

Understanding Barriers to Antenatal Care and Institutional Delivery-Focus Groups

Part III- Community Perspective

Rajsamand, Rajasthan

July 2015

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Working paper Series

Model Districts Health Project

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Understanding Barriers to Antenatal Care and Institutional Delivery in Rajsamand, Rajasthan

Focus Group Discussion

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List of Acronyms

AHS	Annual Health Survey
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Aganwadi Center
CES	Coverage Evaluation Survey
CHC	Community Health Center
EI	Earth Institute
FRU	First Referral Unit
FGD	Focus Group Discussion
Hb	Haemoglobin
HBNC	Home Based Neonatal Care
HPD	High Priority District
HD	Home Delivery
HRP	High Risk Pregnancy
IFA	Iron Folic Acid
IMR	Infant Mortality Rate
JSSK	Janani Sishu Suraksha Yojna
JSY	Janani Suraksha Yojana
LHV	Lady Health Visitor
MCHN	Maternal and Child Health and Nutrition Day
MDG	Millennium Development Goals
MDHP	Model Districts Health Project
MMR	Maternal Mortality Ratio
MNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MoIC	Medical Officer In- Charge
NFHS	National Family Health Survey
NRHM	National Rural Health Mission
OBC	Other Backward Class
PCTS	Pregnancy Child Tracking Health Services and Management System

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PHC	Primary Health Center
PNC	Post Natal Care
RMNCH+A	Reproductive Maternal Neonatal Child and Adolescent Health
SBA	Skilled Birth Attendance
SC	Subcenter
TBA	Traditional Birth Attendant
WHO	World Health Organization

Acknowledgments

This research paper would not have been possible without the support of many people. The MDHP team wishes to express their gratitude to Dr. Pritam B. Yashwant, IAS, former District Collector and Dr. Tarun Chaudhary former Chief Medical Health Officer (now Project Director, Maternal Health) of Rajsamand, Rajasthan for their invaluable assistance and support during the conceptualization of the study. We would like to thank the District Program Manager Mr. Vinit Dave, for his assistance and inputs during the implementation of this research. We express our sincere appreciation to the team members of Prayas, Chittorgarh who have supported the implementation of the study. Special thanks to Mission Director, National Health Mission Rajasthan Mr. Naveen Jain, IAS, Dr. Anuradha Oswal, State Program Manager and Dr. Tarun Chaudhary for their time, consideration and inputs during discussion of the study results. Deepest gratitude is also due to the researchers Gargi Wable and Andrew Thorne-Lyman for the preparation of the initial needs assessment, study and instrument design. We express our appreciation to all the health personnel and study participants, who have given us insightful perspectives on the situation and barriers to antenatal care and institutional delivery in Rajsamand District. Finally, the team expresses immense appreciation to their donor – IKEA Foundation for their continuous support.

Executive Summary

The National Rural Health Mission focuses on extensive antenatal care and institutional delivery services for pregnant women and their children in order to achieve Millennium Development Goals 1, 4 and 5 related to nutrition, child and mortality. The network of ANMs, ASHAs and Medical officers are crucial to provide the benefits of the established public health system. However, implementation challenges prevent people from accessing these services and health personnel from providing them.

Rajsamand is one such district of Rajasthan in India where poor ANC indicators and stagnation of institutional delivery rates, especially in tribal zones was observed. At the request of the (then) leadership in the district, Earth institute at Columbia University conducted a study to assess the barriers experienced in antenatal care, nutrition, and institutional delivery in two blocks, Bhim and Kumbhalgarh. However the results and observations of this study hold true to many areas across different regions of Rajasthan, based on the discussion with the State Health leadership.

The study used a mixed methods approach with a quantitative and qualitative component. The survey with women who had delivered recently at home or an institution, gauged the situation of ANC and delivery services. Late registrations and quality of care were the primary concern highlighted in the data. The reasons varied from structural barriers like distance and time to consumer related barriers such as superstition and low importance perceived of benefits. Reasons for home delivery were related to delay in decision making coupled with 'convenience' factor of home. Key informant interviews with health personnel highlighted the system and beneficiary barriers which make it tough for them to perform their duties. Focus group observations with community members (ASHAs, mother in-laws, religious leaders and Dais) showed that Dais are still trusted members in many communities that depend on their experience and skill for conducting deliveries. Therefore communities do not always see the advantages of delivering at an institution. Misconceptions about nutrition prevent them from continuing with their normal diet which includes buttermilk and ghee. One of the reasons for delivering at home was also people not willing to stay for 48 hours at an institution. Migration in these areas makes it difficult to track a pregnant woman from pregnancy to delivery and providing her the full coverage of services.

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Based on the triangulation of information from the survey, key Informant Interviews and focus group discussions, the following recommendations need consideration and prioritization:

1. Improve the perception of importance of ANC and Institutional delivery

Late ANC registration reduces the number of check-ups and contact with ANM for health related information. Barriers related to attending MCHN day impedes full coverage. Therefore efforts need to be focused on improving the awareness of benefits of ANC and institutional delivery through more rigorous IEC. Only when the perception improves will there be a more permanent change in demand.

2. Providing quality services to generate demand

The want for quality services play a role in where the woman and her family choose to deliver. This is apparent through the benefits they perceive at a private institution-manpower, attentive care, faster delivery and fewer days of stay. Trust in Dais or experienced health personnel's skills also influence their decision making.

3. Improving MCHN Day Standards and Supervision

Having skilled ANMs is crucial to motivate the women to attend ANCs and help her understand the benefits. The basic tests are not being conducted rigorously. Quality supervision is required not only to monitor the quality of ANMs work, but also to draw out the implementation challenges to resolve bottlenecks.

4. Diverting Home Deliveries to Institutions – Addressing the Barriers

Analysis of barriers related to access institutions for delivery highlighted that although most villages are located within an hour of reach, difficult terrains, cell phone access barrier, higher use of private vehicles leading to out of pocket expenditure, might influence families to choose the more 'convenient' option of home delivery.

- Strengthening Subcenters as delivery points to address access and delayed decision making

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- A plan for better use and monitoring of government sanctioned vehicles
- A systematic transport and referral plan for sectors with high home deliveries
- IEC that uses risk messages with positive framing should be applied. Involving the Panchayat to bring awareness in the community regarding timely access for pregnant women and the child is crucial.

5. Family Planning

Efforts to delay first pregnancy needs further stress. IEC strategy with innovative ways of reach and communicate must be adopted. Counsel cannot be simply given to women, but to men and their community as well. Indirect effects and benefits of delaying early pregnancies, including health benefits for the child and economic benefits for the family must be emphasized.

6. Nutrition – Community Based Prevention

Based on the study results, focus on community based prevention of malnutrition is crucial.

- If woman were to more clearly understand the benefits of IFA not only for themselves, but their child, may be uptake would be better. Adolescent girls who already have poor nutrition get married and pregnant early. If community members instead of just the ASHA and ANM counsel pregnant and lactating women, the acceptance will be better.
- Dietary misconceptions regarding 'ghee and buttermilk' intake during pregnancies should be cleared
- Good nutrition should be discussed as a community norm. Women might not perceive its importance as they don't understand the developmental and cognitive effects it has on the child.

7. Community Involvement- Do not depend on ASHA s alone

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Results show that there is no one key person who influences decision making of the woman regarding her pregnancy care and delivery. But the community norms as a whole do. Involvement of more peer women, committees or groups and the Panchayat would help the ASHA and ANM in their work.

Only when practices about good nutrition, ANC and institutional delivery become a norm in the community is acceptance better and it creates a demand from the consumer side to access the benefits of a public health system.

This Working Paper is a three part Series where the results of each of the 3 study components- Survey, Key Informant Interviews and Focus Group, has been separately presented. However the key recommendations provided are a triangulation of the data and findings from all 3 components of this mixed methods study. This is Part III of the Series- Focus Groups.

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The Columbia Global Centers | South Asia is part of a network of Columbia Global Centers that the University has launched around the world. The Center seeks to engage in activities and research linked to business, health, environment, education, urban planning, infrastructure, economic development, arts and culture, by providing a base throughout South Asia. It is a platform for academic partnerships, schools and programs at the University and locally in this region to collaboratively examine discuss and find solutions to complex issues in the various disciplines. Through leveraging its world-class thought leaders, sharing resources, and conducting innovative projects using a multidisciplinary approach, Columbia Global Centers | South Asia aims to engage students, faculty and stakeholders in a truly global conversation.

Model Districts Health Project

The Model Districts Health Project was launched in 2010 as a joint initiative between the Earth Institute and Ministry of Health and Family Welfare, Government of India. Its aim was to demonstrate and support health and nutrition based interventions and activities to address the policy–practice gaps that were highlighted in the mid –term evaluation of NRHM by Earth Institute (Bajpai et al, 2011). More specifically the focus is on the Millennium Development Goals 1, 4 and 5. Currently the project is under the Center for Sustainable Development at Earth Institute and is working in three states- Rajasthan, Telangana and Jharkhand. Within these states EI works in two districts, one which was selected for the Model Districts Project and one High Priority District where EI is the lead development partner for RMNCH+A. In Rajasthan, Dausa and Rajsamand (HPD), in Telangana, Medak and Mahbubnagar (HPD) and in Jharkhand, Khunti and Simdega (HPD) were selected for implementation of the Models District concept.

The Model Districts Project focuses on health systems strengthening through implementation research, strategic technical advice, monitoring and evaluation, and policy advocacy to help ensure the successful scaling up of services. It is ultimately the district governments and district health units that are responsible for implementing the quality improvements, best practices, and innovations based on the situational analysis. State

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governments and NRHM offices have a key role to play in driving innovations at a district level, and providing additional funding on evidence based need.

Introduction - Study

NRHM provides an extensive array of maternal health services to improve the health outcomes for women and children to achieve Millennium Development Goals 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. Monetary incentives for the mothers to render these services and for health cadre to provide them efficiently are given to optimize usage and motivate them to engage with the health system. Providing services which are accessible and affordable play a crucial role in improving health indicators.

Under the Reproductive, Maternal, Neonatal Child and Adolescent Health (RMNCH+A) 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.

Earth institute at Columbia University is the lead development partner for RMNCH+A activities in Rajsamand and works closely with the District Health Team providing technical support and conducting regular gap assessments. Some of the tribal regions in the district had poor indicators for antenatal care, anaemia and pockets of high home delivery load. This study was undertaken at the request of the then District Collector and in consultation with the Chief Medical Health Officer to assess the situation and specifically focus on the barriers faced in Rajsamand.

Background

Antenatal Care

NRHM offers ANC which includes at least 4 ANCs check-ups, early registration within first trimester along with physical and abdominal examinations, Hb estimation and urine

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investigation, two doses of Tetanus Immunization and consumption of IFA tablets¹. However there are barriers related to structure, norms, capacity and monitoring that impede efficient and effective ANC care. A community based study carried out in a tribal district of India highlighted that although a significantly high percentage of women were receiving ANC care at least 3 or more times, early registration rates were still poor as women were not motivated to come on their own accord for check-ups. Additionally the quality of ANC was poor (Bhaisare, Rao, & Khakase, 2015). In the rural north region of India, it was evaluated that although pregnant women had good knowledge on ANC, age and literacy had a significant association with utilization rates. 80% of women were delivering at institutions but registration within first trimester was still very low (Gupta et al., 2015). Another study assessed the coverage of ANC services at subcenters. Although 70% of women registered for ANCs, only 50% registered in the first trimester and only 29% had at least 3 visits. Additionally the women who had IFA for 100 days or more, was negligible (Singh et al., 2015). Although Maternal Mortality rates have decreased from 212 in 2007 to 167 in 2013, the progress has been slow (MMR Bulletin). ASHAs role in informing about ANC services and ANM providing them is crucial to the success of timely and key ANC services. Although NRHM has been able to set up services in most remote regions quality and coverage are crucial at this stage.

Anaemia and Nutrition

Anaemia during pregnancy has important consequences for both a mother and her child. It is responsible for 120,000 maternal deaths each year globally, and 18% of maternal mortality in low and middle income countries (WHO 2009). According to the World Health Organization, anaemia affects half a billion women of reproductive age worldwide. In 2011, 29 % (496 million) of non-pregnant and 38% (32 million) of pregnant women aged 15-49 years were anaemic (WHO 2011). South Asia and Central and West Africa bear most of the burden of anaemia cases (WHO Anaemia Policy Brief). The prevalence of anaemia in pregnant women in India is 58% and accounts for 20% maternal deaths (National Iron Plus Initiative). Therefore the National Iron Plus Initiative has recommended, Iron Folic Acid Supplementation for 100 days during pregnancy and post-partum. However distribution and compliance for IFA consumption has been an issue. A study in southern India found that the

¹ National Rural Health Mission

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compliance of IFA was moderate; with the main reasons for noncompliance being forgetfulness, travel, constipation and vomiting. The side effects noted were vomiting and gastritis (Mithra et al., 2013). A study in Bihar found that women were more likely to receive IFA if they had higher number of counselling and ANC services, and IFA consumption would be optimum if she has at least 4 ANC visits or more (Wendt et al., 2015). The prevalence of anaemia among women in Rajasthan increased from 1998 to 2005, from 48.0% to 53.7% (Balarajan et al., 2013). As per NFHS 3 prevalence of anaemia among pregnant women (15-49) in Rajasthan was 61.7%. These figures highlight the importance of reducing anaemia in pregnancy for a substantial impact on maternal and child health indicators.

Institutional and Home Delivery

Skilled birth attendance is a key factor in determining maternal and child outcomes along the continuum of care. These health professionals are expected to manage normal pregnancies, deliveries, and postnatal care, and identify, manage, or refer complications for women who are delivering and infants (WHO 2005). It has been estimated that almost 40% of pregnancies could require specialized services, and about 15% of all pregnant women develop complications during the intra-partum and immediate post-partum period needing access to emergency obstetric care (Fauveau 2004). A review on Global causes of maternal deaths from 2003-2009 showed that 73% of all deaths from the sample were due to obstetric causes (Sal et al.). Delivery at an institution provides not only skilled birth attendance but also equipment and referral mechanisms to handle basic and emergency obstetric complications. As per CES 2009, institutional delivery rate was 68% in rural India. Improvement of institutional delivery rates, improves the coverage of skilled birth attendance with the advantages of having it at a facility. A study examined trends from two nationally representative survey sample determined that economic status is a more important determinant of institutional birth rather than access and distance. The importance of focusing on generating demand from users was highlighted. The influence of family member's role in decision making has not always been consistent and holds differing level of importance. Therefore although this should be considered within the framework for planning improvement in institutional delivery, other factors influencing women should be explored (Bruce et al., 2015).

Situation-Rajsamand:

Rajsamand is a small, hilly district in Rajasthan with an area of 4500 square kilometers. It has a population of 1.2 million, 84% of which live in rural areas. Female literacy remains low at 48%².

Maternal Mortality: While MMR in Rajsamand has apparently declined from 364 in 2010-11 to 265 in 2012-2013 as per AHS it remains far behind the state's MDG target of 248 maternal deaths per 1,00,000 live births by 2012-13³.

Anaemia: In 2012-2013 the number of women who had haemoglobin below 11 gm/dl was 20735 against 36588 registered for ANC (57%)⁴. In 2013-2014 the number of women who had haemoglobin below 11gm/dl was 26931 against 32932 registered for ANC (82%)⁵.

ANC Registration: In 2012-2013 18701 women registered in first trimester against 36588 ANC (51%)⁴. In 2013-2014 19550 women registered in first trimester against 32932 ANCs registered (59%)⁵. Although it is improving, it is low and requires special focus.

Percentage of Institutional Delivery: Institutional deliveries amongst the total deliveries reported for the district was 89.06% in 2013-2014⁴ vs 89% in 2012-2013⁵. This underscored stagnation in the rate of institutional deliveries in Rajsamand. Additionally the number unreported home delivery is a concern.

Purpose of Study

Based on the national, state and district scenario, a joint decision between Earth Institute and the District Unit was undertaken for EI to conduct a study to understand the status of antenatal care services and the reasons for home deliveries in Rajsamand, focusing on barriers. Findings of the study would enable data driven informed decision making at all levels of the health system by the State, District and development partners to collaboratively address the gaps and re-think strategy where applicable. As most issues cut across all districts in Rajasthan, many of the findings would be relevant to other parts of the state as well.

² Census 2011

³ Annual Health Survey 2012-2013

⁴ Pregnancy Child Tracking Health Services Management System 2012-2013

⁵ Pregnancy Child Tracking Health Services Management System 2013-2014

Study Objectives

1. Explain barriers and facilitators of antenatal care
2. Explain reasons for home delivery to make evidence based- recommendations
 - a. Assess the factors influencing delivery outside of institutions/home deliveries and perceptions about how those factors could be addressed among community members and healthcare providers
3. Explain the barriers and facilitators to prevention and treatment of anaemia during pregnancy
 - a. Assess coverage of preventive iron-folic acid - distribution and compliance among pregnant women

Materials and Methods

Sampling Frame

Kumbhalgarh and Bhim blocks were selected for the sampling frame as they have a high proportion of tribal population and highest number of reported home deliveries compared to other blocks (834 in Kumbhalgarh and 713 in Bhim, the total for Rajsamand being 3379⁵). They contribute to almost 50% of home deliveries for the whole block. Over 50% of public health facilities are understaffed. Access to health facilities in these blocks is also difficult and not easy for all users of the health system, given the hilly terrain and hard-to-reach areas.

Mixed Methods Study

This study consisted of 3 components to understand the study objectives:

1. A quantitative survey which included women who had delivered a child in the last 1 year (age group 18-45 years)
2. Focus Groups with ASHAs, traditional birth attendants (dais), religious leaders and mother-in-laws
3. Key Informant Interviews with health service providers –ANMs, LHVs, Medical Officers, ASHA facilitators

Part III- Qualitative Component- Focus Groups

Community Perspective – Rationale

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

- Role and involvement
- Perception and practices
- 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

Study Design and Procedures

Sample

A total of 62 community members from Bhim and Kumbhalgarh participated in the FGDs. Nine 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.

Discussion Guide and Data Collection

The study was approved by the Columbia University Institutional Review Board and Prayas Chittorgarh, Ethical Committee provided the in country approval. The focus group discussions were recorded after informed consent was obtained. Discussions were conducted by a facilitator from Prayas Chittorgarh and Earth Institute team using a tailored discussion guide based on the broader study objectives.

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Transcription and translation

The discussions were transcribed using the recordings and translated from Hindi/Marwari to English by Prayas Chittorgarh, as per guidelines provided by the Earth Institute team.

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 identification 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.

Results- Themes

- A. Becoming a Dai
- B. Role of Dai
 - a. Pregnancy Care
 - b. Treatment a Dai Provides during Pregnancy
 - c. Dai Conducting Deliveries
 - d. Delivery Experience and Trust
- C. Pregnancy Identification and Disclosure
- D. Immunization Barriers
- E. ASHAs Role and Responsibilities in ANC and PNC care
- F. Barriers faced in ANC and PNC care
 - a. ANC Systems and Infrastructure Barriers
 - b. ANC Beneficiary Barriers
- G. Nutrition
 - a. IFA
 - b. Supplementary Nutrition
 - c. Other Diet
- H. Role of Mother-in-Laws

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- a. Instances taken to the Doctor/Health Institution
- I. Role of Religious leaders 'Bhopas'
- J. Home Delivery (Institutional Delivery Barriers)
 - a. Barriers in the health system and infrastructure
 - b. Other reasons for home delivery
- K. Specific Population
- L. Private Institutions and Quality Care
- M. Belief and Practices post delivery
- N. Maternal Deaths
- O. Incentives and Gratitude and Benefits

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.

Participants

🚩 **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 foetus” or “foetus moving down”. They also might consult her if the labour pains are indicative for going to the hospital and might request her to accompany them.

Participants

👤 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 foetus if it has shifted, or recommend the pregnant women the dos and don'ts. 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.

Participants

👤 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 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

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there is a delay, or emergency where a woman cannot reach the institution the Dai will support the woman and conduct the delivery.

Participants

✚ 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 do ask families where and whom would they would prefer the delivery conducted is 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:

Participants

✚ 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.”

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- ✚ 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 black 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 loose clothes.”
- Some Dais also discussed emergency situations where hygiene and infection control conditions were greatly compromised.

Participants

- ✚ 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, 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 in 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 is available and it becomes easily accessible to people living in difficult to navigate terrain.

Participants

- ✚ 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.

Participants

- ✚ 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 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.

Participant

- ✚ 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

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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.

Participants

- 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.

Participants

- 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.”

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- ✚ 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.

Participants

- ✚ ASHAs: They don’t give the drops; they come to make the card when baby is the stomach. 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

Participants

- 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. We also give them our number as well so that they can call us and inform us and 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

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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.

Participants

- ✚ 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 kilometers 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 compounder 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 checkup. Now 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

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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.

Participants

- ✚ 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, and 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: “All the tests are not possible for the women who are registered late, in case of others all the tests 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 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 is 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.

Participants

- ✚ 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 taking 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.

Participants

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- ✚ 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 , they don't listen"
- ✚ Facilitator: "So do woman bring these packets." Mother-in-Law: "Yes"
Facilitator: "Does your daughter-in-law eat it?" Mother-in-Law: "No my daughter-in-law does not eat it" Facilitator: "Why doesn't she eat 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.

Participant

- ✚ 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.

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They do support her during delivery by keeping relevant numbers handy and accompanying them to the hospital.

Participants

- ✚ 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 thereNo; 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.

Participants

- ✚ 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

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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.

Participants

- ✚ 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 etcHe also asks them to visit the hospitals. Everybody starts to laugh ASHAs: “Bhopa says: Do continue the treatment ...I am 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.”

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- 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 and poor cellphone networks which cause a delay in reaching the ASHA or vehicle were some of the key reasons leading to home delivery or preference to call Dais.

Participants

- 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: “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.

Participants

- ✚ 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

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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 them 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.

Participants

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- ✚ 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.

Participants

- ✚ 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 and 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 doctors, 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.

Participants

- ✚ 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

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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 and trained in assessing a maternal death to identify health system gaps.

Participants

- ✚ 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” 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.


Participant

- ✚ 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.....

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- 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.

Participants

-  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

Participants

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

Discussion and Recommendations Based on Triangulation of Data

(Survey, Key Informant Interviews and Focus Groups)

Based on the triangulation of information from the survey, key Informant Interviews and focus group discussions, the following facts need consideration and prioritization.

1. Improve the perception of importance of ANC and Institutional delivery

- Within the sample 45% of the women who delivered at home and 60% of the women who delivered at an institution had registered in the first trimester. The reasons quoted for late registration within the survey point out that they were not aware, were not informed to register early or had no apparent health problem.

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- a. Although the ASHA is making efforts to inform women, they face the obvious challenge of pregnancy identification. The reasons are varied from women not informing them due to fear of bad omen, being shy to reveal pregnancy and fear of abortion risks. This in turn ties into the perception of 'importance' as many believe no ANC check-up is required as such unless they face a problem.
- b. 47% of the sample belonged to nuclear families. There was not much difference between these in the group that delivered at home verses an institution. However the service providers do feel that this issue to some extent influences the support the women has to access health facilities. She is not able to leave her other children at home if there is no one to look after them. Even if she does deliver at an institution, she is sometimes unable to visit the once a month MCHN day due to the same reason, as it does take up a significant proportion of her day. This in turn affects the number of ANC check-ups.

Efforts need to be focused on improving the awareness of benefits of ANC so that women and community members perceive early registration and ANC follow up as very important. Only when the perception improves will there be a change in demand from the community for these services.

2. Providing quality services to generate demand

- Education is crucial to understanding the counsel of ANCs, benefits of delivering at institution and importance of nutrition during the life cycle of an individual. More than half the sample (56%) did not have any schooling. There was not much difference in proportion of women who delivered at home and at an institution in schooling years. It is clear via the data in this study that apart from education, there are other important factors that play a role in the outcome of place of delivery. For example:
 - a. The women and the community's perception of the importance and benefits of ANC and delivery at an institution and the 48 hour stay are poor.
 - b. Even if they understand the benefits of delivering at an institution, there is a want for quality services. This is apparent through the benefits they perceive

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at a private institution-manpower, attentive care, faster delivery and fewer days of stay. Trust in Dais, who they also perceived as more skilled to conduct deliveries rather than being referred from facilities even for simple deliveries, leads to the high numbers of reported and unreported home deliveries.

- c. Manpower also determines the quality of services that the system can provide. Specialized personnel, lady gynaecologists and availability of 24x7 doctors generate better demand from people.

Changing the perception is not enough. This has to be followed by provision of quality to maintain the continuum of increased service delivery efforts.

3. Improving MCHN Day Standards

- Over 80% of the women had their first ANC check-ups at MCHN days by the ANM. Therefore the ANM is crucial to motivate the women to attend ANCs and help her understand the benefits.
 - a. Assessment by SIFHW has already pointed out that the basic skills of ANMs need strengthening through quality based trainings. However to improve the quality, better supervision is necessary.
 - b. The data in this survey highlighted that, 50%-80% women who had undergone 3 ANCs, had not undergone the relevant basic tests even 3 times. 47% women reported that they were not explained why the different check-ups during ANCs had been done.

Quality Supervision: Supervision is required not only to monitor the quality of ANMs work, but also to draw out the implementation challenges so that the block and district officials can actively discuss how to resolve bottlenecks in a participatory way. This will also be motivate well performing ANMs and ASHAs and identify personnel that are not carrying out their duties. Currently our interaction has revealed that supervisors sometimes only come to drop off the vaccines.

4. Diverting Home Deliveries to Institutions – Addressing the Barriers

- a. **Distance and Time:** Although data revealed that 90% of women were reaching facilities within 60 minutes and they were placed within 60km,

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many deliveries are still occurring at home. This is because it does not take into consideration the time it takes for transport to be contacted and reach the woman's home.

- b. **Terrain:** Difficult terrain makes it tough for woman to reach the road where the vehicle is waiting. 55% of the women hired private vehicles which points to less use of the government sanctioned vehicle. The response of vehicles, especially at night and when they have to navigate difficult terrain is poor.
- c. **Cost:** Almost half the women had to pay more than Rs.250 for transportation cost. In fact proportion of women paying additional costs at public institutions is close to that of women delivering at home and incurring additional costs.
- d. **Case Load:** Most of the case load is going to PHCs and CHCs as per the data. The subcenters are underutilized for deliveries.
- e. **Cell Phone Barrier:** Within the sample 53% women were found to have no cell phones of their own. 41% of women had no cell phone access (did not own a cell phone, neither did husband or close by living family/friends). This highlights the fact that although ASHAs and ANMs may provide them with their own numbers, with relevant numbers for referral and transport services, but people might not be able to make the prompt contact as required. This might also lead to delay while reaching an institution. Many of these areas have poor cell phone network making it difficult even for the ASHA to contact ambulances and private vehicles.

Strengthening Subcenters as delivery points to address some of the above barriers related to access and delayed decision making will be crucial to better uptake of services.

Monitoring of government sanctioned vehicles must be heightened as women and their families are spending even above Rs.1000 to reach the delivery facility, out of pocket.

A Systematic transport and referral plan needs to be in place for each village based on the access (road and cell phone network) and needs to contact and reach facilities, (based on broader guidelines provided). A similar plan to reach functional First Referral Units also needs to be in place to avoid delay of high risk cases reaching these facilities. Additionally a systematic and simple plan also motivates people to use facilities. Private vehicles might be

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more convenient for people and also within closer reach. The challenges faced to access them should be addressed.

IEC and involving the Panchayat and prominent community members to bring more awareness in the community regarding timely access for pregnant women and the child is crucial in improving the perception of the community to deliver at institutions. IEC that uses risk messages with positive framing should be applied.

5. Family Planning

- 53% of the sample had married before the legal age. 74% of these women had their first pregnancy between the age of 16-20 years.
 - a. An effort to delay first pregnancy via family planning education for this vulnerable age group is crucial to bring change, even though it is a sensitive topic to address in communities.
 - b. Women who do get pregnant early on are more shy to come forward for ANC and sometimes do not realize they are pregnant within the first trimester. Their young age already puts them at high risk.

IEC Strategy for family planning and spacing needs to be given more focus and innovative ways of reach and communication must be adopted. Family Planning advice and counsel cannot be simply given to women, but to men and their community. For example may be the focus should be on indirect effects and benefits of late marriage and delaying early pregnancies. This includes health benefits for the child and economic benefits for the family.

6. Nutrition – Community Based Prevention

- There is already an initiative towards community based management of malnutrition. However based on the data this program also needs to include focus on community based prevention of malnutrition.
 - a. IFA consumption is low and irregular mainly because women feel nauseous and sick. However if they were to more clearly understand the benefits that their health has on the developing foetus, rather than just understanding how IFA benefits the “blood and delivery process” may be they would make a better effort for uptake.

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- b. Adolescent girls who marry young, and have poor nutrition are further at risk if they become pregnant early on.
- c. From the interviews it was apparent that ASHAs and other personnel within the health system do not give the required focus and face challenges related to beliefs and family's access to a diversified diet.
- d. If community members instead of just the ASHA and ANM convince adolescent, pregnant and lactating women to take iron supplementation and complement it with a balanced nutrition, the acceptance will be better.
- e. Based on the focus groups and interviews women stop taking buttermilk and ghee based products during pregnancy as the community believes it will accumulate on the head of the child make delivery difficult. These misconceptions prevent them from even consuming their normal diet let alone adopting a healthy diet.
- f. Good nutrition is not a community norm and women do not understand the reason for increased requirements during pregnancy and lactation. They might not perceive this as important as they don't understand the developmental and cognitive effects it has on the child. Anaemic women are at higher risk of giving birth to low birth weight babies. Poor nutrition affects development which affects the productivity of the generation. This vicious cycle continues.

Reinforcement via risk messaging in a positive frame is a potential strategy for improved diet and community based management of prevention of malnutrition.

7. Community Involvement- Do not depend on ASHA s alone

- It was apparent from the interviews of the ASHAs and mother-in laws that there is no one key person who influences decision making of the woman regarding her pregnancy care and delivery.
- When the ASHA alone tries to deal with difficult cases there is the attitude that "she is doing it for money" which also demotivates the ASHA to carry out her work.

Involvement of more peer women, committees or groups and the Panchayat would help the ASHA and ANM in their work.

Conclusion

Based on the discussion and recommendations, improving the quality of ANC care, nutrition and institutional delivery needs to be a joint effort of the Health Unit and the community. However the community involvement has to be propelled by the State and District Health teams. Encouraging women to go for the required ANC check-ups and further deliver at a facility has to be coupled with quality services by the health care workers so that the people feel motivated, trust the system and perceive its benefits. Only when practices about good nutrition, ANC and institutional delivery become a norm in the community is acceptance better and it creates a demand from the consumer side to access the benefits of a public health system. Additionally structural and system barriers related to poor roads and cell phone connectivity needs to be addressed by district and state leadership, and not just the health department. Convergence between different departments although tough, is crucial, as a platform for shared goals is necessary. Education, nutrition, health, sanitation and access to services are interdependent to a large extent.

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