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Women's Perceptions of Quality and Satisfaction with Maternal Health Services

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Study Overview:

WOMEN'S PERCEPTION OF QUALITY AND SATISFACTION WITH MATERNAL HEALTH SERVICES

India has made significant progress in decreasing the maternal mortality rate (MMR) from 437 in 1992-1993 to 212 in 2007-09 [IIPS 1995, ORGCC 2011a], yet the country still accounts for 19% of maternal deaths worldwide [WHO, 2012]. Efforts have been initiated under Reproductive and Child Health, phase II (RCH-II) to improve maternal survival, including Janani Suraksha Yojana (JSY), the conditional cash transfer (CCT) scheme for institutional deliveries implemented since 2005. Institutional deliveries in India have since expanded from 53% of all deliveries in 2005 to 73% in 2009-10 [UNICEF, 2005, 2009]. Similarly in Jharkhand, institutional deliveries have increased from 19% in 2005 to 40% in 2009-10 [UNICEF, 2005, 2009]. Several evaluation studies have acknowledged JSY as the most visible maternal health program and most effective in terms of generating demand. However, evidence is needed to determine women's satisfaction with service provided by public health system and what other facilitators of women's satisfaction should be strengthened (or barriers removed) to support long-term demand and generate changes in health-seeking behavior. This study was designed to explore women's perceptions of quality and satisfaction with maternal health care. The findings will be of value in the design and strengthening of service improvements that are responsive to women's needs and perceptions and result in improved access to and utilization of safe maternal health services.

About the study area: Jharkhand is one of NRHM high focus states and continues to have higher percentage of home deliveries than India as a whole. Jamtara district and Jharkhand both reported 82% home deliveries in 2007-08 [IIPS 2010] Only 19% of the villages in Jamtara had a public health facility and only 34% had an ASHA residing in the village compared to 30% and 54% for Jharkhand. Nearly a quarter (23%) of the district's population belongs to Scheduled Tribes. [ORGCC 2011b] Scheduled castes and tribes together constitute 29% of the total population. Overall, literacy level is around 64%, below the state average of 67%, with female literacy being 50%. Rural income levels are generally low – findings from the community survey show that monthly household income levels of 85% of the respondents were below INR 5000.

STUDY OBJECTIVES

1. To identify dimensions of care that are important to the women's perception of quality of care and satisfaction with maternal health care services provided in order to improve women's utilization of maternal health programs.
2. To gather evidence on the current status of satisfaction with maternal health care services in the context of JSY in the state of Jharkhand, India, in order to improve maternal health programs and women's utilization of these services.

METHODOLOGY

The study had three interrelated components:

The literature review: Various methodologies used in assessing women's perceptions of quality and satisfaction with maternal care and key determinants of satisfaction were explored. The review covered India and other developing countries, especially those with schemes similar to JSY. Efforts were made to identify gray literature from India. Searches of a range of databases relating to public health and social sciences were carried out. The 53 studies extracted were diverse in nature, belonging to different regions, with diverse study populations, employing qualitative, quantitative or mixed methods, and reporting on multiple outcomes. Participants included women who had received antenatal, intrapartum or postpartum care, for either home or institutional deliveries. Studies were analyzed using the narrative synthesis approach for the review of determinants of satisfaction. Tools were obtained, extracted and analyzed for review of development process, contents, validation and method used for assessing satisfaction.

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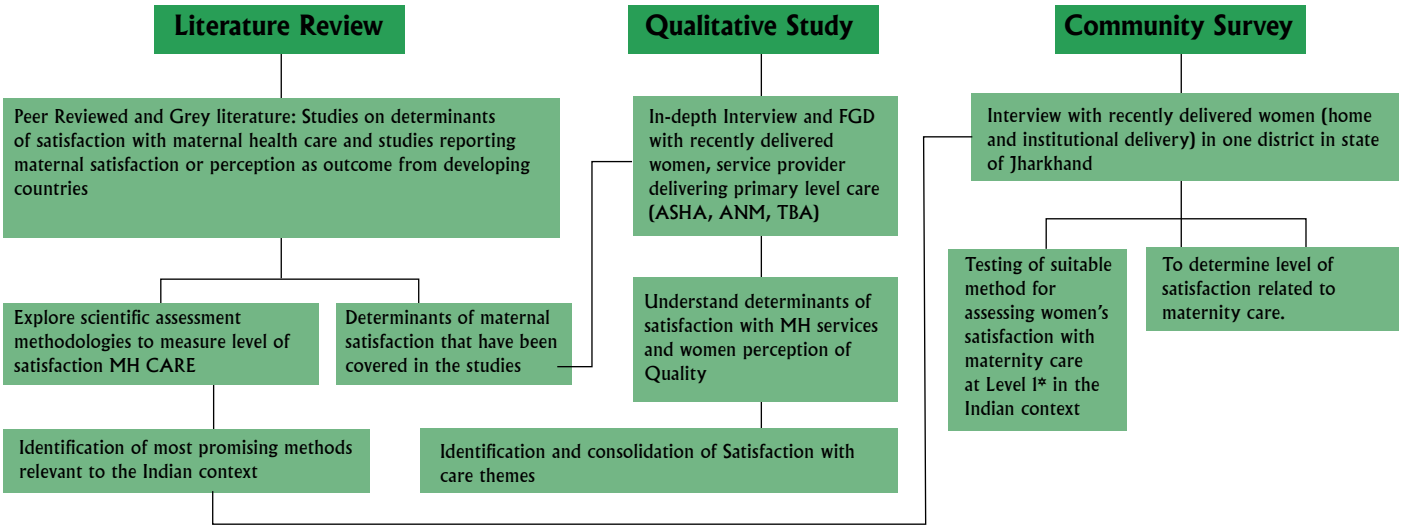
The Qualitative Study: To explore the determinants of care for institutional and home births and to understand women's perception of good care, 23 in-depth interviews (IDIs) and seven focus group discussions (FGDs) were conducted in the community with recently delivered women and select service providers at the primary level (Auxiliary Nurse Midwives, Accredited Social Health Activists, and Traditional Birth Attendants). The study was conducted in Jamtara district, Jharkhand, one of 264 high-focus districts under the Government of India's National Rural Health Mission (NRHM).

The Community Survey: Based on the key themes on determinants of care that emerged from the literature review and qualitative study, the third component of the study – a community survey – helped determine the level of satisfaction for maternal health services in the Jamtara, Jharkhand. A scale to assess level of satisfaction with maternal health services was also tested. The survey was conducted in the spring of 2012 with women who delivered 42 days prior to the survey. The sample size included 210 women who had delivered at primary level health institutions and 290 who had delivered at home.

Study Framework



Note: Level I is maternity care that is provided at Level I facilities (Sub Center and Primary Health Center)

TOPLINE FINDINGS

Determinants of Care for Maternal Health Services:

From the review of literature the determinants of maternal satisfaction that emerged from the studies covered all dimensions of care. The determinant with the largest body of evidence supporting it was interpersonal behavior. Provider behavior in terms of respect, politeness, friendliness and encouragement emerged as a predictor of maternal satisfaction with care in most studies. Major determinants of maternal satisfaction were largely confirmed in the subsequent qualitative study, but there were some differences that emerged in this particular community in India. See the key determinants table.

The qualitative study revealed seven key determinants of care, that particularly influence Indian women's decisions whether to deliver in institutions or at home (listed below in no particular order):
1. Interpersonal behaviors of the providers, 2. Influence of community health workers in deciding the place of delivery, 3. Accessibility of the institution, 4. Emotional support during delivery, 5. Belief in clinical care in terms of presence of skilled staff, 6. Availability of medicine, 7. The cost of the services.

Key determinants of maternal satisfaction

Quality of Care Framework	Determinants identified from Literature Review*	Determinants identified from Qualitative research and Community survey
Access	Distance & transport connectivity	Accessibility to institution
Structure	Cleanliness, clean toilets, hygiene, housekeeping services	Women appreciate cleanliness and the convenience of having someone clean the place of delivery afterwards was valued
	-	Human resources: Availability of trained medical personnel
	Medicines, supplies & services: Availability of drugs and equipment	Availability of medicine in case of complication and pain management
Process of care	Promptness of care: waiting time	-
	Interpersonal behavior: respectful behavior	Interpersonal behavior of the providers
	Privacy & confidentiality	Better comfort and Privacy
	Perception of 'good' care: Length of consultation; completeness of procedures; perception of negligent care; perceived provider competence	-
	Cognitive support: Prenatal counseling	-
	Emotional support: Birth companion of choice	Family members present during delivery
	Preference for female providers	-

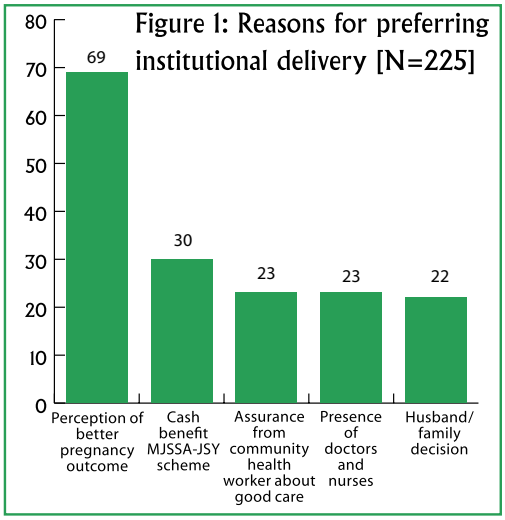
Cost	Financial cost of care	The cost of the services.
Outcome	-	Perception of better pregnancy outcome
Other determinants	Socio-cultural determinants: Literacy	-
	-	Influence of community health workers in deciding the place of delivery

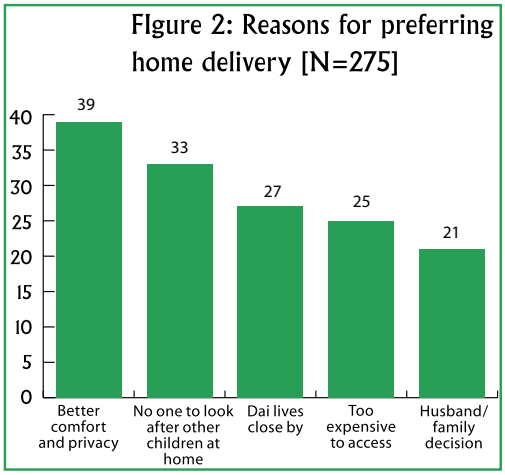
*Note: * Column lists only major determinants, which were reported in five or more studies.*

Reasons for preference for place of delivery:

Institution: The most frequently cited reason (69%) for women who preferred to have institutional delivery was the perception that they would have a better pregnancy outcome with institutional delivery than with home delivery. (Figure 1) Nearly one third women (30%) were attracted by the cash benefit of MJSSA-JSY scheme. A little less than a fourth of the women (23%) preferred institutional delivery on account of assurance from a community health worker (ASHA) about good care at an institution. The same proportion (23%) reported presence of doctors and nurses at facilities as the reason. About 22% of the women reported that institutional delivery was the husband's or family's decision.

Home: Nearly two-fifths of the women reported that they preferred home delivery on account of better comfort and privacy (Figure 2). One in three women reported that they preferred home delivery as there was no one at home who could look after other children at home. Close proximity of a *Dai* or Traditional Birth Attendant (TBA) to their home was the reason among 27% of women for preferring to deliver at home. One in four women reported that they felt institutional delivery was too expensive, while a little less than a fourth reported that home delivery was the husband's or family's decision.





> *"ASHA didi told me that in hospital there will be doctors and other facilities but in the house there won't be any … so it is better to go to the hospital."*
>
> Woman who delivered at institution
>
> *"I won't have any problem going to the hospital, but if the delivery at home is done safely then there is no need to go…. And mother–in–law and other members of the family were present at home."*
>
> Woman who delivered at home

Intention and Actual Place of Delivery:

Of the 225 women who indicated that they intended to deliver in an institution, 70% eventually went on to deliver in an institution with the remainder unintentionally delivering at home. Of the 275 women surveyed who indicated they initially intended to have a home delivery, 81% delivered at home and the remainder ultimately had an institutional delivery, largely due to the development of unexpected complications.

Why unintentional home deliveries?

For women who delivered at home despite a preference for institutional delivery, the most common reasons were that the there was no time to reach the institution; transport was not available; there were no male or other family members to arrange transport, accompany the woman or look after the household in her absence; or the women felt physically too weak to go to the facility for delivery.

Levels of Satisfaction:

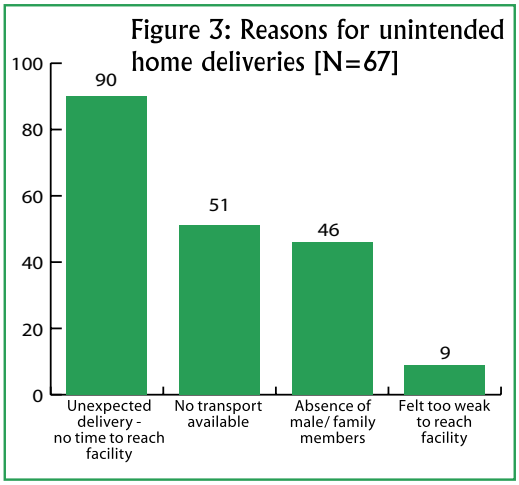
Levels of satisfaction with delivery care have been assessed by using a "Maternal Satisfaction Assessment Scale" (MSA-Scale) developed for the study. The result was analyzed using the socio-economic profile of the respondents. Satisfaction levels were lower among women who had home births than those who had delivered at institutions. And in both the groups of women the satisfaction levels were lowest for the women with the lowest socio-economic status.

Decision about Next Place of Delivery

An overwhelming proportion of women (74% of all respondents) reported that they wanted to have their next child at a health facility. However, 37% of women who had recently delivered at home did not want their next child to be born at an institution. Key reasons included the perception of poor care at the facility, along with poor supplies, presence of male staff, considerations of cost and difficulty in access.

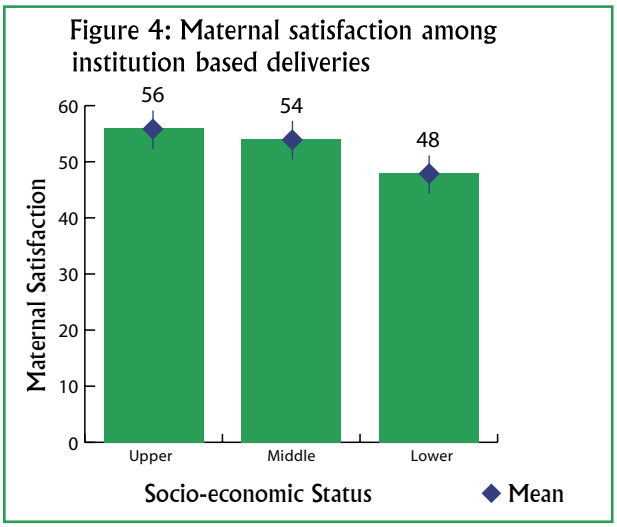
For both the home and institutional deliveries about one out of four women had not planned to deliver there. Of the 223 women who preferred delivering at home and did so, 46% did not want their next delivery in an institution. Of the 52 women who preferred a home delivery, but delivered in an institution, 81% wanted to have their next delivery also in an institution.

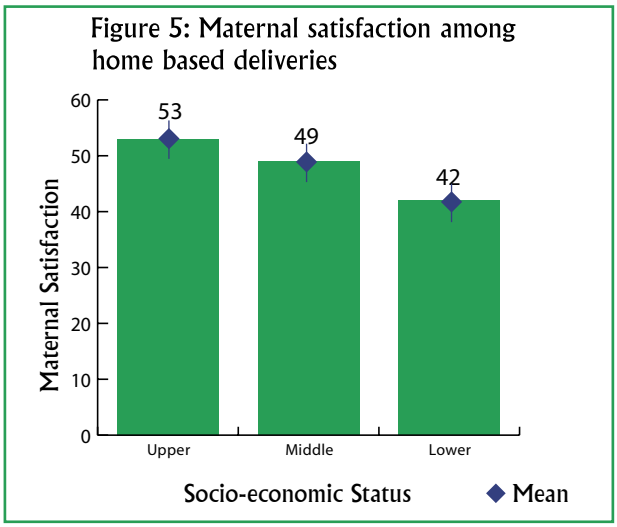
This indicates the experience was largely satisfactory for most such women. Ninety-three percent of the 158 women who preferred institutional delivery and had the same, again wanted institutional delivery for their next child. Similarly 93% of the 67 women who preferred institutional delivery but ended up delivering at home, stated they wanted their next delivery in an institution. This indicates an overall growing preference for institutional deliveries among the community women.



Conclusion

This study on women's perception and satisfaction with maternity care is the first detailed assessment of maternal satisfaction using an evidence-based tool developed in an Indian low-resource setting. The findings of the study highlight women's concerns that continue to serve as barriers to utilizing services. The tool developed in the study can help inform the Government of India's efforts to improve access and utilization of services in the country as well as ensure better understanding of the motivations of women who choose to deliver at home and inspire better service linkages for women who make this choice.





Note: Socio–economic status (SES) index was calculated by combining variables of income, caste status and education through Principal Component Analysis. Percentile scores of the index were divided into three equal parts representing upper, middle and lower SES levels.

References

International Institute for Population Sciences (IIPS) 1995. National Family Health Survey (MCH and Family Planning), India 1992-1993. Bombay: IIPS.

Office of the Registrar General & Census Commissioner (India) (ORGCC) 2011a. India SRS Special Bulletin on Maternal Mortality 2007-2009. New Delhi, India: Office of the Registrar General & Census Commissioner (India). June 2011.

International Institute for Population Sciences (IIPS) Mumbai: IIPS; 2010. *District Level Household Survey (DLHS–3), 2007–08: India.*

Office of the Registrar General of India and Census Commissioner (ORGCC) 2011b. Census of India – 2011. New Delhi: Ministry of Home Affairs, Government of India. Available at: http://censusindia.gov.in/Tables_Published/SCST/dh_st_jharkhand.pdf

Credits

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This study was undertaken by Public Health Foundation of India, London School of Hygiene and Tropical Medicine and University of Aberdeen. Support was provided by the U.S. Agency for International Development funded MCH-STAR Initiative.

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MATERNAL SATISFACTION ASSESSMENT - SCALE (MSA - SCALE)

Maternal satisfaction with care is critical to enhancing the utilization of health services and to ensure improved health outcome. Consequently its measurement is indispensable for identifying areas of quality improvement in maternal care.

The assessment of maternal satisfaction is challenging in developing countries, primarily due to diversity of delivery care services, especially the variability in care according to place of delivery—home and institution—and socio-economic level. Expertise in terms of psychometric methodology is key to developing a standard tool to assess the satisfaction level. The above factors are some of the reasons for non-availability of an instrument to capture maternal satisfaction in India. Women's satisfaction levels with the care increases when services are responsive to her needs. Hence, creating a virtuous cycle of quality improvement and health service utilization.

In order to fill this critical gap a research study was undertaken by Public Health Foundation of India (PHFI), the London School of Hygiene and Tropical Medicine and the University of Aberdeen to systematically generate an evidence-based scale to assess maternal satisfaction.

MSA - Scale Development

A systematic review of literature was undertaken to explore the various methodologies and tools used in assessing women's perceptions of quality and satisfaction with maternal care in developing countries, including India. The review lead to development of thematic areas of care, which were also supported by the qualitative research with recently delivered women and primary care health staff. This was followed by the development and selection of scale items from the existing scales on the identified themes and appraisal of the scale by the expert panel. The scale was pretested in the field and its contents were revisited on the basis of respondent's receptiveness and facility level. The revised scale was further piloted on a sample of respondents to check acceptability and comprehension. Experts also vetted the scale and bilingual experts did translation and back translation. Finally the scale was administered through a community survey with 500 recently delivered women in a district of Jharkhand, India.

Potential use of MSA - Scale

- Equally useful in facility-based surveys of client satisfaction as well as community- based initiatives for safe motherhood
- Potential to be effectively incorporated into the ongoing state and district level quality assurance processes under Reproductive and Child Health program (Phase II) – effectively captures domains that reflect women's satisfaction with maternal care
- Periodic assessment can help health service managers and service providers to assess women perception about the quality of maternal services and be responsive to their needs.

Tool Structure

It is a 10-item tool using a 5-point likert scale for scoring women's assessment of various key aspects of satisfaction. The items of the scale primarily fall under two main thematic areas, the technical care and interpersonal care. Technical care is an evidence based proven aspect of care verifiable by the mothers e.g. pain relief during delivery. While Interpersonal care is the responsiveness and humane aspect of care verifiable by mothers e.g. respect and dignity shown by the care provider.

The scale enquires mother's level of satisfaction for each item in two stages:

- Whether or not you were satisfied with the care (item) received? In case of yes or no response
- What was your level of satisfaction/dissatisfaction? The appropriate number for her response is noted as (1) fully dissatisfied, (2) somewhat dissatisfied, (3) neither satisfied nor dissatisfied, (4) somewhat dissatisfied and (5) fully satisfied.

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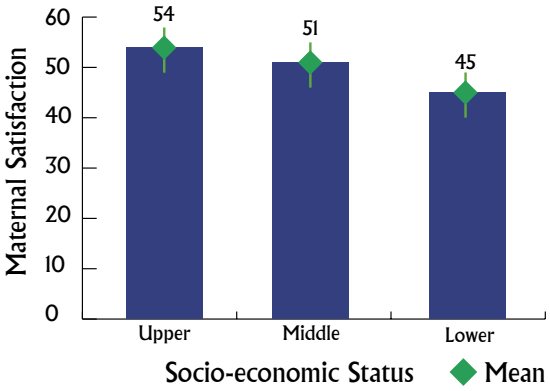
Selected Findings

Figure 1 shows the differential of women's level of satisfaction by socio-economic status (SES). There is a relative decrease of 20% in the satisfaction level of women from the maternity experience from lower SES as compared to women from upper SES.

Figure 1 : Levels of Maternal Satisfaction



Note: Socio–economic status (SES) index was calculated by combining variables of income, caste status and education through Principal Component Analysis. Percentile scores of the index were divided into three equal parts representing upper, middle and lower SES levels.

Key features of the MSA - Scale

- MSA - scale can be used to assess maternal satisfaction with normal deliveries in primary care settings - both institutional and homes.
- Effectively captures maternal perceptions on critical elements of what constitutes 'good care'.
- Convenient to administer for women from rural and low literacy backgrounds to understand and respond.
- Comprehensive in terms of covering various aspects of care, yet retained simplicity in format.
- Easy to calculate the satisfaction level based on maternal interview and simple summation of the individual items ratings
- Scores can be used to assess individual thematic areas of technical and interpersonal aspects of care or can also be pooled for an overall assessment of satisfaction with care received. It can be further converted into percentile scores for comparisons.

Figures 2 and 3 shows that advice the woman receives before and after delivery enhances the level of satisfaction with her birthing experience irrespective of even her SES and health outcome. If she is fully prepared during the antenatal period with the advice from ASHAs - the relative increase of her satisfaction level with the childbirth experience is about 100% as compared to women who received no birth preparedness information during antenatal period. Similarly the postnatal care advice also makes whole delivery process significantly more satisfactory.

Figure 2 : Birth Prepardness Index

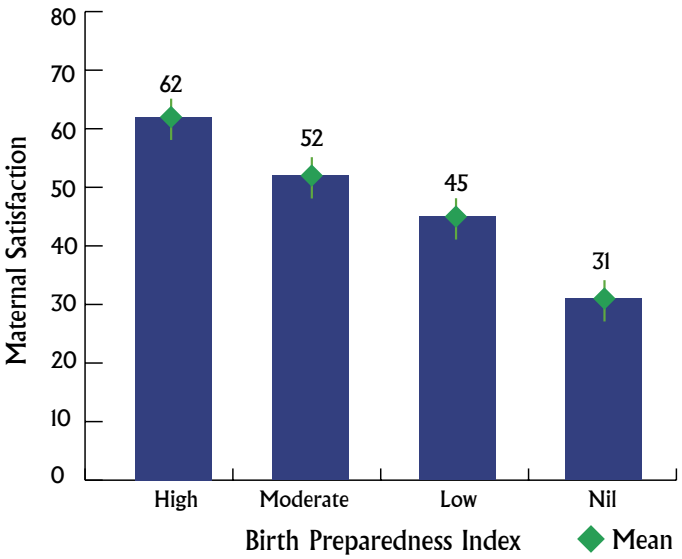
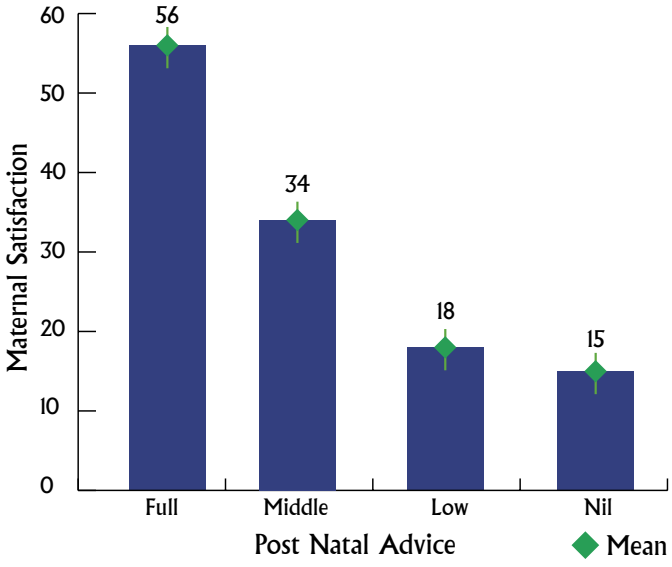


Figure 3 : Postnatal Care Advice Index



Note: Birth Preparedness index is calculated based on standard advice that ASHA provides like recognizing danger signs, making arrangement for transport. Similarly the Post Natal Advice index is based on advice like feeding the baby, immunization of the child.

Credits

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Beyond JSY: MAKING PUBLIC HEALTH FACILITIES MORE ATTRACTIVE PLACES FOR CHILDBIRTH

One of the Government of India's most significant strategies to reduce maternal mortality has been the promotion of institutional deliveries to ensure access to skilled care at birth. This strategy has been made operational largely through the Janani Suraksha Yojana (JSY) scheme, which provides cash incentives to women delivering in health facilities to reduce transportation and delivery costs. JSY also utilized community health workers to promote deliveries in facilities, and this scheme has significantly contributed to the increase in institutional deliveries from 53% in 2005 to 73% in 2009 [UNICEF 2005, UNICEF 2010].

Choosing institutional deliveries, however, has not become the norm for a large number of women.Women from disadvantaged socio-economic groups, including the lowest wealth quintile, illiterate women, and women from scheduled castes and minority religious groups, are more likely to die from pregnancy and delivery complications and the least likely to avail of institutional deliveries than other women [Montagu et al. 2011, WRA 2010]. In the spring of 2012 the Public Health Foundation of India, the London School of Hygiene and Tropical Medicine and the University of Aberdeen conducted a study of women's perceptions of quality and satisfaction with maternal health care to understand the factors that affect women's choice of place for delivery [Bhattacharyya et al. 2012, Ogala et al. 2012]. The study was conducted in Jamtara district, Jharkhand, one of 264 high-focus districts under the Government of India's National Rural Health Mission (NRHM). Jharkhand has one of the lowest percentage of institutional deliveries—only 40% of all deliveries [UNICEF 2010]. The study included in depth interviews, focus group discussions and a community survey of 500 women who recently (90 days prior to the survey) delivered at home or at a primary level health institutions (Table 1).

Table 1: Key background characteristics of respondents

Key characteristics	Institutional Delivery N=210	Home Delivery N=290
Mean age	23	25
% ST, SC and OBC (vulnerable groups)	87	75
Mean years of schooling	4.5	2.2
% illiterate	39	65
% with monthly household income less than INR 5000	81	87
% women with parity 3 and above	23	45
Mean no. of living children	1.8	2.5

Key factors for choosing to deliver in a health facility or at home

In the Indian context births have traditionally occurred at home, so institutional delivery, especially for poor and disadvantaged women and their families, is a relatively new phenomenon. This study's findings have highlighted factors that influence women's choice of where to give birth. The perception of a better pregnancy outcome was mentioned by nearly seven out of ten women (69%) who had intended an institutional delivery (Figure 1). Half the women noted that other individuals—community health worker (23%) or husband/family (22%)—greatly influenced or made the decision for them to have an institutional delivery. Nearly one out of four (23%) mentioned the presence of doctors and nurses in facilities as a reason for preferring institutional delivery.

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For women who wanted a home delivery, two out of five (39%) women cited better comfort and privacy as the reason for electing a home delivery (Figure 2). Nearly one out of three (33%) mentioned "no one to look after other children at home" as a reason for choosing home delivery. One out of four women cited the convenience of the *Dai* living nearby (27%) or the expense of an institutional delivery (25%) as the reason for wanting a home delivery. One out of five (21%) stated it was the husband's/family decision to have a home delivery.

Two out of three women who had a home delivery would consider an institutional delivery for their next birth (Figure 3). More than half such women (54%) cited good supplies as a reason for this, while about half (49%) cited perceived health benefits for themselves and their newborns as a reason. A little less than half (46%) of the women felt the cost of institutional delivery to be reasonable. About a third of the women (29%) mentioned availability of good care at facilities as a reason.

One third of women who delivered at home would not consider an institutional delivery in the future (Figure 4). More than one third (35%) said so because they perceived poor care at the facility. A little less than a third would not consider institutional delivery on account of poor supplies in institutions. Twenty nine percent women thought that there were too many male staff at facilities and another 29% thought institutional delivery to be too expensive. Poor access was also cited as a reason for not wanting to deliver at facilities by 27% women.

What facility managers can do to encourage women to choose to deliver in health facilities

Reduce the negative perceptions associated with institutional delivery

1. Ensure that providers, medicines and supplies are always available: Staff presence and availability of necessary medicines and supplies is the foundation of functional facilities. While staff and supplies availability to a large extent is influenced by health system factors beyond the remit of facilities, yet there are some measures relevant at the facility level.

Recommendations:

1. Institute supply chain improvements to ensure that medications associated with safe deliveries are available in facilities 24x7.
2. Enhance structural maintenance and cleanliness to improve the physical environment of facilities.
3. Ensure availability of staff for attending deliveries 24x7, by residing at or in close proximity to facilities, in order to attend to deliveries that may arrive any time.

Figure 1: Reasons for preferring institutional delivery (N=225)

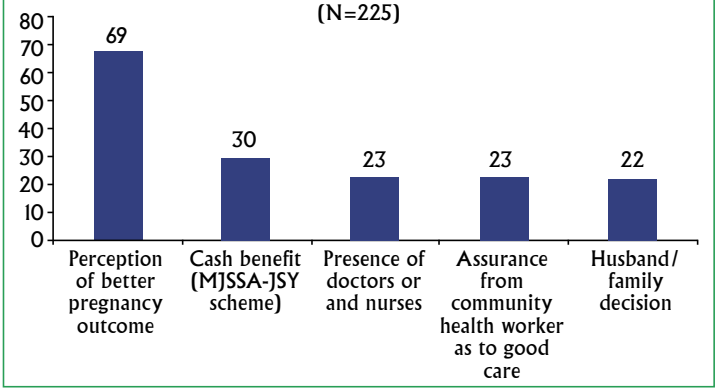


Figure 2: Reasons for preferring a home delivery (N=225)

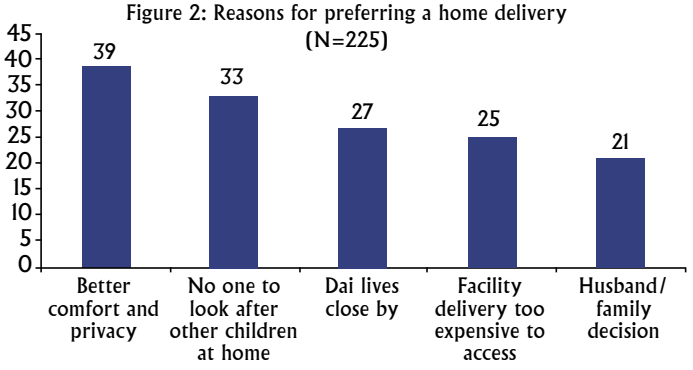


Figure 3: For women who delivered at home, reasons they would consider delivering in an institution in the future (N=183)

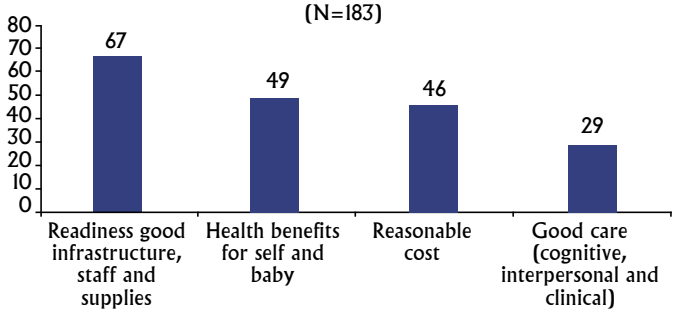
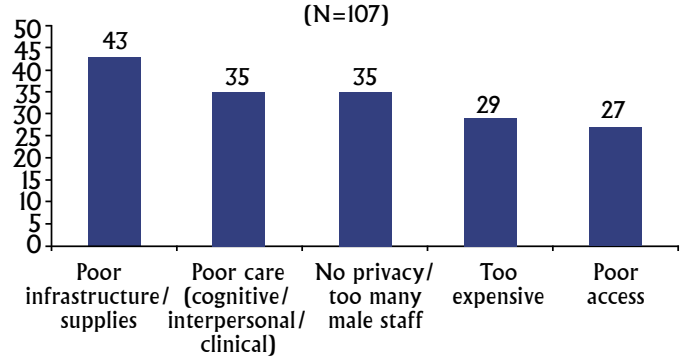


Figure 4: For women who had a home delivery, reasons they would not consider an institutional delivery in the future (N=107)



2. Decrease expenses of delivering in facilities: JSY has reduced this barrier significantly, but this study found that overall expenses often are higher than the JSY incentive amount. Expenses of diagnostics, drugs and injections, which often

have to be procured from outside the facility, and the demand for informal payment by facility staff, are two major reasons for high out-of-pocket expenses for women choosing institutional deliveries.

- Median expenditure on institutional delivery, as reported by women respondents in this study: INR 1,020
- Median expenditure on drugs and injections: INR 700.
- 40% of respondents spent more than INR 1400 (the conditional cash transfer amount provided through JSY) on institutional deliveries.

Recommendations:

1. Curb irregularities in supplies of medications associated with safe deliveries to reduce the burden of private procurement of such medicines by patients.
2. Keep diagnostic services in working order and ensure that there are clear protocols for determining when outside referral for diagnostics during and immediately after delivery are recommended in order to cut down on unnecessary procedures.
3. Check informal payments at health facilities. Full investigation and appropriate action should be taken against staff who impose illegal costs on women coming for delivery.

3. Improve care and community perceptions about care: One of the key barriers to utilizing institutional delivery care is a perception that women will not receive good care by staff in facilities. This included cognitive care, interpersonal care and clinical care.

- 35% of women not willing to deliver in an institution in future cited 'poor care' as a reason
- One out of 7 women preferring a home delivery cited fear of abuse as a reason.

a. Curb abusive behavior: Abusive behavior reported in the community has a compounding effect—it influences the choices of many women, not just the woman who personally experienced rude or abusive behavior.

Recommendations:

1. All staff should be oriented to behave respectfully towards patients. This includes everyone working in the facility who interact with patients from their arrival until they leave the facility. Aspects of respectful care include: timely response to patients in labor, fully answering patient questions, not scolding women for yelling or seeking more comfortable positions when they are in pain, allowing a trusted person to comfort them in the delivery, encouraging cooperation with clinical procedures in a caring and calm manner, not seeking "gifts" or illegal payment for standard delivery practices or postpartum care.
2. Facility managers should consult with community health workers to determine if abuse of patients is being reported in the community and take appropriate action to investigate and respond to any such reports.

b. Reduce community fears of clinical procedures: Women also fear clinical interventions they may have to undergo at the facility. Lack of familiarity with and trust in the clinical staff amplifies this apprehension. Improved communication with community members could help dispel some of the misconceptions and fears and may also have a positive influence on family members who may actually determine where a woman will go for delivery.

Recommendations:

1. Organize tours of the facility for women undergoing ANC care, and their family members, to answer questions about the processes for institutional deliveries.
2. Staff should be encouraged to participate in Village Health and Nutrition Days to answer questions about the processes for institutional deliveries.

4. Privacy for women coming for delivery should be a common practice: Providing basic privacy is very important to women in labor. This is evident from the finding that perceived lack of privacy and presence of too many male staff at the facility is a significant reason for unwillingness to deliver in a facility in future.

Recommendations:

1. Seclusion in the form of a separate room for examination or appropriate use of screens and curtains to maintain privacy is imperative for making women comfortable during physical examination.
2. Privacy in the labor room can be ensured by limiting the entry of outsiders and nonclinical staff, particularly males who are not doctors. In facilities where more than one woman may be delivering in the same room, screens and curtains can be utilized.
3. The message needs to be strongly conveyed to the community that adequate privacy will be provided to women arriving for delivery, and that though there may be male staff at the facility, their entry into the labor room is restricted.

Make going for an institutional delivery easier

5. Strengthen access to transport services:

The availability and access to transport is a major constraint in choosing institutional deliveries. Primary Health Centres (PHCs) and higher facilities have referral transport vehicles that should be available for use by women in labor.

> *"When my labour pain started it was midnight, there was no facility of vehicle and we did not have enough money to hire a vehicle."*
>
> – Mother who delivered at home.

Recommendations:

1. Ensure that the process and phone number for requesting your facility's referral transport vehicle is widely disseminated among Auxiliary Nurse Midwives (ANMs) and community health workers in your facility's catchment area.
2. Keep a list of private taxi drivers and other community members in your facility's catchment area who can be contacted by a woman's family members to request transportation to your facility. Share this list with ANMs and community health workers.

Conclusion

The good news is that more women are choosing institutional deliveries, but there are still many who practice home births. Although there is nothing wrong with choosing to have a home delivery, accessing skilled care in the community and accessing comprehensive obstetric care when complications develop is not easy to do in the Indian context. To keep women coming for institutional deliveries, this study explored the factors that influence their decisions regarding the place of delivery. Many of the barriers for institutional deliveries among these women are essentially rooted in negative perceptions about unfamiliar institutions, which can be overcome through efforts to provide more information and better communication with community members.

References

UNICEF 2005. *2005 Coverage Evaluation Survey.* All India Report. New Delhi: UNICEF India Country Office.

UNICEF 2010. *2009 Coverage Evaluation Survey.* All India Report. New Delhi: UNICEF India Country Office.

Montagu D et al. 2011. Where Do Poor Women in Developing Countries Give Birth? A Multi-Country Analysis of Demographic and Health Survey Data. *PLoS ONE* 6(2): e17155. doi:10.1371/journal.pone.0017155

The White Ribbon Alliance (WRA) 2010. *The Atlas of Birth.* UK: The White Ribbon Alliance.

Bhattacharyya S. et al. 2012. *Women's perception of quality and determinants of satisfaction with maternal health services. Findings from the qualitative study.* New Delhi: PHFI, LSHTM & University of Aberdeen, 2012.

Ogala V et al. 2012. *Women's perception of quality and determinants of satisfaction with maternal health services.Findings from the quantitative research.* New Delhi: PHFI, LHTM & University of Aberdeen, 2012.

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MCH STAR
Maternal Child Health
Sustainable Technical Assistance and Research

Understanding what Indian women want from maternal health services

SUMMARY OF KEY FINDINGS AND RECOMMENDATIONS

The Public Health Foundation of India, London School of Hygiene and Tropical Medicine and the University of Aberdeen conducted a study to explore women's perceptions of quality and satisfaction with maternal health care in Jharkhand, India. The study had three inter-related components – a literature review to explore methods of assessing maternal satisfaction and determinants of satisfaction that emerge from such studies in developing countries; qualitative study of recently delivered women and health personnel in the study area to explore the determinants of care for institutional and home births and to understand women's perception of good care; a community survey of 500 recently delivered women to assess the current status and determinants of maternal satisfaction with care in the context of both institutional and home deliveries.

Influential socio-economic factors and contextual factors

Indian women, by and large, are concerned about the issues that are considered important by women throughout much of the developing world (table 1). However, there are unique aspects of maternal health services that were particularly stressed or de-emphasized by Indian women participating in this study (tables 2, 3). There were also a few issues of significant importance to the satisfaction levels of these women that are not commonly found in other studies of this nature in other parts of the world (table 4).

About the study area: Jharkhand is one of the NRHM high focus states and continues to have a higher percentage of home deliveries than India as a whole. Jamtara district has an equally high proportion of home deliveries. Jamtara and Jharkhand both reported 82% home deliveries in 2007-08 [IIPS 2010] Only 19% of the villages in Jamtara had a public health facility and only 34% had an ASHA residing in the village compared to 30% and 54% for Jharkhand.

Nearly a quarter (23%) of the district's population belongs to Scheduled Tribes. [ORGCC 2011] Scheduled castes and tribes together constitute 29% of the total population. Overall, literacy level is around 64%, slightly lower than state average of 67%, with female literacy being 50%. Rural income levels are generally low – findings from the community survey show that monthly household income levels of 85% of the respondents were below INR 5000.

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Table 1. Key determinants of maternal satisfaction.

Key determinants of maternal satisfaction		
Quality of Care Framework	**Determinants identified from Literature Review**	**Determinants identified from Qualitative research and Community survey**
Access	Distance & transport connectivity	Accessibility to institution
Structure	Cleanliness, clean toilets, hygiene, housekeeping services	Women appreciate cleanliness and the convenience of having someone clean the place of delivery afterwards was valued
	-	Human resources: Availability of trained medical personnel
	Medicines, supplies & services: Availability of drugs and equipment	Availability of medicine in case of complication and pain management
Process of care	Promptness of care: waiting time	-
	Interpersonal behavior: respectful behavior	Interpersonal behavior of the providers
	Privacy & confidentiality	Better comfort and Privacy
	Perception of 'good' care: Length of consultation; completeness of procedures; perception of negligent care; perceived provider competence	-
	Cognitive support: Prenatal counseling	-
	Emotional support: Birth companion of choice	Family members present during delivery
	Preference for female providers	-
Cost	Financial cost of care	The cost of the services
Outcome	-	Perception of better pregnancy outcome
Other determinants	Socio-cultural determinants: Literacy	-
	-	Influence of community health workers in deciding the place of delivery

Table 2. Issues that elicited high positive or negative responses from the study respondents in the qualitative and quantitative research.

Issue	High satisfaction - % with Score of 5	High dissatisfaction - % with score of 1 or 2	The nature of women's concern
Support by family during delivery	79% were fully satisfied		Women feel vulnerable during delivery and value the presence of familiar person as source of support, in both home & institutional delivery
Health condition of newborn	71% were fully satisfied (76% of those with institutional deliveries; 68% of those with home deliveries)		Women feel satisfied with the health of their newborn when the baby isn't too weak or suffering from any newborn ailment
Care received during postnatal period	54% fully satisfied	12% fully dissatisfied (highest % of dissatisfaction scores). Another 4% were somewhat dissatisfied	Women feel that they do not have sufficient contact with health workers after delivery
Women's health condition after delivery		7% fully dissatisfied and another 12% somewhat dissatisfied	Women complained of feeling generally weak and anemic

Table 3. Issues that were difficult to communicate to study respondents in the qualitative and/or quantitative research, difficult for them to comprehend or that seemed to be of little concern to them.

Issue	The issue was difficult for women to comprehend in interviews, discussions or via the survey questions presented	The issue failed to elicit significant verbal responses from the women and/or the issue was found to be neither an indicator of strong satisfaction nor dissatisfaction
The promptness of care offered by facility staff, private doctors or TBAs		In most deliveries women in labor were attended within 30 min of arrival at facility, hence this did not emerge as significant issue in community survey; pattern was similar in home deliveries
Cleanliness in institutions	The socio-cultural context of the women could have affected their notions of cleanliness.	Most facilities in the region were in newly constructed buildings, which were clean. This could have led to overall high levels of satisfaction with cleanliness of institutions
The quality of the clinical services of the health provider	Women did not have the awareness necessary to determine whether or not they were given appropriate clinical care	
The adequacy of cognitive support and counseling offered by the health provider	Women did not have the awareness as to what to expect or what questions to ask, and also to decide whether the support provided was adequate. Social barriers may limit communication with health providers and expectations in terms of cognitive support	
Preference for female providers		As most deliveries were attended by females (nurses or TBAs) this issue did not seem to be a concern for most women

Table 4. Significant issues raised by study respondents.

Issue	Nature of the issue's importance to respondents	Relation with a moderate or high level of satisfaction with services	Relation with a moderate or high level of dissatisfaction with services
Fear that males would be present in delivery room	Most women were satisfied as providers in this study were largely female (nurses or TBAs), but the presence of males was a significant reason for unwillingness of women with home deliveries to deliver in an institution in future. It emerged as an important consideration in the qualitative study – this fear of male presence included being attended by male providers		11% of women who recently had delivered at home raised this issue as a dissuader from choosing institutional delivery
Influence of husband and other family members	One in five women reported that the choice of place of delivery was the decision of husband or other family members		Absence of family support for looking after other children at home or for arranging transport and accompanying woman to facility was a major inhibitor in accessing institutional deliveries
Influence of community health workers	Community health workers play a significant role linking communities with public health system and enabling access to health programs; they give assurance about good care and availability of staff at the facility	23% women cited assurance from community health worker as reason for preferring institutional delivery; 47% were accompanied by her to institutions for delivery	Almost half (45%) women with home deliveries thought that postnatal contact time by community health worker was too little

What we learned about what Indian women want from maternal health services

Indian women, whether they deliver at home or an institution, want the same thing, and are satisfied and dissatisfied by largely the same maternal health determinants as women in other parts of the world. The positive trend is that 63% women who delivered at home were willing to consider an institutional delivery in future. Issues that stand out in the Indian context include women's perception that facilities would not have adequate medicines and supplies, good care may not be available at facilities, the aversion to the presence of males during labor and delivery, the assurance of good pregnancy outcome and the powerful roles of the husband and other family members and also the community health worker in influencing the choice of place of delivery.

- The assessment of satisfaction with regard to clinical care associated with delivery, expressed by low-income women with low levels of literacy may not reflect the reality of the quality of clinical care given to them primarily on account of low levels of awareness regarding the recommended practices.
- Reported rude or abusive behavior of facility staff is a powerful dissuader for women to go to a particular institution for delivery. Reported rude behavior by facility staff has an amplified effect because women who hear about the reported rude behavior also are likely to avoid delivering in that facility and counsel other women not to go there.
- Lack of available transportation remains a powerful dissuader from choosing or experiencing an institutional delivery.
- The presence of family members or a familiar person is extremely important to women during delivery.
- Most women plan to have future deliveries in health facilities if her experience with her most recent delivery at a facility was satisfactory.
- A significant proportion (63%) of women having home deliveries in the past say they would consider having an institutional delivery in future, primarily because they believe there is better assurance of good infrastructure and supplies at facilities, and also the assurance of good outcome for themselves and their newborns.

- The conditional cash transfer provided through JSY is a significant factor in encouraging institutional deliveries, but not the primary one, as more than 60% of surveyed women say they are attracted to going to facilities for delivery primarily for better pregnancy outcomes.
- Women who chose to deliver at home were generally satisfied with the care and services they received during the most recent delivery.
- The issue(s) providing the greatest satisfaction to women during their most recent delivery were support from family members, outcome in terms of the health condition of newborn baby, care received during postnatal and antenatal period and the health advice given by the provider.

Recommendations to improve utilization of maternal health services in India

How the findings can help improve the quality of facility–based services

Facility managers can use the study findings to guide them in strengthening the facilitating factors and decrease the barriers to choosing institutional deliveries. This can be achieved by

- Ensuring that key factors are integrated into quality assurance measures such as in-service training programs and assessments of staff performance, facility protocols, and patient surveys;
- Overcoming community misgivings about facility processes and services by ensuring that the services for delivering mothers are communicated;
- Ensuring that ANC care is so well coordinated that every woman in the catchment area who is at high-risk of delivery complications is known and emergency transport to a facility is available should it be required.

How the findings can help improve the quality of community–based services

ASHAs and Anganwadi workers are the key link workers ensuring that women receive the full continuum of services for safe motherhood from the antenatal period through postnatal care. The TBA also plays an important role as a caretaker and counsel or for women and newborns regardless of whether a woman delivers at home or in institutions. The support these women can provide to ensuring a delivering woman has access to various aspects of care can be achieved through

- Improving birth planning and complication readiness counseling for women at home or in other community settings, regardless of where women plan to deliver because women's responses indicate that they lack good advice on these issues;

- Involving the husbands and other family members in advocacy around institutional deliveries, as they play a significant decision making role regarding place of delivery;
- Motivating and orienting the ASHA or TBA to provide community-based postnatal care, with which many women are dissatisfied;
- Ensuring ASHAs and AWWs identify women who are higher risk of developing complications and counsel them about place of delivery accordingly.

Community organizations concerned about safe motherhood can integrate these findings and tools to ensure that mothers' concerns are shared with program managers and policy makers. This can be achieved through

- Community-based checklists for assessing whether facilities are "mother friendly" based on the determinants of women's satisfaction with the quality of care;
- Community-based checklists for assessing women's knowledge of birth planning and complication readiness, delivery processes, as well as postnatal danger signs for the mother and newborn;
- Creating community forums for facility managers to address women's questions about facility processes and labor processes as well as inform women of their rights and benefits when choosing an institutional delivery.

Areas for further research on client perspectives of quality of care, satisfaction with care, and health seeking behavior

- There is need for in-depth research into the reasons for persistently high home births in some regions in India;
- Findings show that perceptions of better care and outcomes override the attraction of cash transfer in women's preference for institutional deliveries. There is scope to expand this research further to examine the changing community perspectives influencing utilization of institutional deliveries;
- Considerations of high cost of care emerged as a key reason dissuading women from institutional delivery – these could be the result of informal payments and irregularities in availability of medicines and supplies. Research can further quantify the extent to which such irregularities act as an effective barrier to utilization of care;
- Further research into maternal satisfaction could be made more policy-relevant by assessing the relative strength of various determinants in influencing maternal satisfaction; this could help in prioritizing appropriate corrective interventions for improved quality of care;
- Further research is warranted on maternal satisfaction in secondary or tertiary levels of care, especially with complicated deliveries or C-sections.

References

International Institute for Population Sciences (IIPS) Mumbai: IIPS; 2010. District Level Household Survey (DLHS-3), 2007–08: India. Office of the Registrar General of India and Census Commissioner (2011) Census of India – 2011. New Delhi: Ministry of Home Affairs, Government of India. Available at:http://censusindia.gov.in/Tables_Published/SCST/dh_st_jharkhand.pdf

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