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FINAL

**REPORT ON THE USE OF THE COMMUNITY DIAGNOSIS TO EXPLORE
SAFE MOTHERHOOD: A TWO-COUNTRY COMPARISON AND
METHODOLOGICAL CRITIQUE**

TECHNICAL PAPER #6

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EXECUTIVE SUMMARY

The development of effective intervention strategies designed to reduce unacceptably high levels of maternal and neonatal mortality and morbidity requires an understanding of the factors influencing the survival of a woman or her newborn when a potentially life-threatening complication occurs. To gather individual- and community-level information on these factors, MotherCare conducted separate “community diagnoses” in Bolivia and Indonesia (South Kalimantan)—two countries where MotherCare has long-term projects. The community diagnosis research, which was qualitative in nature, used the Pathway to Survival as its theoretical base. The Pathway to Survival is a framework that delineates the steps that may determine the survival of a woman or her newborn when they experience an obstetric or neonatal complication that can result in death (see figure 1). This framework has four components: problem recognition, decision-making regarding care, access to care, and quality of care. The focus of the community diagnosis research was on the first three elements.

Three principal investigative techniques were employed in the Bolivian and Indonesian community diagnosis research: (1) what were termed “semi-structured interviews (SSIs), (2) focus groups (FGs), and (3) direct observations (DOs). In both countries, the SSIs were held

Pathway to Survival Maternal/Perinatal Mortality

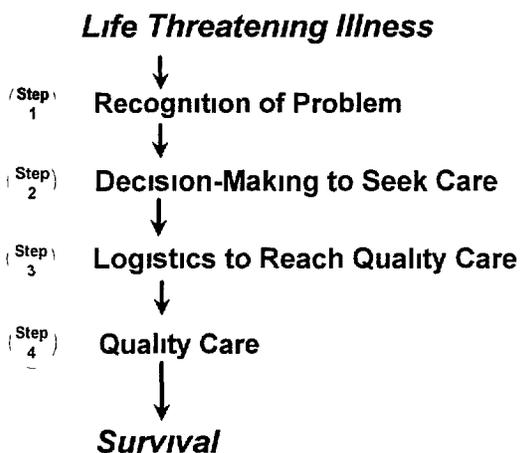


Figure 1
Source: Koblinsky 1995

with women, husbands, and health providers. In Bolivia, SSIs also were conducted with *responsables populares de salud* (community health workers) and community leaders. In Bolivia and Indonesia, FGs were held with women and husbands. In Indonesia, male and female “key informants”^a also participated in the focus groups. The direct observations were conducted on health providers and health facilities. Descriptions of the community infrastructure also were given.

The report which follows contains a discussion of some key findings from the community diagnosis research, comparing Indonesia and Bolivia. The strengths and limitations of the community diagnosis approach as it was implemented in the two countries are outlined and recommendations for the design of future community diagnosis research are given.

^aThe characteristics of the “key informants” are not available.

For this report, some data (those items which were closed-ended) from the SSIs in Bolivia and Indonesia were analyzed. Focus group data and open-ended questions on the SSIs could not be explored because raw data either were unavailable or were not translated into English. Information from open-ended questions in the SSIs and from the focus groups was obtained through synthesis of material contained in the community diagnosis report summaries from Indonesia (*Report Community Diagnosis MotherCare Safe Motherhood Project South Kalimantan, 1996* by Marsaban et al, 1996) and Bolivia [*Diagnostico Barreras y Viabilizadores en la Atencion de Complicaciones Obstetricas y Neonatales (Estudio Cualitativo en Comunidades y Servicios de Salud de Cinco Distritos de Salud en La Paz y Cochabamba* by Seoane et al, 1996)]. Data from the direct observations were not examined.

Results from the SSIs and focus groups reveal valuable information in some instances and are ambiguous in others. The ambiguity often is due to issues with sampling, with questionnaire construction, and to incomplete information given in the summary reports. Despite the ambiguity of some of the data, the community diagnosis research yielded useful information for shaping intervention messages and provider training and community information, education, and communication and counseling (IEC/C) strategies. Results from the SSIs and FGs are briefly outlined below.

First, in Bolivia and Indonesia, the degree to which women recognize obstetric and neonatal complications varies, depending on when the complication occurs. There is little recognition of neonatal problems in both countries, but especially in Bolivia. Awareness of anemia or its signs and symptoms is high in Indonesia and appears low in Bolivia. Indonesian women seem to consider specific problems during labor (e.g., prolonged labor, premature delivery, and hemorrhage during delivery) to be more serious than their Bolivian counterparts, who generally are more concerned with problems occurring after delivery (e.g., *sobrepardo*, translated as 'relapse after birth'). However, Bolivian women often mentioned *malparto* ("bad birth") as a problem during delivery. In general, both Indonesian and Bolivian women and their families view hemorrhage to be serious, though they have trouble distinguishing between dangerous and less severe bleeding.

Second, in Bolivia and Indonesia, husbands play an important role in the decision to seek care. In Bolivia, other family members such as mothers-in-law are critical players, particularly for problems in pregnancy and post-partum. Also in Bolivia, the women themselves often are the principal decision-makers. While Bolivian study participants were stratified according to whether they came from high or low service-use areas, women reported using both the traditional and institutional health systems in about equal numbers, regardless of their classification by service use.

Third, though Indonesian women participating in the SSIs reported having confidence in the skills of the midwives, little other information (e.g., focus group data) is available regarding

perceptions of care in Indonesia. Data from the SSIs in Bolivia indicate that women and their families generally are satisfied with the health care they receive, but data from the focus groups give a different and probably more accurate picture of perceptions of quality of care and treatment at health facilities in Bolivia. In the focus groups, treatment often was described as “cold” and both women and their husbands expressed greater comfort in their interactions with traditional birth attendants than with institutional health providers.

Indonesian SSI participants generally reported knowing where health facilities were and most could reach some facility within about 15 minutes. Information on other possible barriers to accessing care in Indonesia is scant. Specifically, data on cost of transportation and services and on assistance from family members and the community are insufficient. In focus groups in Bolivia, cost emerged as a significant barrier to “regular” care among participants from high service-use areas and to both regular and emergency care among participants from low service-use areas.

The community diagnosis approach in Bolivia and Indonesia had several strengths. Key among these was the fact that the research was guided by a conceptual framework (the Pathway to Survival). Importantly, this framework provides a base for identifying key individual- and community-level factors with the potential to influence the survival of a woman or her newborn if potentially grave obstetric or neonatal complications arise. The use of this framework ensured the collection of critical information needed for the development of effective intervention activities.

The community diagnosis research in both countries also had some difficulties. Specifically, there were problems with the design and wording of the data collection instruments, with data management (including coding), with gaps in the analysis, and with reporting. At times, the problems were severe enough to preclude meaningful analysis or to prohibit definitive conclusions from being drawn.

Specific recommendations for future community diagnosis efforts are given in the body of the report. These include (1) use of multiple data collection techniques, including but not limited to focus groups and true in-depth interviews, (2) delineation of explicit participant selection criteria, (3) development of clearly constructed questions that accurately reflect the concepts they are intended to represent, (4) use of multiple questions to assess domains (e.g., participant satisfaction with care), (5) use of an open-ended question format and extensive probing techniques^b, (6) care in data coding, particularly with regard to merging response categories, (7) use of a framework to guide instrument design (the current community diagnosis research used the Pathway to Survival; future efforts may consider the use of Fishbein’s Pathway to Behavior—see figure 2 in Appendix C—though this framework has not been applied or tested).

^bOpen-ended questions are a rich source of information, though they can present a challenge for analysis.

previously), (8) collection of information on problem recognition, decision-making regarding care, perceptions of the quality of care, intention to use services, skills for performing desired behaviors, and environmental constraints inhibiting the conduct of desired behaviors, (9) implementation of adequate training, monitoring, and supervision for data collection, and (10) detailed descriptions of study methodology and results, including presentation of raw data where appropriate

INTRODUCTION

BACKGROUND

PURPOSE OF THE MOTHERCARE COMMUNITY DIAGNOSIS

Formative research is an important component in the design and implementation of effective interventions. Recognizing this fact, in the winter/spring of 1995-1996, MotherCare II undertook "community diagnoses" in Bolivia and in South Kalimantan, Indonesia. The purpose of the community diagnosis research was to (1) elucidate Indonesian and Bolivian women's reproductive health beliefs, values, and behaviors, (2) learn about the process by which families decide to seek care for pregnancy-related complications, and (3) determine the barriers inhibiting women's use of preventive and emergency health services (*Pareja and Galloway Trip Report, May 27-June 19, 1996* and *Pareja Trip Report, Jan 24 - Feb 12, 1996*)

A summary of the findings and a more detailed description of the community diagnosis process in Bolivia appear in *Diagnostico Barreras y Viabilizadores en la Atencion de Complicaciones Obstetricas y Neonatales (Estudio Cualitativo en Comunidades y Servicios de Salud de Cinco Distritos de Salud en La Paz y Cochabamba)* (Seoane et al, 1996). The document, *Report Community Diagnosis MotherCare Safe Motherhood Project South Kalimantan 1996* (Marsaban et al, 1996) provides a summary of the community diagnosis research in South Kalimantan.

REPORT OBJECTIVES

The aims of this report are threefold. The first objective is to compare select results from Indonesia and Bolivia in order to determine commonalities and differences between the two countries in (1) the recognition of obstetric and neonatal problems, (2) decision-making regarding health-seeking behavior, (3) perceptions of the quality of care, and (4) perceived barriers to accessing care. The second aim is to review the strengths and limitations of the community diagnosis approach as it was employed in Bolivia and Indonesia. The final objective of this report is to make recommendations for the design of future MotherCare community diagnosis tools and research methodologies related to women's reproductive health and to the health of the newborn.

This document is divided into four sections. **Section I** contains a description of the methods used to gather and synthesize information for this report. **Section II** includes a discussion of pertinent findings from the two community diagnoses, comparing Bolivia with Indonesia. Where relevant, implications for the design of future community diagnosis research (but not for program implementation) also are discussed. **Section III** consists of an overview of some of the strengths and limitations of the semi-structured interviews and focus groups, both as they were conducted in the Bolivia and Indonesia more generally. This overview is followed by **Section IV** the conclusions and recommendations. **Appendix A** illustrates a possible framework (Fishbein's) for guiding future community diagnosis research. **Appendix B** outlines some gaps and areas of confusion regarding the information obtained in the community diagnosis.

Appendix C is a matrix providing a summary of the results from the SSIs and FGs in Bolivia and in Indonesia. It contains more in-depth information on the strengths and limitations of the data than is provided in **Section III**.

Throughout this document, **text boxes** are used to illuminate the main points in the adjacent text. A broad overview of key considerations can be obtained by perusing the executive summary and the text boxes. Readers wanting greater detail about a particular topic area (e.g., women's recognition of newborn complications, strengths and limitations of the data on newborn complications), than can be found in the body of the report should see **Appendix C**.

SECTION I—REPORT METHODOLOGY

REPORT OVERVIEW

The information contained in this report was obtained by analyzing select data from the two community diagnoses and by synthesizing the findings presented in *Diagnostico Barreras y Viabilizadores en la Atencion de Complicaciones Obstetricas y Neonatales (Estudio Cualitativo en Comunidades y Servicios de Salud de Cinco Distritos de Salud en La Paz y Cochabamba)* (Seoane et al , 1996) and in *Report Community Diagnosis MotherCare Safe Motherhood Project, South Kalimantan, 1996* (Marsaban et al , 1996) To place this report in context, it is necessary first to give a brief overview of the community diagnosis methodology as it was applied in Bolivia and Indonesia ^c

COMMUNITY DIAGNOSIS METHODOLOGY

GENERAL

In both Bolivia and Indonesia, MotherCare staff and their sub-contractors held what were termed “**semi-structured interviews**” (SSIs) and **focus groups (FGs)** They also conducted **direct observations (DOs)** of health care providers and health care facilities Information from these three data collection methods was supplemented by descriptions of the community infrastructure and the environment (e g , roads electricity, health facilities, geography, climate, and sanitation)

The **Pathway to Survival** (see figure 1) was used as a framework to guide the development of the data collection instruments Other frameworks, such as the newly developed Pathway to Behavior (see Appendix A) also could be used The Pathway to Survival delineates the steps that may determine the survival of a woman or her newborn when they experience a potentially life-threatening obstetric or neonatal complication As described by Koblinsky¹, the Pathway to Survival has four components (1) problem recognition, (2) decision-making regarding care, (3) access to care, (4) the quality of the care obtained The SSIs and FGs addressed the first three steps of the Pathway to Survival (i e , those steps influencing whether or not women or their newborns will present at a health facility when life-threatening complications arise) The direct observations provided information on the quality of care provided at health facilities

BOLIVIA

In Bolivia, data were collected in five districts over approximately four months, from January 1996 through April 1996 A total of 41 semi-structured interviews were conducted with women, 30 with men, 10 with *parteras* (midwives), 10 with *responsables populares de salud* (community health workers) and 10 with community leaders

^cSee *Diagnostico Barreras y Viabilizadores en la Atencion de Complicaciones Obstetricas y Neonatales (Estudio Cualitativo en Comunidades y Servicios de Salud de Cinco Distritos de Salud en La Paz y Cochabamba)* (Seoane et al 1996) and *Report Community Diagnosis MotherCare Safe Motherhood Project South Kalimantan 1996* (Marsaban et al 1996) for more detailed descriptions of study methods

To obtain data on problem recognition women and men participating in semi-structured interviews were asked questions on their awareness of problems during pregnancy birth the post-partum period, and the newborn, on the degree to which they considered specific problems to be serious, and on the kinds of problems they had experienced

To get information on the decision to seek care, interviewees were asked about normative behavior in the community Specifically, women were queried about their perceptions of the care they receive at health facilities, and about who plays the central role in the decision to seek care Respondents who reported that they or their spouse had experienced obstetric or neonatal problems were asked about their care-seeking behavior for those problems and about their perception of the care they received when they went for treatment

To assess access to care, respondents were queried about their perceptions of the cost, comfort, and accessibility of transportation, about the cost of services and medicine, and about distance to a health facility Participants in the SSIs were requested to describe any assistance they received from members of the community when they experienced obstetric or neonatal complications The SSIs also contained some questions regarding knowledge of various family planning methods, method preference, method use, awareness of sexually transmitted diseases (STDs), and preferred STD treatment modalities

The same topic areas mentioned above were discussed in the 20 focus groups (10 with women and 10 with men) held in the five districts

INDONESIA

In Indonesia, the semi-structured interview and focus group components of the community diagnosis were divided into two parts One focused on "Safe Motherhood" issues (i.e., all topics covered in the Bolivia research, with the exception of anemia, family planning, and STDs) The second component focused largely on anemia, with some questions on family planning and sexually transmitted diseases/reproductive tract infections (RTIs)

Data collection occurred in four villages in three districts during March and April of 1996 For the Safe Motherhood component, 90 women who had children under five years of age or who were currently pregnant participated in the SSIs A total of twelve focus groups (six with women and six with men) addressing Safe Motherhood issues were conducted in the four communities Additionally, six focus groups were held (three with men and three with women) with participants who were considered "key informants" For the component dealing with anemia, family planning, and STDs/RTIs, SSIs were conducted with 90 women who had children under five years of age Six focus groups (1-2 in each of the four villages) also were held Focus group participants were women (some of whom were pregnant) with children under five years of age

Additionally, SSIs were conducted with a total of 29 *bidans* (midwives) or *bidan di desas* (midwives—most of whom are young—who have graduated from an accelerated midwifery program) The interview guide contained questions on perceptions of care in service delivery sites, beliefs about community perceptions of service quality, anemia, family planning, and partner notification for STDs/RTIs

REPORT METHODOLOGY

GENERAL

In this document, information on problem recognition, decision-making regarding care, and perceptions of health service quality were obtained through data analysis and through synthesizing the material contained in *Diagnostico Barreras y Viabilizadores en la Atencion de Complicaciones Obstetricas y Neonatales (Estudio Cualitativo en Comunidades y Servicios de Salud de Cinco Distritos de Salud en La Paz y Cochabamba)* (Seoane et al , 1996) and in *Report Community Diagnosis MotherCare Safe Motherhood Project South Kalimantan, 1996* (Marsaban et al , 1996)

This report does not attempt to be comprehensive Only data from the Safe Motherhood component of the SSIs with women and husbands are discussed and only information stemming from the focus groups dealing with pregnancy-related complications is presented Data and findings from the direct observations and from the Indonesian SSIs focusing on anemia, family planning, and RTIs are not explored

DATA ANALYSIS AND SYNTHESIS

The field offices in Bolivia and Indonesia provided the data from the SSIs These data had been entered and coded in-country and were submitted on diskette The SSIs in Bolivia and Indonesia contained both open- and closed-ended questions The open-ended responses either were not included on the diskettes, were incomplete or were in Spanish or Bahasa Indonesian

Therefore, only the closed-ended questions were analyzed

Before beginning data analysis, the SSI instruments used in Indonesia and Bolivia were compared While the items contained in the SSIs in both countries were framed around the Pathway to Survival, the actual questions often differed in significant ways For example, in both countries sections of the SSI were devoted to assessing women's awareness of problems occurring during pregnancy, delivery the post-partum period, or with the newborn In Bolivia, an unprompted format was used Women were asked to list the pregnancy-related problems with which they were familiar In Indonesia, answers were prompted Women were read a list of problems and for each problem on the list, were asked to state whether or not it was serious Because these and other items on the two questionnaires were not identical, **data could not be pooled, nor could direct comparisons be made** Instead, those items which were similar in

both countries, or which addressed the same topic area were selected for separate analyses and interpretation

Only those items corresponding with the first three steps of the Pathway (i.e., problem recognition, decision-making, and access to care) were selected for analyses Under *problem recognition*, questions chosen dealt with awareness of complications, perceived severity of pregnancy-related problems, and previous experience with complications. To explore *decision-making*, selected items addressed who the key players were in health-care seeking decision-making, where help first is sought, and birth-place preferences. Under *access to care*, questions selected for analyses concerned perceived quality of care, distance/time to the health facility, cost of transportation and services, and community assistance.

Once items were selected, data were recoded as necessary and frequency distributions were obtained. Where appropriate, data were stratified by key variables (e.g., whether or not respondents had experienced pregnancy complications, place of residence). Bivariate analyses were performed. Chi-square statistics also were obtained. But, the very small cell-sizes precluded meaningful interpretation and the results of the chi-square tests are not reported herein. Because of small sample sizes and also because many questions had low response rates (particularly for Bolivia), multivariate analyses were not conducted.

Raw data from the focus groups were not translated from Spanish or Bahasa Indonesian into English, nor were transcripts sent to MotherCare, DC. **Since raw data from the focus groups were unavailable, analyses could not be performed. Instead, focus group information as documented by the authors of the community diagnosis reports from Bolivia (Seoane et al., 1996) and Indonesia (Marsaban et al., 1996) were synthesized, and the results of that synthesis are discussed.** In their report on the community diagnosis in Bolivia, Seoane and colleagues provide their interpretations of the focus group discussions. The authors support their statements with many direct and very revealing quotes from participants. Marsaban and colleagues also discuss focus group findings in their report on the community diagnosis in South Kalimantan. However, the report contains very few quotes from focus group participants. Consequently, while results of the SSIs in Bolivia could be supplemented with select quotes from the focus groups, this was not possible with the Indonesian data. In **Section II**, focus group findings from Indonesia are discussed, but with the caveat that almost no data were available for synthesis.

SECTION II—FINDINGS

INTRODUCTION

This section contains a summary of the findings from the SSIs and FGs. In keeping with the format of the Pathway to Survival, the discussion begins with results from the section on *problem recognition*, continues with *decision-making*, and concludes with *access to care*. At the beginning of each subsection, a general overview of findings and methodological or analytical issues is given. Findings are then discussed in more detail. Where appropriate, implications for future community diagnosis research are highlighted. **Appendix B** contains more detail on the limitations of each item appearing in the SSIs and FGs. A general discussion of methodological issues is contained in **Section IV**. However, a few key caveats must be mentioned here. First and foremost, **because purposive sampling was used for the SSIs and the FGs, the results cannot be considered representative of the broader population, and so, cannot be generalized**. Also, while the terms “Indonesian” women and families are used throughout the report, study participants were from South Kalimantan only.

STEP 1 PROBLEM RECOGNITION AWARENESS AND PERCEPTIONS OF AND EXPERIENCE WITH PROBLEMS DURING PREGNANCY, DELIVERY, THE POST-PARTUM PERIOD AND WITH THE NEWBORN

STEP 1 GENERAL COMMENTS

Data from the SSIs do not give a clear indication of the degree to which Indonesian women are aware of the signs of obstetric and neonatal complications.

The ambiguity is due to issues with sampling and with construction of those SSI items designed to garner information on problem recognition. In particular, some women were selected for participation in the SSIs and FGs specifically because they had experienced pregnancy-related complications. These women would be expected to have a higher level of awareness and knowledge of certain complications than women without comparable experiences. Additionally, women were asked to list the problems they had experienced, but not to list the problems of which they were aware. Only if the respondents reported they had not had any complications were they asked to name problems women might experience.² **Thus, the items representing the domain of problem recognition lack content validity (i.e., the questions were not representative of the concepts they were intended to reflect).**

In Indonesia, problems with SSI questionnaire construction mean that results regarding awareness, perceptions, and previous experience are not conclusive. In Bolivia, respondents were aware of many problems, but in some cases, had trouble distinguishing severity. In both countries, women and husbands were less likely to report awareness of newborn problems than they were to report awareness of maternal problems. They also were less likely to consider newborn complications to be severe (as compared to maternal complications).

In Bolivia, selection criteria for the women participating in the SSIs are not given. So, it is not possible to determine the degree to which selection issues may have affected the results. **However, the Bolivian SSI items pertaining to problem recognition had greater content validity than those in the Indonesian instrument.** Using an unprompted question format, women were asked to list the pregnancy-related problems with which they were familiar. **Thus, in Bolivia, awareness could be assessed more easily and accurately than in Indonesia.**

Data from the semi-structured questionnaires and focus groups indicate that women recognize some but not all signs of complications and that they often have trouble distinguishing problem severity (e.g., hemorrhage versus light bleeding)³. Additionally, focus group reports suggest that while some problems are identified easily, others are not.

While it is possible, even likely, that Indonesian women (and other respondents) have trouble determining when bleeding is life-threatening, the report by Marsaban and colleagues on the community diagnosis in Indonesia does not contain any focus group information on severity distinction for hemorrhage or other complications.

In both Indonesia and Bolivia, results from the SSIs with women show variability in the extent to which problems are recognized and the degree of severity attributed to these problems, depending on whether the women are speaking about pregnancy, delivery, the post-partum period, or the health of their newborns. Specific findings demonstrating this variability are discussed below.

Implications for Future Community Diagnoses

To ensure content validity, semi-structured interview items designed to get information on problem recognition and perception of problem severity need to be carefully constructed.

STEP 1 PERCEPTIONS OF PREGNANCY AND PREGNANCY-RELATED PRACTICES Indonesia

In their summary report, Marsaban and colleagues suggest that women are not particularly concerned about their pregnancies and that they maintain a

normal workload (e.g., grocery shopping, cooking, washing, cleaning, and child-rearing) while pregnant⁴. At the same time, they write that women are discouraged—though they do not say by whom—from lifting heavy loads later in pregnancy⁵. In their discussion of the anemia focus groups, Marsaban and colleagues also state that some participants said women should eat “more nutritious food” when pregnant⁶. The SSIs did not contain any items on prescribed or proscribed

Some data indicate that Bolivian and Indonesian women do not view pregnancy as a time requiring special care or attention. However, information is neither definitive nor complete.

food and drink in pregnancy and the focus group field guide contained only one question regarding perceptions of a normal pregnancy **In sum, the community diagnosis in Indonesia does not appear to have gathered definitive information on pregnancy-related norms, beliefs, or individual practices, nor does it appear that women were asked how they feel about their pregnancies**

Bolivia

Bolivian women appear to treat pregnancy in much the same way as their Indonesian counterparts While women are encouraged not to “lift heavy things,” they continue to work in much the same manner as before their pregnancy ⁷ Seoane et al use quotes from female focus group participants to support this statement **As was the case in Indonesia, it does not appear that questions specific to diet or special practices were asked**

Cross-country

In both countries, women participating in focus groups reported that their husbands helped with tasks requiring heavy lifting (e.g., fetching water, or washing bedspreads) However, in their summary document, Marsaban and colleagues state that women reported feeling embarrassed if their husbands were seen as helping too much ⁸ No comparable sentiment was mentioned in the Bolivian report by Seoane and colleagues However, in a separate qualitative research study on anemia in pregnant women in Bolivia, the majority of the women questioned stated that their pregnancies adversely affected their quality of life ⁹ Some reported feeling useless because they were unable to work as much as they had before their pregnancy Additionally, some women reported that their husbands were neither supportive nor understanding of their limitations ¹⁰

Implications for Future Community Diagnoses

Future community diagnosis research should collect more information on how women and communities view normal pregnancies, including normative beliefs, and practices (e.g., regarding diet, workload, health-care seeking behavior, and women’s roles while pregnant) Efforts also should be made to determine the role and expectations of husbands when their wives are pregnant, delivering, or post-partum Information on spousal roles in the care of the newborn also should be gathered ^d

^dLength of interviews and/or focus groups must be considered in the construction of any field guide While information on newborn care is important, it may be appropriate to collect this (and other data on newborns) separately from data gathered on pregnancy and obstetric complications

STEP 1 AWARENESS OF AND PERCEPTIONS OF SWELLING

Indonesia

In the semi-structured questionnaires, one-third of the Indonesian women stated that having swollen feet is a serious problem. About half the women interviewed said that swelling of the face or hands is a serious problem. The rest of the women said that swelling of the feet, face, or hands is not

Some Indonesian women do distinguish among the various types of swelling (i.e., of the feet, face, or hands). Some Bolivian women are aware of swelling, but few consider it to be serious (even when it involves the face).

serious, or that they were unsure of about the level of severity. The results indicate that a few women do appear to distinguish among types of swelling. Specifically, these women perceive puffiness of the face and hands (a sign associated with pre-eclampsia) as more severe than puffiness of the feet (a common problem in pregnancy). However, overall, Indonesian women do not appear to view swelling as a danger sign requiring immediate attention.

Bolivia

In Bolivia, the findings are similar to those in Indonesia. While some women recognize swelling of the feet or face, few consider any kind of swelling to be serious. Hardly any husbands mentioned swelling as a problem. According to the report by Seoane et al., neither men nor women associate the signs of eclampsia with swelling.¹¹ Further, as illustrated by the following quote from a focus group participant, swelling appears to be considered a normal part of pregnancy.

*In each pregnancy, puffiness is normal, it is not a problem
(Artesan, 26 years, 1 son, Barrio N Horizontes/Low Use/LPZ)^e*

STEP 1 AWARENESS OF AND PERCEPTIONS OF ANEMIA

Indonesia

In the Indonesian focus groups, women did not mention anemia or its signs and symptoms without prompting.¹² While

Women in Indonesia generally are not aware of the term, anemia. But, compared with Bolivian women, they appear more aware of anemia's signs and symptoms.

unaware of the term, "anemia," women did recognize the term, *kurang darah*, meaning "not enough blood." Women in the focus groups considered *kurang darah* to be the converse of high blood pressure, and the term often was used synonymously with *tekanan darah rendah*, meaning low blood pressure. The confusion between the terms is noteworthy and, according to the report by Marsaban et al., extends to *Puskesmas* (community health center) staff, *bidans*, and *bidan di desas*.¹³

^e Seoane et al., 1996 Page 90

While Marsaban and colleagues state that few women reported knowing the cause of *kurang darah*, all the focus group respondents were aware that iron tablets, or *obat tambah darah* (medicine to add blood) could be taken to alleviate its signs and symptoms¹⁴ The fact that women did not spontaneously mention anemia or its signs and symptoms, but when prompted, discussed *kurang darah* and its treatment indicates the importance of gathering information on local terminology

In the Safe Motherhood SSIs, women were asked whether *kurang darah* is a serious problem Three-quarters of the respondents stated that it is a serious problem However, given that women often consider *kurang darah* and *tekanan darah rendah* to be synonymous, it is not possible to conclude that women consider anemia per se to be a serious problem

Bolivia

If the number of women mentioning a problem (unprompted) can be taken as an indicator of the degree to which that problem is recognized, or thought important, then women in Bolivia do not appear to consider anemia to be particularly significant When asked to name problems they considered serious in pregnancy only a handful of Bolivian women mentioned anemia or its associated signs and symptoms, although those who did so considered the signs and symptoms to be serious There is little information pertaining to anemia in the report by Seoane et al, because a detailed qualitative analyses on the topic was conducted by the OMNI project¹⁵

Implications

Future community diagnosis instruments should contain questions on perceived causality of signs and symptoms of anemia Data collection instruments also should contain items designed to obtain local terminology for anemia and its associated signs or symptoms

STEP 1 AWARENESS OF AND PERCEPTIONS OF CERTAIN DELIVERY PROBLEMS

Indonesia

In the Indonesian SSIs, when women were asked whether they considered prolonged labor, premature rupture of the membranes, and cesarean sections to be serious, about three-quarters said that they did More than half the women said that fever during delivery is a serious problem and more than three-quarters of the respondents also considered

hemorrhage during delivery to be serious¹⁶ While tests of statistical significance cannot be performed, the results indicate that women do not consider all problems to be equal

Most women in Indonesia consider long labor, premature delivery, and hemorrhage during delivery to be serious, but in Bolivia, these problems appear to be of less concern than many of those occurring after delivery

In Indonesia, the SSIs did not contain any questions specific to retained placenta. In their discussion regarding the focus groups, however, Marsaban and colleagues state that it is one of the most commonly experienced and well-known complications.¹⁷ While the author does not supply any focus group data, she states that women believe oral contraceptives are responsible for the perceived rise in the number of cases of retained placenta.^{f, 18}

While retained placenta is recognized by women in both Indonesia and in Bolivia, women in both countries have unique perceptions regarding its causes and consequences

Bolivia

In Bolivia, all SSI respondents were asked to name the labor/delivery problems with which they were familiar. In general, women were less likely to mention problems during this time period than they were to cite problems occurring in the post-partum period. Those women who did mention delivery-related problems generally spoke of premature delivery, hemorrhage, or *malparto* (bad birth), which can encompass, among others, any of the aforementioned problems as well as prolonged labor.¹⁹ No additional information on *malparto* is available (e.g., perceived causes and consequences, or what signs or symptoms *malparto* encompasses).

Less than one-quarter of women who participated in the SSIs mentioned premature delivery as a problem, though almost all who did so think it is serious. Some Bolivian women mentioned premature labor, and those who did generally consider it to be serious. While focus group respondents discussed prolonged labor, no women participating in the SSIs mentioned it as a problem, and only two spoke about hemorrhage during delivery. This could indicate that the distinction between those problems occurring in labor/delivery and those occurring in the post-partum period may be somewhat artificial. The fact that only two women mentioned hemorrhage in delivery also may indicate that the respondents do not differentiate between hemorrhage and bleeding (since some bleeding during delivery is to be expected). Alternatively, it also is possible that hemorrhage during delivery was cited far less often than post-partum hemorrhage because women accurately consider the latter to be more serious.

^fAccording to Mary Kroeger, a midwife in Java, 60 percent of maternal deaths in Indonesia are attributed to post-partum hemorrhage. She believes the high hemorrhage rate is due, in part, to the fact that TBAs are trained not to touch the placenta and that in many births the placenta needs to be guided out. Therefore, the issue may not be *retained placentas per se* but *unguided placentas*.

In the SSIs, about one-quarter of the women stated that retained placenta is a problem. However, of these, only half consider it serious. Data from the focus groups reveal that women, particularly those from rural areas, believe retained placenta to be life-threatening. However, these women do not associate retained placenta with hemorrhage, but with infection and heart problems. In addition, many women believe retained placenta is caused by premature cutting of the umbilical cord.

Implications for Future Community Diagnoses

Future research efforts should allow for probing on culturally-defined problems during delivery (e.g., the perceived link between oral contraception and retained placenta in Indonesia and *malparto* in Bolivia). Data collection instruments should be modified to include items on specific aspects (i.e., perceptions and behaviors) of normal deliveries.

STEP 1 PROBLEM RECOGNITION/PERCEPTION OF SEVERITY (POST-PARTUM)

Indonesia

For many conditions discussed in the SSIs, about two-thirds to three-quarters of the women in Indonesia consider various problems to be serious. For signs of infection the numbers were lower. Just over half the women interviewed reported that abdominal pain is serious and about one-

In both Indonesia and in Bolivia, women view hemorrhage as a serious, potentially life-threatening problem. However, how women and their families distinguish between mild and severe bleeding is not clear.

quarter said that malodorous vaginal discharge is serious. **When asked about post-partum hemorrhage, virtually all the women interviewed said it is serious.** More women said hemorrhage is serious than said the same of bleeding. These responses indicate that at least some of the respondents distinguished between the two problems. In their Indonesia trip report of May 27-June 19, 1996, Pareja and Galloway state that for hemorrhage during delivery, women consider bleeding to be excessive, or indicative of hemorrhage if three sarongs are filled with blood²⁰. It is not clear whether this same criteria is used for hemorrhage occurring at other times. Further, it is not clear how women distinguish hemorrhage during delivery from hemorrhage in the post-partum period, except that it is possible that women consider post-partum hemorrhage to be a more serious problem because it occurs more frequently.

Bolivia

With the exception of *sobrepardo* (relapse after birth), post-partum hemorrhage was mentioned without prompting by more women in Bolivia than any other problem. Most of these women considered it to be a serious problem, though a few believed it is not serious. In their report, Seoane and colleagues state that several women in the focus groups attributed hemorrhage during pregnancy to lifting heavy things²¹. Data on the perceived causes of post-partum hemorrhage are not available, nor is information on how women distinguish between mild or severe bleeding.

Sobrepardo, which can include symptoms reminiscent of sepsis or hemorrhage, or which may include swollen feet, or pains resembling those occurring during labor,²² generally is considered a serious problem by most women who mentioned this phenomenon. However, a substantial number of women stated that it is not serious. The range of responses with regard to severity is most likely accounted for by the range of symptoms *sobrepardo* encompasses. As the focus group data reveal, and as Seoane et al report, *sobrepardo* is perceived to occur as a result of a woman's behavior, particularly exposure to cold air, cold foods, or cold water. In Indonesia, there does not appear to be a comparable phenomenon.

In Bolivia, more women mentioned *sobrepardo* (relapse after birth) than any other problem. This phenomenon, which includes a wide range of complications and symptoms is attributed to the mother's careless or inappropriate behavior. While women often seek assistance for *sobrepardo*, they do not turn to the institutional health system. No comparable problem emerged from the data gathered in Indonesia.

Implications for Future Community Diagnoses

Since information on behaviors during the post-partum period and on normal recovery from delivery is lacking, field guides should include items designed to capture these domains.

STEP 1 PROBLEM RECOGNITION/PERCEPTION OF SEVERITY (NEONATAL)

Indonesia

All women participating in the SSIs were asked to indicate whether they considered a particular problem that “can happen to a baby”^g to be serious or not. Only about one-quarter believe having twins or triplets is a serious problem. **About half the women asked said that the following are not serious.**

Both Bolivian and Indonesian women are less familiar with problems occurring in their newborns than they are with problems in pregnancy, delivery, or in the post-partum period

Pushing before the expected due date, having the umbilical cord wrapped around the baby’s neck, if the baby doesn’t cry, or if the baby is cold. More than half the women said having a small baby is not a problem. More than half the women said that it is a serious problem if the baby looks blue and if the baby’s eyes ooze, though a substantial number of women said they didn’t know whether or not the latter was serious.

Bolivia

Results from focus groups, SSIs (despite problems with the data) indicate that study participants generally are unaware of potential complications with the newborn. In the SSIs, Bolivian women were asked to name the problems with “the birth of the newborn” of which they were aware. The wording of the question is ambiguous. It is unclear whether the “birth of the newborn” pertains to newborn health or to the delivery process.^h The question lacks content validity and the resulting data must be interpreted with caution. With those caveats, few women mentioned any neonatal problem. **The three problems cited were premature birth, stillbirths or neonatal deaths, and problems with the umbilical cord.** Of these, premature birth was mentioned by a handful of women. Only three of 41 women mentioned stillbirths/neonatal deaths and only one woman cited problems with the umbilical cord. Those who mentioned prematurity believe it is a serious problem. This conflicts with results from the focus groups, where prematurity and low birthweight are seen as transient conditions of little import (though the low number of responses in the SSIs preclude meaningful interpretation of the data).

According to MotherCare staff, temperature changes, breathing problems, listlessness, and poor sucking are neither looked for nor seen as dangerous.²³ Further, in their report, Seoane and colleagues conclude that neonatal problems (e.g., fetal distress) when mentioned, are seen as important for their potential to threaten the mother’s life, rather than the life of the newborn.²⁴ The fact that so few women mentioned neonatal problems appears to indicate a low level of awareness of the possibility of complications and of their

^gIndonesian Safe Motherhood SSI Instrument

^hBolivian Safe Motherhood SSI Instrument

potential severity This lack of understanding of newborn complications does not necessarily imply a lack of concern for the well-being of the infant, however

Implications for Future Community Diagnoses

Data collection instruments should be revised so that ambiguously worded questions regarding the newborn are changed Additionally, information should be gathered on perceptions of normal newborn behavior and on treatment of the newborn

STEP 1 PERCEPTIONS OF NEWBORN DEATHS

General

Data from Bolivia and Indonesia show that women and their families are not knowledgeable about neonatal complications, and that they appear to believe little can be done to prevent neonatal deaths. A better understanding of women's perceptions of stillbirths and neonatal deaths is necessary to determine what messages are appropriate for motivating women and their families to look for problems and seek help when neonatal complications arise

How women perceive a newborn death is unclear. Evidence indicates that in Bolivia, survival of the newborn is considered subordinate to survival of the mother. In Indonesia, neonatal deaths often are ascribed to fate.

Indonesia

According to PATH-Indonesia, families “seem to accept infant and child death as ‘normal’ and as dictated by fate, “by the will of Allah ””²⁵ In their final report, Marsaban and colleagues also state that while some respondents report an intense feeling of grief in the period immediately following a stillbirth or neonatal death,²⁶ this feeling is short-lived, and that the women believe when a newborn dies the child goes straight to heaven and can help pull the mother there when her time comes. **On the surface, it appears that infant and child mortality is considered fated—a common response given in qualitative research. It should be noted, however, that through probing techniques, it often is possible to elicit additional responses in which deaths are attributable to multiple causes**

Bolivia

In their report, Seoane and colleagues state that among many Bolivian families, the birth process is seen as such a threat to the woman's life, that her survival is viewed as a triumph, even if the infant dies. In this context, the authors suggest, a neonatal death is not considered a tragedy.²⁷ At the same time in the SSIs, most Bolivian women said that malposition of the baby is a serious problem. In their analysis of this finding, Seoane et al suggest that malposition is viewed as serious not just because of its association with a difficult and potentially dangerous birth for the woman, but because women believe malpositioned infants generally die during the birth process. Further while less than one-quarter of the Bolivian women interviewed mention abortion as a complication of pregnancy, of these, almost all consider it to be a serious problem. These results indicate that Bolivian women are, in fact, concerned about bringing their child to term and in good health

Implications for Future Community Diagnoses

Future research should probe more deeply into beliefs and perceptions for neonatal deaths

Care also should be taken in the wording of questions related to the neonate (i.e., items should clearly differentiate between the birth process and the neonate) to ensure content validity of individual question items

STEP 1 EXPERIENCE OF COMPLICATIONS

General

In both Bolivia and Indonesia, fewer women reported experiencing a complication with their newborn than during pregnancy, delivery, or the post-partum period About one-third of the Indonesian women interviewed stated that they had a problem in pregnancy, delivery, or during post-partum, whereas only one-quarter said that their baby experienced a complication after birth In Bolivia, even fewer women said that their newborn had a problem, yet almost two-thirds of the women stated that they had a complication during pregnancy, about one-third reported problems during delivery, and less than a quarter reported post-partum complications

Among women participating in the SSIs in Indonesia and in Bolivia, more report experiencing complications during pregnancy, birth, or in the post-partum period than with the newborn In Bolivia, problems with question wording may have influenced results

The low levels of reported newborn complications may reflect actual experience (i e , that few newborns experience problems) However, given that newborn complications are not an infrequent occurrence, the fact that few women reported experiencing problems may, instead, indicate low levels of awareness

STEP 2 DECISION-MAKING AROUND THE USE OF HEALTH SERVICES WHEN COMPLICATIONS ARISE DURING PREGNANCY, DELIVERY, THE POST-PARTUM PERIOD, OR WITH THE NEONATE

STEP 2 DECISION-MAKING WHO ARE THE CRITICAL PLAYERS?

General

It is evident from the SSIs and focus groups in Bolivia and Indonesia that husbands play a critical role in health-seeking decision-making. However, problems with content validity of SSI items and with data coding preclude meaningful in-depth analysis of the decision-making process.

Husbands play a critical role in the decision to seek care in both Bolivia and Indonesia. Data from the SSIs in both countries are incomplete, and/or suffer from problems with content validity and coding. In Bolivia, focus group data reveal that the woman herself and the mother-in-law also can play an important decision-making role.

Indonesia

In Indonesia, about half the women interviewed stated that they would make the decision to seek care themselves or that they decided where they would seek care (for problems occurring in any stage). When data were analyzed for only those women who reported experiencing complications in delivery, the post-partum period, or with their newborns, results were not discernibly different. About three-quarters of the women who reported experiencing complications during pregnancy said that they decided to seek care or that they decided whose care to seek (the question was worded ambiguously). The ambiguity of the question, in turn, makes interpretation difficult. According to Marsaban and colleagues, husbands decided whether to take their wives to the health facility for problems occurring during delivery.¹ However, in the SSIs, about half the women stated that they had made or would make the decision themselves.

In their report on focus groups, PATH states that women and their husbands rely on the judgement of the traditional birth attendant as to whether or not a midwife should be called or the woman brought to a health facility. From the report, it is not possible to determine whether this information was derived from focus group discussions or is PATH's interpretation.

Bolivia

In Bolivia, there were problems with coding or missing data. Findings must be interpreted with caution. Among women who reported experiencing pregnancy complications, most said that their husbands made the decision regarding care-seeking. However, nearly half the women who said that they had a problem during pregnancy were coded as "don't know/no response." Among women experiencing complications in delivery, most women said that either they or their husbands made the decision. Almost no women reporting post-partum complications responded.

¹The report does not contain any information regarding decision-making at other times.

to the question on the decision to seek care. Very few women reported having problems with their newborn, but those women who did reported either that their husband made the decision alone or consulted with them. **Because so much data are missing or coded ambiguously, and because the items themselves were ambiguous, the SSIs were not particularly useful for determining who plays the most significant role in the decision-making process.**

Reports from the focus groups, however, demonstrate the husband's important role in the decision to seek care. Both male and female focus group participants cited the husband's obligation to care for his family, his perceived knowledge of the community, his authority to decide major household expenditures, his concern for his wife, and the knowledge that when his wife is suffering, she may not be able to make the decision.

Data from the focus groups also indicate that the woman, as an integral family member also takes part in the decision. In their report, Seoane and colleagues state that a woman's decision-making authority is greatest during pregnancy. During delivery, the husband and sometimes other family members, such as the woman or mother-in-law, take on a more dominant, decision-making role. In the post-partum period, the woman again becomes central. Seoane et al. state that the husband's role in the decision to seek care for neonatal complications is almost non-existent. This is in contrast to the findings from the SSIs.

Implications for Future Community Diagnoses

It is critical to obtain valid data on the decision-making process surrounding the use of health services. Questions on SSIs need to reflect the concepts they are intended to represent. Additionally, "no response" and "don't know" answers should be recorded and coded as separate categories.

STEP 2 DECISION-MAKING WHOSE HELP IS SOUGHT?

General

In both Indonesia and Bolivia, results of the focus groups and SSIs shed some light on the rationale for selecting one form of health services over another when complications arise, but they do not give the full picture. In the Indonesian SSIs, women report using or having the desire to use the services of midwives, but the role of the TBA in the birth process and in decisions to seek out the care of a midwife is not elucidated clearly. In Bolivia, data from focus groups and SSIs are inconsistent. Also, because of low response rates in the SSIs, results should be interpreted with

In Indonesia, most women report that they sought the help (or would seek the help of a midwife or village midwife) when complications arose (or if complications arose) during any stage. In Bolivia, data from the SSIs yielded questionable results, some of which conflict with focus group reports.

caution Furthermore, the community diagnoses gathered little information on how decisions regarding health care under normal circumstances (i.e., unrelated to the experience of complications) are made

Indonesia

In the SSIs, women report seeking the help of midwives when complications arise About half the women participating in the SSIs stated that they sought care from midwives (*bidans*) and about one-quarter said they went to village midwives (*bidan di desas*) A few mentioned going to the doctor or traditional birth attendant (TBA), and only a handful said they went to the health post/sub-health center (*pustu*) or health center (*puskesmas*) Results were virtually identical when women were asked where they went or would go for complications during delivery, the post-partum period, or with the newborn Though most births occur at home and though TBAs attend a high percentage of these births,²⁸ few women participating in the SSIs reported going to TBAs for help (possibly because the TBAs already may have been present already) Raw data from the focus groups may help elucidate this situation With regard to this topic, however, Marsaban and colleagues—in their report—only state that women and their families rely on the TBA to tell them when a trained midwife should be summoned²⁹ When women were asked whose care is sought when complications arise, the question appears to have been open-ended Women may have assumed the question pertained to the formal health system only, which would account for the high percentage of women reporting that they went or would go to a *bidan* or *bidan di desa* Alternatively, it is possible that women are in fact seeking out the care of the *bidans* and *bidan di desas* However, **more information is needed to determine the circumstances under which Indonesian women and their families seek care, whose care is sought, and for which problems and why**

Bolivia

Seoane and colleagues state that most women focus group participants from areas where there is low use of institutional health services go first to *parteras*, in whom they have confidence³⁰ Whereas, women FG participants from high use areas go first to the institutional health system, because they believe their problems are more likely to be resolved through that channel than with the *partera*³¹ That women chose the traditional system in low use areas and the institutional system in high use areas is to be expected, since focus group participants were selected on the basis of this characteristic However, analyses of the SSIs reveal potentially conflicting results Women from high *and* low use areas who reported having complications during delivery said that they used the institutional health system, or went to a *partera* in about equal numbers, regardless of their preassigned service use category These results should be interpreted with caution however, because of low response rates Data are not available for the other stages either because of questionnaire design or because low response rates make interpretation difficult In their discussion of the focus groups, Seoane and colleagues suggest that husbands and wives, regardless of whether they come from high or low service use areas have confidence that doctors have the knowledge and training to resolve complications³²

However, the authors state that such confidence is not applied universally across all health system levels. In particular, health center physicians are perceived as inexperienced and less competent compared to those at the district hospital. Seoane et al. assert that this perception is particularly salient in communities where service use is low.

Implications for Future Community Diagnoses

Efforts should be made to gather more data on decision-making behavior vis-a-vis health services use in pregnancy, delivery, the post-partum period and with the newborn. Data collection instruments should have an expanded section on the decision-making process—both under normal circumstances and when complications arise.

STEP 2 DECISION TO SEEK CARE WHO ACCOMPANIES THE WOMAN?

General

Data from the SSIs show that when Indonesian women go to health facilities in general (i.e., not specifically for complications), they are accompanied by neighbors. In Bolivia, husbands generally went with their wives to the health facility when the women experienced

complications. Women participating in the SSIs in Indonesia were not asked who

accompanied them when they had complications. In contrast, Bolivian women were asked only about their companions when they went to a health facility for complications during pregnancy, delivery, the post-partum period or with their newborn and not about who accompanies them under normal conditions. Since the questions were different, the two countries cannot be compared. However **the central role of neighbors and husbands in Indonesia and Bolivia respectively should be noted**

In Indonesia, most women say their neighbors accompany them when they go to the post, center, or hospital (in general, not specifically for problems). In Bolivia, when women had complications, they were most often brought to the health center, post, or hospital by their husbands

Implications

Sections of the field guides designed to assess the same information across countries should, to the extent possible, contain items that are standardized. Information should be obtained on who accompanies the woman to the health facility and which family members interact with providers under normal circumstances and when pregnancy or obstetric problems occur.

STEP 3 ACCESS TO CARE

STEP 3 ACCESS TO CARE PERCEPTION OF CARE

General

Marsaban and colleagues do not report any FG data on perceptions of care in Indonesia. Results from one closed-ended item on the SSIs show women report having confidence in the skill of midwives. Given that an entire concept cannot be assessed using only one item, these findings should be interpreted with caution. No other data on perceptions of care are available for Indonesia. Focus groups in Bolivia provided valuable information indicating that treatment (interpersonal) at health facilities is perceived to be poor. In sum, the SSIs were not a good source of information about perceived quality of care at health facilities.

Neither the SSI in Indonesia, nor the summary report by Marsaban and others provide much information on perceived quality of care. The little data available indicate women have confidence in the *bidans* and *bidan di desas*, but these findings should be interpreted with caution. The SSIs in Bolivia contained more items on perceived quality, but these items had problems with content validity. Focus groups were a much richer source of data. Results indicate that families are not comfortable with male providers, and see their treatment as “cold.” The data also show that women who had attended prenatal care had more confidence in the health system than those who had not.

Indonesia

The SSI contained one closed-ended, numeric question on confidence in the village midwives' skill. More than three-quarters of the respondents reported that they were ‘convinced’ of the village midwives' skill. The SSI also contained some open-ended, short-answer questions related to perceived service quality. Because these data were non-numeric (and in Bahasa Indonesian), for the purposes of this report, they could not be analyzed. Hence the only information available on women's perception of the quality of care received comes from the report on the community diagnosis by Marsaban et al. However, the authors only give the results of the numeric question regarding confidence in the skill of the *bidans/bidan di desas*³³. While the focus group instrument contained questions on perceived problems with care at health facilities, these are not reported in the summary by Marsaban et al. **Since perceived quality of care cannot be assessed using only one item, much regarding this domain remains unknown.**

³³N B Even if more information on perceived quality of care were available from the focus groups, the FG items related to perceived quality of care were biased and leading. For example, women were not asked to talk about the things they liked or disliked about their treatment at health facilities, or about what they thought of the *bidans*. Instead the women were asked if they noticed any problems or deficiencies in the health services, if there was something they really disliked about the health facilities, and if they considered the *bidans* and *bidan di desas* to be too young.

Bolivia

Focus groups were a much richer source of information regarding perceptions of care than were the SSIs. **In the FGs, many women expressed discomfort with male health care providers** and stated that their husbands were not happy that they were exposing their “intimate parts”³⁴ to male health care workers. **Further, according to Seoane et al both husbands and wives felt more comfortable interacting with traditional birth attendants (*parteras*)** because they have “better interpersonal trust”³⁵ with *parteras* and because women can remain clothed

In the focus groups, both women and men, particularly those from low service use areas, expressed the expectation of “bad,” “inhuman,” or “cold” treatment in the health facilities. One woman stated that the doctors “don’t respect our customs,” and that they wash women with cold water and give cold food.³⁶ Given the widespread perception that exposure to cold can lead to *sobrepardo*, such treatment may be perceived as threatening

According to the data from the SSIs, women appear satisfied with the quality of care they received at health facilities. However, these findings still should be interpreted with caution. Items designed to assess quality were vague and may not adequately have reflected the concept they were intended to measure. While items from the SSIs with husbands in Bolivia also were explored, large numbers of missing data make interpretation difficult. In some cases so much data were missing, that variables could not be analyzed. Husbands did report being generally pleased with the treatment they received at the health center, post, or hospital when their wives went there for problems in pregnancy, though not all felt they were seen in a timely manner or that their problems were properly resolved. Though limited data are available for other stages of pregnancy, those husbands who did respond to questions about quality of care for problems in delivery post-partum or with the newborn expressed less satisfaction. However, these results must be interpreted with caution for the reasons discussed above. The items assessing quality are of questionable validity and deference effects—in which respondents give answers they believe the interviewer wants to hear—also are possible

Implications for Future Community Diagnoses

Focus groups should continue to be used to obtain information on perceived quality of care. In-depth interviews can be a valuable source of information, but data collection instruments must assess perceptions of care using multiple questions. Additionally, clear distinctions should be made between perceptions of regular care and perceptions of emergency care during pregnancy, delivery, the post-partum period, and with the newborn

STEP 3 ACCESS TO CARE POTENTIAL BARRIERS DISTANCE

Indonesia

Within each district, the communities participating in the community diagnosis were stratified according to whether the health center was nearby or far away. The criterion for classification was not consistent. Communities were termed "near" if the distance to the health center was within "easy distance" by foot or by public transport. "Far" communities were those that were one or two hours from the health center by public transport.³⁷ However, Marsaban and colleagues also stated that "a community may be only two kilometers away from the health center and is labeled 'far' because it is the furthest community in that area."³⁸

Communities also were stratified according to intensity of service use. In their report, Marsaban and colleagues state that level of attendance was determined by staff at the MotherCare South Kalimantan office, but she gives no further information on stratification criteria. Thus, some areas were far from health facilities, but had high service use and others were close to health facilities, but had low service use.

In Indonesia, study communities were stratified according to distance from the health center. Most women reported that they could reach the sub-health center (health post) within 15 minutes. Most women also perceived the hospital or health center as far away, (though about half said they could reach the health center in less than 30 minutes). In Bolivia, most women, regardless of whether they came from a community with high or low service use, said that the health center or post was close-by. These findings suggests that distance to the health facility may not be the most critical factor in decision-making

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Regardless of the stratification, most women from two of the districts said the sub-health center (*puskesmas pembantu*) was close-by, and most women in all three districts said they could reach the sub-health center within 15 minutes. In all districts, a surprising number of women (more than a quarter of the total sample) said they didn't know whether the sub-health center was close-by or not, but very few reported not knowing whether the health center (*puskesmas*) was near or far. These findings may indicate a problem with the question, or it may be reflective of low service use. It also is possible that women used services at the sub-health center and simply did not perceive distance as important. Despite stratification by distance, most women in two districts reported that the health center was far. This suggests that the distance stratification criteria may have led to inaccurate classifications. **Most women, regardless of district, stated that the hospital was far from them.** Very few reported not knowing whether the hospital was near or far. In Indonesia, women reported going to the sub-health center on foot and about one-quarter reported walking to the health center as well. **About half said they could reach the health center in less than 30 minutes and about one-quarter said they could reach the hospital in 30 minutes.** All the women who reported that it took more than an hour to reach the hospital were from one district.

Bolivia

In Bolivia, SSI participants were asked how long it took for them to get to the health facility using whatever source of transportation they had available **Women from low service use areas reported that it took longer for them to reach their destination than it did for women from high service use areas** However, because many responses were missing, findings should be **interpreted with caution** When women were asked their perception of the distance between the community and the health center or post, most women (regardless of whether they came from a high use or low use community) said that the health center or post was “close by” This is one of the items for which very little data were missing, lending credence to the hypothesis that perceived distance to the health facility is less important in the process of decision-making than are other factors (e.g., cost)

Implications for Future Community Diagnoses

When gathering information on distances to health facilities, questions should be designed to collect data on and distinguish between real and perceived distances

STEP 3 ACCESS TO CARE COST AND REGULARITY OF TRANSPORTATION, COST OF SERVICES

Indonesia

Data on transportation costs to health facilities suffer from large numbers of missing responses Of those women who did respond, only a few said that it cost more than Rp 1,000 (less than 50 cents) to get to a health facility

Women were asked about the *cost of antenatal care services* and not about cost of services *when complications arise* More than three-quarters of the women responding said these services cost between Rp 0-1000 (less than 50 cents) Given that the per capita income in Indonesia in 1994 was \$880 U.S., both service and transportation costs appear affordable (though even minimal costs may serve as barriers to the very poor) These results should be interpreted with caution due to problems with missing data, and given that the questions did not address emergency services In their report on the community diagnosis, the authors report findings from the SSI, but no focus group information is provided **Marsaban and colleagues state that the main barrier to health seeking behavior is “the lack of recognition of life-**

In Indonesia, the SSIs did not provide good information on cost of emergency services and Marsaban and colleagues do not cite any cost-related focus group data in their summary report While the average cost of delivery services in Indonesia is known, no conclusions can be drawn regarding the degree to which cost is a barrier to health services utilization In Bolivia, the SSIs provided little information regarding cost of transportation and services. However, data from the focus groups demonstrate that cost of services and related expenses are a critical barrier to “regular” and emergency care in areas with low health services utilization and to emergency care in areas with high health services utilization

threatening complications and the lack of money for transportation and treatment at the hospital”^k However, based on the SSIs and summary report, it does not appear that the community diagnosis yielded enough information to determine how cost is a factor in decision-making

Bolivia

The SSI questions on transportation cost and regularity, and perceived comfort contained too much missing data to conduct meaningful analyses The large number of missing data is due in part to the fact that the pertinent items were asked only to women who had used private or public transportation to go to a health facility for complications during pregnancy, labor/delivery the post-partum period, or with their newborn Of the four women from low service-use areas who responded to the questions on cost, two reported costs of less than U S \$1 00 and two reported spending U S \$4 00 or more Of the women from high service-use areas who answered questions on cost, none reported spending more than U S \$2 00 Because so few women responded to questions on transportation, extreme caution should be used in interpretation

In the SSIs in Bolivia, only those women who went to a health post, center, or hospital were asked about the cost of services and medicines In both high and low service use areas, results were very similar **In each area, about half the women who had used the services stated that they could afford services or drugs, and about half said they could not** No data on these variables were available for husbands As was the case with many questions, a substantial number of responses were missing

While the SSIs yielded only limited information, the focus groups were a good source of data on cost and perceptions of cost According to Seoane et al women from areas where service utilization was high considered fees for regular care (not for complications) to be affordable Women from areas where service use was low either believed the cost was too high, or said it was unaffordable at any price As one woman stated

*The money is the most difficult to obtain, that's why we don't go to the health center, besides, there are other babies at home to be fed
The Ministry of Health should give free delivery care but it is not so^l*

When discussing costs of care for obstetric complications, women from both high and low use communities perceive the costs to be high According to one husband

For lack of money we sometimes don't take the woman to the Hospital, it s that there, they charge us for everything, even the air

^kMarsaban, 1996 (p 2 Executive Summary)

^lSeoane et al , 1996 (p 122)

we breathe That's why sometimes we have to resign ourselves to losing our companion because we are poor^m

In sum, cost-related data from the Bolivian SSIs are inconclusive, but the focus groups are more revealing Cost of services and related expenses (e g , drugs), emerges as an important barrier to “regular” care and to emergency care in areas where service use is low Cost also is an important barrier to emergency care where service use is high

STEP 3 ACCESS TO CARE HELP FROM THE EXTENDED FAMILY

Indonesia

Data from SSIs with women in Indonesia show that when women go to health facilities, **family members (generally the woman's mother, or an older child) sometimes play a role in caring for young children** Only a few women said that their husbands or any other family member look after the children when they go to the health center However, almost half the women responding said that they take their children with them

While the focus group guides contain a section on community assistance and child care arrangements, the subject is not discussed in the summary report by Marsaban et al

In Indonesia, family members other than the husband sometimes help care for children when women generally go to health facilities. In many cases, the children accompany the mother In Bolivia, women report leaving their children with husbands, parents, and other family members. Data from the focus groups show that family members often provide financial assistance

Bolivia

In Bolivia, women reported leaving their children with their husbands, parents, or other family members (all with about equal frequency) Focus group data reveal the importance of the extended family in providing help not just in caring for young children, but in caring for the mother during the post-partum period Additionally, family members sometimes provide money to help defray some of the costs of health services, particularly when the costs are exorbitant, which may be the case with certain complications³⁹

STEP 3 ACCESS TO CARE HELP FROM THE COMMUNITY

Indonesia

In Indonesia, more than one-quarter of the women participating in the SSIs reported

According to the SSIs in Indonesia and Bolivia, most women report they did not receive help from the community In Bolivia, those who said they did receive assistance generally got help in finding transportation.

^mSeoane et al 1996 (p 123)

that they received help from a neighbor or someone in their community A little more than a quarter of the women reported that they did not receive any such help While women were asked to describe the kind of help they received, this data remains in text form and could not be analyzed herein Marsaban and colleagues do not discuss community assistance in their report

Bolivia

In Bolivia, more than half the women who were interviewed and who reported problems during pregnancy, delivery, the post-partum period, or with the newborn said that they did not receive assistance from anyone in their community Those who did report getting help said that they were assisted by a member of the health profession, or by a family member other than their husband Only two women said they got help from a friend or neighbor In their report, Seoane and colleagues state that there is no formalized system of community assistance for obstetric emergencies⁴⁰ Data from the focus groups support this claim **Help from community members consists primarily of assistance in obtaining transportation or in finding a health provider** Further, Seoane et al state that while community leaders consider it their role to organize community assistance, they fail to do so

SECTION IV—STRENGTHS AND WEAKNESSES OF THE SEMI-STRUCTURED INTERVIEWS AND FOCUS GROUPS CONDUCTED IN INDONESIA AND BOLIVIA

In this section, the strengths and weaknesses of the community diagnosis methodology, instruments, and data management procedures are outlined. Detailed information regarding the construction or analyses of specific items in the instruments can be found in **Appendix A**. The section below also contains a general overview of some methodological considerations inherent in using the qualitative methods (i.e., SSIs and FGs employed in the community diagnosis). The discussion of the strengths and limitations is not comprehensive. Issues of cost, burden of data collection and analysis, and details on interviewer training are not discussed. Furthermore, not all methodological considerations are raised.

SEMI-STRUCTURED INTERVIEWS IN INDONESIA AND IN BOLIVIA

Strength The SSIs in Bolivia and Indonesia yielded some important information regarding perceived severity of certain neonatal and pregnancy-related complications. The semi-structured interviews also were useful for identifying some of the problems women knew about, but which fall outside the purview of western medicine (e.g., *sobreparto*).

Strength Some valuable information on problem awareness was obtained through the semi-structured interviews.

Limitation Issues with Method Choice

Semi-structured interviews are particularly useful when the study participant cannot be reinterviewed,⁴¹ as was the case in both Bolivia and in Indonesia. In semi-structured interviews, a pre-prepared guide is used to shape the interview format and to obtain information on a select number of topics. Topics generally are covered in a particular order. The guide is not rigid. Interviewees are not asked to respond to a particular set of stimuli or to closed-ended questions. In addition, the interview structure is sufficiently flexible to allow discussion to be guided by the study participant.⁴²

Limitation Issues with Method Choice The “semi-structured interviews” really were *structured interviews*. If there is scant information about a topic area and if data collection is just beginning, structured interviews are not ideal.

Structured interviews follow a more rigid pattern. As stated by Bernard, the goal of structured interviewing is to “control the input that triggers each informant’s responses so that output can be

reliably compared”ⁿ Structured interviewing can take on many forms (e.g., free-listing or pile-sorting) The SSI instruments used in the community diagnoses were just one example of a structured interview Study participants responded to closed-ended questions and to open-ended, short-answer questions Structured interviews are best when a sufficient amount of trustworthy information about a topic area already exists⁴³ They may be used to gather more detailed information about a particular topic area and to refine understanding of a particular issue (e.g., a certain belief, behavior, or process)

Based on a variety of considerations and constraints, the decision was made to conduct SSIs using a structured questionnaire However, as discussed above this form of data collection is not ideal for gaining a basic understanding of important values, norms, beliefs, and behaviors which cannot readily be observed Respondents must mold their responses to fit the researcher’s preconceived categories As Patton states, the respondents’ true meaning can be distorted because their response choices are constrained⁴⁴

Limitation Issues with Sampling

The aim of qualitative research is to illuminate the questions of interest, (e.g., to understand how women view the post-partum period, what behaviors are prohibited or encouraged, what behaviors they engage in and why) Sampling in qualitative research is conducted to maximize information richness⁴⁵ Study participants are selected not because they are representative of the broader population, but because they are likely to provide important and valid information^o In qualitative research, “the validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information-richness of the cases selected and the observational/analytical capabilities of the researcher than with sample size”^p

Limitation Issues with Sampling
Purposive sampling, while appropriate for true in-depth interviews and semi-structured interviews, yields results that cannot be generalized to the population at large The use of this sampling technique in conjunction with administration of a questionnaire containing mostly closed-ended questions was not ideal

ⁿ(Bernard p 237)

^o In fact, in many qualitative research techniques (e.g. key-informant interviews) informants often are selected because they are *not* representative of the broader population (e.g. they may be community leaders or they may be uniquely insightful, analytical, and articulate) These informants generally have the ability to work within and understand multiple cultures As Crabtree states “These individuals by their very ability and willingness to straddle two cultures often do not represent the native culture” (Crabtree, p 75)

^p(Patton p 185)

The sampling strategies employed in qualitative and quantitative data collection methods are different because the research goals differ. In quantitative research, the aim is to generalize study findings to a broader population. Hence, the study sample must be representative of that broader population. Such a sample is obtained through some method of random sampling.

The sampling strategy used in the community diagnosis was quite appropriate for true semi-structured, or unstructured interviewing, but was less suited for the structured technique employed in the SSI. The SSIs yielded substantial quantitative information, but the purposive sampling (and small sample size) limited its value. As mentioned earlier, results *cannot* be considered representative of the broader population of Bolivian or Indonesian women of reproductive age. Exact percentages cannot be reported since they are not indicative of the true frequency distributions in the broader population. Hence, the value of the quantitative information was diminished.

Limitation Issues with Instrument Design

(A) comparability Because MotherCare wanted to generate information that could be compared across study sites, staff tried to develop two SSI instruments for both countries, each containing the same items and in the same order. However, in the end, the instruments varied significantly, thus limiting comparability of the quantitative information.

(B) content validity Some of the SSI items had problems with content validity. As discussed previously, content validity refers to the extent to which items in the questionnaire are representative of the concepts they are meant to reflect. In the SSI, the content validity of certain items was low for two reasons. First, questions sometimes

were worded ambiguously. Second, because researchers were concerned about the questionnaire's length, efforts were made to limit the number of items asked. As a consequence, in some cases, the number of question items was insufficient to cover a concept adequately.

(C) ambiguity In both the Indonesian and Bolivian versions of the SSIs, the meaning of some questions was unclear, or subject to multiple interpretations. For example, in Bolivia, where post-partum family planning questions were included in the Safe Motherhood questionnaire, women were asked, "If a woman wants to use a method immediately following delivery, which method do you think is the most appropriate?" Because the period "immediately following

Limitation Issues with Instrument Design

- **There were differences in the question wording and instrument design of the SSIs in Bolivia and Indonesia. This variation precluded direct comparison between the two countries.**
- **Some concepts may not have been captured adequately in the SSIs because questions were worded ambiguously or because there were too few items used to represent a domain.**

delivery” is open to interpretation, the item is neither reliable nor valid, and the responses cannot be analyzed in a meaningful way

Limitation Data Coding and Analysis

In Indonesia, most items contained only a few missing responses. In Bolivia, a significantly large proportion of the responses were missing, thus precluding meaningful analyses. For example, when women were asked where they first sought help for problems in pregnancy, responses were obtained for only one-quarter of the women who reported experiencing a pregnancy complication.

Limitation Data Coding and Analysis

- **For some questions, particularly in Bolivia, large numbers of missing data rendered certain items invalid**
- **Some responses were coded ambiguously, thus prohibiting meaningful analyses and inhibiting interpretation**

Sometimes, while the question was straightforward, the response categories were ambiguous, or were too broad. For example, in Bolivia, while the SSI instrument separated the categories “don’t know” and “no response,” these categories were combined when the data were coded. One goal of the SSI was to determine people’s knowledge. By combining non-responders with those who reported “don’t know,” information on knowledge is lost. Merging the two response categories creates other problems as well. When the “non-response” category is too large, the validity of the item declines. When “don’t know” responses are included with “no response” answers, it is not possible to tell whether non-response is a problem.

FOCUS GROUPS IN INDONESIA AND BOLIVIA

General Comments

MotherCare DC does not have the transcripts of the focus groups in Bolivia, but the report by Seoane et al. contains a great deal of focus group data. On the basis of this report, it is clear that the focus groups in Bolivia generally were a good source of information regarding perceptions of pregnancy complications, the role of various actors in the decision-making process, perceptions of the effectiveness of the traditional and institutional health systems in handling complications, and for illustrating how community members perceive the services they receive at health facilities.

In Bolivia, the focus groups were an extremely rich source of information

Without seeing the data, it is not possible to determine whether the focus groups were useful in Indonesia

MotherCare DC does not have the transcripts of the focus groups from Indonesia. The report by Marsaban and others contains virtually no focus group data. Thus, it is not possible to determine whether or not this data collection technique provided valuable and new information.

Limitation Response Effects

In focus groups, characteristics (and hence the validity) of the data obtained may vary, depending on the characteristics of the participants, the interviewers, and the

environments in which the focus groups are conducted. Little information is given in reports by Marsaban et al., and by Seoane et al., regarding the actual characteristics of each group and of the interviewers. It is reasonable, however, to expect that response effects were present, and that they may, to varying degrees, have influenced the validity of the data obtained.

Limitation Focus groups are subject to response effects and deference effects,

Limitation Deference Effects

Deference effects occur when participants give answers they think the interviewer or other group members want to hear. Response effects can interact with deference effects. For example, focus group participants may give the "polite" response to a question if the interviewer comes from their community, whereas they might give a different statement to an outsider. How questions are worded can have a significant impact on the deference effect. Peterson found that for nonthreatening questions, slight changes in wording yielded very little change in the response.⁴⁶ But as Bernard states, when asking about more sensitive topics, small changes in wording can have significant effects on participant responses.⁴⁷

Given the personal nature of some of the questions (e.g., those dealing with family planning, sexually transmitted diseases, and the perceived skill of the health care workers), it is possible that deference effects influenced the quality of some of the data.

The following section contains (1) a brief summary of the findings from the community diagnosis research in Bolivia and Indonesia, (2) highlights of study strengths and weaknesses, and (3) recommendations and conclusions regarding methods, instrument design, data management, training, monitoring, and supervision, reporting, and content of field guides for future community diagnosis research. The suggestions are not exhaustive. In some cases they were developed in response to particular problems experienced in the community diagnoses in Indonesia and in Bolivia. In other instances, they follow guidelines for the conduct of qualitative research more generally.

FINDINGS

- (1) *Knowledge/Awareness of Problems* The degree to which women and their families in Bolivia and Indonesia recognize the signs of complications varies, depending on whether the problem of interest occurs in pregnancy, delivery, the post-partum period, or with the newborn. In both countries, there appears to be less awareness of newborn complications than of complications at other stages.

In Indonesia, swelling is recognized but generally not viewed as serious. The signs of anemia are widely known, though the term “anemia” is not. Women are aware that iron tablets can alleviate anemia-related problems. Women in Indonesia also know of and consider the following delivery problems to be serious: long labor, premature birth, and hemorrhage. Hemorrhage during the post-partum period also is considered potentially life-threatening, though women have trouble distinguishing dangerous bleeding from less serious bleeding.

In Bolivia, swelling is considered normal. Few women mentioned anemia or its associated signs and symptoms. Bolivian women were less likely to mention problems in labor and delivery than in the post-partum period. Premature delivery, hemorrhage, and *malparto* (bad birth) were among the most frequently cited problems during this time period.

Sobreparto (relapse after birth) is the complication Bolivian women mentioned more than any other. *Sobreparto* is viewed as having varying degrees of severity, most likely reflecting the fact that the problem encompasses a wide range of symptoms.

- (2) *Health-Seeking Decision-Making* In both Indonesia and Bolivia, husbands are very influential in the decision to seek care. In Indonesia, most women report seeking or wanting to seek the help of midwives or village midwives for complications. However, data on this topic are incomplete and little information was gathered on the role of

traditional birth attendants. When Indonesian women go to health facilities (not necessarily for treatment of complications) neighbors generally accompany them.

In Bolivia, husbands appear to play a particularly important role in the decision to seek care as do the women themselves (particularly during pregnancy). Mothers-in-law also can be influential. Bolivian data on use of traditional and institutional health services are somewhat ambiguous. Reports on focus group results from Bolivia indicate that faith in a given system of care either traditional or institutional largely is what determines the degree to which they are used. Data from the Bolivian SSIs, however, indicate that regardless of whether women came from high or low institutional service-use areas, they tend to use these facilities and traditional services in about equal numbers. Finally, in Bolivia, husbands most often accompany their wives to the health facility when pregnancy or obstetric complications arise.

- (3) *Access to Care*. There is little information available on perceived quality of care in Indonesia. While some data indicate that Indonesian women have confidence in the *bidans* and *bidan di desas*, information on this topic is sparse (particularly since no focus group data on this subject were reported) and may not be reliable. Data from the SSIs show that Indonesian women generally know the location of various health facilities and can reach some health facility within 15 minutes, though most women reported that the hospital is far away. In Indonesia, SSI data on cost of services and associated expenses suffer from problems with question wording and large numbers of missing responses. Focus group data on the subject were not reported and therefore, conclusions regarding the importance of cost as a potential barrier to care cannot be drawn. While Indonesian women sometimes report receiving help from neighbors when complications arose, the nature of this assistance is not clear.

Data from the Bolivian SSIs indicate that women and their husbands are reasonably satisfied with care received at health facilities. However, data from the focus groups tell a different and probably more accurate story. In the focus groups, treatment was described as "inhuman" and "cold." Women and their families also indicated discomfort with male providers and greater comfort in their interactions with traditional birth attendants than with institutional health personnel. With regard to distance from health facilities, Bolivian SSI participants from low service-use areas reported longer transportation times to health facilities than did their high service-use counterparts, though large numbers of missing responses require that the data be interpreted cautiously. The semi-structured interviews in Bolivia revealed little about transportation or cost of services and related expenses. However, focus group data indicate that cost is a critical barrier to "regular" care and emergency care in areas with low health services use and to emergency care in areas where health services utilization is high. In Bolivia, data from the focus groups show the importance of assistance from the extended family in

providing child care, tending to the mother during the post-partum period, and in providing money to defray the cost of health services. Women in Bolivia generally did not report receiving assistance from their community, though some reported getting help in finding transportation.

STUDY/REPORTING STRENGTHS

- Overall, the community diagnosis exercise is a useful process for identifying training, service-delivery, and individual/community-level needs with regard to maternal and neonatal health in developing country contexts, and for developing key IEC/C messages. The semi-structured interviews and focus groups provided pertinent information on knowledge/recognition of problems, decision-making regarding health-care seeking behavior, access to care, and perceptions of the quality of care. This information provides a base from which interventions are being developed.
- The community diagnosis uses the Pathway to Survival as the basis for instrument design. The importance of using a framework to guide the data collection process cannot be overemphasized.
- In their summary report of the community diagnosis in Bolivia, Seoane and colleagues make good use of focus group data to support their conclusions.

STUDY/REPORTING WEAKNESSES

- Wording and formatting of questions and question flow were not consistent between Bolivia and Indonesia, so direct comparisons between the two countries often could not be made.
- There were several problems with items on the SSI and FG field guides. Specifically, questions were not always worded clearly, single items sometimes were used to represent an entire domain, and questions often were closed-ended when the intention was to elicit dialogue between the interviewer and respondent.
- In the coding process, merging certain response categories led to difficulties in interpreting results.
- The reporting from Bolivia and Indonesia was variable. In their summary document, the Bolivian authors present much detail regarding study results, though more information on methodology would have strengthened the document. The Indonesian summary report contains incomplete information regarding findings and study methodology. Examples of problems that can be found in one or both of the reports include (1) lack of detail regarding participant selection criteria (e.g., for focus groups), interviewer training and quality assurance efforts, and coding schemes, (2) incomplete reporting (or data analysis).

of certain responses and response categories, (3) insufficient use of raw data (e.g., quotes from focus groups or open-ended questions on the SSIs), (4) reporting of percentages for data obtained from small, purposive samples and (5) missing instruments (data collection instruments were not included as appendices in the report documents)

RECOMMENDATIONS AND CONCLUSIONS RESEARCH APPROACH

In some cases, the comments below reflect general principles in the conduct of qualitative research. In others, they reflect issues specific to the community diagnosis research in Bolivia and Indonesia.

Methods

- A combination of data collection methods should be employed, e.g., both in-depth interviews and focus groups. Other techniques such as ratings, rankings, triads, pile sorting and free listing also should be considered.
- Where quantitative information is sought (e.g., where population-based percentages are required), true quantitative data collection methods (e.g., surveys) should be used. In these instances, sampling should be random.
- To limit deference effects, very sensitive topics (e.g., questions on STDs/RTIs or family planning) often are best explored with in-depth interviews as opposed to focus groups.^{48 49} Furthermore, information on these topics often is more successfully obtained in later interviews with the same respondent. Specifically, Bentley recommends using the first interview to establish a good rapport, gain trust, and gather information on less sensitive issues. Sensitive topics can then be addressed in a second or third interview.⁵⁰
- Participant selection criteria should be clearly specified and should remain consistent. For focus groups, efforts should be made to ensure participants are homogenous across the characteristics of interest (e.g., women who have experienced a pregnancy or obstetric complication in their last pregnancy). Focus groups also should contain at least six and not more than 10 participants.

Instrument Design

- Individual researchers and program planners working in a given setting will need to modify and adapt data collection instruments to meet their interests and requirements. However, in order to make cross-country comparisons, where possible, MotherCare should work to ensure items are identical across instruments. In cases where this is not possible, MotherCare should strive for similar wording and formatting of questions and question flow.

- Efforts should be made to maximize question clarity and content validity. Items should be carefully screened for ambiguity, should employ local terminology, should represent the concepts of interest and be clearly understood by the respondent. Additionally, domains should be measured by multiple questions rather than single items.
- Questions should be open-ended and should not lead the respondent. Dichotomous questions, particularly in the beginning of an interview or focus group will inhibit talking and sharing of information and should be avoided.
- If closed-ended questions are used with prescribed response categories, “don’t know” responses should be separated from “no response” answers. Double-barreled items, in which two or more questions are embedded in one, should not be used.
- Probes should be used liberally. They should be clear and precise. “Why” probes should be avoided, as they imply a questioning of the validity of the interviewees response.
- The format of the instrument should be such that questions flow from the general to the specific. Initially, topics should be non-controversial and non-sensitive, to encourage respondents to talk and to establish trust and a good rapport. It often is useful to begin interviews or focus groups with descriptive questions, followed by queries on opinions, feelings, and interpretations. Questions on knowledge or skills should be saved until a rapport between the interviewer and respondent has been established.⁵¹ Demographic questions should be reserved until the end of the interview. However, if certain demographic information is required to ensure that study participants meet selection criteria, an initial screening question on the demographic item of interest can be used before the start of the actual interview.

Content

- While instruments need to be developed and modified to be context specific, their design should be guided by a framework or model (e.g., the Pathway to Survival or the Pathway to Behavior). Efforts in Indonesia and Bolivia used the Pathway to Survival as a framework, this approach gave valuable information on problem recognition, perceptions of care, decision-making regarding care and some environmental or structural constraints such as cost and transportation. Other frameworks also can be used. For example, Fishbein’s Pathway to Behavior (see Appendix A) emphasizes these and other factors, such as intentions to perform a given behavior and the skills needed to do so. While the framework has yet to be tested, it might prove useful.
- General categories to consider for inclusion in field guides are (1) recognition of signs of complications, (2) key players in the process by which care is sought, (3) perceptions of the quality of care in health facilities and from traditional health care providers, (4) intent

to use services (including information on attitudes, knowledge, beliefs, skills, and norms), (5) skills (e.g., ability to negotiate with providers), and (6) environmental constraints (e.g., cost, transportation, availability of services, hours of operation) to behavior performance

Data Management and Analysis

- Careful attention must be given to the coding process. If quantitative information is obtained, “don’t know” and “no response” categories should not be merged and, where possible, an “other” category should be avoided or minimized. In qualitative data, coders also should be wary of merging responses. For example, hemorrhaging and bleeding should be coded separately. For qualitative information, a coding scheme should be documented with a description of the code and its inclusion criteria.
- If data are collected, they should be coded and analyzed. This is an extremely time-consuming process. Time and resource constraints must be considered in decisions regarding research methodology and sample size.

Training, Monitoring, and Supervision

- The use of effective probing techniques is critical to successful qualitative interviewing. Interviewers and focus group moderators should receive intensive training on probing and should receive continuous performance feedback throughout the data collection process.
- Note-taking during interviews and focus groups is critical, even when sessions are recorded on cassettes. Notes should include—among other things—indications of gestures and tones, mood, who is speaking, who is not speaking, a description of the setting and the participant, and direct quotes from the respondent. Notes should be reviewed on a regular basis and appropriate feedback given to the interviewers or focus group recorders.
- Where respondents are reinterviewed one or two times to obtain more sensitive information, the initial IDI cassette and notes should be reviewed so that the interviewer can follow-up on issues that require more probing or clarification.
- The data management process must be supervised to ensure accurate coding of data. Where possible, as a method of quality control, two people should code the same segment of material, this segment should be compared, and—if appropriate—modifications in coding procedures should be made.

Reporting

- Adequate descriptions of study methodology (e.g., participant selection criteria, focus group composition, interviewer training and supervision, coding techniques) must be contained in the summary report of community diagnosis efforts
- Care should be taken in the reporting of percentages. Purposive sampling and the small sample sizes often found in qualitative research generally preclude meaningful reporting of exact percentages

APPENDIX A FISHBEIN'S PATHWAY TO BEHAVIOR—A FRAMEWORK FOR POSSIBLE USE IN FUTURE COMMUNITY DIAGNOSIS RESEARCH

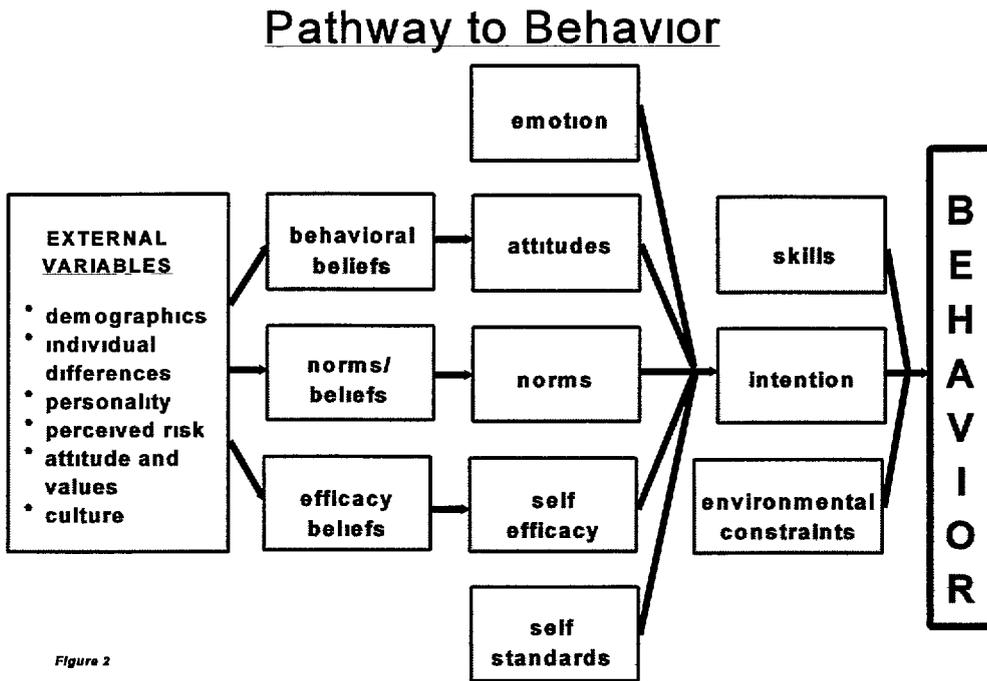


Figure 2
Source Fishbein 1997

APPENDIX B. IDENTIFIED GAPS/AREAS OF CONFUSION

After having conducted the community diagnosis and after gaining additional experience in Bolivia and Indonesia, it is possible to review MotherCare's community diagnosis research and shed new light on questions or topic areas related to the Pathway to Survival that either were not addressed in the qualitative research or were not answered definitively

Below is a list of those gaps or areas of confusion. Additional data collection is not necessary to obtain answers to *every* question. In fact, no one research endeavor needs to or should address all the topics discussed below. In some instances, answering the questions raised will require new research. In others, previous research (unrelated to the community diagnosis), or extant literature may provide adequate information. The list is neither narrow nor exhaustive, some domains or issues are more important for program design and implementation than others. Also, as additional research is conducted and programs are designed, some questions will be answered and many more will likely arise.

N B, this list of gaps pertains to information related to the Pathway to Survival. Were the Pathway to Behavior also used as a base for inquiry, other gaps could be identified, particularly those related to the intention to perform a behavior and the skills required to do so.

PROBLEM RECOGNITION

Domam	Identified Gap/Area of Confusion
Pregnancy Perceptions/Practices	<ul style="list-style-type: none"> • Workload norms and proscriptions • Health promoting/inhibiting behaviors, (e.g., beneficial or harmful traditional practices, prenatal care) • Information sources (i.e., how do women know what they should and shouldn't do during pregnancy?) • Diet: What foods are proscribed/prescribed and why? • Signs and symptoms that are considered "normal" (e.g., swelling)
Swelling Perceptions/Practices	<ul style="list-style-type: none"> • What women do about swelling
Anemia Perceptions/Practices	<ul style="list-style-type: none"> • Indonesian women's beliefs about the causes of <i>kurang darah</i> • Indonesian women's beliefs about the causes of <i>tekanan darah rendah</i> • How (and if) Indonesian women distinguish between <i>kurang darah</i> and <i>tekanan darah rendah</i> • Reasons why women won't take iron pills throughout pregnancy • Whether women will eat more during pregnancy • What Indonesian women do about <i>kurang darah</i>, <i>tekanan darah rendah</i> • What Bolivian women do about anemia or its symptoms

Domain	Identified Gap/Area of Confusion
Certain Delivery Problems Perceptions/Practices	<ul style="list-style-type: none"> • Symptoms and perceived causes of <i>malparto</i> in Bolivia • How women/others distinguish between delivery and post-partum (as opposed to clinical definitions) • How women/others distinguish between hemorrhage and bleeding (or between “normal” bleeding and “excessive” bleeding) • Perceived link between retained placenta and oral contraceptives (in Indonesia) • Importance of retained placenta • Health promoting/inhibiting behaviors • What women do about hemorrhage, bleeding, or other delivery complications
Certain Post-Partum Problems Perceptions/Practices	<ul style="list-style-type: none"> • What women do to treat <i>sobrepardo</i> (in Bolivia) • List of symptoms associated with <i>sobrepardo</i> and their perceived severity • Information on other problems (from the woman’s or family’s perspective) Examples include <i>pasmo</i>, <i>arrebato</i>, and <i>suspension de la sangre</i>¹ • Information on dietary prescriptions/proscriptions • Health promoting/inhibiting behaviors • What women do about other post-partum problems
Certain Neonatal Problems Perceptions/Practices	<p>Perceptions of “normal” newborn characteristics (e g , color, breathing)</p> <ul style="list-style-type: none"> • Information on newborn care • Information on infant feeding practices/beliefs (e g colostrum timing, techniques) • Information on other health promoting/inhibiting behaviors • What families do about neonatal problems
Neonatal Deaths Perceptions/Practices	<ul style="list-style-type: none"> • How (and if) women and their families believe neonatal deaths can be prevented • Current practices to prevent neonatal deaths • Willingness to do certain things (e g warming, exclusive breast feeding clean cord care, etc) to prevent death

¹ These illnesses and their cures are described by CIAES in their report to MotherCare (The Center for Health Research Consultation and Education (CIAES) 1991 *Qualitative Research on Knowledge Attitudes and Practices Related to Women s Reproductive Health* MotherCare Project Cochabamba, Bolivia)

DECISION-MAKING

Domain	Identified Gap/Area of Confusion
Decision-Making Who are the Critical Players?	<ul style="list-style-type: none"> • The husband's role in decision-making when neonatal complications arise
Decision-Making Whose help is sought?	<ul style="list-style-type: none"> • Information on whose help is sought (and in what circumstances) when the TBA is already present • Information on whose help is sought (and in what circumstances) when the TBA is not present • Specific information on when a <i>Bidan</i> or <i>Bidan di Desa</i> is considered the best option (Indonesia)
Decision-Making Who Accompanies the Woman to Health Facilities?	<ul style="list-style-type: none"> • Information on who goes with the woman or newborn when life-threatening complications arise (Indonesia) • Information on who interacts with health providers when a woman goes for regular or emergency care
Decision-Making Other	<ul style="list-style-type: none"> • The most critical factors inhibiting the use of health services under normal and emergency circumstances (Indonesia)

ACCESS

Domain	Identified Gap/Area of Confusion
Access to Care Perception of Care	<ul style="list-style-type: none"> • Information on links between practices at health facilities and <i>sobreparto</i> or other illnesses (Bolivia) • Specific information on the perceived benefits and problems of home births versus births in a health facility for normal and complicated cases • How care provided by <i>Bidans</i> and <i>Bidan di Desas</i> is perceived (Indonesia) • How the care provided by other health care workers is perceived (Indonesia) • Willingness to move (influence of perceived quality of care and effectiveness of services in the decision to seek care, i.e., how perceived quality of services influences the decision to seek care)
Access to Care Potential Barriers (Distance)	<ul style="list-style-type: none"> • How distance considerations affect decision-making for <i>life-threatening</i> conditions • Importance of distance considerations versus availability, cost, or other factors
Access to Care Potential Barriers (Cost and Regularity of Transportation Cost of Services)	<ul style="list-style-type: none"> • How cost considerations affect decision-making for <i>life-threatening</i> conditions • Importance of transportation costs versus availability or other factors
Access to Care Help from the Extended Family	<ul style="list-style-type: none"> • Role women want other family members to play, and when
Access to Care Help from the Community	<ul style="list-style-type: none"> • Current role of the community in promoting maternal health and in preventing maternal deaths when life-threatening complications arise • Role the community is expected to play • Role families want the community to play

APPENDIX C RECOGNITION OF THE PROBLEM IN-DEPTH INTERVIEWS WITH MOTHERS AND SUMMARY OF INDONESIA/BOLIVIA REPORTS ON FOCUS GROUPS

Domain/Item	Indonesia (90 women interviewed)	Bolivia (41 women interviewed)	Comments/Limitations
<p>1A 0—RECOGNITION OF THE PROBLEM Knowledge and Perception of Severity</p>		<p>SSI Responses were unprompted. Virtually all the problems mentioned were cited by less than one-quarter of the women interviewed. The most frequently cited problems were hemorrhage and <i>sobrepeso</i>. About half the women mentioned these problems.</p>	<p>General (SSIs) (1) Sample selection (purposive sampling) and the small sample size mean that data are not necessarily representative of the broader population and that results cannot be generalized. (2) There were important differences between Bolivia and Indonesia in how questions on problem recognition and perceived severity were asked. The numbers reported for Indonesia are from items where responses were prompted (e.g., “is anemia a serious problem or not?”). The numbers reported for Bolivia stem from unprompted responses (e.g., what problems occurring during delivery are you familiar with?). Indonesia (SSI) Women were asked to list the problems they had experienced during pregnancy, delivery post-partum, or with the newborn. If the women reported having experienced no complications in given stage, they were asked to name the problems with which they were familiar. Because these data were open-ended (and in text form), they could not be analyzed for this report. Only closed-ended SSI questions are discussed.</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
RECOGNITION OF THE PROBLEM Knowledge and Perception of Severity (continued)			
1A 1—Hemorrhage (all stages)	<p>SSI Not calculable for Indonesia</p> <p>Report (FGs) Discussed for delivery (see 1A 19)</p>	<p>SSI Responses were unprompted Hemorrhage (in any of the stages) was the most frequent problem mentioned (cited by nearly half the women interviewed) The perception of the severity varied While most women who mentioned hemorrhage believed it was serious, some did not</p> <p>Report See 1A 11, 1A 19, 1A 24</p>	<p>Indonesia (Report—FGs) It is unclear from the report whether <i>women</i> associate hemorrhage with retained placenta or whether it is PATH who makes this association</p> <p>Bolivia (SSI) Hemorrhage and bleeding were coded together If women were talking about bleeding (as opposed to hemorrhage), those who indicated “hemorrhage” was not serious may accurately have assessed the severity of the problem</p>
1A 2—Other (all stages)	<p>SSI Not available for Indonesia (not asked in closed-ended questions)</p> <p>Report (FGs) Temporary leg paralysis was mentioned by some women who associated this condition with difficult or prolonged labor</p>	<p>SSI A few women mentioned problems that were coded as “other”</p> <p>Report Not discussed</p>	<p>Bolivia (SSI) It is not possible to determine what conditions were coded as “other”</p>
1A 3—Pain (all stages)	<p>SSI Not available for Indonesia (not asked in closed-ended questions)</p> <p>Report (FGs) Not discussed</p>	<p>SSI Pain was mentioned by about one-fifth of the women Half of these women thought it was a serious problem while the other half did not</p> <p>Report Pain is mentioned in the context of <i>malparto</i> and <i>sobrepardo</i> (see 1A 14 and 1A 22)</p>	<p>Bolivia (SSI) From the data, it is not possible to determine the location or significance of “pain”</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
RECOGNITION OF THE PROBLEM Knowledge and Perception of Severity (continued)			
1A 4—Spontaneous abortion (miscarriage)	<p>SSI Not available for Indonesia (not asked in closed-ended questions)</p> <p>Report (SSIs) According to the authors, most respondents mentioned miscarriage (unprompted) and considered it dangerous</p> <p>Report (FGs) Not discussed</p>	<p>SSI Responses were unprompted A handful of women mentioned spontaneous abortion Of these, all but one considered it serious</p> <p>Report Not discussed</p>	<p>Indonesia (SSI) Women were not asked about spontaneous abortion in Indonesia The results reported by the authors may indicate that miscarriage is seen as a threat to the woman s health It also may be viewed as serious because it is a loss Unless this topic was discussed in the focus groups, further research is needed to understand the significance women ascribe to miscarriage</p>
1A 5—Baby in bad position (Bolivia and Indonesia) Baby upside-down (Indonesia)	<p>SSI Most women (about three-quarters) said baby in a bad position was a serious problem</p> <p>SSI About three-quarters of the women said an upside-down baby was a serious problem</p> <p>Report (FGs) Not discussed</p>	<p>SSI Responses were unprompted Bad position of the baby was mentioned by less than one-quarter of the women A few of them said it wasn't serious</p> <p>Report According to the authors, malposition of the baby is considered serious and is seen as a problem in birth that stems from complications in pregnancy The primary reason women give for antenatal visits to a <i>partera</i> or doctor is to be sure the baby is in a good position</p>	<p>Indonesia (SSI) The consistency in responses between the two similar questions in Indonesia suggests the items have good content validity</p> <p>Bolivia The findings from the FGs are noteworthy and would have been missed by relying on the SSIs alone</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
RECOGNITION OF THE PROBLEM Knowledge and Perception of Severity (continued)			
1A 6—Swelling of face/eyes/feet (Bolivia) Swelling of face/hands (Indonesia) Swelling of feet (Indonesia)	<p>SSI About half the women interviewed felt that <i>swollen hands and face</i> was a serious problem. Most others said it was not serious, though some stated they didn't know if it was serious or not.</p> <p>SSI More than a quarter of the women felt that <i>swollen feet</i> was a serious problem. Most others said it was not serious. A handful stated that they didn't know if it was serious or not.</p> <p>Report (FGs) Not discussed</p>	<p>SSI Swelling was mentioned by more than one-quarter of the women, most of whom believed this was not a serious condition. Very few husbands mentioned swelling.</p> <p>Report Data from the focus groups indicate women do not see swelling as dangerous. Some view it as indicative of a favorable pregnancy.</p>	<p>Indonesia (SSI) Some women do seem to distinguish between swollen face/hands and swollen feet.</p> <p>Bolivia (SSI and Report) Swollen feet/face/hands were coded together, making it hard to determine whether women distinguish between swelling that is indicative of pre-eclampsia/eclampsia and swelling that may be indicative of pressure edema (a common problem in pregnancy). At the same time, FG data support the finding that women do not see swelling (including that of the face and hands) as serious.</p>
1A 7—Common problems (pregnancy)	<p>SSI Not available for Indonesia (not asked in closed-ended questions)</p> <p>Report (FGs) Anemia was discussed in focus groups. Problems mentioned were nausea, vomiting, headaches, dizziness, fatigue, weakness, lack of energy, and stomach aches/pains.</p>	<p>SSI 'Common problems' was mentioned by only one woman who said it was not serious.</p> <p>Report Not discussed.</p>	<p>Bolivia (SSI) Although 'common problems' was mentioned by only one woman, it may be useful to determine what women consider 'common problems' to be.</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
RECOGNITION OF THE PROBLEM Knowledge and Perception of Severity (continued)			
1A 8—Anemia (Bolivia) Anemia/Low Blood Pressure (Indonesia)	<p>SSI Most (three-quarters) of the women identified this (anemia/low blood pressure) as a serious problem. Almost one-quarter said it was not serious.</p> <p>Report (From the Anemia SSI) More than one-quarter of the women did not associate symptoms of anemia (e.g., low energy, weakness) with a specific term (e.g., <i>kurang darah</i>). Over one-quarter of the women associated anemia symptoms with <i>kurang darah</i>. Some women gave other terms for the same symptoms.</p>	<p>SSI Very few women (only 4 of 41) mentioned anemia. All those who mentioned it considered it to be a serious problem.</p> <p>Report Not discussed (anemia research was conducted as a separate investigation).</p>	<p>Indonesia (SSI) From the Safe Motherhood SSIs, most women seem to feel anemia/low blood pressure (LBP) is serious, but most women participating in the anemia SSIs were not aware of any specific effects of anemia on pregnancy/delivery (NB, it is not clear from the report whether women were asked about effects of anemia or if local terminology was used). Information on women's perceptions of the differences between anemia and LBP is not available.</p> <p>Bolivia (SSI) Fainting, weakness, and anemia were coded together. Even so, only a few women mentioned anemia or its associated signs or symptoms. Fewer women mentioned this problem than many others.</p>
1A 9—Weak/tired/unpowerful/yellow eyes	<p>SSI The majority of respondents said this was a serious problem. About one-quarter reported that it was not serious. Some did not know.</p> <p>Report (FGs) Not discussed.</p>	<p>SSI Not available for Bolivia (not cited in unprompted questions or not coded).</p> <p>Report Not discussed.</p>	<p>Indonesia (SSI) The purpose of this question may have been to get information on hepatitis.</p>
1A 10—Nausea and vomiting	<p>SSI Most women reported that this was not serious.</p> <p>Report (FGs) This was mentioned as a common problem in pregnancy.</p>	<p>SSI Not available for Bolivia (not cited in unprompted questions or not coded).</p> <p>Report Not discussed.</p>	<p>Indonesia (SSI) Responses indicate that the women do distinguish problem severity. Their responses also indicate some degree of content validity in the questionnaire items dealing with problem severity.</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
RECOGNITION OF THE PROBLEM Knowledge and Perception of Severity (continued)			
1A 11—Hemorrhage in pregnancy	<p>SSI Most women (about three-quarters) said hemorrhage in pregnancy was a serious problem. The rest reported that they either did not know whether it was serious or not or did not believe it was serious.</p> <p>Report (FGs) Discussed for hemorrhage during delivery (see 1A 19)</p>	<p>SSI About one-fifth of the women mentioned hemorrhage in pregnancy as a problem. Of these, most considered it to be serious.</p> <p>Report Data from the focus groups reveal that hemorrhage during pregnancy often is perceived to be caused by lifting heavy things. Focus group participants had trouble distinguishing between light and more abundant bleeding.</p>	<p>Indonesia In the SSIs, it is unclear if women were distinguishing between hemorrhaging and bleeding. In their reports on the SSIs and focus groups, the authors state that “retained placenta and the resulting hemorrhaging were perceived to be the most dangerous [of problems]” It is not clear whether study participants made the connection between retained placenta and hemorrhage or whether this association was made by the authors.</p>
1A 12—Attacks/fainting (Bolivia) Convulsions in Pregnancy (Indonesia)	<p>SSI Almost three quarters of the women said that convulsions in pregnancy were serious. Almost one-tenth stated they didn’t know whether it was serious or not.</p> <p>Report (FGs) Not discussed</p>	<p>SSI Only one woman mentioned attacks/fainting as a problem. She considered it to be very serious.</p> <p>Report The authors state that people don’t relate attacks/fainting with swelling. Attacks/fainting were mentioned by only one person (<i>a partera</i>).</p>	<p>Bolivia (SSI) Attacks and fainting were coded together, making it difficult to tell whether the woman mentioning this problem was thinking more of anemia or of eclampsia.</p>
DELIVERY			
1A 13—Convulsions in delivery (Indonesia)	<p>SSI Slightly more than three-quarters of the women interviewed said that convulsions in delivery were serious. This figure is slightly more than the number of women who said that convulsions in pregnancy were serious.</p> <p>Report (FGs) Not discussed</p>	<p>SSI Not available for Bolivia (not cited in unprompted questions or not coded).</p> <p>Report Not discussed</p>	

Domain/Item	Indonesia	Bolivia	Comments/Limitations
RECOGNITION OF THE PROBLEM Knowledge and Perception of Severity (continued)			
1A 14—Bad birth (<i>Malparto</i> in Bolivia)	<p>SSI Not available for Indonesia (not asked in closed-ended questions)</p> <p>Report (FGs) Bad birth is not discussed, though prolonged labor is (see 1A 18)</p>	<p>SSI Almost one-fifth of the women mentioned <i>malparto</i> as a problem but there was no agreement about its severity</p> <p>Report Responses of various focus group participants indicate that <i>malparto</i> consists of a variety of signs and symptoms (e.g. hemorrhage, premature delivery, difficult/painful delivery, and prolonged labor)</p>	Bolivia (SSI) The lack of agreement regarding problem severity may reflect the fact that <i>malparto</i> encompasses a wide range of signs and symptoms
1A 15—Fever (of woman) during birth	<p>SSI About two-thirds of the women said that fever during birth was a serious problem. Most others said it was not serious</p> <p>Report (FGs) Not discussed</p>	<p>SSI Fever was mentioned by only one woman who thought it was serious</p> <p>Report Not discussed</p>	
1A 16—Early water break	<p>SSI Most women (about three-quarters) said this was a serious problem. The vast majority of the remaining women said it was not a serious problem</p> <p>Report (FGs) Not discussed</p>	<p>SSI Not available for Bolivia (not cited in unprompted questions or not coded)</p> <p>Report Not discussed</p>	

Domain/Item	Indonesia	Bolivia	Comments/Limitations
RECOGNITION OF THE PROBLEM Knowledge and Perception of Severity (continued)			
1A 17—Cesarean section	<p>SSI Most women (three-quarters) felt having a cesarean section was a serious problem. The rest either didn't know or said it was not serious.</p> <p>Report (FGs) Not discussed</p>	<p>SSI Not available for Bolivia (not cited in unprompted questions or not coded)</p> <p>Report Not discussed</p>	
1A 18—Labor > 12 hours	<p>SSI About three-quarters of the women said that labor >12 hours was a serious problem. Almost all the rest said it was not.</p> <p>Report (FGs) Some women reportedly associated prolonged labor with stillbirths and neonatal deaths.</p>	<p>SSI Not available for Bolivia</p> <p>Report Some focus group respondents considered prolonged labor (duration undefined) to be a part of <i>malparto</i>.</p>	
1A 19—Hemorrhage in delivery	<p>SSI The vast majority of women (well over three-quarters) said this was a serious problem. Only one person said she didn't know if it was serious or not.</p> <p>Report (FGs) According to the authors, in the focus groups hemorrhage emerged as one of the most commonly perceived problems and the most dangerous complication. The authors state that hemorrhage is linked to retained placenta and that men and women blame the perceived increase in incidence of retained placenta on the use of oral contraceptives.</p>	<p>SSI Only two women mentioned hemorrhage during birth as a problem. One believed it was serious, while the other did not.</p> <p>Report Some focus group respondents considered hemorrhage during delivery to be a part of <i>malparto</i>.</p>	<p>Indonesia (Report—FGs) Use of raw data from the focus groups would have been useful to support the authors' contention that families associate the perceived rise in rates of retained placenta with the use of oral contraceptives.</p> <p>Bolivia (SSI) While only two women mentioned hemorrhage during delivery, a substantial number mentioned post partum hemorrhage (see 1A 24).</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
RECOGNITION OF THE PROBLEM Knowledge and Perception of Severity (continued)			
POSTPARTUM			
1A 20—Infection postpartum	<p>SSI Not available for Indonesia (not asked in closed-ended questions though questions were asked on associated signs and symptoms For example, slightly more than half the women interviewed considered abdominal pain to be serious while most of the rest did not About one-quarter of the women interviewed thought that vaginal discharge with a bad odor was serious, while most of the rest did not</p>	<p>SSI About one-sixth of the women mentioned postpartum infection Infection was generally perceived as serious</p> <p>Report Data from the focus groups show that <i>sobrepardo</i> includes many of the signs and symptoms of post-partum infection <i>Sobrepardo</i> was one of the most widely known complications</p>	Bolivia See <i>sobrepardo</i> (1A 22)
1A 21—Retained placenta	<p>SSI Not available for Indonesia (not asked in closed-ended questions)</p> <p>Report (FGs) According to the authors, retained placenta is reported to be one of the most frequently experienced and well-known complications Oral contraceptives are commonly blamed for what people consider to be a rise in incidence of retained placenta</p>	<p>SSI Retained placenta was mentioned by about one-sixth of the women Half the women said this was not a serious problem</p> <p>Report Data from the focus groups show that the placenta is very significant in the birth process and that retained placenta is seen as the result of premature cutting of the umbilical cord</p>	

Domain/Item	Indonesia	Bolivia	Comments/Limitations
RECOGNITION OF THE PROBLEM Knowledge and Perception of Severity (continued)			
1A 22— <i>Sobrepardo</i>	<p>SSI Not available for Indonesia (Bolivian concept)</p> <p>Report (FGs) Not discussed (Bolivian concept)</p>	<p>SSI Next to hemorrhage, <i>sobrepardo</i> was the most frequently mentioned problem (by somewhat less than half the women) About one-third of the women who did mention it said it was not serious, while the remaining said that it was</p> <p>Report The authors report that the term <i>sobrepardo</i> encompasses the majority of the signs and symptoms of post-partum complications, including sepsis, hemorrhage, pains, fever, chills, shakes, and foul-smelling vaginal discharge</p>	
1A 23—Bleeding postpartum	<p>SSI More than three-quarters of the women said post-partum bleeding was not a serious problem As results from the question on postpartum hemorrhage indicate (see 1A 24), women distinguish between bleeding and hemorrhage</p> <p>Report (FGs) Not discussed</p>	<p>SSI Not available for Bolivia</p> <p>Report Bleeding is not discussed, though post-partum hemorrhage is (see 1A 24)</p>	<p>Indonesia (SSI) Results of asking about bleeding and hemorrhage indicate women distinguish between the conditions, though how they do so is not evident</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
RECOGNITION OF THE PROBLEM Knowledge and Perception of Severity (continued)			
NEONATAL			
1A 24—Hemorrhage postpartum	<p>SSI Post-partum hemorrhage was considered serious by virtually all the women interviewed</p> <p>Report (FGs) Not discussed, though hemorrhage in relation to retained placenta is (see above)</p>	<p>SSI Slightly more than one-quarter of the women mentioned postpartum hemorrhage as a problem. Most of these considered it to be serious</p> <p>Report Some focus group respondents considered post-partum hemorrhage to be a part of <i>sobrepai to</i></p>	
1A 25—Twins/Triples	<p>SSI Only about one-quarter of the women said having twins/triplets was a serious problem</p> <p>Report (FGs) According to the authors, having twins was not viewed as risky</p>	<p>SSI Not available for Bolivia (not cited in unprompted questions or not coded)</p> <p>Report Not discussed</p>	Indonesia (SSI) The low number of women stating that twins/triplets were a serious problem is noteworthy
1A 26—Stillbirth/neonatal death	<p>SSI Not available for Indonesia (not asked in closed-ended questions)</p> <p>Report (FGs) The authors state that stillbirth was associated with prolonged labor</p>	<p>SSI Only three women mentioned stillbirths or neonatal deaths. One believed it was very serious, one said it was serious, and the third said it was not serious</p> <p>Report The authors posit that the low numbers of women mentioning stillbirths or neonatal deaths indicates that compared to maternal complications, neonatal problems are considered less severe, or severe mainly in relation to the threat they pose to the mother</p>	Bolivia (SSI and Report) It is striking that so few women mentioned stillbirths or neonatal deaths. This finding may indicate low levels of awareness or may indicate that neonatal problems are not thought of or viewed as severe when compared to maternal complications. The finding also may reflect problems with question wording, especially given that in the SSIs women were asked to list problems with 'the birth of the newborn' and not with the newborn itself

Domain/Item	Indonesia	Bolivia	Comments/Limitations
RECOGNITION OF THE PROBLEM Knowledge and Perception of Severity (continued)			
1A 27—Premature birth (Bolivia) Pushing before expected date (Indonesia)	SSI Half the women believed premature birth was a serious problem Most others did not Report (FGs) Not discussed	SSI About one-sixth of the women mentioned premature birth as a problem Most of these thought it was serious, but a few said it was not Report Some focus group respondents considered premature delivery to be a part of <i>malparto</i>	Indonesia (SSI) Many more women said early water break was serious, compared to those who said pushing before expected date was serious This may indicate that the questions were not understood, that the items had poor content validity, or that women associate these events with different outcomes
1A 28—Cord problems	SSI About half the women said that the umbilical cord wrapped around the baby's neck was a problem Most others said it was not a problem Report (FGs) Not discussed	SSI Only one woman mentioned problems with the umbilical cord and considered it to be serious Report While the authors do not mention problems with the umbilical cord vis-a-vis the neonate, they do report that focus group participants associate premature cutting of the umbilical cord with retained placenta (see 1A 21)	Bolivia (SSI) It is not possible to determine what "problems with the umbilical cord signifies It may refer to premature cutting or something related to retained placenta, rather than a neonatal problem
1A 29—Pushing Every Two Minutes	SSI About three-quarters of the women said pushing every two minutes was not a serious problem, but a substantial number said it was serious and a few didn't know Report (FGs) Not discussed	SSI Not available for Bolivia (not cited in unprompted questions or not coded) Report Not discussed	
1A 30—Infection of the cord	SSI More than three-quarters of the women said infection of the cord was a serious problem, most others said it was not and a few said they did not know Report (FGs) Not discussed	SSI Not available for Bolivia (not cited in unprompted questions or not coded) Report Not discussed	

Domain/Item	Indonesia	Bolivia	Comments/Limitations
RECOGNITION OF THE PROBLEM Knowledge and Perception of Severity (continued)			
1A 31—Baby did not move	<p>SSI Just over three-quarters of the women said baby did not move was a serious problem Many women stated that it was not a problem</p> <p>Report (FGs) Some women reported that their babies were born weak and listless</p>	<p>SSI Not available for Bolivia (not cited in unprompted questions or not coded)</p> <p>Report Not discussed</p>	
1A 32—Baby looks blue, not red	<p>SSI More than three-quarters of the women said baby looks blue, not red was a serious problem A few said it was not a problem</p> <p>Report (FGs) Not discussed</p>	<p>SSI Not available for Bolivia (not cited in unprompted questions or not coded)</p> <p>Report Not discussed</p>	
1A 33—Baby is cold	<p>SSI About half the women said baby is cold was a problem</p> <p>Report (FGs) Not discussed</p>	<p>SSI Not available for Bolivia (not cited in unprompted questions or not coded)</p> <p>Report Not discussed</p>	
1A 34—Baby is small	<p>SSI Only about one-third of the women felt that having a small baby was a serious problem Virtually everyone else thought it was not a problem</p> <p>Report (FGs) Not discussed However, consuming certain foods was reported to be taboo during pregnancy PATH states that taboo foods are believed to cause the baby to grow too big and make delivery difficult</p>	<p>SSI Not available for Bolivia (not cited in unprompted questions or not coded)</p> <p>Report The authors report that having a ‘low-weight’ baby was considered to be a complication, but was seen as relatively insignificant</p>	<p>Indonesia (SSI) This finding has important implications for nutrition intervention More information is needed on women’s attitudes towards small babies large babies dietary intake, iron, low blood pressure, etc</p> <p>Indonesia (Report-FGs) It is not clear from the PATH report whether the women stated that certain foods will make the baby too big or whether this was the authors’ interpretation</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
RECOGNITION OF THE PROBLEM Knowledge and Perception of Severity (continued)			
1A 35—Baby did not cry	SSI Half the women interviewed identified baby did not cry as a serious problem Most others felt this was not a serious problem Report (FGs) Not discussed	SSI Not available for Bolivia (not cited in unprompted questions or not coded) Report Not discussed	
1A 36—Baby's eye oozing	SSI More than three-quarters of the women said baby's eye oozing was a serious problem A substantial portion of the women said they didn't know Report (FGs) Not discussed	SSI Not available for Bolivia (not cited in unprompted questions or not coded) Report Not discussed	
1B 0—INDIVIDUAL EXPERIENCE			
1B 1—Had a pregnancy complication	SSI About one-third of the women interviewed said they had a pregnancy complication Report (FGs) Most women reported they did not experience complications during pregnancy	SSI Almost two-thirds of women interviewed reported having a pregnancy complication Report Not discussed	General Purposive sampling makes it inappropriate to generalize results regarding experience of complications
1B 2—Had a delivery complication	SSI About one-third of the women reported having a complication during delivery Report (FGs) Not discussed	SSI About one-third of the women interviewed reported having a complication during delivery Report Not discussed	General See 1B 1
1B 3—Had a post-partum complication	SSI About one-third of the women reported having a complication after delivery Report (FGs) Not discussed	SSI Less than a quarter of the women interviewed reported having a complication after delivery Report Not discussed	General See 1B 1

Domain/Item	Indonesia	Bolivia	Comments/Limitations
INDIVIDUAL EXPERIENCE (continued)			
1B 4—Had a complication with newborn	<p>SSI About one-quarter of the women reported that their baby experienced a complication after birth</p> <p>Report (FGs) Most focus group participants reported having had a baby who died at birth, shortly after birth, during infancy or in childhood</p>	<p>SSI Only a few women reported having a complication with the birth of the newborn</p> <p>Report Not discussed</p>	<p>General See 1B 1</p> <p>Bolivia (SSI) The question posed to participants was about complications <i>with the birth</i> of the newborn, not with the newborn itself. The wording is ambiguous, so the question may not yield accurate information about the experience of newborn complications</p>
2A 0—DECISION-MAKING AROUND USE OF HEALTH SERVICES FOR COMPLICATIONS			<p>Indonesia (SSI) There were some problems with SSI data regarding decision-making (see items below). Focus group data should be explored in order to help elucidate and supplement the findings from the SSIs</p> <p>Bolivia (SSI) While there are numerous problems with the items related to decision-making around use of health services, it is clear that the husbands often play an important role in this process</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
<p>DECISION-MAKING AROUND USE OF HEALTH SERVICES FOR COMPLICATIONS (continued)</p>			
<p>2A 1—Who made/would make the decision to seek care (or of whose care to seek) when a complication arose/arises during pregnancy</p>	<p>SSI Over half the women interviewed said they made/would make the decision. Some said their husbands made/would make the decision. A few said they made/would make the decision with their husbands or that their mothers made/would make the decision.</p> <p>SSI Data also were analyzed for only those women who said they had pregnancy complications and who appeared to have sought care. Among these women, almost three-quarters report making the decision to seek help from a specific individual.</p> <p>Report (FGs) Not discussed.</p>	<p>SSI Nearly half the women who said they had a complication during pregnancy were scored ‘don’t know/no response.’ The majority of the remaining women said that their husband made the decision. One said a doctor decided, and a few said they made the decision.</p> <p>Report The authors report that women have a great deal of autonomy in decision-making when it comes to complications during pregnancy.</p>	<p>Indonesia (SSI) This question is ambiguous. Respondents are asked who decided/would decide to go look for whomever was or would be sought out when a complication occurred or might occur. It is impossible to tell whether the question is asking about the decision to seek care or the decision of whose care to seek. Additionally, hypothetical cases and real cases are merged. Multiple concepts should be separated into different questions.</p> <p>Bolivia (SSI) This item is ambiguous. The question posed was “whose decision was it?” The item immediately preceding this one was ‘who was the first person you sought help from when you knew you were having problems with your pregnancy?’ The follow-up question could be interpreted as ‘who made the decision to seek care?’ or as “who made the decision regarding whose care to seek?”</p> <p>Additionally, the high number of missing/don’t know responses is troubling. Because the “don’t know” and “no response” categories were combined, it is not possible to tell whether women really do not know the answer to this question or whether they chose not to answer it.</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
DECISION-MAKING AROUND USE OF HEALTH SERVICES FOR COMPLICATIONS (continued)			
<p>2A 2—Who made the decision to see care (or of whose care to seek) when a complication arose during delivery?)</p>	<p>SSI About half the women interviewed said that they made/would make the decision. In about one-quarter of the cases, women reported that their husbands made/would make the decision. Some women reported that they make/would make the decision with their husbands or that their mothers made/would make the decision.</p> <p>SSI Data also were analyzed for only those women who said they had delivery complications and who appeared to have sought care, but the results were not discernibly different from those above.</p> <p>Report (FGs) PATH authors state that women and their husbands rely on the traditional birth attendant (TBA) to determine when a trained midwife should be called or when the woman should be brought to a health facility. The decision to go or not go then rests with the husband.</p>	<p>SSI Of the 14 women reporting having a complication during delivery, 6 said their husbands made the decision, 5 stated that they made the decision themselves, one said a doctor made the decision, another said her mother made it, and there was one response of “don’t know/no response.”</p> <p>Report The authors report that husbands have primary authority for the decision to seek care during delivery.</p>	<p>Indonesia (SSI) The same problems mentioned for 2A 1 apply to this question.</p> <p>Indonesia (Report) No data are provided in the PATH report to support or contradict the authors’ conclusions.</p> <p>Bolivia (SSI) The same problems with ambiguity and collapsing of response categories that apply to 2A 1 apply here.</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
DECISION-MAKING AROUND USE OF HEALTH SERVICES FOR COMPLICATIONS (continued)			
<p>2A 3—Who made the decision to seek care (or of whose care to seek) when a complication arose post-partum?</p>	<p>SSI As was the case with decisions during pregnancy and delivery, about half the women reported that they decided/would decide to seek care, almost one-quarter reported that the decision was/would be their husbands' and some report either that they made/would make the decision with their husband or that their mother made/would make the decision</p> <p>SSI Data also were analyzed for only those women who said they had complications after delivery and who appeared to have sought care but the results were not discernibly different from those above</p> <p>Report (FGs) Not discussed</p>	<p>SSI Of the 8 women reporting having a complication after delivery, only one responded to this item She stated that she made the decision to seek care</p> <p>Report The authors state that women share responsibility for the decision to seek care with their husbands during the post-partum period</p>	<p>Indonesia (SSI) The same problems mentioned above in 2A 1 apply to this question</p> <p>Bolivia (SSI) The same problems mentioned in 2A 1 apply here The results are so ambiguous that interpretation is not possible</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
DECISION-MAKING AROUND USE OF HEALTH SERVICES FOR COMPLICATIONS (continued)			
2A 4—Who made the decision to seek care (or of whose care to seek) when a complication arose with the newborn (or with the birth of their newborn)?	<p>SSI In about half the cases, women reported that they made or would make the decision to seek care. Slightly less than one-quarter of the women said that their husbands made/would make the decision.</p> <p>SSI Data also were analyzed for only those women who said they had complications with their newborns and who appeared to have sought care, but the results were not discernibly different from those above.</p> <p>Report (FGs) Not discussed</p>	<p>SSI Of the four women who reported having a complication with the birth of their newborn, one said she made the decision themselves, one said her husband made the decision, and two stated that they and their husbands made the decision.</p> <p>Report The authors state that the mother plays an almost exclusive role in the decision to seek care when complications arise with their newborn.</p>	<p>Indonesia (SSI) The same problems mentioned above 2A 1 apply to this question.</p> <p>Bolivia (SSI) The same problems mentioned in 2A 1 apply here. Additionally, the original question regarding having a complication with the newborn was worded very ambiguously, making interpretation difficult.</p>
2A 5—Who in the family generally decides where help should be sought?	<p>SSI Not available for Indonesia (not asked in closed-ended questions)</p> <p>Report Not discussed</p>	<p>SSI Of the eight women who reported that they did not have a complication during pregnancy, delivery after delivery, or with their newborn, five stated that their husbands make the decision and one stated that they make it. Data for the remaining two women were missing.</p> <p>Report Not discussed explicitly. See related discussions above (2A 1-2A 4).</p>	<p>Bolivia (SSI) The assumption is made that the decision occurs in the family, so there is no information on the influence of others (e.g., <i>parteras</i>).</p> <p>This question refers to help-seeking behavior, but does not specify whether it is related to maternal complications. Women may have interpreted it more broadly.</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
DECISION-MAKING AROUND USE OF HEALTH SERVICES FOR COMPLICATIONS (continued)			
2A 6—Where is help first sought (general comments)	<p>SSI For both open- and closed-ended questions on where help is first sought (for all stages), large numbers of women report using <i>bidans</i> and <i>bidan di desas</i></p> <p>Report (FGs) Not discussed</p>		<p>Indonesia (SSI) The data is somewhat suspect since all women report that they would seek out someone</p>
<p>2A 7—Where did you first seek help for problems in pregnancy? (Indonesia)</p> <p>Where is help first sought when problems occur during pregnancy? (Bolivia)</p>	<p>SSI This question was both open-and closed ended Nearly half the women reported seeking help from <i>bidans</i> and almost a quarter said they sought help from <i>bidan di desas</i> Some women went to the doctor or TBA Only a few said they went to the <i>pustu</i> or <i>puskemas</i> There were no discernible differences in responses between women from the three study sites</p> <p>Report (FGs) Not discussed</p>	<p>SSI Data are missing for nearly three-quarters of the women who said they had a pregnancy complication Of those who responded, only one said they first sought help from their mother or father a few said they did not seek help from anyone/were alone, and a handful said “both</p> <p>Report While this question is not discussed for women who experienced problems per se, the authors report that women tend to use the institutional health system for hemorrhage during pregnancy and use <i>parteras</i> for fetal dystocia For symptoms of preeclampsia the authors state that women use neither system but will go to health facilities for attacks and fainting ’</p>	<p>Indonesia It is not possible to tell from the way the question is worded, whether or not the women went through the institutional health system when they sought out the <i>bidans</i> and <i>bidan di desas</i> Focus group data may help explicate the SSI findings but none were reported</p> <p>Bolivia (SSI) The very high number of missing data decreases the value of the item Additionally there were problems with the wording of the questions and response categories Specifically, the response category “no one/was alone” encompasses two ideas that should be separated Also, it is not possible to discern who is referred to in the response category “both” Finally, mother/father are combined into one response category Given the difference in their roles, separate categories should be used</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
DECISION-MAKING AROUND USE OF HEALTH SERVICES FOR COMPLICATIONS (continued)			
<p>2A 8—Where did you/would you first seek help for problems in delivery? (Indonesia)</p> <p>Where is help first sought when problems occur during delivery? (Bolivia)</p>	<p>SSI Results are virtually identical to those for pregnancy (see 2A 7)</p> <p>Report (FGs) Not discussed</p>	<p>SSI All women who said they had a problem during delivery responded to this question Most said they either went to a doctor/center doctor/hospital or that they went to the <i>partera</i> One respondent said she went first to her husband another said she went first to her mother/father, another said she went to other family members and one said she went to a nurse</p> <p>Report While this question is not discussed for women who experienced problems per se, the authors report that women go to the institutional health system for hemorrhaging during delivery</p>	<p>Indonesia The same issues that apply to the above question on pregnancy (see 2A 7) apply here</p> <p>Bolivia (SSI) It appears women often seek health services when they have problems during pregnancy Because doctor, center doctor, and hospital were combined as one response category it is not possible to distinguish among these The same problem with mother/father discussed in 2A 7 applies here</p>
<p>2A 9—Where did you/would you first seek help for problems in delivery? (Indonesia)</p> <p>Where is help first sought when problems occur after delivery?/Was the care of a post or center doctor or nurse sought when problems occurred after delivery? (Bolivia)</p>	<p>SSI Results are virtually identical to those for pregnancy (see 2A 7)</p> <p>Report (FGs) Not discussed</p>	<p>SSI Half the women who reported problems after delivery said they sought the care of a physician or nurse at the center or post The other half said they did not seek such care</p> <p>Report While not discussed for women who experienced problems per se, the authors state that women do not generally use the institutional health system for post-partum complications, regardless of whether they come from communities with high or low use of institutional health services Data from the focus groups indicate that women expect they will be scolded by health providers for having <i>sobrepaito</i></p>	<p>Indonesia The same issues that apply to the above question on pregnancy (see 2A 7) apply here</p> <p>Bolivia (SSI) It is not possible to tell whether the women who said they did not seek care (at a post of a center doctor or of a nurse) did not seek any care or sought care elsewhere (e g parents, hospital)</p> <p>This question is different from those designed to get at the same general information for pregnancy delivery, and the newborn Questions on the same topic should be standardized</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
DECISION-MAKING AROUND USE OF HEALTH SERVICES FOR COMPLICATIONS (continued)			
2A 10—Where did you/would you first seek help for problems with the newborn? (Indonesia)	<p>SSI Results are virtually identical to those for pregnancy (see 2A 7)</p> <p>Report (FGs) Not discussed</p>	<p>SSI Not available for Bolivia</p> <p>Report While not discussed for women who experienced problems, per se, the authors state that the institutional health system becomes an important alternative to the traditional system once a newborn complication is identified. No focus group data are reported.</p>	<p>Indonesia The same issues that apply to the above question on pregnancy (see 2A 7) apply here.</p>
2A 11—When women have problems in pregnancy, delivery, post-partum, or with the newborn/upon the birth of their baby, where do they first seek help?	<p>SSI Not available for Indonesia</p> <p>Report (FGs) Not discussed</p>	<p>SSI Eight women reported they had no problems in pregnancy, delivery post-partum, or with the newborn. Data are missing for two of the women. Three respondents said women first seek help from a midwife. Of the remaining three respondents, one each said women seek help from other relatives, from the post/center/hospital/doctor, or from "other."</p> <p>Report See 2A 7-2A 10</p>	<p>Bolivia (SSI) While more women said (unprompted) that they normally seek help from the <i>partera</i>, the small number of respondents means that little weight should be ascribed to this item. Further, while women seem to seek out the <i>partera</i> for complications in delivery, none reported doing so for pregnancy problems. Thus, the extent to which the <i>partera</i> or others are sought out for help is not clear from the responses to the SSIs.</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
DECISION-MAKING AROUND USE OF HEALTH SERVICES FOR COMPLICATIONS (continued)			
2A 12—Birth place preference (past and future)	<p>SSI More than three-quarters of the women interviewed said their last birth occurred at home. About three-quarters of the women also said they wanted to give birth at home in the future. More than three-quarters of the women who had complications during pregnancy, delivery, in the post-partum period, or with the newborn also said they wanted to give birth at home.</p> <p>Report (FGs) Data from the focus group participants indicate that about 70-80 percent of all births occur at home and most are attended by TBAs. According to PATH, the decision to deliver at home is based on convenience, practicality and affordability.</p>	<p>SSI About half the women interviewed reported that they wanted future births to occur in their homes and half expressed preference for health centers.</p> <p>Report The authors state that the home environment and family support in that setting are viewed as a critical part of the birth process. Focus group data support this contention.</p>	<p>Indonesia (Report) While the PATH report indicates that the decision to give birth at home is based on convenience, practicality and affordability, the authors do not provide any data to support this claim. Thus, it is difficult to determine whether this conclusion is based on focus group discussions or is the authors' interpretation.</p>
3A 0—ACCESS TO CARE ROLE OF OTHERS			
3A 1—Who generally goes with the woman when she goes to the <i>puskesmas pembantu</i> , <i>puskesmas</i> or hospital (Indonesia)	<p>SSI By far the most common response (given by about two-thirds of the women) was that they were accompanied by neighbors. Some reported going with their husbands, and some with their children.</p> <p>Report (FGs) Not discussed.</p>	<p>SSI Not available for Bolivia (Indonesia-specific).</p> <p>Report Not discussed (Indonesia-specific).</p>	<p>Indonesia (SSI) This question may have been interpreted very broadly, since it is not asking specifically about complications. It is noteworthy, however, that the vast majority of women report going to the health center with neighbors. Also, the question was "If you go to the <i>puskesmas pembantu</i>, <i>puskesmas</i>, or hospital, you are usually accompanied by whom? Or do you go alone?" Yet no women reported going by themselves.</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
3A 0—ACCESS TO CARE ROLE OF OTHERS			
3A 2—Who goes with the woman to get help when complications arise in pregnancy?	<p>SSI Pregnancy-specific question not available for Indonesia (see 3A 1)</p> <p>Report (FGs) Not discussed</p>	<p>SSI Data are available for only two-thirds of the women who reported having a pregnancy complication. Most women reported that their husbands went with them. A couple said they went alone, and a few others said the person providing help came to their house.</p> <p>Report Not discussed</p>	<p>Bolivia (SSI) The large number of missing data makes the results difficult to interpret. However, husbands do appear to play an important role.</p> <p>Bolivia That women “go somewhere” when complications arise is implicit in the question wording, yet this may not be the case.</p>
3A 3—Who goes with the woman to get help when complications arise during delivery?	<p>SSI Delivery-specific question not available for Indonesia. See general question (see 3A 1).</p> <p>Report (FGs) Not discussed</p>	<p>SSI Less than half the women reporting complications during delivery said their husbands came with them to get help. A couple said the <i>partera</i> went with them, a couple said a parent went with them, and a couple said they received help in their home, but did not state from whom. Two responses were “don’t know/no response.”</p> <p>Report Not discussed</p>	<p>Bolivia (SSI) While the absolute numbers are small, husbands appear to play an important role in help-seeking during delivery. This item suffers from the same problems with the response categories (mother/father, don’t know/no response) as discussed in 2A 8.</p> <p>Bolivia That women “go somewhere” when complications arise is implicit in the question wording, yet this may not be the case.</p>
3A 4—Who goes with the woman to get help when complications arise after delivery?	<p>SSI Post-partum-specific question not available for Indonesia. See general question (see 3A 1).</p> <p>Report (FGs) Not discussed</p>	<p>SSI Data for four of the eight women who said they had problems after delivery are missing. Of the remaining four who responded, all said their husbands went with them.</p> <p>Report Not discussed</p>	<p>Bolivia (SSI) While the number of responses are very low, husbands still appear to play an important role in accompanying the woman when help is sought for problems after delivery.</p> <p>Bolivia That women “go somewhere” when complications arise is implicit in the question wording, yet this may not be the case.</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
<p>3A 5—Who goes with the woman to get help when complications arise with the newborn?</p>	<p>SSI Newborn-specific question not available for Indonesia See general question (see 3A 1)</p> <p>Report (FGs) Not discussed</p>	<p>SSI Of the four women who said they had problems with their newborn, three said their husbands accompanied them and one said their mother/father did</p> <p>Report Not discussed</p>	<p>Bolivia (SSI) Again, the number of responses are very low but husbands play a role The response category “mother/father” should be divided into two</p> <p>Bolivia That women “go somewhere” when complications arise is implicit in the question wording, yet this may not be the case</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
3B 0—ACCESS TO CARE PERCEPTION OF CARE			<p>Indonesia (SSI) Only one question was asked about service quality i.e. “How was the service quality/response you got from X when you had a problem during Y?” This does provide a general picture of how women might feel about the service they received, but it does not allow any distinction of the elements of quality (e.g., courtesy, timeliness, cleanliness, etc.) These data were entered as a string variable and could not be analyzed.</p> <p>Data from question C5 of the Indonesian Safe Motherhood instrument, in which women who said the service they received was not good stated their reasons, would be more useful to analyze. However, this is in text form and would need to be translated.</p> <p>Future questionnaires should ask <i>all</i> women to explain their answers, not just those who were not happy with the service they received.</p> <p>Bolivia From the SSIs, women appear overwhelmingly satisfied with the quality of care they received. This could indicate one of several things: (1) genuine satisfaction with care, (2) lack of content validity of the items, (3) response bias. In general, items related to this domain yielded questionable results. Focus group information and open-ended responses probably paint a more accurate picture.</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
ACCESS TO CARE PERCEPTION OF CARE (continued)			
3B 1—Were the problems occurring during pregnancy properly resolved at the post/center/hospital?	<p>SSI Not available for Indonesia (not asked in closed-ended questions)</p> <p>Report (FGs) Not discussed</p>	<p>SSI Of the 12 women who said they went to the post/center/hospital for problems during pregnancy, about three-quarters said that their problems were resolved well and one-quarter said they were not resolved well</p> <p>Report Not discussed for pregnancy per se, but focus group data are used to support the authors' statement that the institutional health system is viewed as efficacious in solving obstetric and neonatal problems</p>	<p>Bolivia (SSI) The high number of satisfied responses is somewhat suspect. The question also is very vague and does not necessarily assess perceived quality of care. There may be many reasons why a problem is not "properly resolved." More targeted questions would be more likely to yield good information.</p> <p>Another problem is that it is difficult to determine whether women were answering honestly, or whether there was bias in their responses. This item is not particularly useful.</p>
3B 2—Were the problems occurring during delivery properly resolved at the post/center/hospital?	<p>SSI Not available for Indonesia (not asked in closed-ended questions)</p> <p>Report (FGs) Not discussed</p>	<p>SSI All ten of the women who reported going to the post/center/hospital for problems during delivery said their problems were resolved "well"</p> <p>Report 3B 1</p>	<p>Bolivia (SSI) There may be response bias here. Also, the question is vague. More targeted questions would be more likely to yield good information (see 3B 1).</p>
3B 3—Were the problems occurring after delivery properly resolved at the post/center/hospital?	<p>SSI Not available for Indonesia (not asked in closed-ended questions)</p>	<p>SSI Of the four women who reported going to a health center/post/hospital for problems after delivery, three said their problems were resolved "well." One said her problems were resolved "not well"</p> <p>Report See 3B 1</p>	<p>Bolivia (SSI) The comments above (see 3B 1 and 3B 2) apply here as well.</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
ACCESS TO CARE PERCEPTION OF CARE (continued)			
3B 4—When you went to the post/center/hospital for problems in pregnancy, were you seen in a timely manner?	SSI Not available for Indonesia (not asked in closed-ended questions)	SSI About one-quarter of the women interviewed reported going to the post/center/hospital for problems in pregnancy. Of these, all but two said they were seen in a timely manner. Report Not discussed vis-a-vis women/families. The authors state that health personnel, particularly those working in hospitals, viewed timely attention to the client as synonymous with quality care.	Bolivia (SSI) The relatively large number of women reporting that they were seen in a timely manner could indicate (1) that the women did not wait an inordinately long time, (2) response bias, (3) that women have low expectations regarding waiting time. Direct observations of patient flow might reveal more information regarding time from arrival to consultation, as would asking respondents to indicate their waiting time on average, at their last visit, and in an emergency situation.
3B 5—When you went to the post/center/hospital for problems during delivery, were you seen in a timely manner?	SSI Not available for Indonesia (not asked in closed-ended questions)	SSI Eight of the 10 women who reported that they went to the post/center/hospital for problems in delivery said they were seen in a timely manner. Report See above.	Bolivia (SSI) See above (3B 4)
3B 6—When you went to the post/center/hospital for problems after delivery, were you seen in a timely manner?	SSI Not available for Indonesia (not asked in closed-ended questions)	SSI Three of the four women who said they went to a health center for problems after delivery said they were seen in a timely manner. One responded "don't know/no response." Report See above.	Bolivia (SSI) See above (3B 4)
3B 7—When you went to the post/center/hospital for problems with your newborn, were you seen in a timely manner?	SSI Not available for Indonesia (not asked in closed-ended questions)	SSI Three of the four women who said they went to a post/center/hospital for problems with their newborn said they were seen in a timely manner. The fourth responded "other." Report See above.	Bolivia (SSI) See above (3B 4). Also, the "other" category is not defined and is not useful.

Domain/Item	Indonesia	Bolivia	Comments/Limitations
ACCESS TO CARE PERCEPTION OF CARE (continued)			
3B 8—Are you convinced about the village midwives' (<i>bidan di desas</i>) skill?	<p>SSI More than three-quarters of the women interviewed reported that they were “convinced” of the <i>bidan di desas</i>’ skill</p> <p>Report (FGs) PATH authors report that women expressed concern regarding the skills and experience of the <i>bidan di desas</i> but had confidence in the TBAs</p>	<p>SSI Not available for Bolivia (Indonesia-specific)</p> <p>Report Not available for Bolivia (Indonesia-specific)</p>	<p>Indonesia (SSIs) While some clarity may have been lost in the translation the question is very vague Also a comparison between the midwives’ skill and that of the TBAs is placed as the middle response in this Likert-type scale This is not appropriate Finally this is a “yes/no ’ question, yet the responses are multi-level</p> <p>Indonesia (Report) According to the PATH authors focus group participants doubted the skills and experience of the <i>bidan di desas</i> while expressing confidence in the TBAs These results conflict with the SSIs but probably are a more accurate reflection of perceptions</p>
3C 0—ACCESS TO CARE DISTANCE/TIME TO FACILITY AND COST OF TRANSPORTATION			
3C 1—How far is the sub-health center (<i>puskesmas pembantu</i>) from your house? (Indonesia) Is the closest post/center/hospital vary far away somewhat far away, or close by the community? (Bolivia)	<p>SSI Most women from Districts 1 and 2 reported that the <i>puskesmas pembantu</i> was close A substantial number didn’t know whether it was close or not Women from District 3 were divided in their responses About one-quarter thought it was close, one-quarter said it was far or very far, and about one-quarter said they didn’t know Nearly one quarter of the responses were missing</p> <p>Report (FGs) Not discussed</p>	<p>SSI About three-quarters of the women from <i>low</i> service use areas and about half the women from <i>high</i> service use areas stated that they considered the health center to be close to the community</p> <p>Report No focus group data are reported</p>	

Domain/Item	Indonesia	Bolivia	Comments/Limitations
ACCESS TO CARE DISTANCE/TIME TO FACILITY AND COST OF TRANSPORTATION (continued)			
3C 2—How far is the health center (<i>puskesmas</i>) from your house? See 3C 1 for Bolivia	SSI Most women from Districts 1 and 3 considered the <i>puskesmas</i> to be very far or far from their homes Very few women from district one said that the <i>puskesmas</i> was close About half the women in District 2 said the <i>puskesmas</i> was close and about half said it was far Only a few women from any district said they didn't know whether the <i>puskesmas</i> was close or far Report (FGs) Not discussed	SSI See 3C 1 Report See 3C 1	
3C 3—How far is the hospital from your house? (Indonesia) See 3C 1 for Bolivia	SSI Nearly all the women from Districts 2 and 3 said the hospital was far from their house Almost half the women from District 1 said the hospital was close by Very few women said they didn't know whether the hospital was close or far from their homes There were several missing responses Report (FGs) Not discussed	SSI See 3C 1 Report See 3C 1	
3C 4—Type of transportation used to go to the <i>pustu</i> (public and private, Indonesia)	SSI Nearly all the women responding to this question said they go to the <i>pustu</i> by foot Responses were very similar across the three districts Report (FGs) Not discussed	SSI See 3C 7 and 3C 12 (for Bolivia, transportation is divided into public and private) Report See 3C 7 and 3C 12	Indonesia (SSI) About half the responses fall in the category "not applicable" It is difficult to tell whether these were non-responders, or whether the women in the category "not applicable" did not go to the <i>pustu</i> If the women were non-responders, the large number of missing data makes interpretation difficult

Domain/Item	Indonesia	Bolivia	Comments/Limitations
ACCESS TO CARE DISTANCE/TIME TO FACILITY AND COST OF TRANSPORTATION (continued)			
3C 5—Type of transportation used to go to the <i>puskesmas</i> (Indonesia)	<p>SSI About one-quarter of the women report going to the <i>puskesmas</i> on foot. A substantial portion of women report going by motorboat (in Districts 2 and 3). Some report going by rickshaw. Very few report using other forms of transportation (e.g., bicycle, motorcycle, <i>mikro</i>). Many women responded “not applicable.”</p> <p>Report (FGs) Not discussed</p>	<p>SSI See 3C 7 and 3C 12 (for Bolivia, transportation is divided into public and private).</p> <p>Report See 3C 7 and 3C 12</p>	Indonesia (SSI) See above (3C 4)
3C 6—Type of transportation used to go to the hospital (Public and private Indonesia)	<p>SSI Most responses were “not applicable.” In District 1, most of the women for whom the question was considered applicable reported going by rickshaw. In District 2, most reported going by <i>mikro</i>. In District 3, most reported going by motorboat.</p> <p>Report (FGs) Not discussed</p>	<p>SSI See 3C 7 and 3C 12 (for Bolivia, transportation is divided into public and private).</p> <p>Report See 3C 7 and 3C 12</p>	Indonesia (SSI) In all three districts, the number of women who reported their method of transportation to the hospital was very small. Results should be interpreted with caution.

Domain/Item	Indonesia	Bolivia	Comments/Limitations
ACCESS TO CARE DISTANCE/TIME TO FACILITY AND COST OF TRANSPORTATION (continued)			
3C 7—Type of transportation used to go to post/health center/hospital(public) (Bolivia)	<p>SSI See 3C 4-3C 5</p> <p>Report See 3C 4-3C 5</p>	<p>SSI Data for nearly half the women who reported that they sought help at the post/center or hospital for a complication are either missing or fall under the “don’t know/no response” category Over one-quarter of the total sample reported going to by foot A few reported going by minibus, micro, or by bus</p> <p>Report The authors state that women from rural areas generally use public buses to go to health centers, while urban women use minibuses or go by foot</p>	<p>Bolivia (SSI) While it is noteworthy that among the women who responded, most sought care on foot, too much data are missing to draw any conclusions Also, there is no way to distinguish what transportation women used to go to where</p> <p>As mentioned previously, the “don’t know/no response’ category should be separated</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
<p>ACCESS TO CARE DISTANCE/TIME TO FACILITY AND COST OF TRANSPORTATION (continued)</p>			
<p>3C 8—How long did it take (to get to the <i>puskesmas pembantu</i>, <i>puskesmas</i>, or hospital)? (Public and private transportation—Indonesia)</p> <p>How long did it take? (public transportation—Bolivia)</p>	<p>SSI (for the <i>Pustu</i>) Almost half of the women interviewed (regardless of district) reported that it took 15 minutes or less to get to the <i>pustu</i></p> <p>SSI (for the <i>puskesmas</i>) More than one-quarter of the women said it took them 15 minutes or less to reach the <i>puskesmas</i> and about the same number said it took them more than 15 minutes, but less than 30 minutes. Some women said it took between 30 and 180 minutes. Over one-quarter of the data were coded as missing. All reports that it took more than 30 minutes to reach the <i>puskesmas</i> were from District 3</p> <p>SSI (for the hospital) More than half the data were missing. About one-quarter of the women said they could reach the hospital in 30 minutes or less. A few women said it took them between 30 and 60 minutes to reach the hospital, and a few women said it took them between two and four hours. All the women who reported that it took more than one hour to reach the hospital were from District 3</p> <p>Report (FGs) Not discussed</p>	<p>SSI Over 50 percent of the data are missing. It took longer for the four women from low use areas to reach their destination than it did for any of the 7 women from high use areas</p> <p>Report The authors report that most women can reach a health center within 10-15 minutes. No data source is given</p>	<p>Indonesia (SSI) A large portion of the data was coded as “missing”. Responses should be interpreted with caution</p> <p>Bolivia (SSI) Too much data are missing to lend credence to this item. Additionally, it appears data may have been entered in both hours and minutes, making it difficult to interpret</p> <p>Again, the “don’t know/no response” category should be separated</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
ACCESS TO CARE DISTANCE/TIME TO FACILITY AND COST OF TRANSPORTATION (continued)			
<p>3C 9—How much did it cost? (Public and private transportation—Indonesia)</p> <p>How much did it cost? (Public transportation—Bolivia)</p>	<p>SSI (for the <i>pustu</i>) There were only four women who said they neither walked, nor took a bicycle, or for whom data were not missing. All four women said it cost between 450 and 1,000 rp to get to the <i>pustu</i> via their transportation method.</p> <p>SSI (for the <i>Puskesmas</i>) More than 50 percent of the respondents said it cost 500 rp or less to get to the <i>puskesmas</i>. More than one-quarter said it cost between 500-1000 rp. Only a few said it cost more than 1000 rp.</p> <p>SSI (for the hospital) Almost half the women said it cost them 500 rp or less to get to the hospital. Most other women said it cost between 500 and 1500 rp. A few women said it cost more than 1500 rp, with one stating that it cost 40 000 rp.</p> <p>Report (FGs) Not discussed.</p>	<p>SSI About half the data are missing (women who went on foot were excluded from the analysis). It is interesting to note, however, that of the four women from low service use areas, two reported costs of less than 5 0Bs (less than \$1 00) and two reported costs of 20 0Bs or greater (\$4 00 or more). Of the women from high use areas, no one reported spending more than 10 0Bs (\$2 00) on transportation.</p> <p>Report The authors state that transportation in urban areas costs about 1B and in rural areas, it costs between 3-5Bs. No data sources are given.</p>	<p>Indonesia (SSI) (for the <i>Pustu</i>) Given that so little data are available for women who did not walk or use bicycles, conclusions cannot be made.</p> <p>Bolivia (SSI) There is too much missing data to draw definitive conclusions. However, data from other sources (focus groups) should be used to determine the extent to which transportation cost plays a role in use of health services.</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
ACCESS TO CARE DISTANCE/TIME TO FACILITY AND COST OF TRANSPORTATION (continued)			
3C 10—How regular is this transportation (public)?	SSI Not available for Indonesia (not asked in closed-ended questions) Report (FGs) Not discussed	SSI Well over half the data are missing Only two women said their transportation was irregular, both were from low service use areas Report Using focus group data the authors state that public transportation generally runs regularly during the day but transportation during emergencies and at night is difficult to find	Bolivia There is too much missing data to draw definitive conclusions from the SSIs Focus group data are more informative
3C 11—How comfortable is this transportation (public)?	SSI Not available for Indonesia (not asked in closed-ended questions) Report (FGs) Not discussed	SSI Again, nearly half the data are missing Of the nine women responding, about half said it their transportation was comfortable and about half said it was uncomfortable Report Women participating in focus groups report that transportation generally is comfortable, but not during pregnancy	
3C 12—Type of transportation used (private)	SSI Data not divided into public and private for Indonesia Report (FGs) Not discussed	SSI Too much data are missing to analyze results Report Not discussed	Bolivia (SSI) There is too much missing data to warrant analysis The large numbers of missing responses may reflect problems with the questionnaire design or with interviewing techniques
3C 13—Cost of private transportation	SSI Data not divided into public and private for Indonesia Report (FGs) Not discussed	SSI Too much data are missing to analyze results Report Not discussed	
3C 14—Reliability of transportation	SSI Not available for Indonesia (not asked in closed-ended questions) Report (FGs) Not discussed	SSI Too much data are missing to analyze results Report Not discussed	

Domain/Item	Indonesia	Bolivia	Comments/Limitations
ACCESS TO CARE DISTANCE/TIME TO FACILITY AND COST OF TRANSPORTATION (continued)			
3C 15—Comfort of transportation	SSI Not available for Indonesia (not asked in closed-ended questions) Report (FGs) Not discussed	SSI Too much data are missing to analyze results Report Not discussed	
3D 0—COST OF SERVICES			
3D 1—How much do ANC services cost? (Indonesia) Did you have enough money for (staff) to take care of you at the post/center/hospital? (Bolivia)	SSI Almost one-quarter of the women said the services cost nothing and about three-quarters said they cost between 0-1500 rp Report (FGs) Not discussed	SSI Regardless of whether women with complications were from high or low service use areas, responses were almost evenly split between those who felt they had enough money and those who felt they didn't Report The authors state that families from high service-use areas perceive the cost of regular care (not emergency care) to be reasonable, whereas families from low service-use areas perceive the cost to be high or moderate (but still prohibitive) Focus group data support the authors' contention that for all families cost becomes a major limitation to care in emergency situations	Indonesia (SSI) This item while useful for obtaining information on the cost of prenatal care says nothing about the cost or perceived cost of services for pregnancy-related complications Bolivia (SSI) Since this question was asked only of women who went to a health center, post, or hospital for complications it is not useful for determining the degree to which service cost acts as a barrier to care Also the number of respondents was low
3D 2—How much is the average cost of medicine? (Indonesia) Did you have enough money to buy medicine? (Bolivia)	SSI Almost half the women said medicines were free Report (FGs) Not discussed	SSI Women experiencing complications who were from high and low service use areas were about evenly split between those who reported having enough money and those who reported they did not Report See 3D 1	Indonesia (SSI) About one-quarter of the data were missing for this variable Additionally, since the previous question pertained to antenatal care, women may have responded to this item as if it pertained only to prenatal care and not to emergency situations Bolivia (SSI) See comments for 3D 1

Domain/Item	Indonesia	Bolivia	Comments/Limitations
3E 0—ACCESS TO CARE CHILD CARE ARRANGEMENTS			
<p>3E 1—Who did you leave your children with when you sought help for problems in pregnancy, delivery after delivery, or with the newborn? (Bolivia)</p> <p>When women go to the <i>puskesmas pembantu</i>, <i>puskesmas</i>, or hospital, who usually cares for your children or do you take them along? (Indonesia)</p>	<p>SSI Almost half the women responding stated that their children generally accompany them when they go for care. In some cases, the mother's mother or the mother's eldest child was the reported caregiver. In others, the child(ren) stayed alone. Only a few women said that their husbands or any other family member took care of their children when they went to get care.</p> <p>Report (FGs) Not discussed</p>	<p>SSI For all stages of pregnancy, responses were pretty consistent. With about equal frequency, women said they left their children with their husbands, parents, or other family members. Other responses given were "other people," "other," and "don't know/no response."</p> <p>Report Focus group data support the authors' statement that the extended family plays an important role in caring for children when the mother goes to a health facility.</p>	<p>Indonesia (SSI) The question is very general. Women may have interpreted it very broadly (i.e., not complication-specific or even specific to their own health needs). However, the fact that most women report taking their children is noteworthy. Since they also often report going with a neighbor, it is possible that neighbors act as child care providers. Focus group data might help elucidate the role of the family and neighbors but none are reported.</p> <p>Bolivia As is the case for other questions, the "no response/don't know" category should be separated. Even though there is very little missing data, the small sample size precludes drawing definitive conclusions.</p> <p>Focus groups revealed more about the role of the family, including caretaking of children than did the SSIs.</p>

Domain/Item	Indonesia	Bolivia	Comments/Limitations
3F 0—ACCESS TO CARE HELP FROM THE COMMUNITY			
<p>3F 1—Did women received help from a neighbor or their community when they had problems and did they find this help helpful?” (Indonesia)</p> <p>Did women receive help from people in their community when they had problems? (Bolivia)</p>	<p>SSI Somewhat less than half the data were missing. The “missing” category may include women who said they did not have a problem during any stage but it is not possible to tell. About one third of the women who apparently had problems in pregnancy, delivery, the post-partum period, or with the newborn said they got help from a neighbor or someone in the community. A little more than one-quarter said they did not. Virtually all the women said this help was “helpful.”</p> <p>Report (FGs) Not discussed</p>	<p>SSI About two-thirds of the women reporting problems during pregnancy, delivery, after delivery, or with the newborn stated that they did not receive help from anyone in their community.</p> <p>Report Not discussed outside the context of the family.</p>	<p>Indonesia (SSI) While the question was apparently asked to only those women who reported having a problem in any of the four stages, 37 of the 90 women were reported as “missing.” These probably were women who said they did not have a complication. Coding them as ‘missing’ gives misleading results when frequencies are tabulated.</p> <p>Information was collected on the kind of help women received and from whom, but the data are not in numerical form and could not be analyzed herein. These data and focus group data should be explored to further elucidate this topic.</p> <p>Bolivia (SSI) The term “community” is vague and lacks content validity (see 3F 2). Also, the term “help” needs clarification. Those women who said they did get help specified the content of that assistance, but since the data are textual, they could not be analyzed for this report.</p>
<p>3F 2—Who did women receive help from if they got assistance from someone in their community?</p>	<p>SSI Not available for Indonesia (data were coded as a string variable and for the purposes of this report, could not be analyzed).</p> <p>Report (FGs) Not discussed</p>	<p>SSI Of the nine women who reported receiving help from people in their community, most said they got assistance either from a member of the health profession (<i>partera</i> doctor or nurse) or from a family member (but not their spouse). Two women reported getting help from their neighbors/friends.</p> <p>Report Not discussed outside the context of the family.</p>	<p>Bolivia (SSI) The fact that most women who said they got help from people in their community mentioned their family or members of the health profession indicates that this question may be lacking in content validity. Women may have received some community assistance, but problems with content validity make interpretation difficult.</p>

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