Summer Training at
Indian Institute of Public Health,
Gandhinagar, Gujarat
(April - June, 2013)

MATIND PROJECT PHASE II: EXPLORATION OF DELIVERY EXPERIENCES AND DELIVERY OUTCOMES OF RECENTLY DELIVERED MOTHERS (TWO WEEKS MINIMUM POST DELIVERY) IN RURAL/TRIBAL AREAS IN DAHOD AND SURENDRANAGAR DISTRICTS OF GUJARAT

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Under the guidance of
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Post Graduate Diploma in Hospital and Health Management
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Institute of Health Management Research,
Jaipur
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CERTIFICATE

This is to certify that, Dr. Anita Suresh Mahajan, student of Post Graduate Diploma in Health and Hospital Management (PGDHM), from the Institute of Health Management and Research (IHMR), Jaipur has undergone summer training in, Indian Institute of Public Health, Gandhinagar, Gujarat from April 8 to June 7, 2013.

The candidate has successfully carried out the study assigned to her during the summer training and her approach to study has been sincere, scientific and analytical.

I wish her success in all her future endeavors.

Dr. Anoop Khanna
Faculty and Mentor
IIHMR, Jaipur

Dr. Ashok Kaushik
Dean, Academics and Student Affairs
IIHMR, Jaipur

INDIAN
INSTITUTE OF
PUBLIC HEALTH
GANDHINAGAR

Dtd: 6th June 2013

To whomsoever it may concern

Ms Anita Mahajan worked as an intern under me on the MATIND project during the months of April and May 2013. She is a punctual and sincere worker. She is also very soft-spoken and a quick learner. During her period here she has gained first-hand knowledge of the work that goes into cleaning and analyzing quantitative data. She has also understood the practicalities involved in transcription and translation of qualitative data.

I have no hesitation in recommending Anita to any position of responsibility. She is capable of taking on difficult tasks and seeing them to completion.

Dr Veena Iyer, Assistant Professor,
Indian Institute of Public Health Gandhinagar

Indian Institute of Public Health Gandhinagar

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Preface

Summer internship is an integral part of the PGDHM curriculum. As a part of the course; the students of first year are required to undergo summer placement at any reputed organization to get in depth exposure of various departments in the organization and better understanding of the health care delivery system and its functions.
The major objectives of the summer training programme are as follows:
1) To better understand the existing healthcare delivery system including public and private sectors.
2) To observe the implementation of various National Health Programmes at State/District/Block levels.
3) To acquire more knowledge on roles and responsibilities of key players and stakeholders in health sector.
4) To understand various functions of health system by interactions with key stakeholders, policy makers, programme managers, academicians and researchers.
5) To work on the project/task assigned by summer training organization.

During the training period I had an overview of the MATIND project and I worked as an intern in the Phase II of the MATIND project. Face to face and In-depth interviews were taken from mothers in rural/tribal areas in Surendranagar and Dahod districts. Transcription and translation of recorded interviews of the recently delivered mothers of Dahod and Surendranagar was done by me. Initial Thematic Framework Analysis done and observations and recommendations given to the best of my knowledge. Experiences were captured at home two week minimum post delivery. Also interaction was done with other staff members to gain an insight of the other phases and components of the project.

Acknowledgement

I extend my sincere gratitude to Professor Dileep Mavalankar, Director Indian Institute of Public Health, Gandhinagar (IIPH-G), for giving me the opportunity to do this study and undergoing the process of learning at IIPH-G. I thank him for all the trust and faith he posed in me and I only hope that I have been able to live up to his expectations. His guidance and support was helpful in enhancing my work.

I extend sincere gratitude towards Dr. Veena Iyer Assistant Professor Indian
Institute of Public Health, Gandhinagar (IIPH-G), who has been my mentor for the summer internship program & has been instrumental in helping me shape this study in a desirable way.

I would also like to thank Dr. Smita Solanki (Research Associate), at IIPH-G for supporting my work all along. Last but not the least; I would like to thank the entire staff of Indian Institute of Public Health Gandhinagar, for their support and guidance.

I would like to express my sincere thanks to Dr. S.D. Gupta, Director, IHMR, Dr. Ashok Kaushik, Dean (Academics and Student Affair), Dr. P. R. Sodani Dean (Training), my mentor Professor Dr. Anoop Khanna, IHMR for the proper guidance and cooperation extended by him. I am also grateful to my parents, my family and my friends for giving me moral support.

However, I accept the sole responsibility for any possible error of omission and would be extremely grateful to the readers of this project report if they bring such mistakes to my notice.

SECTION A

1. About PHFI (Public Health Foundation of India)

The Public Health Foundation of India (PHFI) is a public private initiative that has collaboratively evolved through consultations with multiple constituencies including Indian and international academia, state and central governments, multi & bi-lateral agencies and civil society groups. PHFI is a response to redress the limited institutional capacity in India for strengthening training, research and policy development in the area of Public Health.

Structured as an independent foundation, PHFI adopts a broad, integrative approach to public health, tailoring its endeavors to Indian conditions and bearing relevance to countries facing similar challenges and concerns. The PHFI focuses on broad dimensions of public health that encompass promotive, preventive and therapeutic services, many of which are frequently lost sight of in policy planning as well as in popular understanding.

The Prime Minister of India, Dr. Manmohan Singh, launched PHFI on March 28, 2006 at New Delhi. PHFI recognizes the fact that meeting the shortfall of health professionals is imperative to a sustained and holistic response to the public health concerns in the country which in turn requires health care to be addressed not only from the scientific perspective of what works, but also from the social perspective of, who needs it the most.

1.1Charter

The PHFI is working towards building public health capacity in India by:

- Establishing 5 -7 new institutes of public health;
- Assisting the growth of existing public health training institutions/

Departments and facilitating their evolution into major institutes of public health;

- Establishing a strong national research network of public health and allied institutions which would undertake policy and programme relevant research that will advance public health goals in prioritized areas - with suitable international partnerships where useful and appropriate;
- Engaging public health expertise to collectively undertake analytical work

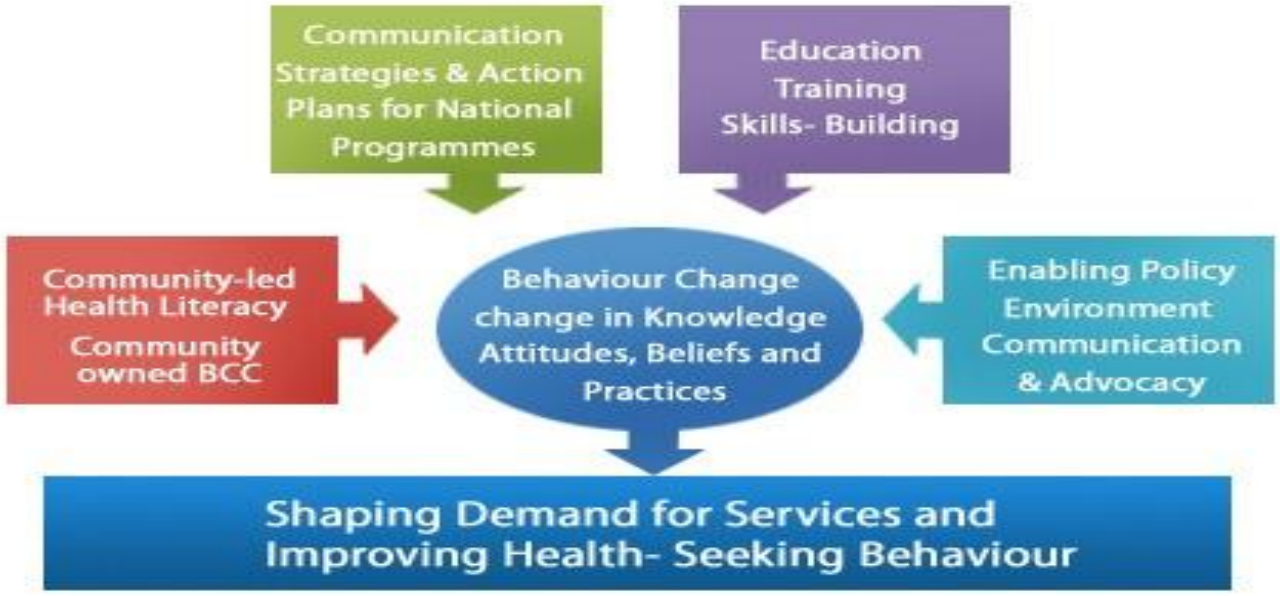
For generating policy recommendations related to public health action, in not only the health sector but also in all other sectors which impact upon health of people, and developing a vigorous advocacy platform to effectively communicate these recommendations to policy makers and other relevant stake holder groups (including civil society organizations which represent the interests of people's health);

- Facilitating in establishing an independent accreditation body for degrees in public health which are awarded by training institutions across India.

1.2 Activities

- Health Communication

Communication that is engaging and empowering, and provides individuals and populations with evidence-based options for positive action is critical to enhancing health literacy in society, thereby enabling its movement towards better public health outcomes.



- Health System Support

The purpose of establishing a Health Systems Support Unit (HSSU) at PHFI is to leverage and learn from research, education, advocacy and training, and provide a platform for offering technical support for strengthening initiatives across the country.

Mandate

HSSU has the following mandate:

- Establishing strategic partnerships with central and state governments and other relevant stake holders in the area of Health System strengthening
- Initiating programmatic and research activities in the arena of health system strengthening including emergency and disaster preparedness in hospitals and communities
- Carrying out operational research, operational improvement and quality improvement activities with private and public agencies on themes of public health relevance
- Hand holding and partnering with non-governmental organisations (NGOs) to work on health services
- Promoting alignment of educational programmes of PHFI with present and future National Health Programme needs

- Engaging in setting up of mentoring, monitoring and management frameworks in public health systems.

2. **About IIPH (Indian Institute of Public Health), Gandhinagar**

The Indian Institute of Public Health – Gandhinagar (IIPH-G) stared on World Health Day – 7th April 2008. The institute's activities received funding support from NRHM/ Ministry of Health and Family Welfare, and Medical Council of India, CSIR, NABARD, Karoliska Institute, NRDC, IPH Bangalore, etc.

IPH G has been providing research based policy advice to Government of Gujarat in its health policy making process. Institute faculties are on various government committees, NGO boards and international advisory committees. The faculty also helps in teaching programs and conducting workshops at other IIPHs and other academic institutions.

Introduction

High maternal mortality in India is a serious public health challenge. Demand side financing interventions have emerged as a strategy to promote access to emergency obstetric care. Two such states run programs, Janani Suraksha Yojana (JSY) and Chiranjeevi Yojana (CY), were designed and implemented to reduce financial access barriers that preclude women from obtaining emergency obstetric care. JSY, a conditional cash transfer, awards money directly to a woman who delivers in a public health facility. This will be studied in Madhya Pradesh province. CY, a voucher based program, empanels private obstetricians in Gujarat province, who are reimbursed by the government to perform deliveries of socioeconomically disadvantaged women. The programs have been in operation for the last seven years.

This project proposes the evaluation and comparison of the impact (including cost effectiveness) of two large scale health programs targeted towards reducing maternal mortality. The work program stresses that innovative aspects be addressed. Both the proposed programs are a first of their kind, in that there have not been similar demand side programs with an explicit focus on maternal healthcare (which in it itself is a new focus area for a large scale innovative program). Also both these programs are large scale programs, implemented by governments over large regions and not pilot experiments. No such large scale programs have been evaluated before though there have been repeated calls in scientific literature for the effectiveness of such programs to be studied.

Also maternal mortality continues to remain a problem for the poor largely because of access barriers to EmOC. India contributes 72% of maternal deaths in south Asia. Maternal mortality also continues to the MDG against which slowest progress has been recorded. Demand side financing as a mechanism to allow poor mothers to access institutional EmoC has never been implemented before on a large scale. The proposal will be a first in terms of comparison of outcomes between the two different demand side financing mechanisms employed in large scale programs. Further, both these programs are targeted toward Millennium development goal 5 (progress towards which has been slow and difficult), to reduce maternal mortality.

The private health sector plays an important role in the provision of healthcare in many low income settings, their contribution as part of a large program to achieving a public good (safe delivery in this case) has not been assessed before.

From a methodological perspective, the work program suggests the development of appropriate methods. The methods used in this evaluation will maintain a strong grounding in scientific rigor.

Also as reported in literature, the challenge to develop feasible indicators for maternal health program impact evaluation is considerable. This proposal will look into this aspect of indicator development in depth and come up with relevant indicators for maternal health programs. Methods relevant to maternal healthcare and specific to demand side financing will be employed and applied to two programs. Outcome parameters that are comparable between the programs

will be generated. Such indicators also have potential for use in other programs dealing with maternal health and financial incentives. Also as in the work program recommendation the health side effects on individuals / systems outside the immediate program will be studied. This project proposed to study the health status and health service utilization of infants born to mothers in the program as opposed to those non beneficiary mothers.

Plans for dissemination, particularly among policy makers, civil society groups and researchers have been clearly defined (an entire work package has been dedicated to this) as suggested in the work program. As stated, open access scientific publications will be published from this project, as far as possible to allow national and international access to reports and evidence coming out of this proposal.

The project is also focused on India, a country contributing to 21% of global maternal deaths.

Success with reducing maternal deaths is desperately necessary in India if we are to meet MDG5 on target. Also the recent political priority accorded to maternal mortality by recent governments has seen the large scale implementation of innovative solutions over the last 4-5 years which have yet to be comprehensively evaluated. The project will contribute thus to achieving this important MDG through targeted program evaluation.

On the whole given the diversity of health systems in the global south (where maternal mortality continues to be a serious problem), innovative context based experiments to tackle the persistent mortality are necessary. The evaluation results from these large demand side programs in India will have important lessons for policy makers and stakeholders within the country and internationally, particularly in the global south, where much progress towards making MDG 5 a reality is necessary.

The steps that will be needed to bring about these impacts include a close collaboration between the consortium and stakeholders including policy makers, civil society groups and researchers in the field. Policy makers and program managers need to be actively engaged throughout the entire evaluation process. Involvements of stakeholders in the initial methodological consultations are also important. On completion of the evaluation, widespread access to the results will be ensured, as there is an urgent need to know what works programmatically in the area of maternal mortality in the context of low income settings. Getting research into policy is an important priority of this project. We intend to actively involve local policy makers in the process of the evaluation research, besides making the results readily accessible to them. Access to decision makers and healthcare managers internationally, will be ensured through making available information about the evaluation and disseminating the results through suitable international forums.

Review of Literature

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Rationale of Study:

MATIND is a European Union (EU) funded FP7 project, coordinated by the Division of Global Health at Karolinska Institute, Stockholm, Sweden, with the main objective of evaluating two innovative large scale programs, which were set up to decrease maternal mortality among women living below the poverty line in India.

India contributes 20% of global maternal deaths and has 26% of her population living below poverty line, and continues to have one of the highest maternal mortality ratios in the world. Progress with MDG 5 in India (slow thus far) is a prerequisite to achieving the goal by 2015. Two Indian programs (JSY – Janani Suraksha Yojana were and CY – Chiranjeevi Yojana) started to reduce maternal deaths by promoting institutional delivery and reducing access barriers to maternal healthcare for poor women.

The two large scale, state run programs operate in two large Indian provinces. Each of these programs operates through the use of different innovative demand side financing mechanisms, which are specifically aimed at improving access for vulnerable groups. The JSY-program is a conditional cash transfer paid retrospectively to the woman on delivering in an institution while the CY-program is a targeted bursary paid prospectively to accredited healthcare providers for delivery of the woman living below poverty.

All payments are made by the state. While both programs are based on similar concepts, i.e. financial incentives for the provision and utilization of care; and the participation of the private sector – there are major differences in the socioeconomic contexts in which each program operates, financing mechanisms, provider payment models and incentives, quantum of financial assistance, level of private sector involvement, all of which will have a bearing on desired maternal health outcomes. No such large scale demand side financing programs for maternal health have been evaluated before.

The adoption of the Millennium Development Goals in 2001, specifically goal 5, renewed the global emphasis on reducing maternal mortality. This international commitment gained political attention; many low income countries prioritized improving women's access to maternal health services. The global MMR decreased from 320 in 1990, and was 251 per 100 000 live births in 2008. Despite the international commitment, maternal mortality remains somewhat unchanged globally. In 2008, an estimated 342,900 women died world-wide from pregnancy related complications. More than half of these deaths occur in six low-income countries; one-quarter in India alone.

Between 1992 and 2006, the Indian Ministry of Health and Family Welfare focused on strengthening the health system infrastructure to better support emergency obstetric care (EmOC) services especially in the public sector. A concerted effort was made to increase capacity for institutional deliveries by upgrading facilities to improve access to skilled birth attendance and EmOC. Key strategies included upgrading community health centers to function as first referral units, creating 24/7 access to health centers for delivery, and training and empowering non-specialist qualified medical doctors to administer anesthesia for emergency

obstetric procedures. In spite of this government investment, national surveys showed that the proportion of institutional deliveries only increased marginally from 26% to 39% during that period.

While it is extremely important to invest in EmOC facilities, developing strategies that increase the use of these services especially among the poor who suffer the largest burden of maternal deaths are equally significant. Most deaths can be avoided by prompt access to EmOC services. However, despite strengthening of the supply side (facilities), poor women are still at risk as they face a number of barriers, particularly financial, to access EmOC in the absence of social safety nets and widely prevalent out-of-pocket payment mechanisms. In 2005, the government recognized the need to prioritize maternal health amongst the poorest and set up the National Rural Health Mission (NRHM) specifically to improve access to care for low income people in rural areas.

Using the platform of the NRHM, the government introduced demand-side financing initiatives for maternal health to reduce financial barriers that often preclude women from accessing skilled attendance at birth. Two large scale demand-side financing programs to promote institutional delivery, conditional cash transfers (CCT) and vouchers, are currently in operation. The intended outcome of both programs is to promote institutional delivery, thus reducing maternal mortality through improving access to EmOC.

A traditional CCT provides a monetary incentive directly to the intended group on the condition the beneficiary satisfies a pre-defined set of requirements. India's Janani Suraksha Yojana (JSY or Safe motherhood program), a nationwide program, is a conditional cash transfer to all women who deliver in public sector institutions. This program will be studied in Madhya Pradesh Province. Chiranjeevi Yojana (CY or Long life program) is operational only in the Gujarat province, and functions in the context of an existing strong private obstetric care sector. It is a voucher based system where private obstetricians are reimbursed by the government to perform deliveries of tribal women or those living below the poverty line. Vouchers, which tend to be cashless, are used to reduce the direct costs of healthcare and increase demand for services

Aims and Objectives:

Overall Aim:

This project aims to develop methodology and apply this to assess the impact of and compare two large scale programs for the financing and provision of maternal healthcare in India, in terms of a) health outcomes (maternal and perinatal), b) the influence of the incentive structure on outcomes, c) extended benefits of the program, d) private health sector contribution to outcomes and e) financial sustainability.

Objectives:

Overall Objectives:

(i) To study financial sustainability for each of the programs by comparing costs of the two financing systems (though a cost utility analysis and a multivariate analysis, including sensitivity analysis) and by analyzing cost trends both from financing agency perspective and from the perspective of mothers.

(ii) To compare the findings on the two programs in India with findings from studies on the impact of NCMS on maternal care in China.

(iii) To disseminate the results of this assessment widely among stakeholders through workshops, academic scientific publications and appropriate national and international forums.

Specific objectives

(Each specific objective will be applied to each program – JSY and CY)

At the provincial (policy) level

(i) To study and compare trends reported by each program over time since inception, in terms of: uptake; institutional emergency obstetric care (EmOC) participation; private sector participation; and recorded outcomes (including institutional delivery, caesarean section rates, complicated delivery and mortality within the programs).

At the level of the public and private EmoC facilities in selected study districts

(ii) To assess and compare the coverage of each program in terms of provision of EmOC and utilization by target mothers and equity in geographic access.

(iii) To describe and compare the institutions (public and private separately) providing EmOC under the respective programs and the quality of care offered by performing a detailed facility survey of each participating institution.

(iv) To assess the influence of each program on the number of institutional deliveries taking place in these facilities among the target group through a time series analysis of the proportion of program births out of all births over a three year period.

(v) To study and compare delivery outcomes under the programs separately for private and public facilities in terms of: Caesarean section proportion, complicated delivery proportion, average lengths of hospital stay, maternal and perinatal mortality between program mothers and non participating women otherwise delivering at the EmOC facilities (public and private sector).

(vi) To explore and contrast in the study districts, the overall experiences of EmOC providers participating in the respective programs, including particular motives for participation, human resource implications, public/private interaction and willingness (and prerequisites) for continued long term involvement.

(vii) To study the eligible non participating private sector EmOC providers (in CY) in the study districts, compare these with participating private institutions and explore reasons for non participation.

At the level of mothers in the community (village level):

(viii) To estimate maternal death rates in the community through a house to house survey in study villages.

(ix) To compare eligible non participant mothers with participant mothers under the respective programs in terms of: their characteristics, their receipt of maternal health care, the direct and indirect costs of this care, their reasons for participation/non participation and their reasons for their choice of facility.

(x) To study and compare the receipt of comprehensive maternal healthcare by participating in each program in terms of: the rate of registration of pregnancy; receipt and source of full antenatal care; place of delivery; type of delivery; duration of hospitalization (if applicable); transportation for delivery; post natal care and receipt of incentives (JSY).

(xi) To study and compare the broader influence of each program on wider health outcomes (measured by infant survival, and infant weight) and health service utilization (measured by immunization status and registration in governmental nutrition programs).

Methods and Materials:

The study outlined in this protocol will assess and compare the influence of the two programs on various aspects of maternal health care including trends in program uptake, institutional delivery rates, maternal and neonatal outcomes, quality of care, experiences of service providers and users, and cost effectiveness. The study will collect primary data using a combination of qualitative and quantitative methods, including facility level questionnaires, observations, a population based survey, in-depth interviews, and focus group discussions. Primary data will be collected in three districts of each province. The research will take place at three levels: the state health departments, obstetric facilities in the districts and among recently delivered mothers in the community.

Title of the summer training project:-

MATIND PROJECT

PHASE II

Exploration of delivery outcomes and delivery experiences of recently delivered mothers (two week minimum post delivery) in the rural/tribal areas. (one of the components of Phase II of the MATIND project).

Face to face and in-depth interviews were taken of recently delivered mothers (minimum 15 days post delivery), of Surendranagar and Dahod districts of Gujarat. Experiences were captured at home two week minimum post delivery. Also interaction was done with other staff members to gain an insight of the other phases of the project.

Objectives/Assigned Tasks:-

Transcription and translation of recorded interviews of the recently delivered mothers of Dahod and Surendranagar districts of Gujarat was done by me, and observations and recommendations given to the best of my knowledge.

GENERAL OBJECTIVE:-

To study the delivery of comprehensive maternal healthcare to women in rural and tribal areas: the rate of registration of pregnancy; receipt and source of full

antenatal care; place of delivery; type of delivery; duration of hospitalization (if applicable); transportation for delivery and post natal care.

SPECIFIC OJECTIVES:-

(i) To describe the socio demographic characteristics of the newly delivered women.
(ii) To study antenatal, natal and post natal care utilization among the newly delivered mothers.
(iii) To compare direct and indirect expenses incurred for delivery and the subsequent financial burden among the families of recently delivered mothers.
(iv) To explore specifically among the recently delivered mothers the reasons for favoring home deliveries.
(v) To explore among recently delivered mothers, the experiences which they had during hospital delivery.

Study Setting: In Gujarat

District: Surendranagar

District: Dahod

METHODOLOGY:-

Study Design: A qualitative study.

Participants: Recently delivered mothers (two weeks minimum post delivery), selected by Snowball technique (qualitative method). Purposive sampling is done.

Data Collection: face to face and In-depth interviews were carried out with a proportion of mothers selected for maximum variation, to explore their perceptions of maternal healthcare. Consent will be obtained from all participants and the discussions and interviews will be recorded and later transcribed and translated for analysis.

Instruments (Topic guide): The guide included the following areas for exploration and experiences: perceptions of health promotion, risk and appropriate care in pregnancy, delivery and the post-partum period, quality of care offered by available facilities, decision making processes and actors (including staff interactions, availability of key staff, medicines and equipment) at the hospital, with regard to care seeking behavior and perceived barriers to care and the impact of ASHA.

Qualitative data derived from recorded face to face in-depth interviews with mothers will be analyzed using the thematic Framework approach.

FINDINGS/LEARNINGS:-

Learning is an ongoing process and the MATIND project is a big project of five years duration including three phases and each phase having various components. The project has completed only 1.5 years.

Two months period is a short duration but with the help of my project supervisor Dr. Veena Iyer Madam, I have learned a good deal from this project. She guided me greatly during my two months learning phase of summer placement.

My findings and leanings are as follows:-

- Using interviews in research project

Conducting completely **unstructured interviews** in which the participant (recently delivered mother) is allowed to talk freely about their delivery experiences. To avoid leading questions or questions those are not understood by the participant. Developing insight of thinking about the interview from the respondent's point of view and considering carefully who would be the most appropriate person to conduct the interview and in what setting. Interviews of the recently delivered mothers were conducted (minimum 15 days post delivery) by the researchers (who were females and doctors themselves) at the home of the mothers to make them comfortable with surroundings so they can speak freely about their delivery experiences.

- Conducting unstructured and in-depth interviews

A researcher tries to understand the informants' (recently delivered mother) worldview in an unstructured interview. Building a rapport with the participant is necessary else the it is difficult to obtain data from rural/tribal women. Some characteristics of depth interviewing are that the researcher has a general objective and may use an **interview guide,** but the respondent provides most of the structure of the interview. The researcher uses this guide, but follows up on 'cues' or leads provided by the informant.
Typically an interview of this kind lasts from 60 to 180 minutes in length.
In depth interviews of the recently developed mothers was necessary to

- enable extended data collection from participants;
- enable researchers to probe aspects of what a participant says, in ways that a more structured approach such as an interview may not, in order to get a fuller

picture of her delivery experience ;
- can explore the experiences of different participants, who may be selected to reflect a range of experiences. For example, primi para and multi para, less educated and uneducated mothers may have different expectations of treatment in a hospital;
- allow the rural/tribal mothers to 'speak for themselves' and thus increase the validity of the data.

The limitations of in depth interviews are that they:
- are costly in time, both for participants and researcher, and therefore may have to be limited in number undertaken during a study;
- may be inefficient, as participants may not restrict themselves to the area in which the researcher is interested;
- may not be generalizable, and are not agreeable to statistical analysis to test hypotheses;
- may be subject to biases (invalidity and unreliability), both because participants may not tell the truth or may hide aspects of their experiences, and because the interviewer may have an unintended influence on what participants say.

Face to face interviews:-

It enabled us to pay attention to non-verbal behavior and establish a rapport.
Face-to-face or personal interviews with the mothers were very labour intensive, but was the best way of collecting high quality data. Face-to-face interviews were preferred because the subject matter was very sensitive, as the questions were complex and the interviews were lengthy. Face-to-face interviewing offered a greater degree of flexibility .It explained the purpose of the interview and encourage potential respondents to co-operate; they can also clarify questions, correct misunderstandings, offer prompts, probe responses and follow up on new ideas in a way that is just not possible with other methods.

- Locating and Selecting Respondents:

Who, How Many?

In this qualitative interviewing, neither the number nor the type of respondents can be entirely specified in advance, as there needs to be willingness to change course as the data is collected. When we were working with as complex as the experiences of delivery and the perception for cost and care received by the mothers, research

needed to permit a capacity to react to what is being found. The details of who is to be interviewed, how respondents are to be found and what will be asked in the interviews all emerged during the study.

Getting Agreement to Undertake Interviews

Seeking the informed consent of the respondent to participate in the study by the interviewer. The interviewer explained why the study is necessary and converting waivers without coercion. Nevertheless such an invitation should be careful to explain that participation is entirely voluntary.
The interviewer reassured the respondent of their **confidentiality** or **anonymity**, and informed them that their identities will not be revealed in the aggregated findings nor their photographs will be clicked. The interviewer introduced herself, explained why the study is being done, why the respondent has been selected and what will happen to the interview data. Respondents were encouraged to ask questions. All of this helped the interviewer to establish a rapport with the respondent.

Structure of the qualitative interview:-

Three phase qualitative interview:-

1 Focused life history

In this phase, the interviewer's task was to put respondents' **experiences in context**, by asking them to provide as much information as possible about themselves, in relation to their delivery experiences and outcomes.

2. The Details of the experiences
Here the emphasis is on the concrete details of the present experience of respondents in the research topic area (perception of the care received by the doctor and nurses, cost incurred, attitude of the staff, support or intervention received during delivery, privacy, information given by providers and expectations of delivery of mothers , to **re-construct their experiences**.

3. Reflection on the meaning

In the third phase, respondents were asked to reflect on the meaning of their experience. This is not about how satisfying the experience may be, but how the respondents make intellectual and emotional connections with the delivery experiences that are the subject of the research topic. The intention here is to find out how respondents make sense of the experiences that they had, and how it relates to other aspects of their lives and their selves. This interview phase will draw on the first and second phases.

This is the topic guide which was used for the interview of the recently delivered mother (two weeks minimum post delivery)

Topic Guide:-

To be asked to recently delivered mothers during face to face interviews

1. **Focused Life history**

Warm up and ice breaking question

What would you like to tell us about your pregnancy?

Probes: Ante natal care, Expenses, Duration since delivery, thoughts and feelings when pregnant (do not probe further)

2. **Details of the experience**

Expectations of mother about delivery

I would now like to ask you about your expectations about pregnancy and delivery before you became pregnant (modify the questions appropriately if the mother is a para 2 or more)

1) Where is your maternal home? Brothers/Sisters, Sister-in-laws? Have you witnessed deliveries, at home or/ and hospitals? As a young girl/before marriage, one imagines what a pregnancy and delivery may be like. Can you tell us what were your thoughts/ feelings about this?

Probes: Have you witnessed deliveries, at home or in hospitals, (from these what had you anticipated for yourself?)

2) Had you known about types of births… normal, normal delivery with episiotomy, forceps, and caesarean? What had you heard about these? (here we try to understand whether mother had formed any views about the various types of delivery)

3) What had you thought about pain during delivery? (Try to comprehend whether she was frightened, anxious, inquisitive … maybe she was before the first delivery, what happened with the next deliveries, did she ever confer about this to anyone?)

4) What had you anticipated about check-ups done by nurses/doctors around pregnancy/ delivery?
   Probes: abdominal examination, P/V, enema, shaving, USG, measuring of vitals (TPR -temperature, pulse, respiration).

5) Tell us about your previous deliveries, when, where, how?

6) How and why did you make the decisions about where to deliver? For your previous deliveries? (In questions 5 and 6 try to understand whether there had been any complications during any of the previous deliveries and how they had been handled)

7) So, from all this, what would you call good quality care during delivery?

8) Take a break in conversation here and if possible summarize mother's narration regarding expectations to ourselves

Perceptions of mother about delivery

9) What had your family and you planned for this delivery? Where? Which hospital/doctor? Why? Had you planned/thought about what you will do

when pain starts, pain progresses.... arrangements of transport facilities, expenses related to transportation.....? Had you thought of these things during your pregnancy?

What all had you thought of or planned --- (get as much details as possible and reasons for the choice-) why did you plan to deliver at a particular facility, if so: What made you go to that particular hospital? (ASHA/ Relative influence) Before you went to the hospital for delivery, what was your opinion about the hospital, doctor, and nurse) Why?

10) After you reached the facility --- First contact at the facility and the period of labour:
Where did you go first? (Hospital)Who went with you (relatives)? Who all were there? (Dr/Nurse) What did they do? Did you have to wait to be seen – how long? After how long were you admitted?

(Probe for monitoring)

What did they tell you- about you and the baby? What happened next? (Examinations/procedures: Get details -was BP examined, PV done, FHR measured (with a stethoscope or jelly applied for fetal monitor, USG, shaving done)? After how long were you admitted? Where were you admitted? Were you given a bed? What was done during this time?

HERE, PROBE TO FIND OUT WHETHER MOTHER WANTED ANY INFORMATION ABOUT HER PROGRESS? HER BABY'S WELL_BEING? DID WHATEVER INFORMATION GIVEN TO HER BY THE DOCTOR OR NURSE, **MAKE ANY DIFFERENCE TO HER**?

(Probe for the following, QoC)

Move about or change positions during labour IV fluids .... Drips, injections,

Shaving

Enema

(Probe for mother's personal feelings about these)

What do you think about this?

Did you want to have it or not? Was it explained to you? How did it make you feel physically and emotionally?

HERE, TRY TO UNDERSTAND MOTHER'S OPINION ABOUT THESE PROCEDURES

11) The delivery process:

NORMAL DELIVERY: After how long did you deliver?

When did they take you to the delivery room?

What did they tell you- what examinations were done?

Who was in the delivery room?

Who did what during the delivery- who delivered the baby?

What position were you in during delivery? (Did you feel like sitting up? Did you sit up?, were you lying down?)

Did anyone apply pressure on your abdomen to deliver the baby?

Who gave drugs?
Who took out the placenta?
Any sutures given?

Did nurse/doctor explain procedures before performing it? If Episiotomy was given, was local anaesthesia given? Were you told that they are going to give you an Episiotomy?

How long were you in the delivery room?

Were there other women in the delivery room? What did you think about the other woman's delivery from what you might have seen or heard?

Were there any strangers watching you during your delivery? ..... (Privacy during delivery)

How did they get you to the ward after delivery?

LSCS DELIVERY: When was the decision made that you need a LSCS?

Why was it decided to go for a LSCS?

What anaesthesia were you given?

When did you regain consciousness?

Were you catheterised?

After how long was the catheter removed?

When did you begin eating solid food?

How often did the nurses and doctor meet you? (Ask for description to understand 'caring' by providers)

For how long were you admitted in hospital?

12) If there was a possibility of referral – were you told that you might have to shift to another hospital? (Probe around this to understand whether there is disappointment, fear, anxiety)

13) **Post natal period**:

How long were you in the ward after delivery?

What was done after delivery during your stay in the ward? (Examinations, drugs, advice given)

How frequently did the doctor or nurse see you after delivery?

How long after delivery did you breast feed your baby? Did the staff give you any advice or instructions regarding the care of the new born and mother?
What instructions were given to you on discharge? Did you follow those instructions?

What were you told in discharge, were you asked to come back for PNC? (Probe around whether postnatal care and discharge advice led to the mother feeling cared for).

Would you have liked to stay longer in the hospital? Why or why not?

3. Reflection on the meaning

Mother's reflections on her expectations in light of her actual experience

14) How do you feel now about the care you received while you were at the hospital?

15) Use some of the specific history given by the mother to probe about how she feels about it now, write caring and support.

16) Did you feel cared for during the process. If yes / in what way did you feel cared for? If no / in what way did you feel they could have done better?

17) Did you understand everything doctor / nurse told you? (Looking for language barrier and depth of communication).

Could the nurse or doctor have said or done something good/different to make you feel better?

18) Did you feel comfortable to ask any questions of the doctor?

19) What had you thought of regarding pain experienced in delivery? (How was your 'pain' experience? shouting in pain)(Probe around her experience of pain and how did providers respond to it?) How did you find their behaviour towards you? (Any abuse?)

20) What could hospitals do to make a woman feel more comfortable during delivery?

Mother's perception regarding entitlement as a result of out-of-pocket payment to provider

1) How much did you spend around you delivery? (ANC period, before delivery, in hospital, food for mother and relatives, travel, medicines.)
2) How did the actual expenditure compare with what you were expecting? Did you expect that you would incur this expenditure?

3) Did you need to borrow money? Sell anything? What? How do you expect to recoup?

4) What was the expenditure in your previous delivery? (May go into details if it is relevant.
5) Have you used any BPL benefits before? (E.g. getting any grocery / kerosene free of cost or for least price)

Does paying for treatment have any effect on what you expect from the doctor? Does it affect your feelings about asking the doctor questions for example?

Did you feel any other mothers at the same time got care that was different in quality and if so, why? (E.g. Which nurses/doctor took care of their delivery? How long did she stay? Would you know how much they paid?)

Closing questions:

Would you recommend this hospital to someone else? If you were to have another baby, would you go back?

Preparing for the interview:-

Practical arrangements for the interview

1. Place to meet
2. Sufficient time for the interview
3. Recording equipment

Method of recording the interview:-

In unstructured interviews, the interviewer normally tape record the discussion rather than attempting to get it all down on paper. This frees the interviewer to really listen to what is being said and respond accordingly. Audio devices were used to record the interviews unless there is a very good reason why this is not feasible (for example, because a respondent is not willing to be recorded). Consent to record the interview is necessary from the respondent. We need to explain the confidentiality and anonymity of the interview, and this can be done when we first agree an interview.

Qualitative interview data analysis:-

The first stage of qualitative analysis is to examine the transcripts of all the interviews. All the tapes of the interviews were transcribed and translated.

Once all the transcripts are complied together, thematic analysis was carried out. It is really a systematic way of identifying all the main concepts which arise in the interviews, and then trying to categorize and develop these into common themes.

The themes developed for these interviews were as follows:-

1. **Expectations of delivery** – very few expectations about delivery (they only desire that the delivery is done and they baby is born and there is no harm to the mother), lack of discussion of issues with unmarried and junior girls, lack of sex education and awareness about safe delivery practices. They do not prefer ante natal check-ups. Limited knowledge about ante natal and post natal check-ups.
2. **Context/ Local medical conceptualizations** - treatments interpreted within these; ideas of witchcraft; treatment of baby before cord falls off, blind faith in forefathers and family god-goddess.

a. Decision-making process – mother-in-law, senior members of the family and husband mostly take the decision as to where and which type of delivery the mother will undergo.

3. **Reasons for place of delivery**
    a. **Reasons for home delivery**- women prefer doing delivery at home, they are scared of the hospital environment, they do not like to stay in the hospital long after the delivery is conducted, they cannot afford money to pay for hospital services due to poverty, the health facility is far from their house, there is no other female member to do the household activities if they deliver in the hospital, they don't prefer male doctors conducting their delivery as they feel uncomfortable with them so they prefer to do it by the dais. So there is less rate of registration of pregnancy.
    b. **Reasons for hospital delivery**- if there is some past bad experience of new born death or maternal death during the delivery among the near relatives and family members, if delivery is not possible at home even after trying hard to deliver at home, if the hospital is located nearby their homes and if the delivery is conducted by the female nurses, ANMs or dais there.
    c. **Reasons for use of private sector** (especially for delivery in this case) – poor quality of public sector, bad experiences in public sector, no proper water supply or electricity supply in the public sectors in the remote areas, the infrastructure is very poor, need for woman to stay in one facility in labour (otherwise can go through referral process), previous good experiences with particular private sector providers in case of multi- para or by word of mouth from the relatives. There are lengthy procedures of paper documentation in the government sector while the private sector is fully equipped to handle all emergency cases. In public sector, shortage of trained and qualified manpower
    d. Link of 108 to public facilities – people have to spend money on private mode of transport during deliveries as the roads are not proper and the transport facility is very poor in the village and in the monsoon the condition of the roads is very bad and there is water logging at many places.

4. **Perceptions of quality**
    a. **Perceptions of quality in general** – they are concerned mainly with the outcomes (life/death) of the delivery, they prefer private sector for cleanliness, and 'giving treatment' (here seems to mean responding to emergencies), and appropriate procedures (e.g. not abdominal pressure), attitudes of staff (not 'scolding'), ease of referral – e.g. providing reports for referral.
    b. **Perceptions of quality in public sector** – lack of proper 'treatment' (response to emergencies?), there is strong lack of trust (effect on interview) on the public sector man power, equipments and public infrastructure, perceived wrong treatments (e.g. pressure on abdomen).
    c. **Perceptions of quality in private sector** – services delivered related to payment, trust of private providers, referral possible (report given), cleanliness, no scolding (conflicts with actual experience?)

5. **Experiences of delivery**
    a. **Perceptions/understanding of reasons for treatment** – limited understanding of check-up procedures and treatments given to the mother like measuring of blood pressure, doing

hemoglobin examination, administering of injections and IV fluids, doing PV, while doing ultrasound, while giving episiotomy and sutures, while giving enema,

b. **Attitudes of staff** – mostly improper and rude behavior reported of the staff when the mother screams in unbearable pain during the delivery process.
c. **Support/intervention during delivery** – during the labour pains, very little moral and emotional support given to the mothers in the process of delivery.
d. **Privacy** – due to poor infrastructure of the public sector, privacy of the mothers during the delivery could not be maintained, in rented buildings the infrastructure does not provide a proper location of the delivery room, so the mother is uncomfortable while doing delivery.
e. **Information given by providers** - e.g. limited information about treatment of baby following delivery, how to take care of the baby, how to handle the baby, breastfeeding advice, advice given to the mothers about the personal hygiene and their diet was very limited.

Recommendations:-

1. Provision of proper infrastructure, manpower, equipments and inventory in the sub centers, primary health center and community health centers.
2. Provision of better roads and transport facilities linking the remote areas with the public and private health care sectors as this will reduce the delay of the pregnant ladies in reaching the hospitals.
3. Spreading awareness about the Chiranjeevi Yojana among the women in the tribal areas and remote areas (especially women below poverty line and those who come in ST (schedule tribe) category.
4. Extensive training of dias and AYUSH doctors in remote and tribal areas for conducting safe deliveries or managing the complicated cases till the pregnant lady reaches the nearby hospital.
5. **Extensive** training of ASHAs, ANMs, FHWs and LHVs about the maternal and child care and follow up of their work in the field area.

Annexure

Topic Guide used for face to face and in depth interviews is as follows:-

This is the topic guide which was used for the interview of the recently delivered mother (two weeks minimum post delivery)
Topic Guide:-

To be asked to recently delivered mothers during face to face interviews

4. Focused Life history

Warm up and ice breaking question

What would you like to tell us about your pregnancy?

Probes: Ante natal care, Expenses, Duration since delivery, thoughts and feelings when pregnant (do not probe further)

5. Details of the experience

Expectations of mother about delivery

I would now like to ask you about your expectations about pregnancy and delivery before you became pregnant (modify the questions appropriately if the mother is a para 2 or more)

6) Where is your maternal home? Brothers/Sisters, Sister-in-laws? Have you witnessed deliveries, at home or/ and hospitals? As a young girl/before marriage, one imagines what a pregnancy and delivery may be like. Can you tell us what were your thoughts/ feelings about this?

Probes: Have you witnessed deliveries, at home or in hospitals, (from these what had you anticipated for yourself?)

21) Had you known about types of births… normal, normal delivery with episiotomy, forceps, and caesarean? What had you heard about these? (here we try to understand whether mother had formed any views about the various types of delivery)

22) What had you thought about pain during delivery? (Try to comprehend whether she was frightened, anxious, inquisitive … maybe she was before the first delivery, what happened with the next deliveries, did she ever confer about this to anyone?)

23) What had you anticipated about check-ups done by nurses/doctors around pregnancy/ delivery?

Probes: abdominal examination, P/V, enema, shaving, USG, measuring of vitals (TPR -temperature, pulse, respiration).

24) Tell us about your previous deliveries, when, where, how?

25) How and why did you make the decisions about where to deliver? For your previous deliveries? (In questions 5 and 6 try to understand whether there had been any complications during any of the previous deliveries and how they had been handled)

26) So, from all this, what would you call good quality care during delivery?

27) Take a break in conversation here and if possible summarize mother's narration regarding expectations to ourselves

Perceptions of mother about delivery

28) What had your family and you planned for this delivery? Where? Which hospital/doctor? Why? Had you planned/thought about what you will do when pain starts, pain progresses.... arrangements of transport facilities, expenses related to transportation.....? Had you thought of these things during your pregnancy?

What all had you thought of or planned --- (get as much details as possible and reasons for the choice-) why did you plan to deliver at a particular facility, if so: What made you go to that particular hospital? (ASHA/ Relative influence) Before you went to the hospital for delivery, what was your opinion about the hospital, doctor, and nurse) Why?

29) After you reached the facility --- First contact at the facility and the period of labour: Where did you go first? (Hospital)Who went with you (relatives)? Who all were there? (Dr/Nurse) What did they do? Did you have to wait to be seen – how long? After how long were you admitted?

(Probe for monitoring)

What did they tell you- about you and the baby? What happened next? (Examinations/procedures: Get details -was BP examined, PV done, FHR measured (with a

stethoscope or jelly applied for fetal monitor, USG, shaving done)? After how long were you admitted? Where were you admitted? Were you given a bed? What was done during this time?

HERE, PROBE TO FIND OUT WHETHER MOTHER WANTED ANY INFORMATION ABOUT HER PROGRESS? HER BABY'S WELL_BEING? DID WHATEVER INFORMATION GIVEN TO HER BY THE DOCTOR OR NURSE, **MAKE ANY DIFFERENCE TO HER**?

(Probe for the following, QoC)

Move about or change positions during labour IV fluids .... Drips, injections,

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(Probe for mother's personal feelings about these)

What do you think about this?

Did you want to have it or not? Was it explained to you? How did it make you feel physically and emotionally?

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30) The delivery process:

NORMAL DELIVERY: After how long did you deliver?

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What position were you in during delivery? (Did you feel like sitting up? Did you sit up?, were you lying down?)

Did anyone apply pressure on your abdomen to deliver the baby?

Who gave drugs?

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Any sutures given?

Did nurse/doctor explain procedures before performing it? If Episiotomy was given, was local anaesthesia given? Were you told that they are going to give you an Episiotomy?

How long were you in the delivery room?

Were there other women in the delivery room? What did you think about the other woman's delivery from what you might have seen or heard?

Were there any strangers watching you during your delivery? ..... (Privacy during delivery)

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Why was it decided to go for a LSCS?

What anaesthesia were you given?

When did you regain consciousness?

Were you catheterised?

After how long was the catheter removed?

When did you begin eating solid food?

How often did the nurses and doctor meet you? (Ask for description to understand 'caring' by providers)

For how long were you admitted in hospital?

31) If there was a possibility of referral – were you told that you might have to shift to another hospital? (Probe around this to understand whether there is disappointment, fear, anxiety)

32) **Post natal period**:

How long were you in the ward after delivery?

What was done after delivery during your stay in the ward? (Examinations, drugs, advice given)

How frequently did the doctor or nurse see you after delivery?

How long after delivery did you breast feed your baby? Did the staff give you any advice or instructions regarding the care of the new born and mother?
What instructions were given to you on discharge? Did you follow those instructions?

What were you told in discharge, were you asked to come back for PNC? (Probe around whether postnatal care and discharge advice led to the mother feeling cared for).

Would you have liked to stay longer in the hospital? Why or why not?

?

6. Reflection on the meaning

Mother's reflections on her expectations in light of her actual experience

33) How do you feel now about the care you received while you were at the hospital?

34) Use some of the specific history given by the mother to probe about how she feels about it now, write caring and support.

35) Did you feel cared for during the process. If yes / in what way did you feel cared for? If no / in what way did you feel they could have done better?

36) Did you understand everything doctor / nurse told you? (Looking for language barrier and depth of communication).

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Does paying for treatment have any effect on what you expect from the doctor? Does it affect your feelings about asking the doctor questions for example?

Did you feel any other mothers at the same time got care that was different in quality and if so, why? (E.g. Which nurses/doctor took care of their delivery? How long did she stay? Would you know how much they paid?)

Closing questions:

Would you recommend this hospital to someone else? If you were to have another baby, would you go back?