Antenatal Care Services and Home Deliveries
Service Providers Perspective
Key Informant Interviews in Rajsamand

2014-2015
Dr. Nirupam Bajpai & 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
Table of Contents

Introduction ............................................................................................................................................. 2
Rationale .................................................................................................................................................. 2
Objectives – Key Informant Interviews ............................................................................................... 2
Materials and Methods .......................................................................................................................... 3
Findings .................................................................................................................................................. 3
Themes .................................................................................................................................................. 3
  A. Aware about most responsibilities under JSY and JSSK ................................................................. 4
  B. Insufficient stress on Family planning, Intra-partum Care, Post-natal care (PNC), Home Based Neonatal Care (HBNC) .......................................................................................................................... 4
  C. Lack of Manpower affecting efficient delivery of services for maternal care under JSY and JSSK .... 5
  D. Majority ANC registrations in Second Trimester and lack of 100% ANC Coverage ...................... 5
  E. Institutional Delivery Barriers .......................................................................................................... 8
  F. High Risk Pregnancies .................................................................................................................... 11
  G. Anemia- Challenges ....................................................................................................................... 13
  H. Public Grievances .......................................................................................................................... 14
  I. Quality of Maternal care services in Private Institutions ................................................................. 15
  J. Maternal Deaths .............................................................................................................................. 16
Conclusions ............................................................................................................................................ 17
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 has 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 key informant interviews with service providers were conducted.

Objectives – Key Informant Interviews
As part of this study service providers were interviewed to assess their perspectives and opinions on:

- on the situation maternal care services in their blocks
- barriers that providers faced to successfully carry out their work
- barriers faced by the users of the health system
- anemia and nutrition
- reasons why specific pockets still had home deliveries being reported
- their suggestions for improvement

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

Sample Size: 22 two service providers were interviewed in Kumbalgarh and Bhim Block

Participants: These included Auxiliary Nurse Midwife (ANMs), Lady Health Visitor Supervisors, ASHA (frontline workers) Facilitators and Medical Officers.

Methods:

- **Informed Consent and Recording:** The interviews were recorded after informed consent was obtained. Confidentiality of their identity will be maintained in line with the Columbia University Institutional Review Board Requirements.
- **Detailed notes** were made for each interview during the interview and further expanded with the help of the recordings by interviewers fluent in Hindi and English.
- **Themes:** The responses for each question for all the interviews were compiled and analyzed to draw out the major themes.
- **Interviewers and researchers perspective:** Interviewers from the Organization Prayas Chittorgarh conducted the interviews which were analyzed by Researchers from the Earth Institute team at Columbia Global Centers. They were able to gauge the knowledge and confidence of the service providers related to services available and provided by the health personnel and current scenario, through the recordings and interactions. Each interview was 30-45 minutes long.

Findings

Most participants were confident and comfortable while expressing their opinions based on their observation, experience and knowledge, especially those that had worked for a longer period within the health system and were more senior in designation and age. Although confidentiality was assured few were nervous and guarded while answering specific questions due to fear of being reprimanded or questioned. They did not describe the actual status of scenario, their opinion being more biased towards the ideal. Certain cadres of workers don’t feel empowered to voice their opinions, as many decisions of the health system are not participatory in nature. While assessing qualitative data this aspect is an important consideration.

Themes

The major themes that were discussed and drawn out were:

A. Aware about most responsibilities under under Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Yojana (JSSK)

B. Insufficient stress on Family planning, Intra-partum Care, Post-natal care (PNC), Home Based Neonatal Care (HBNC)
C. Lack of Manpower affecting efficient delivery of services for maternal care under JSY and JSSK

D. Majority ANC registrations in Second Trimester and lack of 100% ANC Coverage

E. Institutional Delivery Barriers

F. High Risk Pregnancies

G. Anemia Challenges

H. Public Grievances

I. Quality of Maternal Care at Private institutions

J. Maternal Deaths

A. Aware about most responsibilities under JSY and JSSK

Service providers described ANC care which encompassed early registration and checkups. This included TT immunization, Hemoglobin measurement, steps towards prevention and treatment of anemia and counseling on nutrition. Motivating pregnant women to have institutional deliveries and orient them about monetary incentives linked to the schemes, was being followed rigorously. Familiarizing women and their families with transportation and referral services was being done to ensure institutional deliveries.

B. Insufficient stress on Family planning, Intra-partum Care, Post-natal care (PNC), Home Based Neonatal Care (HBNC)

Very few interviewees indicated that they discussed family planning options after delivery and provided PNC which included HBNC. There wasn’t sufficient stress on these services as compared to the others, as assessed by the researchers and reported by service providers.

- **Intra-Partum Care and PNC:** Not a single interviewee discussed the importance of intra-partum care. (It could be that it is implicit once a pregnant woman arrives for delivery.)
  - This fact is bolstered by our observations during block monitoring visits.
  - Disinfection procedures are not known and practiced by all, as per required guidelines and breastfeeding not initiated within an hour (although mentioned in the Service Delivery Register)
  - Infections contracted at facilities during delivery and care of mother and child are most critical for their prognosis

- **HBNC Care:** Some of them described that poor HBNC care accounted for the early infections in mother and child post-delivery which potentially could lead to deaths.

- **Family Planning:** This was mentioned by a few, but there was not too much discussion on how they advised the couple or woman on family planning post delivery
C. Lack of Manpower affecting efficient delivery of services for maternal care under JSY and JSSK

- **Lack of Specialized Personnel:** The lack of specialized personnel, especially anesthetists and gynecologists prevents Community Health Centers (CHCs) from being functional First Referral Units (FRUs). Both block CHCs are non-functional as FRUs.
- **Lack of lady gynecologists** and doctors prevents some women from accessing facilities for delivery
- **High number of referrals from CHCs:** Although some doctors are present, referral of simple cases to other facilities from CHC level leads to loss of credibility for providing basic services
- **Unavailability of 24X7 doctors** at Primary Health Centers prevents people from accessing those facilities, functioning as delivery points, or providing basic emergency care, especially at night.
- **More manpower to Strengthen Subcenters (SCs) functioning as delivery points:** They need someone to help them with cleaning, administrative and accounting work.
- **Filling Vacancies:** Vacancies in administrative staff like accountants and information assistants makes it difficult to cope with their key service delivery activities and update the online systems with relevant data for monitoring and planning.

Although money is an incentive to access public institutions, people nowadays give importance to staff availability and personal attention as important criteria for receiving quality services.

D. Majority ANC registrations in Second Trimester and lack of 100% ANC Coverage

- **Perception of importance of ANC and immunization is low - cultural dominance of the attitude “not required”:** Some people do not comprehend completely the benefits associated with early registration within first 12 weeks. Some women don’t get immunized, especially in in Bhil communities, as elders believe they were fine without immunization and it is not required by this generation as well. Therefore communities like Gameti do not come forward. Women, who have recently been pregnant in the last year, need a booster doze. They delay their registration until then (5-6 months). Some people still feel that is there is no problem there is no need for a checkup. Some
  - Therefore service providers feel that there needs to be an increased awareness and demand for services so that people come forward on their own as well.
  - If ANM has been there living in the community for a long period of time, people trust her and come forward.
  - ASHAs cannot be depended on alone with their multiple responsibilities. Overall community support is required to close in at best possible coverage, because
matters and opinions of the community are held in value. Village Panchayat members should also take active interest in health of pregnant women.

- **Structural Barriers- terrain, distance and roads:** Hilly terrain, poor road conditions and distance from Aganwadi Center or SC prevents ASHAs from making regular visits and ANMs to support them in their work while trying to counsel and encourage women for ANCs. Additionally these women are scared about abortion risks if they travel such terrain and in the later months of pregnancy it becomes more difficult for them. Those that live in far off areas, reached via “kaccha roads” will sometimes have to spend an entire day to visit ANC sessions. For smaller families traveling for a couple of hours and back for ANC is not possible when they have other children to look after. MCHN day is held only once a month or in some places once in 3 months.

- **Migration and ‘Mother’s Home’:** A lot of women migrate with their husbands for work to different cities and towns, therefore cannot register or will do so in the 3rd trimester when they return to their villages for the delivery. There ANCs in between cannot be completed. So although they are accounted for within the catchment population, they don’t really live there. Others immediately go to their parents place for duration of pregnancy and or delivery. There it is possible that the estimated numbers do not match up for the area. **Therefore Migration is an important criterion that needs to be included into the estimations of ANCs.**

- **Superstition and Shyness:** Women do not want to talk about their pregnancy early on until 5-6 months fearing bad omen, till it becomes visually obvious. They do not want other women visiting MCHN day to know about their pregnancy. This is changing with improvement in education and better awareness amongst the younger population. In Bheem, OBC and Rawat communities usually don’t inform personnel when they are pregnant may be because they are shy. Some say that “God” via their Bhopa has asked them to delay immunization, in turn registration and check-up is affected.

- **All staff not working to the best of their capacity:** The service providers have observed that only 60-70% staff works efficiently.
  - They feel that action cannot be taken because this is based on personal opinions, and political pressure prevents officials who do want to address the issue from taking steps.
  - Additionally in cases and situations where planned, strategic action should be taken because the personnel is skilled to perform work, officials issue notices or
remove those individuals thereby preventing people to access these skilled personnel.

*Interviewee—“There is no point of reporting staff names when it is the mindset of the people that has to change.”*

- They were of the opinion that someone at a higher level should provide guidance how to address these situations to avoid fear among the working staff which does affect their motivation levels and work.
- There was a general opinion that those on contractual basis feel somewhat less motivated to carry out their tasks.

- **Only Immunization Important:** Because of the fear of tetanus nowadays, some women only make sure they are immunized, but do not follow up with the ANC checks ups, as they do not perceive them as important.

- **Pregnancies amongst young adolescent girls:** Some young girls marry early and do not realize they have missed their period till 2 months as they aren’t really paying attention to such matters. By the time they register they are past first trimester.

- **Decision to continue with the pregnancy:** If women have a second child too quickly, they initially feel scared to report it to family members and health personnel for fear of being scolded. By the time they inform she is already in the second trimester. The same happens when they have already had 5-6 children.

- **Fear of abortion in the first three months prevents them from early registration:** Some women believe that it is better to render services after the first 3 months once they feel that the pregnancy will last.

- **4th ANC Barriers:** 4th ANC with doctor is either not possible if registration is late, doctor is not there or woman not willing to travel to see doctor.

*Suggestions given by Interviewees:*

- More home visits and home-based care would have to be done to evaluate the situation realistically from a community based perspective, taking cultural norms into consideration.

- Community and Panchayats need to be engaged in matters of health and sometimes it’s difficult for health personnel alone drive behavior change and convince women and her family to take the right steps.
• Holding discussions in a group with women would be very important to convince difficult cases. Additionally this would help in changing the overall perspective of how ANC check-ups are viewed.
• ASHA’s educational level criteria and incentive pool needs to increase, for more quality based service. (The researchers observed that some of the ASHAs are shy, don’t visit certain communities that do not respect them, many of them live under the ‘ghoonghat system’ which makes it difficult to interact with community members.
• Government needs a scheme for early registration – (although this might improve the indicator early registration, it does not ensure quality and required number of ANC services).
• Ground level screening with MOIC and announcement via mics about the schemes would be beneficial.
• Follow up, tracking and action against non performing staff is required.

E. Institutional Delivery Barriers
A vast majority of the women are now accessing institutions for delivery. Although they might not register on time and have all required checkups, they still want to deliver at an institution. Reasons for home deliveries were as follows:

➢ Delay in Reaching the Facility:
  o Delay in Decision Making: Women do not recognize labor pains on time. They bear the pain until the last moment before alerting family members and ASHAs. This in turn delays calling of government sanctioned ambulance. Women who have had many children will also deliver faster. Therefore in many cases where there is intention to deliver at institution the delivery is at home or on enroute to facility.

➢ Transportation Barriers
  ▪ Inaccessible areas/Kaccha Roads: Hilly terrain or and ‘Kaccha roads’ making it difficult for 108 or private vehicles to reach households. Some of the roads are not in the condition where the ambulance can reach and bring a woman safely. Women in labor have to be brought down on a bed or large cloth to the vehicle. It is difficult for a nine month pregnant woman to do so.
  ▪ Vehicles refuse to pick pregnant women up from these areas, especially at night time, when calls go answered.
- **Non-Profitable for private vehicles to serve as transport:** Additionally some of them have to go to collect their cheque and come back, spending more time and money on petrol.

- **Cell phone networks poor:** Certain areas have very poor to no cellular network making it impossible for family or ASHA to contact referral transport or SBA for delivery.

- **Do not go to health facility after Home Delivery:** Even if there was intention to deliver at institution and due to delay at some level it takes place at home, women do not want to go the health center. They do not see the point once all has been performed in the comfort of their home.

- **Demand for Quality Services:**
  - **Manpower - Absence of a woman doctor/gynecologist and skilled manpower:** This has been a deterrent for women not approaching institutions. Once people get to know that a 24X7 PHC or FRU does not have full time dedicated staff, doctors keep changing on rotation instead of having the same doctor consistently, they do not feel comfortable to approach that institution. **Therefore people are weighing in the quality of services they are provided.**

- **Trust:**
  - **SBA performed deliveries being registered as home deliveries:** Some SBA’s perform private deliveries at their or the beneficiary’s home, which cannot be counted as institutional or SBA performed. This is their private practice not linked to JSY benefits. But people have trust in the skills and experience of these individuals to spend extra money and avail their services.
  - If people have faith in a particular Dhai, doctor, ANM then it does not matter who or where the delivery is conducted. In one area an Ayurvedic doctor used to conduct deliveries for 25 years at people’s home, and they all preferred this. This also affected the retention of Medical Officers.

- **Home Deliveries are ‘More Convenient’:**
  - **People do not prefer to stay for 48 hours at the facility:** Some families and pregnant women do not comprehend the advantages of that care for mother and child and want to resume work immediately. Staying for 48 hours also
increases the cost for the accompanying family members. Therefore they prefer going to a private facility where they will be discharged in less than 48 hours. In small nuclear families there might not be anyone to look after the children or accompany them the woman.

- **Dhais**: In certain areas Dhais, especially from the Gameti caste might be promoting home deliveries, as this is their profession. In Bheem area Dhais are also performing deliveries quite often. This is also linked to the fact the people are aware that the other close by public facilities are either going to refer the cases or will not provide quality services. Therefore it is easier and more convenient to get normal deliveries done at home.

- **Safe experience with previous home deliveries**: People believe that if so far home deliveries have been safe for them then there is no point of going to an institution. It is comfortable and does not require a 48 hour stay.

- **No benefits perceived**: Some people don’t see marked differences between them and women who deliver at institutions. Infact more maternal deaths have been observed in relation to institutional delivery. Those that have decided that they are going to deliver with a Dhai don’t even call up. In many cases they deliver without a Dhai.

- **Difficulty to go to facilities at night time**: In distant/interior places and those in hilly locations, it is tough to access 24X7 facilities due to transportation, connectivity and manpower issues. Dhais are commonly approached in these types of cases before ASHAs. Therefore even the health personnel do hold them in value in such situations.

- **Specific communities prefer home delivery**: Certain communities like Rawat and Salvi might prefer delivering at home in some cases. There are high home deliveries reported among tribal population like Bhil.

- **Fear of C-Section and Episiotomy**: Delivering at home eliminates episiotomy and stiches. Some women have been given stiches without LA and they find this extremely painful. An ANM reported that many women have complained that an episiotomy is also done also at time of 2\textsuperscript{nd} delivery, and do not understand why it needs to be repeated.
Interviewee - “People are referred from here anyways, even for small problems, so then either Dhais convince them, or they just prefer delivering at home. No work is done here. In one case I was willing to take the responsibility she was dilated 4 fingers, still they referred her and she delivered in the van.”
“Women who have gone to hospitals the labor pains were misdiagnosed and they were sent home.”

Suggestions given by Interviewees:

- **Deployment of trained staff**: The ANM in Nathela also goes to Richead PHC to conduct deliveries, as currently there is no trained or confident staff for delivery there and people all around that area trust her. Similarly other SBA should be deployed and also compensated accordingly.
- **Understanding the importance of 48 hour stay**: Women need to understand that PNC at a hospital is of much better quality. Therefore PNC counseling should be improved.
- **More efficient Transportation services**: There should be a mobile team available everywhere, in each village if delay is to be avoided to help a women reach the institution, otherwise it is very difficult to achieve total institutional delivery.
- **104 services should not function sector-wise but rather reach out area wise** based on need. More 104 vans are required to reach high home delivery areas.
- **Small Special Programs in extremely poor functioning areas**: Programs addressing specific cultural barriers need to be undertaken at a village or sector level to promote institutional deliveries.
- **Education from the start/young age**: This is a key factor to a woman’s and her family’s awareness about the benefits of delivering at an institution. Additionally with awareness about services families also make the effort to bring the woman in private vehicles as soon as possible. Most people who come understand mother and child will be safe.

F. High Risk Pregnancies

- **High Risk Cases ‘Not present in my area’**: Many of the interviewees reported that they do not have high risk pregnancies as such in their areas. This is possibly linked to insufficient identification and tracking of high risk cases, although their knowledge about HRP factors was good. They only described high risk cases when they had been presented to them with complications during delivery. Then the high risk cases would be taken to higher facility levels after referral from lower level facility instead of being directly referred from home in the beginning.

- **Anemia most commonly observed as causes of complication related to HRP**: Most women have hemoglobin level of 10gm/dl or less, was a major risk assessed during
pregnancy and delivery. Multiparty further contributes to risk. The most common complication talked about was hemorrhage.

- **Transportation Delay ‘Increases Risk’**: Either a late alert from family or difficult to reach areas increases the risk of delivery complications.
  - Similarly if transport is not available from referral facilities to first functional FRU it results in further delay.

  **Interviewee** - “In one case, 108 dropped off the woman in the night when staff had not reached the facility. After the staff arrived and assessed the fully dilated woman it was diagnosed that it was a breech pregnancy and the case had to be referred. The 108 would take 30 minutes to arrive and a private vehicle had to be arranged single handedly by me. Additionally I had to look after the nervous family. These barriers make referral of high risk pregnancies difficult.”

- **Failed attempts at saving HRPs**: If family members are convinced by ANM and ASHA to properly manage high risk cases and they still die in the process, people loose trust in the system.

  **Interviewee** - “Dhais’ daughter was delivering and was severely anemic. She was in need of blood. I convinced them to go to for blood transfusion. They went to RK, referred to Udaipur and from there private. She still had post-partum hemorrhage. Now nobody from the village comes. Trust is a major factor. So People will come for immunization, but deliveries they now prefer to get done at home.”

- **Reasons for poor ANC coverage** also make it difficult to also track high risk pregnancies

**Suggestions given by Interviewees:**

- Primarily the referral systems and FRU facilities need strengthening to manage HRP cases. There are no blood storage unit’s available in both blocks. The delay along the referral line is potentially a major cause of maternal deaths.
- The problem of diet will resolve many issues. There is no concept of nutrition; people don’t give extra care to pregnant women.
- Concentration on line list preparation, and providing the list to 104 drivers.
- The MCHN day quality needs to be strengthened- that is the main scope for positive development.
G. Anemia- Challenges

- **Poor Identification and Tracking:** ANMs need to be trained perfectly to identify and track cases and referral systems need to improve.

- **Low and irregular IFA consumption:** Although in many areas the uptake of IFA is increasing many women do not consume IFA due to the nausea it triggers. Due to fear from higher authority, ANMs and ASHAs report that women are regularly taking it. In rare cases religious leaders like Bhopas or elderly community members dissuade pregnant women from taking IFA if it does not suit them. IFA should be gauged through utilization, and not distribution, and correlating with better hemoglobin levels. The barriers to this are incorrect reporting by pregnant women and inability of field staff to measure Hb properly. To further complicate this when women are detected with anemia, they don’t follow up with the full treatment.

- **Subtraction of healthy protein food from general diet during pregnancy:** Superstitions which exist culturally such as avoiding milk, buttermilk, curd, ghee, groundnuts, affects the woman’s diet. The popular belief is that this will accumulate as the sticky substance over the child’s head causing problems in delivery. This thought is passed down to each generation, cutting down even the bare minimum healthy food a pregnant woman can consume. Health workers have tried to orient the women and her mother-in-law about the difference between stomach and uterus without success.

  *Interviewee*- “If we tell them to eat good nutritious food, and have milk products, they say okay then do you take the responsibility to deliver safely.”

- **Low perception about the importance of diet:** Many can’t afford milk and other nutritious as part of daily diet. To top this they cut out protein rich food during pregnancy and do not consume IFA regularly. This triple effect is not conducive for health of a pregnant woman, and her child. ANMs advice mother-in-laws to look after their daughter-in-laws diet.

  *Interviewee*- “We tell them that they should be looking after their daughter in laws just like their daughter.”

- **Belief that there is no anemia prevalent in the region:** Some interviewees felt that there weren’t too that too many anemic women in their catchment areas. This could be either due to acceptance that generally woman has Hb at 10gm/dl, or that they are not being measured properly.
● **Multiple children**: Women who have been pregnant multiple times have poor health. This in turn affects health of child. The vicious circle of having multiple children, nutrition, poor education, higher chances of abortion deteriorates health of a woman.

**Suggestions given by Interviewees:**

- ANMs need to be trained perfectly to identify and track anemia and referral systems need to improve.
- **WIFS needs to be given importance** as nutrition must start from school when a girl is in her adolescence. Poor hemoglobin at young age continues into motherhood.

**Interviewee**—“*Education is the key for norms to change but that also takes time. For immediate results we the ground workers need to be in the forefront. How can one educate mothers at this stage? But let’s start with the child.***

- A **community based nutrition program** needs to be implemented efficiently as poor nutrition is difficult to resolve on an individual basis. Good nutrition has to become a community norm.
- Special campaigns for hill tribes where the community is adamant and not following diet as prescribed.

**H. Public Grievances**

Usually people are not active and upfront about reporting public grievances as per the opinion of the personnel. However they described the grievances faced by the users of the health system.

● **Transportation and Payment**: 108 not providing services in hard to reach areas with kaccha roads and private vehicles not always assisting in such situations. Many times private transport services want direct cash from the beneficiaries. For certain facilities especially for referral at the District level these private vehicles land up spending more in going to collect a cheque and coming back. So the driver lands up charging more to the family over and above the JSY money. Instead money should be directly given to the mother/family making it easier to avail transportation services in remote areas.

**Interviewee**—“*The patient would have spent less on her own, rather than availing the JSY services.***”
➤ **Bank account opening not flexible:** Due to ID requirements that women are not able to fulfil as per bank rules, it is not easy for them to open an accounts and avail JSY benefits. Different names on ID and documentation makes it difficult for payment to process - father/husband called differently, registered differently, names on documentation different. Additionally some girls are married before legal age, making it difficult to produce and submit documentation.

*Interviewee*—“*In one area the district issued a letter to the gram panchayat in a village facing this problem, which in turn issued a letter to the bank to resolve the issue. However no change was noted. As many girls marry young, sometimes under the legal age for marriage, they have not followed up with bank account requirements.*”

➤ **Location certain of facilities impedes access and optimal utilization:** Some of the PHC and CHCs are not located at convenient places. In few cases they are located away from the actual village on a main highway with no hotels or food stalls close by. This makes it difficult for people to access facilities. If a facility is located in a forest without 24 hour staffing, patients feel unsafe in these situations. In these cases even though the facilities are well equipped and have good infrastructure their usage is not maximized.

➤ **Accessing Private institutions for Sonography:** It is quite common for women who are pregnant for the first time, younger girls and known high risk pregnancy to have a sonography. But sonography services are not easily available at public institutions. If they do visit bigger district hospitals they have to spend for transportations and take multiple trips since caseloads are high. Also doctors cannot keep the sonography services on for the full day and have to cap it at some point. Therefore it is becoming popular to access private institutions for this service, as in the end it turns out to be comparatively cheaper.

➤ **Lack of Skilled Manpower at all facilities and Specialized Manpower at FRUs** (described in previous sections)

1. **Quality of Maternal care services in Private Institutions**
   ➤ **Availability of Staff and Specialized Manpower:** 24X7 staff and specialized professionals like gynecologists and women doctors motivate people to deliver at private institutions.

   ➤ **Demand for personalized attention and required equipment:** Quality care is important to people and having personal attention is preferable to intermittent care at public facilities provided by staff that has to multitask. They also have sonography machines
available which people find easier to access than going to public facility multiple times. Public institutions are not always clean.

*Interviewee*“People are not simply motivated through monetary incentives today. Rs. 1400 is barely anything in today’s world. - You get proper rest and safe delivery at private a facility, which is why people who can afford go.”

*Interviewee* -“We can’t be clinicians and managers. How can we concentrate on both.”

- **Quicker Delivery and Shorter stay:** Private institutions might not have the same protocols in relation to oxytocin. Its administration makes delivery quicker and people believe that their staff is more skilled. They do not understand the risks associated with oxytocin use. People do not like the concept and do not understand the importance of 48 hour stay and private institutions sometimes give them leave in a couple of hours.

- **Salary and Benefits:** There are no additional benefits for working as a 24x7 doctor in a public facility. A private doctor gets higher compensation for fewer hours of service. This is very demotivating for government personnel and affects their retention at public institutions.

**J. Maternal Deaths**

- **No specific pattern of deaths observed:** According to personnel maternal deaths are not a commonly occurring incidence. As numbers are not huge in quantity, especially at a block or village level they haven’t observed any patterns specifically. Most cases they have come across have been related anemia and bleeding. Additionally they are well aware that the deaths that most of them have heard about have all been cases of institutional deliveries. If deaths had not occurred in their area, they were not well versed with the reasons.

- **Poor PNC and HBNC:** ASHAs and ANMs have to make more quality based home visits. Some women don’t understand the importance of hygiene and don't bath for 4-5 days after delivery. Infections, especially related to stitches, leads to complications.

- **Discussing maternal Deaths with the community:** They interviewees suggest that open discussions on maternal death events are important for the community to become aware about causes and how they can engage in preventing them (social review).
Suggestions given by Interviewees:

- Better phone networks, transport systems for referrals and staffing are key components in addressing maternal deaths. Currently there are no quality services for HRP cases.
- (Researchers observation) People can't explain the cause of death, especially systems related cause, but just symptoms associated with death. They need to be better trained to determine this.
- Understanding what happens in other areas will also help improve mechanisms.
- Importance needs to be given to PNC and HBNC care which is weak and not practiced in some areas. ASHAs and ANMs have to make more quality based home visits.

Conclusions
The above discussion of findings from the key informant interviews draw out the barriers and challenges to implementation of ANC services to enable informed decision making on how to address these issues collaboratively.

This document has been prepared to best describe the opinions of the service providers on ANC services including home and institutional delivery. Researcher’s deductions or observations where included, have been specified.