Antenatal Care Services and Home Deliveries-
Community Perspectives
Focus Groups in Rajsamand

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Dr. Nirupam Bajpai and Dr. Esha Sheth

Model Districts Health Project
Columbia Global Centers | South Asia (Mumbai)
Earth Institute, Columbia University
Express Towers 11th Floor, Nariman Point, Mumbai 400021
globalcenters.columbia.edu/Mumbai
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Introduction

The National Rural Health Mission provides an extensive array of maternal health services to improve the health outcomes for women and children to achieve MDG 1, 4 and 5. The packages are comprehensive ranging from family planning services, nutrition, antenatal care, and safe deliveries, post-natal care for mother and child and management of complications at all crucial stages. Earth Institute at Columbia University is the lead development partner for RMNCH+A activities in Rajsamand District Rajasthan and works closely with the District Health Team providing technical support and conducting regular gap assessments. Under the Reproductive, Maternal, Neonatal Child and Adolescent Health program a continuum of care is maintained at different stages. However implementation challenges at ground level impede and slow down the processes of achieving positive changes. Assessing factors that can be changed or approached differently based on ground reality, practicality and feasibility is important while designing health systems for equitable health care.

Rationale

Poor antenatal care indicators, a high number of reported home deliveries and anaemia prevalence in Rajsamand highlights that these maternal care services need further strengthening\(^1\). Therefore Earth Institute conducted a study to understand the barriers to ANC and institutional delivery service use. The findings from this study will also point to gaps in other parts of Rajasthan as most issues cut across the various districts based on shared experiences of other districts. Bhim and Kumbalgarh blocks in Rajsamand have had a high number of reported home deliveries in the last 2 years compared to the other blocks. Based on consultation with the District Health team they were chosen as the sampling frame for the study. As part of the qualitative component of the study focus groups were conducted with ASHAs and community members to understand the key issues.

Objectives – Focus Groups

Focus Group discussions were conducted with ASHAs, Dais and community members in the society who are linked with pregnant women have a potential influence or role on ANC care and delivery. Their knowledge and perspective on the following in relation to ANC and delivery was discussed:

- The role and involvement of participant
- Barriers that ASHAs face to successfully carry out their work
- Barriers faced by the users of the health system to avail health services
- Suggestions for improvement

\(^1\) Pregnancy Child Tracking Health Services Management System
Materials and Methods

Sample Size: A total of 62 community members from Bhim and Kumbalgarh participated in the FGDs.

Participants: A total of 9 Focus group discussions were conducted with ASHAs (3 groups), Mother –in Laws (2 groups), Traditional Birth Attendants (Dais- 2 groups) and religious leaders (Bhopas- 2 groups). District and Block Health teams assisted in the recruitment of focus group participants in consultation with community members.

Methods:

- **Informed Consent and Recording:** The focus group discussions were recorded after informed consent was obtained. Confidentiality of identity of participants will be maintained in line with the Columbia University Institutional Review Board Requirements. This discussion was conducted by a facilitator from Prayas Chittorgarh and Earth Institute team at CGC.

- **Transcription and translation:** The discussions were transcribed and translated from Hindi/Marwari to English by Prayas Chittorgarh, as per guidelines provided by the Earth Institute team at CGC.

- **Analysis:**
  - **Open coding:** A few of the interviews were reviewed and open coded based on the themes drawn out by the researcher. Notes and facilitators inputs guided in theme development and recognition.
  - **Code Refining:** Codes from the different groups were compared for similarity and frequency of appearance. Based on the objectives of the study the themes and sub-themes were refined, definition provided and use described for further coding.
  - **Coding by Themes:** Thematic coding of the interviews was done based on the codebook developed.
  - **Matrix preparation:** Responses for themes were entered in a matrix to be able to view and understand the findings from the focus groups.

Findings/Themes

A. Becoming a Dai

The 3 most commonly quoted reasons for becoming a Dai were:

- It is the work of faith and God
- Situation demanded their help and services, many a times starting with their own family and neighbours. More experiences in delivering children over time led them to be known as ‘Dais’
- Learnt from their mothers or mentors as in many areas there used to be no hospitals and doctors before.
Dai: “I had no interest in it, since deliveries were taking place at my house so I saw it there only and learnt how a baby is born. When I was delivering my baby I did not call any traditional birth attendant and I got my delivery done by my own hand and also cut the umbilical cord.”

Dai: “My mother was a Dai and mother-in-law was also a Dai. They used to tell us to check if the mouth of uterus is open or not, if the way is clear or not, so we thought how the mouth of uterus opens up, how can the way be clear, then we also faced the problem and started noticing it. Then I conducted delivery of my sister-in-law and saw the mouth of uterus opening up and judged that the baby would be out in an hour or two. We had no facilities so I kept on noticing and after sometime the mouth of the uterus opened and the baby was out. This is how we learnt it all.”

B. Role of Dai

1. Pregnancy Care

The Dai only visits or consults a pregnant woman if she is approached by her or the family with a problem. The problems are mainly limited to “pain” and “shifting of the fetus” or “fetus moving down”. They also might consult her if the labour pains are called for going to the hospital and might request her accompaniment.

Dai: “They come to me even at night, complaining about their pain in the stomach, hands, and legs. They had a grandson born near my house; they came around 50 times to me during those 9 months of pregnancy, at night and during day”.
2. Treatment a Dai Provides during Pregnancy

An experienced Dai will give massages to correct the position of the fetus if it has shifted, or recommend the pregnant women the dos and dont’s. If she feels the problem or treatment is beyond her scope of work she will send the woman to the hospital. For example she will not look into treating and advising bleeding problems.

Dai: “Since the foetus comes down again and again so we tell them to put bricks below the legs of bed so that their legs are at height and keep their head down, we tell them to rest for three days. Tell them to rest and also ask them not to crouch and wipe the floor and not to lift heavy weight.”

Dai: “Yes they call us in such situations; we give them massage to get the fetus back to the place.”

Dai: “We check and tell them in advance to take her to hospital. Problems like vaginal discharge, excesses bleeding, excessive vomiting etc. cannot be treated by us so we refer them to hospital.”

3. Dai Conducting Deliveries

- A Dai only conducts deliveries only when she is approached by a woman or her family. In some cases it is the decision of the family to conduct the delivery at home.
But if there is a delay, or emergency where a women cannot reach the institution the Dai will support the woman and conduct the delivery.

Dai: “We do not take much of risk, if the delivery takes place on the way we manage to get it done, and even if delivery take place at home we tell them to get the T.T Shot if they want, we don’t take any risk.

Dai: “If it is a breech delivery and the contractions are not happening then we ask them to take her to the hospital her delivery cannot take place here, hospital have facilities; traditional birth attendant doesn’t even has a needle.”

- However some Dais ask families when they are approached where and whom would they would prefer the delivery is conducted by, but do not force decisions. ASHAs from remote areas, where transportation or phone networks are an issue, reported that they do inform the Dais to keep a clean blade ready and maintain hygiene if an emergency home delivery needs to be conducted. Dais describe how they handle some difficult pregnancies below:

Facilitator: “Did it ever happen that the leg came out first, then how do you handle it?”
Dai: “Yes it happened, my elder sister has 1 year old son now. I got the news from my village that the legs were coming out, there was one other traditional birth attendant, she got scared and ran away and said she didn’t know if it was a ghost or something. Then I went there and felt my sister would die, I then saw the butts were coming out, so I pushed it back inside and put my hands into it, then by inserting the hands straightened the legs, with the help of desi bedi I boiled it with water and mixed jaggery in it and gave it to my sister to drink. A glass of it, it created lubrication and baby came out, so such a delivery was conducted by me.”

Dai: “Delivery does not take place, if it takes time then her feet are washed using warm water, stomach is also fomented with warm water and dry ginger is boiled in water and given to her. An elixir is made and given to her. We make some elixir mixing it with back pepper, dry ginger etc and given to her and then delivery happens usually.

Facilitator: “First do you do something to stop the bleeding? P1- Yes we use clothes, clean it, we cannot even insert much of things as woman can die out of shock. We will make her wear lose clothes.”

- Some Dais also discussed emergency situations where hygiene and infection control conditions were greatly compromised.

Dai: “Once a woman came to me, since she did not come for regular check-ups I checked
her stomach and the baby was suddenly delivered there, there was no knife to cut the umbilical cord so I took two stones and cut it using it and tore the sari and tied it from the two sides and gave the baby by wrapping it in the same sari.”

4. Delivery Experience and Trust
Dais are members of community, mostly senior in age and experience. Both the ASHAs and Dais emphasized on ‘trust’ factor during decision making process of a pregnant woman and her family. The same factor applies to a doctor. When it comes to conducting deliveries, the people do know that it’s best to conduct it an institution. However they would still want to consult a Dai and request her to accompany them. If required then she will also be requested to conduct the delivery. Excluding them completely from the system would not work at a community level unless people feel completely confident about the services provided at a government health institution, manpower available and it becomes easily accessible to people living in difficult to navigate terrain and within a short distance.

Dai: “Whenever women goes to get herself registered and they ask about Dai, they tell her Laxmi devi, in areas people know me. See there is a trust built on us by the people so they call us only, this is a thing related to trust.”

C. Pregnancy Identification (Disclosure) and Registration
- Conscientious and educated women nowadays realize it’s the norm to register within 3 months and get immunized. However there are cases where women and families fear bad omen, women are shy to report a pregnancy, or fear of abortion early on prevent them from informing about their pregnancy. Additionally some women do not want to get immunized out of choice or family’s decision. Certain tribal communities are specifically difficult to convince and refuse to reveal their pregnancy till it starts to show that the woman is pregnant.

ASHA: “The conscious woman in the village come on their own and asks for the test ... And there are women too, living in the interior of jungles who do not talk about their pregnancy we have to ask them with lots of efforts....they don’t talk on their own.”

ASHA: “I had tested her and the result was positive. I thought it best to to start the treatment/care early on a safer side but the women refused to, saying bhenji, please do not tell anyone....And if I would have forced her for a treatment it would have gone against me if something happened. After 13 days she had her abortion again.

- A Dai does not play any role in identifying pregnancies or approaching families and women to find out about the pregnancy status of the woman.
Facilitator: If a woman gets pregnant for the first time she must be unaware of it in the first month, then she must be having the feeling of vomiting or nausea. Are you also called at that time, in the starting?” Dai: “No not at that time”

- Some women who are residents of the villages actually live outside and only come at the time of delivery, while other often go to their parents place immediately. Therefore they are excluded from identification and early registration.

ASHA: “Women who stay out only those women get the cards made from Anganwadi when they come.” Facilitator: “Your village must not be having, do you have it in your village?” ASHA: “There is one woman who went to her parent’s home, she did not even register and did not even get immunize.”

**D. Immunization Barriers**

- Some women in the community believe that only immunization is important in fear of tetanus therefore once they get their shot they are not particular about ANCs. On the other hand many women do not understand the importance of immunization. They fear of bad effects, not wanting to reveal pregnancy to others. In certain communities mother-in-laws believe they weren’t immunized and nothing happened to them, so it is not necessary for their daughter in law. ASHAs try to provide correct counsel where possible, but are often met by resistance and it becomes difficult to single handedly convince the family.

ASHA: “Yes, we face this kind of problem, They say that we won’t get immunized because it could lead to abortion. We also explain them that all this does not make any difference, the earlier they disclose and take medicines it would be better, not disclosing your pregnancy could lead to abortion on the contrary.”

ASHA: “We try to make them understand by saying today you people are getting fever which you, tomorrow when season would change you would get fever again but then you live so it is better if you don't get diseases, we tell them about life threatening diseases.”

ASHA: “Woman does not refuse. Member of her family refuses, they say the elder people in the house are saying no, they are scared that if their daughter-in-law goes there something wrong would happen to her, and if other people in the village see her she would get Nazar.”

- Similarly barriers are faced in immunizing the child when it is born, as people are afraid of the side effects. The ASHAs find it even more difficult to motivate the families, as the community believes the ASHA is doing this work as she gets money for it.

ASHAs: They don’t give the drops, they come to make the card when baby is the
When a woman was not immunizing her child, the nurse told her that I would make your card only if you immunize your child otherwise I will not. Then she immunized her 1 and a half year old child, she got her child because of the card, or else she would have not.

Multiple ASHAs: “Yes when we go to give polio drops they say we are getting money for it, that is why you people have come to the house. When we call them all do not come, so we travel 1-2 km still they do not understand. Booster vaccine is also given. After getting immunized they again say now nothing needs to be done? When we again try to make them understand they say it is part of your job you are getting paid for it.”

E. ASHA’s Role and Responsibility in ANC and PNC care
ASHAs were aware of their array of comprehensive duties related to maternal and child care

ASHA: “To reduce the number of maternal and infant mortality rates, to conduct institutional deliveries, immunization of baby, in 12th week A.N.C means registering and conducting timely four rounds of checkups and then conducting delivery in the hospital.”

ASHAs: “To visit for 42 days after delivery, to advise pregnant woman about diet like eating green vegetables etc, non-vegetarian women can take eggs.”

ASHAs: “If we look at someone’s eyes and they seem whitish, then we come to know there is deficiency of blood, and it is also indicated through their body. We also get there blood test and whose ever range is below 8 we start taking care of them from then onwards.”

ASHAs: “We explain them this in the 7th month, we ask them to get ready with their bags in
which she should keep her clothes as well as baby’s cloth, give them free 104 number so that they can call the 104 any time just by calling them, we also give them our number as well so that they can call us and inform us so that we can also go with them.”

F. Barriers faced in ANC and PNC care
While conducting the required activities related to ANC and PNC ASHAs do face issues related to 100% coverage.

1. ANC Systems and Infrastructure Barriers
Barriers related to access which involve “kaccha” roads and distance, prevents ASHAs from frequently accessing pregnant women in remote communities. This makes it difficult for her to inform the family about MCHN days the day before, especially when certain families require more convincing. On the other hand it prevents women from those communities attending MCHN days regularly. They are scared to walk during early or late stages of pregnancy from distant areas due to chance of complication and it consumes their whole working day. Manpower shortage and absence of women doctors also deter people from visiting institutions for ANC. For example when women need a sonography, they have to visit public institutions multiple times due to high case load.

Facilitator: “And what about houses which are at distance?” ASHA : “When I go there only 3 houses could be covered, I go to the areas where houses are close to each other and then get back.”

ASHA: “Like women for whom it is 2 kilometer or far away they do not come, even if they come they reach late.”

ASHA: “They say if they walk much in the hilly areas there are chances for abortion, they come in the later stage of pregnancy.”

ASHA: “Sir there was facility of sonography, that is not happening now and people are going to Beawar to get it done. There is no female doctor or gynecologist here, only compounding is there.”

ASHAs: “If it’s far away we are not able to make frequent visits but yes we make sure to go and call them for the MCHN day.”

ASHA: “Yes we have to call them on the day, though it is not sure by what means they would reach, it is necessary to visit and call them at least once.”

ASHA: “There is a case where I have waited for her on the road on the way to facility to take her for check up. Now is if I go call her, it would take the whole day to come back after visiting her and taking her. I then made calls to her. It was in the fifth call I was successful in bringing the woman for treatment.”
Suggestions:
ASHA: “Asha worker has to go from house to house in order to inform, so why not train the Asha workers about immunization. Nurse does not go to the home. Once we are trained on it we could conduct immunization at our own level.” Facilitator: “That means you want to be trained.” ASHA: “Then nobody would visit the anganwadi centers, we will have to work by visiting door to door.”

2. ANC Beneficiary Barriers
Issues ranging from perception of the importance of ANC and PNC and immunization amongst communities to caste issues prevent the ASHA from smoothly carrying out her work.

ASHA: “Others come only for two rounds, some of them go to their parent’s place, some women especially who live far away do not come back after getting two vaccines, they say immunization is done what is the need to go further.

ASHA: “Those two women never come to us, no matter how complex the situation is, they are ready to die while delivering the child but not ready to come to us. She is stubborn, I will not go!”

ASHA: “Madam all the test are not possible for the women who are registered late, in case of others all the test are done. All the visits at Anganwadi we somehow do. But the last visit where they have to come to the doctor that always is not not possible. Some of them visit to the anganwadi others don’t, so we call them in installments.”

ASHA: “I went to meet a woman of Kumhar caste who had a girl, but family did not allow me to enter in her house, maybe because of caste or something. Then I also do not like it, I stopped telling her mother-in-law also, because even I feel bad, about this caste type of issues. Then mother-in-law later says did you feel bad? In our caste, such things happen. She said you don’t come, you are a villager, so will get your illness, I felt really bad...what is the point of this type of work then? She asked ANM to give her medicine, I really felt bad about it. I was insulted.”

G. Nutrition
1. IFA- Iron Folic Acid
Although many ASHAs claimed that women are consuming the IFA distributed, there seems to be a significant portion of women who do not regularly take IFA or completely stop because of nauseous feeling and vomiting. This is apparent in the women, especially younger age group who are pregnant and have haemoglobin of not more than 10 mg/dl. Mother-in-Laws and Dais do not advice or have much of a say regarding IFA intake. They are not really aware or involved about this aspect in relation to their daughter-in-law's pregnancy.
ASHA: “Then we see also, one woman threw the tablets in dust bin, we said her that it is for you try it for one month and your blood level would increase, then she took eat and her blood increased and finally they could believe it.”

ASHA: “Also women here are not educated. The ones that feel sick we tell them have it in the evening with milk. They take some milk on top. They say now where to get milk.”

Mother-in-Law: “Now a days very few women take them”. Facilitator: “Why do they deny to take them? Mother-in-Law: “They feel nausea or start to vomit”.

Facilitator: “Do you remember if IFA tablets were given or not?” Mother-in-Law: “I have no idea”

2. **Supplementary Nutrition**

The frequency with which pregnant women collect the supplementary nutrition from the AWC depends on where they stay and distance from AWC. In most cases this food is shared by the whole family as nobody specifically cooks separately for the pregnant women.

Facilitator: “So when halwa is made they only eat or everyone in the family eats it, in such case it would get consumed in just a day.” ASHA: “Everyone eats Sir, they don’t listen”


Facilitator: “Why doesn’t she eats it?” Mother-in-Law: “It contains flour, children mix it with oil cook and eat it”

3. **Other Diet**

ASHAs counsel pregnant women on a healthy diet during pregnancy, but not rigorously or regularly. However the misconceptions amongst elders about “ghee and buttermilk” consumption causing difficulties in delivery are rampant. Dais and mother-in-laws both believe it accumulates over the infant’s head on the uterus. It is possible that this misconception has grown from the fact that all food eaten must be hot to prevent infection. The pregnant women do not follow a strict diet, but if they have a craving or have gone to the market they will pick up meat and fruits sometimes, but not as routine.

Dai: “Yes, to avoid buttermilk and other greasy items.” Facilitator: - why? Dai: “It forms a layer on foetus.” Dai: “Yes it forms a layer on the head of baby and does not come down.”

ASHA: “We make them understand that when we eat milk and ghee, it goes in separate place in stomach and the baby is in different place, so when we eat how it would go there.”
H. Role of Mother-in-Laws

- The role of mother-in-law in pregnancy care decisions is variable. In few communities she still has a strong hold over how things should be done. However most mother-in-laws did claim that now the younger generation does not listen to them and they are not aware about details about their daughter-in-law’s pregnancy. They do support her during delivery by keeping relevant numbers handy and accompanying them to the hospital.

Dai: “Mother-in-law doesn’t care much, if the woman wants she eats curd, ghee, mother-in-law cannot keep a watch on her the whole day.”

Facilitator: “You must be advising something to your daughter-in-law like the precautions to be taken etc. what do you advice?” All start to laugh Dai: “(Laughing) we belong to farming background, stay in village what we can say, we are illiterate too.”

Facilitator: “Alright, your daughter-in-law is running in which month of pregnancy, 5th?” Mother-in-Law: “I have no idea, it may be Jeth month.” Facilitator: “That means she is in her 8th month.” Mother-in-Law: “I don’t even know how to calculate.”

Facilitator: “Was your daughter-in-law also checked?” Mother-in-Law: “I don’t know” Facilitator: “Your daughter-in-law?” Mother-in-Law: “No, I have never been there ....No; we go to the hospital with them for check-up.”

- Instances taken to the Doctor/Health Institution
Communities do consult Dais for minor pain and aches or if they are living far from the health facility. However for potentially serious problems the mother-in-law's report that their daughter-in-laws are taken to a health institution.

Mother-in-Law: “If blood starts to pass we would take her to the hospital first.”
Facilitator: “Do you go to the doctor at Kukarkheda and inform nurse there or go to Bhim?”
Mother-in-Law: “No we inform her first, in case the situation goes critical then go to Bhim.”

Facilitator: “But there are some other problems as well like swelling in the leg, or if starting of pain, excessive vomiting, you must be the first person she informs about these problems then what do you do?”
Mother-in-Law: Murmurs…” Take her to the hospital and get her treated to know what went wrong with her.

Facilitator: “Say if your daughter-in-law has problems like vomiting, swelling etc. and you live up there in the hilly area, so don’t you take her to Dais? “Do you go to hospital first or go to the traditional birth attendant first? Mother-in-Law: “First we consult the traditional birth attendant if she suggests then we take her to the hospital.”

I. Role of religious leaders ‘Bhopas’
Bhopas are approached for guidance on how to fulfil their wish of having child, a girl or boy or just blessings for the unborn child. In majority of the instances their advice is religious, related to praying to God and simple rituals. They do not ever advise them against going to health facilities. There have been a few instances where families have been advised against sterilization or immunization by the religious leader. But the scenario is changing nowadays.

ASHAs: “ That is not the matter....they will go to him even if they have pain, he tells them to deposit a fixed number of coconuts and pray etc ....He also asks them to visit the hospitals. Everybody starts to laugh ASHAs: “Bhopa says: Do continue the treatment ...I am
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with you.”

Facilitator: “People come because they do not have babies, do they also come to ask about the sterilization, which is advised in hospitals after they have a complete family.” Bhopa: “That is done by them.” Facilitator: But do they come to ask if it should be done or not? Bhopa: “No they do not come to temple to ask this.” Bhopa: “Problem related to body, like body pain, delivery related problems or some other problem.”

Facilitator: “Does a pregnant woman who visits you firstly in her 3rd or 4th month comes only once or keep visiting you for all the other months also?” Bhopa: “If bapji has advised her to come for five times she will have to have visit five times as she has offered coconut. She doesn’t need to do much just come five times and offer prayer.”

J. Home Delivery (Institutional Delivery Barriers)

Dais: “Nobody thinks like that, now everyone has become wise, even we give this advice. By chance delivery happens at home.”

1. Barriers in the health system and infrastructure

Poor accessibility for vehicles due to bad roads in certain areas or no roads in hilly areas for vehicles, lack of skilled personnel to deliver at facilities followed by referral and poor cellphone networks which cause a delay in reaching the ASHA or vehicle were some of the key reasons quoted by Dais and ASHAs leading to home delivery or preference to call Dais.

Dai: “And there are no transport available, this is the biggest problem. Facilitator: “So now 104 and 108 reach there or not?” Dai: “It is very difficult for it to reach......Because roads are not good; woman is brought to road in bed from two kilometers.”

ASHAs: “Traditional birth attendant only conducts it, by the time transport reaches delivery is over, I have called vehicle two three times.”.... Our area is such an area where vehicles cannot reach at all, even people on foot reach there with great difficulty. It’s a very narrow road.”

ASHAs: “A woman has to either walk during her labour pain, or the woman is put in a big piece of cloth which two people hold from front side and two from the back as the vehicle could reach only till the road.”

Facilitator: “When you go for a delivery in the hospital and call for the government vehicle does it reaches on time?” Mother-in-law: “Yes it reaches on time, but it could reach only till the concrete roads, our houses are on the top of hills so vehicle cannot reach there, we take time to get down and so even though it comes on time it goes back, it does not wait till long.”

ASHA: “Some people do not want institutional delivery or feel shy because of absence of lady doctor, they say we would call traditional birth attendant to conduct our delivery.”
ASHA: “From here the women are referred to Beawar, as there is no gynaecologist here. The doctor here is not good; if it’s a first delivery then they refer even without having a look.”

Facilitator: “what could be the possible reason that 6 out of 10 deliveries are taking place at homes and only 4 in the hospitals? “ASHA: “I stay in an interior region, there are no signals for phones and it’s hard to connect through phone and call transport, or people to connect to me.”

2. Other reasons for home delivery

The other reasons of home delivery are related to delay in decision making on part of the pregnant woman and her family to inform about labour pains and follow up. Delivering at home is easier and more comfortable rather than going to the hospital and spending three days there. People don’t completely perceive the advantages of hospital care post delivery.

Facilitator: “Ok one is this, what are the other reasons? Dai: “My daughter-in-law was making chapattis, she started to get pain and I was eating chapattis there only, she suddenly delivered, I had four deliveries and none without any assistance.” .... Dai: “Yes, in case of normal then they don’t go.”

ASHA: It has not even been one or two months.....delivery happened at home. The family called someone known and got the delivery done. Her husband came to me while they got delivery done by a traditional birth attendant so that nobody could say that they didn’t call me.”

ASHA:” I don’t know. Some people say that more we tell people about labour pain at early stage, there would be a problem.”

ASHA: “She told me that I have had deliveries at home earlier and so this time also I would have it at home hence I didn’t call you. I said that how many times I have told you but you do not listen. I also got her immunized.”

Facilitator: “Okay what about your area?” ASHA: “Who would take trouble for three days?” They delay in deciding whether to go or not.

Facilitator: “In your area?” ASHA: “They think it would be troublesome at the hospital and it is better if it happens here, it is far also.”

Mother-in-law: “Her granddaughter was delivered in the car itself.” Mother-in-law: “Delivery was over by the time car was still in the gate.” Facilitator: “Was she taken to hospital after that?” Mother-in-law: No she was not taken to the hospital Facilitator: “Why was she not taken to the hospital?” Mother-in-law: “Delivery was over without any problem then what was the need to go to the hospital.”
**K. Specific Population**
ASHAs have reported that at time certain people from specific castes in their area do not allow ASHA to enter the house. Within the Bhil population it becomes difficult to immunize certain women as they do not reveal their pregnancy and do not see the advantages of immunization. As far as Dai are concerned they will go to anyone who calls them, without any preference to working with certain castes. However in certain areas it is apparent that women prefer to deliver at home. **It would be crucial to identify such communities through ASHAs and have special programmes to motivate them.**

Dais: “We do not discriminate Dai: “People from all the caste come.”
Dais: “Gomti, Rajputs and other higher caste people also come to call us; she is called by the people of her own community. Earlier deliveries were conducted at home.”

Facilitator: “Which other caste mostly go for home deliveries one is Rajput, who else?”
Dai: “Honawarh, Chandara, Kherver.”

**L. Private Institutions and Quality Care**
The reasons for home delivery have been highlighted. But overall people prefer institutional delivery. To them the quality of care has become more important. Presence of doctors and ANMs giving personal care is preferred. Those who can afford it will access private institutions as they think it provides better care, faster delivery and earlier release.

ASHAs: No sonography is not available there, but when someone goes to other government institution, they spend money for bus fare, 50 rupees for coming and 50 for going, then they are given dates, like after a week, then when they go, there are long queue and if they get late then they are asked again to come next day. So this way they end up spending 500 rupees, and in the same amount it could be done in private.”

ASHAs: “There is dearth of doctor at Bhim, and the staff is also less here, so patients also don’t come, there’s no doctor also here so long queues, so people mostly go to private.”

Facilitators: Why do they all go to Majera? ASHA: Yes it has facility, and doctors are available.
ASHAs: A trust is built on these sirs, they are always there and staying there too. At the CHC here morning one person checks, during the day it is someone different and by the night it changes again, so different people come to check here. And then people don’t like this.”

Mother-in-Law: “If the doctor is not prescribing treatment timely we feel our daughter-in-law and the child would die. If we had to go and wait there for hours without any treatment, we go to another doctor. We also consider the feedbacks from other women and refer to doctors.”

**M. Belief and Practices post delivery**
There are some misconceptions which need to be rectified amongst the communities in regards to breastfeeding. Most people believe that breast milk is not formed for the first 3 days. It might be true that women are finding it difficult to breastfeed; however this has
become the generally accepted idea. Instead the child is fed “Janamgutti” or “gulla” secretly or knowingly. Additionally there are confusing ideas about hygiene and when a woman should bath after delivery, especially after home deliveries.

Facilitator: “Ok the deliveries which take place in the hospitals, are they also given Janamgutti secretly? Dais: “Yes it is given, I give Janamghutii for sure.”

Dai: “Baby passes black stool, if it is not given jaggery then the baby stays in problem for seven years. If medicines are given the baby passes stool, then when the baby is feed with jaggery the stool gets clear in two days and it has to face no problem.....Yes, at homes jaggery is sucked.”

Facilitator: “After how long do you feed the baby with mother’s milk?” Dai: “After two days. What else do you feed...?” Facilitator: “Which milk do you get and feed”. Dai: “Milk which is available outside in the market.” Facilitator: “Does hospital staff also recommends it?” All start to laugh.

Mother-in-Law: “Everyone is given gulla only, gulla is given in the first delivery, and milk is not formed for first three days. Some women start lactating after delivery while some don’t...”

Facilitator: “How many times do you give gulla in a day?” Mother-in-law: “Thrice a day....Two-two drops (Laughing) it gets drowsy so it keeps sleeping, because of janamghutti...”

N. Maternal Deaths
ASHAs awareness about reasons of maternal deaths in their surrounding areas is limited, unless it happens in the village that she resides. Therefore apart from the issue of under reporting, ASHAs are not involved sufficiently trained in assessing a maternal death to identify health system gaps.

Facilitator: “Ok, whatever maternal deaths have happened have you heard anything about them?” ASHAs: “Not heard.”

Facilitator: “When there’s a maternal death then is there no discussion about it in the sector meeting?” ASHAs: “It does happen, Sir” Facilitator: “If it is discussed in the sector meeting then you should have known.”.....Silence....

ASHA: “They want in writing how it happened, there’s no discussion. I would give it for my area; some other ASHA would give it for her area.”

O. Incentives and Gratitude and Benefits
- The ASHAs are officially given incentives for their activities; however most of them seemed to be confused about the difference between JSY and JSSK.
ASHA: “If the baby gets ill within 28 days of birth then free treatment is provided.” Facilitator: “And when they get food in the hospital, under which scheme does it come; JSY or JSSK?” ASHA: “Under JSY” … ASHA: “No don’t know” 
Silence.........

- The Dais are given some form of gratitude from the families like cash or grains amounting from 200 to 500 rupees. However they expressed that now that they are making efforts to bring the women to the hospital they also should be compensated in some way.

Dais: “Those who have their villages far away and cannot have transport facility or are having other problems are being handled by us, so there must be something for us as well; there must be some help for us from the government’s side. We bring them from village so we should also get something.”

- The other issue highlighted to benefits a pregnant woman receives for delivering at an institution is the inability to encash the cheque because of barriers in opening accounts.

ASHA: “Newly married women do not have identity cards because their names are not in the ration card so they don’t even have Adhar cards. They don’t have any of the 3 proofs.”

**Conclusion**
The focus group discussion enabled the identification of barriers, gaps and practices from the community’s perspective. It is crucial to review these in order to build strategy on how to resolve issues and identify the key members of the health system and the community who will play a role in bridging the gaps to further strengthen service delivery.