Accessibility and utilization of maternal health care in urban India

A demand side perspective

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Executive summary

Introduction

Maternal health can be defined as the health of women during pregnancy, childbirth and the postpartum period (WHO, 2012c). Of all the maternal deaths in the world, 99% occurs in developing countries. The highest maternal mortality ratios can be witnessed in India where approximately 20% of all maternal deaths take place (Richard et.al. 2002). The majority of these deaths occur due to preventable causes. Maternal health care consists out of postnatal care during the pregnancy, skilled assistance during labor and postnatal care after birth. Both antenatal and postnatal care consist out of multiple health checkups in order to safeguard the health of mother and child. Unfortunately, many women are excluded from the health care system that is present in their country. This problem is strongly prevalent amongst Indian women from low socioeconomic groups, resulting in low or incomplete uptake of maternal health care. The barriers that woman come across when wanting to access health care can be categorized under five dimensions namely, Availability, Accessibility, Affordability, Adequacy and Acceptability (Penchansky & Thomas, 1981). These dimensions consist out of barriers that can be seen as supply side barriers and demand side barriers. Supply side barriers refer to various service delivery inputs such as the availability and quality of human resources and the availability of health facilities supplies and equipment, (Obrist et. al, 2007, Standing, 2004). The demand side refers to the behavior and inputs of the recipients of health care such as the ability to finance transport and care and their knowledge on the need for maternal care.

This baseline study aims to provide an insight to the accessibility and utilization of maternal health care in a North-Indian city. The main goal of this study was to collect data on the degree in which maternal health care is utilized in medical facilities, the barriers that women came across when accessing this type of care and how women's experiences with accessing and utilizing maternal health care can influence their expected future behavior.

Methods

In order to get a better understanding of the accessibility and utilization of maternal health care in urban areas, research has been conducted in Lucknow, the capital city of the Northern Indian state Uttar Pradesh. Fifty women from the urban slum Kashyap Nagar have participated in this study by sharing their experiences on accessing and utilizing maternal health care during their last pregnancy. The data collection focused on the demand side perspective e.g. that of the women from Kashyap Nagar and a mixed method approach was taken. Data from the women's perspective was collected by the use of questionnaires and interviews. In order to get a good understanding of the demand and supply side barriers women were asked to indicate to what degree these factors influenced the accessibility of maternal health care. Women were also asked about their motivations for using maternal health care, how the location where they received this care was selected, their experiences with utilizing maternal health care and if they expect to utilize this type of care again when pregnant again. In order to present the supply side perspective of this topic, additional interview questions were asked to doctors working in public and private medical facilities in Lucknow. Subsequently the data was analyzed with SPSS in order to prevent the main findings. Also, case studies have been developed in order to get present the context in which these findings can be interpreted.

Main findings and conclusion

It can be concluded that the utilization ratios in Kashyap Nagar are higher than the state average and that the majority of the researched women from this community have good experiences with accessing and utilizing maternal health care services in public and private health facilities. The majority (94%) of the researched women have utilized one or more components of maternal health. Antenatal care is the maternal health care component that is most often utilized by the women as 88% indicated that they received this type of care. During the delivery most women also receive skilled assistance as 50% gave birth in a facility and 44 women received assistance from a skilled birth attendance. Postnatal care has a lower uptake as only 66% of the researched women received any postnatal care after their delivery. Of the researched women 66% received ANC in a facility and 50% gave birth in a medical facility. Of the 33 women that received PNC the majority (63.6%) utilized this care in a medical facility. The majority of the women utilized the care in a public facility. Only eight out of the 50 researched women utilized MHC from a private health care provider. The care was predominantly utilized in public health care facilities e.g. in government Hospitals, PHC's and BMC's.

When looking at the completeness of the utilized care, it can be noticed that the vast majority of the women does not use the recommended MHC that is of key importance for the health of mother and child. The average utilization ratio for ANC consists out of two checkups during the pregnancy, one checkup less than the recommended three checkups. 17 women did not receive the recommended during the months that they were pregnant. The assistance women received while giving birth has been incomplete in certain cases. Also, the quality can be questioned as in 50% of the cases the women gave birth at home and some cases received insufficient care in health facilities. The PNC that was utilized often (42%) consisted out of one vaccination or drug such as a painkiller. Only 12 of the researched women (24%) indicated that they received more than one post-natal check-up.

When accessing the health services some of the researched women did have to overcome difficult barriers that were mostly related to the affordability and the acceptability of the services. This therefore implies that the strongest barriers to the access of MHC that women from this community encountered are a mix of supply and demand side barriers. Most of the women were able to overcome these barriers but those that did not succeed in doing so subsequently did not utilize any MHC in a facility. The research findings have shown that the earlier experiences women have with accessing and utilizing MHC are the two most important factors when deciding whether or not to utilize MHC in the future. It can be expected that these overall experiences women have had will have a positive influence on the future utilization behavior as most women indicated that these experiences were predominantly positive and because they indicated that they expect to use MHC again. However, this promising conclusion needs a side note. The future utilization of in-facility MHC by the researched women is strongly dependent on certain factors that are not controlled by the women and that can potentially emerge as new barriers.

Firstly, the knowledge on the importance of maternal health care has a strong influence on the utilization behavior of women. The majority of the women indicated that they used MHC because they believed it was important for their own health and that of their child. The vast majority of the women retrieved this information from the people around them, especially from their family. Also the decision to use maternal health care and the location where the care will be utilized is strongly dependable on the knowledge and the approval of social relations, especially of that of their husband. The lack of autonomy in deciding when and where to utilize MHC can have negative consequences. For instance, if the opinion of the people surrounding the women

changes with regard to the acceptability of MHC, for instance due to financial restraints, the expected future utilization behavior can be negatively influenced as new accessibility barriers may arise.

Secondly, factors that play an important role in deciding where to utilize future MHC are the very same factors where the women were less satisfied with, such as the availability of human and medical resources, waiting times and the attitude of the doctors and nurses. As Lucknow is currently witnessing the overcrowding of the health sector it can be expected that women will come across more hurdles when accessing MHC in the future as overcrowding is often related to problems such as long waiting times and rude behavior of nurses. These changing circumstances can therefore have a negative influence on the overall use of MHC and the in-facility use, which subsequently can be reflected in the maternal health status of the researched women. Therefore, it can be stated that the findings of the present study look promising but might be threatened by possible future barriers that may arise from factors that are currently very influential on the MHC utilization behavior of the researched women.

Table of contents

List of abbreviations 10

Prologue 11

Introduction 12

Chapter 1 | Theoretical Framework 14

1.1 Introduction 14

1.2 The international approach to the improvement of maternal health 14

1.3 General approaches to health 15

1.3.1 The Human Rights Based Approach 15

1.3.2 The gender approach to health 16

1.4 Approaches to the improvement of accessibility of health care 17

1.4.1 The supply side approach 17

1.4.2 The demand side approach 18

1.5 Barriers to the accessibility of health care 20

1.5.1 The five dimensions of Accessibility 20

1.6 Conclusion 24

Chapter 2 | Contextual Framework 25

2.1 Introduction 25

2.2 Maternal health a worldwide challenge 25

2.2.1 Maternal health and maternal mortality 25

2.2.2 Maternal health care services 26

2.3 National Context 28

2.3.1 Geographical location 28

2.3.2 Demographics 29

2.3.3 Ethnicity, language, religion and caste 30

2.3.4. Socio-economic development 31

2.3.5 Status of women 32

2.4 The Indian health care system 33

2.4.1 Maternal health in India 34

2.4.2 The Indian health care system 34

2.4.3 Accessibility and Utilization of maternal health care in India 37

2.5 Regional Context 39

2.5.1 Geographical location and demographics 39

2.5.2 Maternal health in Uttar Pradesh 41

2.5.3 Lucknow city, geographical location and demographics 42

2.5.4. The health care system in Lucknow city 43

2.6 Conclusion 44

Chapter 3 | Methodology 45

3.1 Introduction 45

3.2 Research questions 45

3.2.1 Research questions 45

3.2.2. Conceptual model 45

3.3. Research methods 48

3.3.1 Research approach and methods 48

3.3.2. The questionnaire 48

3.3.3 Operationalization of concepts 49

3.3.4. The host organization 50

3.4. Selection of the research area and units 50

3.4.1 Selection of the research area 50

3.4.2 Description and selection of the research units 51

3.4.3. Research team 53

3.4.4 Ethics 53

3.4.5. Main limitations and risks 53

3.5. Conclusion **54**

Chapter 4 | Research location and participants **55**

4.1. Introduction **55**

4.2 Research location **55**

4.3 Research units **56**

4.3.1. Household situation 56

4.3.2. Maternal history 57

4.4. Conclusion **58**

Chapter 5 | Accessibility and Utilization **59**

5.1. Introduction **59**

5.2 Utilization of maternal health care **59**

5.2.1 Utilization of maternal health care in general 59

5.2.2. Utilization of antenatal care 60

5.2.3. Utilization of delivery care 63

5.2.4. Utilization of postnatal care 65

5.3 Experiences with accessing Maternal Health Care **66**

5.3.1. Availability 66

5.3.2. Accessibility 67

5.3.3. Affordability 67

5.3.4. Adequacy 70

5.3.5. Acceptability 70

5.3.6. Personal characteristics 71

5.3.7. Barriers perceived by women that did not use any MHC in facilities 72

5.4 Experiences with utilizing maternal health care **73**

5.4.1. Overall satisfaction 73

5.4.2. Facility 73

5.4.3. Interaction with the health personnel 74

5.4.4. Referral 77

5.4.5. Use of private health care facilities 77

5.5 Expected future use 78

5.5.1. Factors of influence on the utilization maternal health care 78

5.5.2. Factors of influence on the choice of maternal health care provider 80

5.6 Conclusion 80

Chapter 6 | Discussion 83

6.1. Introduction 83

6.2. The accessibility of maternal health care in a theoretical context 83

6.2.1. The gender and Human Rights Based Approach to health 83

6.2.2. The demand side approach to health 84

6.2.3. Accessibility, the perceived barriers in a theoretical context 85

Chapter 7 | Conclusion 89

7.1. Introduction 89

7.2. The accessibility and utilization of MHC by women from Kashyap Nagar 89

7.2.1. To what extent do women from Kashyap Nagar utilize public and private MHC? 89

7.2.2. What motivates women to utilize maternal health care? 90

7.2.3. How do women select the location where the maternal health care will be utilized? 90

7.2.4. Which barriers reduce the accessibility of MHC and how do women overcome these? 91

7.2.5. What kind of experiences do women have with utilizing public and private MHC? 91

7.2.6. What factors do women expect to influence their future health seeking behavior? 91

7.3 Final conclusion 92

References 94

Appendix 100

List of abbreviations

ANC	Antenatal care
ANM	Auxiliary Nurse Midwife
AWC	Anganwadi Center
AWW	Anganwadi worker
BPL	Below Poverty Line
CDPO	Child Development Program Officer
HDI	Human Development Index
IMF	International Monetary Fund
JSY	Janani Suraksha Yojana
MDG	Millennium Development Goal
MMR	Maternal Mortality
NHP	National Health Policy
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
OBC	Other Backward Castes
PNC	Postnatal care
PHC	Primary Health Center
PPP	purchasing power parity
SBA	Skilled Birth Attendant
UN	United Nations
U.P.	Uttar Pradesh
WB	World Bank
WHO	World Health Organization

Prologue

Women living in urban communities in India face various obstacles when accessing maternal health care. The following story presents the story of one of the researched women that came in contact with various accessibility barriers which she had to overcome in order to receive maternal health care. The following case study aims to give an insight to the type of experiences women can have with accessing and utilizing maternal health care and which various factors come to play when deciding to use maternal health during a possible future.

When 21 year old Lakshmi was pregnant of her first child she planned on using maternal health care as she had learned from her friends and the community that it was important to use these services. She visited a hospital so that she could receive antenatal care during her pregnancy. However, the doctor that was appointed to her refused to provide medical care to her as he believed that her child was illegitimate. After her bad experience with accessing care she was reluctant to visit a hospital again. Especially after she has seen that hospitalized women that were about to deliver their child, were beaten by doctors and nurses. But when she faced complications during labor she was rushed to a health center by her family. During the delivery none of the doctors or nurses was available or willing to assist her. When the baby was seconds from being born a sweeper that was cleaning the room intervened and assisted her while giving birth. Immediately after the delivery she was forced to leave the medical facility. As her family wanted her to receive postnatal care her husband got nutrition powders from a community health worker to strengthen his wife. He also visited a hospital with her parents, sister in law and neighbor where he had to pay a bribe of INR.700 (US $ 12.68) to the health personnel so that his wife would receive an injection against the pain she was feeling. The family paid these costs and an additional X-ray from the INR. 1400 that they received under a conditional cash transfer scheme called "Janani Suraksha Yojana".

Looking back on her experiences when accessing maternal health care, Lakshmi recognizes many supply side barriers. She feels that the quality of the treatment she received and the cleanness of the facility were insufficient. Also the availability of doctors, nurses and resources was insufficient and their attitude was disappointing as all the care givers and the registration officer asked for bribes before wanting to distribute the care. However, what was most upsetting to her was the disrespectful treatment by the doctors and nurses. She believes that the fear she developed for hospitals due to the way the personnel treat patients, proofed to be the biggest barrier. She overcame this barrier due to the necessity of medical treatment and only received the medical care because her family paid the bribes that the personnel requested. Due to these experiences Lakshmi does not know how easy it will be to use maternal health care during a possible future pregnancy. Despite of the bad experiences she has had she feels that she would still try to use these services again in the future. However, her earlier utilization experiences and the opinion of her natal family and in-law-s could influence this expected future use. When selecting the location where she will utilize this care, the opinion of her husband, the availability and attitude of doctors and nurses and the experiences that friends have had will be decisive factors.

Introduction

Inequalities in health and economic development influence the realization of human potential worldwide. The most essential obstacle to realizing human potential that can be recognized is the exclusion from social systems (London, 2008). The Universal Declaration of Human Rights (1948) safeguards the right to health but unfortunately this right is not met as many countries, and especially in developing countries, many are excluded from health care systems. Therefore, it can be stated that when persons are excluded from health care systems the human right to health care is often violated (Cook, 1993). Those that are excluded from utilizing health care are often part of the vulnerable groups in a society. In many countries and especially in those where patriarchal structures are prevailing, women are often those that are marginalized. Therefore, health standards are often not met by women. The deprivation of women's health can especially be recognized in the access they have to reproductive health. This type of health addresses the reproductive processes, functions and system at all stages of life (WHO, 2012g). Protection of women's reproductive health has often not been a priority for governments and women face many barriers when wanting to utilize reproductive health. The low uptake of maternal health care, which falls under reproductive care, demonstrates the need for services that are more accessible for women, especially those that are part of low socioeconomic groups.

Maternal health addresses all the care women receive during their pregnancy, while giving birth and in the weeks after birth (WHO, 2012a). Utilization of these services is of key importance as poor maternal health can cause women to suffer from chronic complications and in the worst case, cause them to lose their life. In the last years progress has been made in improving women's maternal health as the worldwide maternal mortality has dropped by almost 50% in the last decades. However many deaths and inequalities can still be witnessed as 99% of all maternal deaths occur in developing countries from preventable causes, stressing the importance of focusing on the access of maternal health care in these regions.

The highest maternal mortality ratios can be witnessed in India where approximately 20% of all maternal deaths take place (Richard et.al. 2002). Although the utilization rates of maternal health care in India have been increasing over the past years, large disparities between states, regions and households can be noticed. Women have often a disadvantaged gender position which becomes even more detrimental when women are poor and fall outside the cast system. A strong correlation between their low socioeconomic status and a low maternal health can be noticed. Many of the maternal deaths can be retraced to insufficient use of maternal health care during and after the pregnancy. Reasons for the low uptake of these services can be retraced to many factors, ranging from worldwide trends and policy shifts to the circumstances in which women live.

When researching the accessibility of health care different perspectives can be taken to this topic as maternal health is influenced by developments on the global, national, sub-national and district level. However, as utilization of maternal health care ultimately comes down to the community level in which women live, it is of key importance to pay attention to the perspective of the women themselves. Therefore, the present study will take a demand side perspective on the access that Indian women from low socioeconomic groups have to maternal health care.

As urban utilization rates of maternal health care are often higher than those in rural areas a research bias for rural studies can be noticed. A deeper understanding on the accessibility of

maternal health care in urban areas has often been overlooked by scholars and the civil society. However, by researching the accessibility and utilization in urban areas valuable information can be gathered on the development of maternal health in India. Insight can be given on factors that these women do not perceive as access barriers so that one can learn which dimensions are of importance when wanting to increase the utilization of maternal health. Also, a deeper insight can be given on how sufficient the higher uptake is to the improvement of maternal health on the manner in how sustainable the current developments are.

For all of the above mentioned reasons this thesis will focus on the accessibility and utilization of maternal health care in urban India. The focus of this study will be placed upon the utilization of maternal health care in medical facilities. Women in urban areas often have to cover shorter distances to these facilities and therefore are face less physical barriers when accessing this type of care in a facility. In addition, is the use of facilities stimulated by the Indian government via the use demand side financing as it is believed that medical facilities are better equipped in providing a higher quality of maternal health care.

In order to gather information on the research theme fifty women from the North Indian city Lucknow were surveyed on the their utilization behavior, the accessibility barriers they perceive and in which manner this influences their expected future behavior. The selected women were all residents of a slum area and had a minimum of one child in the last four to twelve months. Via the use of surveys and in dept interviews information was gathered on the research topics. In order to get an understanding of the supply side perspective on the accessibility of maternal health doctors were asked questions as well.

This thesis begins by outlining presenting a theoretical framework in which general approaches to the improvement of health as well as those to the improvement of the accessibility of health care. Attention will also be paid to findings of empirical studies on the dimensions that can have an influence the accessibility of health care. In the next chapter, the contextual framework, an overview is given on the thematic and regional context in which the present study has taken place. Attention will be paid to the diversity of India, the Northern state Uttar Pradesh and Lucknow city. Also the Indian health system and the uptake of maternal health care in the state in which the present study has taken place will be discussed. In the third chapter the methodology of the study will be presented in which, inter alia, the research questions, conceptual model and research methodology will be discussed. The fourth chapter aims to provide an understanding of location where the research and the socioeconomic background of the research participants. In the fifth chapter the research findings of the present study will be presented. Subsequently will these findings be discussed in the light of the existing literature in chapter six. In the final chapter the conclusions of this study will be presented.

Chapter 1 | Theoretical Framework

1.1 Introduction

In this chapter an overview will be given of approaches to improve health in general as well as those that focus on the accessibility of health care. After a short overview of the international commitment to the improvement of maternal health, two general theories to health will be discussed, the Human Rights Based Approach and the gender approach to health. Next, two approaches will be discussed that are central to the improvement of the accessibility of health care, the supply approach and the demand approach. Lastly, an overview of barriers will be presented that according to diverse empirical studies have an influence the accessibility of health care.

1.2 The international approach to the improvement of maternal health

During the years that development aid has been given to countries in the South, diverse approaches have been used by Northern countries to address the complex problems that prevent women from having children in a safe manner. The approaches used before the 1970's in developing countries were often based on Northern systems of medical care, concentrating on urban medical centers and the use of highly trained personnel and modern technology (Rosenfield & Main, 1985). As it became clear that contextual circumstances in the developing countries formed barriers that influenced the accessibility of these services and that the primary health-care programs were not adequately focused on maternal health, new strategies were opted. Subsequently, a shift can be noticed since the 1970's to an approach where the needs and resources of the developing countries were taken into account when designing and implementing medical systems. Yet, it was not until the 1980's that the problem of high maternal mortality rates became a focus point.

With the "Safe motherhood initiative" the growing need for more emphasis on maternal health care was being addressed as it called for global initiatives to intensify policy intervention for maternal mortality (Hogan et all, 2010). The focus on maternal mortality became an important issue in international aid and health services research during this decade (Brouwere et all, 1998). In the following years the focus was placed on the theme reproductive health as international commitment continued to contribute to the reduction of maternal mortality. International conferences, such as the Cairo Programme of Action, were held, and the goal to reduce the maternal mortality rates was set (AbouZahr & Wardlaw 2001). The approach to improving maternal health changed as well as during the International Conference on Population and Development in 1994 the focus on maternal health transferred from a demographically driven approach to a human rights approach (Potter et. al. 2008). Currently, this approach receives a lot of emphasis in international health (Standing, 2004).

However, it was not until the development of the Millennium Declaration the reduction of maternal mortality became not only a focus point to the international community but a high priority, strengthening the international commitment (Hogan et all, 2010). More information on the millennium development goals and the improvement of maternal health can be read in Box 1.1. Currently, positive trends in the improvement of maternal health due to the influence of the Millennium Declaration can be noticed. However, research shows that more progress is needed to achieve the goals set for the year 2015.

Box 1.1: The Millennium Development Goals and the improvement of maternal health.

In 2000 the Millennium Development Goals (MDG's) were adopted by the international community. These goals aim to encourage development by improving social and economic conditions in the world's poorest countries. Under the United Nations International Development Goal 5 "Improve Maternal Health", the reduction of maternal mortality was adopted by the International Monetary Fund (IMF), the World Bank (WB), Organisation for Economic Cooperation and Development (OECD), and was supported by 149 heads of state at the Millennium Summit in 2000 (AbouZahr & Wardlaw 2001). This Millennium Development Goal (MDG) for 2015 includes target 5.A: "Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio" and Target 5.B: Achieve, by 2015, universal access to reproductive health (UN, 2012). This development goal is strongly interlinked with other development goals namely, MDG1 "Eradicate extreme poverty and hunger", MDG3 "Promote gender equality and empower women", MDG4 "Reduce child mortality rates" and MDG6 "Combat HIV/Aids, malaria and other diseases". Therefore the MDG's can be somewhat seen as a holistic approach to improving women's overall wellbeing. By decreasing the maternal mortality rate (MMR) the economic effects for poor people will be reduced as well as the gap between maternal deaths of women from high and low socio-economic groups (Filippi et all. 2006). As low education levels and low statuses of women are often seen amongst those groups that have high maternal mortality rates, working on women's empowerment is expected to have a positive influence on decreasing the MMR. Because intra-partum and early postpartum strategies will not only improve maternal survival but will also have a positive influence on the survival of young children, MDG 4 is also strongly interlinked with reducing maternal deaths. Lastly, improving maternal health will also help the treatment and will reduce the spread of infectious diseases as mothers and their baby will undergo medical check-ups that can address infections and possible transmissions of diseases.

1.3 General approaches to health

To improve general health care for the poor diverse approaches have been used throughout time. This paragraph presents an overview of two approaches that are currently often used namely the Human Rights Based approach and the Gender approach to health. Both approaches are important for the present study as they are often used in maternal health policy development.

1.3.1 The Human Rights Based Approach

Human rights refer to the intrinsic rights that belong to individuals and that are equal to all human beings (UNDP, 2003). According to the "Universal Declaration of Human Rights" these rights are the foundation of peace, justice and democracy. With the adoption of the "UN Statement of Common Understanding on Human Rights-Based Approaches to Development Cooperation and Programming" by the United Nations Development Group in 2003, a consistent and coherent definition on the Human Rights-Based Approach was formed for the United Nations (UN). (HRBA, 2012) The Human Rights Based Approach (HRBA) was developed to realize the rights that are mentioned in the international human rights treaties. Although different HRBA approaches are being maintained in different organizations there are common factors that all approaches share. Firstly, the same stakeholders are being identified. HRBA's address two types of stakeholders. The first group consists out of those that do not experience full rights, also known as the right holders. The second group, known as the duty bearer, consist out of those that should be responsible for fulfilling the rights of the first group (Bruno-van Vijfeijken, 2009). With this approach a discourse between citizen-based rights and consumer focused views can be discovered. The HRBA views health as an entitlement instead of a market

based sector. As the latter differentiates uses based on their purchasing power it is considered by the HRBA as less suitable form of right as they tend to exclude the poor (Standing, 2004). Secondly, a common foundation can be noticed as all HRBA's aim to enable active social mobilization by using the agency of vulnerable groups. In this approach individuals, groups and communities are not seen as passive beings, emphasizing the importance of agency in HRBA's. These vulnerable individuals, groups and communities are seen as active agents with capabilities. The approaches aim to give them a voice that will enable them to make decisions and change their conditions of vulnerability (Londen, 2008).

As mentioned there are multiple approaches that fall under the umbrella of the HRBA (UNAIDS, 2004). This is also the case with HRBA's in the health sector. According to Londen (2004) four different approaches can be distinguished when human rights are being used to promote health equity. In the first approach the human rights based framework is being used to design activities that support accountability and hold the government accountable as a duty bearer. The second approach lays its focus on pro-active development of policies and programs. This approach aims to operationalize health objectives in such ways that they are consistent with human rights. Here the approach helps the government to see how they can realize their tasks. In the third approach human rights violations are being restored by for instance addressing health violations in a court. The last approach uses the human rights framework to mobilize the civil society to realize the right to health. In order to achieve this goal various strategies can be used including holding governments accountable, developing policies and programs or addressing right violations. Besides these approaches a trend can be noticed in the HRBA's in the health sector. Current HRBA's aim to link the local with the global as new right based approaches to health policy development aim to link local struggles of vulnerable groups with the global context (Londen, 2008)

1.3.2 The gender approach to health

According to UN Women (2012) gender refers to socially constructed attributes and opportunities that are associated with being male and female and that are learned through socialization processes. In many countries and societies, women and girls are treated as socially inferior as gender norms and values attribute unequal responsibilities and rights. These gender inequalities are defined by the WHO (2012a) as "*differences between men and women which systematically empower one group to the detriment of the other*". The effect that these inequalities have on the allocation of resources to women is strongly associated with poor health and reduced wellbeing. Studies have shown that the gender based inequalities that women face have a direct effect on the accessibility and utilization of health care services (WHO, 2009). This is for instance the case as women in developing countries are often hampered in their freedom of movement or not allowed to see a male doctor. In addition, studies have shown that there is a gender bias in the management of diseases, resulting in women often not being able to utilize the care that they need. However, gender norms and values are context specific and therefore subject to change, making it possible to have a better influence on not only the health of women but also on the enhancement of productivity and the improvement of development outcomes for the generation to come.

In the 1994 Platform for Action document the statement was made that women's right to the enjoyment of the highest possible standard of health must be secured throughout the life cycle in equality with men (Gijsbers et al. 1994). One strategy to reach this goal is to create gender awareness via the WHO's "gender mainstreaming" approach. This concept stands for creating responsibility, knowledge and awareness of gender among all health professionals

(WHO, 2012). The approach promotes the inclusion of gender components in project's such as, research, interventions and health system reforms, from the start instead of including it in a later stage in the project. In this approach it is vital that all health professionals must be aware of the role that gender plays so that all can address this issue when needed. This approach is a reaction to previous strategies where often gender departments were responsible for addressing gender related strategies within running programs hence, decreasing their strength. The 2012 World Development Report (WDR) indicates that reducing gender gaps in health has been successful where a single barrier, in household, marker or institutional level, has been identified. Yet, in contexts where multiple barriers can be identified progress has been slower. Therefore, the need to place gender approaches central in the health sector remain of key importance.

1.4 Approaches to the improvement of accessibility of health care

When aiming to improve maternal health in developing countries complex problems come to play. Optimal accessibility of health care is vital when trying to reach this goal. Improving accessibility is concerned with assisting people to claim appropriate health care aiming to improve their health (Gulliford et. al. 2002). Accessibility can be defined as 'the timely use of service according to need' (Jacobs, 2011, p. 2). To achieve optimal accessibility the WHO paradigm Primary Health Care (PHC) was introduced to reduce inequities in health by enabling universal access to health care (Jacobs, 2011). As it often takes time before new health initiatives reach the poorest, targeting strategies are preferred when working in developing countries. The two targeting options for increasing the accessibility of health services are, building the capacity of the provider (the supply side strategy) or to reduce access and utilization barriers (the demand side strategy). Both strategies and affiliated approachess will be discussed in the next sections.

1.4.1 The supply side approach

Within the health sector, a difference has always been made between demand and supply side mechanisms. Studies used to mainly focus on either the supply side of health systems or on health policy interventions that often aimed to reduce supply barriers (Ensor & Cooper, 2004). The supply side refers to various service delivery inputs such as the availability and quality of human resources, availability of health facilities, availability of supplies and equipment, protocols of diagnose, treatment availability and the environment of health facilities (Obrist et. al, 2007, Standing, 2004). The supply side barriers that arise for women of low socio-economic groups are rooted in problems related to inadequate supplies and unmotivated or unskilled health workers (Ekirapa-Kiracho et al. 2011). Supply side approaches often allocate resources to suppliers so that they can provide services based on the cost of inputs or train the health personnel in these facilities. The health seeking process of patients has been frequently left out and interventions that addressed patients were often limited to information, education, and communication campaigns.

Supply side strategies focus on the state as service deliverer as it has the responsibility to ensure health care to its citizens (Berry et al, 2004). The state is appointed the role to finance, provide, regulate and monitor the delivery of health services so that the services are accessible for all. The role of the state as service deliverer is also supported by the 2004 WDR that states that the state must guarantee the provision of pro-poor services. Here a possible framework is proposed in which the relationships of accountability between the policy maker, the provider and the citizen are being examined. This approach is however criticized for being too narrowly

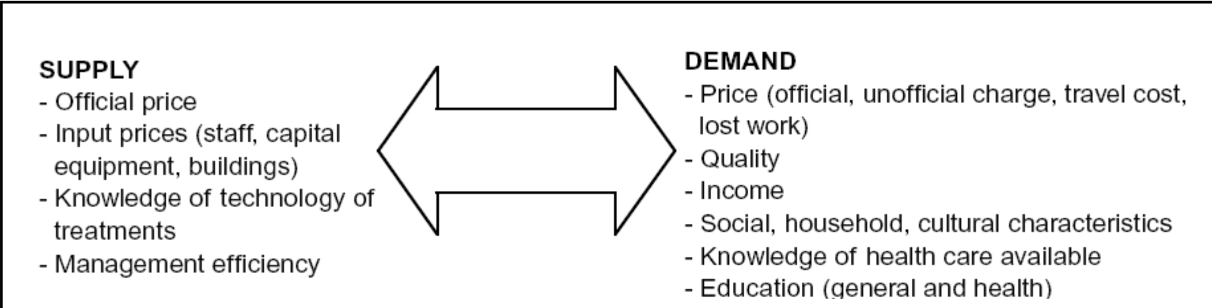
focused on the role that accountability has in improving the responsiveness of frontline providers (Berry et al, 2004). The report also addresses a challenge for the supply side approaches as states in developing countries are often unable or unwilling to commit to its responsibility. Problems like weak relationships between the policy maker, the provider and the citizens and weak state mechanisms are often to be found problematic. Supply side that strategies focus on these challenges include strengthen of pro-poor policy making functions, the building of provider capacity and the reduction of the barriers that the poor face and the increase of their participation (Berry et al, 2004).

1.4.2 The demand side approach

The demand side refers to the behavior and inputs of the recipients of health care (Standing, 2004). As supply side health reforms only had a limited success, attention shifted from the factors that hinder service uptake to the factors that influence the ability to utilize health care. Research suggests that removing demand side barriers may be just as important as supply factors in developing inclusive service delivery and hence improve maternal health. The demand side approach also developed due to the economic and institutional crisis and transformations of national health sectors such as marketisation and diversity in providers, the collapse of some public sector services, and governance and regulatory failures. Demand side approaches focus on the health seeking process in order to get a deeper understanding how individuals in the context of social groups and communities seek access to health care and on changing and improving the responsiveness of the supply side.

The Grossman model explains that demand is influenced by factors that decide whether a person recognizes an illness and its willingness and ability to look for appropriate health care (Ensor & Cooper, 2004). The quality of the health care in this model is determined by the person as well as the community. The community can influence a person's preferences through cultural, religious and other social factors. The price of the medical care and the availability of resources are also taken into account in this model. Figure 1.1 gives an overview of some of the differences between the barriers that are being ascribed to the demand and supply side. In the following sub chapter a more elaborate overview of these factors will be presented.

Figure 1.1: Barriers supply and demand side. Source: Ensor & Cooper, 2004



It is argued that one can try to improve health service delivery by either changing or assisting the health seeking behavior or, by addressing the change that is needed in the supply side. This has led to two views on what empowerment should be based on; an approach based human rights and social justice ideologies and an approach that is based on a consumer voice and choice ideology. These ideological differences have let to the development of six main approaches within the demand side approach.

According to Standing (2004) these approaches can be divided in the following groups:

- Behavioral change
- Rights-based approaches
- Improving accountability through the demand side
- Participatory approaches
- Multisectoral/multiple stakeholder approaches
- Demand side financing

Changing user behavior to improve health outcomes has been approach that has been used in diverse interventions. Well known is the Behavioral Model by Andersen from 1968 that was developed to understand why families use health services; to define and measure equitable access to health care and to assist in developing policies to promote equitable access (Andersen, 1995). The underlying thought of these approaches within the demand side approach is that factors influence the behavior of people when seeking medical help and that education influences people to make healthier lifestyle decisions. Also the believe that the behavior of the individual and his surroundings are vital for health improvements and that some health use improvements can only derive from changes in behavior (Standing 2004). Currently, the behavioral demand side approach focuses on the manner in which messages are communicated. Terms like 'information, education and communication', and 'behavior change and communication' are often used.

In the Rights Based Approaches from the demand side perspective, the discourse of rights stemming from empowerment and struggle from the grass roots level is equally important as the macro level view on rights that view these in the perspective of constitutions or international law. Grass root demand side elements in this approach in the health sector include the women's health movement, rights advocacy that focus on access. In this approach health is presented as a social justice issue that claims equal consideration and treatment on the basis of need.

Accountability is a topic that is currently very high on the development agenda. In the health sector, civil society and intermediate organizations have been ascribed the role to provide pressure on the poor governance by providing alternative accountability structures. The improvement of accountability through the demand side is according to the 2004 WDR possible through the strengthening 'client power'. An example of such an approach is for instance making the income of health service providers more dependent on the demand from poor clients. The concepts of 'voice' (demand) and 'responsiveness' (supply) are seen as a fit way to operationalize accountability in health service delivery.

As people are to a certain degree responsible for their health and that of those around them, they can have a participating role in the improvement of health care. As greater participation is frequently linked to the improvement of accountability there is an important role for (future) health recipients. Although the level of involvement may vary in different types of strategies, individuals and communities can participate in the struggle to improve health systems by for instance being involved in priority and standard setting, the mobilization of resources and the monitoring of services and providers.

Due to the wide context in which improvement of health care for the poor must be realized, the multisectoral/multiple stakeholder approach is used. The creation of institutional arrangements and the emergence of diverse partnerships between diverse stakeholders are

important components of this approach. Also in this approach the emphasis on governance and accountability are important issues.

Demand side financing has been defined as *'A means of transferring purchasing power to specified groups for the purchase of defined goods or services'* (UNDP, 2006, p.19). This approach is well known for the use of conditional cash transfers and voucher schemes to potentially increase the demand for health services by those that make part of low socio-economic groups in developing countries. Demand financing brings different strategies together as it aims to change the provider behavior by promoting competition and choice and links demand to supply by targeting certain resources to disadvantaged groups. In addition it attempts to change demand side behavior by improve the tendency to utilize social sector goods by allocated transfers (Standing 2004).

1.5 Barriers to the accessibility of health care

As mentioned in the previous subchapter, there are diverse barriers that stand between the need to use health care and the actual utilization of this service. In this paragraph an overview of supply as well as demand side barriers will be presented that according to diverse empirical studies have an influence the accessibility of health care and that are of importance in the light of the present study.

1.5.1 The five dimensions of Accessibility

Accessibility can be of two main types; physical and socio-economic (Joseph & Phillips, 1984,). Socio-economic access itself is influenced by several variables that influence the utilization of a service. The socio-economic variables of influence are often; age, sex, mobility, income, knowledge and education level, social status and gender. Factors that influence the access to health care often translated into utilization rates. The degree of utilization of health services can be used to reveal the accessibility of a service, as the presence of a service does not guarantee the use. The level of use in relation to the need, can be used to measure the degree of accessibility. In this approach access can be considered in terms of whether or not those who need care can obtain it.

When researching these barriers a framework can be used that selects five dimensions that encompass most of the barriers that patients come across namely; Availability, Accessibility, Affordability, Adequacy and Acceptability (Penchansky & Thomas, 1981). In this approach access can be seen as the degree of "fit" between the patients and the system. Table 1.1 presents the definitions of these concepts according to Obrist et. al (2007).

Table 1.1: Five accessibility dimensions. Source: Obrist et. al. 2007

Dimension	Definition
Availability	The existing health services and goods meet clients' needs.
Accessibility	The location of supply is in line with the location of clients.
Affordability	The prices of services fit the clients' income and ability to pay.
Adequacy	The organization of health care meets the clients' expectations.
Acceptability	The characteristics of providers match with those of the clients.

All five dimensions encompass multiple factors that have the potential to act as accessibility barriers. The dimension "Availability" addresses the type and number of existing services in relation to the number of patients and their type of need, in this case the need for maternal health care. It also encompasses the supply of health personnel and the availability of medical supplies and the degree that the offered products and services correspond with the needs of the patients (Penchansky & Thomas, 1981). Studies have shown that the availability of resources a sufficient amount of human resources, resources such as beds, medicines and donated blood and referral mechanisms are often insufficient (Hulton et. al. 2007).

"Accessibility" addresses the relationship between the location of the care distributers and the location of the clients. Topics like transportation options and the travel time for patients also fall under this dimension. Studies have shown that the distance that women have to cover in order to reach health services can act as strong accessibility barriers (Ekirapa-Kiracho et. al, 2011, Obrist et. al, 2007)

"Affordability" refers to the ability of patients to pay for the utilized health services, including the indirect additional costs (Bloom, 2001, Jacobs et. al, 2011). Included in these additional costs should be the transport costs and the time that utilizing care takes. Several studies have shown that the location and transport costs often seem to impact utilization negatively as these costs often make up for 25% of the total utilization costs (Ensor & Cooper 2004). Studies in several countries such as Vietnam and Ghana have shown that this negative relation also exists with respect to the time that patients have to spend on accessing and utilizing care. In addition informal costs, e.g. bribes, paid to health care staff or for commodities should also be taken into account as these costs have proofed to form barriers as well.

"Adequacy" addresses the manner in which the clients' expectations with regard to the facility are being met. Factors that fall under this dimension are for instance the opening hours and the maintenance status of the facility. The women's impressions of the state of the facility, for instance the beds, sheets and toilets influences the experiences women with utilizing care have (Hulton et. al. 2007). If these experiences are negative they can be perceived as barriers for further utilization behavior.

"Acceptability" refers to the level in which the characteristics of health facilities take local and social values in count. This dimension addresses the relationship between the clients' attitudes about personal and practice features of the medical providers and vice versa (Penchansky & Thomas, 1981). Whereas the first three accessibility dimensions of this framework refer to the provision of services by the health care system, the remaining two dimensions stand for the intrinsic quality of the health care from the point of view of the client (Gijsbers et al. 1994). Important factors for this dimension are for example patients receiving information on what the medical treatment encompasses and that questions are answered in an adequately and understandable manner. Studies have shown that women often do not receive any explanation to what was happening during their pregnancy and childbirth and that they often do not receive necessary health messages while being pregnant (Hulton et. al. 2007). The acceptability can also relate to the interpersonal skills of the health personnel (Jacobs et. al, 2011). About a quarter of women with low socioeconomic statuses that utilize maternal health care in a facility in a developing country have negative experiences with the health personnel, especially when receiving care from nurses or midwifes. These negative experiences range from being neglected and treated in an unequal manner to being disrespected by being verbally or physically abused. Research has for instance shown that in multiple countries women are shouted at or slapped during childbirth (Hulton et. al. 2007).

The acceptability of services also relates to the acceptance of health care utilization by the women's social relationships e.g. the community and household. Complex social, economic and cultural factors are often barriers to access and utilization of health care by women (Ojanuga & Gilbert, 1992). Cultural patterns and social factors can influence the accessibility of health care as for instance a study has shown that access to care for women in India is impeded due to the prevailing bias for boys exists with respect to the utilization of health care (Ensor & Cooper, 2004). Also the degree in which women are dependent on their husband's decision whether or not they can seek help and the influence that community's have on the decision making process can be seen as acceptability barriers (Stephenson & Tsui, 2002, Devadesan et. al. 2011, Ensor & Cooper, 2004). The above mentioned dimensions are likely to have a stronger impact on the accessibility of health care by poor and other vulnerable groups in comparison to those that have a higher socioeconomic as the costs of access, lack of information and cultural barriers often hinder the poor from benefiting from public spending (Ensor & Cooper, 2004).

Factors related to the individual circumstances that have found to have an influence on the access to health and that are relevant for the present study can be brought down to the education level of a patient, the level of autonomy that women enjoy, the household situation of women and earlier experiences that clients have with utilizing health care.

Research has shown that education has a positive correlation with good health (Ensor & Cooper 2004). Understanding the need of good health practices, knowledge about the characteristics of, and need for, medical treatment has a positive influence on especially the health status of women. A correlation can be seen between the education level of women and their maternal health care use.

Autonomy has been defined as the "*capacity to manipulate one's personal environment through the control over resources and information in order to make decisions about one's own concerns or about close family members"* (Bloom et. al, 2001, p. 68). The level of autonomy that a woman has can be determined by looking at her control over finances, decision making power and freedom of movement. Research has shown that the relationship that a woman has with her natal family and mother in law often has an influence on her overall autonomy and access to health care (Sai and Raine, 2007, Bloom et. al, 2001). When women earn their own income and have a say in the spending of the household income this also increases her autonomy when wanting to seek health care as powerlessness often contributes to poor health outcomes and inaccessibility of health care services (Ojanuga and Gilbert, 1992).

The accessibility of health care also interlinks with the previous experiences women have had with accessing and utilizing care. As earlier mentioned can supply side problems such as shortage in supply and unskilled staff can cause a client to have a negative experience when utilizing care and can an mixture of supply and demand side barriers have a negative influence on the accessibility of health care. The experiences that a client has had with previously utilized services can also act as a barrier for future use. When a client has had negative experiences in a health care facility it can result in the client not returning for further care. In addition, it can also influencing other client's health seeking behaviour and lead them to make the decision to not use the services as well (Cooper & Ensor, 2004). The quality of the clients experience is therefore essential in creating long term high utilization rates of reproductive health care services. Table 1.2. presents an overview of all the supply and demand side barriers that fall under the five A's, according to the existing literature.

Table 1.2: Supply and demand side barriers to the accessibility and utilization of health care

Dimension	***Possible supply (s) and demand (d) Barriers***	***Supporting Literature***
Availability	Unqualified health workers, absent staff (s) Motivation of staff (s) Drugs and other supplies(s) Lack of opportunity (exclusion from services)(s) Late or no referral (s)	Obrist et. al, 2007, Jacobs et. al, 2011, Hulton et. al. 2007, Paul et. al, 2011, Ekirapa-Kiracho et. al, 2011, Gijsbers van Wijk 1996
Accessibility	Waiting time (s) Available transportation (s)	Obrist et. al, 2007, Ensor & Cooper, 2004, Jacobs et. al, 2011, Ekirapa-Kiracho et. al, 2011, Gijsbers van Wijk 1996
Affordability	Costs and prices of services (s) Household resources and willingness to pay (d) Transport costs (s) Lost in possible derived income (d) Bribes by health personnel (s) Availability of compensation schemes (s)	Obrist et. al, 2007, Ojanuga & Gilbert, 1992, Jacobs et al, 2011, Paul et al, 2011, Ekirapa-Kiracho et. al, 2011, Gijsbers van Wijk 1996
Adequacy	State of the facility (s) Opening hours (s)	Obrist et. al, 2007, Hulton et. al. 2007, Jacobs et al, 2011, Gijsbers van Wijk 1996
Acceptability	Staff interpersonal skills, including trust, respect and dignity (s) Households' expectations (d) Community and cultural preferences (d) Stigma (d) Knowing prices beforehand (s) Stories of other clients (d) Earlier experiences with utilization health care (d)	Obrist et. al, 2007, Ensor & Cooper, 2004, Ojanuga & Gilbert, 1992, Stephenson and Tsui, 2002, Jacobs et al, 2011, Gijsbers van Wijk 1996
Personal characteristics	Autonomy (d) Gender role in society (d) Socio-economic status (d) General education level (d) Aware of the importance of health care (d) Information on health care services/providers /compensations(d)	Obrist et. al, 2007, Ensor & Cooper, 2004, Ojanuga & Gilbert, 1992, Jacobs et al, 2011, Govindasamy & Ramesh, 1997 George, 2003, Ekirapa-Kiracho et. al, 2011, Joseph & Phillips, 1984, Bloom et, al, 2001, Stephenson and Tsui, 2002, Gijsbers van Wijk 1996

1.6 Conclusion

Access to health care is an entitlement that is unfortunately not a matter of course for many people, and particular women. Poor women tend to under-utilize health services and when wanting to reduce the number of women that die during pregnancy, childbirth or after delivery, complex problems come to play. Health care should be available, accessible, affordable, appropriate, and acceptable. In order to improve health outcomes in developing countries a holistic approach is of key importance and the use of only on strategy is not enough. Various barriers, ranging from the location where care is available to the level of autonomy a women has, can be distinguished that prevent women from accessing maternal health care. Therefore, it is of key importance that approaches address supply as well as demand side barriers as these barriers are not always mutually exclusive and tend to interact. In addition approaches should be gender sensitive.

The following chapter will build on this first chapter by presenting the regional and thematic context of the present study. An overview will be given of the status of maternal health care in India and how contextual factors such as culture influences on maternal health care and government interventions influence the accessibility of maternal care

Chapter 2 | Contextual Framework

2.1 Introduction

This chapter aims to give an overview of the thematic and regional context in which the present study has taken place and consists out of three main sections in which the national, regional and local thematic context will be presents. The first paragraph of this chapter will provide information on maternal health and maternal mortality in general, and on the challenges that developing countries face when wanting to improve maternal health. In the second paragraph information will be given about India, the country in which the present study has taken place. Attention will be paid to geographical, demographic and cultural factors. Attention will also be paid on the Indian health care system. In the last paragraphs of this chapter the regional context will be discussed. In this section attention will be paid to the state Uttar Pradesh and its capital city Lucknow, where the present study has taken place. In these paragraphs more specified information will be given in order to give the reader a better understanding of the regional context in which the present study has taken place. This chapter will finish with a conclusion in which the following chapter will be introduced.

2.2 Maternal health a worldwide challenge

Pregnancy and childbearing have brought risks for women throughout history. Maternal mortality is seen as a key indicator of women's health and status and shows differences between socio-economic classes. This sub chapter describes the international status of maternal health and mortality and explains what maternal health care encompasses according to international guidelines.

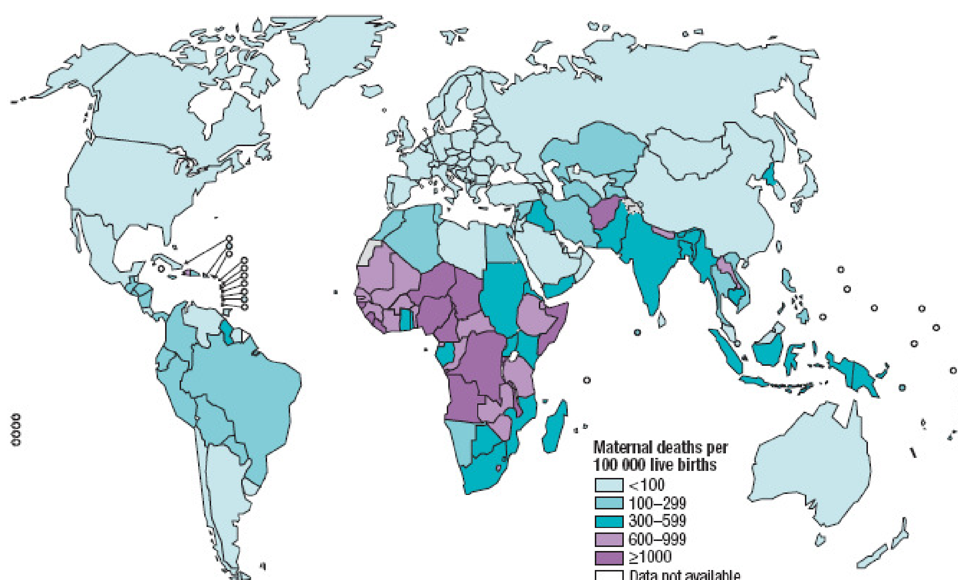
2.2.1 Maternal health and maternal mortality

Maternal health can be defined as the health of women during pregnancy, childbirth and the postpartum period (WHO, 2012c). Maternal Mortality refers to the death of women during pregnancy, childbirth, or in the 42 days after delivery (AbouZahr & Wardlaw 2001). The World Health Organization (WHO) states that the major death causes for these maternal deaths are caused by hemorrhage, infection, high blood pressure, unsafe abortion, and obstructed labor (WHO, 2012c). Annually 358000 women die in pregnancy and labor from preventable causes due to the lack of access to services (WHOb, 2012h). The majority of these deaths occur in the first 24 hours after delivery (Potter et. all. 2008). In addition to maternal mortality it is estimated that yearly 9.5 million women suffer from pregnancy related illnesses such as injuries and infections and disabilities. 1.4 Million Women suffer from the consequences of the life threatening complications that they endured (Filippi et all. 2006). Figure 2.1 gives an overview of countries and their maternal mortality ratios.

Maternal health facts

- 99% of all maternal deaths occur in developing countries.
- Maternal mortality is higher amongst women living in rural areas and poorer communities.
- Skilled care before, during and after childbirth can save the lives of women and

Figure 2.1: Maternal mortality ratios for the year 2005. Source: WHO, 2009



The lack of access to skilled routine and emergency care plays a big role in the amount of women that die during or after their pregnancy. As maternal mortality clusters around delivery, the access to skilled attendants during and after birth and a timely referral for emergency care is vital (Filippi et al. 2006). As women in developing countries are increasingly seeking care during childbirth, it is also essential that the quality of the care provided is optimal.

When looking at maternal mortality trends positive signs in the decrease of maternal mortality can be noticed. Between 1990 and 2010 the maternal mortality worldwide declined by 47% (WHO, 2012g). Some countries located in sub-Saharan Africa have halved the number of maternal mortality and other regions have been even more successful as their mortality rates dropped even lower. Yet, not enough progress has been made as many disparities in maternal health statuses of women can be found. In developing countries a maternal mortality rate of 240 per 100 000 births can be noticed versus 16 per 100 000 in developed countries. Of the 287 000 maternal deaths in 2010 almost all of these took place in low resource settings. In the latter only 46% of the women benefit from skilled care during childbirth and over a third of the pregnant women utilize the recommended four antenatal care check-ups (WHO, 2012b).

The inequities in access to health services often highlight the gap between rich and poor. In developing countries the risk of a woman dying during or after pregnancy is very high, namely 1 in 31. In comparison with the western world a big contrast can be noticed as woman's life time risk in these countries is 1 in 4300. However, also large differences between the different developing countries and differences within the countries themselves can be notices as disparities between income groups and rural and urban areas often occur. As these complex differences and high maternal mortality rates continue to exist, maternal mortality remains a major challenge to health systems worldwide.

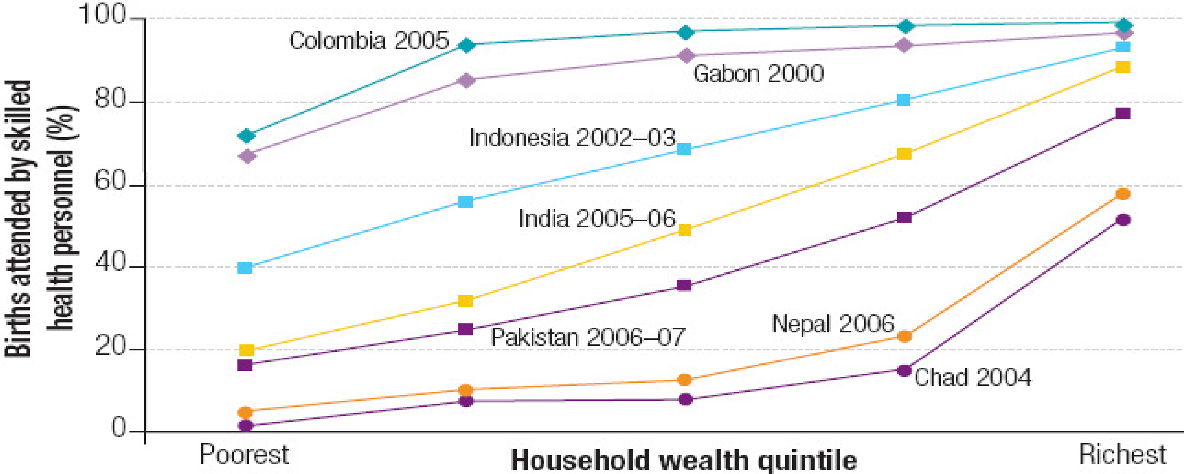
2.2.2 Maternal health care services

Maternal health care encompasses various checkups. In order to get a general understanding of these procedures the three main components that maternal care consists of, antenatal care, delivery care and postnatal care, will be discussed in this paragraph.

Antenatal care (ANC), also known as pre-natal care, consists out of health checkups aiming to reduce health risks for the mother and child during and after the pregnancy. As many women in developing countries have nutritional deficiencies, it is estimated that almost half of all pregnant women worldwide have anemia, meaning that the health risks for mother and child are high. The WHO recommends a minimum of four ante-natal visits for pregnant women in order to receive a tetanus toxoid vaccination, screening and treatment for infections and for identification of warning signs during the pregnancy (WHO, 2012d). The importance of antenatal care lies in the possibility to assess risks as well as to detect and treat conditions, hence preventing potential lethal complications. In the years 2005-2010 53% of pregnant women in the world utilized the recommended minimum four times antenatal care. When looking at the utilization rates of antenatal care in developing countries a positive trend can be noticed. In developing countries the utilization of at least one antenatal checkup rose from 64% in 1990 to 81% in 2009. However, only 36% of these women received four of more times antenatal care during 2005-2010. Research suggests that there has been little improvement over the last year. Furthermore, the quality of the care that has been provided is questionable.

Care during childbirth ensures that obstetric emergencies are effectively managed. As mentioned in the first paragraph, most maternal deaths occur during or shortly after giving birth. These deaths could almost all be prevented if women would be assisted by a health care worker. However, recognition of complications by women and their surroundings and the availability of health workers with required skills, equipment and medicines are pre-conditions when wanting to prevent maternal deaths. Figure 2.2 gives an overview of births that have been attended by skilled health personnel in 7 countries, showing that women part of the poorest households still often give birth without the assistance of skilled health personnel.

Figure 2.2: Births attended by skilled health personnel. Source: WHO, 2009



Postnatal care (PNC) is vital for detecting and treating infections and other conditions that mother or child can suffer right after the delivery. In addition, PNC can play a role in educating women and their families of detecting danger signs and care seeking behavior. The number of postnatal check-ups that should women should receive is under debate as there is no consensus on the final number that should be utilized. However, it is generally suggested that mother and child should make three or four postnatal visits. If the childbirth has taken place in a health facility it is strongly recommend that they are assessed within one hour after childbirth and before discharge (WHO, 2012e). Follow up contacts are recommended in the following time span: two to three days, six or seven days and six weeks after giving birth. Especially the post-

natal checkups in the first week after birth are vital as the majority of maternal and newborn deaths occur in this first week, especially on the first day (WHOd, 2012).

2.3 National Context

This paragraph describes the geographical location of the present study, the demographics of India's population and the country's socioeconomic development. In addition it aims to give an understanding of aspects of the Indian culture that are relevant to the present study.

2.3.1 Geographical location

The Republic of India is located in Southern Asia, bordering China, Nepal and Bhutan to the north-east, Burma and Bangladesh to the east and Pakistan to the west. The south of India is bounded by the Indian Ocean on the south, the Arabian Sea on the south-west, and the Bay of Bengal on the south-east. The Andaman and Nicobar Islands share their maritime borders with Burma, Thailand and Indonesia. This geographical location is shown in figure 2.3.

Figure 2.3: Political map India Source: Oxford reference (2012)

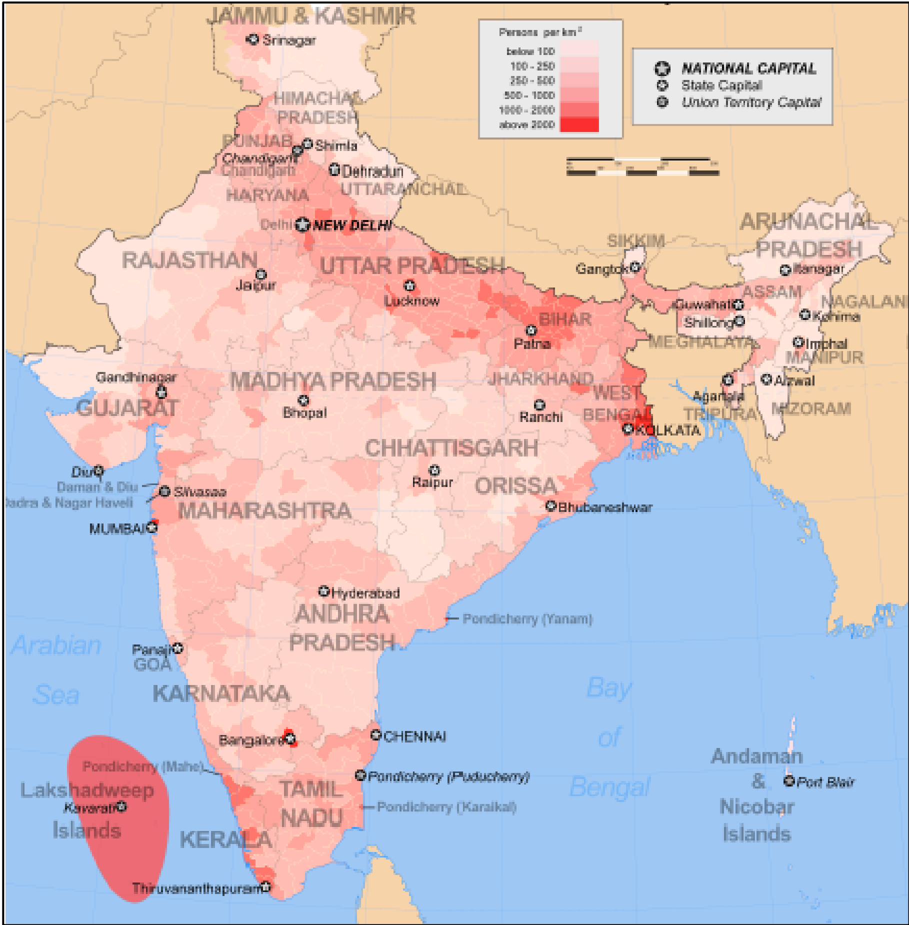
In India, three main geological regions can be distinguished namely the Indo-Gangetic Plain, the Himalayas and the Peninsula. The latter is known as "South India" and the first two regions are often referred to as "North India". The country's lowest elevation is zero meters at the Indian Ocean. The highest point can be found in the Himalayas at Kanchenjunga. With 8,598 meters this is the third highest mountain in the world. Due to the large area that the country covers, diverse physiological regions such as highlands, plains, deserts, and river valleys are present. The exact size of India is subject to debate as some borders are contested. The UN lists the total area as

3,287,263 square kilometers and total land area as 2,973,190 square kilometers. Making India the seventh largest country in the world.

2.3.2 Demographics

India consists out of 28 states and 7 union territories. India's population is the world world's second-most populous country. Due to its high growth rate, India has a fertility rate of 2.5, it is expected to be the world's most populous nation in 2025 (UNFPA, 2011). India had a population of 1.24 billion people in 2011, meaning that the country consists out of more than a sixth of the world population (UNFPA, 2011). Figure 2.4 presents the population spread across the country, highlighting the high density in the north.

Figure 2.3: Population density in India Source: CIA World Factbook (2012)



As in many developing countries, an urbanization trend can be noticed in India as many migrate from rural areas to the urban areas. As the urban population in the beginning of the 1950's consisted out of 60 million people (17% of the population), last year's urban population consisted out of 31% of the total population. The annual urbanization rate from 2010 to 2015 is an estimated 2.4%. It is expected that by 2025, 42.5 percent of the population will be urban. The biggest city in India is the capital New Delhi which inhabits 21.72 million people (CIA, 2012). Other major Indian cities are Mumbai (19.695 million residents), Kolkata (15.294 million) and Chennai (7.416 million). In these cities housing is a major problem, and has lead to very large slum populations. Problems like unemployment, underemployment and shortages of basic facilities such as clean drinking water, sewerage and electricity are no exceptions in these

communities. According to the 2001 Census the total slum population in urban India was 42.6 million, 15% of the total urban population (govt. India, 2008).

2.3.3 Ethnicity, language, religion and caste

India is not only known for its geographical and physical diversity but also for its cultural diversity. This high level of diversity is reflected in the various religions and languages that are present in this country. The following paragraph will give an overview of the ethnical, linguistic and religious context that are the foundation of this diversity. Special attention will be paid to the caste system and the implications for those that are being marginalized due to this system.

Within the Indian society ethnic groups like the Indo-Aryan (72%), Dravidian (25%) and Mongaloid and other (3%) can be distinguished (World Factbook, 2012). Modern anthropologists classify Indians based on their ethnic origin as well as linguistic lineages in the following four types: Caucasoid, Mongoloid, Australoid and Negrito (IGVdb, 2005). The first two populations are mostly found in the northern and eastern parts of India, the Australoids are largely confined to central, western and southern India. The ''Negritos'' are only found in the Andaman Islands. The different groups also have different linguistic backgrounds as they belong to four major language families: Indo-European, Dravidian, Tibeto-Burman and Austro-Asiatic. The exception are the Andaman Islands where a linguistic isolated language developed known as Great Andamanese, that is not related to any known language.

The number of languages that are spoken in India is under debate as various counting methods are used and many Indians are bilingual. According to the 2001 census there are 114 languages in India of which 22 are spoken by one million or more persons. In addition there are 1,600 dialects (Census, 2001). The most spoken language in India is the official language Hindi which is spoken by 41% of India's population. English is the subsidiary official language next to Hindi and is mostly used for national, political and commercial communication. Other languages that are spoken by many in India are Bengali (8.1%), Telugu (7.2%), Marathi (7%), Tamil (5.9%), Urdu (5%), Gujarati (4.5%), Kannada (3.7%), Malayalam (3.2%), Oriya (3.2%), Punjabi (2.8%), Assamese (1.3%), Maithili (1.2%) and other languages (5.9%).

India counts various religious movements, with Hinduism being the most wide spread religion. 80.5% Of the Indian population is Hindu (World Factbook, 2012). Other religions that can be recognized are the Islam (13.4 %,) Christianity (2.3%) and Sikhism (1.9%). The northern states that border Pakistan and Bangladesh and the southern state Kerala and Lakshadweep islands have a higher percentage of Islam followers. In general, Christianity has flourished in the more southern and eastern states.

The Indian society consists out of diverse groups based on ethnicity, language, religion, tribal group and caste. However, the Indian government does not recognize racial or ethnic groups within India but listed many of the tribal groups as Scheduled Castes and Tribes in "The Constitution (Scheduled Tribes) Order" (Census, 2001c). The Hindu caste system is nowadays illegal but is still widely practiced across India. The caste system consists out of four major castes called Varnas: Brahmins, Kshatriyas and Shudras. These Varnas are subdivided in hundreds of subcategories called "jatis" (Gifford & Zezulka-Mailloux, 2003). The Hindu caste system causes vertical hierarchism trough the Indian society under which scheduled casts have suffered for years. The scheduled casts call themselves Dalit, which means broken, and are deprived of many Human Rights under this system. The right of health is amongst these deprivations. The casteless Dalits, also referred to as untouchables or outcast, are on the bottom of the social latter and are often discriminated against by members of higher castes. Dalits are in charge of performing work that in India us seen as humiliating such as, the cleaning of drains,

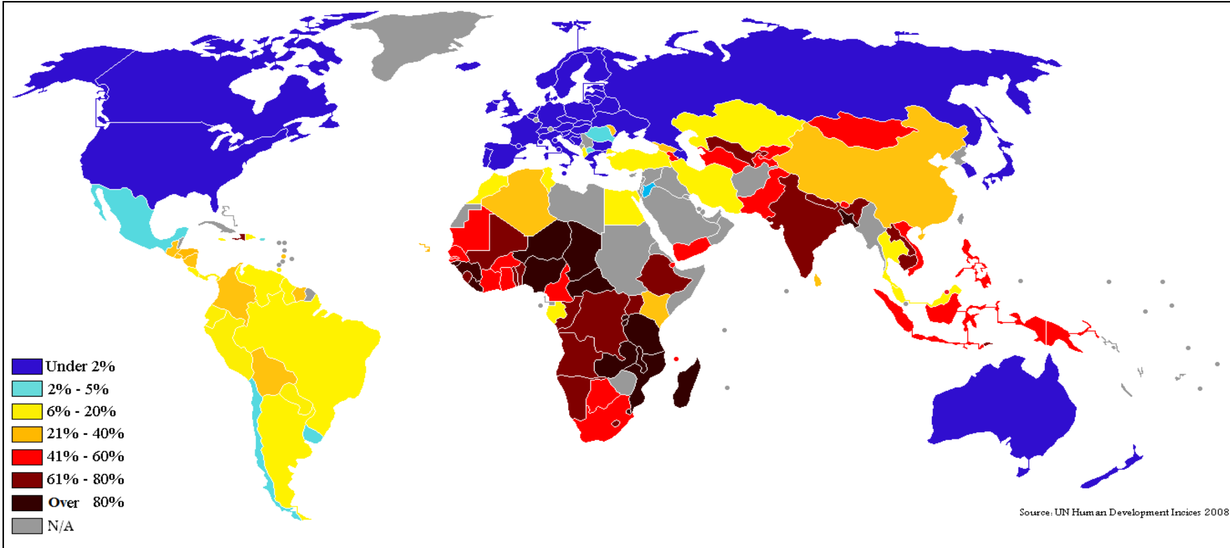
gutters and toilets and the disposal of dead carcasses and bodies. Dalits make up for about 16% of the total Indian population and have due to the social stratification the lowest socio-economic status in India.

2.3.4. Socio-economic development

The transition from a closed to an open market economy during the early 1990's accelerated India's growth rate with 7% since 1997. India's integration to the global economy made India a newly industrialized country and a major global player as it has the fourth largest economy in purchasing power parity (PPP) terms (World Bank, 2012). Although more than half of India works in agriculture, services are the major source of economic growth as it accounts for more than India's output with only one third of country's the labor force. The educated English speaking Indians have become major exporters of information technology and software. Since 2011 India's economic growth has slowed down due to a high inflation and interest rates and the lacking progress of economic reforms. These reforms have largely suffered due to corruption scandals that had a negative impact on legislative work. Scientists have been skeptical about India's recovery due to the high level of poverty, and therefore high level of youth that has a weakened health and that are uneducated (UNFPA, 2011). Indian government officials have expressed confidence in the economy and the roll that the youth will play in the future. Yet, the World Bank (2012) expects the slowdown in GDP to carry on as it believes that the weakness in investment, tighter macroeconomic policies, slow growth in the core OECD countries and the possible next global recession will take its toll on India's economic development.

Due to the increased development India was ranked place 134 of a total of 179 countries in the 2011 Human Development Index, indicating that it has a medium human development (HDR, 2011). Yet, this positive signal does not reflect on all of India's citizens. Although diverse indicators show progress and development, Dalits and especially women do not share in the success. Although India's middle class has been growing, the high poverty rates remain the biggest challenge in India's quest for development. Even though the poverty has been declining, the country still faces very high poverty levels that account for an estimated one third of the world's poor. According to the World Bank (2012) 68.7% of the Indian population lived in 2010 at US$ 2 a day (PPP) and 32.7% falls below the international poverty line of US$ 1.25 per day. Figure 2.4 presents a world map based on the percentage of the population that lives on less than 2 dollar a day in the years 2000-2007.

Figure 2.4: Percentage population living on less than US$ 2 a day. Source: file HDR 2007/2008



According to the Indian government did the percentage that lived below the poverty line declined by 7.3% from 37.2% in 2004-05 to 29.8% in 2009-10 (Govt. 2012b). It is also stated that rural poverty declined in 2010 by 8% to 33.8% and that urban poverty declined by 4.8% to a total of 20.9%. Yet, this development is unequal as the poverty rates among Dalit communities, schedule castes and schedule tribes are still higher than those among other groups (SIDA, 2001). Those that are the poorest in rural areas are those that are the lowest on the social latter namely the Scheduled Tribes (47.7%), Scheduled Castes (42.3%) and the Other Backward Castes (OBC) (31.9%). Of other classes 33.8% experiences poverty. In urban areas these marginalized groups also make part of the poorest as 34.1% Scheduled Castes experience the highest level of poverty followed by Scheduled Tribes (30.4%) and OBC's (24.3) against 20.9% for all higher classes. In rural areas nearly 50% of the agricultural laborers are below the poverty line in rural areas. In urban areas this type of poverty is high (47.1%) amongst casual laborers. A low education level (primary level and lower) of the head of the household is also translated in high poverty rates in both rural and urban areas. In order to improve the country's development, the government is investing in initiatives the will bring basis services such as education, health care, health insurance and infrastructure to the poor (World Bank, 2012).

2.3.5 Status of women

Women in India generally have a low status and a gender bias towards men influences their development in a negative way. In order to understand gender in India diverse factors such as increasing economic inequities, the feminization of poverty and the changing role of the Indian state within a liberal economy come to play (SIDA, 2001). In addition changing notions of caste, religion, and social traditions influence the role that gender has on the lives of women living in present India. The low position that women have in the current Indian society and the inequalities that they face hampers their development in various ways. The appointed gender role causes women to have for instance lower gross enrolment ratios and lower health statuses and, causes them to be less economically productive, politically involved and pressured to marry from a very young age. Women are particularly affected by religion as it often lays restrictions on their public and private roles. The development of women and their status is also undermined due to violence that is committed against women. Violent crimes, such as rape and sexual assault, and domestic violence, such as spousal abuse and dowry deaths, have an effect women's general and mental health, economic productivity, self-esteem and the welfare and nutrition of her children. India is ranked at 129 in the 2011 HDI with a value of 0.617, placing it at number 134 in the world rank out of a total of 187 countries with data (HDR, 2011).

The gender bias towards men is also reflected in the Indian sex ratio. The sex ratio in India, which presents the proportion of women compared to the proportion of men in the country, was 940 females per 1000 males (Census, 2001). The 2011 Census indicated that the sex ratio for children was 914 females for 1000 males, indicating that the gap is increasing. The cultural view that male children are preferred over female children is an important reason that this ratio is unbalanced in favor of men (Patel, 2002). The under-five mortality rates and malnutrition are higher for girls than for boys, which is often explained by a bias towards sons in regard to early childhood care. In addition, India has witnessed a trend in female foeticide and sex selective abortion as the estimates of number of selective abortions of girls rose from 0 - 2 million in the 1980s, to 1.2 -4.1 million in the 1990s, to 3.1- 6 million in the last decade (Jha et. al, 2011). Low infant and adult sex ratios are widely seen to be indicators of the miserable situation of women in India (SIDA, 2001). Figure 2.5 gives an overview of the Indian sex ratio in 2001 indicating, that the states Punjab and Haryana show the largest male/female disparities.

The higher disparities in northern states can explained by the stronger gender bias that is often prevailing in Northern Aryan kinships.

Figure 2.5: Indian sex ratio 2001. Source: SIDA, 2001

Studies have shown that there is no significant association between the caste of Indian women and the extent of female disadvantage in child survival. Many observers have attributed this contrast to the relatively egalitarian character of gender (Murthi et. al. 1995). However, there is a correlation between the sex ratio and maternal mortality rates. The explanation for this correlation is often brought back to cultural explanations, discrimination in nutrition and differential access to health care whilst the government health expenditure is low.

In the Indian constitution gender equality is ensured as a fundamental right which also empowers the state to adopt measures of positive discrimination in favor of women by ways of legislation and policies (Patel, 2002). The development of various conventions on equal rights of women, policies, laws and acts such as the Pre-natal Diagnostic Tech Act in 1994 have been also been introduced to remove gender discrimination. Yet, persistent gender inequalities, violence against women, poverty and restricted access to resources for women show that achieving gender equality in India continues to be a major challenge.

2.4 The Indian health care system

The following paragraph gives an overview of maternal health in India and presents the health care system of India. When discussing the health care system attention will be paid to the overall public health structure and the three stakeholders that can be recognized in the India health system namely the Indian Government, the Private sector and NGO's. Next, the accessibility and

Utilization of maternal health care will be discussed to provide an understanding of the maternal health care use in India.

2.4.1 Maternal health in India

India has very high maternal mortality ratio in comparison to other countries as approximately 20% of all maternal deaths in the world take place in India (Richard et.al. 2002). Within the country a wide range of maternal mortality rates can be seen, with especially poor and marginalized women suffering from rates far higher than the national average. In the last 30 years a positive trend can be recognized as India's maternal mortality ratio substantially declined from 677 maternal deaths for every 100,000 live births in 1980 to 254 in 2008 (CRR, 2011). Over the MDG period a decline in the MMR can be witnessed of 4% (Hogan, 2010). The increase of skilled birth attendance has been a major contributor to this development. Yet, still more women die in childbirth in India today then European countries witnessed over a hundred years ago due to reasons that can easily be prevented. Table 2.1 presents the Indian MMR since 1980.

Table 2.1. Indian MMR 1990-2008 per 100,000 live births. Source: Hogan, 2010

Year	MMR mean	MMR minimum	MMR maximum
1980	677	408	1080
1990	523	310	835
2000	318	190	506
2008	254	15	395

2.4.2 The Indian health care system

In the Indian health sector diverse institutions are present, ranging from government services to private health care facilities and NGO's. In the following paragraph these three stakeholders will be discussed.

The national expenditure on health by the Indian government shows a positive trend. The government has been criticized by different scholars with respect to its national expenditure as it percentage of GDP spend on health used to be 0.9%. The neglect of reproductive health can be seen as a major cause of the levels of avoidable maternal death (Cook, 1993). In the last decade the expenditure rose from 0,9 to 2% in 2010 and the State sector health spending increased from 5.5% to 7% of the budget in 2005 to 8% in 2010 (UN, 2012b). However, this positive trend did not occur in all states during these years as the public health expenditure also declined in poor states as Uttar Pradesh (SIDA, 2001).

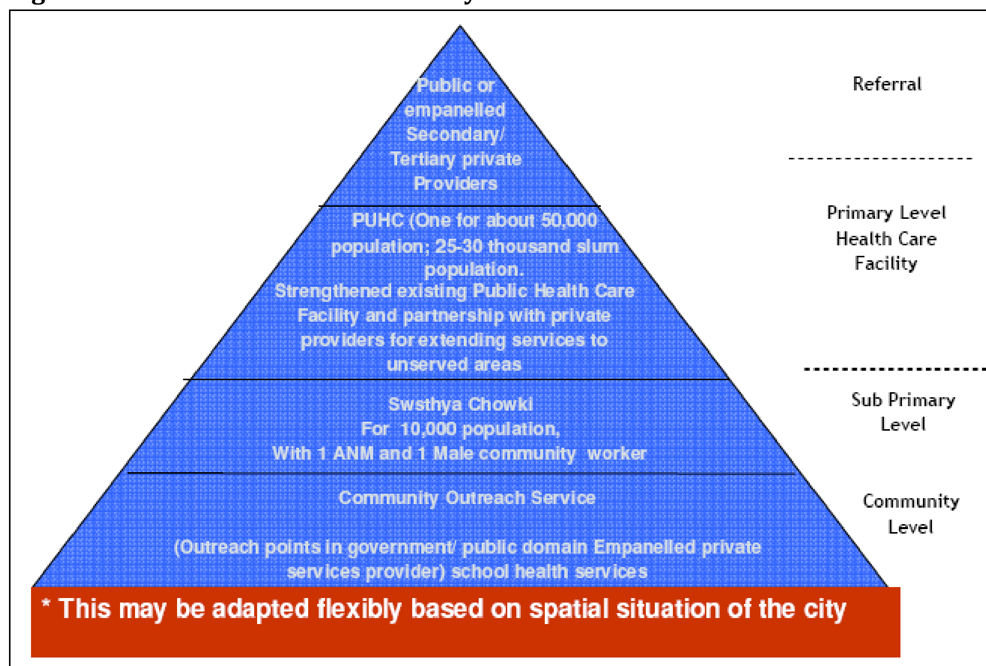
The structure of the Indian health care system can by divided in different levels; the national level, state level, district level and community level. The national level consists of the Union Ministry of Health and Family Welfare which has three departments: "Health", "Family Welfare" and "Indian System of Medicine and Homeopathy". Each state is headed by a Minister and has a Secretariat under the charge of Secretary/Commissioner (Health and Family Welfare). The organizational structure in the state mirrors the pattern of the central government. The director of Health Services is the head of the State Department of Health and Family Welfare. This structure can however differ amongst states but all have program officers that focus on one and more subjects. In various states, including in the state where the present study has taken place, there have been zonal, regional or divisional set-ups created between the State Directorate of Health Services and District Health Administration. Each of these regions covers

three to five districts and acts under authority delegated by the State Directorate of Health Services. The district level structure interlinks the state and the regional structure as well as peripheral level structures such as Public Health Centers (PHC's). The information that is received from the state is being adjusted and transmitted by to the periphery so that health services meet the local needs of the district. The Chief Medical and Health Officer have the overall control. On the community level Community Health Centers are available for every 80,000 to 120,000 persons to provide basic health services.

In order to address the problems with respect to maternal health in India, the government also implemented various programs. In 1997 the Reproductive and Child Health program was launched (Stephenson, 2002). This program was based on the existing Safe Motherhood Program and linked maternal and child health with the strengthening of referral systems for obstetric care. The RCH was followed by the RCH-II program that besides immunization, antenatal care and skilled attendance during delivery also focused on reducing maternal mortality (Richard et. al., 2002). In the same year the National Rural Health Mission (NRHM) was launched by the government to strengthen health services in the rural areas. This program aims at improving the availability and accessibility of effective health care for especially people residing in rural areas (Govt. of India, 2012). Strategies of this program include improving access, community ownership, strengthening of public health systems, enhancing accountability and promoting decentralization. With the 2002 National Health Policy (NHP) the accessibility in service delivery was addressed. With the NHP the government aimed to evolve the policy structure in a manner that it would reduce inequalities and make public health services accessible for the poor achieving an acceptable standard of good health in India (UN, 2012b). By decentralizing the public health system and improving the infrastructure this strategy aimed to ensure a more equitable access to health services in the country.

As the urban population in India has increased and is it is expected to continue this trend in the following years, the Indian government has recognized the need for attention for urban health (Govt. of India, 2010). Despite the closeness to health facilities, India's urban population has a restricted access due to the inadequacy of the urban health delivery system and demand side factors such as the socioeconomic status of the women. In order to effectively address the urban health care problems the National Urban Health Mission (NUHM) has been designed by the Indian Government. Within this intervention the inaccessibility of the health care facilities in urban areas will be addressed. With this intervention the following problems are being recognized; overcrowding of patients, ineffective in outreach and referral system, lack of standard and norms for urban health care delivery system, social exclusion, lack of information and assistance to access the modern health care facilities and lack of economic resources (Govt. of India, 2010). Figure 2.6 shows the structure of the urban healthcare system according to the NUHM. It gives an overview of the different levels in urban health care delivery and explains when services will be delivered by whom.

Figure 2.6: Urban Health care Delivery model. Source: Govt. 2010



Unfortunately the NUHM has not been implemented in the city where the current study has taken place. Therefore, the structure that can be found in the region where the current study has taken place will be presented in the next section of this chapter.

In addition to an adapted health care strategy and newly developed programs the India government also aims to make health care more accessible through demand side financing. This concept aims improve access to and utilization of health services, particularly among the poor. Diverse initiatives for urban as well as rural areas can be found. The Conditional cash transfer scheme (CCTS) Janani Suraksha Yojana (JSY) or 'Women's security scheme' is the most widely implemented scheme that is fully sponsored by the government and that falls under the umbrella of the National Rural Health Mission (WHO, 2010). In textbox 2.1 more can be read about this initiative.

Textbox 2.1: Janani Suraksha Yojana

Via the Janani Suraksha Yojana cash is being transferred to assist poor pregnant women to give birth with the assistance of a skilled birth attendant. The JSY is the largest conditional cash transfer programme in the world in terms of the number of beneficiaries, and represents a major Indian health programme (Lim, Dandona et. al. 2010). Its main objective is to increase institutional deliveries amongst Below Poverty Line (BPL) women and thereby reduce overall maternal and neonatal mortality rates (HSO&P, 2008). According to JSY's guidelines, after delivery in a government or accredited private health facility, women receive 600 Indian rupees (US$13.3) in urban areas and 700 rupees ($15.6) in rural areas. In ten high-focus states, including Uttar Pradesh, that have a low in facility birth coverage, all women irrespective of socioeconomic status and parity are eligible for the cash benefit. The cash incentive is higher in these states than in the other states namely 1000 rupees ($22.2) in urban areas and 1400 rupees ($31.1) in rural areas. In the non-high focus states, women are only eligible for the cash benefit for their first two live births, if they have a government-issued below-the-poverty-line card or if they are from a scheduled (low) caste or tribe. Like the national maternity benefit t scheme, JSY also provides a small amount of financial assistance of 500 rupees ($11) for the two first home births by women that live below the poverty line and that are 19 years or older. Health workers from high focus states that introduce the women receive payments of 200 rupees ($4,4) in urban areas and 600 rupees ($13,3) in rural areas per in-facility delivery that they assist in.

In addition, there are also CCTS's that address the private sector and that are non state led initiatives such as the "Agra voucher" and the "Sambhav voucher scheme". These schemes are designed for women of reproductive age living below the poverty line. Via these schemes vouchers are handed out which can be used by the targeted women to receive free maternal health services. With this approach NGOs and health volunteers are involved in mobilizing beneficiaries, management and disbursement of vouchers (Gupta et al. 2010).

The development of the private health sector can be traced back to the bias towards the inadequacy of Primary Health Centers (PHC's) and the Structural Adjustment Programs that were implemented in the '90's in India. Within India a bias towards the urban area could and can be noticed in terms of availability of health care facilities as most of these are located in urban areas (SIDA, 2001). PHC's were established to cover the Indian population in all regions. However, due to a shortage of centers and poor health care a large private health sector has developed. Under the Structural Adjustment Programs health centers and services have been increasingly privatized. It is estimated that 84% of health expenditure is now private. A large share of this household health expenditure comes from the poor, spend on improper treatment, drugs for self-treatment or as a result of their unavailability in public facilities (Standing, 2004). The privatization of the health sector often leads to the diminishment of the degree in which patients need are met due to sector's focus on profit (Londen, 2008). Negative consequences of the privatization of the health industry with the respect to the level of accessibility for the poor is amongst others the introduction of user fees, the possible strengthening of the male bias towards health care due to rising health costs and higher drug costs.

NGO's often, with government support, implement community based programs to promote community interaction and involvement and by educating and providing incentives to involve the community in health initiatives the NGO sector aims to improve the health status of those with a low socioeconomic status.

2.4.3 Accessibility and Utilization of maternal health care in India

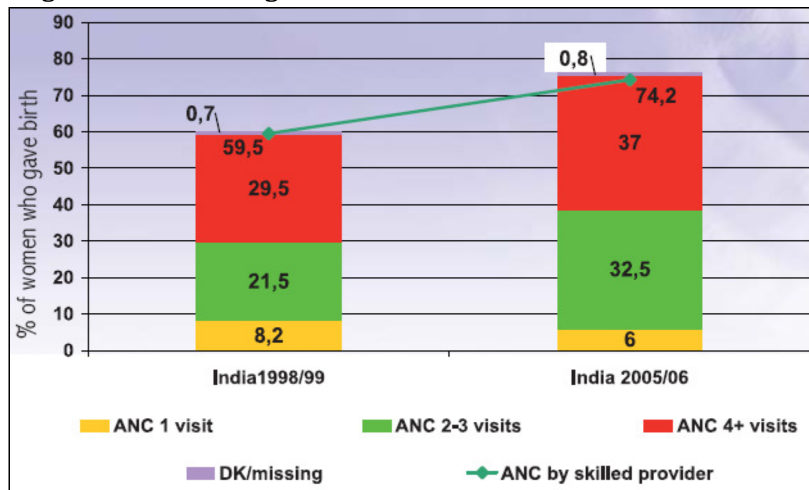
As mentioned earlier on in this chapter is the Indian health system is not fully accessible for all its population, especially for those that have a low socio economic status. The barriers that woman face correspond with the barriers that are being experienced in many developing countries and that can be brought back to the five dimensions; Availability, Accessibility, Affordability, Adequacy and Acceptability. The accessibility of maternal health care services suffers under the demand as well as supply side barriers that have been discussed in the theoretical framework. The influence that gender has on maternal health care utilization is still prevalent in India as women found in a disadvantage when it comes to health care utilization (SIDA, 2001). Specifically the lack of education is also seen as a major barrier as well to effective access to services in India.

The utilization of maternal health care varies amongst the Indian population. Differences exist between states, regions within these states and households. The states with the highest development rates, urban areas and households with higher socioeconomic statuses, are those with the highest utilization rates. When taking the income level of households into account it can be seen that households with a low income in general seek less treatment. In general these households treat less than half of the illnesses that they suffer, subsequently spending a low percentage of their household income on health. High income households generally seek treatment 65% of the cases (SIDA, 2001).

The utilization of Antenatal care (ANC) in India has slightly increased between 1998/1999 and 2005/2006 as almost 15% more pregnant women receive ANC as

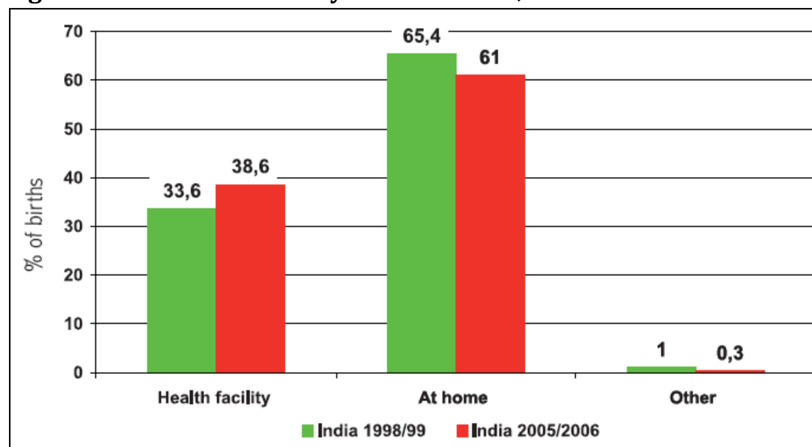
approximately 76% of women the researched women received ANC. Of these women 74% did so from a skilled provider (WHO, 2012f). Figure 2.7 gives an overview of the percentage of women that received ANC.

Figure 2.7: Percentage of antenatal care visits. Source: WHO, 2012f



Of the births that took place between 2000 and 2005 approximately 39% occurred in health facilities. Figure 2.8 shows that the vast majority of the childbirths in India occurred at home.

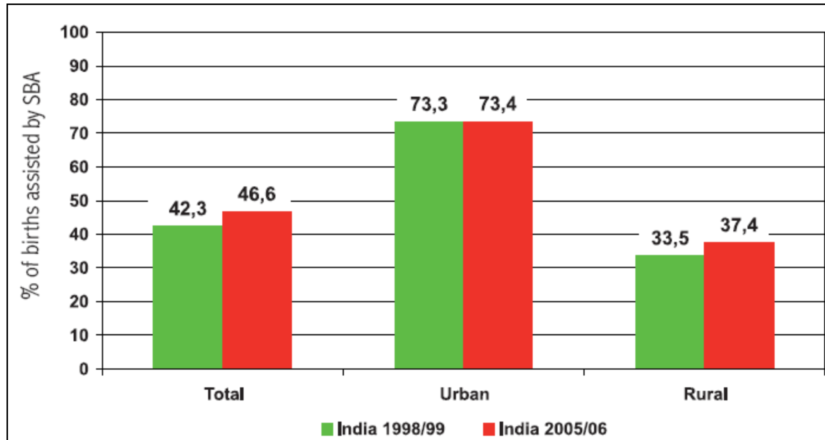
Figure 2.8: Place of delivery. Source: WHO, 2012f



As earlier discussed, reduces the presence of a Skilled Birth Attendant (SBA[1]) the risk of a woman dying during or after childbirth substantially. In the years 2005/2006 approximately 47% of births in India were assisted by SBA. Women that delivered their children in urban areas were more often assisted by a SBA. Figure 2.9 shows the degree in which SBA's were present during childbirth.

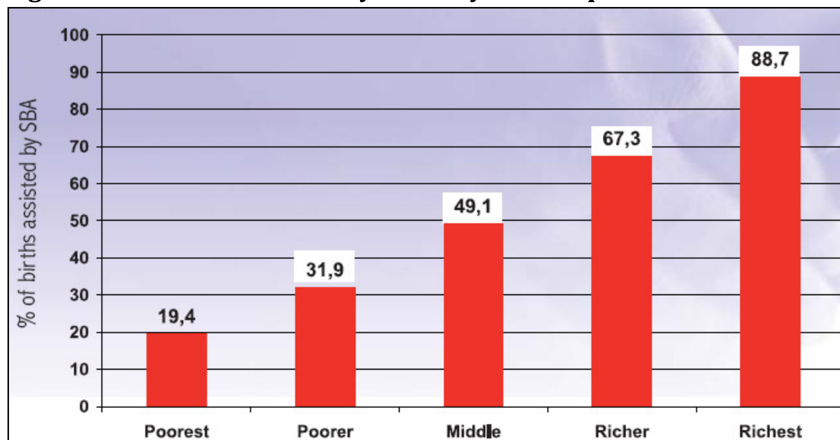
[1] . In India a skilled provider includes a doctor, auxiliary nurse midwife, nurse, midwife, lady health visitor and other health personnel.

Figure 2.9: Births assisted by a SBA in India. Source: WHO, 2012f



When looking at the socioeconomic status of women it can be noticed that the poorest women had almost 5 times less access to skilled care compared to those that are part of the richest wealth quintiles. Figure 2.10 shows the births that have been assisted by a SBA, subdivided by socioeconomic status.

Figure 2.10: Births assisted by a SBA by wealth quintile. Source: WHO, 2012f



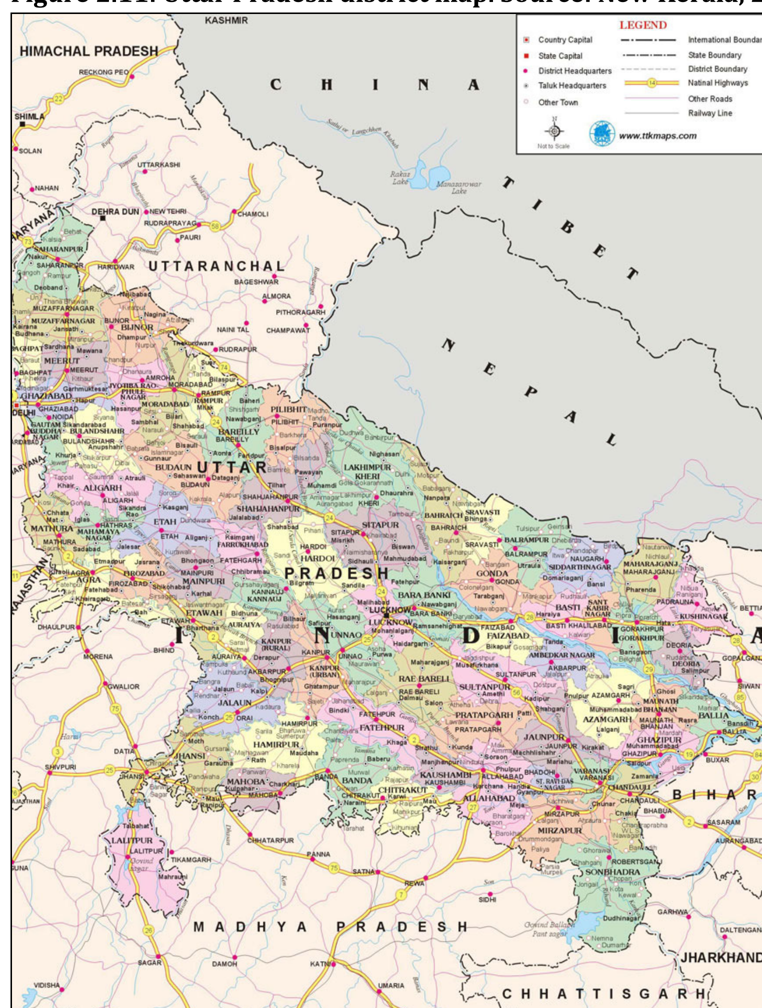
2.5 Regional Context

In this paragraph information will be given about the state Uttar Pradesh and Lucknow, the city in which the present study has taken place. Firstly, the geographical location and demographic information of Uttar Pradesh will be presented. Next, the maternal health status of the state will be discussed. Subsequently, these factors will be discussed for the capital city Lucknow. The foci of these sections will be laid upon urban maternal health as the present study takes place in an urban setting.

2.5.1 Geographical location and demographics

Uttar Pradesh (U.P.) is located in north western India, bordering Nepal and the Indian states Uttarakhand and Delhi to the north. It shares its national borders also to Bihar to the east, Jharkhand to the southeast, Chhattisgarh to the south, Madhya Pradesh to the southwest and Rajasthan to the west. U.P. is the most populous state in India, with a population of 199,581,477 million people (Census, 2011). Figure 2.11 displays the geographical location of U.P.

Figure 2.11: Uttar Pradesh district map. Source: New Kerala, 2012



The State consists out of 70 districts in which 69 cities and towns are located. The total urban population of 34.539.582 persons makes up for 12.7% of the total Indian population (Gov. of India 2010). The total slum population has 4,395,276 citizens. On average, households in U.P. consist out of six members of which 14% are headed by women (NFHS-3, 2006). Household heads are predominantly Hindu (82%) or Muslim (17%). Many of the people living in U.P. belong to marginalized groups as 25% of the residents belong to the scheduled castes, 1% belongs to the scheduled tribes and 50% belongs to other backward classes. U.P's population can be considered as a young population as a high proportion is underage. 42% of the population is younger than 15 years and only 5% is older than 65 years. The median age at first marriage in U.P. is 16.2 years for women and 20.1 years for men. Of the married women, 59% got married before the legal minimum age of 18 compared to 51% of the men. The fertility rate in U.P. is the second highest of India. The average amount of children that women in India have during their lifetime is less than 3 children, in U.P. women have about four children in this time span.

U.P. is one of the least developed states in India in terms of socio-economic and demographic terms (Singh et al, 1998). In this state 29% of the households live in a permanent house that is called a "Pucca". The following housing characteristics can be distinguished amongst all households: 43% of the households have electricity, 67% have no toilet facilities, 94% has a improved source of drinking water but only 9% has a water facility at home. Although India's national poverty's ratios have rapidly reduced, the ratios in U.P. have only shown a

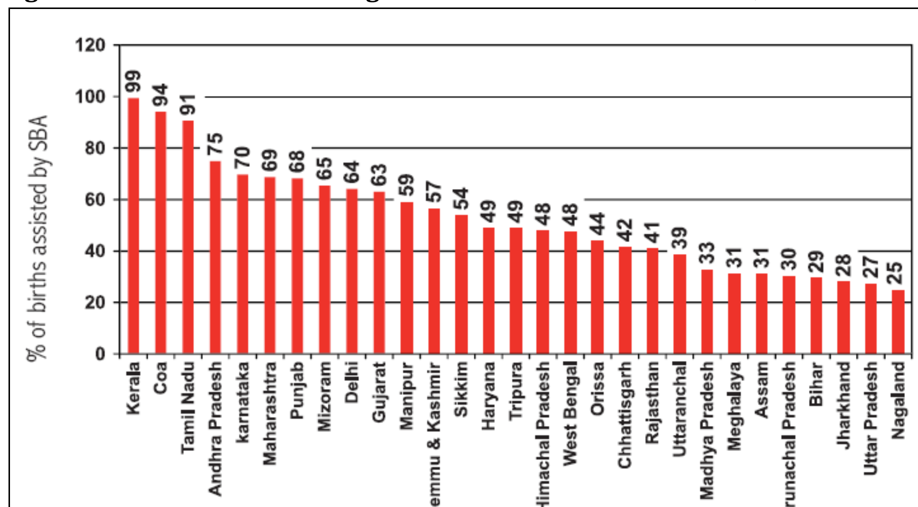
marginal decline. On average 25% of the population of U.P. belongs in the lowest quintile of the wealth index and 14% of the population belong to the highest quintile (NFHS-3, 2006). These disparities are higher in rural areas as 36% of the rural households are in the lowest wealth quintile. In urban areas 4% of the households are in the lowest wealth quintile. In U.P. a strong preference for sons can be noticed as 34% of women and 28% of the men have indicated that they would like to have more sons than daughters. The gender disparity can also be noticed in U.P's enrollment ratios as 64% of girls between 6-17 years are attending school while 74% of the boys in this age group are enrolled (NFHS-3, 2006).

2.5.2 Maternal health in Uttar Pradesh

Uttar Pradesh is one of the states with the highest MMR with up to 517 deaths per 100,000 live births in 2007. Low uptake of ante-natal health care services and delivery services characterize maternal health in UP (Richard et. al. 2002, Singh et al, 1998). The NFHS-3 shows that on average 23% the women that gave birth between 2000-2005, received ANC from a doctor and 43% from other health personnel for their last birth. The remaining 34% did not receive any ANC. The utilization of ANC is higher in urban areas where 79% received ANC. In rural areas 62% of the women used this care. Despite these promising numbers the amount of ANC visits is insufficient as only 27% of the pregnant women in U.P. utilized the recommended minimum of 3 ANC visits. When comparing these numbers U.P. has the second lowest ANC utilization visits of all states and falls far behind on the national average of 52%. Younger, urban Hindu women with more education that have their first child are found to be more likely to receive ANC. Scheduled tribe women and those that are Muslim are less likely to receive this care. About 90% of the women that belong to the highest wealth quintile utilize ANC, only about half of the lowest quintile does this as well.

In U.P, 78% of the women give birth at home in comparison to the national average of 65%. Only 22% of the births take place in a health facility, the national average is 39%. The lack of a SBA during childbirth is also more prevalent in U.P. in comparison to other states in India. Of the births that took place in 2000-2005 27% were assisted by a health professional and 40% of the baby's were delivered by a traditional birth attendant. The remaining 33% of the deliveries took place with the assistance of a relative or untrained person. The intra-country disparity and low rank of U.P. with respect to access to skilled care is demonstrated by figure 2.12.

Figure 2.12: Childbirth under guidance of a SBA. Source: WHO, 2012f



The utilization of postnatal care is extremely low as on average only 15% of the mothers had a postnatal check-up after giving birth. The recommended checkup within two days after giving birth was only 13%. Of the PNC that was received, 44% took place after women gave birth in a medical facility. Only 3% of the home births were followed by a checkup.
Factors that are interlinked with poverty and ineffective or unaffordable health services are seen as the key causes for the high MMR in Urban U.P. The lack of political, managerial and administrative will is also often seen as an underlying cause for these high maternal mortality rates. The Indian health care system for Urban areas differs for each State; a commonality is that they are often unable to manage primary health care for its citizens. The urban public health care often deal with numeral problems such as shortage of funding, shortage of human resources, limited public private partnerships, dysfunctional referral systems, underutilized primary health care centers and an over load on tertiary hospitals (Govt. of India, 2010). Urban poor in India often visit private health facilities to meet their needs as government facilities are often seen as inadequate of doing so. The private sector in urban areas often consist out of private practitioners and small nursing homes with 1-20 beds that serve curative care for mostly urban and semi-urban clients.

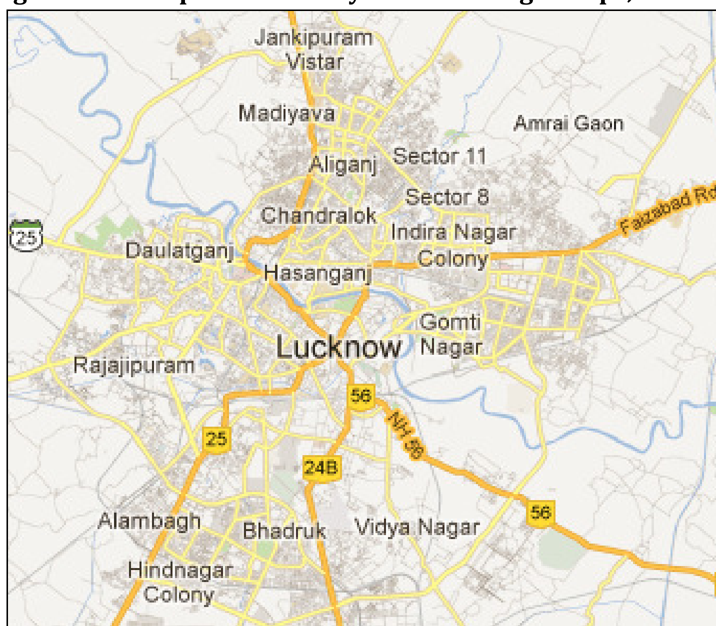
2.5.3 Lucknow city, geographical location and demographics

In the following paragraph information will be given about the capital city of U.P. Lucknow where the present study has taken place.

Lucknow became a million-plus city in 1981 (LCDP, 2006). Last year Lucknow had 2815601 residents, ranking it as the 11th biggest city in India (Census, 2011). The population grew extensively as the jurisdiction of the Lucknow Municipal Corporation was extended. Despite the decrease in population density during these years there can be noticed an upwards trend as the population density has grown due to population growth. The city is therefore rapidly expanding in the urban areas at the banks of the Gomti river. The population has also grown under the influence of rural to urban and urban to urban migration as the city attracts many migrants that are looking for better employment opportunities. Often these new migrants can be found in these informal settlements.

Alongside the rapid growth of the city, Lucknow has also witnessed a growth in slum areas. According to the Improvement and Clearance Act of 1962 an area is a slum if "*the majority of buildings in the area are dilapidated, are over-crowded, have faulty arrangement of buildings or streets, narrow streets, lack ventilation, light or sanitation facilities, and are detrimental to safety, health or morals of the inhabitants in that area, or otherwise in any respect unfit for human habitation*". Factors such as repairs, stability, extent of dampness, availability of natural light and air, water supply; arrangement of drainage and sanitation facilities are also taken into account (LCDP, 2006, p.) It is estimated that 60 to 70% of Lucknow's population lives below the poverty line. The slum areas are scattered around the city but are often found in the river bed of the Gomti river, at both sides of the Hyder canal, in the vicinity of the railway tracks and alongside the Lucknow-Faizabad road. It is estimated that there are 530-787 slum areas present in Lucknow. In Lucknow there are authorized and unauthorized slums. In the first type 85% of the houses are Pucca houses, in the latter this is only 40%. Figure 2.13 shows the map of Lucknow city

Figure 2.13: Map Lucknow city. Source: Google Maps, 2012



There are 393,000 households located in Lucknow city. The majority of Lucknow's population consists out of people from eastern U.P. However, also people from other regions can be distinguished as also Bengalis, South Indians and Anglo-Indians have settled in Lucknow (UHI, 2010). The vast majority of Lucknow's residents are Hindu (77%) or Muslim (20%). Other religions that are present are small groups of Sikhs, Jains, Christians and Buddhists. The sex ratio in this city is 915 females per 1000 males, corresponding closely with the national average of 914 females for 1000 males. The disparities are bigger in the sex ratio for children as there are 901 girls per 1000 boys. However, Lucknow has shown a positive trend with respect to gender disparity as in 1971 the ratio was 829 females for 1000 males (LCDP, 2006). Yet, the cause of this development can be debated as the growth of the percentage of women can also be attributed by the mobility of male family members. Many men work outside the city and leave their female family members behind in the city as it is seen as a good environment.

2.5.4. The health care system in Lucknow city

The public health care in Lucknow is greatly underfunded as health is one of the cities lowest expenditures. Less than 1% has been spent on health for the last five years. The health services in this city are provided by the public sector and private sector. The prevalent emergence of the private sector in India, can also be witnessed in Lucknow. The private sector in health consists out of private hospitals, nursing homes and clinics. These private facilities play a major role in the provision of general and maternal health services to the urban poor. In addition charitable hospitals can be recognized which provide subsidized health services to the poor. The public health facilities consist out of public hospitals, Railways hospitals, dispensaries and Cantonment hospitals and dispensaries.

The public health structure is mainly operated by the Department of Medical Health and Family Welfare and The Lucknow Municipal Corporation. In the this health care system two different levels can be witnessed namely, First Tier facilities and Second tier facilities. Via the First Tier facilities primary health care is provided in various parts of the city. Facilities that fall under this section are for instance Urban Family Welfare Centers, School Health Dispensaries and Medical Care Units. The provision of ANC registration and ANC checkups are one of their

main jobs. The Second Tier facilities consist out of male and female or joint hospitals. These facilities provide secondary health care the community's located in Lucknow. In Lucknow there are one government medical university and seven other secondary care health facilities are available. Apart from these facilities there are nine Bal Mahila Chikitsalya's available. These mother and child centers are appointed to provide maternal health services to women that are part of vulnerable groups. These centers provide basic ANC, delivery care and PNC. However, for many services such as ultrasounds or assistance during life threatening births, women have to be referred to hospitals. The distribution of maternal health services in communities falls under the Integrated Child Development Services structure. The Lucknow director of this program directs Child Development Programme Officer (CDPO) that focuses on maternal and child health subjects. Anganwadi workers, that fall under the CDPO, are active on the community level. Each Anganwadi Center (AWC) serves 1000 people. The Accredited Social Health Activists (ASHAs) also work in the community as their goal is to create awareness on health and its social determinants amongst women and communities and to increase the utilization of health and the accountability of the health services. Although ASHA's originally were trained to work in rural areas they also work with urban communities.

In Lucknow many of the health care challenges that India faces can be recognized. The overcrowding of patients can be witnessed as many first tier health facilities have to provide care for a 70.000 to 100.000 population (UHI, 2010). The centers are set to deliver care to a population of 50.000. This overload can also be witnessed amongst Auxiliary Nurse Midwives (ANM's) that are also in charge of delivering health care in slum areas and convincing women to have an institutional birth. They often have to cater to 500 persons instead of a 100. The affordability of health services is also a major challenge for the urban poor. The monthly household income in rupees in Urban slums varies from 0-500 rupees (10.38%), 501-1000 (31.11%), 1001-2000 (36.63%), 2001-4000 (14.90%) and above 4000 (5.79%). On average 30% of the household income in Lucknow is spent on health, resulting in many families taking a loan to be able to cover their health expenditures.

In Lucknow 47.3% of the births that take place are institutional births, it is expected that many women make part of a higher wealth quintile. Information about the accessibility and utilization of maternal health care services in Lucknow is unfortunately not available as disagreements about the definition of slums and about data have prevented scholars to draw conclusions about service delivery challenges in slum areas (LCDP, 2006).

2.6 Conclusion

This chapter has shown that India is a diverse country with respect to its geography, population and culture. Although many positive trends can be noticed in the highly populated country's development, major challenges in the field of poverty reduction and maternal heath continue to exist. The perseverant cast system and prevailing gender inequalities on top of supply and demand side barriers prevent women from accessing maternal health care in its fullest form. As the utilization rates of antenatal care, delivery care and postnatal care show positive signs during the last years, many challenges lie ahead as many women from low socio-economic groups do not attribute to this trend. As the diverse country of India shows different development stories with respect to maternal health it is of key importance that information is gathered about the maternal health care use by the poor and its accessibility throughout the country. In order to decrease the information gap in the capital city Lucknow, this modest present study aims to contribute to the data collection. In the following chapter information will be given about the way the present research has been conducted.

Chapter 3 | Methodology

3.1 Introduction

In this chapter the research questions and conceptual model of the present research will be discussed. Next, information will be given about the chosen research methods such as the type of research, data collection methods and the target group. Also, the main limitations and risks of the study will be addressed in this chapter.

3.2 Research questions

In the following paragraph the research questions and the conceptual model of this study will be presented.

3.2.1 Research questions

In order to get a better understanding of the maternal health care use in medical facilities in urban Lucknow, the barriers that women come across when wanting the utilize this type of care and the influence that utilization has on their possible future behavior the following research question was designed:

"What experiences do women of low socio-economic status have, living in Kashyap Nagar Lucknow, with respect to accessing and utilizing public and private maternal health care services, and how can this be expected to influence their future health seeking behavior?"

The research took place in the urban slum "Kashyap Nagar". More information about the selection and location of this community will be given in paragraph 3.4. In order to research the above mentioned facets the following sub-questions have been formulated:

- To what extent do women from Kashyap Nagar utilize public and private maternal health care services?
- What motivates women to utilize maternal health care?
- How do these women select the location where the maternal health care will be utilized?
- Which barriers reduce the accessibility of maternal health care services for these women, and how do the women in question overcome these?
- What kind of experiences do women from Kashyap Nagar have with utilizing public and private maternal health care medical facilities?
- What factors do women expect to influence their future health seeking behavior?

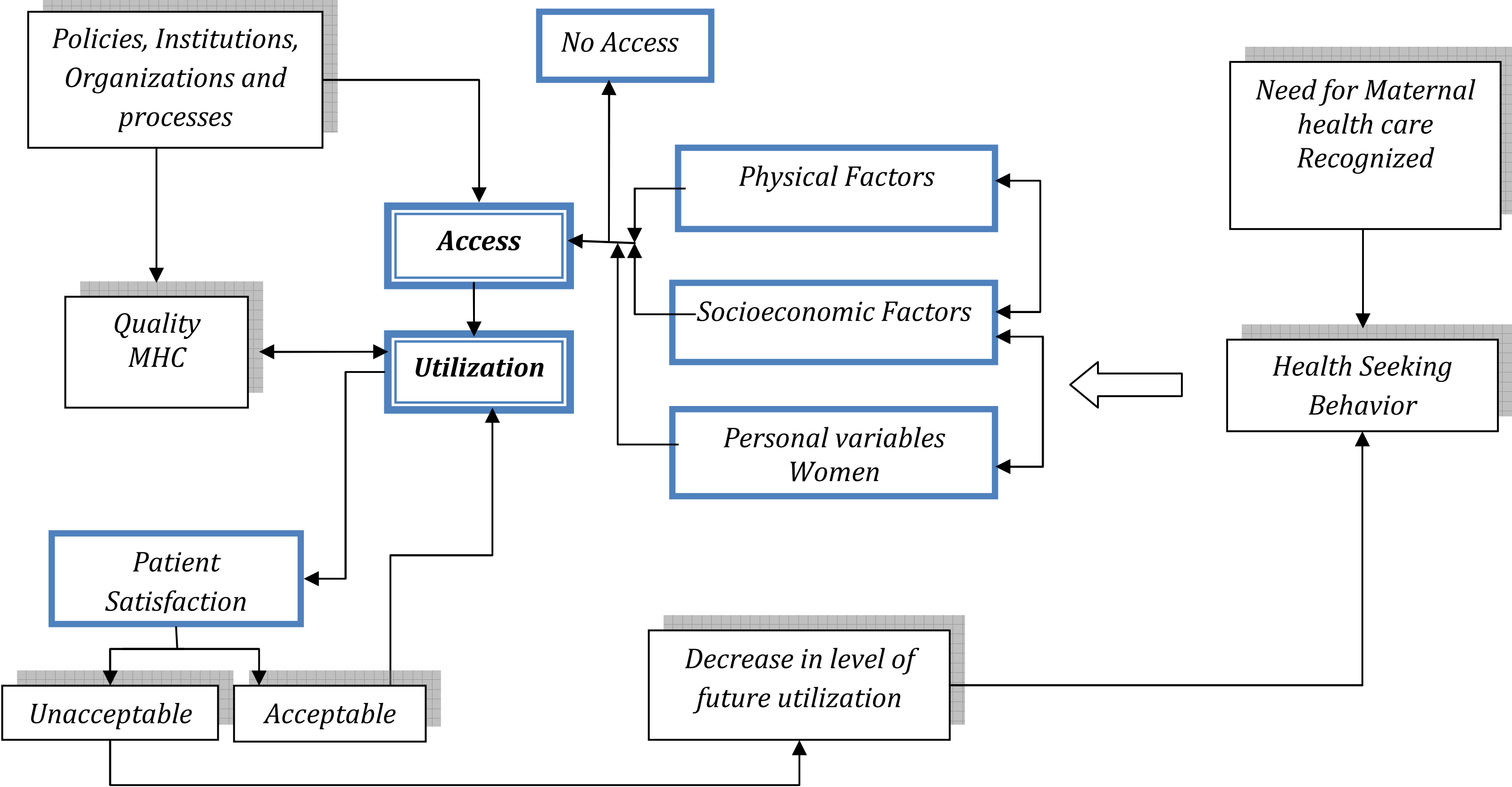
3.2.2. Conceptual model

Based on the information presented in the theoretical framework, some assumptions of the factors that influence the accessibility and utilization of maternal health care services can be made. Based on the literature overview it can be assumed that when the need for maternal health care is recognized, by the woman, her family or community, health care might be sought. Although health seeking behavior on its own is a complex and interesting research topic, it will not be fully included in this research. The present study lays it foci on the process that women experience once the choice to utilize maternal health care (MHC) is made. The accessibility of

these services is influenced by several demand and supply side barriers. The possible demand side barriers can be brought down to three overarching dimensions: physical factors such as the living distance and travel time from a health care facility, socioeconomic variables such as the ability to pay for services and the cultural acceptability of maternal health care and the personal variables of the women such as education level and household composition. These factors can either function as a barrier preventing women from utilizing MHC or have a minimal or no negative influence on the accessibility of a service.

However, during the accessing phase it is also possible that a woman comes across supply side barriers that make it not possible to utilize the services. Supply side barriers that hamper the accessibility can for instance be the facilities opening hours that do not correspond with the women's needs or health personnel asking for bribes. If women do utilize MHC they can come across other supply side factors that have a negative influence on their utilization experience. Such barriers can for instance be the health personnel of a facility that treat women disrespectfully or inadequate care that is being received by the women. These experiences can have negative influencing on the continuation of the maternal health care, as women subsequently could decide to not utilize al ANC services or not to deliver their child in a facility. The dissatisfaction of the patients with regard to the utilized services can also have a negative influence on anticipated future use of MHC for the women themselves and their family and community members as their stories might convince other women to not utilize any MHC as well. These connections and assumptions are translated into a conceptual model that is displayed in figure 3.1. The boxes that are marked in blue showcase the focus of the present study.

Figure 3.1 Conceptual Model "Accessibility and Utilization Reproductive Health Care"



3.3. Research methods

The following paragraph will give information about the chosen research approach and the methods that have been used to collect data. In addition, the host organization that guided this research and that will be using the research findings will be introduced

3.3.1 Research approach and methods

For this research a mixed method approach has been used that combines quantitative and qualitative methods. This approach has been selected as it brings potential benefits in terms of data quality and depth of understanding (Hulme, 2007). By gathering quantitative data a large overview can be given of the MHC use and the barriers that women have come across when accessing these services. The qualitative information will be used to get a better idea of the context and how the quantitative can be interpreted. The study researches the topic from the rights holders perspective, and aims to contribute to the accountability of the duty bearers in Lucknow.

For this study data has been collected via the main research method a questionnaire and via the use of interviews. In order to gather information from the women's perspective a questionnaire has been developed that has been used to survey 50 women that live in the slum Kashyap Nagar. Additional interview questions have been asked about the context of their story. The information derived from the interviews has been used to compile case studies that represent the diverse stories that were told by various women. Selection of the women took place while the women were surveyed. The selection criteria were based upon the earlier provided information by the participant, the level of representativeness of the stories and the insights that could be given by these stories. Also the level of trust that developed between researcher and recherché was taken into account.

In order to get insight in the perspective of the supply side, addition interview questions for this research have been formulated by the researcher and included in the interviews scheme used by fellow International Development Studies student Prarthana Ramdas. These questions were asked Ms. Ramdas during the interviews with doctors of the by her researched public and private facilities. By integrating these questions it was possible to gather information about the perspective of health workers on certain topics that the women were also asked about for this study. The questions focused on the perspectives that doctors had on the MHC utilization behavior of women, the communication with women from low socioeconomic groups, additional costs for drug prescriptions and the expectations of women with respect to the MHC services.

3.3.2. The questionnaire

The questionnaire has been used to gather data about the knowledge, attitudes and behaviors of the target group of this study. The theoretical approaches to the accessibility of health services have been integrated in this questionnaire by the formulation of questions that address the five accessibility dimensions (availability, accessibility, affordability, adequacy and acceptability). Also, gender related questions have been incorporated in this questionnaire in order to get a basic understanding of the women's autonomy. The questionnaire consists out of 164 questions, which have lead to 200 variables that could be analyzed.

The questionnaire consists for a large part out of closed questions meaning, that questions with a set of fixed alternatives were presented to the women from which they could choose an appropriate answer. The use of closed end questions was based on the advantage that they offer as the data derived from these type of questions is easier to process and has a higher level of comparability, especially when working with translators (Desai & Potter, 2006). In

addition, several open answer questions have been included in the questionnaire as it brings variation within the questionnaire and present women with the option to answer spontaneous. The questionnaire consists out of five sections, each focusing on different aspects of the research question. Within the questionnaire different routes can be taken, based upon the answers that have been given. This way information can be gathered about the reasoning why women did or did not make certain choices.

The first section of the questionnaire aims to gather information about the health seeking behavior of the woman and the care that she has received. It aims to find out which ANC she utilized and how often and what the reasoning behind this decision was. Also questions with regard to the selection of the location where the care was received, the health personnel she had contact with and role of her surroundings in selecting the health facility are included in this section. The second section focuses on the experiences women had while utilizing MHC. Different questions are being asked to get an understanding of the way the supply side met the expectations of the women. Special attention is being paid to the dimensions adequacy and acceptability. Questions are being asked with regard to the communication with health personnel, referral and the use of private facilities. The third section addresses the barriers that women can come across when wanting to utilize MHC. Both supply and demand side barriers have been incorporated in this section. Additional open ended questions have been asked to get a perspective on to how women have dealt with these barriers and if they have use conditional cash transfer schemes during their last pregnancy. In the fourth section attention is paid to the anticipated future use of MHC by the women in order to determine the influence of prior experiences with accessing and utilizing MHC. In the last section background questions are asked such as the household composition, income and educational background. The full questionnaire can be found in Appendix A of this thesis report.

3.3.3 Operationalization of concepts

Within this study different concepts have been used. Although many are self explanatory or imbedded in the theoretical framework a few key concepts will be exemplified in this paragraph.

Utilization; the level of use (Joseph & Phillips, 1984). In the context of this research; the use of maternal health care services. The level of utilization will be measured by the use of several questions in the survey that will address the previous use of maternal health care services by women of whom the target group exists. This will be measured by the use of personal factual closed questions. If women indicate that they have indicated MHC, questions were asked about the degree of use to find out which maternal health care services were utilized.

Negative physical factors; physical factors that can act as barriers when one wants to utilize the maternal health care services. These physical factors can encompass barriers such as a long distance to a health facility and no financial means to travel the distance to the facility. This variable has been measured by the use of questions that address the attitude of the respondent with respect to the degree this variable is seen as a barrier. This attitude has been measured by the use of statements that can be interpreted by either the positive or negative response that has been given by the respondent. The following measurements have been used; strongly disagree, disagree, neither agree nor disagree, agree and strongly agree.

Satisfaction level; the fulfillment of a need. In the context of this research; the fulfillment of the needs that women have with respect to the care and treatment they expect to receive when

utilizing the services in public or private facilities. This variable has been measured by the use of questions that address the attitude of the respondent with respect to the degree their expectations have been met by the facilities. This attitude has also been measured by the use of a likert scale.

Expecting; to feel or realize beforehand. In the context of this research; the expectations of future utilization behavior that women have based on their previous experiences with respect to accessing and utilizing maternal health services. This variable has been measured by the questions that address the weight that is given to past experiences and the influence this has on the attitudes that women have towards maternal health care or the facilities that offer these services.

3.3.4. The host organization

When conducting research in a foreign country it of key importance that local knowledge of the region and context is taken into account. Therefore, this research has been conducted in cooperation with a local Non Government Organization (NGO) called SAHAYOG. SAHAYOG is an Indian NGO founded in 1992 and is based in Lucknow, Uttar Pradesh. The organization has the following mission: "promote gender equality and women's health from a human rights framework by strengthening partnership-based advocacy" (SAHAYOG, 2011). Values that play an important role in the way this organization operates are equity and equality, participation, transparency and effectiveness. The strategic issues that the organization has focused on in the past include the themes "Maternal Health and Rights", "Gender Equality, Masculinities and ending Violence against Women" and "Youth Sexual and Reproductive Rights and Health". The following four strategies are being used within the organization:

- Facilitating and building capacities of community-based organizations
- Anchoring civil society networks for campaigns and advocacy
- Capacity building for research and monitoring
- Information production and dissemination

The theme "Maternal Health" is translated to an approach that promotes women's right to maternal health. Focus is placed on access, accountability and entitlements. SAHAYOG's interventions to improve maternal health adopt rights-based approaches that "put women at the centre and enhance their agency in claiming their right to health" (SAHAYOG, 2011). Attention is given to different levels ranging from community to policy level. The present study has been adapted to the wishes and interests of SAHAYOG's so that the research results can be of use in practice.

3.4. Selection of the research area and units

In the following paragraph information will be given about the selection of the research are and the research participants. Next, information will be given about the context in which the research took place and the main limitations and risks of this research.

3.4.1 Selection of the research area

The selection of the research area for this present study has been based on local knowledge. This decision was made as it is very challenging to targeting people who are considered poor as income data India can be unreliable and not all slums in Lucknow are registered (Govt. of India,

2010). Spatial targeting is also complicated as the issuing of Below Poverty Line (BPL) cards is often not up to date, and not well-documented. Additionally, migration leads to the scattering of living spaces in urban areas, which means that the target group for this study could not exactly be mapped out by using geographical location as a guide. This is also the case in Lucknow City where the large numbers of poor live scattered throughout the city (UHI, 2010). Therefore, it is recommended that individuals who are familiar with the area, are being used to identify the locations where the poor can be found (Govt. of India, 2010).

As SAHAYOG does not work in urban areas, the host organization had limited knowledge about suitable research sites. Therefore, Mrs. Sudha Singh who works for the local NGO Humsafar was contacted to help locate a suitable research area where the target group could be found. As she works in several slums in Lucknow she comes across many women that have a low socioeconomic status and that would fit the description of the target group. Therefore, she was appointed by SAHAYOG as the most suitable person to select possible research areas. Under her supervision the following urban areas were selected: Janta Nagra, Baad Shahbagh, Qutuppur and Kashyap Nagar. It was decided that Kashyap Nagar would be the most suitable location for the data collection as Mrs. Singh herself lives in Kashyap Nagar. Because of her formal and informal relationships with these women and the surrounding community she has a strongly established a trust level with them. This was an important factor for selecting Kashyap Nagar as the research location it is often seen as very difficult to establish trust levels of such manner with women that live in a slum based community. Hence, influencing their willingness to participate in the research. In addition, Mrs. Singh knew it was possible to find 50 women within this one community that would match the target population description, making the fieldwork less expensive and less time consuming.

Kashyap Nagar can be seen as a representative slum area as there are many communities in Lucknow that share commonalities with this community such as the type of housing, poverty levels and household compositions. However, there are communities in Lucknow that are with their migrant resident seen as more vulnerable. As neither HUMSAFAR, nor any of the other partner organizations of SAHAYOG had any contacts with these communities, it was not possible to conduct fieldwork in these areas in the limited time that was available for this research.

3.4.2 Description and selection of the research units

The women or research units in this study had to meet certain requirements in order to be found eligible to participate.

Firstly it was important that they were part of a low socioeconomic group. The selection was based on their residency in a slum area. The Wealth Index was used as a control method. It was considered to use the household income or caste of the women to define their socioeconomic position. However, both were seen as ineffective by the host organization and reports (Govt. of India, 2010). As policies against caste-based discrimination have gained ground, the membership of a scheduled tribe or caste no longer inevitably correlates with socio-economic disadvantaged position within society (Moore et. al, 2006). Assessing ones socio-economic status by the use of income standards is often seen as questionable and misleading as information is often incorrect. By using a Wealth Index, a ranking system that was used for the National Family Health Survey in Uttar Pradesh, a control mechanism was implemented to get a better understanding of the means that the women and their families have. During the fieldwork data was collected that made it possible to calculate their rank in the Wealth Index. This system combines information on 33 household assets and housing characteristics that all have an equal weight when calculating the wealth of a household. The total score in this index is afterwards

translated to a rank in one of the five wealth quintiles (IIPS, 2008). The original Wealth Index was partially transformed to make it more suitable for use in urban areas. Although the Wealth Index weights al factors equally and therefore cannot be seen as a waterproof method it is helpful in categorizing households other than by only looking at their income or caste (see Appendix B for the Wealth Index and the score results of the researched households).

Secondly, the age of the women was taken into account. It was decided that in order for women to be found eligible for this research they had to be between the ages of 15- 51. This age range was based on marital and childbirth information. The approximate childbearing years in India starts at age 18 and ends at age 50 (Moore et. al, 2009). Research shows that the average age of Indian women at marriage is 18.2 years old and that in Uttar Pradesh women are 17.5 years old (Unicef, 2007). However, in UP, 59% of women of age 20-24 get married before the legal minimum age of 18 (IIPS, 2008). Yet, this information could not be representative for the research area as studies have also shown that the mean age of women who are married and living in Indian urban slums is 13.8 years old (Govt. of India, 2010). The mean age at which the marriage is consummated by these girls is 16 years old. On average, women become mothers after about two years after marriage (Moore et. al, 2009) and about 14% of women living in urban UP between the age of 15-19 have begun their childbearing period (IIPS, 2008). Therefore, girls of 15 years old will also be included in the research.

Lastly, the household composition of women was taken into account. As the research focuses on the experiences that women have had while accessing and utilizing maternal health care services, women had a minimum of 1 live or still born birth in the last 3 to 24 months were targeted. By only including women who gave birth in the 3 to 24 months prior to the research, women would be able to recall their experiences more clearly hence, increasing the accuracy of this research. In addition their experiences would be more representative with respect to the current health system and facilities within in Lucknow. It was decided not to involve women that were pregnant or gave birth in the last two months prior to the research as they might not utilized all the services that MHC encompasses. All research conducted was based on the experiences that women had with respect to their youngest child. This way, information would be most up to date and more accurate as it could be prevented that women would tell stories based on their experiences from other pregnancies as well. When selecting the research units no distinction was made with respect to their religion and marital grounds as these factors are not seen as factors that should be controlled for.

The researched women were selected by Mrs. Singh based upon the above mentioned requirements. As she had knowledge about which women gave birth in the last three to twelve months she could approach these women directly. When asking them to participate in the research the women often had to have the consent from either their husband or mother in-law before participating. When giving information about the research and the survey that would be used, all approached women and their family gave their consent to participate in the research. Leading to a non-response of 0%. Appointments with the women were made so that it was possible to take questionnaires and interview the women in a short time span. many women could be surveyed. The women either visited Mrs. Singh's house to be surveyed or were visited by the research team, depending on their own wishes or those of their family. It was stimulated to visit Mrs. Singh's house as it would be more time efficient and the women would feel less hampered in answering questions truthfully as no family members would watching over their shoulder.

3.4.3. Research team

The research was carried out by 3 research assistants and myself. Two teams were formed, consisting out of Ms. Singh working together with Ms. Ramdas and Ms. Sneha Gupta who was working together with me. All research assistants were trained before starting the fieldwork. Attention was paid to diverse topics such as the research questions, survey questions, ethics, financial compensation and working schedules. All the assistants received a guidebook in which the some of this important information was mentioned again (please see Appendix C for the guidebook). The fieldwork took place in week 13 and the data was collected by the research team in 5 days. The team worked in the slum Kashyap Nagar and interviewed the women at the home of Mrs. Singh and at the homes of the researched women. The research materials were designed in English and later on translated by Shraddha Pandey and Shishir Chandra of SAHAYOG. The order of the answering options in the Hindi and English version were compared by Miss. Gupta so that the data entered in SPSS would be correct.

3.4.4 Ethics

When conducting fieldwork, especially in developing countries or those in transition, ethical dynamics relating to knowledge generation, ownership and exploitation have to be taken into account. Different kinds of barriers can develop based on the power differences between researcher and researched, hidden assumptions and the behavior of the researcher. In order to safeguard the position and power of the researched women an information sheet and consent form were designed, based on the documents used by Ms. Rachel Bell[2]. In these forms, information is given about the research and the rights that the women have (see Appendix D for the information sheet and Appendix E for the consent form). The research assistants had been trained to give the women all the information they wanted and to let them sign the consent form in which they state that they understand their rights. When the women were not able to write themselves they signed with their fingerprint.

3.4.5. Main limitations and risks

With every research there are limitations and risks that have to be taken into account. In this case, the main limitations were related to the available time and funds. During the first weeks of the internship it became clear that SAHAYOG did not have a specific research question and was not able to assist in finding or selecting possible urban research locations or to provide a budget or assistance for the fieldwork. As a result, a lot of time had to be spend on finding a good research perspective and researching the city. Luckily, SAHAYOG was able to introduce Mrs. Sudha Singh of the NGO HUMSAFAR that had the knowledge that was necessary. However, as she had obligations to her own organization it was in the beginning very difficult for her to find the time to assist me in my research. Multiple appointments were postponed or cancelled, making it impossible to visit different research sites or to conduct a try-out. Another reason causing delays was the process of finding suitable translators/research assistants for the data collection and the translation of research materials. The fieldwork also had to be postponed as the research materials were not translated on time or were not translated correctly and because of the unforeseen cancellation of a research assistant. Because of the above mentioned limitations the

[2] Rachel Bell has conducted a baseline study on Maternal Health Practices and Services in Relation to the IGMSY Conditional Maternity Benefit for her International Development Studies master thesis in the school year 2010/2011 in cooperation with SAGAYOG.

fieldwork was postponed to the last month of the 3 month internship and had to be finished in 5 days, making it not possible to adjust research methods to the situation in the field.

Another limitation was the small budget on which the research had to be conducted. Understandably, SAHAYOG did not have budget to support the research. As a result the data collection targets and methods, as designed in the research proposal, had to be altered. As there were fixed prices for the compensation of research assistants, and volunteers were not able to assist, it would have become too expensive to carry out the original research plan myself. As a result the target group was brought back to 50 women and the research costs were reduced to INR. 13261.

As a result of decreasing the target group, the researched women cannot be seen as a representative sample of the proposed population. Also, it was not possible to use the earlier developed probability sampling strategy to retrieve a representative sample of the target group. As it was not possible to meet the Child Development Programme Officer or the Anganwadi worker of the locale centre, it was also not possible to gather information about the population of which the target group is part of. The limitations also reflected on the earlier proposed research methods. The focus group meetings and additional interviews could not be carried out as there was no time and no funds available for these extra methods.

The risks involved in this study are mainly interlinked with the language barrier. My inability to speak Hindi made it only possible to guide the conducted fieldwork in an indirect manner. As I could not personally check the translated research materials or possible wrong interpretations during the fieldwork, it was very difficult to get an understanding of possible mistakes or different ways in which the survey was carried out. Although the survey mainly consists out of closed ended questions, it is inevitable that differences in interpretations of filling in answers have taken place. By reading along the survey questions in my English version, asking control questions and talking about the surveying with the translators it was tried to minimize these risks.

3.5. Conclusion

In order to get a better understanding of the maternal health care use in Urban Lucknow, the barriers that women come across when wanting the utilize this type of care and the influence that utilization has on their possible future behavior research was conducted in Kashyap Nagar. Data was gathered through the use of a questionnaire and via interviews. Although the present study encountered various limitations it was possible to gather data of 50 women. In the following chapter information will be given about who these women are and their living conditions in the slum Kashyap Nagar. Subsequently, will the gathered research data be presented in the chapter five.

Chapter 4 | Research location and participants

4.1. Introduction

This chapter aims to provide an understanding of the background in which the research has taken place. In the first paragraph information will be given of the research area, the slum Kashyap Nagar. In the second paragraph the personal variables of the researched women and their maternal history will be discussed.

4.2 Research location

The data collection for the research has taken place in Kashyap Nagar, a community that is part of the urban city block Daliganj in Lucknow. Daliganj is located in the "old" part of the city centre that once was established in the Nawab period (LCDP, 2006). Currently, this settlement and those alike are known for being densely populated and having inadequate infrastructure. Within Daliganj residents different socioeconomic groups can be distinguished, ranging from wealthy families to the poorest of Lucknow.

Kashyap Nagar is located north of the Gomti river, and inhabits approximately 600 families. This community is divided in two parts, Kashyap Nagar 1 where about 350-400 families live, and Kashyap Nagar 2, that houses approximately 200 families. The latter is also seen as the periphery of Kashyap Nagar. The families that are currently living in Kashyap Nagar are of the second and third generation of the original residents to this area over 50 years ago. Kashyap Nagar has been classified as a slum in 2006 by the development council of Lucknow. This classification is based on the absence of a paved road, the absence of safe sanitation, the absence of primary health care facilities and its resident's unsafe tenure. The degree of tenure in the community differs between the families. The families living in the center of the community possess permits that have been allocated by the government, giving these residents permission to use the government land for housing up to 90 years. After that the government decides whether or not the permit will be extended for another 90 years. Because of this regulation, a big proportion of Kashyap Nagar's population has some sort of safe tenure. Yet, this does not apply to all residents. As there are also families that have not received this permit, a proportion of Kashyap Nagar's residents are living illegally on government land, subsequently leading to unsafe tenure.

The residents of Kashyap Nagar have used diverse building materials for the houses. The most common materials that have been are semen, bricks, mud, metal roofs, plastics and PCV. Often bricks and tires are being used to attach the roof to the rest of the house. Some houses have water facilities or toilets inside. Often, water tanks are being used by these residents. Also, some pipelines have been installed in the community. However, the water coming out of it is according to the community very unhygienic and has a bad smell. The residents that lack sanitation means use the river and river bank for washing and toilet purposes. Women are constraint by this as they can only go to the riverbank for toilet use in the dark.

Figure 4.1. Satellite picture of Lucknow city.
Source Google Maps Source Google maps

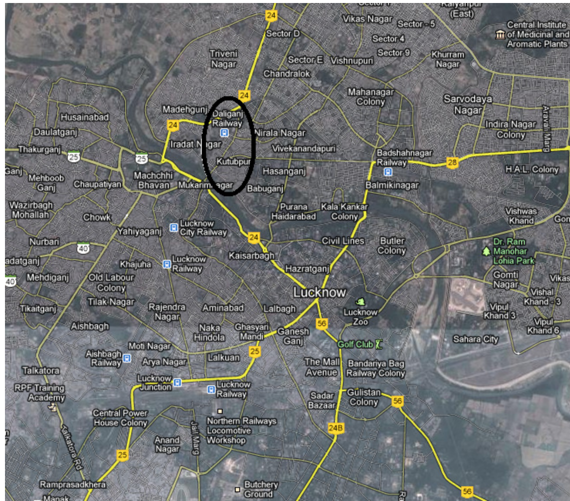


Figure 4.2. Satellite picture of Kashyap Nagar
Source Google Maps Source Google maps

4.3 Research units

This paragraph will give an overview of the household situation of the researched women and their previous pregnancies.

4.3.1. Household situation

The research units for this research consist out of 50 women with a low socioeconomic status, living in the urban slum Kashyap Nagar.

The women that participated in the research were between ages of 19 and 35 years old and have a mean age of 24 years old. Of these women 40% live in a joint family and 56% live in a nuclear family. One woman indicated that she lives alone. On one woman no data was available. All women indicated that they were married. The approximate monthly household income is INR. 4129. The income range has a minimum of a monthly income of INR.1000 and a maximum of INR. 12500. In most of the households the men were the main providers, working full time and outside the home, often as a day laborer (42%). Other income generating jobs of the husbands consist out of selling fruit or fish or other products as a street vendor, working in a factory or private shop, driving tempo's, farming, or working as a servant, painter, rickshaw puller or electric house worker. Often these jobs are on project base, meaning that many families don't have a steady income. Six of the women indicated that they had income generating jobs as three women did stitching work, two women washed dishes and one woman performed household work for another family. 54% of the women indicated that they had a say in how the household money is being spend, 58% also indicated that they could spend family money without consulting their family members first. This often applies to the full household income according to the researched women.

The average Wealth Index rank of the women was rank 2 (52%), indicating that the women are part of a low socioeconomic group. 28% of the women is categorized as rank 1, meaning that they are part of the lowest socioeconomic group. The remaining 20% has been categorized as belonging to rank 3, meaning that they are somewhat better off. None of the researched women had a rank higher than rank 3. Most of the women indicated that they are part of the caste group Kashyap (52%) that is seen as an OBC. The remaining women were part

of the following caste groups: Lodh, Pandit, Kahar, Kewat, Paramaa thakur, Harijan, Gautam, Rawat and Brahman, all seen as Dalits except for the latter.

The education level of the researched women was low as the vast majority of the women (46%) had not completed any educational standard. The remaining women have completed the following standards 2nd (6%), 3rd standard (8%), 5th standard (24%) 6th standard (2%) 8th standard (8%) 9th standard (2% woman) 10th standard (2%) and 12th standard (2%). 13 women (26%) had received some form of vocational training and 3 women were taught a profession by their family or friends.

4.3.2. Maternal history

The researched women had on average 2.5 pregnancies, with a minimum of one and a maximum of eight pregnancies. Of these women 32% was only once pregnant, 30% had two pregnancies and 20% had three pregnancies. The remaining women had four pregnancies (10%), six pregnancies (2%), seven pregnancies (4%) or eight pregnancies (2%). Seven women indicated that they were pregnant when the research was conducted, one woman did not know whether she was pregnant or not. Of the researched women, 9 gave birth to their first child before the legal age of marriage. One woman had her first child when she was 13 years old, three women had their firstborn at the age of 15, one women delivered her first child at the age of 16 and 4 gave birth for the first time when they were 17 years old.

None of the researched women had undergone an abortion and 92% never had a miscarriage. One woman shared with us that she has had three miscarriages, two women shared that they had two miscarriages and one woman had one miscarriage. One woman had one stillborn child and one other woman had two stillborn children. On average, the women had 2.2 children. Most women had one child (36%) two children (32%) or three children (18%). The remaining 12 women had five (2%), six (2%) or seven children (2%). The average age of their lastborns is 12 months old. All of the women had their last baby during the last 3 to 24 months. In this period more girls were born as 54% of the last born are of the female sex and 46% are of the male sex.

Table 4.1: Age and pregnancy history of the researched women

	Mean	minimum	maximum
Age	24,8	19	35
Number of pregnancies	2,5	1	8
Number of children	2,2	1	7
Age last born (in months)	12	3	24
Abortion	0	0	0
Miscarriage	2	1	3
Stillborn	0,08	1	2
Age first born (in years)	4	0,3	13

4.4. Conclusion

The data collection for the research has taken place in the slum Kashyap Nagar where women were found that met the criteria that were set for the target group and that were willing to participate. The women were surveyed about their last born child that was born 4 to 24 months prior to the research. In the next chapter the research findings will be presented in which the maternal health care utilization for these pregnancies will be explained. Also, attention will be paid to the barriers that women face and their anticipated future utilization behavior.

Chapter 5 | Accessibility and Utilization

5.1. Introduction

This chapter aims to present the information needed to answer the following main research question: *"What experiences do women of low socio-economic status have, living in Kashyap Nagar Lucknow, with respect to accessing and utilizing public and private maternal health care services, and how can this be expected to influence their future health seeking behavior?"* The findings are based on the answers given on the questionnaire questions and the stories that were shared during the interviews with the women and the gynecologists. Therefore, this chapter consists out of an overview of quantitative data and qualitative case studies. The structure of this chapter is based on the sub questions of the present study. Therefore, firstly information will be given about the MHC utilization behavior of the researched women. Also, information on the reasons that played a role in choosing a MHC provider will be provided in this paragraph. Secondly, information will be provided on the factors that according to the women reduce the accessibility of maternal health care services. Also, attention will be paid to how women respond to these perceived barriers. Thirdly, the experiences women had while utilizing the services will be explained. Including the experiences they had with the referral system and the communication they had with the health personnel. Lastly, attention will be paid to the anticipated future MHC use of the women.

5.2 Utilization of maternal health care

This paragraph aims to give an overview of the utilization rates of the three components of maternal health care namely antenatal care (ANC), delivery assistance (DA) and postnatal care (PNC). In order to get a more in depth understanding of the MHC use, the reasons for this degree of utilization and the manner in which the care provider is selected, each MHC component will be presented in a new paragraph. However, first an overview will be given of the general MHC use by the researched women.

5.2.1 Utilization of maternal health care in general

The utilization rates of MHC look at first sight very positive as almost all of the researched women stated that they used one or more MHC components during their last pregnancy. Only 3 out of the 50 researched women shared that they did not use any form of MHC during their last pregnancy. Table 5.1 gives a short overview of the utilization rates of the MHC components. As women often used a combination of care the total of used care is higher than 50.

Table 5.1: Utilization of the MHC components

Type of maternal health care	Users	Non-users
Antenatal care	44	6
Delivery assisted by skilled birth attendant	45	5
Postnatal care	33	17

Of the women that utilized one or more MHC components, 22% did not travel to a public or private facility to receive the care but received this at home. The biggest proportions of the 39 women that utilized care in a facility, used either ante-natal care and had an in facility birth (16%) or utilized antenatal care, postnatal care and had an in facility birth (14%). Table 5.2 shows the distribution of use between the different MHC components in facilities. As these ratios do not tell anything about the completeness of the ANC and PNC utilization that was utilized more in depth information about these rates will be given in the following sections.

Table 5.2: utilization of MHC in medical facilities

MHC component	Frequency	Percent
No utilization in a facility	11	22
Only ANC	5	10
Only Birth	5	10
ANC & Birth	8	16
ANC & PN	6	12
ANC, Birth & PN	14	28
Birth & PN	1	2
Total	50	100

5.2.2. Utilization of antenatal care

Of the researched target group the vast majority of the women (88%) received antenatal care in either a facility or at home. However, the researched women often did not receive the recommended amount of four antenatal checkups. The average utilization ratio consists out of 2.8 checkups during the pregnancy. The range of checkups lies between 0 and 10 checkups. Of the researched women 29 did not receive the recommended three ANC checkups during the months that they were pregnant. The research results show that in total seven women utilized the recommended four checkups and that six women received more than four checkups. Hence, of the 50 women that were researched, only 26% received the amount of checkups that they were supposed to receive. Unfortunately, 3 women did not receive any antenatal checkups during their last pregnancy.

The gynecologists that were interviewed indicated that the return rates for general MHC were quite high but that they often see that women do not utilize all the services that ANC compasses. In the public hospital Queen Mary's most women visit the facility during their second trimester (week 14-27). The gynecologist explained that women often don't see the first trimester as an important stage in their pregnancy as they often don't notice any problems. A gynecologist from a BMC indicated that 70 to 80% of the women that visited the facility for MHC came back during their pregnancy for more antenatal checkups. She believes that the benefits that women receive under the JSY scheme is a big motivator for these women. The private health facility "Miranda Clinic" has witnessed a change in the moment during the pregnancy in which women from slum areas visit her clinic. Her patients used to only visit her clinic during their third trimester (week 28 till giving birth) but due to the introduction of the Sambhav voucher scheme women now often visit her clinic in the early beginning of their pregnancy.

When looking at the motivations of women with respect to utilizing ANC diverse reasons can be distinguished. The 3 reasons that were mostly mentioned as underlying causes for using ANC were the health of the baby (mentioned by 45% of the women), the health of the woman

herself (mentioned by 36%) and because her in laws or community wanted her to use ANC (both mentioned by 18 % of the women). These and other reasons for using ANC that were given by the researched women are presented in table 5.2. As women were asked to indicate the three most important reasons for using ANC the table shows more answers than if the women were only able to indicate one factor.

Table 5.2: Factors of influence when deciding to use antenatal care

Factors	Frequency
Health of the woman herself	31
Health of the baby	23
Advise in-laws	8
Complications previous pregnancy	7
Advise community	7
Advise natal family	3
Costs could be refunded	3
Good previous experience	3
Advise AWW	2
Advise husand	1
Facility was close by	1
Friends used ANC	1

Many of the interviewed health personnel recognize these underlying motivations. One gynecologist of a public hospital explained that women living in urban areas have a better knowledge of the care that they should receive. Although this knowledge is often insufficient, it does motivate women to utilize ANC. Also, the social relationships women have are seen as a major influence on this utilization behavior. The owner and gynecologist of a private hospital shared that especially the mother in law of the pregnant woman has a strong say in the health care that the women should utilize "*the mother in law has a lot of control over the care that her daughter in law receives. Sometimes they tell me that the woman in question does not need the care I recommend. When they do so, I argue with them so that hopefully she will change her opinion*". The six women that did not use any ANC gave diverse reasons that were based on fear, transport, costs and knowledge. Women indicated that they were afraid of the costs of the services, needles or how the medical staff would treat them. Also transport was seen by some as the reason not to utilize as it would be difficult to find transport or travelling would take too. Two women also indicated that costs for the services would be too high. One woman also indicated that she did not know that ANC existed and one other woman indicated that she did not think that ANC is important.

Most of the women received ANC in a facility as 59% of the women visited a public facility and 16% a private facility. The remaining 25% received the care at home. The women that delivered at home were assisted by either a nurse or an Anganwadi worker. The vast majority of women that used a public facility visited the government hospital Balrampur (27%). The private facility that was most often used by the women was Private Clinic Kashyap Nagar (9%). An overview of the types of locations where women received ANC are presented in table 5.3. This table shows that 45 locations were visited, indicating that one women visited two types of locations. More specific information on the medical facilities that were visited are presented in appendix F.

Table 5.3: Locations where the antenatal care was utilized

Location	Frequency
Government hospital	19
PHC	3
BMC	4
Private facility	7
Anganwadi centre	1
Home	11

When selecting the location where the ANC would be utilized, the opinion of the husband, (mentioned by 48% of the women), availability of doctors and nurses (mentioned by 45%) and the travel time (mentioned by 36%) were seen as the most important factors on which the decision for the location was based on. When deciding to use ANC, time is an important factor for women to take into account. Although women living in urban areas often have to cover shorter distances to reach a health care facility, travelling in the city still takes up some time. As many of the public hospitals have a high patient load a visit to a hospital often results in long waiting times for the women before receiving medical care. Table 5.4 gives an overview of all the factors that influenced the selection of the location where the ANC would be utilized and how often they were mentioned. As women were asked to indicate the three most important reasons for using ANC the table shows more answers than if the women were only able to indicate one factor.

Table 5.4: Factors of influence when selecting the location for antenatal care

Factors	Frequency
Costs antenatal care	7
Experiences surroundings	5
Availibility resources	4
Availibility doctors and nurses	20
Attitude doctors and nurses	3
Opening hours	6
Waiting time	1
Opinion in-laws	3
Opinion husband	21
Opinion natal fam	2
Opinion of the community	1
Medical emergency	2
Afraid of possible ceasarian	1
Earlier good experiences	1
Travel conditions	11
Travel time	16
Travel costs	1
Family member works in this facility	1
Waiting time	1

When the women were asked who recommended this location, the community was most often named (35%). Other persons that often recommended on the location were the women's in-laws, in particular the mother in law (35%) and the natal family of the woman (16%). The community consists according to the women out of the family living in the same area and the neighbors. Although the influence of the community with respect to making the decision to use

MHC has decreased, the communities' advice is still strongly taken into account when selecting the location where the ANC will be utilized. The case study in box 5.1 shares the story of the antenatal care that Amisha[3] used and shows the influence that a woman's family can have on the utilization of antenatal care.

Box 5.1: The influence of the personal relationships of women on their utilization behavior.

When Amisha was pregnant of her third child her mother decided that she had to use antenatal care. She received vaccinations in a private clinic as her mother in law believed that the quality care was higher in private clinics. As Amisha was afraid that she would have to take medicines or that these would be subscribed to her she only received two checkups. She did not get an ultrasound as her mother in law decided that she was healthy and would not need any more care. In total they spend INR1000,- for consultations and vaccinations in the private clinic. Amsiha her family planed that she would deliver her child in the government hospital Balrampur as giving birth in a private facility would be too expensive. As Amsiha had an 'emergency birth', she and her family did not travel to a hospital and she gave birth at home.

5.2.3. Utilization of delivery care

When looking at the location where the women delivered their child a division between two groups can be made as 25 women (50%) gave birth at home and the other half gave birth in a health facility. Of these in facility births, two took place in a private facility. The exact division between the different locations is presented in table 5.5. More specific information on the medical facilities that were visited are presented in appendix F.

Table 5.5: Locations where the baby was delivered

Location	Frequency
Government hospital	18
PHC	2
BMC	3
Private facility	2
Home	25

The above mentioned locations were selected based on various preferences that the women had. When the women were asked which factors were most important when selecting the birth location the availability doctors and nurses (mentioned by 50% of the women), travel time (mentioned by 42%) and the attitude of doctors and nurses (18%) were seen as the most important factors. When selecting a location that met the criteria that women had set, many women based their decision on earlier experiences they had. A woman who chose to deliver at home told us the following "*I have given birth at home twice with the assistance of the nurse. She was there when I needed her and she provided good care. With this pregnancy I am planning on delivering at home again because of these good experiences*". As some of the participants were pregnant for the first time they did not have any earlier experiences with this type of care and therefore based their choice of selection often on stories that they have heard from others. This proofed to be quite difficult as the many women heard diverse stories about the different facilities that are located in Lucknow. As one woman shared "*I don't know if doctors and nurses*

[3] The names of the women that have participated in this research have been altered in the case studies order to respect their privacy and to guarantee their anonymity.

treat women well in Balrampur hospital as I hear a lot of conflicting stories. Some women did not have any problems whilst others have had very bad experiences. It is very confusing". The criteria on which the selection of the location was based are presented in table 5.6

Table 5.6: Factors of influence when selecting the delivery location

Factors	Frequency
Avalibility doctor & nurses	25
Availibility resources	7
Attitude doctor & nurses	9
Opening hours	1
Quality care	2
Travel conditions	4
Opinion husband	7
Opinion In-laws	5
Opinion community	1
Opinion natal family	1
Medical emergency	2
Overall easier	1
Children otherwise home alone	1
Afraid of ceasarian	3
Afraid of hospitals	1
Family member works there	1

The birth location was most often suggested by the in-laws of the researched women (28%). Also in the case of selecting the location where the delivery would take place the recommendation by their community was taken into account. However, despite these suggestions, the anticipated location, was not always the location were women ended up having their child. When a 25 year old woman was pregnant of her fifth child she decided she wanted to have her baby in the hospital. However, she ended up giving birth at home. *"I was planning on delivering in the hospital but the baby came very fast, I did not have any time to travel to the hospital. That's why an ANM was called and I delivered the baby at home"*. The opposite happened to a woman who planned on giving birth at home. "*I did not want to give birth in a hospital as I heard bad stories about government hospitals from my friends, but when I had a medical emergency I did not have a choice and had to go to the hospital*".

The assistance that women received during child birth differs amongst the researched women. Of the women that delivered their child at home, the vast majority (80%) received help from a nurse. In the remaining cases the women delivered with the help of a midwife (12%), an auxiliary nurse midwife (4%) or with the help of family members (4%). The in facility births were assisted by either a doctor (30%) or nurse (44%). Table 5.7 gives an overview of all the persons that assisted the researched women during their delivery. As some women were assisted by multiple persons there are more answers given than the number of women that were researched

Table 5.7: Assistance during delivery

Person who assisted during the delivery	Frequency
Doctor	15
ANM	32
Relative or friend	3
Midwife	4
Retired community nurse	1
Sweeper/ no one	2

Unfortunately, not all women received the assistance when delivering their child that should have been provided. As the figure above indicates, a few women did not receive any assistance or by someone that was not skilled to do this. A few of these stories will be presented in the case studies in paragraph 5.3 and 5.4.

5.2.4. Utilization of postnatal care

The utilization of postnatal care amongst the researched women is the lowest utilized type of care that MHC encompasses. Of the researched women, 34% did not receive any PNC. When the 33 women that received PNC were asked why they received PNC, the most indicated reasons were that they used this care as it would be beneficiary for their own health (mentioned by 48% of the women) the health of their baby (mentioned by 45% of the women) or that they received the PNC as they had had complications after giving birth (21%). Tabl3 5.8 gives an overview of all the answers that were given by the women when being asked why they used PNC. As they could indicate three factors there are multiple answers integrated in this table.

Table 5.8: Factors of influence when deciding to use postnatal care

Factors	Frequency
Complications after birth	7
Complications previous pregnancy	2
Good experience previous pregnancy	3
Advice natal family	2
Advice community	2
Recieved automatically	2
Health of the woman herself	16
Health baby	15

Of the 22 women that did not receive any PNC, 77% indicated that they did not know PNC existed. Other reasons for not using any PNC were the costs of the services, the bad treatment of the staff or that the husband or women herself did not believe it was necessary.

Although 33 women did indicated that they received postnatal care, the care received can be seen as highly insufficient. Of the women that used PNC, 21 participants (42%) indicated that the care they received consisted out of only one vaccination or drug such as a painkiller. Only 12 of the researched women (24%) indicated that they received more than one post-natal check-up. Many stories like the following were told by women that delivered in a facility: "*After giving birth in the hospital I was automatically given a tetanus toxoid injection, I did not receive any other medical care and left the hospital. Afterwards, I did not go back*". Also the following story resembles many experiences of women that gave birth at home: "*After I gave birth at home the nurse was called and I received a vaccination and pain killer, I did not receive any other care after giving birth but I don't need any more care because I am feeling fine*". On average the women received one post-natal check up, the maximum amount of check-ups was five times. When asking the women of they received the amount of checkups that was recommended by their caretaker, only 8 women indicated that this was the case. 15 women indicated that they did not receive the recommended treatment. The remaining 10 women indicated that they were not informed on the amount of checkups that they should receive or that they could not remember the amount of mentioned checkups. The women that did not receive the recommend checkup(s) told that they did not wanted to go back for this treatment. In 40% of the cases this happened because the women believed it was not necessary as they felt fine. Other reasons that were given

were that they did not know they were supposed to have any other checkups, that the waiting time was too long, or that they felt too ill to go for the remaining checkups.

The women received the PNC most often at home from a nurse (39%). Of the researched women, 15 women indicated that they received PNC from a doctor in a facility. Eight women received care from an ANM. The remaining women had contact with an AWW or AYUSH. The facility that was most often used to utilize PNC was the government hospital Balrampur, where 7 women (21%) received their checkup(s). The community recommended on where to utilize PNC in 30% of the cases. When selecting the location where the PNC would be used, availability of resources (mentioned by 39% of the women), availability doctors and nurses (mentioned by 33%) and the travel time to the location (27%) were seen as the most important factors on which the decision was based on. These and other factors are displayed in table 5.9.

Table 5.9: Factors of influence when selecting the location for postnatal care

Factors	Frequency
Avalibility doctor & nurses	15
Attitude doctor & nurses	4
Availibility resources	13
Costs services	4
Waiting times	1
Opening hours	1
Travel time	9
Travel conditions	4
Experiences friends/family	2
Opinion husband	4
Opinion in-laws	2
Opinion natal family	1
Afraid of hospitals	2
Medical emergency	1

5.3 Experiences with accessing Maternal Health Care

In this paragraph information will be given on the barriers that women came in contact with when wanting to access MHC. No distinction is being made between the different health care components. The information will be used to get a better understanding of the experiences that women from Kashyap Nagar have when utilizing maternal health care facilities. In order to present the barriers in a clear manner they are categorized in the dimensions that have been presented in the theoretical framework namely: availability, accessibility, affordability, adequacy, acceptability and personal characteristics. Each section will present a dimension and explain how these barriers were perceived by the researched women and how the women responded to this hurdle.

5.3.1. Availability

The unavailability of health care facilities was not experienced by the women as an accessibility barrier as there are many health care providers in Lucknow city located in the city block Chowk, 4 kilometers from Daliganj. The vast majority of the researched women (86.5%) that utilized one or more MHC components in a facility indicated that the availability of doctors and nurses in the facilities did not serve as a barrier at all. The possible lack of medical resources such as instruments or drugs or not seen as a barrier by 86.5% of the women. During the interviews women did not indicate that they saw referral services as a barrier as most of them did come in contact with this service or were in the position where they felt that the facility could not assist

them due to a lack in resources. The following paragraph will discuss the degree in which women were referred. The availability barriers are presented in table 5.10. Attention is being paid to the frequency and percentage of the given answers.

Table 5.10: Perception of barriers with respect to the dimension "availability"

N=37	Not at all	Just a little	Not a lot or a little	Quite a lot	Very much
Availability doctors	32 (86.5%)	2 (5.4%)		1 (2.7%)	2 (5.4%)
Availability nurses	32 (86.5%)	2 (5.4%)		1 (2.7%)	2 (5.4%)
Availability resources	32 (86.5%)	3 (8.1%)			2 (5.4%)

5.3.2. Accessibility

The researched women often did not recognize access barriers to MHC with respect to the opening hours, waiting times and transport means. The majority of the women (91.9%) did not experience that the opening hours of the facility were a barrier. Also the waiting time was often not seen as a barrier although more women did see it as a barrier compared to the other accessibility barriers (18.9%). One woman described how she had to wait hours before receiving help as the health personnel kept assisting patients that were from a higher socioeconomic class. The women that experienced the waiting times as a barrier did not leave the facility because of this. As one woman phrased it: *"I can't do anything about it so I wait"*. The majority of the women (83.8%) did not experience that the availability of transport was a barrier as many bicycle rickshaws and public transport is available in the city. However, during the interviews women did share stories of not being able to travel to a health facility while being in labor. The connection between being physically unable to travel and the inability or unwillingness of health care facilities to provide ambulance services was however not made. The possible acceptance of not being able to utilize MHC when transport could not be arranged should therefore be taken into account. The accessibility barriers are presented in table 5.11

Table 5.11: Perception of barriers with respect to the dimension "accessibility"

N=37	Not at all	Just a little	Not a lot or a little	Quite a lot	Very much
Opening hours	34 (91.9%)	2 (5.4%)			1 (2.7%)
Waiting time	30 (81.1%)	2 (5.4%)	2 (5.4%)	2 (5.4%)	1 (2.7%)
Availability transport	31 (83.8%)	4 (10.8%)		2 (5.4%)	

5.3.3. Affordability

Most of the women did not see the costs that utilizing MHC entails as a barrier. As public health care in Lucknow is supposed to be free of cost it is possible that women did not have to invest in order to receive MHC. Another explanation can be related to the way women perceive barriers in general. During interviews women indicated that costs at first were a problem when accessing the health care but that they did not see it as a barrier. Their reasoning behind this was that it

did not prevent them from using the service and therefore, it was not a barrier. The following statement was made by one of the women "*I had problems with paying for the costs but I did not let it stop me and used maternal health care anyway so it was not a barrier for me*". Of the researched women 27% indicated that the maternal health care costs were a barrier. The additional costs for medicines were not seen as a strong barrier by 83.8% of the women. The transport costs were classified as a barrier by 21.6% of the researched women. The time that was lost during travelling, and that could for instance be spent on deriving an income, was not seen as a barrier by 81.1%.. When looking at the bribes that were asked by health personnel it can be seen that the bribes asked by nurses were viewed the most as a barrier. Although bribes are often not rated as a barrier at all (89.2% with respect to doctors asking bribes, 81.1% for nurses and 83.8 for registration officers) more women indicated that nurses asking for bribes acted as barrier . These affordability barriers are presented in table 5.12

Table 5.12: Perception of barriers with respect to the dimension "affordability"

N=37	**Not at all**	**Just a little**	**Not a lot or a little**	**Quite a lot**	**Very much**
Costs services	27 (73%)	5 (13.5%)		3 (8.1%)	2 (5.4%)
Additional costs medicines	31 (83.8%)	3 (8.1%)	1 (2.7%)	2 (5.4%)	
Transport costs	29 (78.4%)	4 (10.8%)	1 (2.7%)	2 (5.4%)	1 (2.7%)
Time lost travelling	30 (81.1%)	5 (13.5%)		2 (5.4%)	
Doctors asking for bribes	33 (89.2%)			3 (8.1%)	1 (2.7%)
Nurses asking for bribes	30 (81.1%)	1 (2.7%)		4 (10.8%)	2 (5.4%)
Registration officers asking for bribes	31 (83.8%)	2 (5.4%)		3 (8.1%)	1 (2.7%)

When the women were asked how they responded to the financial barriers that they came across, four women shared that they left the facility, one woman had the goal to educate herself on conditional cash transfer schemes before returning. Seven women indicated that they paid the bribes that the staff has asked for, two refused to do so and waited until they received treatment. Of the women that paid the bribes, three borrowed money to do so. Understandably,
borrowing money in order to receive MHC can get women and their family into serious problems. The case study in box 5.2. illustrates the story of one of the researched women and the consequences that she and her family now face due to their inability to finance the care themselves.

Box 5.2: The affordability of maternal health care.

When 24 year old Priya was pregnant of her second child she used antenatal care as she experienced complications during her previous pregnancy and believed it was good for the health of her baby. When it became clear that she would need a caesarian she was admitted at the government hospital "Dr. Ram Manohar Lohia". After her caesarian she was admitted in the hospital for one week and afterwards she had to make two postnatal visits. In order to pay for the medical bills Priya's family borrowed INR 18000,- from a money lender. Due to these medical costs the family now has a debt. Priya lives in a joint family and depends on the household income of INR 3000 per month that she and her husband earn as a tailor and painter. Looking back on the financial consequences that MHC utilization caused Priya now feels that she would not borrow money again, even if it would mean that in a future pregnancy she and her baby would not receive the medical attention that they would need.

Of the researched women, 24 were asked if they had heard about conditional cash transfer schemes. Of these women, five indicated that they were not aware of the existence of such schemes. Of the researched women, 18 used a CCTS, in all cases this was the JSY scheme. Although women were very happy with the existence, many shared the same complaint. The use of the scheme often worked as an incentive for doctors and nurses to ask for bribes. As the health personnel is often aware of the fact that women received money under the JSY scheme, they ask for a contribution for their work. On several occasions new born babies were taken away from the women, forcing theme too pay a bribe in order to get their child back. Therefore, few women were compensated by the scheme as they would end up spending all the money on bribes, medicines and travel costs. Women that did not use the scheme were either not aware of the existence, did not want to use health care in a facility or were simply not interested due to personal reasons. One of the women who decided that she did not wanted to use a CCTS told us the following: *"I don't want to use a scheme, I am not greedy person".* The JSY scheme was according to these women used for skilled attendance during the delivery and for postnatal care. Of the women that were asked if they would utilize MHC again even if there would not be a CCTS in place, 13 women indicated that they would still do so, five would not. The case study in Box 5.3 aims to give an idea of the influence of the availability of CCTS on MHC use.

Box 5.3: The husbands opinion and the availability of CCTS on MHC use

The young mother Sarita married her husband at a young age. During her marriage her autonomy was strongly reduces as she her husband locked her up in a room in their home for two months after she got married. After this time period she was allowed to move around in the house but was forbidden to leave the house. At age 15 she gave birth at home to her first child. Two years later she again gave birth to a baby boy at home. During these pregnancies she did not receive any MHC as she was afraid of needles. As her abusive husband did not allow her to have contact with the community and cut her off from her natal family, causing Sarita to be even more isolated. Her isolation prevented her from coming in contact with family or community members that could try to convince her to use MHC despite her fears. When she was 20 years old and pregnant of her third baby she did not use any ANC care and again did not plan on using PNC after the delivery. However she did decide that this time she would give birth in a facility. As she was aware that she would receive a financial compensation under conditional cash transfer scheme she could convince her husband of her plan and registered for this scheme. As her husband's drinking and gambling problem had exhausted their financial resources the scheme gave a positive incentive to use MHC. Unfortunately, Sarita did not have the possibility to travel to the hospital as the delivery unexpectedly started when she went to urinate. Her husband did not see any necessity in having anyone assisting her during her delivery but when he later on panicked he called for a midwife who delivered the baby. After the delivery Sarita did not receive any PNC as her husband believed it was necessary.

5.3.4. Adequacy

The adequacy of the facility was measured by asking questions about the cleanness of the facility, the quality of the treatment and the feelings torch the health personnel. The research results show that these indicators did not serve as a strong barrier for most of the participants. The state and cleanness of the facility was not seen as a barrier by 89.2% of the researched women. The trust that women had in the quality of the treatment that facilities provide did not hamper the women to use MHC in 89.2% of the cases.

Table 5.13: Perception of barriers with respect to the dimension "adequacy"

N=37	Not at all	Just a little	Not a lot or a little	Quite a lot	Very much
Cleanness facility	33 (89.2%)	1 (2.7%)	1 (2.7%)		2 (5.4%)
Quality treatment	33 (89.2%)	1 (2.7%)		1 (2.7%)	1 (2.7%)

5.3.5. Acceptability

When looking at the degree in which woman see their surroundings as an accessibility barrier, it can be stated that in most cases (97.3% to 100%) this is not the case. It was only indicated by four women that they saw the opinion of their husband, in-laws and natal family as a barrier. Also in the case of these questions women often did not classify certain behavior of these persons as barriers because they chose to not let it influence their behavior. As one women shared with us "*my mother disagreed on me using maternal health care, but I did not let it bother me and used it anyway*". Most women (78.4%) shared that their in-laws are very positive to the idea of their daughter in law using MHC. The remaining women (each degree accounting for 2,7%) indicated that their in-laws tolerated it, thought it was a bad idea but let her go, had forbidden the woman to go, did not care or did not express their feelings. The remaining women indicated that they did not know what kind of opinion they had on this subject (10.8%). Although some family members disagreed with the use, the women went against their will and used the care anyway. The interviewed health personnel recognized a trend in the health seeking behavior as women more often take control in seeking MHC. They visit the health care facilities often with guardians like their mother in law but the gynecologists that were working at MBC's shared that they also see women increasingly visiting the facilities on their own. In addition to assessing the influence of the women's social relations, the women themselves can sometimes also be seen as a barrier. Two women indicated that they saw themselves as barriers as they were afraid of needles which prevented them from utilizing certain components of MHC. The fear that doctors and nurses would not work with the women respectful and equal manner was seen by some women (13.5%) as a big barrier. In table 5.14 an overview is given on the acceptability barriers that women perceive.

Table 5.14: Perception of barriers with respect to the dimension "acceptability"

N=37	Not at all	Just a little	Not a lot or a little	Quite a lot	Very much
Acceptance husband	36 (97.3%)			1 (2.7%)	
Acceptance in-laws	36 (97.3%)			1 (2.7%)	
Acceptance natal family	36 (97.3%)			1 (2.7%)	
Acceptance friends	37 (100%)				
Acceptance community	36 (97.3%)	1 (2.7%)			
Fear disrespect doctor	32 (86.5%)	1 (2.7%)		3 (8.1%)	1 (2.7%)
Fear disrespect nurse	32 (86.5%)	1 (2.7%)		3 (8.1%)	1 (2.7%)

5.3.6. Personal characteristics

In order to get an understanding of women's knowledge can act as a barrier, women were asked how they perceived their knowledge on compensation schemes and available facilities served as a barrier. Of these women, 13.5% believed that their knowledge on compensation schemes acted as an accessibility barrier. The knowledge on available facilities were seen by the same proportion of the women as a barrier. In table 5.14 the above mentioned results are presented.

Table 5.14: Perception of barriers with respect to the dimension "personal characteristics"

N=37	Not at all	Just a little	Not a lot or a little	Quite a lot	Very much
Knowledge compensation schemes	32 (86.5%)	2 (5.4%)		2 (5.4%)	1 (2.7%)
Knowledge available facilities	32 (86.5%)	1 (2.7%)		3 (8.1%)	1 (2.7%)

Of the researched women, 34 women shared that they believed that they knew enough about the available facilities. On average women knew one facility, only two women could mention more than 2 health care facilities. The collected data shows that government hospital Balrampur is the best known facility as 27 women indicated that they heard of the hospital. Also Queen Mary's hospital is well known as 18 women were aware of the existence of this facility. Often, the women only knew the location where they utilized the MHC when being asked of which facilities they were aware of.

Of the researched women, 39 believed that MHC is important. The natal family of these 39 women shows to be the main source of this information as women indicated 18 times (46.2% of the information sources) that they learned that MHC is important from their natal family. Other sources that have educated the women on this topic are the community (mentioned 30.8% of the times), mother in law (mentioned 18%), friends (mentioned 10.2%), the

Anganwadi center (mentioned 10.2%), husband (mentioned 2.6%) and an educational television program (mentioned 2.6%). In order to get an understanding of the autonomy that women had when deciding if they would want to use MHC, they were asked who had the most influence on the decision to use MHC. These results show that the husband of the woman has the biggest influence (52.4%). 26.2% of the women indicated that they had the most influence on this decision. Other people that the most influence had the in-laws (16.7%) and the natal family (4.7%).

As the background variables of the women prove to be very homogenous with regards to the background factors they were surveyed on, it us unfortunately not possible to make any statements about the relationships between certain personal characteristics, such as for instance caste, education level and level of autonomy, to the utilization of maternal health care.

5.3.7. Barriers perceived by women that did not use any MHC in facilities

In order to get an understanding of the barriers that might have had an influence on the decision to not utilize MHC in a facility, the women that did not visited a facility were asked which barriers prevented them from using in facility care. Of the 11 women that did not use any MHC in a facility, eight indicated that they did not try to access MHC in a facility and therefore did not face any barriers. Of the three remaining woman one woman tried to access the services but gave up, the other two indicated that they tried to overcome the barriers but that they were unsuccessful. The main barrier that prevented the women from accessing MHC was caused by the behavior of the health personnel. All three women were denied access by the caregivers. Two of the women stopped trying to access MHC in facilities because of this incident. One woman kept on trying to receive health care at the facility but access remained to be denied to her. She shared the following: *"I tried everything I could to receive MHC but they kept denying me, I even offered the doctors bribes. I told them accept the money and help me! But they still refused*". Table 5.15 gives an overview of the barriers that the participants came across when wanting to access MHC.

Table 5.14: Barriers that prevented women from utilizing MHC in facilities.

Barrier	Very strong	Just a little
The costs of the health care	1	
Understanding compensation schemes	1	
Where to go	1	1
Time lost travel	1	
Time lost waiting	2	
Opinion husband	1	
Opinion family in law	1	
Opinion community	1	
Quality treatment	1	
Cleanness facility	1	
Opening hours	1	
Availability doctors	2	
Availability nurses	2	

Availability materials	1	
Fear disrespect doctors	2	
Fear disrespect nurses	1	

5.4 Experiences with utilizing maternal health care

In this paragraph information is given on the experiences women had with utilizing MHC in a facility. Attention will be paid at their overall satisfaction and their impressions with respect to the health care facilities and the interaction they had with the health personnel. Also, the use of private facilities and the referral system from the women's perspective will be discussed.

5.4.1. Overall satisfaction

The women were overall very satisfied with the maternal health care that they received in the different facilities. Overall, the biggest proportion of the women that answered the question about their satisfaction levels with respect to MHC, stated that they were very satisfied with the care (89.4%). The remaining women stated that they were either somewhat satisfied (5.3%) or very dissatisfied (5.3%). Several gynecologists ascribe the satisfaction of women with the care to the correct expectations that women have of the care that they will receive. The women were also asked to give a grade between 1 and 10 for the MHC they received. The average grades that were given for the different parts of MHC are presented in table 5.15.

Table 5.15:Mean grades quality MHC

MHC components	Grade
Antenatal care	8.5
Care during delivery	8.5
Postnatal care	8.7

Although these satisfaction levels are very positive, it should be noted that many of the researched women had difficulties with giving grades, often resulting in them giving either the highest or the lowest grade. Also, they often did not translate bad experiences into grades as they seemed to tolerate the problems that they run into while utilizing MHC in facilities.

5.4.2. Facility

Of the women that utilized one or more MHC components in a public or private health facility 33 were able to indicate their satisfaction with respect to the location, opening hours, waiting time, availability of drugs and the number of staff that was available in the facility. The woman were on average fairly to very satisfied with the location where they utilized the MHC (mean score 1.64). Of the 33 women that answered questions about the facility, 6% indicated that they were very dissatisfied with the location of the health care facility. 12.2% indicated that they were fairly satisfied and 81.8% indicated that they were very satisfied. As Kashyap Nagar is located nearby the area where most of the health facilities are located, namely on the other side of the Gomti river, the travel distance is minimal and there are many public and private health facilities available in this area. When asking women about their satisfaction with respect to the opening hours, the vast majority (81.8%) indicated that they were very satisfied. 12.2% indicated that they were fairly satisfied and the remaining women (6%) indicated that they were very dissatisfied.

When assessing the satisfaction levels with respect to the time that the women had to wait before they received medical attention the overall satisfaction rate is somewhat lower. 27.2% of the researched women indicated that they were very dissatisfied with the waiting times and 9.1% was fairly dissatisfied. 15.2% was fairly satisfied and 48.5% was very satisfied. The main complaints with respect to the long waiting times before receiving MHC checkups were that the women would often feel very bored while waiting and would feel very uncomfortable because of the pain they endured. Also, while waiting women felt uncomfortable and stressed as they worried about their children at home that they could not feed.

The women were overall very satisfied with the availability of drugs as the majority was very satisfied (78.8%) or fairly satisfied (9.1%). The remaining women were fairly dissatisfied (3%) or strongly dissatisfied (9.1%). The women that were dissatisfied complained about having to buy medicines outside the hospital for high prices. What has to be kept in mind with interpreting these satisfaction levels is that many women did not use any drugs or only received a proportion of the prescriptions that women during and after their pregnancy should receive. Many women that participated in this research were not aware of this when answering this question. High satisfaction levels with respect to the availability of staff are also present. 81.8% of the researched women were very satisfied with the available staff and 21.1% indicated that they were fairly satisfied with the staff. Only two women indicated that they were very dissatisfied. The above mentioned satisfaction levels are presented in table 5.16.

Table 5.16: Satisfaction levels regarding the health care facility

N = 33	**Very dissatisfied**	**Fairly dissatisfied**	**Neither satisfied nor dissatisfied**	**Fairly satisfied**	**Very satisfied**
Location	2 (6 %)	4 (12.2%)			27 (81.8%)
Opening hours	2 (6 %)	4 (12.2%)			27 (81.8%)
Waiting time	9 (27.2%)	3 (9.1%)		5 (15.2%)	16 (48.5%)
Availability of drugs	3 (9.1%)	1 (3%)		3 (9.1%)	26 (78.8%)
Number of staff	2 (6 %)			4 (21.1%)	27 (81.8%)

5.4.3. Interaction with the health personnel

During the utilization of MHC the women had often contact with several persons of the medical staff. Of the women that utilized MHC in a facility, 21 had the most contact with a doctor. Six of these women also had contact with a nurse and one woman also saw an ANM. The remaining women had the most contact with a nurse or ANM of which three also saw a doctor. In order to get an understanding of the experiences women have had with respect to the staff's interpersonal skills they were asked several questions on this topic. Questions focused on trust women had in the care givers and the respect, dignity and cultural sensitivity the health personnel showed while interacting with the women. 23 of the women that saw a doctor answered questions with respect to factors. Of the women that had the most contact with a nurse or also saw a nurse, 23 answered the same questions related to their experiences with this contact.

When asking the women about the confidence and trust they had in their doctor, 22 out of the 23 women indicated that they had a great deal of confidence and trust in the doctor that

treated them. One woman did not have any confidence in her doctor. When asking the women how much they understood of the information that their doctor shared with them, 18 women indicated that they understood everything that the doctor explained to them. The others understood most of the information (1 woman), some of the information (1 woman) or nothing of it (2 women). These answers correspond with the views that the researched gynecologists shared. The researched doctors did not perceive any communication problems. They believed that they were able to communicate in a clear manner with the women as they adopted their communication strategies in such a way that women with a lower education level could still understand them.

The majority of the women (95.6%) indicated the doctor's understood their background and values. Only 4.4% did not feel the same. The majority of the women also felt that the doctor they came in contact with did not look down upon their lifestyle (91.3%) or gave advice that went against their personal believes (95.6%). Although women were still positive about the way the doctor interacted with them, 13% of the women felt that the doctor did not take their feelings in account and treated them unequal. The remaining women did not agree with this viewpoint according to the given answers. Yet, it is expected that the women were more often treated in an unequal manner than indicated as many women found it difficult to categorize the level of inequality. During the interviews they expressed the assumptions they had regarding the manner in which the doctor treated them. They often believed that the doctor should treat them in an unequal manner due to their low socioeconomic class and did not see any harm in this. The above mentioned satisfaction levels are presented in table 5.17.

Table 5.17: satisfaction levels regarding the doctor's interpersonal skills

N = 23 The doctor…	Strongly disagree	Disagree	Indifferent	Agree	Strongly agree
understood my background and values	1 (4.4%)			3 (13%)	19 (82.6%)
did not look down upon lifestyle	1 (4.4%)	1 (4.4%)		1 (4.4%)	20 (86.9%)
did not gave advice that went against personal believes		1 (4.4%)		1 (4.4%)	21 (91.2%)
took my feelings into account		3 (13%)		2 (8.7%)	18 (78.7)
treated me as a an equal		3 (13%)		3 (13%)	17 (74%)

The women that had the most contact with a nurse or ANM were asked the same questions as those that received most of the care by the doctor. The research results show that women had a bit less confidence in the nurses as 16 out of the 23 women indicated that they had a great deal of confidence and trust in the nurse that treated them. Three women had a fair amount of trust and two women had no confidence at all. The two remaining women could not indicate the level of confidence and trust they had in the nurse. 18 women indicated that they understood everything that the nurse explained to them. The others understood most of the information (1 woman), little of the information (1 woman) or nothing of the information provided (1 woman). The remaining women could not answer this question. A complaint about the nurses that was often heard was that they would often ask women many questions on sensitive subjects that were not relevant to the MHC that was sought. Women often blamed nurses of being nosy which

made them feel uncomfortable. The satisfaction levels with respect to the treatment by the nurses are presented in table 5.18.

Table 5.18: satisfaction levels regarding the nurses interpersonal skills

N = 23 The nurse…	Strongly disagree	Disagree	Indifferent	Agree	Strongly agree	Don't know
understood my background and values	4 (17.4%)		1 (4.4%)	2 (8.7%)	15 (65.2%)	1 (4.4%)
did not look down upon lifestyle	4 (17.4%)	1 (4.4%)		2 (8.7%)	16 (69.6%)	
did not gave advice that went against personal believes	3 (13%)	1 (4.4%)	1 (4.4%)	2 (8.7%)	16 (69.6%)	
took my feelings into account	3 (13%)			3 (13%)	16 (69.6%)	1 (4.4%)
treated me as a an equal	4 (17.4%)	1 (4.4%)		2 (8.7%)	15 (65.2%)	1 (4.4%)

The above mentioned research results show that a wide range of satisfaction levels amongst the women can be noticed. The experiences that a doctor from the Queen Mary hospital shared under scribes these findings as she shared that the experiences of their patients also range from very bad to very good experiences. She shared the following: "*At our hospital we have a very high patient load, resulting in long waiting times and the staff being overworked. As there is a high indoor patient load it is sometimes very difficult for nurses to find the time and patience to treat their patients with respect as they are very busy. But they are supposed to handle them in a curious and helpful manner*. The conflicting experiences that women can have with regard to the treatment by health personnel, is shown in Box 5.4.

Box 5.4: Interpersonal skills of the health personnel during an in-facility delivery

When 24 year old Rashmi was pregnant of her third child she did not plan to give birth in the hospital. She had two home deliveries prior to this pregnancy with the assistance of a nurse and did not encountering any problems. However, when she was unable to deliver her third child due to the baby's breach position, her landlord advised her to go to Balrampur hospital. Together with her sister and landlord she travelled by bicycle rickshaw to the hospital where she arrived at noon. Because it was a Sunday there were almost no doctors present in the hospital. Therefore a nurse took her in, appointed her a bed and instructed her to wait. After this the nurse left her room to drink beverages with her colleagues, even though Rashmi was in severe pain and needed immediate medical assistance. In the mean time the elder sister and sister in law of Rashmi had travelled to the hospital to assist Rashmi. However, they were kept out of the room and the nurse had forbidden them to enter the room. As Rashmi was screaming due to the horrible pains she endured, her family heard her crying for help and begged the nurse to enter the room in order to help Rashmi. The nurse insisted that it was not necessary as all women cried during childbirth and that it was all part of it and she was fine. She told them to "let her do it on her own". Her family was left crying in the hallway, feeling powerless. After 11.5 hours of labor, without any medical assistance or drugs, the baby had turned by itself and Rashmi was able to push her half way out. It was only then that the nurse came back to assist her. Luckily, both mother and child survived the delivery. After giving birth the nurse took the baby in order to have some tests performed. However, she returned without the baby. She told Rashmi and her family that they should share the happiness of the child being born and demanded INR400,-. If they would not pay her this amount, she would not bring back the baby. As the idea of losing the baby scared Rashmi and her family, they paid her the bribe. After the delivery Rashmi stayed in the hospital and received postnatal care from several doctors. She did not have any contact with the nurse that was present that Sunday. The doctors visited her twice a day and she was very pleased with the treatment she received. After eight days she was discharged and went home.

Looking back on the traumatizing experience Rashmi realizes that the nurse knew she had received INR1000,- under the JSY scheme and that she also wanted to benefit from this scheme. Rashmi herself did not benefit from the scheme as she had spend all her money on paying bribes and the transport to the hospital. Rashmi is not planning on having more children but if she would find herself being pregnant she does not want to utilize MHC in a facility ever again. Although Rashmi had very good experiences with the care she received from the doctors, her traumatizing delivery has convinced her to never visit a facility for this purpose. She however would use MHC again at home with the assistance from a nurse. This is what she had done during her previous pregnancies and she has always had good experiences with this type of care. She also would not recommend other women to deliver at Balrampur hospital.

5.4.4. Referral

When the researched women were asked if they were referred by a health care facility to another facility only two out of the 50 researched women indicated this was the case. The first woman visited Balrampur hospital and was referred to Queen Mary's hospital as the staff and medical equipment that was necessary for her treatment was not available. However, she never went to Queen Mary's as she had heard bad stories about this hospital and was afraid to go. The second woman was referred to Queen Mary's hospital from BMC Indira Nagar as the latter lacked medical equipment. She did follow up on her referral.

5.4.5. Use of private health care facilities

Eight of the researched women (16%) utilized a MHC component from a private facility during their last pregnancy. They had different reasons for wanting to utilize private health care. Four

women indicated that they decided to use MHC in a private facility because they heard there were better facilities in these centers. One of these women came specifically for an ultrasound while being pregnant. Two women did not want to go to public facilities because they heard about the bad experiences that community members had and one woman only wanted private care as she herself had bad experiences in a government hospital. One woman went to a private hospital because she was suddenly in pain and needed medical assistance. More than half of the women (56%) that did not visited a private facility did not saw any need to go to a private facility while they could receive MHC at home or at a government hospital. Other reasons that were given by the women for not using any private health care were that it was not advised by the mother in law, that they were not referred to these type of facilities or because they did not consider it or could afford it. As one woman explained: "*I never considered going to a private facility, why should I? These facilities are not for us, if we need care we can go to a public facility*".
In order to get a better understanding of the way the private and public facilities visits are selected and interchanged during a pregnancy, a case study is presented in Box 5.5.

Box 5.5: The use of public and private facilities.

When 23 year old Anju was pregnant of her first child her elder sister advised her that she should use maternal health care. As Anju had heard bad stories about the hygienic conditions of government facilities and the patient overload she decided that she only wanted to utilize health care from private facilities. Her natal family did not agree with this choice as they did not want to pay for the high costs. However, Anju did not give and was confident in her decision. Her mother eventually accepted her choice and covered half of the health care expenditure. Anju's husband paid the remaining costs. During her pregnancy she received five checkups and she was very satisfied with the facility and the health personnel. The total costs were approximately INR1800,- as each checkup cost around 400 to 500 rupees. When Anju was in labor the private nursing home advised her to undergo a caesarian. As she was afraid of the complications that could occur she decided she wanted to deliver her child in the government hospital Balrampur. She had registered here during her pregnancy in case she would need to utilize MHC in a public facility after all. After travelling to the hospital by bicycle rickshaw she was admitted in Balrampur. In this hospital she was not advised to undergo a caesarian and was able to give birth to her child without any medical interventions. The negative presumptions she had regarding the hygienic standards and attitude of the staff did not correspond with the experiences she had in this public hospital. The only negative experience she had was with a nurse who asked for a INR400,- bribe as Anju gave birth to a healthy baby boy and received money from a CCTS. Based on the experiences Anju had during her last pregnancy, she would use MHC from Balrampur if she would be pregnant again. In her case, her own positive experiences weigh against the negative stories she heard of her community members.

5.5 Expected future use

This paragraph aims to give an understanding of the factors of which women expect that they will have an influence on their future health seeking behavior. Also, an overview will be given of the factors that according to the women will be of importance when decided where the MHC should be utilized.

5.5.1. Factors of influence on the utilization maternal health care

When the women were asked whether or not they would use MHC during a possible future pregnancy, 33 women indicated that they would use this type of care again. Only three women shared that they would not use any MHC. The remaining 14 women found it difficult to answer this question as they did not plan to have any more children. All of these women were using

family planning methods like condom use or were sterilized. The researched women indicated that the experiences they had with accessing and utilizing MHC and the opinion of their husband had the strongest influence on their decision to use MHC in the future. These and the other factors that are expected to have an influence of the future use are presented in table 5.19

Table 5.19: factors influencing possible future behavior

Factor	Number of times mentioned
Experiences Access	22
Experiences Utilization	23
Location	7
Opinion husband	12
Transport	1
Opinion in-laws	4
Opinion friends	1
Health previous pregnancy	6
Opinion natal family	2
Opinion community	2
Experiences surroundings	1

As most of the women have had positive experiences with accessing and utilizing MHC and often did not perceive their husbands opinion as a barrier, the anticipated future use of MHC looks promising. However, these earlier experiences are not always a good indicator of possible future use. As one woman shared: "*I had good experiences with using the maternal health care in Queen Mary's hospital. But if my family does not want me to use care during my future* pregnancy, I will not use it". The case study in Box 5.6 shows amongst others the influence of the family's opinion on possible future MHC utilization.

Box 5.6: Expected future utilization of maternal health care

21 year old Shilpa and her husband had been trying to have a child for quite some time. Sadly, Shilpa suffered of 3 miscarriages. Afterwards she heard from her community that MHC might help her get a healthy baby. That is why when she found out she was pregnant again, she decided to use MHC. She went to the government hospital Balrampur as it was nearby so that the she could receive ANC three times without losing a lot of travel time. She also considered using ANC from a private health facility but decided to not do so as she believed that the care that she received in Balrampur was sufficient. She decided that she would have the baby at home with the help from a retired nurse as her social relationships had good experiences with this type of assistant and she believed that with this method she would have her baby in a safe manner. In addition, it was more convenient as Shilpa would not have to wait long in order to receive medical attention. And believed she would have a safe delivery this way. After giving birth Shilpa received some medicines as part of the PNC as her community recommended this to her. The nurse did not advise her to use more PNC and Shilpha herself also thought it was not necessary as she felt fine. Also, her husband believed there was no need for further postnatal care.

During the interview Shilpa shared that she was pregnant again. Even though she utilized MHC during her previous pregnancy and did not have any bad experiences while doing so, she had decided that this time she would not utilize any MHC. She believed the MHC that she has used during her last pregnancy fixed the problem that caused her to have the miscarriages. Also, her husband did not believe she needed to receive any MHC.

5.5.2. Factors of influence on the choice of maternal health care provider

The participants were also asked if they could indicate how important the earlier discussed factors would be when selecting a location where they could receive MHC during a possible future pregnancy. Women indicated that the availability and attitude of the doctors and nurses, the availability of resources and the acceptance of the husband are the factors that have the strongest influence on deciding for a certain MHC provider. These and the other factors that have an influence on this process are presented in table 5.20.

Table 5.20: factors influencing decision for possible future health care location

N=37	Not important	A little important	Indifferent	Important	Very important
Availability doctors and nurses	1 (2.7%)			13 (35.1%)	23 (62.2%)
Attitude doctors and nurses	3 (8.1%)			10 (27%)	24 (64.9%)
Availability resources	1 (2.7%)			13 (35.1%)	23 (62.2%)
Opening hours	10 (27%)			11 (29.7%)	16 (43.3%)
Waiting time	18 (48.5%)	2 (5.4%)		3 (8.1%)	14 (43.3%)
Costs services	14 (43.3%)	1 (2.7%)	1 (2.7%)	9 (24.3%)	11 (29.7%)
Transport costs	17 (45.5%)	1 (2.7%)		6 (16.2%)	13 (35.1%)
Time lost travelling	16 (43.3%)		1 (2.7%)	7 (18.9%)	13 (35.1%)
Travel conditions	17 (45.5%)		2 (5.4%)	5 (13.5%)	13 (35.1%)
Acceptance husband	11 (29.7%)	1 (2.7%)		1 (2.7%)	24 (64.9%)
Acceptance in-laws	20 (54.1%)	2 (5.4%)		5	10 (27%)
Acceptance natal family	16 (43.3%)	1 (2.7%)		10 (27%)	10 (27%)
Acceptance community	21 (56.8%)	1 (2.7%)		12	3 (8.1%)
Experiences family and friends	27 (73%)	1 (2.7%)		5 (13.5%)	3 (8.1%)

5.6 Conclusion

The utilization of maternal health care amongst the 50 researched women looks very promising as only three women did not use any maternal health care during their last pregnancy. Antenatal care is the MHC component that is most often utilized by the women as 88% indicated that they received this type of care. During the delivery most women also receive skilled assistance as 50% gave birth in a facility and 44 women received assistance from a skilled birth attendance. Postnatal care is the MHC component that is most often not used as only 66% of the researched women received any postnatal care after their delivery.

When looking at the completeness of the utilized care, it can be noticed that the vast majority of the women does not use the recommended MHC that is of key importance for the health of mother and child. The average utilization ratio for ANC consists out of two checkups during the pregnancy, one checkup less than the recommended three checkups.

17 women did not receive the recommended during the months that they were pregnant. The assistance women received while giving birth has been incomplete in certain cases. Also, the quality can be questioned as in 50% of the cases the women gave birth at home and some cases received insufficient care in health facilities. The PNC that was utilized often (42%) consisted out of one vaccination or drug such as a painkiller. Only 12 of the researched women (24%) indicated that they received more than one post-natal check-up.

The motivations for using MHC are diverse. However, certain reasons for using care during and after the pregnancy can be repeatedly recognized amongst women. The most mentioned reasons for using ANC are the health of the baby (mentioned by 45% of the women), the health of the woman herself (mentioned by 36%) and because her in laws or community wanted her to use ANC (both mentioned by 18 % of the women). Also the motivation to use PNC is the health of the woman herself (mentioned by 48% of the women) the health of the baby (mentioned by 45% of the women). Also due to complications after giving birth (21%) caused women to use PNC.

When selecting the location where the health care will be utilized different factors come to play. However, certain factors like the availability doctors and nurses and travel time to the facility can be recognized as criteria that were important when selecting the location for all three MHC components. When selecting the location where the ANC would be utilized, the opinion of the husband, (mentioned by 48% of the women), availability of doctors and nurses (mentioned by 45%) and the travel time (mentioned by 36%) were seen as the most important factors on which this decision was based on. The availability doctors and nurses (mentioned by 50% of the women) and travel time (mentioned by 42%) were also seen as important factors when selecting the birth location. In addition, did the attitude of doctors and nurses (18%) play an important role in selecting this location. When selecting the location where postnatal care should be utilized the availability of resources (mentioned by 39% of the women) and again the availability doctors and nurses (mentioned by 33%) and the travel time to the location (27%) were seen as important factors. Although many women are utilizing health care services from facilities, a big proportion receives the care in the home sphere (34%), indicating that many women feel that this location meets the above mentioned requirements.

Eight of the researched women utilized a MHC component from a private facility during their last pregnancy and 25 women visited a public facility. The government hospitals Balrampur and Queen Mary's were most often visited and also the well known facilities amongst the women. The family and community of women often had an important role in recommending the location where the care should be utilized. The ANC was often recommended by the community (35%). Other persons that often recommended this location were the women's in-laws, in particular the mother in law (35%) and the natal family of the woman (16%). The birth location was most often suggested by the in-laws of the researched women (28%) and the location where PNC could be utilized was most often recommended by the community (30%).

Next to these utilization rates the accessibility barriers to MHC were researched. The collected data shows that the majority of women do not experience accessibility barriers that have been categorized in the dimensions availability, accessibility, affordability, adequacy, acceptability, education and personal characteristics. Barriers that were most often perceived by the women were related to either the costs that accessing and utilizing care costs and the time is lost while doing so. Of the women that utilized maternal health care in a facility, 28.9% indicated that the time they had to wait before receiving medical attention and the time that they lost while traveling to the facility acted as a small to strong barrier.

The costs of the MHC services served for 27% of the women as a small to strong barrier and the transport costs for 21.6% of the women. Nurses asking for bribes served as a small to strong barrier for 18.9% of the women. In addition the refusal of care by health personnel acted as a strong barrier for three women as it prevented them from utilizing MHC. The remaining 14 women that did not use any MHC from a facility did not perceive any barriers as they never had the intentions to use the care in this location. A side note to these findings is related to the perception of barriers by the researched women. Many did not see the researched factors as a barrier if it did not prevented them to access the services. If they had overcome the barrier they often did not receive this factor as barrier. Therefore, the actual barriers that women faced may be more severe than this data shows.

Furthermore, was the satisfaction with the utilized care researched. These research results show that the women were overall very satisfied with the maternal health care that they received in the different facilities. Dissatisfaction with respect to the facility was experienced most often when having to wait for the MHC. 51.5% of the women indicated that they were fairly to very dissatisfied with the waiting times. Dissatisfaction regarding the interpersonal skills of the health personnel was mostly witnessed during the contact with the nurses. The highest level of dissatisfaction (21.8%) was related to the way nurses that looked down on the lifestyles of women and the way they treated their patients as unequal's. A side note to these findings is related to way women perceived themselves due to their socioeconomic status. Many believed that they were unequal and less important than the health personnel and in specific the doctors. Therefore, they often did not feel dissatisfied when the care givers treated them in a way that would be perceived as an in proper manner by many.

Lastly the expected future use was researched. Most of the women indicated that they expect to use MHC again if they would be pregnant again (66%). The remaining women did not plan on using MHC (6%) or did not know if they would use MHC again (28%). The experiences they had with accessing and utilizing MHC and the opinion of their husband had the strongest influence on their decision to use MHC in the future. Due to their earlier accessibility and utilization experiences women were better able to indicate which factors would be of importance when selecting the location where their expected future MHC use would take place. Almost all researched factors were seen as important. The factors that were most often mentioned were again the availability of health personnel and resources (97.3%) and the attitude doctors and nurses (91.9%). Also the opinion of their husband was seen by many women as important (70.3%).

In the following chapter the experiences that women have had with accessing and utilizing maternal health care will be discussed and compared to the existing literature on this topic.

Chapter 6 | Discussion

6.1. Introduction

In this chapter the principal results of the present study will be discussed in the light of existing literature. Firstly, the two approaches to health, namely the Human Rights Based Approach and the gender approach to health will be discussed. Secondly, the relevance of a demand side approach to this study will be reviewed. Lastly, the accessibility barriers that have been presented in the theoretical framework will be compared to the findings of the present study.

6.2. The accessibility of maternal health care in a theoretical context

In this paragraph the relevancy of the earlier presented theories will be discussed in the light of the present study.

6.2.1. The gender and Human Rights Based Approach to health

In the Human Rights Based Approach two stakeholders can be identified namely the right holders and duty bearer. In this theory the government is often appointed as the duty bearer when it comes to the accessibility of health care. However, the present study has shown that direct and indirect more duty bearers can be distinguished. The accessibility of maternal health care is influenced by many social relationships and institutions that interact in complex ways. Due to the fast growing private sector in India, many private clinics and nursing homes have emerged in urban areas. These private facilities are increasingly utilized by women from low socioeconomic groups as public health care systems are often seen as insufficient. Also NGO's are increasingly involved in increasing and defending women's entitlements to health. The government that can be seen as the main duty bearer should therefore also interact with these stakeholders as co-duty bearers. By supporting the work of NGO's and stimulating the use of private health care facilities, via for instance the Sambhav Voucher Scheme, the sometimes problematic access to maternal health care can be addressed in a holistic approach. However, as the present study has shown are the social relationships that women engage with also influential on the accessibility of health services. The husbands of the researched women and her in-laws, and especially the mother in law, have a strong say in the decision making process of women. As many women experience a limited level of autonomy their surroundings adopt a role in which certain responsibilities could be appointed to them that are often appointed to duty bearers. Although approaches should aim on increasing the autonomy of women, the social relationships should be taken into account when addressing the accessibility problematic.

This limited autonomy also addresses the importance of a gender approach to health. The manner in which the researched women are hampered by socially constructed attributes and opportunities can be brought back to financial autonomy and the decision making power they experience. The women were in 88% of the cases dependent on the income generated by their husband or other male family members. Almost half of the women (46%) did not have a say in how the money should be spend and many women could not spend money without consulting their family (42%). The decision power that women have regarding the use of MHC also shows the influence of others on their autonomy as only 26.2% of the respondents indicated that they had the most influence on the decision to use MHC. The husbands had most often this decision making power (52.4%). Also the role of housewife that was appointed to can often could hamper the accessibility of in-facility health care as many women had to be at home to take care of their children. The present study therefore under scribes the importance of a gender

approach to women's health. The inequalities that women face with respect to their autonomy correspond with other research results which proved that gender based inequalities that women face have a direct effect on the accessibility and utilization of health care services (WHO, 2009).

6.2.2. The demand side approach to health

The present study has taken a demand side perspective on the accessibility and utilization of maternal health care while incorporating demand as well as supply side barriers. This approach aims for a better understanding of the factors that hinder service uptake as well as the factors that influence the ability to utilize health care. The behavioral approach within the demand side approach as discussed by Standing (2004) and Andersen (1995), proves to be very relevant in this present study. This approach addresses the role that education has on influencing lifestyle decisions and the manner in which the person's surroundings are seen as vital for health improvements. The influence of women's social relationships and the women's knowledge on maternal health care can be seen as likely causes that are underlying the patterns of the access that the researched women experience. The present study has shown that these persons have an influence on the entire process health seeking behavior, accessing and utilizing maternal health care. Women's social relationships also have a strong role in educating women about the need for MHC. It was mostly the natal family (46.2%) and the community (30.8%) that made women aware of the importance of MHC. Also, as discussed above, has the women's husband often a strong say whether or not help can be sought. In addition doe the women's social relationships influence the amount of care women should receive and where they should receive this care. Also, the woman's lack of knowledge with respect to the completeness of the MHC they utilized, their unawareness of the importance of postnatal care and the lacking encouragement by their surroundings to utilize all MHC emphasized the importance of this type of demand side approaches.

The importance of improving accountability through the demand side is also under scribed by this present study as the strengthening of client power and the use of participatory methods seems to fit the need in Kashyap Nagar. Many of the researched women gave the impression that they were not aware of the power that they could have as a client. When faced with health personnel that did not interact in a civil way or facilities that did not meet the women's criteria women often decided the utilize care at home as it was seen more convenient. Being treated in an unequal manner was not seen as a bad interpersonal skill of the staff as women accept the prevailing power differences that their low socioeconomic status prescribes. Therefore, within this approach a role can be seen for civil society and intermediate organizations in order to influence the voice that women have in order to ignite the responsiveness of the health sector in Lucknow.

Demand side financing has been a method that has been widely implemented by the Indian government to increase the use of health care by the poor. The earlier discussed conditional cash transfer scheme Janani Suraksha Yojana has been used by 18 of the 24 interviewed women on this topic. Based on this finding it can be expected that the scheme is well known in Kashyap Nagar. Although the scheme has been very effective in India the findings of this study imply that the benefits, namely women having institutional deliveries, may not be sustainable. The researched women felt that the scheme often worked as an incentive for doctors and nurses to ask for bribes. As the health personnel are aware of the amount of money women receive, they are more often inclined to ask for bribes so that they can also benefit from the scheme. In addition it is possible that one of the main barriers for women, namely the waiting time in facilities, is due to the over-crowding that can also be (partially) traced back to

the success of the scheme. The goal to change demand side behavior by improve the tendency to utilize social sector goods by allocated transfers can be partially witnessed in Kashyap Nagar. Although women were pleased with the compensation it offers, 13 out of the 18 women would still utilize MH from medical facilities.

6.2.3. Accessibility, the perceived barriers in a theoretical context

The five accessibility dimensions that have been discussed in the first chapter, namely Availability, Accessibility, Affordability, Adequacy and Acceptability, consist out of various demand and supply barriers. In the present study similar barriers have been recognized. However, research results have also shown that certain factors have the potential to act as barriers but did not always were perceived in this manner by the researched women. Many women indicated that the supply and demand barriers did not act as barriers or were not perceived as a strong hurdle. Therefore, it must be concluded that many of the research findings contradict with the barriers that have been recognized in other empirical studies. These differences could be partially explained by the urban setting of the present study. Urban regions offer women more MHC providers than that rural area do, there are more transport options and the distances that have to be covered are considerably shorter. The positive influence of women's social relationships can also be seen as a reason why women on average come across fewer barriers. The research results from the present study have shown that these persons have a supporting role in informing women of the importance of MHC, the decision to use MHC and recommending and selecting the most suitable location. Also, the manner in which the researched women perceive barriers can be of importance. Women indicated that they did not perceive hurdles that they had to overcome as barriers, resulting in very research results that could differ from the study's perception of what a barrier encompasses. In order to give a clear overview of the barriers that have been presented in the existing literature and the barriers that were perceived by the researched women, table 6.1. is presented. In this table the differences and similarities between the present study's main findings and the previous studies will be discussed.

Dimension	*Supporting Literature*	*Factors influencing the accessibility of health according to existing literature*	*Factors influencing the accessibility of health in the present study*
Availability	Obrist et. al, 2007, Jacobs et. al, 2011, Hulton et. al. 2007, Paul et. al, 2011, Ekirapa-Kiracho et. al, 2011, Gijsbers van Wijk 1996	The availability of medical facilities can be seen as a precondition for the provision of accessible health care. When utilizing care patients can come across unqualified and unmotivated health workers which can act as an accessibility barrier. Also the lack of health care facilities, staff, drugs and other supplies, the exclusion from services and problematic referrals can act as a barrier.	The results of the present study partially correspond with the factors of this dimension that are presented by the excising literature. The researched women did not perceive the availability of health care facilities as a barrier as many services are offered in their vicinity. The majority of the researched women did not feel that the health personnel was unqualified or presumably unmotivated as they trusted the persons that provided the medical care to them. Women also did not perceive the availability of staff and resources as a barrier. These factors however did play an important role when selecting the locations where the MHC would be utilized and in the expected future selection process. Therefore the present findings do indicate that these factors have the possibility to act as a barrier once women perceive that the health facilities do not meet these needs. The exclusion from services can be seen as a very strong barrier in this study as the women that were not able to utilize MHC indicated that the refusal of care by the health personnel was the main factor that prevented them from accessing MHC. The present study cannot show to what degree the referral process proofed to be an barrier as only two of the respondents were referred and no other women indicated that they felt that they it was necessary that they were referred However, the one of these women experienced that the referral acted as a barrier as it caused her to not utilize a MHC component in the referred to facility.
Accessibility	Obrist et. al, 2007, Ensor & Cooper, 2004, Jacobs et. al, 2011, Ekirapa Kiracho et. al, 2011, Gijsbers van Wijk 1996	Available medical facilities can be found difficult to access when to opening hours that do not meet the client's needs, no transportation is available or when long waiting times that discourage clients to utilize health care	The research results show that also this dimension can partially be seen as a barrier. The opening hours were not seen as inconvenient by most of the researched women and the availability of transportation was also not perceived as a hurdle. However, the waiting times were more often seen as a barrier and indeed discourage women to use MC in a facility as they often felt very uncomfortable when waiting for medical treatment.
Affordability	Obrist et. al, 2007, Durrenda & Gilbert, 1992, Jacobs et al, 2011,	Costs for medical care, transport and bribes can be seen as barriers. Also the household resources, willingness to pay	The results of the present study partially correspond with the barriers that fall under this dimension. The majority of the respondent did not perceive these factors as strong barriers but about a fifth of the

	Paul et al, 2011, Ekirapa-Kiracho et. al, 2011, Gijsbers van Wijk 1996	and the availability of compensation schemes influence the level of accessibility	researched women experienced all the factors included in this dimension as a minor to strong barrier.
Adequacy	Obrist et. al, 2007, Hulton et. al. 2007, Jacobs et al, 2011, Gijsbers van Wijk 1996	The state of the medial facility and the quality of the health care that is provided can have an influence on the accessibility of health care.	This dimension was generally speaking not seen as an accessibility barrier by the researched women in the present study. However, these factors are often seen as very important when selecting the future location where MHC will be utilized, indicating that they could act as barriers once the available facilities do not meet the women's expectations.
Acceptability	Obrist et. al, 2007, Ensor & Cooper, 2004, Durrenda & Gilbert, 1992, Stephenson and Tsui, 2002, Jacobs et al, 2011, Gijsbers van Wijk 1996	The staff's interpersonal skills, the expectations and preferences of the household and community, cultural preferences, stigma and knowledge of prices beforehand can influence the accessibility of health care. Also the earlier experiences with utilizing health care, stories of other clients can act as a barrier.	The factors that fall under the dimension "Acceptability" correspond partially with the barriers that can be recognized in the present study. Although not all factors acted as barriers they do have the potential to become barriers due to the influence certain individuals and experiences have on women's utilization behavior. The contact that women had with doctors was often perceived as a positive experience. The interpersonal skills of some of the nurses that assisted the women had a more negative influence on this experience as almost one quarter of the participants indicated that the nurse treated them in an unequal manner and looked down on them. In some cases the attitude of the health personnel proved to be the strongest barrier. The opinion and therefore acceptance of the women's social relationships, e.g. the husband, in-laws, natal family, community and friends, was not perceived as an accessibility barrier in this study. However, the opinion of the husband has in over half of the cases a very strong influence on a woman's ability to utilize MHC and in one case it prevented a woman from accessing MHC during her first two pregnancies. Also, women's social relationships play an important part in suggesting locations were MHC can be used and women value their opinion when selecting the location for possible future utilization. This indicates that these persons do have the ability to become strong barriers for women id they would not support the use of MHC. Women were not asked about the stigma that is affiliated with MHC use but as their family and community did not act as a barrier it can be assumed that a possible stigma did not act as a barrier amongst the researched

			women. It is believed that the expectations of the utilization of MHC women were often correct as they were satisfied with the care they received and as the researched health personnel did not experience many wrong expectations. It is expected that in certain circumstances the knowledge about the price of care can influence the choice of the health care provider. Some women indicated that they did not make the decision to utilize private health care due to higher prices that are being asked by the health personnel. The present study shows that the previous experiences women have had with accessing and utilizing MHC are seen as the most important factors when deciding whether or not to use MHC again. Therefore, this theory proves to be very relevant as it indicates that bad experiences have the potential to act as a very strong access barrier. However, the stories of their surroundings do not seem to have a strong influence on this decision and therefore is expected to not act as a strong barrier when making this decision.
Personal characteristics	Obrist et. al, 2007, Ensor & Cooper, 2004, Durrenda & Gilbert, 1992, Jacobs et al, 2011, Govindasamy & Ramesh, 1997 George, 2003, Ekirapa-Kiracho et. al, 2011, Joseph & Phillips, 1984, Bloom et, al, 2001, Stephenson and Tsui, 2002, Gijsbers van Wijk 1996	The general education level that patients have and access to information on the availability and importance of health care services, providers and compensation schemes influence the level of access to health. Also the level of autonomy that women experience, their gender role in society and the socio-economic status that women have can influence this accessibility.	The research findings show that certain factors of this dimension are of importance in the community of Kashyap Nagar. About a sixth of the researched women that utilized MHC in a health facility perceived their knowledge on the available facilities as a barrier. Also, findings have shown that women often were unaware of the different facilities that were located in their vicinity. Their knowledge of MHC is often based on what their natal family and community shares with them and can therefore often be limited. The findings of the present study with respect to the use of compensation schemes are likely to correspond to the existing literature as the JSY scheme was used by a considerable number of women. This suggest that the availability of compensation schemes relief some barriers for women. The level of autonomy is also perceived to influence the accessibility to MHC as the women are often financial dependent and obedient to their husbands. As the researched personal characteristics of the women, such as their autonomy and education level and caste, are found to be homogenous it is difficult to say to what degree these characteristics play a role in accessing and utilizing MHC and how these factors influence their choice of health care provider.

Chapter 7 | Conclusion

7.1. Introduction

In this chapter the conclusion of the present study is presented. Each section will answer a sub question, leading to answering the research question of this study.

7.2. The accessibility and utilization of MHC by women from Kashyap Nagar

This paragraph aims to answer the sub questions as described in Chapter 3 "Methodology" based on the main research results that have been presented in this thesis. Each sub question will be answered in a different section.

7.2.1. To what extent do women from Kashyap Nagar utilize public and private MHC?

Empirical studies have shown that women from low socioeconomic groups that live in urban areas have more access to health care than those that are living in rural areas and therefore often utilize more MHC. When comparing the findings of the present study with the average MHC utilization rates that are present in the state Uttar Pradesh, it can indeed be noticed that the overall utilization rates in Kashyap Nagar are higher than the state average. The research results of the present study have shown that the utilization of MHC in Kashyap Nagar is quite high as 94% of the researched women utilized one or more MHC components. Also the average utilization ratio of the different MHC components is higher than the state average. In total, 88% of the researched women indicated that they utilized ANC. On average 66% of the women living in U.P. utilizes ANC and in urban areas an average of 79% can be witnessed. The women in Kashyap Nagar also received more skilled assistance while giving birth as 90% indicated that they were assisted by a skilled birth attendant during the delivery. In U.P 33% of the deliveries took place with assistance of a skilled birth attendant. The utilization of postnatal care is both in U.P. and Kashyap Nagar very low. In Kashyap Nagar 66% of the researched women received PNC. Yet, these rates are even lower in U.P. as on average only 15% of the mothers received PNC after giving birth. Based on these research results it can be concluded that the utilization of MHC in general and in facilities shows a positive step in the direction for improved maternal health in India. However, it is of key importance that the care that is utilized is complete in order to be effective. Each MHC component contributes to the health of mother and child and the full utilization of this care is of key importance when wanting to address the health problems that pregnancy and childbirth can cause.

When assessing the completeness of the MHC that has been utilized it by the participants it can be noticed that the researched women often only utilize parts of MHC. For instance women only use ANC because they prefer to deliver their child at home and don't see the importance of PNC, or they use more MHC components but only receive one or two ANC checkups. When looking at the utilization of ANC it can be noticed that very few women utilize all the recommended care as only 26% of the researched women received the recommended four checkups. This is actually a lower than the state average as 27% of the women in U.P. receive these recommended checkups. Also the completeness of the assistance that women receive during labor can be questioned as women shared stories of in-facility deliveries where they were only partially assisted by the health personnel if at al. The utilization of PNC was also often incomplete as only 24% of the women that received care that did not consist out of a pain killer or one vaccination. The low utilization of PNC can especially be a danger sign as most maternal deaths take place in the first week after birth (WHOd, 2012).

In order to improve maternal health in urban areas the Indian government tries to promote the use of MHC and in-facility deliveries in various ways, ranging from improving the supply side to addressing demand side barriers in order to make medical facilities more accessible (Govt. of India, 2010). When looking at the facility use amongst the researched women it can be noticed that the majority of the researched women (88%) utilized one or more components of MHC in a facility. Of the researched women 66% received ANC in a facility and 50% gave birth in a medical facility. This in-facility birth ratio is quite high for Indian standards as in India on average 65% of the women give birth at home and in U.P. 78% of the women. Of the 33 women that received PNC the majority (63.6%) also utilized this care in a facility. When taking a closer look at the facilities that are visited by the women it can be seen that the majority of the women utilized MHC in a public facility. Only eight out of the 50 researched women utilized MHC from a private health care provider. The MHC was predominantly utilized in public health care facilities e.g. in government Hospitals, PHC's and BMC's. The government hospital Balrampur was most often visited for ANC, BC or PNC. When utilizing ANC, 26 out of the 33 women visited a public facility and six women visited a private facility to receive this type of care. Women also delivered their child most often in a public facility as only two of the researched women gave birth in a private facility. Only one woman utilized PNC in a private facility. None of the researched women indicated that they utilized MHC from informal health care providers.

7.2.2. What motivates women to utilize maternal health care?

Women indicated that several factors influenced them to use the different components that maternal health care encompasses. However, certain motives are more prevalent than others. The most important reasons for women to utilize MHC were based on the perception that MHC use would be beneficiary to their own health and that of their unborn child. Also the opinion of the women's in-law's and community has an important influence on the choice to use maternal health care. As women indicated that most of their knowledge on the importance of maternal health care stems from their natal family, community, mother in law and friends, it can be concluded that women's social relationships are very influential when deciding to utilize MHC.

7.2.3. How do women select the location where the maternal health care will be utilized?

When the decision is made to use MHC, various factors come in to play when deciding on the location where the care will be utilized. The research results show that the availability of human and medical resources and the time that has to be spend on travelling to the location are the most important factors on which the choice of location is based on. This can be a possible explanation for the substantial levels of MHC use in the home sphere as women often know when a nurse is available and know that they can receive the care in a fast manner at a convenient time. Also, the personal relationships that women have, have an influence on this decision making process as half of the researched women indicated that the opinion of their husband is very important when selecting the location where ANC can be utilized. The decision to utilize care in a private medical facility is often based on the perception that these care distributers offer better facilities with respect to the available resources, interpersonal skills of the staff and hygienic conditions. The majority of the women did not feel the need to go to a private facility as they had other options. This suggests that many of the researched women do not feel that private health care is an option worth considering, most likely due to their low socioeconomic status.

7.2.4. Which barriers reduce the accessibility of MHC and how do women overcome these?

The majority of the possible barriers that are often distinguished by empirical studies as hurdles that women from developing countries have to overcome when accessing health care were experienced by approximately a sixth of the researched women. The strongest barriers that the researched women came across can be related to the demeanor of health personnel. In particular the refusal of care by health personnel was perceived as a very strong barrier by some. In some cases women had to pay bribes in order to receive medical treatment or in order to get back their child that the health personnel used as blackmail in order to receive bribe money. In other cases health personnel refused the women care as they for instance believed that the women were pregnant of an unlawful child. Most of the women overcame the refusal of care by paying bribe money. Others waited until they received the medical care for free and some left the facility. Three of the researched women did not receive any in-facility care due to this barrier as the health personnel continued to withhold the services that the women were entitled to.

When assessing all the different dimensions namely, Availability, Accessibility, Affordability, Adequacy and Acceptability, it can be seen that factors that are most often seen as barriers fall under the dimension “Affordability”. In addition to these bribes women often would spend money on health care, transport and medicines. Women overcame these barriers by spending the money that was necessary, which in some cases meant that women had to borrow money. Also, more women indicated that they experienced the waiting times as accessibility barrier. During the research women shared that they came across more hurdles than that the research findings on this topic show as they did not want these hurdles to be classified as barriers. The reason for this was that they perceived these challenges not as barriers as they had overcome them. Therefore, it can be expected that the researched barriers play a stronger role than that these research results have shown.

7.2.5. What kind of experiences do women have with utilizing public and private MHC?

The vast majority of the women that utilized MHC in a medical facility were fairly to very satisfied with the care they received in both public and private facilities. Most women were satisfied with the location of the facility, opening hours and available medicines and staff. However, more than half of the women were dissatisfied with the opening hours as they had to wait long times while they were in pain, feeling bored, or feeling uneasy as they left their children at home.

The women often received MHC from with either a doctor or nurse who the women in most cases both trusted. The majority of the women were satisfied with the interpersonal skills of the doctors that treated them and often felt that they were assisted in a respectful and equal manner. However, they women did share during interviews that they did not believed that they should be treated as an equal by a doctor, indicating that the women might have been easily satisfied with the manner in which doctors addressed them. Women were on average a little les satisfied with the interpersonal skills of the nurses as more women felt that the nurses did not understood their background and values, looked down on their lifestyle, gave advice that went against their personal believes and treated them in an unequal manner.

7.2.6. What factors do women expect to influence their future health seeking behavior?

Most of the women indicated that they expect to use MHC again during a possible future pregnancy. The present study confirms the theory that women base their future utilization behavior on earlier experiences. Women indicated that the experiences they have had with

accessing and utilizing MHC are the most important factors when deciding to use MHC again. These findings indicate that women indeed valued their experiences high enough to continue their utilization behavior. However, it can therefore also be expected that approximately the same amount of women will decide to utilize the care at home again and not make use of the care facilities offer. The research findings also show that the social relationships women have, have a strong influence on the decision to use MHC again. Especially the husband has an important role in the decision making process. When selecting the location where the future MHC will be utilized the factors of influence that are most often mentioned are the availability of health personnel and resources, the attitude of the health personnel and the opinion of the woman's husband.

7.3 Final conclusion

The above mentioned findings can be used to answer the main research question namely:

"What experiences do women of low socio-economic status have, living in Kashyap Nagar Lucknow, with respect to accessing and utilizing public and private maternal health care services, and how can this be expected to influence their future health seeking behavior?"

It can be concluded that the utilization ratios in Kashyap Nagar are higher than the state average and that the majority of the researched women from this community have good experiences with accessing and utilizing maternal health care services in public and private health facilities. However, some of the researched women did have to overcome difficult barriers that were mostly related to the affordability and the acceptability of the services. This therefore implies that the strongest barriers to the access of MHC that women from this community encountered are a mix of supply and demand side barriers. Most of the women were able to overcome these barriers but those that did not succeed in doing so subsequently did not utilize any MHC in a facility. The research findings have shown that the earlier experiences women have with accessing and utilizing MHC are the two most important factors when deciding whether or not to utilize MHC in the future. It can be expected that these overall experiences women have had will have a positive influence on the future utilization behavior as most women indicated that these experiences were predominantly positive and because they indicated that they expect to use MHC again. However, this promising conclusion needs a side note. The future in-facility utilization of MHC by the researched women is strongly dependent on certain factors that are not controlled by the women and that can potentially emerge as new barriers.

Firstly, the knowledge on the importance of maternal health care has a strong influence on the utilization behavior of women. The majority of the women indicated that they used MHC because they believed it was important for their own health and that of their child. The vast majority of the women retrieved this information from the people around them, especially from their family. Also the decision to use maternal health care and the location where the care will be utilized is strongly dependable on the knowledge and the approval of social relations, especially of that of their husband. The lack of autonomy in deciding when and where to utilize MHC can have negative consequences. For instance, if the opinion of the people surrounding the women changes with regard to the acceptability of MHC, for instance due to financial restraints, the expected future utilization behavior can be negatively influenced as new accessibility barriers may arise.

Secondly, factors that play an important role in deciding where to utilize future MHC are the very same factors where the women were less satisfied with, such as the availability of

human and medical resources, waiting times and the attitude of the doctors and nurses. As Lucknow is currently witnessing the overcrowding of the health sector it can be expected that women will come across more hurdles when accessing MHC in the future as overcrowding is often related to problems such as long waiting times and rude behavior of nurses. These changing circumstances can therefore have a negative influence on the overall use of MHC and the in-facility use, which subsequently can be reflected in the maternal health status of the researched women.

Therefore, it can be stated that the findings of the present study look promising but might be threatened by possible future barriers that may arise from factors that are currently very influential on the MHC utilization behavior of the researched women. This stresses the need for scholars, policy makers and ultimately the duty bearers to keep investing in increasing and safeguarding the accessibility of maternal health care in urban areas so that the positive trend with regard to the increasing utilization rates may continue.

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Appendix A – Questionnaire

Introduction
I would like to ask you some questions about your last pregnancy. This means that all questions are about the time period when you were pregnant with your youngest child. Only one answer per question is possible, unless indicated otherwise. The first part of this survey consists of questions that focus on the care you have received during your most recent pregnancy.

Section 1: Health seeking behavior & Care received

1. **Did you receive antenatal care for your most recent pregnancy?** With ante-natal check-ups we mean the care that you received during your pregnancy until the moment you gave birth. Services that are included in ante-natal care are for instance; checking of your weight, blood pressure check, Tetanus *vaccines*, feeling of the abdomen, an internal exam, recommendation for an ultrasound etc.
   - o Yes. Please go to question 3
   - o No
   - o I can't remember. Please go to question 13

2. **What was/were the reason(s) you did not receive any ante-natal care? A maximum of 3 answers is possible.**
   - o I did not know ante-natal care existed
   - o I did not know that costs could be refunded
   - o I believed using it would not make any difference
   - o My family in law did not want me to use it
   - o Transportation to nearby facilities are difficult to get/expensive
   - o The care was only available at facilities which are far away, too much travel time
   - o The care was only available at facilities which are far away, too much travel costs
   - o The care was only available at facilities which are far away, too much discomfort
   - o I heard bad stories about the experiences of relatives/friends
   - o People in my community thought it was strange if I would use it
   - o I had bad experiences with ante-natal care during a previous pregnancy
   - o I was afraid it would have a negative effect on my baby's health
   - o I was afraid of the costs of the services
   - o I was afraid the persons in the facility would treat me badly
   - o The waiting times at the facility would take too much of my time
   - o Other: …………………

Thank you for answering this question, please go to question 13 to continue the survey

3. **If yes, why did you receive ante-natal care? A maximum of 3 answers is possible.**
   - o The ante-natal care services were available close by
   - o My friends received antenatal care so I thought it was a good idea
   - o I had complications during a previous pregnancy
   - o I believed it was important for my baby's health
   - o I believed it was important for my own health
   - o I had good experiences with using post-natal care during a previous pregnancy
   - o My husband wanted me to use it
   - o My in-laws wanted me to use it
   - o My natal family wanted me to use it
   - o I knew that the costs of care would be refunded
   - o People in my community told me it would be good
   - o Other: …………………

4. **Where did you receive the ante-natal help? Multiple answers are possible.**
    - Government hospital Queen Mary's
    - Government hospital Balrampur
    - District hospital
    - Mother and Child Care Centre - Naval Kishore Road
    - Mother and Child Care Centre – Chitwapur
    - Mother and Child Care Centre – Silver Jubilee
    - Mother and Child Care Centre – Aliganj
    - Mother and Child Care Centre – Redcross (Kaiserbagh)
    - Mother and Child Care Centre – Tudiyaganj
    - Mother and Child Care Centre – Aishbagh
    - At a relative/friends house, with help from ……………………… (please insert who provided this care)
    - At home, with help from ………………….....…….......……….(please insert who provided this care)
    - Other: …………………

5. **Which factors were the most important when selecting the location where you could receive maternal health care services?** Maximum of 3 answers is possible.
    - Costs for the services
    - Travel time
    - Travel costs
    - Travelling conditions
    - Opinion of husband
    - Opinion of family of law
    - Opinion of natal family
    - Opinion of community
    - Experiences of family/friends with this facility
    - Availability of doctors and nurses
    - Attitude of doctors and nurses
    - Availability of drugs and other resources
    - Opening hours of the facility
    - Waiting times
    - other namely: ……………………………….

6. **Were there any other conditions that were important when selecting this location?**
    - No
    - Yes, namely: ………………………………………………………………………………
      …………………………………………………………………………………………………….
      …………………………………………………………………………………………………….

7. **Was this facility recommended to you by anyone? Multiple answers are possible.**
    - Yes, it was recommended to me by the Anganwadi centre
    - Yes, it was recommended to me by the Auxiliary Nurse Midwife (ANM)
    - Yes, It was recommended by my neighbors/people living in my community
    - Yes, other namely ………………..
    - No

8. **Who did you see in this facility? Multiple answers are possible.**
    - Doctor
    - Auxiliary Nurse Midwife (ANM)
    - Anganwadi worker
    - AYUSH (Ayurveda, Yoga, Unani, Siddha, Homeopathy)
    - Vaids, Hakim
    - Informal doctors
    - Relative/friend
    - No one
    - Other: …………………

9. **How many times did you visit a health facility for ante-natal check-ups?**
    - Approximately …….. times

- I cannot remember

10. Did the doctor inform you of how many check-ups you were supposed to have during your pregnancy?
- Yes, please specify the number: ….
- No
- I cannot remember

11. Did you receive all the ante-natal check-ups your doctor recommended?
- Yes. Please go to question 13
- No
- I cannot remember. Please go to question 13

12. What was the reason you did not receive all ante-natal check-ups? A maximum of 3 answers is possible.
- Not all the services were being provided by the facility/person I visited
- I did not know all of these services were part of antenatal care
- I did not think it was necessary to use all of these services because I felt fine
- I forgot to go back for the remaining check-up(s)
- It would take too much of my time to travel to the facility
- It would take too much of my time to wait for my appointment
- I was too tired to travel to the facility
- It became too expensive to pay for the traveling costs
- It became too expensive to pay for these services
- My husband didn't think it was necessary
- My family didn't think it was necessary
- I had bad experiences with the staff during previous check-ups
- I had no trust in the treatment I was given during previous check-ups
- Other: …………………

13. Where did you give birth to your youngest child?
- Government hospital Queen Mary's
- Government hospital Balrampur
- District hospital
- Mother and Child Care Centre - Naval Kishore Road
- Mother and Child Care Centre – Chitwapur
- Mother and Child Care Centre – Silver Jubilee
- Mother and Child Care Centre – Aliganj
- Mother and Child Care Centre – Redcross (Kaiserbagh)
- Mother and Child Care Centre – Tudiyaganj
- Mother and Child Care Centre – Aishbagh
- At a relative/friends house, with help from ……………………… (please insert who provided this care)
- At home, with help from ………………….…………………………..(please insert who provided this care)
- Other: ………………………

14. Which factors were the most important when selecting the location where you could give birth? Maximum of 3 answers is possible.

- Costs for the services
- Travel time
- Travel costs
- Travelling conditions
- Opinion of husband
- Opinion of family of law
- Opinion of natal family
- Opinion of community
- Experiences of family/friends with this facility
- Availability of doctors and nurses
- Attitude of doctors and nurses
- Availability of drugs and other resources
- Opening hours of the facility
- Waiting times
- other namely: ………………………………

15. Were there any other conditions that were important in when selecting this location?

- No
- Yes, namely: ……………………………………………………………………………………
  ………………………………………………………………………………………………….

16. Was this facility recommended to you by anyone? Multiple answers are possible.

- Yes, it was recommended to me by the Anganwadi centre
- Yes, it was recommended to me by the Auxiliary Nurse Midwife (ANM)
- Yes, It was recommended by my neighbors/people living in my community
- Yes, other namely ………………..
- No

17. Who assisted with the delivery of your youngest child? Multiple answers are possible.

- Doctor
- Auxiliary Nurse Midwife (ANM)
- Anganwadi worker
- AYUSH (Ayurveda, Yoga, Unani, Siddha, Homeopathy)
- Vaids, Hakim
- Informal doctors
- Relative/friend
- No one
- Other: ……………………………

18. Did you receive post-natal care for your most recent pregnancy? With post-natal care we mean the care you yourself received after giving birth and not the care your baby received.

- Yes. Please go to question 20
- No.
- Can't remember. Please go to question 20

19. What was/were the reason(s) you did not receive any post-natal care? A maximum of 3 answers is possible.

- I did not know post-natal care existed
- I did not know that costs could be refunded
- I believed using it would not make any difference
- My family in-law did not want me to use it
- I heard bad stories about the experiences of relatives/friends
- People in my community thought it was strange if I would use it
- I had bad experiences with post-natal care during a previous pregnancy
- I was afraid it would have a negative effect on my baby's health
- I was afraid of the costs of the services
- I was afraid the persons in the facility would treat me badly
- It would take too much of my time
- I used traditional methods of postpartum care at home and believed that was enough
- Other: …………………

<u>Thank you for answering this question, please go to Section 2, question 30 to continue the survey</u>

20. If yes, why did you receive post-natal care? A maximum of 3 answers is possible.
- o My friends received post-natal care so I thought it was a good idea
- o I developed a complication in the post-partum period
- o I had complications during a previous pregnancy
- o I believed it was important for my baby's health
- o I believed it was important for my own health
- o I had good experiences with using post-natal care during a previous pregnancy
- o My husband wanted me to use it
- o My in-laws wanted me to use it
- o My natal family wanted me to use it
- o I knew that the costs of care would be refunded
- o People in my community told me it would be good
- o Other: …………………

21. Where did you receive the post-natal care? Multiple answers are possible.
- o Government hospital Queen Mary's
- o Government hospital Balrampur
- o District hospital
- o Mother and Child Care Centre - Naval Kishore Road
- o Mother and Child Care Centre – Chitwapur
- o Mother and Child Care Centre – Silver Jubilee
- o Mother and Child Care Centre – Aliganj
- o Mother and Child Care Centre – Redcross (Kaiserbagh)
- o Mother and Child Care Centre – Tudiyaganj
- o Mother and Child Care Centre – Aishbagh
- o At a relative/friends house, with help from …………………… (please insert who provided this care)
- o At home, with help from ………………….......................... (please insert who provided this care)
- o Other: …………………

22. Which factors were the most important when selecting the location where you could receive post-natal services? Maximum of 3 answers is possible.
- o Costs for the services
- o Travel time
- o Travel costs
- o Travelling conditions
- o Opinion of husband
- o Opinion of family of law
- o Opinion of natal family
- o Opinion of community
- o Experiences of family/friends with this facility
- o Availability of doctors and nurses
- o Attitude of doctors and nurses
- o Availability of drugs and other resources
- o Opening hours of the facility
- o Waiting times
- o other namely: ……………………………….

23. Were there any other conditions that were important when selecting this location?
- o No
- o Yes, namely: ………………………………………………………………………………………
  ……….

24. Was this facility recommended to you by anyone? Multiple answers are possible.
- o Yes, it was recommended to me by the Anganwadi centre
- o Yes, it was recommended to me by the Auxiliary Nurse Midwife (ANM)

- Yes, It was recommended by my neighbors/people living in my community
- Yes, other namely ………………..
- No

25. Who did you see? Multiple answers are possible.
- Doctor
- Auxiliary Nurse Midwife (ANM)
- Anganwadi worker
- AYUSH (Ayurveda, Yoga, Unani, Siddha, Homeopathy)
- Vaids, Hakim
- Informal doctors
- Relative/friend
- No one
- Other: …………………

26. How many times did you visit a health facility for post-natal care?
- Approximately …… times
- I can't remember

27. Did the doctor inform you of how many check-ups after giving birth you were supposed to have?
- Yes
- No
- I cannot remember

28. Did you receive all the post-natal check-ups your doctor recommended?
- Yes. Please go to section 2, question 30
- No
- I cannot remember

29. What was the reason you did not receive all post-natal check-ups? A maximum of 3 answers is possible.
- Not all the services were being provided by the facility/person I visited
- I did not know all of these services were part of post-natal care
- I did not think it was necessary to use all of these services because I felt fine
- I forgot to go back for the remaining check-up(s)
- It would take too much of my time to travel to the facility
- It would take too much of my time to wait for my appointment
- I was too tired to travel to the facility
- It became too expensive to pay for the traveling costs
- It became too expensive to pay for these services
- My husband did not think it was necessary
- My family did not think it was necessary
- I had bad experiences with the personnel during previous check-ups
- I had no trust in the treatment I was given during previous check-ups
- Other: …………………

Section 2: Experience utilization

The following questions focus on the experience you had while using ante-natal and/or natal and/or post-natal maternal health care services in a ***facility****. If you used these services from different facilities, please answer these questions based on the facility whose services you used the most. If you did not use any maternal health care services from health care facilities during your last pregnancy, please go to the next section, section 3: Access.*

30. Overall, how satisfied are you with the experience you had when using ante-natal, natal and post-natal services? Please indicate your level of satisfaction with a number between 0-10, 10 being completely satisfied and 0 not being satisfied at all. If this is not applicable to you, please circle that response.

30. Ante-natal services: ………. /not applicable
31. Natal services ………./ not applicable
32. Post-natal services : ………./ not applicable

33. With whom did you have the most contact when receiving maternal health care in a facility?
- Doctor
- Nurse
- Auxiliary Nurse Midwife (ANM)
- Other: …………………

The following questions are about the contact you had with a doctor. If you were not treated by a doctor please go to question 41.

34. How much confidence and trust did you have in the doctor(s) treating you?
- Great deal
- A fair amount
- Not too much
- None at all
- Don't know

35. During the visit, how much could you understand of what the doctor said?
- Everything
- Most of it
- Some
- Only a little
- Nothing

36. **Thinking about the maternal health care that you received during your last pregnancy, to what extent do you agree with the following statements?** Please put an "X" in the box that reflects your opinion the most.

I felt that…	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
36 .the doctor didn't understand my background and values					
37. my doctor looked down on me and the way I live my life					
38. the advice that I was given by my doctor went against my personal beliefs					
39. the doctor didn't take my feelings into account					
40. the doctor did not treat me as an equal					

<u>The following questions are about the contact you had with the nurse(s). If you were not treated by a nurse please go to question 48</u>

41. How much confidence and trust did you have in the nurse(s) treating you?

- o Great deal
- o A fair amount
- o Not too much
- o None at all
- o Don't know

42. During the visit, how much could you understand of what the nurse said?

- o Everything
- o Most of it
- o Some
- o Only a little
- o Nothing

43. **Thinking about the maternal health care that you received during your last pregnancy, to what extent do you agree with the following statements?** Please put an X in the box that reflects your opinion the most.

I felt that…	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
43.the nurse(s) didn't understand my background and values					
44.The nurse(s) looked down on me and the way I live my life					
45.the advice that I was given by the nurse(s) went against my personal beliefs					
46.the nurse(s) didn't take my feelings into account					
47.the nurse(s) did not treat me as an equal					

48. Thinking about all of the experiences you have had with health care visits during your most recent pregnancy, have you ever felt that the doctor or medical staff who treated you, judged you unfairly or treated you with disrespect and less dignity? Multiple answers possible.

- o Yes the doctor
- o Yes the nurse
- o Yes other medical staff
- o No, go to question 50
- o Do not know, go to question 50

49. What happened to make you feel you were judged unfairly or treated with disrespect? Multiple answers possible.

- o The doctor or staff talked down to me
- o Heard staff say something negative about me
- o The doctor or staff kept me waiting
- o Took other patients instead of me / treated other patients better
- o Was refused care / had difficulty getting care
- o Received bad quality care
- o The doctor or staff didn't spend enough time / rushed
- o Acted negatively or disrespectfully / rude / impolite
- o Physical abuse by doctor or staff
- o Didn't listen or pay enough attention to me / Ignored me
- o Didn't involve me in decisions about my care as much as I wanted
- o Didn't explain things well or at all
- o Doctor wanted money from me
- o Other: …………………

50. How satisfied were you with the following aspects of the facility? Please put an X in the box that reflects your opinion the most.

	Very dissatisfied	Fairly dissatisfied	Neither satisfied nor dissatisfied	Fairly satisfied	Very satisfied
50.Location					
51.Opening hours					
52.Waiting time					
53.Availability of drugs					
54.Number of staff					

55. If any of the above questions is answered with fairly or very dissatisfied, please explain why you felt dissatisfied with these aspects:

………
………
………
………
………
………
………
………

56. Have you been referred by a health facility to another facility because they did not have the resources (such as medicines or the equipment) to help you?

- Yes
- No. Please go to question 52
- I cannot remember. Please go to question 52

57. Why were you referred?

- There was no bed/place for me to stay
- There was no staff available that could help me
- The medical equipment I needed was not available
- The medicines I needed were not available
- I was not told
- I was told but I couldn’t understand
- I can’t remember
- Other: ………………….

58. From which facility were you referred?

- Mother and Child Care Centre - Naval Kishore Road
- Mother and Child Care Centre – Chitwapur
- Mother and Child Care Centre – Silver Jubilee
- Mother and Child Care Centre – Aliganj
- Mother and Child Care Centre – Redcross (Kaiserbagh)
- Mother and Child Care Centre – Tudiyaganj
- Mother and Child Care Centre – Aishbagh
- District hospital
- Government hospital Queen Mary’s
- Government hospital Balrampur
- Other: …………………

59. To which facility were you referred?

- Government hospital Queen Mary’s
- Government hospital Balrampur
- District hospital
- Mother and Child Care Centre - Naval Kishore Road
- Mother and Child Care Centre – Chitwapur
- Mother and Child Care Centre – Silver Jubilee
- Mother and Child Care Centre – Aliganj
- Mother and Child Care Centre – Redcross (Kaiserbagh)
- Mother and Child Care Centre – Tudiyaganj
- Mother and Child Care Centre – Aishbagh
- Other: …………………

60. Did you go to the facility you were referred to?

- Yes, go to question 62
- No

61. Why did you not go to this facility?

- o I had no transport
- o I had no time to visit the other facility
- o I didn't think I needed the service after all
- o My family in-law didn't think I would need the service after all
- o I didn't understand what to do
- o I was afraid of additional costs for the services
- o I was afraid of being treated at the other facility
- o Other: …………………

62. Overall, how satisfied or dissatisfied are you with the quality of the maternal health care services you have received during and after your most recent pregnancy?

- o Very satisfied
- o Somewhat satisfied
- o Somewhat dissatisfied
- o Very dissatisfied

63. Have you used any maternal health care from private health care facilities during or after your last pregnancy?

- o Yes
- o no

64. What was the reason for this decision?

………
………

65. Have you used any maternal health care from private health care facilities during or after a other previous pregnancy?

- o Yes
- o no

66. What was the reason for this decision?

………
………

Section 3: Access

When a woman is pregnant and is considering using maternal health care services she often comes across difficulties that influence the options that she has. I would like to ask you some questions concerning your experiences with accessing maternal health care services during your last pregnancy.

If you received ante-natal care, post-natal care in a facility or you gave birth in a health facility please answer the following questions. If this was not the case, please go to question 104.

67. Thinking back about when you realized you wanted to use maternal health care services, which facilities did you know of that offered maternal health care services?

- Government hospital Queen Mary's
- Government hospital Balrampur
- District hospital
- Mother and Child Care Centre - Naval Kishore Road
- Mother and Child Care Centre – Chitwapur
- Mother and Child Care Centre – Silver Jubilee
- Mother and Child Care Centre – Aliganj
- Mother and Child Care Centre – Redcross (Kaiserbagh)
- Mother and Child Care Centre – Tudiyaganj
- Mother and Child Care Centre – Aishbagh
- Other: …………………

68. Did you feel that you had enough knowledge about the available facilities?

- Yes
- No

69. Did you feel that maternal health care services were important?

- Yes
- No. Please go to question 71

70. Where did you learn that the use of maternal health care services were important?

- I heard it from family
- I heard it from friends
- I heard it from community members
- I was taught at school
- I was taught at the Anganwadi center
- The Auxiliary Nurse Midwife thought me
- I can't remember
- Other: …………………

71. Thinking about the difficulties you had to overcome when wanting to use maternal health care services, to what extent did the following factors serve as barriers that you had to overcome in order to use these services? Please put an "X" in the box that reflects your opinion the most.

	Not at all	Just a little	Not a lot or a little	Quite a lot	Very much
71.Costs health care					
72.Travel cost to facility					
73.Additional medicine costs					
74.Understanding compensation schemes					
75.Understanding where to go					
76.Availability transport					
77.Time lost travel					
78.Time lost waiting					
79.Opinion of husband					
80.Opinion of family in law					
81.Opinion natal family					
82.Opinion friends					
83.Opinion community					

	Not at all	Just a little	Not a lot or a little	Quite a lot	Very much
84.Quality treatment					
85.Cleanness facility					
86.Opening hours facility					
87.Availability doctors					
88.Availability nurses					
89.Availability materials					
90.Availability doctors					
91.Doctors asking for bribes					
92.Nurses asking for bribes					
93.Registration officers asking for bribes					
94.Fear disrespectful doctors					
95.Fear disrespectful nurses					

96. Were there any other factors/problems that you had to overcome when wanting to use maternal health care services that were not mentioned? If so please mention them in the space below.

………
………
………
………
………
………
………
………

97. How did you overcome the difficulties that you described as “Quite a lot” and “Very much” in the previous questions?

Number difficulty: …….. I overcame this by…………………………………………………………………………….
…….
…….
…….
Number difficulty: …….. I overcame this by…………………………………………………………………………….
…….
…….
…….
Number difficulty: …….. I overcame this by…………………………………………………………………………….
…….
…….
…….
Number difficulty: …….. I overcame this by…………………………………………………………………………….
…….
…….
…….
Number difficulty: …….. I overcame this by…………………………………………………………………………….
…….
…….
…….

Please use the blank page on the back of the questionnaire if there is not enough space to mention how you overcame the other difficulties that you faced.

98. Did you use a conditional cash transfer scheme for maternal health care services?

- o Yes
- o No, please go to question 102

99. For which maternal health care services did you use this conditional cash transfer scheme?

- o Ante-natal care
- o Giving birth in an facility
- o Post-natal care

100. Which conditional cash transfer scheme did you use?

- o Jojana Surakasha Yojana
- o Sambhav voucher scheme
- o Other: …………………

101. Do you think you would have used these services if this scheme was not available?

- o Yes
- o No

102. How did your family in-law feel about you using maternal health care services?

- o They were very positive
- o They tolerated it but did not support me
- o They told me it was not a good idea but let me go
- o They were against it and had forbidden me to go
- o They did not care
- o They didn't express their feelings about it
- o I don't know

103. Who had the most influence on the decision to use maternal health care services?

- o Myself
- o My husband
- o My parents in law
- o My natal family
- o My community
- o My friends
- o Other: …………………

Thank you for answering this question, please go to section 4, question 133 to continue the survey

104. Did you try to use maternal health care services for your most recent pregnancy?

- o yes
- o I tried but then I gave up
- o Not at all. Please go to section 4, question 133

105. Thinking about the difficulties you had to overcome when wanting to use maternal health care services, to what extent did the following factors prevented you from using these services? Please put an "X" in the box that reflects your opinion the most.

	Not at all	Just a little	Not a lot or a little	Quite a lot	Very much
105.Costs health care					
106.Travel cost to facility					
107.Additional medicine costs					
108.Understanding compensation schemes					
109.Understanding where to go					
110.Availability transport					
111.Time lost travel					
112.Time lost waiting					
113.Opinion of husband					
114.Opinion of family in law					
115.Opinion natal family					
116.Opinion friends					
117.Opinion community					

	Not at all	Just a little	Not a lot or a little	Quite a lot	Very much
118.Quality treatment					
119.Cleanness facility					
120.Opening hours facility					
121.Availability doctors					
122.Availability nurses					
123.Availability materials					
124.Availability doctors					
125.Doctors asking for bribes					
126.Nurses asking for bribes					
127.Registration officers asking for bribes					
128.Fear disrespectful doctors					
129.Fear disrespectful nurses					

130. Were there any other factors/problems that you had to overcome when wanting to use maternal health care services that were not mentioned? If so please mention them in the space below.

………
………
………
………
………
………
………
………

131. Did you try to overcome these barriers?

- Yes
- No. Please go to question

132. What prevented you from overcoming the difficulties that caused you to not use maternal health care services? Please elaborate on the factors which influence was graded by you "Quite a lot" and "Very much" in the previous questions.

Number difficulty: …….. It prevented me to use the services because……………………………………
………
………
Number difficulty: …….. It prevented me to use the services because……………………………………
………
………
Number difficulty: …….. It prevented me to use the services because……………………………………
………
………
Number difficulty: …….. It prevented me to use the services because……………………………………
………
………

Please use the blank page on the back of the questionnaire if there is not enough space to mention how you overcame the other difficulties that you faced.

Section 4: Future use of maternal health care services

Experiences with accessing and using maternal health care services during a previous pregnancy can have an influence on the way you will feel about using these services again in the future. Although you might not know whether you will have another baby and it is difficult to look into the future ,I want to ask you to imagine how you would feel about using maternal health care services if you would become pregnant again.

133. Now thinking about the future, how confident are you that you can use maternal health care services when you would need it?

- Very easy
- Easy
- Not easy, not difficult
- Difficult
- Very difficult
- I don't know

134. Would you try again to use maternal health care services if you would be pregnant again?

- Yes
- No
- I don't know

135. Which factors will have the most influence on your decision to use maternal health care services? A maximum of 3 answers is possible.

- Earlier experiences with accessing these services
- Earlier experiences with using these services
- The location of the health care facility
- The transport means to the facility
- The availability of schemes that cover costs
- The opinion of my husband
- The opinion of my in-laws
- The opinion of my natal family
- The opinion of my friends
- The opinion of my community
- How my previous pregnancy(s) went
- Stories I have heard from others using this facility
- Other: …………………
- I don't know

136. How important do you think will the following factors be when selecting the location where you could receive maternal health care services in the future? Please put an "X" in the box that reflects your opinion the most.

	Not important	**A little important**	**Indifferent**	**Important**	**Very important**
136.Costs for the services					
137.Travel time					
138.Travel costs					
139.Travelling conditions					
140.Opinion of husband					
141.Opinion of family of law					
142.Opinion of natal family					
143.Opinion of community					

	Not important	**A little important**	**Indifferent**	**Important**	**Very important**
144.Experiences family/friends					
145.Availability of doctors and nurses					
146. Attitude of doctors and nurses					
147.Availability of drugs and other resources					
148.Opening hours of the facility					
149.Waiting times					

Section 5: Background information

150. What is your marital status? I am:

- Married
- Divorced
- Widowed
- Other: ………………..

151. **Which of the following household situations is applicable to you? Multiple answers possible.**

- Living alone
- Living in a joint family
- Living in a nuclear family
- Living with my natal family
- Other: ………………..

152. Could you provide us with some information about the pregnancy's you have had? Please fill in the following table by answering the questions.

Pregnancy Order	**Result of pregnancy**				**Is child alive or dead at present?**	**Sex of child**	**Age of child**
	Live Birth	**Miscarriage**	**Aborted**	**Still Birth**			
Number:							
Number:							
Number:							
Number:							
Number:							
Number:							
Number:							

153. Are you currently pregnant?

- Yes
- No
- I don't know

154. Are you engaged in income generation work within or outside your house?

- Yes, within the house
- Yes, outside the house
- No, please go to question 157

155. How many hours do you work a week?

- Full-time (40 hours a week or more)
- Part-time(less than 40 hours a week)

156. What kind of work do you do?

……

157. Is your husband engaged in income generation work within or outside the house?

- Yes, within the house
- Yes, outside the house
- No, please go to question 160
- Not applicable, I don’t have a husband

158. How many hours does he work a week?

a. Full-time (40 hours a week or more)
b. Part- time(less than 40 hours a week)

159. What kind of work does he do?

…….

160. What is approximately your household income per month?

Rs. ……………………

161. To which caste do you belong?

…….

162. What is the highest standard you completed in school?

- First standard
- Second standard
- Third standard
- Fourth standard
- Fifth standard
- Sixth standard
- Seventh standard
- Eight standard
- Ninth standard
- Tenth standard
- Eleventh standard
- Twelfth standard
- None

163. Have you completed any form of education?

- o No
- o Yes, Vocational training
- o Yes, Higher Education (such as university)
- o Yes, my relatives/friends thought me my profession
- o Yes, namely: …………………..

164. What is your age?

- o I am ...... years old
- o I don’t know exactly, I think I am approximately .... years old
- o I do not know

Appendix B – Wealth Index and scores

Wealth Index	HH. No.		HH. No.		HH No.		HH No.		HH. No.		HH. No.	
Researcher: A B C D E	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Household goods												
1.Mattress	-	-	-	-	-	-	-	-	-	-	-	-
2.Pressure cooker												
3.Chair												
4.Cot or bed												
5.Table												
6.Electricity												
7.Electric fan												
8.Radio or transistor												
9.Television (back & white)												
10.Television (colour)												
11.Gas stove												
12.Sewing machine												
13.Mobile telephone												
14.Any other type of telephone												
15.Computer												
16.Refrigerator												
17.Watch or clock												
18.Water connection												
Means of transport												
19.Bicycle												
20.Motorcycle or scooter												

21.Animal-drawn cart												
22.Car												
Agricultural Land												
23.No agricultural land												
24.Irrigated land only												
25.Non-irrigated land only												
26.Both irrigated & non-irrigated land												
Land and registration												
27.Ownership of a house												
28.Owning farm animals												
29.Owning a bank/post office account												
30.Mosquito net for sleeping												
Total												

Classification
Level 1 = 0-7 points
Level 2 = 7-13 points
Level 3 = 13-19 points
Level 4 = 19-23 points

Wealth Index scores

Household Goods	Household possessions
Mattress	18
Pressure cooker	37
Chair	21
Cot or bed	28
Table	14
Electricity	43
Electric fan	38
Radio or transistor	7
Television (back & white)	4
Television (colour)	27
Gas stove	39
Sewing machine	13
Mobile telephone	34
Any other type of telephone	2
Computer	0
Refrigerator	10
Watch or clock	27
Water connection	16
Means of transport	
Bicycle	21
Motorcycle or scooter	8
Animal-drawn cart	0
Car	0
Agricultural Land	
No agricultural land	5
Irrigated land only	6
Non-irrigated land only	2
Both irrigated & non-irrigated	1
Ownership of a house	4
Owning farm animals	0
Owning a bank/post office	13
Mosquito net for sleeping	4

Appendix C – Guidebook

What kind of women do we want you to survey?
We are looking for women who **gave birth 6-12 months ago,** between March 2011 and August 31th 2012. We are interested in their stories about accessing and using maternal health care services. We would also like to find out what kind of influence these experiences have on their expectations of using maternal health care services in the future.

Does this mean that we only want to survey women who have used maternal health care services?
No, we are also interested in the stories of women who did not use any maternal health care services, or only a few components of these services. This way we can find out what prevented them from using (all) these services. If a women has not used any, or all of the services, the survey will be considerably shorter, as many questions can be skipped.

Do I have to read out all the question-and answer-options?
As it is expected that most of the women will provide you with a full story instead of direct answers to your questions, it might be difficult to follow the structure of the survey during the conversation. Therefore, you can find information on the structure of the survey and which questions not to forget, on the next page. This way you can hopefully integrate these questions in your conversation, preventing you from forgetting to ask questions that are very important for the research.

When surveying the women you don't have to read out all the answer options, you can let the women respond spontaneously and look up their answer in the options presented under the question. These structured answers have been developed for data-analysis purposes only. If the relevant answer is not mentioned, please write it down in the answer option "Other: …………………".

What not to forget!

- The survey comes attached with an information sheet and a consent form for the women. Please explain this to them before they participate in the survey en let them **sign the consent form**. If they cannot write, please let them sign the form with an "X".
- All questions are about the women's **most recent pregnancy**. During the conversation they might mention stories about what happened to them during other pregnancies. Please check regularly whether or not their answers are still about their youngest child.
- Please only note down **1 answer per question**, unless indicated otherwise. This way the results can be used and compared after your findings have been analyzed.
- You will come across women who might not know the answer to your question or who will refuse to answer your question. When there is no answer option for this response, please note down one of the following codes under the question
    - **Woman does not know: 98**
    - **Woman refuses to answer: 99**
- There is a Wealth Index attached to this survey, which will be used to determine the economic position of the women. Please note down your research letter, the household number and the total of the times questions have been answered with yes and no.

Structure of the Survey

The survey consists of 5 sections, each of them focusing on the different aspects of the research. In the text below a short overview is given on the different sub-topics so you can have a quick overview of the questions that you will need to ask.

Section 1: Health seeking behavior & Care received

Q1: Received ante-natal care?

Yes → Q3 - Q12 (why, where, why in this location, contact with who, all recommended check-ups?)
No → only Q2 (why not?) → Go to Q13-17

Q13 – Q17: Where did you give birth? (why this location, contact with who)

Q18: Received post-natal care?

Yes → Q20 – Q29 (why, where, why in this location, contact with who, all recommended check-ups?)
No → only Q19 (why not?) → **Go to Section 2, Q30**

Section 2: Experience utilization

If she did not use any MHC services in a facility, go to question 65

Q30: Satisfaction (give grades for all MHC services)

Q 34: Contact with doctor?
Yes → Q34 – Q40 (confidence & trust, understanding, statements respect)
No → Go to Q41

Q 41: Contact with nurse(s)?
Yes → Q41 – Q47 (confidence & trust, understanding, statements respect)
No → Go to Q48

Q48- 66: Quality facility and communication (respect, satisfaction with resources, referral, private health facility)

Section 3: Access

If she did not use any MHC services in a facility, go to Q104 (try to use MHC? Barriers, table, why did she not overcome the barriers?)

Q67 – Q71: Awareness (facilities, importance MHC) **Barriers faced when wanting to access** (tables)

Q 98 – Q101: Conditional Cash Transfer Schemes (which scheme, for which services?)

Q102 – 104: Attitude family & who made the decision to use? → go to section 4

Section 4: Future use of maternal health care services

Q133 – Q136: Will they use services again? Based on what reasoning?

Q 136 – Q149: Future selection of facility: which factors are important? Please consult the tables.

Section 5: Background Information

Please ask all women all the questions!

Q150 – Q176:

- Marital status
- Household situation
- Pregnancy history
- Work woman (hours, type income)
- Work husband (hours, type income)
- Household income
- Say in spending
- Cast
- Education
- Age

Appendix D – Information Sheet

What is the purpose of the study?
The study is investigating the accessibility of maternal health care services for women living in Alamnagar and the experiences they have with using these services. Adeline Bennink is a student at Utrecht University in The Netherlands, undertaking a Masters in International Development Studies. The researcher, together with SAHAYOG, is conducting a study to assess the barriers that women have to overcome when wanting to use the maternal health care services and to assess whether or not earlier experiences with using maternal health care services are expected to have a positive influence on the anticipated future use of these services.
The study will be used for educational purposes, a final thesis will be based upon analysis of the field research data. The research will also inform a provisional report with the main findings from which will be presented and discussed with relevant stakeholders.

Why have I been selected?
You have been selected as a possible participant for the study as you are living as in Alamnagar, an area where different kinds of facilitators for maternal health care services can be found. You are invited to participate in this survey on the subject of the access and use of maternal health care services. The researcher might also ask you a few extra questions after the survey if they would like to know more about your experiences.

What will happen to me if I take part?
If you agree to take part you will be asked to fill in the enclosed survey together with a research assistant. You are also invited to answer a few additional interview questions. It is possible to only participate in the Survey. The information you share will be included in a report assessing the challenges faced by women when accessing maternal health care services and their experiences using these services. We cannot and do not guarantee or promise that you will receive any direct benefits from this study. However this study aims to identify the initial challenges en experiences allowing for possible recommendations for improvement. Your participation in this research will be anonymous and will in no way influence the level of care you receive or are able to access.

Confidentiality and disclosure of information
With your consent the questions that will be asked after the surey will be audio-recorded, and later written up removing identifying data. You can choose to stop the recording at any time. Any information that is obtained in connection with this study and that could be used to identify you will remain confidential. Information from the survey will be used for the researcher's MSc thesis, however all comments will be anonymised and you will not be identified.

Do I have to take part?
It is up to you to decide to join the study. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. If you withdraw from the study the anonymised data you have provided may still be used.

Feedback to participants
A summary of the final report and key recommendations will be shared with the participants and local stakeholders.

Further questions?
If you have any questions, please feel free to ask us. If you have any additional questions later, Adeline Bennink (a.a.a.bennink@students.uu.nl) will be happy to answer them.

Appendix E – Consent form

Once you have been informed about the project, and have decided to participate, please sign the following consent form.

1. I confirm that I have read/been read and understand the information sheet explaining the research project. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

3. I agree to the use of audio-recording and understand that all comments will be anonymised and will remain confidential.

4. Should I give my consent for photographs I understand that they may be used in the final research report.

5. I agree that the information I provide may be directly quoted in the final report but that all comments would be anonymised.

6. I agree to take part in the project.

Participant …...................................... Signature .... Date ....

Researcher/assistant …......................... Signature .... Date ....

Appendix F – Additional Tables

Table: Locations where the antenatal care was utilized

Name of the facility	Frequency
Govt. hospital Queen Mary	3
Govt. hospital Balrampur	12
Govt. hospital Gorakhhpur	1
Govt. hospital, Gomti Nagar	1
Govt. hospital Civil Hospital Lucknow	1
Govt. hospital Rommanohar Lohiya	1
PHC Hardoi Sahbaadanji	1
PHC Ghosaaiganj	1
PHC Malihabad Lucknow	1
BMC Indira Nagar	1
BMC Aliganj	2
BMC Aishbag	1
Pvt. nursing home Kaiserbagh	1
Pvt. hospital mohibullapur	1
Pvt. clinic Kashyap Nagar	3
Pvt. clinic Chaukaan	1
Pvt. Neera Nursing Home	1
Anganwadi center	1
At home with AWW	5
At home with nurse	6

Table: Locations where the child was delivered

Location	Frequency
Govt. Hospital Queen Mary	3
Govt. Hospital Balrampur	10
Govt. Hospital Rommanohar	1
Govt. Hospital Nehru Vatika	1
District hospital Kushi Nagar	1
PHC Makhseta, Sittapur	1
PHC Ghosaiganj Lucknow	1
Rommanohar Lohiya	2
BMC Aliganj	2
BMC Indira Nagar	1
Pvt. Hospital Kilkaari	1
Pvt. Hopital unknown	1
At home with nurse/midwife/family	25