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Women's perception
of quality and
Determinants of care
Regarding maternal
health services

Findings from the Qualitative Study

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Executive Summary

Background: Globally in 2010, there were an estimated 287,000 maternal deaths and a maternal mortality ratio (MMR) of 210 per 100,000 live births (WHO, 2012). In India various efforts have been undertaken under Reproductive and Child Health, phase II (RCH-II) to improve maternal survival. One of such effort is Janani Suraksha Yojana (JSY), the conditional cash transfer (CCT) scheme for promoting institutional deliveries, which has been implemented since 2005. Institutional deliveries in India have since expanded from 53% in 2005 to 72.9% in 2009-10 [UNICEF, 2005, 2009]. Similarly in Jharkhand, institutional deliveries have increased from 18.7% in 2005 to 40.1% in 2009-10 [UNICEF, 2005, 2009]. Several evaluation studies have acknowledged JSY as the most visible maternal health program and most effective in terms of generating demand. However, none of the studies has touched upon the crucial aspect of women's perspective on the quality of care provided. This component of the study assesses the determinants of care for both institutional and home births and to understand women's perceptions of good care. This focus was expected to reveal some key barriers and facilitators in the demand and utilization of maternal health services.

Methodology: The study was conducted in Jamtara district, Jharkhand, one of 264 high-focus districts identified by NRHM. One part of the study was qualitative in nature, and those results are shared in this report. Qualitative methods were used in this study to focus on understanding perceptions, issues and challenges regarding maternal satisfaction with health services. Twenty three in-depth interview (IDIs) and seven focus group discussions (FGDs) were conducted in the community with recently delivered women and select service providers (Auxiliary Nurse Midwives, Accredited Social Health Activists, and traditional birth attendants), providing care at the primary level.

Results: The findings from the study revealed that the influence of community health worker generally known as Accredited Social Health Activists (ASHAs) is one of the key factors behind choice of place of delivery. The JSY scheme also plays a key role in generating demand for institutional births, along with the assurance of appropriate medical care in case of any emergency.



Seven key factors that influence women's decisions whether to deliver in institutions or at home are

1. Interpersonal behaviors of the providers
2. Influence of community health workers in deciding the place of delivery
3. Accessibility of the institution
4. Emotional support during delivery
5. Belief in clinical care in terms of presence of skilled staff
6. Availability of medicine
7. The cost of the services

Women's perceptions of what constitutes good delivery care can be broadly categorized to include the presence of doctors and appropriate medical care in case of complications; pain management through medicines/injections before labor; availability of transport for immediate referral; presence of family members during delivery; and the value of monetary incentives over expenses. Nevertheless, there are few challenges that hinder women from opting for institutional delivery, such as, availability of transport to reach the institution, lack of birth preparedness, rude behavior of staff, and informal expenses.

Key Observations: The results of the qualitative data provided some insight into the positive and negative perceptions that sway women's choices about where to give birth. Following are the key issues women raised that could improve how the quality of care is measured and assessed and increase demand for institutional services.

- Publicly available, accessible and affordable transport is a major factor in ensuring that women choose to go to facilities for delivery;
- Lack of birth preparedness was a major factor affecting women who had unplanned home births;
- Women want to be treated humanely during delivery – good interpersonal behavior by providers is important;
- Privacy and emotional support during delivery will influence demand for services;
- Having clean areas for delivery and post-delivery care is important to women, even when their own living standards are not high;
- For both institutional and home deliveries, women desire medicine and procedures that induce labor and speed up labor even when such interventions may not be desirable;

- Costs and cash incentives do matter, and women are careful to calculate formal and informal costs in making their choices about place of delivery.

Understanding women’s perceptions of quality and their concerns can help increase the demand for institutional deliveries and decrease the risks associated with home deliveries. Quality assurance measures for maternal health services should address the primary issues that impact women’s choices to delivery in facilities or at home.

ABBREVIATIONS

ANC	Antenatal Care
AWW	Anganwadi Worker
APL	Above Poverty Line
ASHA	Accredited Social Health Activist
ANM	Auxiliary Nurse Midwife
AWC	Anganwadi Centre
BPL	Below Poverty Line
BRGF	Backward Regions Grant Fund
CHC	Community Health Centre
CCT	Conditional cash transfer
DLHS	District Level Household & Facility Survey
FGD	Focus Group Discussion
FRU	First Referral Unit
HMIS	Health Management Information System
IEC	Institutional Ethics Committee
IFA	Iron and Folic Acid
IDI	In-depth Interview
JSY	Janani Suraksha Yojana
MMR	Maternal Mortality Ratio
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PHFI	Public Health Foundation of India
PNC	Postnatal Care

QoC	Quality of care
RCH	Reproductive and Child Health
SBA	Skilled Birth Attendant
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid

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1. INTRODUCTION

1.1 Background

Globally, an estimated 287,000 maternal deaths occurred in 2010. Although this marks a 47% decline from levels in 1990, two countries account for a third of global maternal deaths: India at 19% (56,000 deaths per year) and Nigeria at 14% (40,000 deaths per year) [1]. Efforts under Reproductive and Child Health, phase II (RCH-II) to improve maternal survival include Janani Suraksha Yojana (JSY), the conditional cash transfer (CCT) scheme to promote institutional deliveries, which has been implemented since 2005 in India [2]. Institutional deliveries in India have since expanded from 53% percent in 2005 to 72.9% in 2009-10 [3, 4]. Similarly in Jharkhand, institutional deliveries have improved from 18.7% in 2005 to 40.1% in 2009-10 [3, 4]

For the last two decades there has been a growing interest in the quality of health services in developing countries and increasing efforts toward maintaining acceptable quality standards [5]. Still, in developing country contexts, there are considerable gaps in services though emphasis has been placed on increasing service availability. Efforts to ensure the quality of care (QoC) have not been sufficient [6]. The concept of quality broadly encompasses clinical effectiveness, safety and a good experience for the patient and implies care that is effective, patient-centered, timely, efficient and equitable [7, 8]. Perceived quality is a key determinant of utilization, and user satisfaction is the 'patient's judgment on the quality and goodness of care' [9, 10, 11]. Quality also indicates an appropriate response to consumer's expectations [6]. Patient satisfaction is thus indispensable to quality improvement with regard to design and management of health care systems [10]. This is also a process of democratization of health services, as service is then oriented to meet users' expectations [12]. Evidence from developing countries confirms that a patient's perception of quality of care and satisfaction with care is critical to utilization of health services [8, 14, 15, 16, 17,



18, 19]. Studies on patient perception and satisfaction with services in India are surprisingly very few and largely restricted to family planning [20]. Validity and reliability of the few studies that do exist have not been tested.

Under the current health sector reform program in India, which is implemented through the National Rural Health Mission (NRHM) since 2005, the strategies for maternal and newborn health include: 1) provision of quality antenatal care, 2) ensuring access to a skilled birth attendant, 3) institution and home-based newborn care, and 4) referral linkage and transport. In order to promote safe delivery care, JSY is being implemented under NRHM with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among poor pregnant women [21]. JSY is a 100% centrally sponsored scheme and it integrates cash assistance with delivery and post-delivery care [22, 23]. Several evaluation studies have pointed to JSY as one of the most visible and highly effective maternal health programs in terms of generating demand [24, 25]. However, none of the studies have touched upon the crucial aspect of women's perspective on the quality of care provided to women who access institutional care. The focus under JSY has been on increasing demand for services, with less emphasis on improving the quality of services.

Indicators to Understand Women's Perspectives on JSY Services

Decision about next delivery and reason

Reason to choose institutional delivery

Source: NHSRC: Programme evaluation of JSY, 2011

Evaluation studies of the scheme report there is a high level of awareness about JSY among recently delivered mothers in rural areas. As far as source of the awareness of the scheme is concerned, most of the mothers knew about the scheme from ASHAs. Regarding satisfaction of services, it indicates that the women were attended after their arrival for delivery and a delay of 15 minutes or more was reported by only a meager proportion of mothers. A similar evaluation was carried specifically for Jharkhand [25]. This evaluation also reveals that ANC seems to be associated with institutional deliveries as mothers who delivered at institutions received more prenatal and postnatal care from community health workers. The study also revealed that some women were satisfied with the services, particularly the provision of free medications. However, those who were dissatisfied would not return due to expenses and behavior of the staff.

Against this broad background there is a need for evidence to determine: 1) the level of women's satisfaction with services provided by the public health system; 2) whether cash incentive schemes

are in and of themselves a significant facilitator of women's satisfaction; and 3) what other facilitators of women's satisfaction should be strengthened or barriers removed in order to support long-term demand for services and generate significant changes in health-seeking behavior.

This study was thereby designed as research into women's perceptions of quality and satisfaction with maternal health care. It was expected that this study would also reveal some key barriers and facilitators related to demand and utilization of maternal health services. This learning will provide inputs in developing context-specific strategies of care with quality as a central theme. Focus on service improvements that are responsive to women's needs and perceptions will sustain and enhance gains made in institutional maternal care services under JSY. Consequently it will also enhance the effectiveness of the program in achieving the desired outcomes in terms of reduced maternal and neonatal mortality and improved maternal health.

1.2 Overall Objectives

1. To identify the determinants of care and women's perception of quality regarding maternal health care services.
2. To estimate the current status of satisfaction with maternal healthcare services in the context of JSY in the state of Jharkhand, India.

The study has two interrelated activities:

- (1) A literature review to explore scientific assessment methodologies and determinants of women's satisfaction with quality of maternal care; and
- (2) A primary research component to determine perceptions, determinants and levels of satisfaction on quality of care in maternal health services in Jharkhand in the context of JSY.

The primary research has two components: a qualitative study, where, through in-depth interviews with recently delivered women and service providers in Jamtara district of Jharkhand, the research team explored the determinants of care for institutional and home births across the continuum of care and women's perceptions of what constitutes good care. The second component is a community survey, yet to be conducted. Utilizing the key determinants of care that have emerged from the literature review and qualitative study, the community survey will increase understanding of the level of satisfaction with maternal health services in one district in the state of Jharkhand.

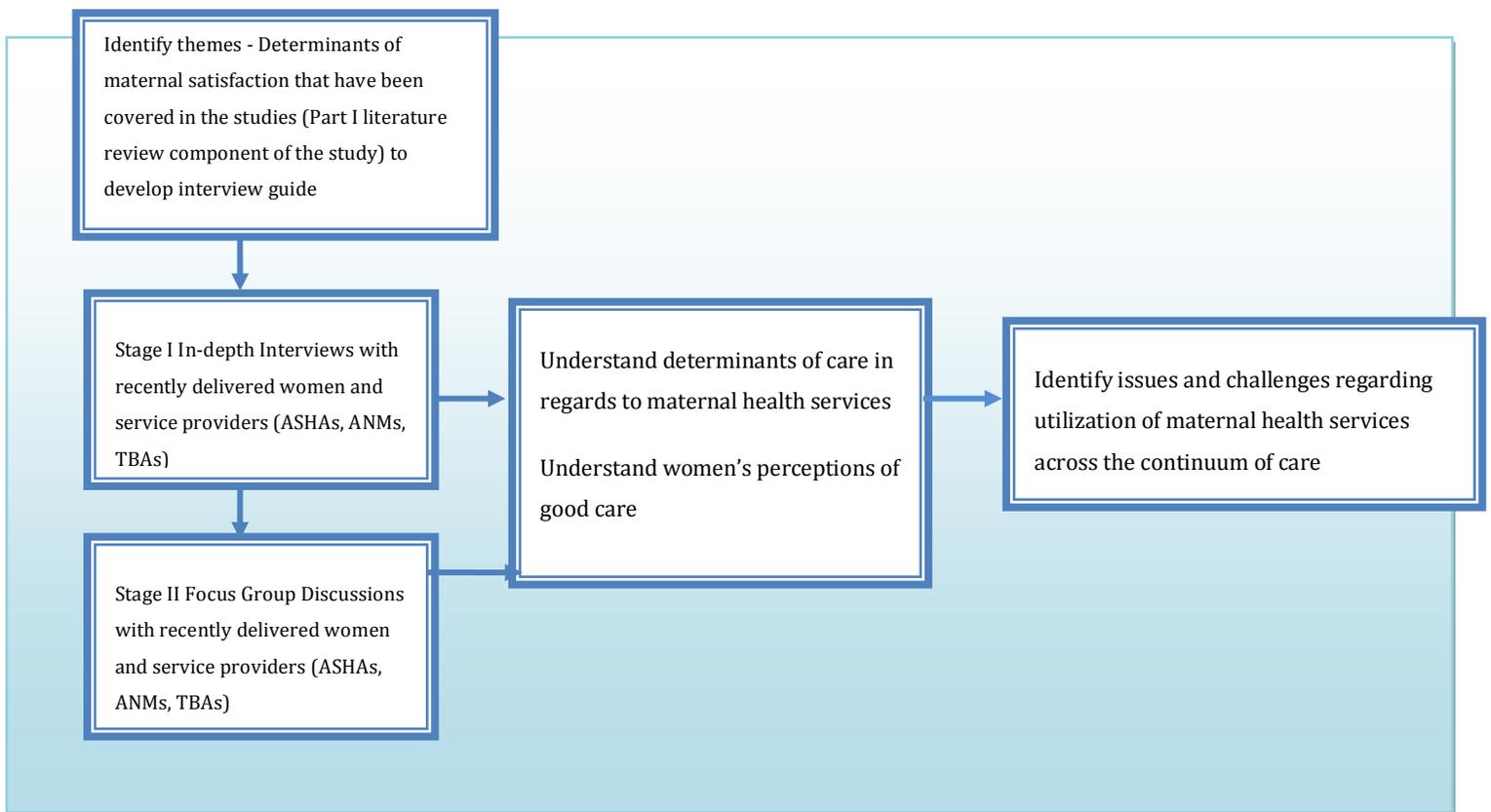
The present report focuses on the qualitative aspect of the study.



Specific objectives for the qualitative study:

1. Understand the determinants of care for both institutional and home births
2. Understand women's perceptions of good care

Figure 1.3 Framework for the Qualitative Study



2. METHODOLOGY

2.1 Study Area

The study was conducted in the state of Jharkhand, which is one of the high-focus states under NRHM. In order to select a district representing the socio-economic profile of the state, at the first



level 18 high-focus districts identified by the state government were selected¹. These 18 districts also are included in the 264 high-focus districts identified by NRHM. At the second level, based on two indicators (proportion of persons below poverty line and proportion of scheduled tribe population), Jamtara district was selected as it represented the socio-economic pattern of the state².

Jamtara is a newly formed district of the state, it is a relatively small district with 4 blocks, 118 Panchayats and 1,161 villages, out of which 90 are uninhabited.

The district has 132 Health Sub Centres, 15 Primary Health Centres (PHCs), 4 Community Health Centres (CHCs), 1 First Referral Unit (FRU) and 1 District Hospital³. The number of institutional deliveries stands at 26% of all deliveries in public health facilities, which is slightly less than the state average of 31%. (Table 2.1)

Figure 2.1: Study Area. Jamtara district, Jharkhand,



Table 2.1 Indicators of maternal health services

	Mothers who had at least 3 Antenatal care visits during the last pregnancy (%)	Institutional Delivery in public health facilities (%)	Home delivery (%)	Postnatal care provided within 48 hours (%)
Jharkhand	44	31	30	40
Jamtara	60	26	39	45

Source : HMIS, 2009-10

2.2 Study Participants

¹High-focus districts are selected in the state on the basis of 3 parameters – left wing extremism, proportion of tribal population and status of backward district under Backward Regions Grant Fund (BRGF).

² Percent having BPL card: Jharkhand- 33, Jamtara- 31; Percent of ST population: Jharkhand- 27, Jamtara- 35. (Source: DLHS 3)

³District Health Action Plan (2011-12)

The study focuses on maternal health services and care provided at Level I in India’s public health system. Level I include births at Health Sub Centres, PHCs, Additional PHCs and at home. In this district only normal deliveries are conducted at the CHCs, so these facilities are also part of the study. Accordingly, data of deliveries conducted in the last three months was obtained from the district health information system and a list of functional Level I facilities were identified

Table 2.2 List of all Functional Facilities at Level1

Community Health Center (only conducts normal deliveries)
Nala
Kundhit
Narayanpur
Primary Health Center
Bagrudih
Mihijam
Pabia
Health Sub Center
Mohanpur

Source: HMIS, 2012

From each functional institution the list of women who had delivered in last three months prior to the study was obtained from ASHAs and the respondents were selected randomly. In order to understand issues and challenges regarding maternal satisfaction with health services, in-depth interviews (IDIs) and Focus Group Discussions (FGDs) were also conducted with Accredited Social Health Activists (ASHAs), Traditional Birth Attendants (TBAs) and Auxiliary Nurse Midwives (ANMs) as they are the frontline workers providing the first contact with maternal health services at Level 1 facilities in the public health system. Primary level care is also provided by private doctors, but this study did not include them as the focus is to understand women’s perceptions of quality of care and satisfaction provided by the public health delivery system.

Two methods of gathering qualitative information were applied to interact with the respondents

- In-depth Interviews (IDIs)
- Focus Group Discussions (FGDs)

First, IDIs were conducted and based on the response and preliminary analysis of the findings, the FGD guide was further refined and the discussion was conducted.

Table: 2. 3 Study Participants [Title needed here]

Methods	Study Participants
Stage I In-depth Interview	Women who had institutional deliveries = 8 Women who delivered at home = 9 ASHA, TBA, ANM = 6 <hr/> N =23
Stage II Focus Group Discussion Each group consisted of 5-8 participants	Women who had institutional deliveries = 2 groups Women who delivered at home = 2 groups ASHA, TBA, ANM = 3 groups <hr/> Total FGD = 7 groups Total Recently delivered women= 32 Total Service Provider= 17

2.3 Study Instruments

Steps followed in developing the study instruments:

1. Thematic inputs for drafting the IDI and FGD guides were based on the determinants of care themes for maternal care that were most commonly reported in studies included in the literature review [Part I of the broader study]. Some studies that dealt with the overall patient satisfaction with care also influenced the selection of themes.
2. Validating the themes: Based on the themes that were identified from literature, a field visit was undertaken in December, 2011. An interview guide based on the themes was developed to conduct interviews with recently delivered women, in a geographic setting similar to that of the study area to validate the themes that were selected.

Key determinants of maternal satisfaction themes identified from literature:

- Availability and adequacy of human resources (availability of female practitioner)
- Physical environment and cleanliness
- Outcome of care such as health of the newborn
- Interpersonal behavior of the provider
- Waiting time
- Cost of care
- Availability of medicines, supplies
- Support from a birth companion of choice
- Length of consultation
- Privacy and confidentiality

3. The questionnaire was translated into the study area's local languages (Hindi and Bengali).
4. Peer review was conducted by experts working in maternal health at the national level and within the state of Jharkhand. The experts included representatives from the technical support division of the Union Ministry of Health and Family Welfare, the membership of National White Ribbon Alliance, Child in Need Institute (CINI), and senior researchers at PHFI. They reviewed the main themes, flow of the questions and also provided inputs based on the translations.
5. Pre-testing was conducted in the study district with two respondents in each category-- recently delivered women and service providers.
6. The instrument was further refined and finalized based on pre-testing (Appendix- I).

2.4 Data collection and data entry process

The following steps were taken for conducting the IDIs and FGDs:

Translation of Instruments: The finalized instrument was translated into the local languages of the study district.

Training and selection of the team: A team of two researchers who have experience in conducting qualitative studies and who know the local dialect of the area were familiarized with the study instrument by the Principal Investigator of the study. After training they were also involved in the pretesting of the instrument. One researcher conducted the interviews and the other researcher noted important discussion points during the interviews.

Conducting interview: The researchers followed these steps while conducting the interviews:

Informed Consent: The researcher, after making relevant introductions, read the informed consent statement to each participant and had her sign the form.



In- depth interview conducted by the research team



When a participant did not wish to sign the consent form, or if they were illiterate, an audio-recording of the respondent's verbal agreement to conduct the interview was made.

Audio-Recording: All interviews were recorded for transcription. At the outset of each interview, permission to audio-record the discussion was requested, with reassurances of appropriate anonymity provided. Complete anonymity is not possible given that broad characterizations of the participants may be provided in the final research reports (e.g. in terms of type of respondents, like mother, service providers and location etc).

The researcher followed these steps while interviewing the respondents (refer to Annexure I):

- **Throw-away questions:** These were essential demographic questions or general questions used to develop a rapport between interviewers and respondents. These questions were placed toward the beginning of an interview schedule.
- **Essential questions:** These exclusively concerned the central focus of the study. These were placed together or scattered throughout the interview schedule, but they aimed to gather specific desired information.
- **Extra and probing questions:** These are equivalent to certain essential questions but worded slightly differently. These questions were included in order to check the reliability of responses. Further probing questions were asked to draw out more complete stories from the respondents.

Handling of refusal: At times, there were refusals on part of the respondents to answer questions. These refusals were either *partial*, where respondents did not clearly say no, rather they did not respond to some of the questions. The interviewer politely tried to understand the reason for such refusal, and then tried to rephrase the question. Even then, if the respondent did not reply, her decision was respected. There were few instances where the selected respondents refused to be interviewed.

Reflections: At the end of each interview, researchers completed the section on notes and observations. This was intended to capture information on the ease of the interview, whether respondents answered questions freely, and any other relevant information. These were prepared for each interview. At the end of each day, researchers reflected upon and discussed the interviews conducted. This was necessary to improve the coherence and flow of the interview schedule.

Transcription & Translation: Time and care was taken to reproduce the audio-recording in the transcriptions as this is the main focus of the analysis. Although it is accepted that all non-verbal

utterances neither can nor should be transcribed, efforts were made to reproduce pauses, laughter and so on, especially where significant and/or relevant to the discussion. The interviews were conducted in the local language, so the researcher, who was well versed with the language, directly translated the interview to English. In order to check the quality of the transcription and translation both were checked by two researchers.

Quality control: Efforts were taken at every stage in the study process to ensure quality from the identification and recruitment of respondents, to following respectful interviewing practices. Attention was paid to ensure adherence and relevance of the discussions to the study purpose, aims objectives and interview schedule. This is of particular importance in terms of the emergent themes and additional probing described in the section above. Transcription and translation quality was carefully considered and two research associates for the study conducted quality checks.

2.5 Data Analysis

In order to organize the data from transcripts of interviews, the “framework approach” of qualitative analysis was used. This approach combines the use of predetermined thematic codes permitting the generation of new themes as they emerged from the participants’ accounts.

Steps involved for data analysis:

- Familiarization with raw data by re-reading field notes, audio recordings/transcripts.
- Identification of emerging or recurrent themes. Additional emerging or recurrent themes/sub-themes added, as necessary.
- The interview data was systematically searched for content relevant to the themes and sub-themes and coded as appropriate. Atlas- ti software was used to segregate data as per theme and subthemes.
- Indexing and charting was done by applying the thematic framework systematically to the data.
- Interpretation of the data was done based on relevant themes and sub-themes.

Developing the main themes of care: Two levels of thematic codes were developed and applied to the data:

- A priori themes were developed first based on the interview guide. The codes corresponding to the themes focusing on different determinants of maternal satisfaction

were identified. The focus was to understand women's perceptions of good care and the determinants of care related to maternal health services.

- Emerging theme codes: the second layer of codes dealt with emerging dimensions/determinants of satisfaction reflecting women's perceptions of good care. This was also based on synthesis and cross comparison of data from different groups of respondents, both those having institutional deliveries and home births, and also with the service providers' perspectives.

Indexing and Charting: The main themes, once developed, were applied systematically, where the priori and the emergent codes were attached to the relevant segment of the text with the help of software Atlas-Ti. The data was transferred into a word document as charts with columns representing the codes and rows representing the respondents.

Interpretation and analysis: The text corresponding to the thematic codes was retrieved and was analyzed.

Ethical approval

At the time of interview, the informed consent form was read (and explained) to the identified respondents. Since most of the respondents in the study are illiterate, a verbal consent was taken, that was recorded prior to the interview. The research was approved by the Public Health Foundation of India (PHFI) Institutional Ethics Committee (IEC) and the University of Aberdeen (Aberdeen, United Kingdom).

3. ANALYSIS

This section highlights the findings based on the IDIs and FGDs with recently delivered women and also with services providers, delivering conducted between January and February 2012. Twenty-three IDIs and seven FGDs were conducted and transcribed. All transcripts have been coded and analysis presented in this report is descriptive in nature. The analysis is done separately for women who had institutional deliveries and those who delivered at home. In terms of this descriptive, thematic analysis, the main themes emerging are described in Table 3.1.

Table 3.1: Main Themes of Care

TOPICS	MEGA THEMES (topic guide, priori themes, deductive)
Determinants related to maternal health care and services	<p>Influence of community/ peers/ family and socio- economic factors leading to choice of place of delivery</p> <p>Accessibility of institution - Facilities that can be reached easily (geographical accessibility), timely availability of transport.</p> <p>Structure – Physical infrastructure and overall environment of the delivery place that is acceptable to the women.</p> <p>Human resource- Availability of relevant human resources.</p> <p>Supplies – Availability of medicines and other necessities</p> <p>Emotional Support- Reassuring environment, dependability and feeling of emotional security and support; alleviation of fear and anxiety particularly during delivery.</p> <p>Cognitive support- Necessary information is conveyed in a language that women can understand and helps individual adapt to changes.</p> <p>Promptness – Timeliness in care as per the need of each woman, particularly during complications.</p> <p>Privacy –Providing women a culturally sensitive environment and secluded place for check up and delivery.</p>

	<p>Inter-personal aspect of care- Respectful behavior of the staff to make the women comfortable and secure irrespective of their socio- economic background.</p> <p>Outcome -Any result, including complication of mother and newborn.</p> <p>Continuum of care - Link between Antenatal Care (ANC), delivery and Postnatal Care (PNC), linkages between community health worker and institution staff.</p> <p>Expenditure - Services are provided as per norms without additional costs.</p> <p>Experience based on previous place of delivery - Comparison to understand level of satisfaction (not applicable for primiparae).</p> <p>Decision about place of delivery for next child - Decision about place of delivery for next child and sharing of experience with others in community.</p>
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3.1 Profile of the respondents and process of care for maternal health services

The respondents are mostly 18-23 years old and illiterate. Only a few had achieved a primary level of education. They are mostly Hindus and belong to scheduled castes. The majority of them have Below Poverty Line (BPL) cards and their husbands work as casual laborers. In most of the cases they had 2-3 children at the time of the study.

Table3.2: Demographic Profile of the Respondents

	Institutional Deliveries		Home Births	
	In-depth Interviews N= 8	Focus Group Discussions N= 18	In-depth Interviews N= 9	Focus Group Discussions N= 14
Age				
18-20	3	10	2	4
21—25	5	8	7	10
Educational Status				
Illiterate	6	9	8	5
Literate, informal education	1	7	1	6
Primary Level (1-4 class)	1	2	0	3
Religion				
Hindu	6	16	5	7
Muslim	2	2	4	7
Caste/ community				
General	2	0	2	0
Scheduled Caste	4	12	5	10
Scheduled Tribe	2	6	2	4
Main economic activity of the head of the household				
Cultivator	2	1	0	2
Agricultural Laborer	1	3	3	1

Casual Laborer	5	10	6	8
Other	0	4	0	3
Below Poverty Level (BPL) Card holder	7	1	6	4
Total Number of Children				
1	4	5	3	1
2-3	4	12	5	7
More than 3 children	0	1	1	6

Process of care

This section narrates the type of care that a woman receives during antenatal, delivery and postnatal period. It summarizes the respondents' overall accounts of type of maternal service utilization in the study area (refer Table 3.3).

Institutional Deliveries: In the third or fourth month of pregnancy women inform the health worker, ASHA⁴, about their pregnancy. The ASHA takes the woman to the Aganwadi Centre (AWC) for the first round of antenatal care (ANC). Here the woman is given two doses of tetanus toxoid injections and provided with the recommended doses of iron and folic acid tablets for their entire pregnancy. The ASHA also takes the woman to the nearest institution for ANC check up and helps her to undergo blood and or urine tests, if prescribed by the nurse/doctor. She also advises the pregnant women about what constitutes a healthy diet. When labor pains start, family members inform the ASHA, who arranges for a vehicle to take them to the institution. At the institution women are checked by the ANM to determine the position of the child and, depending on the situation, the woman will be provided with injections/medicine for pain relief. The ASHA and family members usually accompany the woman in the labor room along with nurse and the doctor. After the child is born, the support staff at the institution, who are known as TBAs⁵, cut the cord and clean and wrap the child. Both mother and child are then shifted to the postnatal care (PNC) ward where they are kept for a few hours, ranging from 3 to 12 hours, before discharge. On arrival at home, the local TBA is informed, who performs all the traditional rituals for the first five days. Generally she gives oil massage to the mother and baby, cleans and washes their clothes, and at times gives hot compresses to the mother if she is in great pain. During the PNC period, the ASHA

⁴ In Jharkhand ASHA is called Sahiya, but for the wider audience for this study we are using ASHA.

⁵ Traditional birth attendants (TBAs) are referred to as Dais, most of them are not trained in skilled delivery. For this report we are using the term TBA throughout.

also visits the woman and her baby at home, helps them with some immunizations of the child and counsels the mother on breastfeeding as well as on what constitutes a healthy diet for the mother.

Home Births: Because these respondents delivered at home, there is some sort of ANC or PNC care. Half of the respondents reported that ANC care was provided by the ASHA and that they received two doses of tetanus toxoid injections as well as the full course of iron and folic acid tablets from the AWC. However, in all the cases, the ASHA was not present during delivery. The TBAs are also not informed prior to the delivery and they do not provide any ANC. TBAs only visit the women during the time of delivery and the first five days post delivery, and they are not trained. In few instances, due to health complications of the mother, private doctors assisted the TBA during the delivery, mainly offering injections/medicine for inducing labor. A few respondents reported that family members helped in the delivery as they did not have adequate time to inform the TBA. However, the TBA was called to cut the cord and to clean the mother and the newborn. The TBA plays the most important role in the process of maternal health care for deliveries that take place at home. Even when in some cases where a private doctor assisted the delivery, the rituals and role performed by TBAs did not change. Upon arrival, the TBA gives an oil message to the woman and does an internal check-up to estimate the position and situation of the baby. She assists women in delivery and cuts the cord. After delivery, she cleans the mother and newborn and also cleans the place of delivery. One hour after delivery she makes sure that the child is breastfed. Half of the in-depth interview respondents received care from TBAs in the first five days following delivery. During her visits, the TBA generally washes clothes of the mother and newborn, gives them oil message and bathes them. Sometimes she also gives the mother a hot compress, if she has a lot of pain. Only a few reported that the ASHA visited them during PNC and had advised and assisted with the vaccination of the child.

Table 3.3 Utilization of Maternal Health Services

	Institutional Deliveries		Home Births	
	In-depth interviews N= 8	Focus Group Discussions N= 18	In-depth interviews N= 9	Focus Group Discussions N= 14
Place of ANC				
At home by ASHA	1	8	4	0
At AWC	0	2	0	3
BY ASHA and AWC	5	8	0	5
At institution	2	0	0	2
No ANC	0	0	5	4
Place of Delivery				

Sub center	3	0	0	0
PHC/ CHC	5	18	0	0
Home	0	0	9	14
Place of PNC				
At home by ASHA	4	3	2	1
At home by TBA*	1	1	6	2
At AWC/ institution	0	4	0	0
By ASHA and TBA	0	3	0	0
Not received	0	7	1	11

Some women went to private shops/ clinics to get medicine and conduct test during Antenatal period

* In this study TBA is consider as a provider outside the health system and her role during PNC is restricted to giving massage to mother and bathing the mother and baby for first 5 days after delivery.

The following two sections describe the determinants of care themes that were identified through the literature review and provided thematic inputs for conducting the IDIs and FGDs. The determinants of care themes are analyzed separately for women who had institutional and home births. To understand each determinant of care theme as discussed in table 3.1, each themes were further segregated (Details in Annex III).

3.2 Determinants of care in regards to maternal health services for institutional deliveries across the continuum of care

Community/peer/family influence: Women who chose to have institutional deliveries were highly influenced by the community health worker, the ASHA. The majority of women reported that they were advised by an ASHA to have an institutional delivery, hence they went to the institution for delivery. This is strengthened by the comments of few other women who said they chose to have institutional deliveries based on the pleasant experience reported by other women in the village who had opted for institutional deliveries.

Accessibility of institution: For women having institutional deliveries, the institution chosen was not very far, and most of the respondents

“ASHA didi told me that in hospital there will be doctors and other institution but in the house there won’t be any facility so it is better to go to the hospital.”
Women delivered at institution

“We people don’t know anything. Whatever the ASHA says, we do that only.” Women delivered at institution

“..before this scheme not many women use to come to the hospital for the delivery, but now they have started coming in good numbers”. ANM

“.. this is one of the reasons because from the scheme at least they are getting something, as the people come from all around very far and interior places. If the patient has delivered the baby at home then also they take the mother and the baby to the hospital just to cut the tube and get the compensation of Rs. 1400.” TBA

reported that it was easily accessible by private/public transport. The average time taken to reach the health facility varied between 15 and 30 minutes. The women reported going to the institution either by car, cycle or even walking. Geographically facilities were generally well situated and reaching them was not a major problem for these women.

Structure: Almost all the respondents stated that they were satisfied with the overall physical infrastructure of the institution. All of them stated that the table on which they delivered the baby was clean, even the bed where they stayed during immediate PNC was also clean. However, a few of them reported that there were no bed sheets or mattress provided in the institution, and they had to bring these from their homes. In order to understand the women's perception of the specific physical infrastructure they were asked separately about the cleanliness of toilet, PNC ward, maintenance of walls, floors and availability of running water. Interestingly to all these questions they answered *"Everything was clean."*



In-depth interview with recently delivered women

Human resources: According to all the respondents, nurses and ANMs were always available at the institution, even at night. Many of them reported that they had reached the institution around 9pm and the doctor and the nurse were present. This was supported by the ASHAs, who said that, if the ANMs are not present when they bring patients to facilities at night, they call the ANMs from their residences, as some stayed at the premises of some facilities.

Supplies: When questioned about the availability of supplies at the institution, the majority of the respondents stated that they got all the medicines, injections and saline water free of cost from the facility. In fact, as per some respondents, the main reason they chose to have an institutional delivery was because they understood they would get all medicines from the institution free of cost. However, some differed in their opinions, as they had to pay for certain medicines and injections purchased from a pharmacy. This was also supported by comments from ASHAs, who said that many times patients have to buy certain injections and medicines from a private pharmacy as these are not available from the institution. On further probing it was discovered that the most of the

facilities only provide basic medicines, such as pain relievers. If any other medicine is needed, the patients have to buy it on their own. The ASHAs also reported that on many occasions when they take the women to the institution, the doctor/nurse prescribes certain medicines and injections, which they have to buy from the pharmacy.

While the opinion regarding supply of medicine varied, the responses as to the supply of food in the institution for the patients were quite unanimous. It was clear that the institution did not provide any food for these women

before and after delivery. Family members brought food from home for the patients. Only two women reported that after the delivery of the child they were given either milk and bread or tea and biscuit.

“Apart from the doctor and me, ASHA was also there (in the labor room).” Woman who delivered at an institution

Emotional support: All the respondents agreed that presence of their family members at the time of delivery provided lot of emotional support to them. Some respondents reported that their family members were not allowed inside the labor room. For others, however, the pregnant woman’s mother and/or mother-in-law was present in the labor room during the delivery of the child. Irrespective of family members, the ASHA was present in the labor room with the women at all times. This remark was reaffirmed by all the ASHAs who stated that women develop a relationship of trust with them during their pregnancies hence their presence in the labor room reassures the women about the situation.

Convenience: The women who had institutional deliveries were relieved of the tension of cleaning up the placenta and blood after delivery; the baby is also cleaned by the staff, which is primarily

done by the TBA after deliveries at home. For a few women when there was an absence of male members in the household, the support from staff at the institution during delivery was one of the key reasons why they preferred to deliver at the institution.



Familiarity: Many women reported that if someone else from the family had delivered in the institution, there was a feeling of familiarity that was comforting, but most women were not familiar with the institution where they delivered. For ANC check-ups they primarily visited the AWC or had home visits by ASHAs. Very few women, reported visiting the institution before delivery.

“We should be told why we are being given any particular injection or medicine...we should be given proper information.” Woman who delivered at an institution

Cognitive support: When asked about the cognitive support provided at the institution, respondents were not very clear about it and only one woman stated that the doctor and the nurse spoke in her mother tongue, so she was able to understand everything properly. There was not much information shared with women, particularly about medicine and injections. The majority of the women reported that they were not informed of the progress of their labor and in terms of monitoring the progress of the labor the provider did it manually (using finger).

Promptness: Almost all the women were satisfied with the promptness of services at the institution. The number of deliveries conducted daily at the Level 1 facilities is generally low, and women reported that they were taken to the labor room immediately after arrival. In some cases women gave birth within one hour of their arrival at the institution, while some others had to wait almost an entire day before they delivered the child. Nevertheless, all women stated that from the time they were admitted to the institution, health personnel monitored them quite regularly, and there was never a time when they felt as if they were not attended. As one of them said, *“They never left me alone.”* The women were also satisfied with the timeliness of pain management at the institution. Most of them stated that immediately upon arrival, if they had extreme pain, they were given medicines/injections to get relief from the pain. Moreover, they did not have any complaints about the promptness with which things were handled in the labor room, including



Focus Group Discussion with recently delivered women



cleaning and wrapping of the child after birth. No respondent reported about any complication either of mother or child during delivery.

Privacy: Overall all the respondents were satisfied with the level of privacy at the institution, which are mostly the AWC during ANC check up and the Level 1 health facility at the time of delivery. All of them stated that they were examined in a separate room with a curtain and in

the room there were no male staff/family members. Although many complained that the place was a bit crowded, the crowd was limited to other pregnant women and the ASHAs accompanying them.

“No, I didn’t feel like that (embarrassed), because there were only women there (in the check-up room).” Woman who delivered at an institution

“She was scolding me during the delivery.....actually it was my fault I was shouting.....touching my stomach...” Woman who delivered at an institution

“She [nurse] was telling me that if you do not push, it is very difficult for the child to come out. Delivering a child is a process of pain so it will be little painful.” Woman who delivered at an institution

“There was a case where a pregnant lady went for the institutional delivery. She was first from her village to go to the hospital for delivery but after she got a bad treatment from the nurses then she came back and advised nobody to go for the institutional delivery... now the women of that area don’t want to go the hospital for delivery and cite this woman’s example whenever they are told to go for the institutional delivery.” ASHA

“We are overloaded and sometimes get irritated....even when we explain to the patients that we cannot give them medicines they go on asking for it. They are not ready to understandit...then we have to scold them...” ANM

Generally in the examination room there would be ANM, ASHA and the pregnant woman. The internal check up before delivery was done by the ANM in a separate room and there were no males present, hence the women did not feel either uncomfortable or embarrassed.

Interpersonal aspect of care: Women’s satisfaction levels regarding the attitude and behavior of staff at the institutions were fairly satisfactory. Many of them reported that they were treated with care upon arrival to the institution and few women complained about staff being abusive or rude at the time of delivery of the child. A few women stated that either the doctor, nurse or ASHA had asked them to push harder for the child to come out, but staff were more or less compassionate and tried to explain that childbirth is a painful process. The ASHA further reiterated the importance of behavior of the institution staff

which sometime acts as an obstacle for them to motivate women for institutional delivery.

One key determinants of interpersonal care is the whole delivery process is conducted by a skilled attendant, which includes taking out the placenta and cleaning the mother and baby. But the majority of the women who had delivered at an institution reported that though the ANM conducted the delivery, her role was limited till the baby came out. The TBA would then remove the placenta and also cut the cord. This statement was reaffirmed by an ASHA, who stated that though they usually do not cut the cord, but at times when the TBA is absent they do this. Similarly the ANMs stated that TBAs always cut the cord.

Outcome: The sample was selected for those women who had normal deliveries. Therefore, all the women reported that their deliveries were normal and without any complications. In cases where the woman was weak and had high blood pressure, they were given drips before the delivery.

ASHA's role in continuum of care: ASHAs play a key role in terms of ensuring the continuum of care process and is the link between the ANC, delivery and PNC services. She is the person who the



Focus Group Discussion with ASHA

women interact most during the whole pregnancy process. Irrespective of differences in the experiences and opinions about institutional delivery, all women interviewed who had institutional deliveries were very satisfied with the role of the ASHA during the entire pregnancy as well as after childbirth. It was evident that ASHAs are perceived to provide a good continuum of care between ANC, delivery and PNC. All women reported

that once they informed the ASHA about their pregnancy, she immediately took the woman to the AWC for first round of ANC check ups. The ASHA is also instrumental in making the Mother and Child Information Card, a pre-registration process, at the institution. The ASHA also took women to the nearest institution for ANC check up if needed and helped her to undergo blood and or urine

tests, as prescribed by the nurse/doctor. She also advised the pregnant women about having a healthy diet.

For institutional deliveries the majority of the women reported that the ASHAs had advised family members to contact her (through her mobile) when there is labor pain, so she can arrange the transport. All women stated that the ASHA arranges for a vehicle to take them to the institution. All women felt very reassured by the presence of the ASHA with them at the hospital. They all emphasized that the ASHA stayed with them throughout, from the time they were admitted to the hospital until they were discharged and went back home. Most women stated that the ASHA visited them at home after they were discharged from the hospital.

The average number of visits of the ASHA during PNC varied between two and three. The general advice given by the ASHA at this point is mainly about how to take good care of the child, such as giving oil massage, not giving cow or goat milk, and proper diet of the mother. Women reported, that since it was winter, the ASHA also advised them to protect the child from cold. Many women stated that the ASHA helped them with the immunization of the children and also recommended they breastfeed the newborn. However, interviews revealed that there is gap in terms PNC immunization counseling (only polio drops were reportedly given). In spite of information sharing by the ASHAs, newborns were given food like goat's milk and honey.

Despite the vital role of the ASHA during PNC, most of the women also informed the TBA, who took care of the mother and the newborn for the first five days. This is mainly because of the traditional customs, where for five days women are treated as *"impure and polluted."*Hence, all rituals at this time are conducted by the TBA, who belongs to a specific caste.

"...I gave 600 rupees to the nurse, who assisted in the delivery. ASHA was also asking for rupees 100..." Woman who delivered at an institution

Expenditure: Despite the cash incentives provided through JSY, respondents reported that there are many informal expenditures that have been imposed on women delivering in facilities. Half of the respondents who had institutional deliveries reported to have paid tips which vary between 100 and 600 rupees. Apart from tips, some also have to spend on medicines. Depending on these expenses, a fare bit of JSY scheme's money is spent on such items. Moreover during the PNC they

had to pay the TBA who provided care in terms of massages and cleaning the mother and baby for the first five days after delivery. They also incurred costs by paying the barber, who performs some rituals at home after the baby is born.

Though some of the respondents interviewed had already received the JSY money, many more were yet to receive it. There is a time lag between the date on which they apply for the money and when they get it. On average, according to the women interviewed, it takes about two months for women delivering at Level 1 facilities in Jamtara District to receive the money.

Experience based on previous place of delivery: Many respondents reported that they had delivered their first child at home but delivered their second child in an institution. When asked to compare experiences, all stated they were more satisfied with the institutional delivery. In addition to the value placed on pain relief, which is mostly through administering uterotonics, these women reported that the presence of doctors and availability of medicines at the institution made it more convenient and comfortable for them to go for institutional delivery.

Decisions about place of delivery for next child: Most of the respondents said that they would prefer to have the delivery of their next child at an institution rather than delivering at home. The primary reasons given were, which is sometime based on own assumption and also experience of other women in her community (the reasons are not ranked in any order): the availability of doctors, nurses in case of complications, free medicines, pain management and also cleaning up of the mother and baby after birth. Many suggested that it was more expensive to deliver the child at home, as they have to pay for the TBA and sometimes private doctors, and buy medicines. The last two costs can be avoided in institutional delivery, which are avoided in the hospital. Some even stated that in the hospital they have more privacy than at home, where there is free inflow of family members and neighbors in the labor room. They all agreed that institutional deliveries are much safer, and if there are any complications it can be taken care of by the medical professionals. All such advantages are lacking at home. Some of them stated that they would prefer institutional delivery even if the JSY scheme was not operational. Most of the respondents said they would suggest their friends and acquaintances to opt for institutional delivery because of the above mentioned advantages and they would also prefer institutional delivery for their next child.

3.3 Determinants of care in regards to maternal health services for home births across the continuum of care

Community/family/peer influence: Most of the women agreed that ASHAs had advised them for institutional delivery and some even reported that they preferred institutional delivery as they were aware of the JSY scheme.

In few cases it was clearly communicated that it was the woman's family's practice to deliver at home – based on experience of other women in the family and also her own experience based on previous births. A few women stated that they were more comfortable at home as they felt insecure at the hospital, due to presence of unknown people around, including the male doctor. Some women expressed that they were scared to go to the institution because of rude and abusive behavior expected from the doctor and staff there, and, in a few cases, they were scared of clinical intervention. This perception was based on experiences reported by other women in the neighborhood who had institutional deliveries.

Accessibility of institution: Most of the respondents reported that the institution was not very far from their residence, and the average time to reach the institution was around half an hour. Nonetheless, the majority women stated they could not deliver at the institution because of non-availability of transport at the time labor pain started. Many women reported that they

"In the hospital people from all around are looking at you, sometimes even the doctor might be a male. If he does check me, I would die of shame." Woman who delivered at home

"I won't have any problem to going to the hospital, but if the delivery at home is done safely then there is no need to go to the hospital. This is the reason why we do not like going to the hospital. And mother-in-law and other members of the family were present at home." Woman who delivered at home

"...but what to do. When my labor pain started it was midnight, there was no facility of vehicle and we did not have enough money to hire a vehicle". Woman who delivered at home

"There was no one at home, only my mother-in-law was there, so I told her not to go anywhere but to stay with me. I wanted to go to the hospital...but there were less people in my family to take me to the hospital". Woman who delivered at home

wanted to have an institutional delivery, but could not as there was lack of communication and promptness in arrangement of transport facility at that time. Most of them reported that by the time the ASHA could arrange for the transport, they had delivered, while according to others there was no one at home to inform the ASHA when labor started.

Infrastructure at home: There is no separate place for delivery in homes and most of these women live with an extended family in one- or two-room houses. During delivery they make a makeshift partition of the room. In terms of hygiene it is the same standard that is practiced daily and no special arrangements are made for the delivery. The women reported that the family provided hot water and a new blade and cord to the TBA. It was reported that the TBA boiled water and sterilized the blade before using it. Only one woman stated that the TBA had brought the blade herself. Although in most cases the TBA cleans the room after delivery and washes the clothes and bed sheets that were used during delivery, it is also the responsibility of the family members to take care of the hygiene as most of them share the same room.

Human resource: All women reported that irrespective of whether it was night or day, the TBA arrived to the place of delivery, as soon as she got the news that the woman's labor pain had started. It is noted from the interviews that most TBAs who assisted in the delivery were either from the same neighborhood or belonged to the nearby neighborhood that assured her prompt arrival. This was reaffirmed by TBAs. Some of the women also mentioned that they had called a private doctor to assist with the delivery, even though a TBA was present.

In some cases women who called a private provider reported that the doctor helped with the delivery, cut the cord and also gave some

"The private doctor and TBA came to our house whenever we called them, so there was no need to go to the hospital." Woman who delivered at home

"She [TBA] stayed back for two-three hours. At 2.30 in the morning I delivered my child and late in the morning she went." Woman who delivered at home

"When people called us first we check the blood pressure of the patients by reading her pulse, and then only insertion of the number of fingers, insertion of three fingers indicates that now she can deliver the baby. We came to know if there is any complication and whether the patient can deliver the baby at home or at hospital." TBA

injection or medicine to them, if needed. Hence, in these cases the role of the TBA was limited to cleaning of the mother and the newborn as well as the place of delivery. On further probing it was realized that doctor was called mainly to induce labor and help the woman to deliver quicker.

Supplies: The respondents were not very clear about the availability of supplies during delivery. However, they all mentioned that the TBA did not bring any specific things with her for delivery. Because the delivery was at home, there was no issue about supply of water and food for women. However, in cases where a private doctor assisted with the delivery, women reported that he brought injections and medicines, which were given to the mother before and/or after delivery, depending on the situation. During the ANC period women reported that their families bought vitamins and other medicines from private clinics if they were not available through the ASHA and at the AWC. Women reported that their families paid private clinics for conducting tests.

Emotional support: Many respondents reported that the presence of family members, especially their mother, and the known environment at home provided a lot of emotional support to them during delivery. The TBAs also highlighted the emotional support that a woman receives if she delivers at home.

Some women feared the unknown environment of the health facilities, particularly the presence of male doctors. Apart from family members, the prior acquaintance with the TBA also provided emotional support to these women.

“When the lady delivered the baby at home then they will get all the care and support from the people around which is not given at hospital., After deliver if the woman has some problems like back pain, feels like lethargic, then nobody will give them extra support or care in the hospital, but if she deliver the baby at home at least there is someone who could massage and give them extra care....Whatever she wants to eat they will get at home with love and care.” TBA

“At home all the family members are present and all the worries and tension were automatically gone.” Woman who delivered at home

“I felt good when the TBA was here, I thought she would manage everything and I was not scared.” Woman who delivered at home

Cognitive support: Since the TBA is from the same village, there was no issue in terms of language, and the women could understand the information and advice she provided. Similarly a few women who visited the AWC and institution for ANC check up said they could easily understand whatever the ANM said as she spoke in the local language. However, women reported that the institution staff did not explain why they were given injections and medicine. During the whole delivery process the

"Yes she spoke in the same Bengali that we speak...So I understood."
Woman who delivered at home

"I went to the government hospital for the checkup, they gave me injection and I do not know why it was given to me." Woman who delivered at home

other female members of the household also actively participated so the woman was aware of the progression of the labor. In one case, when the TBA understood there was a complication, like the baby was not coming out easily she advised the family members to get a doctor or nurse.

Promptness: All women were highly satisfied with the promptness of the TBA during delivery. Women were also satisfied with the type of constant attendance that was provided by TBAs along with the family members. Many of them stated that after delivery the TBA stayed, on average, for two to three hours. In regard to pain management, she only provides massage and in one case where labor was prolonged, it was reported that the TBA advised the family to get a doctor who could give an injection to speed up labor. This is reaffirmed by the TBA.

"We had called her [TBA], and immediately when she got information, she came to our house." Woman who delivered at home

Privacy: When questioned whether there was enough privacy for women during delivery, almost all of them stated that they were satisfied with the privacy at home. One woman, however, reported that she had delivered the baby in the presence of her older male child, as there was no other place for him to go. Even then she was comfortable as she felt this was inevitable due to scarcity of rooms in the house. The cases where a private doctor

"The men were not at home, they had gone for work...and anyways, had they been at home, they would have definitely gone out...even they understand this." Woman who delivered at home

"...after giving injection the doctor was supposed to go out from the room." Woman who delivered at home

also assisted the delivery, during delivery time he was not present in the room as his role was limited to providing an injection to induce labor.

Interpersonal aspect of care: Women were satisfied with the behavior of the TBA and also the doctor, wherever he was present. One of the respondents stated that the reason they did not go to a specific hospital was because of the rude attitude of the staff there. The answer to who cut the cord and handled the placenta was unanimous among respondents. This task was done by the TBA. One of the TBAs mentioned that though she assists women in delivery, she does not cut the cord and this is done by a TBA of a specific community. This adheres to the caste structure prevalent in the community which strictly follows traditional rules for such rituals.

Outcome: The majority of the women having home deliveries did not report any complications but in a few instances it was reported that the newborn developed mild complications. *“ just after the birth when the TBA bathed my child...soon after he caught cold”*. A few women reported calling the private doctors for treatment after delivery because of a general feeling of weakness.

Role of ASHA in Continuum of care: Because these respondents delivered at home, there is not much continuum of care and support provided by ASHA between ANC and PNC. Only a few respondents reported that ANC care was provided by the ASHA, and they had received two doses of tetanus toxoid injections as well as the full course of iron and folic acid tablets from the AWC. In most of the cases the women were not aware of the check-ups they needed to do as there was no proper counseling by ASHA. The few respondents who went to their natal place for delivery reported that they were not contacted by the ASHA or they were refused services. During delivery the ASHA was not present as the delivery is conducted mainly by the TBA and in a few instances the family called

“No, nobody has told us to about any checkup or information before delivery.”
Woman who delivered at home

“I went to her but she said that the services were not given to those who come from their husband’s house. After that we never go to her.” Woman who delivered at home

“She (TBA) came everyday for five days. She did oil message, gave hot compress...”
Woman who delivered at home

a private doctor. Similarly PNC was mainly provided by the TBA. For the first five days after delivery, the TBA comes twice daily to the woman’s place. During her visits, she generally washes the clothes of the mother and newborn, gives them oil message and bathes them. Sometimes she also puts a hot compress for the woman, if she has a lot of pain. Only a few women reported that the

ASHA visited them during PNC and had advised and assisted with the vaccination of the child. The role of ASHA for home births is quite limited as compared to those women who had delivered at the institution.

Expenditure: According to the respondents, families incurred more expenses for deliveries at home. Except for one respondent, none of the women delivering at home received any money from the JSY scheme. The one who received JSY money got the cord cut at the hospital after delivery, hence unlike others she had to spend around 300 rupees for transportation to and from hospital. The main items of expense included buying medicines for mother and the newborn, paying the TBA and doctor, where applicable, and the barber, who performs certain rituals after delivery. On average, they spent between 200 and 1000 rupees for medicine and doctor/TBA fees. The money they paid to the TBA also varied from 300 to 600 rupees. Many times the TBA preferred payment in kind, such as rice, paddy, and a new set of clothes, rather than cash. Some of the respondents mentioned that during their pregnancy they had spent almost 10,000 rupees, which included all expenses mentioned above.

Experience based on previous place of delivery: Experiences and the level of satisfaction of the respondents regarding the place of previous delivery depended if the previous delivery was at the institution. Some women who had their previous delivery at an institution were not completely satisfied with the current delivery. One of the facts that they most cherished about institutional delivery, and which was lacking when they delivered at home, was the availability of doctor and medicine to induce/augment labor or decrease pain. Moreover, respondents also noted that at the institution they did not have to bother about cleaning the mess after delivery, it was taken care of by staff. In spite of the TBA who does most of the cleaning, ultimately the family members and in some cases the women who stayed in nuclear families had to take care of the hygiene. However, women who had given birth to other children at home were satisfied with the situation, as they could not compare their experience to that of delivering in an institution..

“Hospital is better. Because in hospital we get treatment, and they clean also...” Woman who delivered at home

“In hospital we get everything cleaned but at home, we ourselves have to do that.” Woman who delivered at home

Decision about place of delivery for next child: When questioned about where they would prefer to deliver in future if they had another child, many women said they would prefer institutional delivery. Others stated very confidently that since they already had two or more children, they would not want to have any more children. However, they all noted that they would definitely recommend other pregnant women to opt for institutional delivery. In their opinion the availability of trained medical personnel and medicines at the hospital were the main reasons for preferring institutional delivery. Another reason provided was that after delivery in an institution cleaning was done by the staff and family members did not have to bother about it.

3.4 Women's perceptions of good care regarding maternal health services:

All recently delivered women were asked in the IDIs and FGDs what aspects of care they valued most during the time of delivery. The most common responses, not arranged in any order: availability of health providers and appropriate medical care (primarily medicine) in case of complications; emotional support; privacy during delivery; availability of transport to reach the institution; and monetary incentives that exceed expenses.



Focus Group Discussion with recently delivered women

Women considered the presence and *availability of trained medical personnel and supplies in form of medicine* at the institution one important reason why they preferred institutional delivery. Even some women, who have had home births, would prefer to have institutional delivery for the next child because of this same reason. According to these women, doctors and the nurses are in a better position to assess the position and condition of the child and the mother. Women felt more secure at the institution as there was assurance of appropriate medical care in case of any emergency.

Apart from human resources, women were satisfied with the provision of free medicines, saline water and injections, which were provided to them before and during delivery. Though some of them had to buy medicines and/injections from the pharmacy, they did not complain, as they considered it to be crucial for the delivery care. Also women were highly satisfied with the handling of pain management through medicines/injections during and before labor at the institution. Even many women who had home births, had called a private doctor for providing pain relieving medicines/injections during delivery.

Emotional support during delivery: The presence of family members is one of the key aspects that women believe constitutes as good care, whether she is delivering at home or institution. In the institution often the ASHA is present in the delivery room along with her family members, which is highly

appreciated by women as it provided a lot of emotional support to them in the unknown hospital environment. Family support is one of the key factors for women preferring to deliver at home.

Privacy during delivery is highly valued, whether women delivered at home or in institutions. Delivering in a secluded place where there is an absence of males is most desirable. The presence of male staff is one of the factors for women not willing to deliver at the institution. During home births, it is difficult to maintain a high level of privacy during delivery, as these respondents live in joint families in houses with one or two rooms. This makes the woman feel uncomfortable. The situation is worse if the woman is at her husband's place and her behavior is judged by her mother-in-law and other members from her husband's side, and this issue is more prominent in case of home births. On the contrary, at the institution delivery takes place in a separate room, where, other than medical personnel who are female staff, only the ASHA, and female family members are present. In women's perception this provided them with the much needed privacy that they

"We are poor people, so if the government opens up free facilities, we will go. If there are facilities provide eating-drinking, medicines, and doctors are available. We go there." Woman who delivered at institution

"I just feel that the delivery should happen as soon as possible and my pain is reduced. That's all that I wanted." Woman who delivered at home

"At home I felt good when my mother and family members were there..." Woman who delivered at home

"I am scared that anybody can touch me and also feel that men will also be there during the delivery." Woman who delivered at institution

required at that time without her behavior being monitored. Though many suggested that they would generally prefer their family members to be present in the labor room, they were quite clear that they would specifically prefer their mothers to be with them.

Another aspect of delivery care that was very important to these women was the issue of **convenience** particularly related to cleaning the place after delivery, as well as the mother and newborn. After the birth at an institution, the child and the mother were cleaned by the TBA, who even helped to clean the labor room. This was perceived as a major advantage by women, because at home though the TBA cleans the delivery place but often, due to the Hindu concept of impurity associated with delivery, they have to put a new layer of mud in the surface of the floor, which they consider as a hassle. Also when there are fewer members in the household, particularly female members, the care and support can be provided by the staff at the institution.

Women's perceptions of "good" care

- Doctors were present and appropriate medical care (medicine) was available in case of complications
- Pain management was available through medicines and/injections before labor
- Immediate referral transport was available and affordable
- Family members were allowed to be present during delivery
- The convenience of having someone clean the place of delivery afterwards was valued
- Monetary incentives outweighed formal and informal expenses

"When my labor pain started it was midnight, there was no facility of vehicle and we did not have enough money to hire a vehicle." Woman who delivered at home

Availability of transport is one of the most important reasons for home deliveries particularly for deliveries that occur during the night. Despite health facilities in this study being geographically accessible, women reported they could not reach the institution due to non-availability of transport at the time of labor. Accessibility to the institution by provision of a readily

available vehicle is a one of the key issues for women in terms of defining what good care.

Expenditure is also one of the deciding factors for determining good care. The ASHA's influence of motivating women based on monetary incentives provided under the JSY scheme acts as a important factor for institutional delivery in this region. According to some respondents it was more expensive to deliver at home than at the institution, where certain costs, like buying medicines, paying doctor's fees, and some of the TBA costs are taken care of. However, women still have to spend quite a bit at the hospital, mainly in form of tips to nurses and TBAs, and sometimes for buying certain medicines/injections. Regardless of such expenses, women perceive institutional delivery to be monetarily more beneficial. Though there is a time lag between the birth of the child and when they get money from the JSY scheme, women reported they felt more secure to incur such expenses in the anticipation that it would be covered by the money they would receive from the JSY scheme. However, the issue of informal payment at facilities is deterring women to avail the services. The flexibility of payment to the TBA and also mode of payment are also deciding factors for women to choose home deliveries.

"I had to go to the hospital and spend 600 rupees for the doctor. So my sister's child was born at home, what else she would have done?" Woman who delivered at institution

4. DISCUSSION

Determinants of care related to maternal health services: Maternal satisfaction has emerged to be most significantly influenced by interpersonal behavior from the review of literature. This includes courtesy and respect, sympathy and encouragement during delivery. Promptness of care was also attached great value by women and waiting time was a significant determinant of maternal satisfaction. Women's satisfaction also depended greatly on whether they perceived care to be 'good'. Their perception was influenced by different aspects of care, such as length of consultation, perceived competency of the provider or perceived completeness of the procedures conducted on them during examination or delivery. Cognitive support through counseling, sharing information on condition and care, explaining procedures and consulting during care was also a major determinant of satisfaction, as it enhanced women's understanding and sense of participation in the delivery process. Emotional support, privacy and preference of female provider also emerged as significant determinants of satisfaction.

Among studies from India, access, structure, promptness of care, interpersonal behavior, perception regarding process of care, maintenance of privacy and cost of care were reported as determinants of maternal satisfaction. Cognitive support and emotional support were not reported as determinants in any of the Indian studies. Maternal/newborn outcome and maternal literacy were also observed to influence maternal perceptions of satisfaction.

The analysis based on the IDIs and FGDs reveals the determinants that often women consider during seeking care for maternal health services and particularly during delivery also follows the factors that were identified from the review.

Key determinants of maternal satisfaction		
Quality of Care Framework	Determinants identified from Literature Review	Determinants identified from Qualitative research
Access	Distance & transport connectivity	Accessibility to institution
Structure	Cleanliness, clean toilets, hygiene, housekeeping services	Women appreciate cleanliness and the convenience of having someone clean the place of delivery afterwards was valued
	-	Human resources: Availability of trained medical personnel
	Medicines, supplies & services: Availability of drugs and equipment	Availability of medicine in case of complication and pain management
Process of care	Promptness of care: waiting time	-
	Interpersonal behavior: respectful behavior	Interpersonal behavior of the providers
	Privacy & confidentiality	Delivery in a secluded place and absence of male members
	Perception of 'good' care: Length of consultation; completeness of procedures; perception of negligent care; perceived provider competence	-
	Cognitive support: Prenatal counseling	-
	Emotional support: Birth companion of choice	Family members present during delivery
	Preference for female providers	-
Cost	Financial cost of care	The cost of the services.
Outcome	-	-
Other determinants	Socio-cultural determinants: Literacy	-
	-	Influence of community health workers in deciding the place of delivery

Accessibility to institutions in terms of ready availability of transport is a key determinant. Despite geographical accessibility of institutions, women could not reach the institution due to non-availability of transport at the time of labor. Emotional support in the form of the presence of known people like parents, in-laws or the ASHA was a comforting factor to women. Similarly for home births, in which the TBA is a comforting presence in most cases. also, the emotional and comforting factor from the provider is one of the key determinants.

In terms of interpersonal behavior of providers few women as well as community health workers reported instances of rude behavior by the staff. This factor has a strong bearing on women's satisfaction of services and in long run can play a key role in influencing their and other community women's decision to avail the service.

Availability of medicine is considered good care by women. There is a popular misconception that if medicines/injections are given, then the delivery will happen quickly so women and their family members often insist on this. They consider the health service to be good and believe the provider is more capable of providing good care based on medicines that they provide. So sometime if the provider doesn't feel the need to administer pain relieving medicine, the patient/ family members often demands them , which leads to unpleasant situations with the institution staff. The factor of non-availability of medicine and injections is also one of the reason women feel that it is not safe to have home births in case of complication. They know that the TBA doesn't have any medicine neither she can give injection to induce labor.

The decision of women for institutional delivery is highly influenced by the community health worker, ASHA. One reason for this could be attributed to the fact that given the socio-economic condition of respondents in this study, these women have limited exposure and knowledge about the available health facilities hence they rely totally on the advice of the health worker. An ASHA's assurance of good care in the institution, combined with the JSY incentive, are significant factors for choosing institutional delivery.

Cost of care in terms of formal and informal payment is one of the key determinants. The birth of a child is a moment of happiness for the family, and according to the traditional customs, the family distributes sweets to friends and relatives to share the happiness. This custom has paved the route to lot of informal expenditures for the family as often they have to pay tips to the providers at the institution. Instead of free service which she is entitled for she is sometime paying in terms of informal payments and purchase of medicine. The factor can be one of the key reasons which can deter women for further using the service.

Factors like cleanliness particularly having a clean place after delivery recognized by the respondent as key elements of care.

The determinants of care that emerged from the present study further supplements the factors that have emerged from literature of developing countries. Factors like emotional support,

interpersonal behavior, accessibility to institution, assurance of medicine and supplies have come across as trigger for choice of place of delivery.

Maternal Service utilization: From the analysis it is noted that the level of women's satisfaction varies largely at different stages of pregnancy and childbirth. This brings forth the issues and challenges faced by women in availing of maternal health services. Hence, for a nuanced understanding it becomes pertinent to identify the specific challenges at different stages.

ANC: Though most of the women who had institutional delivery got ANC care provided by the ASHA, it was comparably less for women who had home births. In many cases women themselves took initiative to go to the AWC to get the injections and iron and folic acid tablets. According to traditional practices, usually women go to their natal home at the seventh or eighth month of pregnancy and often deliver the child there and in the present study we found only few women followed this practice.. This is most common for the delivery of a woman's first child. In these cases while in the first few months the ASHA visited her for ANC but after she went to her natal home, the ASHAs of that place did not provide any ANC to women, and justified it by saying that the woman did not belong to her jurisdiction. Therefore, women ended up having home births in such situations. This highlights the level of rigidity with which ASHAs work in this area and it needs to be addressed and provision should be made so that ASHAs from one locality have the authority to refer these cases to local ASHAs, who should be made obliged to take up the responsibility.

No instance of systemic provision of birth preparedness was noted during the qualitative survey. Though women stated that ASHAs encouraged them to have institutional delivery none reported of ASHAs counseling them about birth plans, identification of danger signs or arrangement of transport during emergencies. When ASHAs were asked how they prepared women for the birth, they were not sure about their role in this respect and only replied that they always try to motivate and encourage women to choose institutional deliveries. Absence of birth preparedness during pregnancy is a major issue in this region that hinders women from both availing institutional delivery when they want one or reducing the risks associated with home deliveries if that is their choice. Many women reported that by the time they realized that their labor had reached a critical stage, it was too late for them to inform the ASHA and arrange for a vehicle to go to the institution, and they delivered the baby at home. Some even said that once their labor pain started they went to the institution but the doctor said it was false labor and they returned back. However, later when the labor pain started again it was too late for them to return. Given the socio-economic condition

of these people it is not always feasible for them to arrange transport to go to the institution, and more so if they have done it already once, it becomes very difficult the second time. This can be handled if ASHAs counsel women on these issues including how to monitor the strength and duration of contractions to understand whether it is real labor or not.

Delivery Process: One of the main reasons why women could not deliver at the institution was non-availability of transport at the time labor pain started. Institutional delivery was more in areas that were near to the institution as it could be accessed easily, even by rickshaws. But in some cases the institution was located almost 25kms from the village and given the poor condition of roads it was very difficult to take women there for delivery. Despite the introduction of referral transport like Mamata Vahan in Jharkhand, the vehicle was not available at proper time to provide prompt service.

Among women who had institutional deliveries, many were not very comfortable with the presence of male staff in the labor room and some were not satisfied with behavior of the staff both at time of delivery and after delivery. There are instances of abusive behavior of the nurses to women if they would not deliver promptly or cried of labor pain. Women reported that nurses asked for large tips from the family members before handing over the baby to them. The amount of tips varied according to gender of the child, being more for a boy child. If tips were not given, they refused services, including cleaning of the baby and providing local anesthesia to women before stitching. There needs to be a change in the attitude of staff to provide a safe environment for women and their family members. Apart from this, few women, who had institutional delivery also complained that they did not have full knowledge about the medicines /injections that were given to them before and after delivery.

From the socio-economic condition of the respondents it was evident that they lack knowledge as well as awareness about benefits of institutional deliveries, apart from JSY scheme. On the contrary many of them have certain negative views about institutional delivery. Their source of information was limited to women in the neighborhood who had institutional delivery and many of whom were not satisfied with the experience. The negative experiences were mainly rude and abusive behavior of the staff at the institution. Some women also developed specific pre-conceived notions about the institution which instilled an element of fear in them and hindered availing of the services at the institution. Few others were also scared about the clinical processes at the institution and thought since childbirth is a natural process it does not require any clinical attention unless there was some complications. Moreover, the known environment of the house and the presence of family members

provided a sense of comfort and security to women when they had home births. All these factors hindered women from availing institutional delivery. This clearly indicates that absence of awareness among women is a big challenge for utilization of maternal health services.

PNC: Although in most of the cases the ASHA was instrumental in providing ANC, but their assistance during PNC was limited particularly for those who had home births. It was noted that PNC care was generally provided by the TBA rather than the ASHA in cases of both institutional and home births. Though in cases of institutional delivery, the ASHA was more likely to visit the mother and newborn for PNC at least twice or thrice in the next few days after birth, but for home deliveries she did not visit them at all. Even during her visits ASHA advised women only about healthy eating habits and breastfeeding the child. Except in a few cases, she did not advise them about when and where to get their children vaccinated. Hence, there exists a major gap in the continuum of ANC and PNC provided by ASHAs. Perhaps two reasons can help us to evaluate this situation better. First, as per traditional practices, for the first few days mother and newborn are taken care of by women of specific caste, TBAs, who is also the prime counselor for those days. The presence of the TBA is inevitable even if ASHA pays regular visits. This might deter the ASHAs to provide PNC as she might feel her role is already being taken up by TBAs. Second, ASHAs are ensured to get money from JSY scheme when they take the women to the institution for delivery and after that they do not have any accountability to any authority regarding PNC. This might be another reason why they are not very regular during PNC. This is a great challenge which requires proper attention, as PNC is equally important as ANC.

5. CONCLUSION

Seven key factors that influence women's decisions whether to have institutional or home births are interpersonal behaviors of the providers, influence of community health workers in deciding the place of delivery, accessibility of the institution, emotional support during delivery, belief in clinical care in terms of presence of skilled staff, availability of medicine and lastly the cost of the services. The results of the qualitative data provided some insight into women's perceptions about the care which she values most in deciding the place of delivery. The quality of service provision can be geared in the direction where her needs can be fulfilled as with ASHAs playing a key role in promoting health-seeking behaviors, women are aware of risks of pregnancy and are more likely to

seek institution-based deliveries. Women want to be treated humanely during delivery – interpersonal behaviors, such as treating individuals with dignity and respect, and providing emotional support, can influence the demand for services. Publicly available, accessible and affordable transport is a major factor in ensuring that women choose to go to facilities for delivery. Availability of manpower and provision of medicine during delivery care needs to be addressed. Costs and cash incentives do matter, and women are careful to calculate formal and informal costs in making their choices about place of delivery. Understanding women’s perception of quality and addressing them in institution based quality assurance program can not only bridge the demand and supply perspective but also can increase institutional deliveries by providing safe, affordable and respectful care.

Recommendations supported by these findings will be included in a final project report that incorporates the results of the study’s community survey.

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Appendix I

Informed Consent Sheet and Information on the Study processes

Background and Purpose

We are doing research to explore issues around women's perception of quality and satisfaction with antenatal, intrapartum and postpartum care. We request you to consider participating in this study because we feel that you will be able to provide us with information that will help us in understanding and improving quality of care for maternal health services.

What will happen during the study

If you agree to participate, we will be asking you some questions on events pertaining to care received during and after the delivery. The interview process will take about 45 minutes to 1 hour.

Confidentiality

All your responses in this interview will be kept confidential. Your name or identity will not be linked in any way to the research data. While information from this study will be used for research purposes and may be published, your name will not be used in any publications.

Subject's Rights

By consenting to participate in this study, you are acknowledging that you have heard or read the information provided on the study, and you agree to participate. You do not waive off any of your legal rights. You will be given a copy of this sheet to keep. In case you have any questions, you are free to contact the researchers. We will be happy to answer them.

Contact details: Name _____ Phone _____

You have the right to refuse to take part in this study. Your participation is entirely voluntary, and you can choose to opt out at any point if and when you do not wish to further comment or participate.

Potential Benefits

Your participation is expected to help the researchers investigate and understand quality of care received during and after delivery. There are no direct benefits from your participation in the study. There are no costs to you for participating in this research study.

Name and Signature of Participant:

Signature of parents/ in- laws (In case women is of 15- 18 age group)

Name and Signature of Researcher:

STUDY INSTRUMENT

In- Depth Interview Guide

In- depth Interview with Women who had institutional delivery

Introduction

NOTE TO INTERVIEWER: Do not read the items in italics and in bracket, it is only for probing. This guide is designed for 30-40 minute in-depth interview with women who have delivered in last 3 months at institution.

- Welcome the woman
- Introduce yourself
- Introduce the verbal consent
- Permission for recording the interview

Demographic and Delivery information

1. How old are you? (Record in full years)? _____
2. What is your highest completed education/degree? _____ [a)Illiterate, b)Primary school (till 8 standard), c)Secondary school (till 12 standard), d)Graduate and above]
3. Religion: _____ [a) Hindu, b) Muslim, c)Christian, d)other]
4. Caste: _____ [a) General, b) SC, c) ST, d) OBC]
5. Whether have BPL card : _____ [(a)Yes, b)No]
6. Occupation of the head of the household _____
7. How many children do you have? _____
8. Age of your last child _____ [Record in months]
9. Where did you receive antenatal care _____ (a)Subcenter, (b)PHC/ APHC, (c)CHC (d)District Hospital (e) private institution (describe type), (f) other, (g) none
10. Where did you deliver _____(a)Sub center, (b)PHC/ APHC
11. Where did you receive postnatal care _____(a)subcenter, (b)PHC/ APHC, (c)CHC (d)District hospital (e) private institution (describe type), (f) other, (g) none
12. Did you intend to deliver at that place only or somewhere else? If no, then please explain.

Key Questions

1. After you found that you are pregnant what did you do? Did the ASHA contact you and how many times she visited you? What advice did she give (*counseling on food, advise you to go to a particular institution, transport arrangement*)? Information about ANC from other sources

(family, friend, community). Did you go for any check up and where (institution, camps on VHND day)? During the check up was the place secluded or crowded? Did you understand the information that the staff gave you? Cost for ANC (transport, buying any medicine). Was the advice useful and were you able to practice? Did this advice and practice helped you in prepare you for the delivery? (sense of less fear, familiarizing with the institution)

2. What advice ASHA gave you for delivering at the institution and how did she prepared you?
3. Tell us why you chose to deliver at the institution *(based on personal experience, experience of other women, family decision, motivated by community health worker, awareness of MJSSA-JSY scheme or because of a health complication)?*
4. How far is your home from the institution and time taken to reach the institution *(who arranged the transport, was it readily available, who paid, who accompanied you)?*
5. Were you attended immediately upon arriving at the institution for delivery? *(waiting time for registration, time taken to the delivery room after onset of labor. Did any staff ask for your health history before the delivery?)*
6. In case of any complications what the staff do? *(Did the staff responded immediately in case of emergency, did the staff arranged referral)*
7. Tell us about your impression of the institution, how the institution looked *(Clean & well constructed institution, clean delivery table in the labor room, clean sheet in the bed, Separate and clean bed in PNC ward, Toilets and washing facilities available and clean, Adequate running water, Maintenance of wall/ floors, Waiting area for family members)*
8. When you went for your delivery were the MO and ANM present? Who attended to you and who conducted your delivery? *(Probe for other supporting staff like TBA, cleaner presence, presence of delivery staff at night)*
9. Tell us something of the delivery process *(probe : Who were present in the delivery room, was the staff attended you constantly or you are left alone? Were you given any medicine or injection, Did the staff provided some physical comfort and help you in pain management during labor, Did the staff tell you about your progression of labor and if there were any complications? Did any staff use abusive language before, during or after labor? Was the place secluded? Was any procedure followed that you felt uncomfortable about? Was the delivery position comfortable to*

you, if not, did you suggest how you wanted to deliver and did they listen? Did you know who took out the placenta and who immediately took care of your baby?)

10. How long did you stayed at the institution and what happened during this period (*probe: Did the staff immediately wrap the baby? Was there any complication for the newborn, if so what did staff do? What information did the staff give you about your and the baby's health and did you find it easy to understand? Did staff explain how to manage any pain or discomfort you felt after delivery? Facility for family members accompanying you*)
11. Did you have to pay for any tests, buy medicine from outside or pay for emergency transport to a second institution during your delivery or immediately after delivery? Did you pay any tips for services or did any staff refuse care if not provided money?
12. During your stay in institution were you provided food and drinking water or did you have to pay for food and water or bring it from home? (*If you availed of any food and drink provided by the institution were they affordable, expensive?*)
13. What did you like best in the institution? Please explain and why. If there was any bad experience, then what was it? What did you value the most in your experience?
14. Where did you deliver last time? As compared to it are you satisfied with this delivery, explain?
15. PNC care by ASHA at home (*No of visits by ASHA, counseling on food, care for mother and newborn*) Did you understand the information that the ASHA gave? Was the advice useful and were you able to practice? Was there any complication with your baby, if so did ASHA identified and what she did?
16. Did you received the JSY money? Was the money a deciding factor for you to delivery at the institution (*good amount or insignificant*). How did you utilize the money?
17. Would you return to the institution for your next delivery? Why/why not? Would you refer or encourage your friends, relatives to come to the institution?
18. Can you suggest specific ways that services for antenatal care, delivery and postnatal care can be improved?

Thank the women for participation

Ask if there is something that she would like to add or if she has any questions?

In- depth Interview with Women who had Home Delivery

Introduction

NOTE TO INTERVIEWER: Do not read the items in italics and in bracket, it is only for probing. This guide is designed for 30-40 minute in-depth interview with women who have delivered in last 3 months at home.

- Welcome the woman
- Introduce yourself
- Introduce the verbal consent
- Permission for recording the interview

Demographic and Delivery information

1. How old are you? (Record in full years)? _____
2. What is your highest completed education/degree? _____ [a)Illiterate, b)Primary school (till 8 standard), c)Secondary school (till 12 standard), d)Graduate and above]
3. Religion: _____ [a) Hindu, b) Muslim, c)Christian, d)others]
4. Caste: _____ [a) General, b) SC, c) ST, d) OBC]
5. Whether have BPL card : _____ [(a)yes, b)No]
6. How many children do you have? _____
7. Age of your last child _____ [Record in months]
8. Where did you receive antenatal care _____ (a)Subcenter, (b)PHC/ APHC, (c)CHC (d)District Hospital (e) private institution (describe type), (f) other, (g) none
- 9) Where did you receive postnatal care _____(a)Subcenter, (b)PHC/ APHC, (c)CHC (d)District hospital (e) private institution (describe type), (f) other, (g) none
10. Did you intend to deliver at home only or any other place? Please tell us about it.

Key Questions

1. After you found that you are pregnant what did you do? Did the ASHA / TBA contact you and how many times she visited you? What advice did she give (*counseling on food, advise you to go to a particular institution, transport arrangement*)? Information about ANC from other sources (*family, friend, community*). Did you go for any check up and where (*institution, camps on VHND*)



day)? During the check up was the place secluded or crowded? Did you understand the information that the staff gave you? Cost for ANC (*transport, buying any medicine*). Was the advice useful and were you able to practice? Did this advice and practice helped you in prepare you for the delivery?

2. Did ASHA advised you about delivering at the institution?
3. Tell us why you chose to deliver at home and that too with the JSY scheme why? (*based on personal experience, experience of other women, family decision, motivated by TBA or because of a health complication*)?
4. Tell us why you did not go to the institution for delivery? [*Probe: How far is the institution is it accessible by public transport? Was the institution not functional- no staff? Please cite reason*]
5. Who did the delivery at home? (TBA, ANM or a doctor). Providers with known credentials and expertise in your community? Did she conducted deliveries of any other members of your family?
6. Were you attended immediately upon onset of labor? if there is delay, the reason? [*Probe: whether the TBA belongs to your village or she is from different place, TBA availability during delivery at night/ emergency*]
7. In case of any complications what the TBA did? (*Did the TBA responded immediately in case of emergency, did she arranged referral*)
8. Tell us how clean and comfortable was your delivery place at home [*Probe : Proper and clean delivery place at home, Toilets and washing facilities available and clean, Adequate running water, Cleanliness maintained by TBA as per family's expected hygiene level*]
9. Tell us something of the delivery process (*probe : Who were present in the delivery room, was the TBA attended you constantly or you are left alone? Were you given any medicine or injection, Did she brought new blade/ threads? Did she boil the blade / thread? Did she provide some physical comfort and help you in pain management during labor? Did the TBA tell you about your progression of labor and if there were any complications? Did she use abusive language before, during or after labor? Was the place secluded? Was any procedure followed that you felt uncomfortable about? Was the delivery position comfortable to you, if not, did you suggest how you wanted to deliver and did they listen?)*

10. What happened after the delivery (*probe: Did the TBA immediately wrap the baby? Was there any complication for the newborn, if so what did staff do? How many times she visited you after delivery and what information did the TBA give you about your and the baby's health and did you find it easy to understand? Did TBA explain how to manage any pain or discomfort you felt after delivery?, Was there any complication with your baby, if so did TBA identified and what she did?*)
11. Did you have to pay for any tests, buy medicine from outside or pay for emergency transport to during your delivery or immediately after delivery, How much did you pay the TBA?
12. What did you like best about delivering at home? Please explain and why. If there was any bad experience, then what was it? What did you value the most in your experience?
13. Where did you deliver last time? As compared to it are you satisfied with this delivery, explain?
14. Did ASHA visited you during PNC period at home (*No of visits by ASHA, counseling on food, care for mother and newborn*) Did you understand the information that the ASHA gave? Was the advice useful and were you able to practice? Was there any complication with your baby, if so did ASHA identified and what she did??
15. Would you go to an institution for your next delivery or would you plan to deliver at home? Why?
16. Can you suggest specific ways that services for antenatal care, delivery and postnatal care can be improved?

Thank the women for participation

Ask if there is something that she would like to add or if she has any questions?

In- depth Interview with Service Provider

In- depth Interview with ASHA

Demographic information

1. What is your highest completed education/degree? _____ [a)Illiterate, b)Primary school (till 8 standard), c)Secondary school (till 12 standard), d)Graduate and above]
3. Religion: _____ [a) Hindu, b) Muslim, c)Christian, d)others]
4. Caste: _____ [a) General, b) SC, c) ST, d) OBC]
5. How long have you been working as ASHA _____(in total years)
1. What factors do you think women consider in deciding place of delivery? [*Probe: Did they choose to go to a institution based on personal experience, experience of other women, family decision, motivated by community health worker, awareness of MJSSA-JSY scheme) or because of a health complication?*]
2. When women contact you when she is pregnant? What you do during her ANC check up? How do you mostly communicate information about her health condition, after ANC examination? Do you also talk to the family members? How do you prepare the woman & her family for delivery? How do you counsel the woman/family to deliver at the institution
3. Please tell us if the health facilities are accessible to women for delivery, in terms of distance to the institution, time taken to reach the institution and availability of public transport,. Whether remoteness of some areas is a reason for home deliveries?[*Probes: How do women get to the institution? Do they have to pay for transport to get to the institution for delivery? Is there the availability of transport even at night if there is emergency?*].
4. Generally how long does it take for a woman to be admitted for delivery?
5. Who conduct deliveries at the institution? Is there any shortage of staff, if so at what level? Are staff conducting deliveries available during night also?
6. Do you accompany the woman in the labor room? What do you do there? How do you comfort the woman in labor? How long do you stay in the institution with the woman after delivery and what you do?
7. After the woman comes home what do you do? [*no. of visits; information shared*] In case of complication with the newborn what do you do?
8. On an average how much does a woman spend during her whole delivery process [buying medicine, transport to the institution, if any, conducting tests in private clinics, if any]?
9. While providing care for mother and newborn how do you try to make the whole delivery process a satisfactory experience for the woman? **Please cite examples.**
10. While providing care for pregnant women what is the most important thing that you consider [*Probe: clinical care, promptness care, providing the women comfort, provide emotional support,*



provide good information, treat all women same irrespective of her background, help during emergency like arranging transport, medicine]

11. In your experience what do women value most and feel they are satisfied with in terms of the care provided?

In- depth Interview with ANM

Demographic information

1. What is your highest completed education/degree? _____ [a)Illiterate, b)Primary school (till 8 standard), c)Secondary school (till 12 standard), d)Graduate and above]
3. Religion: _____ [a) Hindu, b) Muslim, c)Christian, d)others]
4. Caste: _____ [a) General, b) SC, c) ST, d) OBC]
- 5 How long you are working in this role _____(in total years)

1. What factors do you think women consider in deciding place of delivery? [*Probe: Did they choose to go to a institution based on personal experience, experience of other women, family decision, motivated by community health worker, awareness of MJSSA-JSY scheme or because of a health complication?*]
2. Please tell us if the health facilities are accessible to women for delivery, in terms of distance to the institution, time taken to reach the institution and availability of public transport,. Whether remoteness of some areas is a reason for home deliveries?[*Probes: How do women get to the institution? Do they have to pay for transport to get to the institution for ANC? For delivery? For PNC? Is there the availability of transport even at night if there is emergency?*].
3. Tell us issues regarding infrastructure of the health facilities, challenges in providing good maternal health care [*Probe : Issue of sufficient delivery tables, cleanliness in ward and labor room, equipments, ambulance, Toilets, washing facilities, running water, Waiting area for family members]*
4. Tell us whether in your institution there is shortage of staff, if so at what level? Are staff conducting deliveries available during night also?
5. Whether availability of medicine is an issue in your institution? If not available in the institution, from where do women/ family members purchase, do you facilitate the process, if so- how? Is drinking water/food available in institution for patients?
6. Generally how long does it take for a woman to be admitted for delivery? Are you able to immediately respond to emergency cases? Does staff continuously monitor women in labor room? Do you follow any procedures for pain management during delivery? What procedure you follow for newborn and incase of any emergency for newborn how do you handle?
7. During check up for ANC and particularly during delivery how do you ensure that there is privacy?

8. In order to make the women comfortable during delivery what do you do? [Probe: whether the woman is comforted verbally; presence of family member during delivery; offering seat & making women comfortable during examination]
9. How do you mostly communicate information about her health condition, after examination [Probe: progress of labor; complication; need for episiotomy, assisted delivery or C-section; adverse outcome]? Do you also talk to the family members about her condition? Do you get enough time to spend with the mother? Do you communicate in local dialect?
10. How do you comfort a woman in labor? Do you ensure a comfortable position for delivery? Generally who handles placenta and provides immediate care for the baby? How do you counsel the mother on postnatal care? How often is a woman's condition monitored post-delivery within 48 hrs / during her stay in institution/ home? Do you generally record the health and delivery history of all women who come for delivery to the institution?
11. On an average, how many women have complicated/ assisted delivery (need for c- section, use of forceps etc) in a month? What complications can be managed in your institution and what type of complications require referrals to other facilities? What is the average number of maternal and newborn deaths and still births in your institution in a year?
12. On an average how much money does a woman spend during her whole delivery process [buying medicine, transport to the institution, if any, conducting tests in private clinics, if any]?
13. While providing care for mother and newborn how do you try to make the whole delivery process a satisfactory experience for the women? Please cite examples.
14. While providing care for pregnant women what is the most important thing that you consider [Probe: clinical care, promptness care, providing the women comfort, provide emotional support, provide good information, treat all women same irrespective of her background, help during emergency like arranging transport, medicine]
15. In your experience what do women value most and feel they are satisfied with in terms of the care provided?
16. If a woman is satisfied or dissatisfied with service provided is there any way for them to register their opinions? If not, do you think patient opinions need to be recorded and, if so, how?

In- depth Interview with TBA

Demographic information

1. What is your highest completed education/degree? _____ [a)Illiterate, b)Primary school (till 8 standard), c)Secondary school (till 12 standard), d)Graduate and above]
3. Religion: _____ [a) Hindu, b) Muslim, c)Christian, d)others]
4. Caste: _____ [a) General, b) SC, c) ST, d) OBC]
5. How long you are working in this role _____(in total years)
1. What factors do you think women consider in deciding place of delivery? [*Probe: based on personal experience, experience of other women, family decision, motivated by community health worker, awareness of MJSSA-JSY scheme or because of a health complication?*]
2. When women contact you when she is pregnant? What you do during her ANC check up? How do you mostly communicate information about her health condition, after ANC examination? Do you also talk to the family members? How do you prepare the woman and her family for delivery?
3. When do you arrive when she is in labor and what you do (probe: preparing the place for delivery, do you carry delivery kit? Do you follow any procedures for pain management during delivery). How do you ensure a comfortable position for delivery?
4. In case of complication what do you do (arrange for referral, contacting ASHA/ ANM)
5. In order to make the women comfortable during delivery what do you do? [*Probe: whether the woman is comforted verbally; presence of family member during delivery*]
6. How do you mostly communicate information about her health condition? Do you also talk to the family members about her condition? Do you get enough time to spend with the mother? Do you communicate in local dialect that she understand?
7. How do you counsel the mother on postnatal care? How often is a woman's condition monitored post-delivery within 48 hrs ?[*no. of visits; information shared*] In case of complication with the newborn what do you do?
8. On an average, how many women delivery you attend in a month? What is the average number of maternal and newborn deaths and still births in a year?
9. On an average how much money does a woman spend during her whole delivery process [buying medicine, transport to the institution, if any, conducting tests in private clinics, if any] ?
10. While providing care for mother and newborn how do you try to make the whole delivery process a satisfactory experience for the women? Please cite examples.
11. While providing care for pregnant women what is the most important thing that you consider [*Probe: clinical care, promptness care, providing the women comfort, provide emotional support, provide good*]



information, treat all women same irrespective of her background, help during emergency like arranging transport, medicine]

12. In your experience what do women value most and feel they are satisfied with in terms of the care provided?

STUDY INSTRUMENT

Focus Group Discussion Guide

Focus Group Discussion with Women who had Institutional Delivery

NOTE TO THE GROUP FACILITATOR:

- *Please establish a comfortable environment for the FGD and welcome the participants.*
- *Explain the purpose of the study*
- *Obtain verbal consent and permission for recording the interview*
- *Fill the table -profile of the respondents (it can also be done at the end of the FGD)*

1. **ANC care**

- *Generally which health worker women inform first (apart from family) when they are pregnant?*
- *Apart from ASHA, information about ANC from other sources (family, community, other health workers, eg., ANM, TBA ,AWW).*
- *Where women go for their ANC check up (home, facility- private, public; AWC)? What information they provide?*
- *Was the advice useful and all can understand and learn something new*
- *During the check up whether the place secluded or crowded?*
- *Cost for ANC (transport, buying any medicine).*

2. *What aspects of ANC care were most important (probe: counseling, conducting test providing medicine, others)*

3. **Birth preparedness:**

- *During ANC what advice did the ASHA gave for delivering at the institution and what help did she offer (probe : how to identify complications, saving money for obstetric emergencies and transportation, arranging a blood donor, arranging an escort to go to the institution with her, and, advise for clean delivery at home)?*
- *During the onset of labor did ASHA respond immediately by arranging the transport? Or does the family arrange the transport?*
- *What was the most important advice you all received from the ASHA before delivery? What was the most important advice you received from the ANM or the AWW before you delivered, if anything? Was your family able to provide you with good advice about preparing for birth? If so, what was it?*

4. *Do women deliver at in-laws place or natal place in this area? If they deliver at natal place, does the ASHA visit them? (explain in detail).*

5. *Tell us why women chose to deliver at the institution (based on previous experience, experience of other women, family decision, motivated by ASHA, awareness of MJSSA-JSY scheme or because of a health complication)? If there is more than one answer, ask her to rank what was most important.*

6. How far is the institution and how much time did it take to reach the institution
 - What type of transport one avails?
 - Who mostly arranges the transport? And whether it is readily available? Did the driver know how to find your house and where to take?
 - Who pays for transport (ASHA/ Self)?
 - Who mostly accompanies the women?
 - Did you all were aware what institution you were going to go to before you went?
7. **Delivery Care**
 - Process of care received after reaching the institution:
 - Availability of MO and ANM
 - Attended immediately upon arriving at the institution for delivery
 - Presence of supporting staff, such as the TBA, cleaner
 - Availability of staff during night
 - In case of any complications what did the staff do? (*probe: referral process, how and where?*)
 - Were you frightened any time during your visit to the institution? If so, what frightened you?
 - Did anything the staff did make you feel uncomfortable?
8. Tell us something of the delivery process :
 - Who were mostly present in the delivery room apart from the staff and was it comfortable having others in the delivery room?
 - Were you given any medicine or injection or saline and did the staff explain why it was given?
 - Did the staff/ASHA/family members provide some physical comfort, like massage and help you cope with the pain during labor?
 - Did any staff use abusive language before, during or after labor?
 - Was the place secluded (*presence of other people apart from staff, family members, provision of curtain in the delivery room*)?
 - During delivery what aspects of care were most important (*probe: availability of staff, medicine, presence of family members, support to cope labor pain, others*)?
9. How long did you stay at the institution and what happened during this period:
 - Was there any complication for mother or the newborn, if so what did staff do?
 - What information did the staff give about mother's and the baby's health and it was it easy to understand (*probe: immunization, breastfeeding, thermal care (no bathing in the first 24 hours, keeping the newborn warm), Were you told your baby's weight or whether it was normal, low or high*)?
 - Did any of you ask the staff any questions about your delivery? If so, did they answer you in a respectful manner and in a way you could understand?
 - Were any of you given any injection after delivery? Did staff explain how to manage any pain or discomfort you felt after delivery?
 - Did anyone tell you about problems you could have after delivery and what to do about them?
10. Expenditure incurred during ANC- delivery and PNC care (*probe :conducting tests, medicine (injections, saline), transport, informal payment*)
 - Did any staff threaten to refuse care if not provided money?
 - Were any such payments difficult for you?

11. During your stay in institution were you provided food and drinking water or did you have to pay for food and water or bring it from home?
12. Have you been to the institution before you went for delivery? (for any answer ask when she first visited the institution, what was her expectations of the place, and whether those expectations were met).
13. Tell us about your impression of the institution, how the institution looked inside and outside
 - Building- overall cleanliness, built
 - Was there a place to sit and wait until you went to the labor room? Was there a clean delivery table in the labor room? Was there a clean sheet in the bed, clean beds
 - Were toilets and washing facilities available, working and clean? Was there running water?
14. What did you value the most in your experience about care received at the institution? Was there any bad experience?
15. If this was not the first delivery, where did you deliver last time? As compared to it are you satisfied with this delivery, explain?
16. **PNC care** by ASHA at home (*No of visits by ASHA, counseling on food, care for mother and newborn*).
 - Were the information useful, one could understand and able to practice?
 - In this group was there any complication with your baby and what type, who identified the complication and help provided by SHAHIYA/ ANM
 - PNC care by other health workers (e.g., TBA) (*No of visits, counseling on food, care for mother and newborn*).
 - Compare her service with that of ASHA (Who was more helpful, informative? Or both were helpful or neither was helpful?)
 - What aspects of PNC care were most important and why (*probe: counseling, referral for any complication, immunization for newborn, other*)
17. Did all in this group get the JSY money? was there any difficulty?
 - Was the money the most factor to delivery at the institution(*or was just somewhat important or not important at all?*)
18. *Would you return to the institution for your next delivery?* (reason for either answer)
 - Difficulties at home
 - Advantages of hospital
 - Would you refer or encourage your friends, relatives to come to the institution(reason for any answer)?
 - In your opinion, do some mothers in your community miss out on accessing JSY (delivering in a institution)? Who and Why?
19. Can you suggest specific ways that services for antenatal care, delivery and postnatal care can be improved? Improvement regarding role of ASHA, nurse or any other provider.

Focus Group Discussion with Women who had Delivery at Home

NOTE TO THE GROUP FACILITATOR:

- Please establish a comfortable environment for the FGD and welcome the participants.
- Explain the purpose of the study
- Obtain verbal consent and permission for recording the interview
- Fill the table about profile of the respondents (it can also be done at the end of the FGD)

1. ANC care :

- Generally which health worker women inform first (apart from family) when they are pregnant?
- Apart from ASHA, information about ANC from other sources (*family, community, other health workers, eg., ANM, TBA, AWW*).
- Where women go for their ANC check up (*facility- private, public; AWC*)? What information they provide?
- Was the advice useful and all can understand and learn something new
- During the check up was the place secluded or crowded?
- Cost for ANC (*transport, buying any medicine*).

ANC care by TBA : Do women also inform TBA if so what she does during this period? (*probe: number of visits, advice*)

What aspects of ANC care were most important (*probe: counseling, conducting test providing medicine, others*)

2. Birth preparedness:

- During ANC what advice did the ASHA give provides for delivering at the institution and what help did she offer you to prepare for birth (*probe : how to identify complications, saving money for obstetric emergencies and transportation, arranging a blood donor, arranging an escort to go to the institution with her, and, advise for clean delivery at home*)?
 - What was the most important advice you received from the ASHA before you delivered? What was the most important advice you received from the ANM or the AWW before you delivered, if anything? Was your family able to provide you with good advice about preparing for birth? If so, what was it?
3. Do women deliver at in-laws place or natal place in this area? If they deliver at natal place, do the ASHA visit (explain in detail).
 4. Tell us why you all did not go to the institution for delivery and that too with the JSY scheme? (Detailed probe and add more reasons)

- Is the institution far?
 - Unavailability of transport
 - Negative feedback from other women- staff behavior, institution not functional, had no staff
 - Personal inhibition of going to the hospital
 - Informal payment to the staffs
 - Cultural practice (other women in your family delivered at home)
 - Faith with the TBA (If there is more than one answer, ask her to rank what was most important to her)
5. When labor pain started mostly who was informed first (ASHA, TBA, Doctor)
- How soon they arrived? If there was delay, the reason?
 - Was the TBA available at night?
6. **Delivery Care:** Who did the delivery at home? TBA, /private doctor/ or both). Explain the process in details
- Who were mostly present in the delivery room,
 - Were any of you given any medicine or injection (who gave it)?
 - Did the TBA/ Dr. bring new blade/ threads? Did she sterilize the blade / thread?
 - Did she provide some physical comfort and help you cope with the pain during labor, like massage?
 - Did she use abusive language before, during or after labor or did anything that make you feel uncomfortable?
 - Were you satisfied with the care you received? Were you frightened any time during your delivery at home? If so, what frightened you?
7. What happened after the delivery:
- Did the TBA/Dr immediately wrap the baby?
 - In this group did any of you or the newborn had any complication? What were the complications and what did the TBA/SBA/Dr. do?
 - How many times she visited you after delivery and what information did the TBA give you about your and the baby's health (*probe : bathing, keeping the baby warm, breastfeeding?*) Did TBA explain how to manage any pain or discomfort you felt after delivery?
 - What was the most important advice you received about your health after delivery? About your newborn's health? Who gave you that advice?
8. Tell us how clean and comfortable was the delivery place at home
- What did the TBA/Dr and family members do to clean the place before and after delivery
 - After delivery did any of you feel the place was a mess, did you feel uncomfortable about the blood/ fluids in the house?
9. Generally how much one had to pay for medicine or anything else during your delivery or immediately after delivery
- Average payment to the TBA and other people and how it is paid (cash/kind)?

- Was the payment process convenient as per the family's economic condition?

10. PNC care

- TBA (number of days, information she shared about PNC)
- ASHA (No of visits, type of information shared)
- Were the information useful, one could understand and able to practice?
In this group was there any complication with your baby and what type, who identified the complication and help provided by SHAHIYA/ ANM

What aspects of PNC care were most important and why (*probe: counseling, referral for any complication, immunization for newborn, other*)

11. As compared to last delivery, are you all satisfied with this delivery, explain?
12. In this group how many would go to the institution for next delivery or would again plan to deliver at home? Why?
13. Can you suggest specific ways that services for antenatal care, delivery and postnatal care can be improved?

FGD with ASHA

- What factors do women consider in deciding place of delivery? [*Probe: Did they choose to go to a institution based on personal experience, experience of other women, family decision, motivated by ASHA, awareness of MJSSA-JSY scheme) or because of a health complication?*] If more than one answer, ask them to rank importance of each.
 - ANC care and birth preparedness and reaching the institution:
 - In which month of pregnancy do women contact you?
 - What you do during her ANC check up? and what information you share with women and her family members?
 - Where do you take women for check up- AWC/ institution or mostly at home?
 - How do you counsel the woman/family to deliver at the institution (probe : how to identify complications, saving money for obstetric emergencies and transportation, arranging a blood donor, arranging an escort to go to the institution with her, and, advise for clean delivery at home, if women decides to deliver at home)
 - At what time during labor do women contact ASHA? Sometime is it too late? What is the reason behind it?
 - How do you arrange to send the women to the institution and particularly if the labor pain starts at night?
 - In cases when you could not arrange for transport, what was the reason for it? In those situation what did women do?
 - Who pays for the transportation ? How much does it usually cost?
3. Reason for home deliveries:
- Factors that cause women to choose home deliveries(distance to the institution, transport not available on time, cultural reason, fear factor for institution, lack of fait/ trust with staff at institution, informal payments , others)
4. ASHA role in the institution
- Role during registration- waiting time
 - Do you accompany the woman in the labor room? What do you do there?
 - How do you comfort the woman when she is in labor?
 - How long do you stay in the institution with the woman after delivery and what you do?
5. Delivery care at the institution?
- Is there any shortage of staff, if so at what level?
 - Whether staff conducting deliveries available during night also
 - What is the behavior of staff at the institution toward women in labor?
 - How is the availability of medicine
 - How is the information/ counseling by the staff at the institution

6. PNC care : No. of visits, information shared
 - In case of complication with the mother or the newborn what do you do?
7. On an average how much does a woman spend during her whole delivery process
 - Buying medicine
 - Transport to the institution if any
 - Conducting tests in private clinics, if any
 - Giving tips to nurses/any other staff
8. While providing care for mother and newborn how do you try to make the whole delivery process a satisfactory experience for the woman? **Please cite examples.**
8. While providing care for pregnant women what is the most important thing that you consider [Probe: clinical care, promptness of care, providing the women comfort, provide emotional support, provide good information, treat all women same irrespective of her background, help during emergency like arranging transport, medicine]
9. In your experience what do women value most in terms of the care provided (separately for ANC, delivery and PNC)?

FGD with ANM

1. What factors do you think women consider in deciding place of delivery? [Probe: Did they choose to go to a institution based on personal experience, experience of other women, family decision, motivated by community health worker, awareness of MJSSA-JSY scheme or because of a health complication?]
2. Please tell us if the health facilities in this area are accessible to women for delivery, in terms of
 - Distance to the institution
 - Time taken to reach the institution and availability of public transport
 - Whether remoteness of some areas is a reason for home deliveries?
 - Usual mode of transport to reach the facility?
 - Who generally pays for the transport- Self/ ASHA?
 - Availability of transport even at night if there is emergency?
3. Tell us issues regarding infrastructure of the health facilities:
 - Challenges in providing good maternal health care
 - Issue of sufficient delivery tables,
 - Cleanliness in ward and labor room,
 - Equipments available and functional,
 - Were toilets and washing facilities available, working and clean? Was there running water?
4. Tell us whether in your institution there is shortage of staff, if so at what level? Whether staff conducting deliveries available during night also?
5. Whether availability of medicine is an issue in your institution?
 - If not available in the institution, from where does family members purchase?
 - Do you facilitate the process, if so- how?

- Is drinking water/food available in institution for patients?
6. Generally how long does it take for a woman to be admitted for delivery?
 - Are you able to immediately respond to emergency cases?
 - Does staff continuously monitor women in labor room?
 - Do you follow any procedures for pain management during delivery?
 - What procedure you follow for newborn
 - In case of any emergency for newborn how do you handle?
 7. During check up for ANC and particularly during delivery how do you ensure privacy?
 8. In order to make the women comfortable during delivery what do you do? [*Probe: whether the woman is comforted verbally; presence of family member during delivery*]
 9. How do you mostly communicate information about her health condition, after examination and what type of information you communicate
 - Progress of labor
 - Complication
 - Need for episiotomy
 - assisted delivery or C-section;
 - Any other adverse outcome?
 - Do you also talk to the family members about her condition?
 - Do you get enough time to spend with the women?
 - Do you communicate in local dialect?
 10. How do you comfort a woman in labor?
 - Generally who cuts the cord and provides immediate care for the baby?
 - How do you counsel the mother on postnatal care?
 - How often a woman's condition is monitored post-delivery within 48 hrs / during her stay in institution/ home?
 11. On an average, how many women have complicated/ assisted delivery (need for c-section, use of forceps, etc.) in a month?
 - What complications can be managed in your institution and what type of complications require referrals to other facilities?
 - In your institution, in a year, what is the average number of
 - maternal deaths
 - newborn deaths
 - still births
 12. On an average how much a woman spends during her whole delivery process:
 - Buying medicine
 - Transport to the institution if any,
 - Conducting test in private clinic, if any
 - Giving tips
 13. Information sharing with ASHA about women's health.
 14. While providing care for mother and newborn how do you try to make the whole delivery process a satisfactory experience for the women? Please cite examples.

15. While providing care for pregnant women what is the most important thing that you consider [*Probe: clinical care, promptness of care, providing the women comfort, provide emotional support, provide good information, treat all women same irrespective of her background, help during emergency like arranging transport, medicine*]
16. In your experience what do women value most in terms of the care provided?

FGD with TBA

1. What factors do you think women consider in deciding place of delivery? [*Probe: based on personal experience, experience of other women, family decision, motivated by TBA, awareness of MJSSA-JSY scheme or because of a health complication?*]
2. Tell us why women do not go to the institution for delivery and that too with the JSY scheme why?
 - Is the institution far?
 - Unavailability of transport
 - Negative feedback from other women- staff behavior, institution not functional, had no staff
 - Informal payment to the staffs
 - Cultural practice (other women in your family delivered at home)
 - Faith with the TBA
3. In which month of pregnancy women contact you?
 - What you do during her ANC check up?
 - Linkage with ASHA
4. Generally when do women inform you at time of labor?
 - What you do?
 - Preparing the place for delivery
 - Do you carry delivery kit,
 - Procedures followed for pain management during delivery?
 - In case of complication what do you do
 - arrange for referral
 - suggest family to call ANM/ private doctor, contacting ASHA
 - In order to make the women comfortable during delivery what do you do? [*Probe: whether the woman is comforted verbally; presence of family member during delivery*]
5. How do you counsel the mother on postnatal care?
 - How often is a woman's condition monitored post-delivery within 48 hrs?
 - What do you tell mothers generally immediately after birth about how to care for their baby in the first weeks of life? (Probe: breastfeeding, thermal care)
 - No. of visits
 - In case of complication with the newborn what do you do?
6. On an average, how many women delivery you attend in a month?
 - What is the average number of maternal deaths
 - Newborn deaths and
 - Still births in a year
7. On an average how much a woman spends during her whole delivery process:
 - Buying medicine,
 - Transport to the institution if any,
 - Conducting test in private clinic, if any
 - Paying the TBA for delivery

8. While providing care for mother and newborn how do you try to make the whole delivery process a satisfactory experience for the women? Please cite examples.
- 9 While providing care for pregnant women what is the most important thing that you consider [Probe: clinical care, promptness care, providing the women comfort, provide emotional support, provide good information, help during emergency like arranging transport, medicine]
- 10 In your experience what do women value in terms of the care provided?

Appendix III

Themes and queries to understand determinants of maternal satisfaction

Institutional Delivery

	Themes	Queries
1.	Community/ peer/ family influence: Influence of community/ peers/ family on place of delivery	<ol style="list-style-type: none"> 1. Information based on experience of other women. 2. Family decision 3. Motivated by community health worker (JSYM/JSSA-JSY scheme)
2.	Accessibility of health facility : Facilities which can be reached easily (geographical accessibility)	<ol style="list-style-type: none"> 1. Proximity of the health facility, distance to the facility. 2. Time taken to reach the facility 3. Facility accessible by public transportation 4. Availability of transport even at night. 5. Arrangement of referral transport in case of emergency
3.	Structure - Physical Infrastructure and overall environment of the delivery place that is acceptable to the women.	<ol style="list-style-type: none"> 1. Proper and clean delivery table in the labor room. 2. Separate and clean bed In PNC ward. 3. Toilets and washing facilities available and clean 4. Adequate running water 5. Waiting area for family members
4.	Human resource- Availability of relevant human resources.	<ol style="list-style-type: none"> 1. Availability of ANM and medical officer at the facility 2. Availability of cleaning staffs (like dai, sweeper) 3. There availability of the delivery staff during night
5.	Supplies - Availability of medicines and other necessities	<ol style="list-style-type: none"> 1. Availability of medicines and other supplies. 2. Timely arrangement by the provider if not available 3. Enough food and drinking water available
6.	Emotional Support- Reassuring environment, dependability and	<ol style="list-style-type: none"> 1. Family members accompanied the woman

	feeling of emotional security and support; alleviation of fear and anxiety particularly during delivery.	<ol style="list-style-type: none"> Family members present during delivery and in PNC ward Making women comfortable during examination (seats offered)
7.	Cognitive support- Necessary information is conveyed in a language that women can understand and helps individual adapt to changes.	<ol style="list-style-type: none"> Contact time with staff was sufficient Adequate explanation of examination conducted during ANC check up and follow up till delivery Staff willing to answer questions politely and listen carefully with interest what women want to say Giving information about progress of labor and women is able to understand. Explanation and reason provided if there is adverse outcome Culturally and linguistically sensitive Communication by the staff.
8.	Promptness – Timeliness as per specific need of the women	<ol style="list-style-type: none"> Waiting time for registration Time taken to take women to delivery room after onset of labor Availability of staff during delivery at night. Constantly attended during labor and delivery, not left alone. Physical comfort- Pain management during labor Resuscitation of baby if there is complication Immediate care for newborn (wrapping of the baby)
9.	Privacy –providing women with privacy, culturally sensitive environment, place was secluded.	<ol style="list-style-type: none"> Privacy maintained during check- up (ANC) during labor and in the delivery room. Knowledge of who conducts the whole delivery process.
10.	Inter-personal aspect of care- Respectful Behavior of the staff to make the women comfortable and secure irrespective of their socio-economic background	<ol style="list-style-type: none"> Women received well upon arrival for delivery and immediate access to staff. Use of non-abusive language particularly during labor Support and counseling in the event of adverse outcome. Who handled placenta and immediate care for the baby. Proper counseling for mother and newborn Health condition monitored at least 2 time within 48 hrs
11.	Outcome: Any result	<ol style="list-style-type: none"> Delivery without any complication Live birth
12.	Continuum of care : Link between	<ol style="list-style-type: none"> ANC from ASHA (no of visit, type of information shared and she complied with).

	ANC- delivery and PNC and role of ASHA	<ol style="list-style-type: none"> Does ASHA prepare her for the delivery, like familiarizing her with health facility Effective Coordination during emergency (delivery) and referral for mother and newborn. ASHA accompanied women to the facility, assisting in registration, presence in delivery room and during her stay in the facility. PNC from ASHA (no of visit, type of counseling)
13.	Expenditure : Services are provided as per norms without additional cost	<ol style="list-style-type: none"> Drugs and services free Transportation for reaching facility Transportation cost for referral Tips/ informal payment for services. Delivery of services not conditional upon prior payment Timely payment of <i>MJSSA-JSY</i> money
14.	Experience based on previous place of Delivery: Comparison to understand level of satisfaction (not applicable for primi para)	<ol style="list-style-type: none"> Place of delivery for previous child Comparison of level of satisfaction, better or deteriorated
15.	Decision about place of delivery for next child: Decision about place of delivery for next child and sharing of experience with others in community	<ol style="list-style-type: none"> Place of delivery for next child and reason Recommendation to others in community based on her experience

HOME DELIVERY

	Themes	Queries
1.	Community/ peer/ family influence: Influence of community/ peers/ family on place of delivery	<ol style="list-style-type: none"> Information based on experience of other women. Family decision Motivated by Traditional Birth Attendant (TBA)
2.	Accessibility of health facility : Facilities which can be reached easily (geographical accessibility)	<ol style="list-style-type: none"> Health facility not accessible (lack of transport; facility not functional)
3.	Structure – Physical Infrastructure and overall environment of the delivery place that is acceptable to the women.	<ol style="list-style-type: none"> Proper and clean delivery place. Toilets and washing facilities clean Adequate running water
4.	Human resource- Availability of relevant human resources.	<ol style="list-style-type: none"> Availability of TBA in the community TBA available during night
5.	Supplies – Availability of medicines	<ol style="list-style-type: none"> Availability of medicines and other supplies. Timely arrangement by TBA if not available

	and other necessities	
6.	Emotional Support- Reassuring environment, dependability and feeling of emotional security and support; alleviation of fear and anxiety particularly during delivery.	<ol style="list-style-type: none"> 1. Familiarity & comfortable in the home surrounding 2. Reputation of the TBA in the community & personally knowing the TBA. 3. Presence of family members during delivery
7.	Cognitive support- Necessary information is conveyed in a language that women can understand and helps individual adapt to changes.	<ol style="list-style-type: none"> 1. Contact time with TBA was sufficient 2. Adequate explanation of examination conducted during ANC checkup and follow up till delivery 3. TBA willing to answer questions politely and listen carefully with interest what women want to say 4. Information provided if there is complication and need for referral 5. Explanation and reason provided if there is adverse outcome 6. Culturally and linguistically sensitive communication by the TBA.
8.	Promptness - Timeliness as per specific need of the women	<ol style="list-style-type: none"> 1. TBA responded immediately in case of emergency. 2. Availability of TBA during delivery at night. 3. Constantly attended during labor and delivery, not left alone. 4. Physical comfort- Pain management during labor 5. Resuscitation of baby if there is complication
9.	Confidentiality -providing women with privacy, culturally sensitive environment, place was secluded.	<ol style="list-style-type: none"> 1. Privacy maintained during check- up (ANC) during labor and in the delivery room. 2. Knowledge of who conducts the whole delivery process.
10.	Inter-personal aspect of care- Respectful Behavior of the staff to make the women comfortable and secure irrespective of their socio-economic background	<ol style="list-style-type: none"> 1. Use of non-abusive language particularly during labor 2. Support and counseling in the event of adverse outcome. 3. Awareness of the woman's health and delivery history 4. Proper counseling for mother and newborn
11.	Outcome: Any result	<ol style="list-style-type: none"> 1. Delivery without any complication 2. Live birth
12.	Continuum of care : Link between ANC, delivery and PNC	<ol style="list-style-type: none"> 1. ANC from ASHA (no of visit, type of information shared and she complied with) 2. Did ASHA or TBA prepare her for delivery, in what manner 3. Effective Coordination between ASHA and TBA during emergency (delivery) and referral for mother and newborn. 4. ASHA's presence in home delivery. 5. PNC from ASHA (no of visit, type of counseling)
13.	Expenditure : Services are provided as per norms without additional cost	<ol style="list-style-type: none"> 1. Cost of Drugs and services 2. Transportation cost in case of referral. 3. Delivery of services not conditional upon prior payment 4. Cost for any ANC and PNC check up 5. Any other related costs
14.	Experience based on previous place of Delivery: Comparison to understand level of satisfaction (not applicable for primi para)	<ol style="list-style-type: none"> 1. Place of delivery for previous child 2. Comparison of level of satisfaction, better or deteriorated

15.

Decision about place of delivery for next child: Decision about place of delivery for next child and sharing of experience with others in community

1. Place of delivery for next child and reason
2. Recommendation to others in community based on her experience

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