batch of Master Trainers so she started her participation in 2008.

Tamil Nadu
Aahana have devoted herself as a midwife from 1976 and onwards. In 2008 she joined the second batch of Master Trainers.
Waheeda has been working as a staff nurse in a hospital then she chose to become a Trainer and to teach midwifery classes.
Aabharana have been in the nursing field for 27 years, she has PHD degree in MSC nursing. For 20 years she was a staff nurse, and for the last 7 years she has been teaching the subject.
Kahini is a nurse/midwife and during her post graduate program she chose obstetrics as her special area. She has now been working 28 years in this field.

Andhra Pradesh
Eesha have been in the nursing field for 25 years. She started her participation in this project in 2006 in the first batch of Master Trainers.
Olimani is now working as a district public health officer. She has been working as a nursing tutor were she taught many subjects, she was working as a principal when she got promoted to become a district public health officer.

Thesis Outline
I start by giving an introduction of the situation for women in India. In this chapter which I call “Women in India”, I present some general gender theories which give an opening for the situation for women in India. I focus on some social, as well as religious theories behind gender inequality. In the subchapter “Women and Health”, I discuss how these gender inequalities affect women’s access to health care.
In “The project” I introduce the project I have investigated, portray what goals were established and the plan to achieve them.

In a subchapter I illustrate one of the problems this project have identified and are working to improve; “Maternal Mortality”. Here I present some other articles that have studied this problem and discuss some theories explaining the high maternal mortality. “Cultural conceptions” discusses theories within medical anthropology and illustrate how different cultures perceive illness and treatment. I use these theories as a way of explaining why some women in India do not want to go for check-ups or for delivery in the hospitals.

In the subchapter “The situation for midwives” I illustrate how midwives are perceived in India today, and what status they have and I discuss how this may influence the maternal health care.

In “Achievements” I present my analysis of my informants’ perceptions of what has been accomplished in this project, both general improvements and their own personal and professional development.

Finally, “Problems and additional needs” illustrates my interviewees’ perceptions of difficulties, shortcomings and additional needs with this project; what they perceive needs further improvements and what has been problematic.
**Women in India**

In her book *Gender Trouble*, Judith Butler argues that gender is culturally constructed. Gender is therefore something that might differ between different cultures. The gender role is constantly constructed and reconstructed and may change with time not only between different cultures but also within one culture. (cf. Butler, 1999) The aspect of gender as culturally constructed is important to have in mind when talking about gender inequalities in a society.

Carole Pateman discusses in her book *The disorder of women*, how women never have been entirely excluded from participation in the political world, but that they have been included in different ways than men, and filled different political positions, often of lesser importance. She argues that the problem with differentiated access to political power lies in patriarchal power and the government of women by men, (Pateman, 1989: 2-4) and this is also the case in India.

Inequalities between men and women must be understood both on a religious and a social level. For starters India is mostly a patrilineal society, this means that decent counts through the male line, and like most patrilineal societies patrilocality have served as the standard in India. This means that when a couple gets married they most often move to the area and the premises of the husband’s family and relatives. This can have a huge impact on the women who move to a new surrounding and without her family and friends. In this family she is the newcomer, where she does not have the support system she is used to. (Stone, 2006: 71-73, 78) In the book *Social status of Indian women*, the author says that in India women are considered to be the weaker sex, physically, emotionally and intellectually, and most girls will have an inferior role in their families from childhood. A girl must be protected, given dowry and be married into a good family. (Qureshi, 2003: 1-2)

The Indian society has strong norms for appropriate social roles for men and women. Women belong mostly to the home sphere while men primarily are associated with the outside world. Women’s responsibilities lie in domestic chores, to keep the household running, look after children, to cook and to clean, all chores related to the household. Even females who have the possibility to work outside of their homes are expected to also do the household chores. (Qureshi, 2003: 9) This was also pointed out by some of my interviewees, for example Rabhya is saying:

“In case of females, they cannot spend much more time in the workplace after their hours. They have to run home and they will, there they have to cook, they have to look after their children, look after the home, their husband and the relatives. They are having many responsibilities, till now we are still having that joined family concept”.

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Another factor is religion. It is of importance to take into account the tradition of complex structures regarding ritual impurity, something that affects not only Hindus but all inhabitants in India. Douglas proclaims in her book “Purity and Danger” that the caste system is built on thoughts about impurity; some castes have a higher status and purity than others. And to come in contact with someone from a lower caste or to come into contact with something that has been touched by a member from a lower caste will be polluting. (Douglas, 1966: 51-54) According to tradition, both pollution and impurity have had huge importance in India. It contains complex structures both social and religious regarding ritual impurity. There exist a wide range of things considered polluting. Bodily emission is associated with religious impurity, and therefore controlled with specific rules and regulations. Menstruation is part of this and is considered to hold impurity. This impurity marks all women as belonging to a permanently impure gender. (Nelson, 1998: 98) This mark may also have an effect on gender bias and the status of women more generally. I will develop this theory in the chapter “The situation for midwives”, where I will discuss the effect this may possibly have today.

Significant changes have occurred in various places in India when it comes to health, education and employment status for women, but still several problems persist. Both the government and nongovernmental organizations (NGO) are working to improve the situation of the gender bias and inequality when it comes to status. Despite this the situation is still severe and many women are facing discrimination and harsh conditions. (Jacob, et al, 2006: 101-104)

By law men and women have equal rights, the same as for caste, religion, race and descent. (URL 6) But this is not always working in practice, my interviewees all agree upon the situation of inequality when it comes to the status of men and women. Aahana, one of the Master Trainers from Tamil Nadu, stated:

“In India, in Tamil Nadu, women are always left out, so here we have male dominance. But of course in my stage I have different view, my father and my brothers they have taken care of me, they were the protectors so I have never thought that men are dominant. But in general man dominance is the reality in India as well as in Tamil Nadu. Women are not given so much freedom like in your country especially”.

She continues to say that inequality is connected to employment, schooling and even nutrition especially in the remote areas:

“The good food will not be given to the female child, and when we take school dropout, until today we have different percentages of more girls than the boys, and regarding marriage
many girls, they are getting married to the one they like of course, love marriages are going on, but in general ladies do not have so much freedom”.

She describes how women have to ask their husbands or fathers for acceptance and permission. “For anything we should get an acceptance from our father or somebody who is the male protector”. As another example Aabharana gives an example from her own life regarding the situation between herself and her husband, she states:

“Even though we are earning more than them see for example myself, my husband is working with education in the government hospital, he is earning less and I am earning more but whatever decision about for example education, any family problem, my own problems or his own problems, everything, he will counsel with me but whatever decision he thought in his mind, he decided already that only he will implement. So that much we cannot say that women’s liberty has come up in India, no. I will not agree with that”.

Waheeda agrees with the statement that males are dominant but want to state that her own situation differs from this. “The males are dominant. We have to be beneath them, we have to work under them. Equal rights they will not give. But for me it is not like that, but for most of the people the males are dominating.” She feels that it is of importance to tell me about the normal situation in India but states that the situation is different for her. Later on during the interview when asked about obstacles in her professional life she states: “I did my MSC nursing without pain. My husband has allowed me. I studied my MSC nursing without salary and my husband gave permission to me”. She starts by telling that she is equal with her husband, but it shows in her statements that she needed her husband’s permission to study. I really do believe that she feels equal with her husband; she got the opportunity, with her husband’s permission, to study, something she wanted to do. That is a lot more compared with other women in her surroundings.

In this section I have given a little introduction to gender inequalities and the situation for women in India. In the next segment I will illustrate how these inequalities influence women’s health and access to health care.

**Women and Health**

Social differences in India are related to economic differences and persistent differences due to caste belonging, however gender differences are also important factors to explain the high mortality rates for women. Because many women in India are not as highly valued as men, and their needs, including health care, are not prioritized, women suffer from a great disadvantage. Women have restricted access to available health services due to their lack of independence, private means and
decision making powers. (Karolinska institute & Indian Institute of Management Ahmedabad, 2005: 6-7) There are around 100,000 women every year in India that face maternal death, and somehow it has not been a subject of any significant political, social or media debate in the country. (Karolinska institute & Indian Institute of Management Ahmedabad, 2005: 5)

Women’s inferiority in the political life is also reflected in their access to health services that focus exclusively on women’s issues, including that of pregnancy and child birth. Because women are considered inferior, their specific illnesses and health issues are also considered to be of little importance. Gender issues, i.e. the socially constructed meanings given to each sex, are therefore important factors to explain and deal with inequalities between men and women in the health sector. (Watkins & Whaley, 2000: 43-44)

“Women, Gender and Human Rights” is a report from a study, and includes several papers dealing with global outlooks on gender issues. In one of the papers, “Women’s Health and Human Rights”, it is argued that the health of women is not only influenced by biology genetics and physiology but also by the role of women in a society. The inequality between men and women is an important factor to explain the problems of women’s health. Women earn less money, have lower level of education, if any, and are also often under the control of men, including fathers and husbands, factors that often combine to deprive women of good health and access to health services. (Levison & Levison, 2001: 125-127) This situation as described above is emphasized by my interviewees. They accentuate that the situation for women in India today has improved but it still exist inequality between men and women. The lack of autonomy for women can be an explanation to why there still exist a lot of homebirths in India. Women and girls are often taken to the hospital in a later state of illness than men and boys. Women’s lack of autonomy is of importance to explain what access she has to health care services. (Jacob, et al, 2006: 101-104)

Several of my interviewees discussed the differences in status between men and women. They state that there is a difference between rural and urban areas. Men have even more power in the rural areas. In urban areas the differences in status is not so wide in higher class families. If the woman has her own income she will have more autonomy. One of my interviewees named Aadhaya declares that:

“In the rural area the status of women is low. But in the urban area, in the higher/middleclass the rights are equal for the male and for the female. They are considering what the female want or whatever suggestion that is given by the female. They are accepted by the family members. Thus the status of women is low in the rural area so the disparity is there. Sometimes females are not able to make decisions for themselves, how many children should
be there or what kind of education they have to provide for the children. Whatever important decision that is taken in the family, it mainly is taken by the male”.

This situation was common; it was discussed several times during the different interviews. They emphasize that by law men and women are equal but it is not working in practice. The traditional practice is still in place but as Rabhya states “there are changes, it is changing, and the process has started. So it is changing.”

In order to promote women’s health, Levison and Levison argues, basic human rights needs to be promoted, the right to education, the right to participation in the political life and the right to employment with equal pay for equal work effort. (Levison & Levison, 2001: 125-127) This opinion is shared by the Master Trainers, they stress the importance of education and the development that will be the outcome. Aadhaya said:

“Nowadays the education is increasing and most persons think that without education we are helpless. If education is there, development of the person will be there. They are talking and sharing their ideas and views with the family and they are taking the decisions together”.

In the book “Birth on the threshold: Childbirth and modernity in South India” Cecilia Van Hollen is portraying the United Nations fourth world conference on women, in Beijing. She illustrates how the majority of women’s organizations in India want to prioritize socioeconomic changes while the countries in the West put the focus on rights and equality. The women’s organizations in India stated that to put so much attention on the individuality will draw the attention away from the social, political and economical structures that they feel denies women of their rights in the first place. (Van Hollen, 2003: 207-208)

In this chapter I have illustrated the situations for women in India both in general and connected to health. This situation is something that the project, I have investigated, are working to improve. In the next chapter I will describe this project and the goals they have established.
The project

The project I have investigated is a collaborative project between Swedish and Indian organizations. The goal with this project is to improve the maternal health care in India. To do this the project is aiming to strengthen the midwifery education. As I described in the chapter “Interviewees”, several women with experience within maternal health was selected from four different states to become Master Trainers. These women received training for three months in both India and in Sweden. The training consisted of advanced knowledge and skills regarding midwifery and midwifery techniques and how to demonstrate these. It include clinical experience, training in conducting workshops and meetings, how to design and conduct training programs for tutors, prepare guidelines for assessments both of teaching and practice, and how to write papers and carry out research.

The training in Sweden included mostly observation. It also consisted of training regarding the midwifery model of care that is implemented in Sweden; they had to assess what role the midwives have on reducing both maternal and infant mortality in Sweden. They also studied the Swedish midwifery society and its role and finally they practiced new training techniques and methods in both class room and clinical areas.

After their training they helped in the constructing of four Centers for Advanced Midwifery Training (CAMT). This is resource centers for midwifery, with classrooms, skill labs, library and other resources. It was here they in turn would educate midwifery tutors, which is also a part of this project. Eesha is describing the project as follows: “It is a woman empowerment, strengthening of women and strengthening of midwives”.

The overall developmental goal of this collaborative project would be to contribute to reduce maternal mortality and morbidity on a national level. This goal will be achieved through strengthening midwifery and EmOC services in both public and private health systems in India. By developing a strong and proactive network of interlinked institutions that will support various governments, NGO’s and private efforts, this can become a reality. The project believes that reducing maternal morbidity and mortality will help with poverty reduction and gender equality. To be able to perform the project has established certain objectives. These are to strengthen midwifery skills to be able to provide safe services to women, develop a pool of shared knowledge and understanding regarding present situations of midwifery and EmOC services in India. They want an understanding regarding organizations of midwifery and maternal health services in Sweden as well as other countries, and investigate how their curriculum can be adapted and applied in an Indian situation. The project wants the maternal health care to be focused on midwifery and they want to implement new guidelines for the midwifery subject, and develop a proper supervision that can monitor these
changes. One key point is to develop networks; organizations including academic institutions, professionals, government agencies, different women’s groups etc. to work together to support the improvements of maternal health studies. This can be carried out by doing research, pilot testing and monitoring. These studies can be an encouragement for different decision makers in both state and central governments and for professional organizations to support the improvements in maternal health care services. (Karolinska institute & Indian Institute of Management Ahmedabad, 2005: 8-9)

To be able to investigate the project achievements I choose to interview the Master Trainers, those midwives that got the opportunity to receive training and education through this project and in turn educate midwifery tutors and future midwives. I wanted to investigate how they perceived this project, the goals, the execution, and accomplishments.

One of the problems the project is working with is the high maternal mortality. In the next chapter I will portray the situation in India regarding this issue.

**Maternal mortality**

20% of the total number of global maternal deaths occurs in India. (Karolinska institute & Indian Institute of Management Ahmedabad, 2005: 2) Hence maternal mortality is a major problem in India and has resulted in several research projects and publications on the subject, including for instance a article titled “Implementing Reproductive and Child Health Services in Rural Maharashtra, India: A Pragmatic Approach”. (Barua, et al, 2003) In this article they are describing a joint project that The Foundation for Research in the Health System and some districts health administrations have been working with. They argue that the Indian government has provided a very limited maternal and child healthcare. They identify several different reasons behind these limited services, including the lack of skills and experience of the health workers, the problems with availability of equipment and poor contraceptive and drug supplies. (Barua, et al, 2003: 140-149) This article has identified some of the same problems as those that are in focus in the project I have been investigating.

There exist several other relevant works regarding health care. In an article titled “Maternal Health in Gujarat, India: A Case Study” (Mavalankar, et al, 2009) it is stated that despite the fact that the state have come a long way in improving health, the progress in reducing maternal mortality has been slow and that it still exist a lot of problems in this area. When looked at health indicators, Gujarat is doing better than the national average. The Gujarat government have worked with improving maternal health care, they have started collaborating with private maternal health services to be able to provide delivery care to poor women and they have worked with improving emergency
transport systems. However, with all this done a lot of problems still remain. (Mavalankar, et al, 2009: 235-237)

A major problem with maternal health care in India is that there are not enough health clinics to provide adequate health care and many people have to travel great distances to get medical treatment. Many women, an estimated 65% of all women who give birth, have no choice but to give birth at home. (Karolinska institute & Indian Institute of Management Ahmedabad, 2005: 1-7) This was something my interviewees confirmed but they want to state that in several parts of India the situation is improving. According to Kahini the situation in Tamil Nadu can be described like follow:

“Previously there was a difficulty to access the health care facilities now our government has taken force. They are making referral easy by providing ambulance. When we call we will immediately receive an ambulance. After the NRHM program (National Rural Health Mission, my note) now even in rural areas we are getting access to healthcare more easily. One thing that is still lacking is for the scheduled tribes”. ¹

She states that scheduled tribes are still deprived of health services, but compared to the last decade it’s been improved. The government is now concentrating on tribal as well as rural areas.

Another relevant work regarding this issue is an article titled: “Human Resources for comprehensive EmOC: an Innovative partnership with the private sector to provide delivery care to the poor”. The authors declare that the problems concerning the lack of government Obstetrics and gynaecologists are worst in rural areas and that the situation in some states is very bad. Gujarat is one of these states, where there only have been seven obstetricians working, in rural areas, in the government sector. The reason behind this is the low salaries when working within the government compared to the private sector. (URL 7)

This situation differs between different states; in some states there are still serious lacking with access to health care in rural areas, but this is improving. Eesha describes the situation in Andhra Pradesh:

“In rural area they are facing problems, they are not getting proper services, including maternity services, and there is absence of doctors and sometimes nurses. If they are staying there they are insecure, facilities are not available so they are referring the cases from rural to

¹ Scheduled tribe is a term for an indigenous group of people acknowledged by the national legislation. The common term in India translates as tribe, clan, group. It is certain communities in India that were suffering from severe social, economic and educational backwardness as a consequence of the traditional practices of untouchability or primitive agricultural practices, lack of infrastructure facilities and geographical isolation.
urban areas. The mothers are referred from rural to urban areas with complications, thus until they reach both the mother and baby will suffer from complications”.

Another problem that the project has identified is the lack of midwifery professionals, the midwives/nurses are lacking in skills and also there is neglect of midwifery training among doctors. Delivery care and maternal health care has been neglected, while resources have been improved in other services like child immunization. The project acknowledges the gender biases as one huge reason behind this neglect. Women’s lives are less valued and not enough importance is placed on their health care. Inadequate amount of health personnel, both doctors and nurses are creating numerous problems within the health sector and within the maternal health care. Aahana says:

“it is really inadequate; nowadays we have a lot of problem, with the hospital workers. The government has a policy, that those who retire are not being replaced, certain functionaries especially the hospital workers. We find it very difficult; we can hire a hospital worker for 500 rupees, but who will come for 500 rupees? This is a problem; we are unable to keep our health premises clean, this is a major problem”.

The lack of personnel makes it difficult if not impossible to keep the maternity units clean, poor hygiene is a consequence of “lack of personnel and inadequate supervision” as Aahana states. This was something I experienced during my participant observations. During my two months in India I visited several hospitals in the four different states. I got to observe the difficulties to keep the hospital and maternity units clean. In every hospital I visited there were loads of patients and family members that inhabited both the labor room and the hallways throughout the entire maternity unit. In the labor room several mothers were giving birth at the same time and doctors and midwives were running from one patient to the next. There was almost no time at all to clean and maintain a hygienic surrounding. At one hospital, disposable gloves were drying on a clotheshorse after being washed for reusing purpose, this was a common occurrence I was told. Drapes were hanging in several places in both the labor rooms and around the maternity unit; drapes covered with blood splashes both old and new ones. The lack of personnel was noticeable and stated by many of the employees I got the opportunity to speak to. This is also mentioned in the project proposal, where they discuss that poor management practices and weak governance is a cause for the irregular supply of medicines and for the absence among health providers. (Karolinska institute & Indian Institute of Management Ahmedabad, 2005: 2)

Even though most of the women in India face disadvantages, it is even more severe for poor women, and mostly for poor women in rural areas. (Karolinska institute & Indian Institute of Management Ahmedabad, 2005: 2-3) They have larger disadvantage when it comes to articulating their demand
for health services and for getting services. The government hospitals have a bad reputation which results in the fact that a lot of poor women who do not have the possibility to get private health care, because of the cost, choose not to seek any care at all during their pregnancy and child birth. They prefer to deliver at home even though the risk for complications is high. (Karolinska institute & Indian Institute of Management Ahmedabad, 2005: 2-3) Eesha from Andhra Pradesh is saying that:

“All maternal mothers are not provided with healthcare facilities. Lack of knowledge and lack of skills, from the service providers, is responsible for the situation of midwifery in India today. They are trained, they are midwives but they are unable to provide proper care because lack of facilities and improper setup of labor rooms. This is the problems identified, part of treatment they are receiving but they are not getting quality care“.

Olimani state that one reason behind their fear of government institutions and its poor quality of services is that people’s perception is that spending money equals receiving. “If I go to private institution I spend money and I receive. Here it is free services so they think that free services have no quality, it is not really correct. One thing we should think of is that the communication should work. We should be able to convince them that even these drugs are bought with money and also comes from good companies”. One could think that lack of money would be the main reason that prevents women from seeking help, but it seems to be the case that even poor women are selective when it comes to what treatment they wish to have. Giving birth at home may, from this perspective, make more sense than going to a public hospital.

In this chapter I have described the situation regarding maternal mortality in India, and why mothers do not receive medical treatment. In the next section I want to give a wider view of why women do not always go for check-ups or choose to rather give birth at home then in hospitals.

**Cultural conceptions**

Another reason that women do not go for check-ups and choose to not visit hospitals is that many of them do not see any reason for it. Here I want to draw attention to Kleinman´s theories, he illustrates how individuals in different societies have different views on what is normality, what counts as a disease and what does not. (Kleinman, 1988: 10-11) He states that to be able to understand the disease and symptoms, we must first understand the normative conceptions of the body, in relation to self and the outside world, which exists in the culture. (Kleinman, 1988: 13)

Social anthropology focuses on human beings as social creatures who organize their worlds in different ways. The subfield of medical anthropology focuses on how different cultures explain illnesses, the causes behind the sickness, who people turn to for help and which form of medical
treatment that is deemed appropriate for each illness. (Helman, 1990: 1-2) Medical anthropology is a subdivision of social anthropology but it is also connected to medicine and other natural sciences. Helman claims that the conception of ill-health often is a central feature of cultures and that we cannot understand how people react to ill-health and death without the knowledge of what culture they have grown up in and how they perceive the world they are living in. The combination between anthropological theories of human beings as social creatures and medical theories about illness, the causes behind them and healing is often very successful and may help explain differences in diagnosis, treatment and general understanding of the disease. (Helman, 1990: 7-8) What is considered an anomaly and what is regarded as normality is decided by a culturally shared worldview.

An author that studied this phenomenon is Lisbeth Sachs; she illustrates how people from many cultures find it odd to visit medical professionals when they do not have any symptoms or are feeling ill. To receive controls that states that you are ill when you are feeling perfectly fine or the opposite to be declared healthy when you are feeling ill can be regarded as both strange and unreal. (Sachs, 2007: 182) India have been working with Western medicine for many years now and most people are used to this, although some traditional forms of medicine are still being used, which can result in a form of skepticism towards Western medicine for some people in India.

My interviewees emphasize that the women perceived that because they had no complications they required no treatment or controls. It was highlighted that many of the women they encounter do not have the knowledge of how significant the controls during a pregnancy is. For this reason education is of great importance my interviewees’ states. They are trying to improve awareness by educating women and future mothers.

In an article titled “Cultural Influences on Health Care Use: Two Regional Groups in India” the author discusses how the access to medical health services do not always lead to utilization. He states that this is problematic to study because of the huge differences when it comes to access of services. He claims that even though there are proper services available this does not always reflect on how many people actually utilize these services. He gives an example of West Bengal and Kerala, the first one has greater economic development but still has a higher maternal mortality then the latter. He state that the reason behind this is that the people in Kerala are more politically aware and they have made sure that all health services are equally distributed in their state and also that Kerala have a high rate of literate women who have been interested in using the facilities once they opened. (Malwade Basu, 1990: 275) I studied West Bengal during my stay in India, and even though I was told that the situation has been improved, they stated that some rural areas still lack proper services. It is
of importance to remember that India is a large country and that the different states have their own state governments, their own language and specific cultural traditions. Health inventions must conform with people’s lifestyles in order to work, and to develop such health inventions it is required a knowledge regarding the health culture of a population. Sometimes the culture combines with the behavior that is requested by health providers and sometimes it differs completely. Malwade Basu says that cultural backgrounds affect how existing health care services are being utilized. Cultural and regional identity influence people’s knowledge, attitudes and practice in regards to using health care facilities. He says that certain factors may explain why women choose or do not choose to visit hospitals, including their educational level and whether they have their own income. However, this is not enough to explain women’s different choices, he claims. In addition to socioeconomic factors cultural belief systems and practices must be accounted for, such as kinship patterns and traditional marriages, all of which influence women’s autonomy. (Malwade Basu, 1990: 176) I will not investigate the differences between the different states I visited, but study the project as a whole. However I think these theories make good examples on how important it is to study specific cultural beliefs when investigating medical practices.

We cannot forget the differences between our cultures. As an example Olimani says that the biggest difference lies in education. She argues that in Western societies and developed countries there are mainly literate people, and it is easier for them to become aware, to get access to information through media, papers, internet, and television. In India a lot of people are illiterates. This is the difference according to her.

It is of importance to acknowledge the effects of religion and cultural beliefs and not to forget that it still plays a major part in people’s lives. Olimani tells me about people’s beliefs when it comes to misfortune, and she says that: “Ultimately they think it is God who has done this to them because of lack of prayers. To overcome the curse they perform pujas”. This might also be a reason behind their choice not to visit hospitals. Illnesses interpreted as acts of God as a punishment for bad behavior are not likely to be cured by a doctor, and especially by doctors who are so bad at what they are doing that they do not even charge a patient fee.

The state governments in India are considering the low number of women that goes for check-ups to be a problem and are working to increase the number of women that visit the hospital for check-ups and chose to deliver at the hospital. As an example Aadhaya says:

“Nowadays the mothers in the rural areas are not coming for the registration so health personnel do not know that these mothers are pregnant. First in the end of the seventh or eighth month they are coming to the healthcare centers. At that time if the mother is anemic
and the hemoglobin is less than seven or less than six at that time it might be difficulties because of that during the delivery, the mother might bleed to death”.

The same is affirmed by Waheeda, who say “regular check-up is here in the urban areas, but in rural areas, prior to the check-up we have to go and call them here. If we are conducting any meeting we have to go and call them because the education is less. Otherwise they will go for the delivery only.” Aabharana also acknowledge this “we are requesting a minimum of three – five visits but they are not coming, slowly some educated people will come, uneducated people we will have to go and call them here”.

Except for a general lack of education among rural women, they also identify income as an issue. During the journey to and from the hospital and the time it takes inside the hospital the patient will not receive any income. Only those who can afford the loss of income have the possibility to go to the hospital. Waheeda announce “husbands too will be coming here and then there are not enough income, it will be loss of money, so they won’t come because of the lower income”. To improve the amount of check-ups and hospitalized deliveries governments in some states is giving money to families that follow their recommendations and choose to give birth at the hospital. This is pointed out for example by Waheeda:

“They usually go for daily wage but if they come here to the hospital they will get no wage. But nowadays those who are coming will receive 6000 rupees, so nowadays they are coming, 6000 rupees for each delivery. They are not keeping the money for themselves, they are giving it to the husband, and the husband is taking it”.

This is one way for the governments and professionals to convince more people to seek treatment and help during pregnancy and child birth. Another way of handling this is told by Eesha, who tells me about different traditional celebrations related to pregnancy, for instance one during the fifth month of pregnancy when they give the mothers bangles, sweets, flowers and often a new sari and they prepare sweets and her favorite food. She also informs me of other traditions when they will give the mother a bath and perform puja for the mother. In some places they also perform a cradle ceremony. These celebrations are performed at home but in some hospitals they are implementing some of these traditions in order to encourage the mothers to attend the antenatal clinics.

“The offering of bangles and flowers will be celebrated in the antenatal clinic. Some midwives they are celebrating this in a sense to encouraging the mothers to attend the antenatal clinic. Most of the mothers here they don’t want to attend because of their own problems so they won’t come. Some mothers they come in time of delivery only which results in lack of birth
preparedness. They are not aware of the importance of antenatal clinic so that is the problem. So for encouraging them they are performing celebrations to make the women happy”.

Bangles are like glass bracelets that you put on your arms, it gives noise which they consider stimulates the baby. The baby hears the noise and enjoys it. The bangles ceremony give the midwives the opportunities to inform mothers and their husbands about their services, they can create awareness and educate especially about the sex determination, as declared by Olimani: “The mothers in law are demanding for a male child, during the ceremony we can explain to them who is responsible for a male baby so that awareness will spread. Bangle ceremony is one cultural thing we are doing”.

The tradition of dais² or traditional birth attendances are mostly replaced by midwives and institutionalized deliveries. But in some places traditional birth attendances are still practice, generally in rural, remote and tribal areas. And first after complications will they send the mothers to the institution. If midwives are not able to convince the mothers to go to the hospitals other actions might be initiated to improve the situation during home deliveries. Madhula informs me that the government in Gujarat provides a kit to every mother so that the midwife, in case of home delivery, quickly without instruments can travel to the mother to help during the delivery. The midwives can help arrange for a home delivery, prepare the space, and instruments if the mother absolutely want to deliver in her home environment. There they help during the delivery and give additional advice regarding breastfeeding and so forth.

To give a more thorough picture of cultural perceptions I want to present and discuss some traditional health care systems and perceptions that my informants told me about; beliefs that may influence the mother’s actions.

As a tradition the squatting position has been used by women giving birth, to squat down and sometimes hold on to a rope to get strength to push. I was told that when the Western traditions and institutionalized deliveries replaced most home births this tradition was abolished in India, and now the mothers are supposed to lie down on the delivery table during labor. However, as told by Aabharana:

“Squatting position is the position that gives more dilation; the baby comes down very easily. So they were using that squatting position in olden days. The dilatation will be easier so that type of practice together with holding the rope; we used to make the mother stand and then

² Dai or traditional birth attendance, as it also is called, is a woman who earlier handled the deliveries, read more about it in the chapter “The situation for midwives”.
ask the mother to hold the rope and whenever she is having a pressure she used to squat down and pull the rope so that it gave her support”.

Even though this type of practice may still be used in some places this beneficial tradition has mostly been lost and as stated by Aabharana “as soon as the mother is getting pain we want her on a table only, squatting is a very good practice but is being left out”.

I got the information from Olimani that people from the tribal areas are very dedicated to keep their traditions and they want to give birth in a sitting position. She says that in some hospitals they give the mother the freedom to choose this position if they are very obsessive about it.

Like in Sweden, food, what or what not to eat are still important factors when it comes to pregnancy and childbirth. In Sweden it is common to give a pamphlet that states what is appropriate to eat and what you should avoid when you are pregnant, what kind of food that causes risks. The same traditions exist in India, for example jaggery, which is a kind of sweet, is avoided. Aadhaya states:

“Jaggery they are not giving because they feel that it sometimes causes miscarriage. But jaggery is rich with iron and carbohydrate, so now we emphasize that they eat this. Then we are emphasizing on green leafy vegetables and all. Previously people were not aware about how green leafy vegetable is healthful but now they are used to taking this. This way this is changing. Change takes place in this state and country”.

The same risks are connected to other food items, Waheeda informs me that “papaya we do not eat and any other fruit during the antenatal period. After having a baby we wait up to 1 year to eat mango, banana and jackfruit. It will hurt the baby they think”.

Aadhaya informs me about another tradition related to people’s perception about risk related to food, which is to not eat Brinjal. Brinjal is a vegetable also called eggplant. She says that:

“The pregnant mother is not ready to take Brinjal because the color of Brinjal is black. They believe that if you were to eat Brinjal a black baby will be born. Health personnel are trying to convince them but sometimes they are not convinced, this is socio cultural phenomenon, our culture is different, customs is different so in this way we are different”.

The same thing is stated about iron tablets, “take iron tablets and your baby will be black they are thinking, so they are not taking the iron tablets” Waheeda tells me. Fair skin is generally considered to be more attractive than dark skin, and babies with fair skin are considered particularly beautiful.
In this chapter I have described the situation regarding maternal mortality related to the status of women and cultural conceptions. The status of women is not only affecting them when it comes to receiving medical care, but also when they are providing care. In the next chapter I will illustrate the situation for midwives in India and develop my theories behind the low status of women and midwives.

**The situation for midwives**

An important problem regarding the maternal mortality in India is that there are not enough fully qualified specialized midwives and other medical professionals do not have the knowledge and training required. Historically, the development of midwifery services has been very limited in India, and there has not been any special training to become a midwife; all nurses are registered as both nurses and midwives. The entire nurse staff is being rotated through different departments in the hospitals, therefore not developing enough midwifery skills. (Karolinska institute & Indian Institute of Management Ahmedabad, 2005: 1-7) This has an effect on both the patients and the health providers according to my interviewees, Olimani states “they don’t choose to become midwives. It is part of their training”. According to Eesha the effect is that:

> “Even though they are having the certificate of registered midwife, almost all the midwives are forgetting that they are midwives. Throughout India not only in one particular state, they recognize themselves as nurses but they have forgotten that they are midwives”.

Lack of knowledge and skills in midwifery is a big problem. Aahana from Tamil Nadu says that: “The nursing teachers do not possess the adequate knowledge as well as skills, so whatever students we prepare they will be inadequate in their knowledge and skills especially in midwifery”. She proclaims that the curriculum for GNM, (general nursing and midwifery), has been reduced from a 3,5 years course to a 3 years course. It is a short course in which they are unable to give and receive enough qualitative training.

The low status of women also affects the midwives and health providers dealing with pregnant women, as most of them are women themselves. They suffer from different disadvantages; for one thing, it is hard to find a woman in the high political positions surrounding medicine and health services. Hardly any nurses or midwives are involved in the politics in India. This results in problems regarding their ability to fight for improvements which results in low priority for maternal health. (Karolinska institute & Indian Institute of Management Ahmedabad, 2005: 2) The status of midwives is relatively low, because it is a woman profession and a subordinate kind of work, and this was explained to me by several of them, for an example Aahana who said “in India, of course in Tamil
Nadu especially, nurses will not have so much status. They don’t have status, it is a subordinate service“.

As I discussed in the chapter “Women in India” social and religious structures regarding impurity and pollution are and have been of importance in India. Pregnancy and child birth are both considered polluting, both for the mothers and for the persons handling the birth. Previously, these were female family members or a Dai (traditional birth attendance), and in the absence of midwives these are still used. To be in contact with bodily fluids, and especially blood connected to menstruation and childbirth, is considered polluting, and because of this maternity care became previously an occupation for women from the lower and less ritually pure castes. (Pinto, 2008: 34) People from higher castes try to avoid activities connected with blood, bodily fluids and death, because of the ritual impurity involved. I believe that this can influence the situation both for pregnant women and for midwives today.

Even though most of my interviewees consider gender and socioeconomic structures as explanations behind the low status of women and midwives it still is of importance to remember these traditions and not to forget that religious structures still plays a major part in people’s lives despite its official abolishment. I feel that it is of importance to remember that gender differences and structures are built on traditions and the caste system is still structuring important spheres in Indian peoples’ lives. I believe that this still has an effect on women’s status, even though the situation of women is improving. Discrimination based on caste belonging is now legally abolished and caste is considered outdated, which means that modern and developed people do not want to be associated with castes.

Van Hollen argues the same when it comes to utilizing modern medicine. The traditional medicines are not regarded as contemporary, in contrast to modern technologies and hospital visits for treatment. The author says that people believe that modern people, or as they say “those who have come to know” are suppose to use this kind of treatment, and that those people who are in the dark, sometimes described as illiterates or uneducated persons are the ones that do not regard hospitals as the most appropriate way to receive treatment. (Van Hollen, 2003: 209)

I experienced a similar way of thinking during my fieldwork, both regarding caste and traditional health care. It was regarded as out of date, and they were all announcing that they are modern and educated people who look at the world in a different way and not according to tradition. To utilize and talk about both caste and traditional medicine was regarded as something bad, to be associated with this way of thinking is to say that you are uneducated and out of date. This was sometimes problematic during interviews because they did not want to acknowledge caste and its influence nor
the use of traditional health care, although both still exist, probably because of a wish to be regarded as one of those “who have come to know”.

Many of my interviewees feel that their gender has affected their professional life and that they face obstacles due to the fact that they are women. During one of my interviews in West Bengal the Master Trainer discussed the effects of domination in a working place, not only male domination but also the effects of domination depending on hierarchy. It is difficult to voice your opinions for fear of losing your employment or to face disadvantages; for instance being send to rural areas far away from ones families. Rabhya says that “in nursing here we are all women so domination of male persons is there”. She continues:

“Even our female administrators they are not ready to listen to your voice, they are there only for dominating you, for giving order to you that you have to carry out. In whatever position you are having”.

The same thing was exemplified by Aahana a Master Trainer in Tamil Nadu, she announced:

“The doctors, they are the leaders. They are the leaders and the nurse/midwives do not have adequate knowledge and they may not possess skills to deliver the expected care, this is their view, but we have good nurse/midwives and we were doing far better work also than the doctors in the previous decades, now of course there is a gap, facilities were not so good”.

They consider that the lack of development in midwifery as due to the fact that it is a women’s profession and that all patients are women. Rabhya says:

“You are giving care to the women, she is also female and the nursing profession or the dai they are all female that’s why it is not developed. If it would be male persons’ that deliver, that would give much more, it would already be developed. So much maternal mortality would not be there. So it is influenced by the gender”.

In this chapter I have portrayed the situation for women in India, both in general but mostly regarding health care. In this last section I have illustrated the situation for midwives how they are perceived especially related to gender. In the next chapter I will portray the achievements the project have reached, and illustrate how they have been working to improve the situation for women.

Achievements

Before this project a lot of goals were established, as I discussed in the section “The project”. My goal with this study was not to investigate if the midwives’ knowledge has been increased or to
investigate to what extent the maternal mortality actually has been reduced. What I wanted to investigate was the Master Trainers’ perceptions, what they think have been achieved and how they experience this collaborative project. In this segment I will demonstrate my interviewees’ perceptions regarding achievements.

One of the most important achievements with this project is that the Master Trainers feel that the training has brought realization of the problems and the need for improvements. Rabhya declare that “before the project we didn’t think it is a problem. When it came then we thought: yes we have problems”. She continues telling me that they thought that if it was something they had the power to change their administrators would have informed them. She notified me that they were in the understanding about the high maternal mortality but they were thinking “it is high, but what we can do?”. They did not think that they could make a difference when it came to the MMR\(^3\). Several of my interviewees say how much this project have helped them to figure out that they can help in the improvements, and Rabhya is saying that: “This project has made us think”, while Madhula is saying that “now we realize that we have to do something for our country and our community”.

I gave them an open question regarding the topic of achievements; I wanted a variation of answers and I wanted their perceptions on what they thought could count as achievements. For this reason I did not ask them about the specific different goals the project had established and if they were accomplished.

All the Master Trainers experience increased knowledge after their participation in this project. They underwent training in both India and in Sweden, where they received knowledge and skills on both a theoretical and a practical level. As for example Aahana is saying that “this training can increase the knowledge of the tutors and through adequate knowledge, the development of basic as well as the higher skills in midwifery increases the quality in the care provided for the mothers and this will eventually decrease the MMR and IMR\(^4\)”. It is stated that if they start from a small base then they will work their way towards reducing both MMR and as well as the IMR in their country.

Related to this is another achievement were portrayed, the training they have been receiving in this project has made both the Master Trainers and the tutors aware of the importance of teaching both theoretical and practical knowledge. As Rabhya is saying “after this training they are considering the theoretical as well as the practical knowledge, taking lectures in the classroom and they are showing practical aspects in the labor room or in the maternity unit”. Before the project they felt that their focus were mostly on the theoretical knowledge. Here we can see that their teaching methods have

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\(^3\) MMR = Maternal Mortality Rate
\(^4\) IMR= Infant Mortality Rate
increased, as Rabhya also is announcing “previously they were using only one or two methods for teaching but now they use various teaching methods like PBL (problem based learning) role-playing, case studies then case presentations, micro teaching, everything they learned during this training and now they utilize this for their students in their institutions”.

As a result of this project a midwifery practitioner course have been developed; a course for improving the skills of midwives. This is a good aspect according to Aadhaya who says: “And nowadays after this project our government has started the nurse midwifery practice course. So now after this course midwives can independently work for the mothers, those who are giving birth to the baby. So this is also good because of this project“.

A big improvement is building of relationships and linkages between states, organizations, universities, schools and professionals that have occurred. Through this project they have been working together outside of their own areas, with people they would otherwise never talk to. This has improved their understanding regarding situations in other places and together they can work with improvements, give each other support, advice and assistance. Rabhya is declaring “we are attending conferences with the Academy of Nursing Studies. We can exchange our views in these conferences, it helps us”. Aadhaya is mentioning some people she meet and what these meetings have done to help her “they are helping us a lot to develop individually, with different research projects. In our country previously we did not know people from other organizations, now we have come to know these people. Various private organizations, so linkages are there”.

Aabharana is also portraying how she have built relationships and meet people through this project, she informs me about the Asian pacific conference she visited during this project and that she got to meet nurses and midwives from several countries. “This have definitely helped us, to know their settings and how they are as midwives, how they have been treated, how they are working, what skills they are actually practicing, how those skills are different from ours, what new things we could learn from their skills. All of this we have learned” she states.

**Personal and Professional Development**

The largest achievements when evaluating my interviewees’ responses are their feelings about their personal and professional developments. This is the most positive consequence of the project according to my analysis of their perceptions. They feel that their knowledge and skills concerning midwifery have rapidly improved thanks to this project. Some of the things they mentioned include having improved specific midwifery skills and having strengthened both their knowledge and practice. To give a wider picture I will give some examples of midwifery skill they proclaim have been improved; knowledge regarding a normal delivery, sutures, and to identify high risk cases, evidence
based practice, episiotomy skills, antenatal examinations, newborn resuscitation, how to identify, prevent, manage and to control of PPH (postpartum hemorrhage) and good positions during labor and reducing of labor pain. These skills are some of those mentioned during the interviews, as I declared before I did not investigate how they improved these skills and if they actually have been improved, I wanted to investigate their perceptions regarding the project and the achievements.

Another personal and professional development they perceive has been improved is their leadership skills. For example Rabhya states that: “Leadership is also one thing that has been developed, I have received training in leadership skills and been given the chance to practice these skills during the training of the tutors”. Aadhaya informs me that: “I developed leadership under this training when I was exposed in various conferences like national conference, international conference and local conferences”. Together with their leaderships skills their teaching skills have also been improved. Aadhaya proclaims that they have received training in “communication skills that is one of the teaching skills and I learned the problem solving skills” and also in “various teaching methods like PBL, problem based learning, role-playing, case studies then case presentations and micro teaching”.

Except for these academically related skills the project has given result on more psychological level. They all acknowledge that they after the project feel much more comfortable in their roles both as midwives and teachers. They feel that they have developed a lot more confidence. “I have become more confident” Aahana states and Aadhaya say: “I feel more secure in my role”. These quotes are only two examples regarding this. It was stated by them all sometime during the different interviews.

The Master Trainers announced that they have also gained a lot of inspiration. This project has awakened them as Rabhya is describing it “beforehand we were just sleeping, after this project we woke up”. It have open their eyes and given them motivation. Saachi is declaring that: “I can adept myself and I am getting much more interested after this project, how to implement all these things so that the mothers will be benefitted, it’s a good project, it is a beautiful project”.

Both their work and social status have increased, significant for some of them and less significant for some of the others. But they all agree on the fact that it has increased and that it had some consequences for them on both or at least on either work or social life. The majority of them feel that their work status have increased significantly. Aadhaya declares that: “Our status is increasing, increased because of us, the Master Trainers in the profession. Even our commissioner has come to know, that these persons are doing a good job in their profession. So our dignity and our professional status have increased”.
Rabhya enunciate: “I am telling you that my colleagues’ they know that I have taken a special training, I went to Sweden so I have seen a lot of things, their advanced things, I have a little more advanced knowledge then them so they are having respect for me and whenever they are having any problems or they need some information they ask me”. Olimani also recognize this change “they are looking at me as a different person, they are giving me respect and responsibility because of the project, my colleagues respects me”.

When it comes to increasing of the social status my informants differ some about the degree of development. Some of them do not feel that their status have improved significantly outside of their profession while others experience an expansion of social status. One of them is Rabhya who is stating that:

“In my society also they know that I went to Sweden for training. So they are also giving me much more importance because I have gone to Sweden. In my society, my neighbors whenever they are feeling ill or they are having any problem, somebody is having conception or pregnancy, they ask me. They come to me and they tell me that: you know so much, means like a doctor. So they take my suggestions and advice. They come to me”.

Eesha feels that she has experienced an empowerment within her own family because of her participation in this project. She declares:

“My social status have also increased, when I first started (my participation in this project, my comment) my family objected but then I convinced them and now they are accepting me to go everywhere, earlier I did not go anywhere. Last month I stayed in Peddapur, earlier even not for one day I stayed outside of my home. But after coming to this project I am outside without the family. They have accepted, so some empowerment I got”.

This section have demonstrated achievements, in the next part I will portray some problems my informants enlightened me about, what they feel went wrong, and what still needs to be improved.

Problems & additional needs

Even though all my interviewees agreed upon the positive outcomes with the project they were not in the dark about shortcomings and lacking. They feel that in some ways this project have some imperfections and additional needs.

One problem most of my interviewees had to face was the double work responsibilities. When this project started they were chosen to participate, they were to help develop the CAMT centers, teach midwifery skills to tutors, perform follow-ups to investigate if the tutoring was accomplished and
most of them were supposed to continue their former work of tutoring midwifery students. Several of them state that this was too many responsibilities; they did not have the acquired time to be able to accomplish all this. Rabhya states: “In our place the Master Trainers have to work within their own responsibilities means this work, we also have to work with this project. So sometimes we have to work double”. Madhula is arguing the same thing, she says: “I never have time to concentrate on the CAMT”. This was something they found problematic, how could they achieve the goals they wanted with this project when they at the same time have their other fulltime work to perform. Madhula announced that “for this work we want deputation”. This they regarded as a failure, they feel that the people responsible for the project should have arranged with the governments so that all Master Trainers were to receive special deputation for their continuance with the project. In some states they encountered problems with the collaborations with their state governments and/or the training institutions. Convincing the governments about the problems with double work responsibilities was not the only difficulty they faced with the governments.

Another example regarding problems with the government is given by Rabhya:

“When the project was started at that time the government was very helpful, the people from the project visited the government, they were stimulating them or they were sensitizing them about the importance of the project, so at that time the government was ready. But when the project ended the governments has switched off their thinking, so everything is going back like it was previously”.

Another problem some of the Master Trainers faced was problems with their own training institution, at all these places one coordinator was placed to organize and to help make the project work. In Tamil Nadu this person was a principal from one of the schools, instead of one of the Master Trainers like in some of the other states, this they felt was problematic. “The coordinator was highly indifferent to this project and she was unable to perform her duty. One of the Master Trainers should have been given the responsibility to be the coordinator, like in the other states” Aahana annunciate.

An additional imperfection was that both the tutors and some of the Master Trainers were chosen not willingly to attend the project. Eesha stated “but willingly they are not coming” when spoken about the tutors. To attend this training they had to leave their homes, their place of work and their families to travel far away for a long time. Olimani declares: “The tutors are married they have to leave their family, their district that are very far away from the CAMT like a 12 hours travel, so it is very difficult for them”. The same problems are encountered by the Master Trainer Waheeda, who states: “One problem; I have to leave my family, I am 6 hours away from Chennai, so I am leaving my family, leaving my husband and my child. How can I be happy here? It is difficult for me. Put this in my
place and I could be happy”. They want this training to be expanded to more places around the different states so they do not have to leave their home to participate in the project.

Another problem they wanted to share was the differences between the two batches. During the project two different groups of Master Trainers were trained. And those involved in the second batch did not receive as much training as the first batch. Several things were lacking as my informant Saachi states “in the second batch, I will tell, our practical exposure to Sweden was less”. They did not spend as much time in Sweden as the first group got the opportunity to do, she also feel that they did not receive enough knowledge regarding gender issues and appropriate leadership training, she state “we didn’t get any theoretical classes regarding the gender aspect or regarding advocacy, and leadership, in the second batch”. This was something they were supposed to learn, how could they implement this in their work if they did not receive the adequate knowledge? , she asked.

One of two other major problems was the lack of follow-ups. As one of their responsibilities as Master Trainers they were supposed to arrange and perform follow-ups, to investigate how their training of the tutors been accomplished. Visit them in their working place and see if they implemented the things they learned. This lack was considered a major problem by all of my informants. Olimani states: “Probably it should have been more follow-ups, even the government should have considered this very seriously because so much money are spent”. Kahini declares “we need some more follow-ups, at least every sixth months or so, they need some feedback. Evaluation is very important”. Aabharana states the problem like following:

“We didn’t do proper follow-ups. We had to give some time before the follow-ups to see how much they are implementing the knowledge they got in the project, but we didn’t give it that much time. We have been forced to go for a follow-up within 10 days time after being relived from this project. We should have been given some more time for them so that they can convince the administrative people to give them some resources, materials, more manpower and time to set up the labor room. All of the sudden we cannot bring any change, the medical officers, the top level they still think that the nurses are physicians handmaidens only, so they will not give us that much freedom. We have to talk to them, convince them and that will take time. But we didn’t give that much time for those trainees. Therefore how can we expect a very good result?”.

The problem was that several of them were relived from their duty very soon after the training of the tutors. “We had no possibility to perform the follow-ups. This is an important aspect of the training because if there are any defects we would be able to make corrections. The tutors and the students will suffer because of this and it will affect the mothers”, Aahana declares. She continues “actually I
had a very bitter experience here which I never expected. I have never had any bitter experience like this and in a foreign collaborated project I expected so much, this are not the way we ought to do it. And we couldn’t, especially I, did not have the time to follow-up”.

Waheeda agrees “as soon as training was over, we did one follow-up but then we were no longer here in the project. We were not able to follow-up, what they have done we could not see. If I were here for a longer time I could have gone for each labor room and seen the organization”.

Olimani informs me that the tutors that participated in this project are not teaching the knowledge which they have acquired, which is a failure by the governments and the schools where the tutors are working. “An order should have been given to them that soon after the training they should have gone back and taught the subject”.

The other major shortcoming was the need of continuance of the project. This project was planned to be in motion for about three years, and after this project the governments would hopefully keep utilizing its achievements and continue developing maternal health care. When I visited India it was in the finishing stadium, they were evaluating and assessing its outcome. Even though they all knew that the project only was to be in motion for a certain amount of time all my informants feel that this ought to be changed. They are all asking for continuance of the project. Kahini declares: “We need some sustainability of this project; this project may not be able to reach this level now. The design is very good but it has to continue, the governments have to utilize the project and the people in it then only will we find changes”. They feel that at this level it will not be enough development and changes. It has to be implemented in the different states and utilized properly.

They do not feel completed; they do not think that the achievements that were expected have been accomplished so far. Saachi states “this project should be continued so that we can get much more chance to get training. It is a good project; to reduce the MMR and the IMR and it should be continued and it should be implemented, whatever training we got that should be implemented. Then only it would be fulfilled”. Aabharana have the same opinion: “This project is not completed as a whole. What we have designed was not implemented. If it would have been completed and organized properly some change would be brought but now I don’t think so”.

They did not feel that they were able to utilize it properly, they did not have enough time and they also faced problems with the different governments who were not able to help them in the way they felt necessary. However, even though they were not able to utilize it they wanted to state how much they enjoyed this project and appreciated its design, Aahana states: “I think this design is very good
but we have not utilized it in a proper way especially in Tamil Nadu, otherwise a beautifully designed project”.

Olimani also point out that it needs to be a continuance of the project. She states that “teachers should keep coming, after a few years trends are changing so they need to be updated. And teachers are bored they need to come here and be encouraged and strengthened”.

Other problems they faced were difficulties with implementation, because of cultural differences. Some of the things my informants learned and observed in Sweden were problematic to implement. This was something they wanted me to acknowledge. These implementation-problems were mostly related to policymaking differences, and problems regarding budget. Eesha states “we can implement, but on policymaking level, for example budget problems, those things are not in our hands, but if the facilities are available we can bring some changes”. Another problem related to budget and population rate is stated by Olimani:

“One some practices can be implemented. (In Sweden, my addition) you have good labor room, ultra cleans techniques, but that cannot be possible in India because it is an over-populated country and very few employees are there, the ratio is not properly maintained so maintaining ultra clean techniques may not be possible but we can practice sterile techniques. Good communication we should be able to practice and parental education is very important, that we can implement from Sweden”.

Other cultural differences that make some Swedish practices hard to implement are related to gender. To bring husbands in to the labor rooms for example. In most places there are several women giving birth at the same time in one labor room, this makes it problematic because the women do not want other men in the same room. This is a practice they would like to implement according to Kahini “one birth companion, a husband or family member they should accompany during labor”. Olimani states: “Husbands don’t come at all; they do not realize that husbands have participation. In few hospitals this are changing but not in the peripheral site. He should be there to take care of the mother as support”. Aabharana discusses this problem: “Yes definitely it is a problem I think because of the culture, to let a male inside the labor room it is a question, and can be implemented if you have cubicles I think, if we in the government setup also have cubicles that is only for that particular mother and father then it may be possible”. She states that it is mostly a problem on a policy making level, the problem is that no nursing persona are at the policy level. From all the other health services there are people at administrative level but no nurse exists at the top level. She states that if policy making was done by a nurse then changes can occur.
Together with these problems they also acknowledge some additional needs they feel are necessary to meet in order to be able to make a difference and accomplish the goals of improved maternal health care. For instance, more practical training within the project was required by some of them. They think that even though the project have provided both training in skills and knowledge it was not enough, Madhula says: “I think we should give more hours for practical. Theory we are providing but side by side we should provide practices”. Saachi thinks all the training should be more, both practical and theoretical training “the tutor training should be much more because the tutors they need to update their knowledge. So training is one of the components to update their knowledge. So they need some training”.

Several of them also acknowledge their own shortcomings, Madhula states that “but what happens nowadays, we are here so we forget and we don’t have more time for the practice”. The same thing is declared by Olimani “we should strive to practice midwifery when you are a teacher otherwise I will lose my skills”. These are problems they all faced; they do not have the time to practice on their own skills. They feel that this should be a priority when you teach others.

Several of them also want improved CAMT centers, Olimani states: “A better library, computers in the CAMT, the skill-lab need to be refined. This is the only advanced midwifery center in the whole state and it needs to be properly equipped”.

One problem I consider is that most of the Master Trainers are in their upper middle age. One of them who I got the opportunity to interview had already retired at that time. What will happen when the rest of them retire? I feel that to be able to utilize their knowledge to the fullest; maybe they should have focus more on the younger generations. The tutors in this project varies in age and several of them will be able to teach for a long time but the same should be able to be said about the Master Trainers as well, because they have received even more training and knowledge through this project then the tutors. And to lose this knowledge and lose well-educated midwives that can function as teachers and support for tutors will have negative consequences and will diminish the effort that’s been accomplished so far.
Summary and discussion

I have in this thesis explored a collaborative project that focuses on improving the maternal health care in India. I have portrayed the problems and factors behind the lack of maternal health care that the project has identified and also presented some additional theories regarding the situation. One of the big issues lies in inequality between the sexes, to illustrate this I have presented some general gender theories that can help explain the situation for women in India. I have presented Pateman’s theories regarding women’s lack of access to political power due to patriarchal power and the government of women by men, a situation that my interviewees recognize and explain. For example several of them state that they need their fathers’ or husbands’ permission for all sorts of activities and decisions. To explain this situation regarding inequalities between men and women I have presented both religious and social factors. For starters India is predominantly a patrilineal society. I believe that this may have an effect on women’s opportunities for decision-making and autonomy.

As most couples practice patrilocal residence rules, women might suffer certain disadvantages. A woman has to move to a new surrounding, without her family and friends where she becomes the newcomer. Another social factor I felt important to describe is the strong norms for appropriate social roles for men and women that are established in the Indian society. These roles make it hard if not impossible for women to be free and make their own decisions. As described by my interviewees; women are connected to the home sphere, where their responsibilities are to take care of the home, to cook, and to look after children and the rest of the family, often her parents-in-law. This makes it difficult for women, who have jobs also outside of their homes, to focus on their work and fight for promotions and improvements. For Indian midwives, the double responsibility for their job inside as well as outside their homes, often have negative consequences for their chances to engage in specialized training or for the rights of women as professionals within the health sector.

On a general level, women are considered to be the weaker sex, physically, emotionally and intellectually, and most girls will have an inferior role in their families from childhood. A girl must be protected from unwanted attention (from men), and later on be given dowry and be married into a good family. Many women in India are for various reasons not as highly valued as men, therefore their needs are not as prioritized. The result is that women might suffer from a great disadvantage. All these factors as stated in this thesis might contribute to an explanation for the gender-related inequalities. Another possibility I present lies in religious factors. Despite the legal abolishment of discrimination due to caste belonging in India, the system with its complex norms for maintaining ritual purity is still affecting not only Hindus but the lives of all inhabitants in India. The concern for maintaining ritual purity will affect and restrict most aspects of peoples’ lives, including their choice of occupation, food, marriage partner, and social and physical relations with others. Of interest to
this thesis are bodily emissions which are associated with religious impurity, and therefore socially controlled with specific rules and regulations. Menstruation is considered particularly ritually impure, but also blood connected to child birth. Women in general are therefore considered to be ritually impure, and midwives, who are intimately associated with the female body and its fluids, are therefore also considered to be of low ritual purity and status.

All these factors can be possible explanations for gender inequality and explain women’s difficulties with accessing proper health care and also the situation for midwives in India. When women are considered inferior, it also makes their specific illnesses and health issues of lesser importance. This affects maternal mortality, one of the major issues in the project I investigated.

The project asserts that the maternal mortality in India is 20% of the total number of global maternal deaths. This major problem is due to the lack of proper health clinics that can provide adequate health care. Many people have to travel great distances to get medical treatment. Many women, an estimated 65% of all women who give birth, have no choice but to give birth at home. Another problem identified through this project is the lack of midwifery professionals. Delivery care and maternal health care has been neglected. The lack of personnel makes it difficult if not impossible to keep maternity units clean, and poor hygiene is a consequence. Midwifery is an occupation that due to these factors faces extreme difficulties. There are not enough fully qualified specialized midwives, and other medical professionals do not have the knowledge and training required. Historically, the development of midwifery services has been very limited in India, and there has not been any special training to become a midwife; all nurses are registered as both nurses and midwives. My interviewees all declare that their profession does not bring a high status. They are viewed more as nurses than registered midwives.

The low status of women also affects the midwives, as most of them are women themselves. They suffer from different disadvantages, for one thing, it is hard to find a woman in the high political positions surrounding medicine and health services, for instance in union work. Hardly any nurses or midwives are involved in the politics in India. This results in problems regarding their ability to fight for improvements which results in low priority for maternal health.

Another major factor I discovered through my investigation is that governmental hospitals have bad reputation which results in the fact that a lot of poor women who do not have the possibility to get costly private health care, choose not to seek any care at all during their pregnancy and child birth. They prefer to give birth at home even though the risk for complications is high. Kleinman’s theories, illustrate how individuals in different societies have different views on what is normality, what counts as a disease and what does not. Cultural backgrounds effect how health care services are being
utilized, and cultural perceptions influence people’s knowledge, attitudes and practice towards using health care facilities. Certain factors may explain why women choose or do not choose to visit hospitals, including their educational level and whether they have their own income. However, this is not enough to explain women’s different choices. In addition to socioeconomic factors I also present cultural belief systems and practices that must be accounted for, for example traditional marriages, and residence rules, all of which influence women’s autonomy. I give several examples for how the governments and professionals work to convince more people to seek treatment, for example to implement different traditional celebrations related to pregnancy, in order to meet women’s expectations of good health care while making sense culturally.

I present the goals that were established in this project and the plan to achieve them. The major goal with this project is to improve the maternal health care in India. To do this the project is aiming to strengthen the midwifery education. In this thesis I present my analysis of what the Master Trainers perceive have been achieved and I also present what problems and additional needs they think are important to acknowledge. Here I will give my conclusion regarding what goals and positive outcomes this project has had according to my interviewees’ perceptions.

The goal of strengthening the midwifery education has in a way been achieved or at least been started. Those midwives who have received training in this project have had the opportunity to develop their knowledge and skills. But as most of my interviewees say the achievements expected have not yet been met. Of course the knowledge have improved for those midwives that received training and as one of my informants say they are starting from a small base towards reducing the maternal mortality. They feel that this project was not utilized properly, which I feel is disappointing because of the good purpose. Positive consequences are of course that they feel that this project have made them realize their possibilities, the need for improvements, what problems that actually exist and how they can work to improve the situation.

With this knowledge they have the opportunity to work for development. The project have given them useful connections and helped them start to build relationships with other professionals, other institutes and other states, which is something they did not have before. It is easier to work together to bring about change and development and through conferences and meetings they can discover what changes are necessary and possible and how they can keep working to improve the situation. This is a positive outcome that I feel will continue to develop maternal health care and the situation for women and midwives in India. Another major achievement I believe will bring good consequences is their own personal and professional developments. The training they have been given have resulted in more confidence, they feel more secure thanks to their improved knowledge.
and skills. Together with their new leadership and teaching skills this will have a great impact in their tutoring competence. Skilled tutors will help create skilled midwives that feel secure and competent which I believe will help in improving the maternal health care.

The difficulties with the governments are a major problem, and I believe this is the reason behind most of the projects’ shortcomings and troubles. One major issue is the lack of follow-ups. The Master Trainers were selected to teach and help improve the midwifery tutors skills and knowledge. These tutors in their turn are the ones who will teach future midwives. As one of the Master Trainers’ responsibilities, follow-ups were suppose to take place after the tutoring to investigate and evaluate its success. According to my informants this evaluation was not possible mostly due to the governments. The government officials did not give the Master Trainers the time required to perform this assignment; a lack of resources and planning that my informants were disappointed about.

Another major issue will be the consequence of not being able to continue the work that has been started. To not keep utilizing the Master Trainers for educating midwives and to not utilize those tutors and midwives that have received training in a proper way might make the established goals difficult to accomplish. If these goals have not yet been reached, as stated by my interviewees, this project needs to continue. I agree with what several of my informants said; it is a beautiful project with well-developed goals and it has had a good start. I just wished it could have been utilized to its fullest potential.
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