Sharing Experiences in International Cooperation | Issue Paper on Health Series, No. 9 d

Community Perceptions of Facilitators and Barriers to Maternal and Child Health Service Use

Implementation research from the Maternal, Neonatal Child Health Services Project "Public Health Improvement Initiative" in Rajshahi and Naogaon Districts, Bangladesh

DASCOH
Strengthening Systems for Development

Swiss Red Cross

Authors: Nurun Naher Shoma 1
Dhiman Dutta 2
Reazul Karim 1
Akramul Haque 1
Masud Rana 1
Shohel Rana 1
Tozammel Hauque 1
Ebrahim Khalil 1

Report writing team:
Nurun Naher Shoma 1
Dhiman Dutta 2
Monika Christofori-Khadka 3

Affiliation:
1 DASCOH Foundation
2 Swiss Red Cross, Bangladesh
3 Swiss Red Cross, Switzerland

January 2023

Contact: monika.christofori-khadka@redcross.ch

Table of Contents

Acronyms

AHI	Assistant Health Inspector
ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Newborn Care
C-Section	Cesarian Section
CAH	Community Action for Health
CBHC	Community Based Health Care
CBHFA	Community-Based Health and First Aid
CC	Community Clinic
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHCP	Community Health Care Provider
COVID-19	Corona Virus Disease 2019
CS	Cesarean Section
CSPM	Conflict-Sensitive Programme Management
CV	Community Volunteer
DASCOH	Development Association for Self-reliance, Communication and Health
DG	Director General
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
EDD	Expected Date of Delivery
EmONC	Emergency Obstetric and Newborn Care
ESP	Essential Service Package
FGD	Focus Group Discussion
FP	Family Planning
FWA	Family Welfare Assistant
FWC	Family Welfare Centre
FWV	Family Welfare Visitor
GoB	Government of Bangladesh
HSP	Health Service Provider
Hujur	Local religious leader
IDI	In-depth Interview
Kabiraj	Local traditional healer
LGI	Local Government Institution
MNCH	Maternal and Child Health
MMR	Maternal Mortality Rate
MNCH	Maternal Neonatal and Child Health
MoH&FW	Ministry of Health and Family Welfare
NGO	Non-Government Organization
NMR	Neonatal Mortality Rate
PHC	Primary Health Care
PHIIR	Public Health Improvement Initiative
PNC	Postnatal Care
PPH	Postpartum hemorrhage
SACMO	Sub Assistant Community Medical Officer
SBA	Skilled Birth Attendant
SRC	Swiss Red Cross
TBA	Traditional Birth Attendant
UFPO	Upazila Family Planning Officer
UH&FPO	Upazila Health and Family Planning Officer
UH&FWC	Union Health and Family Welfare Centre
UHC	Upazila Health Complex
UP	Union Parishad
WHO	World Health Organization

Abstract

Objective of the study

To explore community's perceptions about facilitators and barriers, which determines facility-based delivery and uptake of maternal health care services in rural areas of Rajshahi and Noagoan, Bangladesh.

Methods

This case study-based design research was carried out between September 2021 and March 2022 in rural areas of Rajshahi and Naogaon district in Northern Bangladesh. Qualitative data was collected to elicit community-level norms, experiences and perceptions related to facility-based delivery service use. Eleven interactive focus group discussions, which draw on participatory research techniques to engage participants in analyzing the local situation or problem; and 58 individual semi-structured interviews with women, their husbands, and local health care providers and health authorities, were conducted. The respondents were encouraged to share their stories, points-of-view, and suggestions through an open-ended and "narrative" format using a topic guide in the local language Bangla. The study included respondents from the local ethnic indigenous monitory.

Results

In most cases, men were the decision makers for choosing a health care provider for the routine antenatal care and delivery. Women mostly relied on informal health care providers, such as traditional birth attendant, traditional healer and pharmacy owner for antenatal care, delivery and post-natal care. They still play an important role in the community. Ultrasound is a popular diagnostic tool, mainly preferred by the family to determine the sex of the child. This is also often the first point of contact of a pregnant woman with a professional health care provider. Due to quality and human resource constraints, many women deliver either at home, in a tertiary hospital or a private clinic, as the latter two have the means to care for complications. However, the quality of care and the standard of Government and private clinics, as well as the tendency to do Cesarian Sections in private clinics is often a concern that need to be investigated further. Because of the "Shad" ritual pregnant women often have to change health providers because they change the physical location during the pregnancy from their in-law's home to their "fathers home", thus implying challenges in the continuity of care. Findings further revealed that postnatal care is the most neglected part of care seeking both in terms of perception and practice.

Conclusion

The study findings imply the importance to recognize the formal and informal health system, including Government and private sector health providers. Approaches which foster mutual appreciation, understanding of each other's competence and limitations, and development of quick links of referral need to be explored and put into practice to increase quality of care and reduce complications. An integrated approach of increasing family awareness in the" in-laws house" as well as the "fathers house" including all the family members is important rather than addressing only individuals, such as the pregnant women and/or the husband. Appropriate awareness generation and effective behavior change communication to convert the knowledge to appropriate practice needs to be applied. Likewise integrating private and government facilities in the referral path, as well as extending and managing the pregnancy pathway of a woman before and after the "Shad" ritual in two different geographic locations requires innovative approaches and engagement. Educational and financial barriers are influencing at individual level for which we need to plan appropriate interventions which will not only increase show immediate outcome rather will generate sustainable impact to reach the long-term target. Lastly, adequate post-natal care needs to be addressed and institutionalized effectively to counteract complications and ensure the long-term wellbeing of woman and children.

Chapter 1: Introduction

Background

Global context

Globally about 295'000 women died during and following pregnancy and childbirth in the year 2017 out of which 96% (284,700) are from Sub-Saharan Africa and Asia [1]. Global evidence suggests that increased skilled attendance at birth and facility-based delivery are effective means that contribute to reduce the maternal mortality rate [2] Since decades, efforts to reduce key barriers to facility-based delivery are applied in countries as part of safe motherhood programming. In low and middle-income countries these barriers can be categorized into four broad themes: (1) perceptions of pregnancy and childbirth; (2) influence of sociocultural context and care experiences; (3) resource availability and access; and (4) perceptions of quality of care [3]. Population based surveys quantify the distribution of these determinants, but qualitative research provides greater in-depth understanding of existing practices and preferences and how these continue to shape health-seeking behaviors and their outcomes for both mothers and babies [1].

Country and local context

In Bangladesh, the fourth Health, Population, and Nutrition Sector Program for 2017-2022 aims to reduce the maternal mortality ratio (MMR) target to 121 per 100,000 live births by 2022. Between 2001 and 2010, the MMR declined significantly: from 322 to 194 maternal deaths per 100,000 live births [4]. This was a remarkable progress, linked to fertility reduction; increased access to maternal health care; increased use of maternal health services in the antenatal, delivery, and postpartum periods; and due to socioeconomic improvements. According to the Bangladesh Maternal Mortality Survey 2016, the MMR stalled between 2010 and 2016, although Bangladeshi women are increasingly seeking maternal care from health facilities. In 2016, the MMR stood at 196 maternal deaths per 100,000 live births, almost identical to the estimate of BMMS 2010[1]. The MMR further reduced to 176 per 100,000 live birth in 2017[2]. (WHO, UNICEF, UNFPA, World Bank Group and UNPD - September 2019).

Bangladesh committed to primary health care (PHC) for all in 1978 through the Alma- Ata Declaration on Primary Health Care. In the rural areas of Bangladesh, PHC is delivered at three levels (ward, union and upazila level), providing free health care services and referrals to the tertiary level for specialist treatment. For Maternal, Neonatal and Child health (MNCH) services, the prime entry point of a pregnant woman is the Community Clinic (CC) at ward level, which provides Antenatal and postnatal care and in some CCs in Rajshahi trained female Community Health Care Providers (CHCPs) also conduct normal deliveries. In other areas, a woman has to reach the nearest union health and family welfare center (UH&FWC), which provides normal deliveries, basic emergency obstetric care and refers complicated cases to the Upazila Health Complex (UHC), which is supposed to provide comprehensive emergency obstetric care. However only normal vaginal deliveries are conducted due to lack of either gynecologist and/or anesthetist. Since the Ministry of health in Bangladesh is divided into the Directorate of Health (DGH) and the Directorate of Family Planning (DGFP), many services are duplicated at the union level. Coupled with a lack of human resources and adequate, sufficient, and timely logistic supply of medicines and materials, this leads to a low level of efficiency and quality, and in the end insufficient service coverage. The district hospitals and university medical colleges and centres provide tertiary level care. Additionally,

there are numerous private providers, mostly specialized in emergency obstetric care, which is a lucrative business.

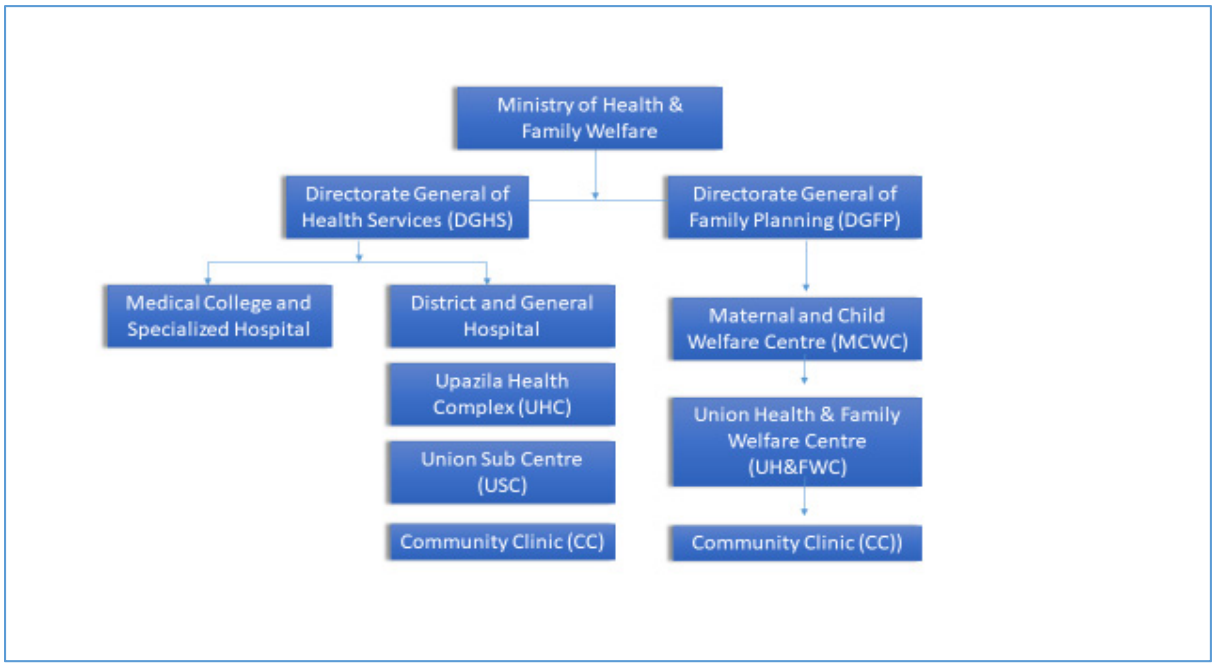


Figure 1: Health system structure of Bangladesh

The Bangladesh Maternal Mortality Survey explains that Bangladesh is not the only country with such stalling figures of the MMR. The exploration of causes or barriers to seek care were done in different contexts and results showed that perceived barriers are different for different context. For example, perceived benefit and risk from access of care, personal resources in terms of time, money and social support, perceived quality of care, the trustworthiness and cultural sensitivity of care provider, feelings of mutual respect, etc. are evaluated as barriers in high income countries [4]. Whereas culturally and contextually different care standards, personal risks, physical danger during travel, unavailability of the promised care due to resource constraints are some causes of not accessing care in low- and middle-income countries [5].

Different studies have been undertaken in Bangladesh to understand the drivers, barriers and facilitators of seeking care during pregnancy and delivery. In Bangladesh, the perception about the physiology of pregnancy and the childbirth process and traditional and local understanding play an important role in decision making about place of delivery and care [9]. The most practiced three delay models of analyzing barriers of care seeking are used by several researchers and it is evident that many factors influence the decision of care seeking and timely receipt of care at facilities. The ability to recognize symptoms and decision-making power are of importance [10]. The decision-making delay is longer while referring from home than referring from delivery center where skilled provider is present [11]. Medicalization of the process of childbirth, unnecessary exposure and examination of the birth canal, comfortable relationship with traditional birth attendants (TBA) and convenient environment at home are other evident factors associated with the decision making and service acceptance at the facility [6,7]. Transportation, cost of childbirth at a health facility, perception of quality of care among care giver and receiver are also drivers of decision making and service receiving [3].

However, how decisions are made at community and household level in Bangladesh have not yet been explored and evidence is missing.

Studies examining the provider side have found that quality of care is also fundamental to improve maternal health outcomes but the status is poor in Bangladesh [3]. According to the Bangladesh Health Facilities Survey, 2017 only 16% of facilities fully qualify to provide normal delivery care [8]. Quality assurance is the most neglected issue and only 12% of union-level facilities and CCs have documented quality assurance activities [8].

Swiss Red Cross supported MNCH project in Rajshahi and Noagoan districts of Bangladesh

With the aim to improve the maternal, neonatal and child health, the Swiss Red Cross (SRC) is supporting the implementation of a MNCH program in Rajshahi and Noagoan districts in Bangladesh since 2013. The project is implemented by the local non-Government organization "Development Association of Self Reliance, Communication and Health", DASCOH foundation. The project started with the lower tier of the primary health care system (community clinics) and community engagement. Later, in consecutive phases the program extended gradually to the upper tiers of the PHC system with a broader engagement of the local community, authorities and the health system. The project tries to influence and change community health care seeking behaviors through awareness raising about the importance of antenatal care (ANC), facility-based delivery and post-natal care (PNC) and strengthening the service delivery system through ensuring accessible and quality primary/essential health care. Over the period of project, the intervention districts were extended from Rajshahi districts to part of Naogoan districts. Phase III of the project (from October 2019- April 2023) was implemented in five upazilas, three upazilas Bagmar, Charghat and Tanore in Rajshahi district and the two upazilas Porsha and Sapahar in Nagaon district.

Rationale of the study

The implementation of a series of interventions in this long 9 years project tenure was expected to create changes in MNCH indicators and community perception of MNCH and practices. In recent years, we have noticed that despite the different project interventions, many people do not choose to use some of the available services, particularly facility-based delivery, or do not seek care quickly enough when they experience a complication or emergency during pregnancy or labour. Not only at national level, also at project level had the progress stalled, even though major investments by the project were done. The project for example ensured trained and adequate number of human resources for MNCH service, built the capacity of skilled birth attendants, developed referral pathway guidelines and ensured ownership by local authorities and communities of their health center. Also physical accessibility to the health centers because of better roads was improved through the engagement of the local authorities. While huge improvements are seen in comparison to the baseline, progress over the years of implementation has fluctuated and stalled (see figure 2).

	Baseline Phase II	Achievement in year			Baseline Phase III	Achievement in year
Name of indicator	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
% of births attended by skilled birth attendant	29%	76%	70%	62%	20.5 %	74%
% of women having attended 4 times or more ANC during their last pregnancy	13.8%	58%	54%	53%	73%	40%
% of women who received PNC within 24 hours after the delivery	?	70.6%	51%	50%	38.6%	61%

Figure 2: Progress of MNCH indicators measured by the project in the project intervention area from 2016 to 2021.

In order to understand why progress has stalled and why not more women are seeking maternal care and delivery services, the project team has embarked on a study to explore facilitators and barriers of using MNCH services, with a focus on understanding perceptions at household and community level about maternal and child health services, and decision-making factors at household level. Findings will help to rethink about the way of implementation, reevaluate progress and adapt the program design.

Since other SRC supported MNCH projects in Nepal, Pakistan and Laos reported similar challenges in stalling MMR rates, the four countries embarked jointly on the research, using the same research framework. The research tools were contextualized to each county context, translated into the local language and piloted before application.

.

Chapter 2: Methodology

Case Study Design

This is a qualitative study, where qualitative information was collected through interactive group discussions and individual semi-structured interviews.

Study aims and objectives

This research is designed to improve the understanding of social determinants of institutional delivery with the aim to explore the community perceptions of facilitators and barriers to maternal and child health service utilization and generate the knowledge on socio-cultural and behavioral barriers and enablers and decision-making processes for facility-based delivery. Community expectations, perceptions and experiences were examined to characterize local

beliefs about available services, including whether and when they are necessary, their quality of care, factors that encourage or reduce intention to use services, and facilitators and barriers to acting on such intention. In particular, the study compares experiences of women (and their families) of different socio-cultural background who have experienced healthy births as well as those who underwent complications, considering both community-based and facility-based delivery.

In specific this means:

- To understand the process of decision-making mainly related to facility birth, including birth planning and choices made if complications emerge
- To identify facilitators and barriers to use of existing services under normal circumstances and at onset of complications/emergencies
- To explore experiences and perceptions of relevant maternal health services as defined above, including local views of their accessibility, acceptability and quality, and how these affect care-seeking
- To document experiences and perceptions of local health care providers, including their opinions regarding community decision-making, facilitators and barriers related to maternal health care use.

To meet the study objectives, the following guiding questions will be answered:

- How do women make decisions about whether to use/ not use available services during pregnancy and labor, and what are the respective roles of women, family members, and otherstakeholders in this decision-making?
- What are the facilitators and barriers to using available services, both during pregnancy/ normal labor and in cases of emergency?
- At the onset of complications/ obstetric emergency, what contributes to the “3 delays” from the perspective of community members?
- How do women, family members, and others in their communities perceive the quality of services?
- How do health care providers view facilitators and barriers experienced by the community touptake of facility-based delivery and related services, including during complications or emergency?

Study area and characteristics

The study was implemented in two intervention districts where the Swiss Red Cross supported MNCH program “Public Health Improvement Initiative Rajshahi” is ongoing.
All intervention areas from the Phase II of the project (Charghat, Tanore and Baghmara upazila of Rajshahi and Porsha and Shapahar upazila of Naogoan District) were included in the study and were the study area. The three mentioned upazila under Rajshahi district are about 27, 28 and 42 km away from the Rajshahi city which is a divisional city with available tertiary care public hospital. Porsha and Shapahar are about 99 and 103 km away from the city. In all upazilas are government and private health care facilities with ability to provide MNCH services in the facilities (see table 1).

District	Upazila	Population	Number of union	Number of Upazila Health Complex	Number of union level facility	Number of Community Clinic	Literacy Rate
Rajshahi	Baghmara	3,54,664	16	1	17	38	46.3
Rajshahi	Charghat	2,06,788	6	1	5	23	44.3
Rajshahi	Tanore	1,91,330	7	1	10	20	48.8
Naogoan	Porsha	1,32,095	6	1	5	12	42.5
Naogoan	Shapahar	1,61,792	6	1	5	17	42.2

Table 1: Study area's population and health system characteristics (Source: CENSUS 2011)

Study population and sampling

The study population were women, who delivered a baby within the past six months, either at home, in a health facility and with and without complications. Furthermore, husbands of the women, health service providers, representatives of local government institutions and health system administrators and local community people were part of the study population. The study population comprised also of Adhivasi women, a tribal minority residing in the area and making up 1.1% of Bangladesh's population.

The study population was purposefully selected. Respondents were identified by project staff and Community volunteers (CVs). CVs who are women from the community who are working as project volunteers continuously for creating awareness, identifying pregnant and high risk mother and thereby to improve the MNCH behavior of the communities. The CVs know the women well and were therefore used to identify and reach the expected respondent especially for individual interviews and they also supported to arrange the group discussions in the communities. Additionally, the project used service data from the health facilities and project data to identify study respondents.

Methodology used and respondents' distribution

For this qualitative study, focus group discussions (FGD) with community members and in-depth individual interviews (IDIs) were used.

Service delivery data were used to identify women and members of households, where a delivery took place in the past six months to invite them as participants for the group discussion. Additionally, community volunteers identified eligible people for the FGD, in order to have a representation of pregnant women, mothers, fathers and community members from different socio-economic strata and ethnic background. Convenient places were selected for conducting group discussions in the village. COVID-19 prevention measures were followed.

In total 11 FGDs were conducted with 197 participants The group discussions were held among the selected participants and used participatory methods to encourage interaction between respondents. Specific tools community mapping to visualize the context, pregnancy pathway to understand the socio-cultural aspect of the reproductive care seeking at different

stages of pregnancy, delivery and post-partum. A “horse and cart” activity was used to extract facilitators and barriers of care seeking. From the discussions, we also identified the individuals eligible as respondent for the in-depth individual interview (IDI) to further share their experiences in depth.

Category	FGDs (n=197 participants in n= 11 groups discussion)		IDIs (n=60)	
Community women	Rajshahi-2 (44)	Naogoan-1 (16)	Rajshahi-12	Naogoan-4
Community men	Rajshahi-2 (36)	Naogoan-1 (17)	Rajshahi-6	Naogoan-2
Health service providers (HSP) formal and informal	Rajshahi-2 (37)	Naogoan-2 (30)	Rajshahi-11	Naogoan-10
Local Government Institution (LGI)		Naogoan-1 (17)	Rajshahi-5	Naogoan-2
Health administrators			Rajshahi-4	Naogoan-4
Total	117	80	38	22

Table 2: Distribution of FGDs and individual interviews (IDIs) by district

Additionally to the FGDs, project staffs who were trained for conducting the interview as per prescribed interview guideline and topic guides conducted 60 in-depth interviews individual interviews. There were different categories of respondents like mothers, husbands and health service providers and other relevant people involved in MNCH service provision.

IDI with mothers (11)	Facility delivery, without complication	2
	Facility delivery, with complication during pregnancy	3
	Facility delivery, with complication during labour/birth	3
	Facility delivery, with complication after birth	1
	Facility delivery with C-section	2
IDI with Adibashi mothers (5)	Facility delivery, without complication	1
	Facility delivery, with complication during pregnancy	1
	Facility delivery, with complication during labour/birth	1
	Facility delivery, with complication after birth	1
	Facility delivery with C-section	1
IDI with Fathers (5)	Husbands of women who gave birth at home without complication	1
	Husbands of women who gave birth at home with complication during pregnancy	1
	Husbands of women who gave birth at home with complication during labour/birth	1
	Husbands of women who gave birth at home with complication after birth	1
	Husbands of women who gave birth at facility with C-Section	1
IDI with Adibashi Fathers (3)	Husbands of women who gave birth at home without complication	1
	Husbands of women who gave birth at home with complication during pregnancy	1
	Husbands of women who gave birth at home with complication during labour/birth	1
	Community Health Care Provider (CHCP)	2
	Family Welfare Assistant (FWA)	1

IDIs with HSPs at the health facilities (11)	Family Welfare Visitor (FWV)	1
	Medical Officer	1
	Midwife	1
	Nurse	1
	Owner	2
	Sub Assistant Community Medical Officer (SACMO)	2
IDIs with informal HSPs (not facility based) (6)	Dai/Traditional Birth Attendent (TBA)	2
	Homeo doctor	1
	Kobiraj (traditional healer)	2
	Pharmacy owner (Drug seller)	1
Administrators (8)	Civil Surgeon, Naogaon	1
	Civil Surgeon, Rajshahi	1
	Deputy Director-DGFP	1
	Divisional Director-DGHS	1
	UFPO	2
	UH&FPO	2
Local Government Initiative representatives & Others (7)	Union Chairman	2
	Union Parishad women members	3
	Upazila Chairman	1
	Upazila Chairman	1
	Social Elite	4
	Community Resource Person /Community Volunteers (CV)	2
	Head Teacher	1
	Freedom fighter	1
Grand Total		**60**

Table 3. IDI respondent distribution by characteristics

Data collection

Training of data collectors

The project team of DASCOH conducted the research without hiring external staff. The team comprised of six field facilitators and three area coordinators along with one project officer for health and the project officer for community mobilization. They rotated their roles as data collector, note keeper and facilitator/moderator. The documentation officer was assigned for recording and archiving all the data, transcription, storage and translation. Two persons from the monitoring and evaluation team were assigned for monitoring the data collection process and overall supervision. The health manager SRC and the health lead of DASCOH provided direct support and led the training. The training was conducted for four consecutive days and comprised of classroom learning, demo practice and field testing in the community. To avoid the bias field-testing was done in a non-intervention area and later extended for two more days to build the capacity of the team as per need. An integrated planning was done for the data collection in the intervention area. The onboarding training topics of the fieldworkers can be found in annex ii. Data collectors were also trained to recognize if the interview poses distress to the interviewed person and to notify the supervisor to request and/or arrange a psychological support for the respondent.

Pictures 1-4: Training session for community-based research

Pretesting and Piloting

The research tools and interview guides were pre-tested and modified after the pilot in order to address all the possible challenges of data collection. Three focus group discussion were done at three pilot areas with community women to have an idea of the time required for the discussion and to train the team on conducting the community mapping, pregnancy pathway and horse and cart method in practice. Women, men and two health service providers were interviewed individually to test and practice the IDI tools.

Based on the findings from the pilot testing, the English version of the interview guidelines was modified and contextualized for easier understanding. Additional probes were designed to conduct the pregnancy pathway session from the experience to use during the data collection. The teams learnt to capture respondent's experience and opinion rather than assessing their knowledge and learnt to not to influence the FGD or IDI with own views.

Pictures 5-6: Pretesting of IDI and FGD interview guides in the community.

Data collection period

Data collection was done from 6 September to 28 September 2021. Covid restriction was lifted at that time and the infection rate was about 10% at the start, gradually decreasing and at completion it was about 4%. During data collection, the team was assigned to collect data in the upazila where they usually did not perform their duty, i.e. the project team Noagoan did the data collection in Rajshahi in order to limit bias.

All respondents are anonymized in subsequent reports and referred to by role.

Ethical approval and informed consent

Ethical approval for conducting the research was obtained from the Bangladesh Medical Research Council, which is an autonomous authority under the Ministry of Health and Family Welfare. The rigorous approval process went through pandemic induced delays. The approval is added as an annexure (annex i).

All participants taking part in either group discussions or individual semi-structured interviews underwent a process of informed consent. All relevant information was provided about the study, its objectives and procedures. All participants were allowed to ask questions at any time. Contact details of the principal investigator and field supervisor were shared with respondents in case they may have additional questions at a later stage. All were also reminded that participation is entirely voluntary and that they can leave or stop the interview at any stage. The data collectors were trained on the consent procedure and were regularly supervised to ensure they maintain confidentiality, anonymity and that they make participants feel comfortable during data collection.

Pictures 7-11: Snapshot of focus group discussion with community women, men, pregnancy pathway drawn by community women and IDI with HSP.

Challenges and limitations during data collection

The purposive sample selection and study conduction by the project team might have induced some sorts of bias in terms of project intervention's interest. As the project team conducted the research, there were also chances of courtesy bias. By interchanging the project team to be an interviewer in another district, which is not the usual workplace of the project staff, this courtesy bias was addressed. Since the data were collected from the intervention area where the project is ongoing, additional courtesy bias happened, because the community volunteers (CV) were used to identify and reach the expected respondents and supported to conduct the group discussions in the communities. Respondent might have hesitated to share negative opinions or behaviors in the presence of the CV. Therefore, the data collection team tried to conduct the discussion and individual interview without the CV as much as possible to avoid such bias. Interviews with health or family planning authorities, service providers or LGIs may also have led to biased responses, i.e. program staff may have felt pressured share all positive thoughts and experience in terms of MNCH care seeking behavior and practice.

In order to do focus group discussions or individual interview with women, female data collectors from other geographic areas were moved to the data collection places to enhance an open and sharing environment.

During the data collection, all regular activities of the project were ongoing. This assignment might have felt like an additional burden to the interviewers.

Data analyses

The data was analyzed manually in two stages. At the primary stage the raw data (the audio, transcription file, field note) were repeatedly reviewed and edited to align with the audio taped information. A data analysis workshop was held from 27 to 28 October, 2021. In this workshop the data analysis team again reviewed the script and identified themes of all FGDs and IDIs and structured them in excel templates. Interview scripts were coded by the themes. The team entered the themes according to each stage of pregnancy and delivery in excel sheets. Separate templates were developed for each respondent group and categorized by pregnancy stage and type of data collection.

The themes, which have emerged during the horse and cart focus group discussion and the individual interviews were grouped as following:

Category	Facilitators	Barriers
Individual	• Husband aware • Educated family • Expectation of healthy outcome of pregnancy • Safe delivery • Avoid risk of newborn • Pre-planning • Regular antenatal care	• Lack of awareness • Preference to give birth at home • Lack of previous plan and experience • Lack of time or laziness • Avoid risk of too much traveling • No antenatal checkup and screening • Lack of person to take and stay at facility • Superstition/misconception • Priority of household task

Socio cultural	• Husband's cooperation • Supportive family members	• Lack of support in home and family • Lack of support of mother in laws • Non-cooperation of husband Superstition • Negligence of husband and family • Lack of guidance • Counseling by alternative provider • Reliability on alternative or traditional care • Fear of getting service for ethnic minority
Physical and structural service provider related	• Cleanliness of facility • Trust and reliability • Nutritional counseling • Transport arrangements • Nearer distance of the facility • Availability of transport and good communication system • Advice and care of service provider • Investigation and screening • Service provider's advice for facility delivery • Free service, medicine and supplement • Quality and behavior of service provider • Ability to manage complication during delivery	• Lack of transport • Lack of good communication system • Distance of the facility • Lack of trust in government hospital providers • Environment and cleanliness of facility • Crowd and cue at government facility • Long waiting time • Shortage of supply at facility • Service provider serves the powerful and rich first • Fear of having unnecessary caesarean section at facility • Fear of episiotomy at facility • Availability of village doctor and TBA • Unavailability of doctor at facility • Noncooperation of service provider • Male service provider
Economic	• Keep saving/Planned savings for delivery cost • Financial planning	• Poverty, lack of money

Table 4: Grouping of emerging themes for data analyses

At the second stage these structured datasets from the excel templates and the primary coding were analyzed again for the identification of subthemes. Data were compared across different types of respondents and between the different data collection methods, with a focus on identifying and understanding the decision-making process during care seeking. Barriers and facilitators to use of services was identified. This analysis is providing a comprehensive idea of the community perception and helps to identify addressable points, persons or areas to work for improving maternal neonatal and child health behavior.

The findings of the study are structured in the next chapter according to the stages of pregnancy (antenatal care, delivery and post-natal care) and describe MNCH care seeking behavior, decision making and also perceived barriers and facilitators to service use at each stage.

Chapter 3: Results

PREGNANCY AND ANTENATAL CARE

Becoming pregnant soon after marriage is culturally expected and desired

The news of getting pregnant is usually exciting and welcoming for the family, despite a few exceptions. Older family members are even sometimes waiting for welcoming a new baby as soon as possible irrespective to the age of the mother or the duration of the marriage. Family members for the sake of becoming pregnant as soon as possible after marriage even actively discourage family planning methods.

"My husband brought Maya Bori (oral contraceptive pill) which I used to take every night. I went to my mother's-in law house and my mother-in-law found it in my bed in my absence. Then she said taking this pill at so early age could damage the guts, so no need to take, if baby come let it come. Then I stopped taking and after three or four months, I became pregnant. My mother in-law asked me who bring these for me." (A woman during IDI at Patari, Shapahar, Naogoan, Facility delivery/C section for complication during delivery)

However, sometime the news of pregnancy is not pleasant to family if the financial status of the family is a challenge, or the pregnancy is unexpected. From both focus group discussions and individual interviews, it was extracted that in some cases after a woman becomes pregnant all responsibilities go upon her parents and sometimes, she is send to her father's house for initial care seeking and other management. The change of households during pregnancy and change of responsibilities affects decision making and delay in care seeking.

"I had vertigo, fever, then I informed my husband. He took me to my mother house. I tell my mother that my period is off for three months and my mother understood everything looking at me. I couldn't eat, nausea, vertigo and fever were present. My father took me to for treatment at Chaumuhoni." Respondent from individual interview who delivered at home, Patari, Sapahar

Pregnancy tests are commonly the first point of interaction with the formal and informal health system

The study found that once a woman perceives that she is pregnant, the confirmation of pregnancy by self-testing was very common. Pregnancy detection strip (urine test strip) are easily available at the local pharmacy, sometimes the women buy them themselves or ask their husband to buy for them. They also visit the pharmacy and get advised by the drug seller to do pregnancy self-testing by urine sample. The nearest Community clinic is another point of care where women go for the confirmation of pregnancy and get tested.

"I was diabetic, I had high blood pressure. I thought it might be high blood pressure for which I was feeling vertigo. In this way one month, two months have passed. My period was off; it was not regular earlier though. I was confused. Everyone advised me to do stick test (Urine test strip). And I found myself positive on stick test. (A mother during IDI at Maria, Baghmara, Rajshahi, Facility delivery/C section for complication during delivery)

"I brought a stick and examined and saw that my wife conceived. I took her to the Nondongachi to Nitanando doctor (Village doctor)". Husband of woman at Charghat, Rajshahi, Home delivery without complication

Usually the news of getting pregnant is first shared with the husband, sometimes the husband also helps in confirmation of the pregnancy by buying pregnancy stick from the nearest pharmacy. Later on, other family members get informed specially the mother-in-law and mother. Female members of the family (for example the sister-in-law, sister, etc.) or neighbors are on the priority list of sharing or disclosing pregnancy news.

"When I became pregnant my husband and family were happy at that news and took care of me. At first three month I couldn't eat well." (Adibasi Woman during IDI, Mundumal, Tanore, Facility delivery with complication during pregnancy)

The care seeking practice at early pregnancy varies in terms of type of provider. In the community, the Family Welfare Assistant (FWA) works for providing domiciliary services related to reproductive health, with a special focus on family planning and pregnancy listing. They conduct home visits at regular intervals, identify and list pregnancy along with providing oral contraceptive pill and condom for short term family planning method to the eligible couple. They are another important person who also get to know the news of pregnancy after confirmation. The list of pregnant women is sent to the Family Welfare Visitor at the union health and family welfare center (UH&FWC) where MNCH services are available to follow up on ANC utilization and also send to family welfare inspector for entering into the management Information System of the DGFP.

"Usually the pregnant woman's name come in our pregnant women list within 3-4 months. Then it goes to FWV. Women here usually don't share with any one when they miss their period, they remain in tension. Later their husband or in law take [them] to doctor. FWV do the stick test for confirmation" Deputy Director, Family Planning, Naogoan during individual interview"

Apart from the FWA the traditional birth attendant also provides informal home visit and identified pregnancy from their own interest.

Women rely on traditional and professional service providers for antenatal care visits

The first point of antenatal care seeking varies among the respondent. While many of them are well aware of medical care for antenatal period, many of them still rely on traditional care or alternative care for pregnancy. It was found that the local village doctor, pharmacy owner/drug seller, private "doctors/practitioners", TBA, traditional healers (so-called Kabiraj) and Hujur/religious leader, private clinic's doctor are also utilized.

"Other than usual medical care women are interested to go and take care from alternative providers. There are some female quacks. They provide medicine and do Normal Vaginal Delivery, they provide iron supplement and conduct the delivery. Those were earlier and now as well. There are homeopathic doctors to whom people are going. Education, awareness and economic condition influence those decisions." Divisional Director, Rajshahi

Overall, women and their husbands stated mainly that they sought care at different health providers from community clinic staff, union health complex and private clinics. A clear pattern on who decides on which health provider could not be established with the existing data.

"It was a pharmacy. I took treatment and asked what to do. My father asked him about what to eat, what medication to take? I was weak, so he gave me medication to improve my taste and advised to take milk and improve energy and make my body strong. My mother informed my mother in law. Doctor (Pharmacy owner) told me that baby is in good condition, water is okay and asked me to take food adequately and also informed that it will be a baby boy. Then they took me back to in laws house." Mother during IDI, Masnatola, Patari, Shapahar, home delivery with complication after birth.

"Well, the responsible person of nearby community clinic (CHCP), very close to us, she loves us very much. When she goes to her [wife], the CHCP gives her medicine and she eats it. At home, I provided milk to drink, eggs to eat according to the advice of the CHCP. There was no problem after that." Husband of pregnant woman during IDI, Charghat Baghmara, Home delivery without complication.

"I went to doctor at 5 months. Then did my check up, blood test, ultrasonogram. I went to popular diagnostic at Rajshahi to Dr. Rakhi Debi, Gyneocologist." Mother during IDI, Telipukur, Maria, Baghmara

"After check in there, they said she is pregnant. Then after coming home, I did regular checkup at the clinic that we have in Nimpara (UH&FWC)" Husband of the pregnant women who had c section at facility, Charghat , Baghmara

Local community women are aware that if the family does not permit the woman to avail services, complications and difficulties can arise.

"When pregnant women are advised by family not to go for ANC, they can't take the proper service, it become difficult." Adibasi Mother, Home delivery and without complication, Mundumala, Tanore

Care seeking with traditional health providers prevails in certain conditions. Pregnant women mention about alternative care providers during the individual interviews and focus group discussion. Informal service providers confirmed that alternative care seeking is still quite popular. Seeking traditional health providers depends on the signs and symptoms during pregnancy, such as digestion problems, and effectiveness of the alternative treatment.

"While becoming pregnant I went to kabiraj to take saline, blessed water, blessed oil. People go to doctor as well. When oil and water are not effective to cure then go to Homeo doctor for medicine for a normal delivery. I planned for normal delivery." Mother during FGD at Shapahar, Naogoan

"At first one- or two-month pregnant women are usually not interested to seek care from anywhere, I didn't see. When three or four months then they seek care. If there is not any problem like wind [digestion problems] or anything spiritual, then they go to medical. If it is due

to wind, then they come to kabiraj or TBA house." Alomgir Kabiraj (Traditional Healer), Nitpur, Porsha

"We firstly would go to hospital may be, would take advice. Sometimes it might be due to wind, rural people believe that mostly and for this they will go to kobiraj, hujur, this type of provider. Who are aware will seek care from kobiraj but I think aware people should seek care from a doctor". TBA, Tetulia, Porsha

The care seeking pattern during pregnancy among the adbasi women are more or less same that are evident from their statement. In early pregnancy most of them usually prefer nearest or traditional care and seek medical care if any complication arise.

ANC seeking care intervals are irregular and promoted through direct and indirect incentive systems

It was found that standard antenatal care in terms of appropriate time, interval and regularity is still a challenge. Antenatal care is mainly considered as taking nutritional supplements and avoiding heavy work and travel. Respondents are well aware about nutritional supplements, and some even buy them from a pharmacy or shop while they are not going to government health facility for antenatal checkup. For minor to mild pregnancy symptoms, they take care from the village doctor or pharmacy.

We found the respondent do ANC at different interval according to their convenience and the number varies from one to more than seven visits. The first ANC also starts at very late stage of pregnancy even at four or six months. Reasons for this delay could be the fact, that in the first couple of months women rather visit a traditional healer, than go to a professional health provider.

"They remain unaware in initial 2-4 months. In most of the cases they get to know at -/7 months. In many cases husbands are aware and they send for ANC at 6-7 months, so first checkup happened at 6-7 months." (FWA, Nitpur, Porsha)

"While visiting door to door, I ask them (women) how long they have been pregnant. Some say four months; some say five months. Then I asked them whether they go to facility or not. Many answered no, then I say to them, you are in five months, you should go to the clinic now, you have to checkup at least four times until you have a baby. (CRP at Patari, Shapahar, Naogoan)"

Even if pregnant women are willing to go for ANC, her household chores (cooking, washing, taking care of others, etc.) remain the priority and this conflicts with outdoor patient visiting times at the government facility. The same applies to the male partner who cannot accompany his wife, because in the rural community men are engaged with daily work for income generation and do not prioritize ANC.

"Decision for care seeking depend on socioeconomic condition. If there are not any physical problems, then they are not interested to go for ANC. If they go for ANC one day is loss,

because work will be off for one day. Who work as daily labour, if they don't work for one day there is no income for that day." UH&FPO, Dhapahar, Naogoan

Some traditional birth attendants also have misconceptions about the time of seeking antenatal care with a professional health provider.

"At first it [the fetus] should grow up to a stage, then whatever is good need to be done, community clinic, palopara clinic at gajipur is there or hospital for treatment. or you can go to pharmacy for treatment." (TBA, Auchpara, Baghmara)

From the service providers point of view the community clinic is the nearest center to receive ANC during pregnancy. The distance of the facility plays an important role in accessing antenatal care. People try to go to a health center which is nearer and convenient to reach through a safer road and safe transport. Transport cost also influence the antenatal care seeking. However, where service quality is poor, people take into account longer distance and costs, preferring good quality service irrespective to distance.

"Pregnant women come here for care during pregnancy and after pregnancy. During pregnancy we provide regular ANC and they can take this service. We provide date for ANC here. From our area both Puthia and Charghat upazila health complex are far. So this [the union health complex] is the place where people come for service. Many people go outside as well. Many of them come here by self-wish and many of them come over someone's counseling, FWA also bring them. To my knowledge there are no other center for ANC here other than community clinic (only ANC, PNC) who provide such service." (SACMO, Union level facility, Nimpara, Charghat)

"Not all pregnant women take all ANC services, but they usually go for ANC. 1st [the first one scheduled in first trimester] and 4th [which is scheduled as 4th in third trimester if she takes all regularly. In practice it's the second time they go for ANC when they are in the third trimester. [In late pregnancy] ANC rate is high, and 2nd and 3rd ANC rate is very poor." UFPO, Charghat, Rajshahi

Improved literacy and health awareness are mentioned as other factors, why women come to antenatal care services.

At first ANC very few women usually come, they come at third stage for their first ANC. These number are really poor. Now a days 200 ANC are recorded where there were 20 at some period of time in past. Routine checkup is for normal and without complication pregnancy, but for complication everyone come. They are coming out from taboo, communication is improved, but still male dominancy is there [in terms of decision making for seeking health care services during pregnancy]. Literacy is a very big factor. We are providing free service and they rely on us. The economic condition is not so important here." UH&FPO, Shapahar.

However, the ANC uptake is perceived as very low by the health providers. It is stated by the health administrators that the rate of ANC is not as per the expectation.

"Who are aware come, who are not aware they remain in home after they become sick. We see 50% come and 50% do not come. Who do not come to us few of them might go to other hospital, but mostly go no-where." CHCP, Tetulia, Porsha

While interviewing service providers and health administrators, they revealed that most of the pregnant women come for at least one ANC for taking a certification of pregnancy which is provided by the service provider and authorized by the facility head. This certificate is considered as necessary document for getting the maternity allowances from local government institutions. Under the Ministry of Women and Child Affairs and under the social protection services initiatives of the government, poor and vulnerable pregnant women are eligible to get maternity allowance. There are two programs (1) Demand-Side Financing of Maternal Health Voucher Scheme and other is (2) Maternity Allowance Program for the Poor both focus on maternal and child health[15]. Both programs are ongoing in several upazila of the countries under which pregnant women receives some allowances during their pregnancy and delivery. After getting the certificate, women seem not so interested to continue ANC visits as per the standard guidelines, even though it is conditionally linked with the allowance but in reality this does not play out.

"Whoever come here for ANC are mainly for taking certificate, because to avail maternity allowance this certificate of pregnancy is a necessary document, usually they come at 14/15 week for taking certificate and not for ANC services." UFPO, Porsha, Naogaon.

Husbands and male family members are decision-makers

While many respondents are mentioning the necessity of care during pregnancy; at the same time there are also few who mentioned pregnancy as natural process and no intervention is necessary according to their opinion. Some respondents stated that care seeking is done only if there is a complication.

"My pregnancy was not alright, bleeding was there with regular interval, I didn't understand anything. Then went to kobiraj. My in laws took me there. Kobiraj said I am pregnant and caught by ghost, this baby will not stay and there could be danger from continuous bleeding. During bleeding in laws brought sacred oil and water, I went to kobiraj as advised by my father in laws. He is my relative also, he came and gave me sacred water. But it didn't improve with water and then I went to my father's house and my father took me to Shaon hospital (private clinic) at Shapahar." Respondent from IDI who has complication during pregnancy, Patari, Sapahar

"In the initial two months, I couldn't eat much but later I could. Egg, milk, fruits whatever I need to take, I eat. My husband encouraged me to eat what I like. For vomiting I brought medicine from Kalipada. He said I have mild jaundice and my blood is less. So will be in trouble during delivery. So I went to FWC. Two times. Took iron and calcium from there. My vomiting increased and I bought medicine for vomiting by myself." Mother, IDI, Telipukur, baghmara, Home delivery without complication

Decision-making and care seeking process at pregnancy is not so simple or straight here in community. Several factors influence. Husband or male members play the key role in decision-making. Decisions are often taken by discussing with other family members specially the mother-in-law. While discussing with few women it was also found that decisions are taken by the mother-in-law when it is for ANC. If the women are in their father's house as per the tradition or local/family norms, then decision are taken by the pregnant woman's father. Usually, the mother in law or mother or any female member accompany the women to the health facility. Husbands are also there during ANC visit in a few cases. Sometimes a pregnant woman, who is aware that she should take ANC care, can't go to ANC without the families' permission and the process takes time and delay in care seeking occurs.

"At first three month I couldn't eat well. Then as per advise of all family member I was taken to doctor and took medicine." Adibasi Mother, Home delivery and complication during pregnancy, Mundumala, Tanore

"Everyone of family agreed to take care, so we the visited doctor. Whatever the level of poverty is there, no one want to take risk. By the grace of almighty everything was good." Husband, at Charghat, Rajshahi, Facility birth by c section

Decision-making in complications was also driven by the socio-economic status and availability of money in the family. Reported causes of complications mentioned were financial barrier for diagnosis and investigation for complications, carelessness and lack of support of the husband or family and delays in diagnosis of the complication.

"When I was 6-7 months pregnant, I had a problem. There was abdominal pain. I used to drink less water. My sister in-law and Alka Didi took me to Mundumala Mission Diagnostic Hospital, and my husband was there too. I was examined. They asked to several investigations but I could not do much investigation due to lack of money An Adibasi mother during individual interview from Mundumala."

"When I told my husband he didn't want to keep the child. My father and other said that there is no need to throw away what God gave. There was negligence to my unborn child, When I wanted to eat something he used to tell that no need to eat so much or care so much as he will it will ruin the child. I tried as much possible in poverty. After five months I went to do an Ultrasonography by myself, he didn't agree to take me." A mother during IDI who delivered at facility with complication, Sondanga, Baghmara

Ultrasound as a facilitator to engage with the formal health system and providers during ANC

Ultrasonography in pregnancy is found as the most popular and necessary screening tool irrespective to ANC, geography or economic status of the family. Most of the pregnant women expressed that they have at least one or two ultrasonography during their pregnancy period. The practice of doing an ultrasonography in the mid pregnancy is also reveal as common among the adhivasi women irrespective to medical care or doctor's advice. The women who were not receiving regular ANC from medically trained providers also either had one or two ultrasounds by initiative of themselves or referred by the village doctor or traditional healer. The main reason is the sex identification of the unborn child. In most of the cases, the

respondents expressed that after knowing the pregnancy is with a male child or baby boy the attitude of the family changes and care increases. In few cases, the USG was done for screening purposes. Complications were identified and patients were counseled and referred for better treatment.

"After doing checkup at seven months, we did computer (ultra sonogram). My wife said let's check and see if there is a girl or a boy. Then we did a checkup. Then I asked what the situation is, they said it will be a boy. I asked how is the baby? The baby is fine, no problem, they replied. Now I see later there was a problem when the baby was born." Husband of a Adibasi woman who gave birth at home with complication during delivery, Mundumala, Tanore, Rajshahi

"See, they do ultrasound only to know the sex of the baby, nothing else, and nothing they do." CHCP, community clinic, Tetulia, Porsha

"When they came to know its a baby boy, their attitudes changes towards mother, care increases." UFPO, Charghat, Rajshahi

Health administrators are seeing ultrasonography as a good opportunity and entry point to seek comprehensive examination and care from medically trained provider. They also said that doing an ultrasound by a nonmedical or un-trained person is strongly prohibited. Interestingly the traditional healers or alternative providers also suggest doing ultrasonography at a certain stage of the pregnancy.

"Nowadays even at rural area ultra-sonogram are available. Whether they go to doctor or not they are realizing that one ultra-sonogram is must. And the person who is doing the ultrasonography is getting the chance to advise and give information about the baby's position. If position is okay then normal vaginal delivery are happening, if it is breech then asking to consult with a doctor. It might be true that they are doing it at 7 months but in this way they are visiting a doctor at least." Civil Surgeon, Rajshahi

"I myself prefer to refer at health center after treating the pregnant women for 5-6 month. Now its digital era, they can do ultrasonography to see whether its baby boy or girl, I asked them to visit a good doctor." Kabiraj, Nitpur, Porsha

Quality of care impacts ANC uptake and continuity of care

The health system structure has a very standard mandate of providing care according to which pregnant women can receive antenatal service at satellite clinic, community clinic, union health and family welfare center, union sub center and upazila health complex.

The respondent from the interviews and discussions expressed some common perception about the quality of care, which has also been reiterated by the service provider while interviewing them individually. Lack of adequate human resources, long waiting time, large crowds, fixed service dates for antenatal care and lack of adequate medicine supplies are some common factors that were mentioned which affect the quality of antenatal care.

"In fact, our staff ratio is very low. One person goes out for [outreach] two or three days. Patient pressure is huge, so she serves as much as possible in a short time. Maybe she asks about symptoms, but checking the blood pressure, the symptoms of eclampsia may not be possible. But it is said gently. But they don't come anymore. At the first antenatal checkup average 30 people actually come, later maybe 5 or 6 people." UFPO, Porsha, Naogoan

"See here FWV see pregnant women each Sunday and Wednesday, the other four days is general patients only. When a mother comes on a Monday, we say today we will not see any pregnant women, because we will see her only on Wednesday as it is fixed for ANC care. In this way women are harassed; mothers go away without taking care. So, the woman decides later that she will not go again as she saw that the health provider was sitting there at that day [but did not take care of her]. This relevancy has a reason. All this creates the problem." SACMO, Tetulia, Porsha

A respondent mentioned that ANC at the government facility is not as comfortable as the government facility has a huge crowd and very small amount of medicine supplies.

"For service I went to a mission hospital once. I didn't go to the government hospital as lots of crowd is there always. I bought calcium and iron by myself; from government hospital they give very small amount, only for 2/3 days so I do not go there." Adibasi Mother, Mundumala, Tanore, Home delivery without complication.

BIRTH

During the interviews and group discussions women and other respondents were asked about their childbirth and delivery experiences. Though the awareness about facility delivery is increasing, which is also reflected from the respondent's opinion, a lot of respondents are preferring a home delivery if there is no complication.

Reasons for home delivery

Still home delivery is a more preferred option for normal delivery. By whom the pregnant woman and/or her family will seek help during delivery is also linked with the place they choose for delivery. Usually traditional birth attendants, village doctors and family members are preferred to conduct home delivery. Female and known providers are always the first choice.

"It is better to give birth at a service center or hospital but in the area, it is customary to give birth to the first child at home." Women in FGD, Baghmara, Rajshahi

"Many people rely on local TBA, Family member also do that but number are few. Professional TBA are there. There are areas from where women are not interested to go outside home. Here are social and familial issues. Neighbors are delivering at home so for you it also will be at home. This type of concept work here, here this is culture". UFPO, Porsha

Preference for home delivery is determined by the economic status of the family, perception of more privacy, proximity to the informal providers, religious practices and the practice of covering-up,

"Many of those pregnant mothers whose financial situation is bad, they have been delivering at home for a long time." Female UP Member, Shirointi

"Everyone in the home agreed that I should deliver at home. My husband was not at home. My father-in-law didn't decide to take me hospital. They said that we are poor, so if we go to hospital, we will not be able to afford cost, CS might be required. Grandparents said they could do the delivery so no need to go to hospital, and so no one took me to hospital." Mother IDI, Patari, Shapahar, Home delivery complication after birth

"One thing is that when someone wants to make a home delivery, there may be an emergency situation, they may face a problem, but they are still interested in doing so considering the privacy in mind." CS, Naogoan

"Basically, it is more at home. I have been saying from the very beginning that they have a lack of awareness that they are at home and there are no facilities, there is no environment, they have to stay at home and there is a lack of awareness……..
Here again there is an issue of religious restriction and covering (Hijab), the use of hijab and practice of the people here is a too much because of which they do not want to go out [Due to religious restriction and practicing hijab women don't want to show themselves to outsider]." SACMO, Nimpara, Charghat

Delivering at nighttime is also a reason for doing a home delivery.

"People who are not aware, they try home delivery. FWV and I always tell them you are doing home delivery that fine, but we can give you better services if you take them to facility. For this number of deliveries are very few here. And those delivered here are coming here by self or TBA bring them. If it is daytime they bring but if it is night and from far away, then TBA try at home. TBA refer or bring the mother to facility if there is any problem." SACMO, Tetulia, Porsha

Reasons for delivering in a health facility

Mouth to mouth experience about quality of care and previously built good rapport with the health provider are factors to choose a facility-based delivery.

"My child was okay in abdomen, FWV in government medical did my checkup regularly. I decided to deliver in FWC but later went to Bhabaniganj clinic and had normal delivery…My relative deliver there so during my labour they took me there." A woman during IDI, Facility delivery without complication, Maria, Baghmara,

"I used to visit Sapahar Government Hospital (UHC). I went to take medicine and they gave advice. Then I went to the hospital for vaccination again after six months and seven months.

Seven months later, I went to checkup again. Doctor said there is no problem. When I checked again, I measured the pressure and weight, and then gave the medicine. Therefore, I kept consulting with him for nine months. Later I delivered there, though my relative and neighbor asked me for home delivery." A mother during IDI, facility delivery without complication, Patari, Sapahar.

Preference for facility delivery is mostly found when complications are predicted.

"Everyone planned that delivery will be at home. If it doesn't happen in home [because of prolonged labour or complications], then will take decision accordingly". Mother, Masnatola, Patari, Shapahar, Home delivery and complication after delivery

We have also found opinions in favor of elective caesarian section by the women and their family. It was also mentioned by the respondent from service provider group that due to unbearable labor pain many of the family are choosing C-Section, decided for by the husband. They are explaining this elective C-Section as prevention of complication by doing C-Section.

"We went for check up again in 8 months. Then caesarean section was done in a clinic at Rajshahi.I had cough during delivery. After the baby is born, various blood tests were done. The report was good. The baby weighed 2.5 kg. I was accompanied by my mother-in-law and husband. My husband decided to do Caesarian section delivery." Women at FGD, Bagmara, Rajshahi

"At the beginning of 8 months, I took her and admitted her in Rajshahi Medical College. The doctor saw her and said- you have to take your baby at 8 months now. Will not be normal, will have to be picked up by Caesarian section. Then the baby was picked up by Caesarian section." Father at FGD, Baghmara, Rajshahi

"Delivery usually happened in upazila or private clinic. Whose husband has good financial condition they decide to do caesarean section. Women nowadays are not capable of bearing the labour pain. So in many cases you will see caesarean section are happening due to their own choice. "UFPO, Charghat, Rajshahi

Preference of birthplace may shift to a private clinic due to various reasons. A few respondents stated the private facility as their health provider of choice for normal deliveries and in complications.

"If there were any complication during delivery, I would go to private clinic.: Adibasi mother, Home delivery without complication, Tanore, Rajshahi.

"There is no problem in getting services in private clinics if money is available." Father during FGD, Rajshahi

One of the important reasons we found is the experience of the patient and family with government facilities and the anticipated risk of not getting appropriate and good quality of care.

“Delivery should be done at private clinic; we can't take any risk. If there is a problem with the baby or the mother, we will not take any risk at all. Then we have to go to the clinic to manage the situation by ourselves. An old man was coming to government facility, he said, he couldn’t get medicine. The man (service provider of the government health facility) came and said that it was past 12 o'clock and he could not give the medicine. Several times they said that it would be actually very good if patient come before twelve. Just I gave an example. Those whose financial condition is good and have good relation with the respective officers (government facility service provider), they receive expected medicine they need.” Father, home delivery complication during pregnancy, Tanore, Rajshahi

Pressure from local peers and brokers appear to be other “motivators” to go to a private clinic.

“Women go to the private clinics around first then go to Sapahar for delivery. Here few (2 to 4) deliveries happening at homes in my union. My husband’s niece was delivered at home. Now, every house take decision by themselves and they go to private clinic.” Female UP member, Shironti, Shapahar, Naogoan

“There are brokers from private clinics. They counsel a lot and take the patient to private clinic. I rechecked my patient (referred mother) whether they went to the facility or not and they said one of their brother took them to private clinic. They said if they need to spend 10 taka more, they will spend, but they need the good service.” CHCP, Tetulia, Porsha

Interviewed health managers mentioned their concern regarding the practice of doing unnecessary caesarean sections. It was shared that brokers from the clinics are promoting their business strongly and attracting patient in different way to the facilities. Many respondents shared the perception that private facilities are running only for business purpose and do unnecessary caesarian section during labour to increase the patients bill.

“Private clinics are primarily established to perform caesarean sections of mothers. They rarely do other operations. Their business-centric network is very powerful and they know when the patient's EDD is. They communicate with the patient. There is no problem in following all the protocols but not everyone wants to follow the protocol.” UH&FPO, Shapahar, Naogoan

"Why would mothers go to a private clinic if they get good service at home. The big problem is going to a private clinic means having a caesarean section. Here, 98% are caesarean section, 2% are normal delivery. Get out of it, increase normal delivery”. Civil Surgeon, Rajshahi

Only few families can resist C-Section in a private clinic, as with information asymmetry, patients have to be extremely strong and insisting to get their voices heard.

.

I was planning to deliver at FWC but went to Vobaniganj (private) clinic. My sister delivered there so they took me there, my husband too. When my labour pain started I went there and delivery happened. My husband didn’t agree for C Section. Everything was alright but clinic's people insisted for C Section. My husband didn’t agree. They were so unhappy for that as they want to do my C Section but we didn’t.” Mother during IDI, facility delivery without complication, Telipukur, Maria, Baghmara

However, health managers, service providers and community volunteers are mentioning that institutional delivery has increased and that awareness on maternal and child health is better nowadays than earlier. They tried to correlate it with increase access to girl's education and government and NGO initiatives.

"In general, deliveries are less at home now. More deliveries are happening in hospital, if you go to a clinic in a private hospital, all kinds of caesareans are being done and the few mothers who are delivering at home are due to the choice of the older family member (grandparents). But the rate is low now a day." FWV from Charghat, Rajshai.

"Now more girls are going to school, there are discussions about maternal health there, learning about different things, mixing with different types of girls, this way they are getting more exposure and knowledge is increasing, awareness is increasing." Civil Surgeon, Rajshahi

"Yes, we can say that institutional delivery has definitely increased. Our Institutional Delivery is already 50%. That is not so poor. Nowadays people have become more aware than before. We have helped to change the mindset of those who do institutional delivery. Due to which the institutional delivery has increased a lot and the government and non-government health service organization is behind the increase in this delivery. We can see mass awareness about maternal and child health". Civil Surgeon, Naogoan

Now people are becoming more aware than before They are taking pregnant mothers to the nearest clinics. The poor, the middle class go to the clinic, but the rich don't. They go to Sapahar or Rajshahi for services. CRP. Patari, Shapahar, Naogoan

Decision-making about the place of delivery

Husbands appear to be a gate keeper for the choice of the place for delivery. They decide where the woman should deliver and are quite explicit in mentioning their preference for home delivery:

"When my wife became pregnant I tested with stick in home and brought medicine from community clinic, she took that, didn't took her for ante natal checkup. Delivery happened in home, no problem was there. For mild problem I use to bring medicine from pharmacy." A husband from Charghat Rajshahi during individual interview.

"My plan was; when the first baby will come, delivery will be at home." Adibasi Father, Mundumala Tanore, Home delivery without complication

Home delivery remains a family choice and tradition in most of the cases this is supported by TBA or village doctor. Traditional birth attendants are assuring the pregnant women about home delivery.

"The "doctor" (=TBA) told me that baby is in good condition, water is okay and asked me to take food adequately and also informed that it will be a baby boy. Then they took me back to in laws house. She told me that delivery will be at home. I need to take medication to open my cervix" Mother, Masnatola, Patari, Shapahar, Home delivery and complication after delivery

"I called the village doctor. The village doctor came and said that if the time started then, it would delivery within 21 hours, meanwhile after one hour the pain increased and after half an hour the baby was released. The baby was born at home. There was no problem during delivery except abdominal pain. Adibasi Husband, Mundumal, Tanore, Home delivery, complication after birth"

Sometimes the pregnant women decide about home delivery, even though they are taking their ANC from medical practitioners. When they assure the woman that there is no complication with the continuing pregnancy, women decide to deliver at home. Even though the service providers motivate them for facility-based delivery, the assurance of "no complication yet" by a medical practitioner influences them to deliver at home.

"When it is said in ANC that mother is fine, everything is normal, then they are delivering at home." RMO, Porsha

"Many of them likes to deliver at home. When there is a problem at home, then they rush to the medical." CRP, Patari, Shapahar

"Most of the deliveries are occurring at home. Mother-in-law has a misconception. Also, there are some trained midwives in our area or there are some village doctors who are also delivering at home. They can see and have service from them directly at home." FWA, Nitpur, Porsha

Service providers are encouraging the pregnant women to choose a heath facility for the delivery. However, several factors are influencing their decision of home delivery or the self-referral to another non-governmental facility.

"We personally advise to deliver at upazila health complex, but health complex doesn't have facility for caesarean section, if it would be available there (Upazila health complex) that would be great." CHCP, Tetulia, Porsha

"When they come to me for delivery, I asked them to take her to clinic for service, as I don't do this right now. I advised for health complex as well. Whoever ask for advice, I suggest health complex." Ibrahim Kabiraj, Auchpara, Baghmara

We also found the seven months' ritual "shad" very important after which women are send to their father's house for delivery. There the pregnant women parents take the decision about the place of delivery. With the ritual "shad", care seeking at late pregnancy is involved with a change of decision-makers and a possible change of health providers. The risk of discontinuing ANC or loss of rapport and communication with previous providers is an important concern.

"We also perform seven months' ritual. We send the mother to her father's house for delivering the baby" Father at FGD, Shapahar, Naogoan

Sometimes discrimination of care between care for the daughter and daughter-in-law is reported. The care for daughter and daughter in law also differs from mother in laws perspective and family.

"In all these family's female members (mother-in-law /nanod) behave negatively. Different attitude works in the case of one's own daughter, but another approach works in the case of the son's wife. They said we didn't go, why should the wife (son's) go? Such attitude works behind the scenes." Divisional Director, Rajshahi

"Fathers play a leading role in decision-making. Then they take the doctor's advice. The role of money is less here; they do take a doctor's advice for illness. Gender bias is very low. If there are 5 or 6 children in the family, or girl child then there may be different arrangements for boys or girls, but this is very rare." UH&FPO, Shapahar

In the Adhivasi community, during delivery and postpartum periods, the care seeking for complication and referral acceptance were mentioned the same as the rural Bengali community. However, decision making process is more influenced by the mother-in-law. Adhivasi women mentioned that a good birth planning and support from husband play important role for taking care during pregnancy and birth.

Challenges during complications

Misconception and lack of knowledge were found regarding the nutrition or food intake and complication during delivery specially the size and weight of baby and associated complication. Also care seeking during complication is common, yet often delayed, because women try to give birth at home. It becomes severe, where service providers are unable to do anything. Reaching the appropriate health facility for complication management came out as a challenge. Some respondents were well aware about the inability of the upazila health complex to manage complications. However, in many cases the delay occurred when referring from union level facility to UHC and then still needing to take the patient to a private clinic or tertiary care hospital. Distance of tertiary care hospital is a barrier to reach timely during an emergency. So, people are choosing nearby private clinics. People who are aware about their complication beforehand are choosing a tertiary care facility at Rajshai or Naogoan from the very beginning and ensure that they reach this facility in time.

We found that mothers who were identified with risks during delivery with breach position were advised to have a Caesarian Section during their antenatal checkup. Birth asphyxia during home delivery by TBA without any appropriate interventions was also mentioned by one respondent. We also found mothers with prolonged labour who tried home delivery for a long period and were taken to a facility for the last stage for complication management.

"Two days after the EDD have passed, a TBA came, and normal delivery was done at 3 o'clock at night. A few days before the delivery, I had abdominal pain and my water broke. It took a long time for the baby to deliver. According to the date of Ultrasonography, the pain starts after the date is over, the doctor (drug seller) gave pain medicine, and the baby was born normally. After the baby is born there was no movement, no heartbeat, no cry. When the TBA failed despite all her efforts, the woman was taken to a clinic near home. They said that the child had eaten dirt inside the womb, and they asked to take him to Rajshahi Medical College Hospital." Adibasi Mother, FGD, Mundumala Tanore. Home delivery with complication

"I gave birth at 2 o'clock at night. My mother-in-law and grandmother help me to give birth together. Then the bleeding was huge. The baby's condition was not good. My condition was not good. My mother-in-law and husband took me to Rajshahi Medical College Hospital. I was given 1 bag of blood there." Adibasi mother at FGD, Mundumala, Tanore, Rajshahi, Home delivery complication during delivery

"At 5 months during ultrasonography at Bhabaniganj Clinic, I was told that my baby is upside down. I did ultrasonography again at 6 and 7 months. At this time went to the doctor for white discharge, cold, cough, irritation and take medicine as per prescription. At Bhabanigajna Farzana Clinic had a caesarean section 9 days before the probable delivery date. The baby weighs 3.3 kg" Mother at FGD, Bagmara Rajshai.

"When labour started, noon went by, but delivery didn't happen. I lost all the water, but the baby was not delivered. They gave me injection at home, but nothing happened. I asked my husband to take me to clinic. At clinic doctor saw my situation and advised to do caesarean section immediately. Then my cesarean section was done. "Adibabsi mother, Mundumala, Tanore, Rajshahi, facility delivery with complication during delivery

I didn't know that my wife has eclampsia. I just knew that she had hypertension. I took back her in home and brought medicine as required, I took her for check after one and half month regularly. It was my first child. My in-law one day said that her daughter is having abdominal pain, Bagha or Charghat is so far but they were taking her to there [Charghat Upazila Health Complex] for treatment, her pressure raised and the child might be died on the way to facility. When we reached the hospital (Upazila Health Complex) they denied admitting her as the condition was very severe, then I took her to nearby private clinic. Doctors did normal delivery there; I asked the doctor and she explained that it happened due to high pressure. A father during IDI whose wife had complications during labour, Charghat, Rajshahi

"The baby died of head injury during home delivery. I was taken to Naogaon Sadar Hospital after giving birth and baby died 3 days later. Baby died of injuries during delivery by an incompetent TBA. He would not have died if he had gone to the facilities." Mother at FGD Shapahar, Naogoan

Quality of care in emergencies is not appropriate

According to respondents the emergency service doesn't work at upazila level for CEmONC, because most of the UHCs do not have that pair of gynecologist and anesthesiologist and it

is not possible to arrange them immediately. However, the private facilities are providing this CEmONC service 24/7.

One FWV cannot provide such service alone. Even to conduct a delivery she needs support of one or two colleagues which is challenging in many places.

Lack of coordination between the existing service providers and support staffs is another very crucial challenge to meet. The third delay at the health facility was also mentioned as an important barrier to avail timely emergency obstetric care.

"They don't have a plan - where to go for services, there are transportation problems. It is too late to decide whether to go or how to go. Most of the patients come to the Upazila Health Center / Hospital for complications. Upazila health centers do not have medical facilities for all kinds of complication management. Many of them come and go elsewhere without getting services at complication. If caesarian section is needed they go to the district hospital also. Many go to private clinics without wasting time. However, it is too late to start or provide emergency services everywhere.
It takes one to one and a half hour to start operation in public and private hospitals. Taking one to one-and-a-half hours of emergency services can cause a lot of damage or even endanger child's lives. APH, PPH, Rapture Uterus or baby and there are many other important things that need to be addressed immediately." Divisional Director, Rajshahi

"Our main problem is human resources. Each union should have 12 employees and work in coordination between different departments. How many posts are empty, most of them empty, they do not work by coordination among themselves. There are institutional, personal and ego issues. At present there are not more than 12 workers in a union. This staff is not enough to see 2000 pregnant mothers; the number of staff needs to be increased." UFPO, Charghat, Rajshahi

While discussing with the respondents we found out some additional issues which are supporting MNCH care. Different pathological tests are essential to measure different parameter during pregnancy and in complications but the availability and quality of laboratory tests and services are really questionable. Lack of expert technologists and standardization of the process and machines also emerged as important.

"There is no pathologist in the Upazila Health Complex here. Not only that, there are no consultants, there are posts but no people, they exist only on paper.
The condition of the pathology [department] and test report here is also very bad. Those who work in government hospitals report that no one actually does the test.
Different values in the reports come from different places, because there is no standardization. There is no place to solve these problems." Owner of a private facility, Porsha, Naogoan

Likewise, the cleaning of the delivery room is an issue. Due to the non-availability of cleaners, women are left in dirty conditions to deliver.

"The Aya [cleaner] will come at 10 am the morning and leave at 2 in the afternoon. But the delivery will not be at this time. Most of them come at night. When someone's daughter is in

pain for delivery, who will explain to the people with her? It's better to have a caesarean section than they are in so much pain. A delivery takes a lot of time, 10/12 hours. So much time is needed for counseling of the sick people." Owner of a private facility, Porsha, Naogaon

It is also evident by the service provider statement that lack of time to counsel the pregnant mother, overcrowding at some specific facilities, lack of counseling skills to the family and behavior with patient family often make the families and women reluctant to come again to the facilities. It is also mentioned by the upazila level health manager that in a crowded facility often it is not possible to measure all the parameter of antenatal checkup and provide a standard ANC services.

"Most of us are the cause of failures. We have lots of reason also and they have also. What's our fault? What's wrong with them? It would not have been their fault if I had counseled about the position and condition of baby with her in the right way or with her family, with her husband or with the Guardian in a good way. It is not their fault. If they are responsible 40% then we are 60%." FWV, Sardah, Charghat

POSTPARTUM CARE

While respondents from the health providers and health authorities mentioned that awareness about antenatal care and facility-based delivery is somehow increasing and a positive perception in favor of the facility delivery and care seeking at facilities are found, post-natal care is reportedly less prioritized. Most common problems identified or perceived by the health provider respondents are postpartum hemorrhage, tear, anemia for mother and neonatal sepsis, difficulties in breastfeeding, pneumonia or cold related problems for the newborn. Post-natal care seeking only happens if any of the above complications arises. Not only that, but service providers also mentioned that care seeking for mother is happening less often than for the child. Care seeking practice from alternative providers is also common for newborns in the study area. Often only nutritional care is considered important during this post-natal period.

"This is a big problem for us. Like ANC, it takes mother and child to have 4 PNC checkups. But in this case mother and family are all reluctant. Bleeding is a major cause of maternal death, but in the absence of PNC, the mother suffers a lot before she realizes it. PNC 1 is happening a little, PNC 2 are less and the rest are not really happening at all". Civil Surgeon, Naogoan

"Four PNC visits are required. ANC and PNC both have total of four visits. Even if she is healthy, she needs to be taken care of. Even if both mother and baby are healthy, they need the care. In my opinion, this is rarely taken by the mother in case of normal delivery." Health Assistant, Baghmara, Rajshahi,

"Postpartum service, in fact it is very rare here. If there is any problem after delivery, you should actually come but everyone here prefers to take the services from the village doctor. Due to laziness, lack of awareness and lack of our manpower, it is not possible to do as much as we should." UFPO, Porsha

“Lack of awareness, education is here. Even though superstition is decreasing, it is still there. Many people do not want to take their baby outside. When they become sick only then go to clinic. I didn’t receive women for postpartum care, but I saw children. CHCP, Tetulia, Porsha

“If the newborn cries excessively they seek care from kobiraj, seek blessed water, this is system. Kobiraj provide treatment in this way”. Alamgir Kabiraj, Nitpur, Porsha, Naogoan

While discussing about the necessity of postpartum care for the mother and baby it was found that immunization is considered important, even by alternative service providers. They motivate the mothers to seek immunization services. Practice of providing alternative food other than colostrum just after birth are also found. Mothers who had a home delivery, experience their “first PNC” only during the child first immunization, and the counseling service is being considered as PNC.

“Yes, PNC is also done in satellite, then in community clinic and also in immunization center. Again, we go to the field and tell them. We do provide the PNC care. Mothers come to us first after having children. We will give them advise first what they should do. We do provide the service first as they first come to us.” Health Assistant, Yusufpur, Charghat

Postpartum complication both for mother and baby are seen in the communities of which complications of the baby are prioritize over mother. Most common complications seen for mother and baby are postpartum haemorrhage, anaemia, difficulties in breastfeeding, newborn pneumonia, etc.

“They mostly come with PPH and vaginal complications. The woman come with tear which are in bad condition, but the baby might be healthy. We found mother's life is at risk.” CS, Rajshahi

“And the patients who come later are having more anemia with postnatal complication, and also some patients with delivery complications come at late stage and die later.” RMO, Porsha, Naogoan

“Post-natal care” from traditional providers is a common practice.

“My newborn was not stopping crying, then I brought sacred water from TBA and baby became well. I didn’t go to doctor for any sickness of my baby, there is a pharmacy near, I take my baby there and bring medicine.: Mother, Mundumala, Tanore, Rajshahi, Home delivery without complication

“*Everyone and grandmother were asking why we are staying at home with this postpartum mother because she is caught by something. What is this? This is a bird who stays in the night sky and makes sounds, and it is almost 4-5 days have passed. My aunt told me that. I went to kobiraj's house. My aunt took me there along with my husband and mother. Kobiraj asked me to massage oil and water. I started oil water massage and my baby got well and I able to start breast feeding.” Mother, Patari, Shapahar, Naogoan, Home delivery complication after birth.*

“I am saying that if a women conceived and from the very beginning to end remain under homeopathic treatment then delivery will occur normally very well, and she will only need

immunization service for child which is not under homeopathic capacity. This should be taken from outside. For example, BCG, measles, polio this should be taken ultimately."
Homeopathic service provider, Nitpur, Porsha

Chapter 4: Discussion

The findings from the study reveals the perception of the community (service seeker) regarding the MNCH care seeking behavior, same perception from different perspective of service provision structure in health system and society, and also several barriers and facilitators perceived to access MNCH care. According to our objectives we will try to discuss and compare the findings revealed here with other related national and global research. It is evident from this analysis and other studies that the care seeking behavior is a process which is linked to different factors. In Bangladesh's rural community where the study was conducted, we found the process of decision-making and care seeking is not so straight forward. It is mostly or finally done by the male member of the family like husband, father or father in law. However, the opinion of the female member is taken and given importance as well. Here the role of the female member and their concept of care seeking builds on their educational and awareness level. Also the decision by male members depend on financial stability, awareness level and sometimes accessibility of the services at ease. Delay in decision making often causes severe loss and affects either mothers or neonate's health severely. However, the delay in decision is influences by several factors from service seeker and service provider's end as well.

Including informal and formal health providers as "health teams"

While health providers think that the knowledge level is increasing and they do believe that care seeking at different stage of pregnancy is important for better outcome, local people are often still of the perception that pregnancy doesn't need additional care, or if needed can be accessed from traditional and in formal care provider like pharmacy owner, village doctor, kabiraj etc. This is influenced by different members of family, culture, and experience. Along with the knowledge of pregnant women the knowledge and awareness of family member specially husbands and in laws are playing important role for seeking care from medical personnel or health facilities. Respondent's knowledge on ante-natal care is also important. We found some positive statement in favor of regular ante natal care from health facilities. However, health providers are still not able to convince women about the advantages of an institutional based delivery for normal vaginal delivery. Reasons may be the poor experiences in Government health facilities, the lack of quality of care, and the lack of human resources, particularly in case an emergency happens. Many respondents reported care seeking with informal service providers for antenatal care, home delivery and post-natal care. Despite of having knowledge about MNCH care, knowing the accessibility of standard care from medical provider most of the respondent rely on informal care provider at nearest accessibility. Sometimes they named those providers "medical doctor" which is not true in reality. Even during complications those providers remain the first choice and referring to appropriate places is delayed.

Quite many respondents reported post birth complications, which may be related to the informal care seeking and home-delivery. Another study from a rural community of Bangladesh found that 29% mothers who sought care with obstetric complications had a

history of visiting at least one formal provider and 70% of mothers who sought care with obstetric complications had a history of visiting at least once an informal provider [13].

Establishing a good rapport with the many informal health service providers is essential to understand their knowledge, when and how they refer a woman to a professional health provider, and when how they work together with a professional health provider.

The knowledge and skill of informal provider to provide ANC, medication, counseling and also experience, knowledge and skill of traditional birth attendant during delivery still need more research to evaluate the quality, appropriateness and impact on community, considering the current practice. Understanding informal providers' opinion about the biomedical health system and helping to establish links between the formal and informal health care system may bring about appreciation for each other and foster referral and working together, rather than experiencing each other as competitors.

Ultrasound as a window of opportunity

Ultrasound is considered as an important medical checkup by families in Bangladesh, mainly to determine the sex of the child. Sometimes doing an ultrasonography is considered as the only checkup for antenatal period. Since ultrasound can only be done by a formal and trained health provider, the ultrasound check-up is a good entry point to do a comprehensive ANC check out, which includes identification of complications and anticipated complication management and counselling. This opportunity should not be overlooked, as during ultrasound women will be reached who otherwise only visit informal health providers. A comprehensive checkup may contribute to avoid or reduce further complications, and, with a positive ANC experience could possibly motivate a pregnant woman to come for more ANCs to a professional health provider.

Frequent change and unavailability of appropriate service provider disrupts care seeking

From the analysis we see that Bangladesh culture and practice in the rural community is to deliver child at pregnant women's paternal house while most of the time during pregnancy they stay in their in- law's house. The regular ante-natal care for a certain period is taken from a specific provider which suddenly changes usually at 7 the month of pregnancy. After the swad-ritual in the 7 th month of pregnancy the women are sent to their father's house for the remaining care and delivery. When the homes of the in-laws and the father's home is not in the same village or union, the woman risks losing the communication and comfortable rapport and relation with previous health provider. It is unclear, whether the woman continues to go for ANC to a new health provider (whether formal or informal) and if she takes her records with her. But interestingly it was found that pregnant women are more comfortable and expect that their parents would take better care than the in-law's house. However, it needs to be explored, if and how the decision-making in the "fathers house" changes, and how and whether building up of new rapport with new health provider in the new place happens. On the side of the health providers, there is need and scope to link the woman before the shad ritual to the health provider nearest to her "fathers house". Likewise, health information about ANC, safe delivery and PNC should be given to the family members of the "fathers house" long before the pregnant daughter arrives, in order to prepare the family and decision-makers well. Innovative approaches in information sharing, electronic patient records, and inclusion of "fathers house"

address and health provider phone numbers in the ANC card of the pregnant woman may help to assure uninterrupted care.

Mouth to mouth propaganda and person experience are important drivers of institutional delivery. The mothers and fathers groups may be good vehicles to spreading and emphasizing positive experiences about institutional deliveries.

Private clinics hold an important market share and need to be part of the referral system

Even though Bangladesh has a unique and organized infrastructure of providing Government health services at primary health care level, the functionality is limited due to unavailability of necessary human resources and materials, particularly in regard to basic and comprehensive emergency obstetric care. The two major life-saving procedures, Caesarian section and blood transfusion, are available in only a few public facilities The latter are mostly available only at private health providers, and thus it is necessary to integrate and engage private providers to ensure CEmONC at upazila level. From this study finding we have seen that private provider are often choice of care seeking for many of the respondent and they are only available option for managing complication at some specific emergency when caesarian section is required. Unfortunately, public providers and health mangers still express challenges in ensuring standards and quality care at the private clinic, in particular the high CS-rate, which rather fosters the income and prosperity of the private clinic, than being a life-saving procedure for the woman and her baby. However, unless the Government health facilities can ensure that the necessary human resources and materials are present and available 24/7 and are remunerated and contracted for exclusive Government services only (i.e. with a non-practicing allowance), it remains a necessity to engage private providers. Regulating the quality of care in private clinics, the quality certification, and opening regulations of clinics, as well as regular supervision and appealing to the social responsibility of the clinic owners and performing health providers are important measures which require further input. A study to understand the “real” drivers of performance and quality care and regulations and possible regulatory gaps in private health providers may be important to better integrate and regulate private providers in the overall health system of Bangladesh.

Decision making processes are dominated by men

From findings of the study and previous section of discussion we can conclude that the process of decision making is complex and related to different factors. The process is not lead by any single person or not always same for each family. But commonly found that final decisions are taken by the male member either husband, father-in-law or father which is derived from discussion with senior member of the family like grandparents and also mother-in-law, mother or other female member and interestingly influenced by the experience of older member, tradition, neighbor’s and relative’s experiences as well.

Chapter 5: Conclusion and recommendations

Despite of a remarkable progress in reducing MMR and NMR Bangladesh has facing a stagnant reduction rate in the mentioned indicators which is expressing the difficulties of reaching the targets of the Sustainable Development Goals 2030. Despite increasing awareness, the practice of care seeking at facility and the rate of institutional delivery in this particular study area are not increasing as expected despite of several interventions.

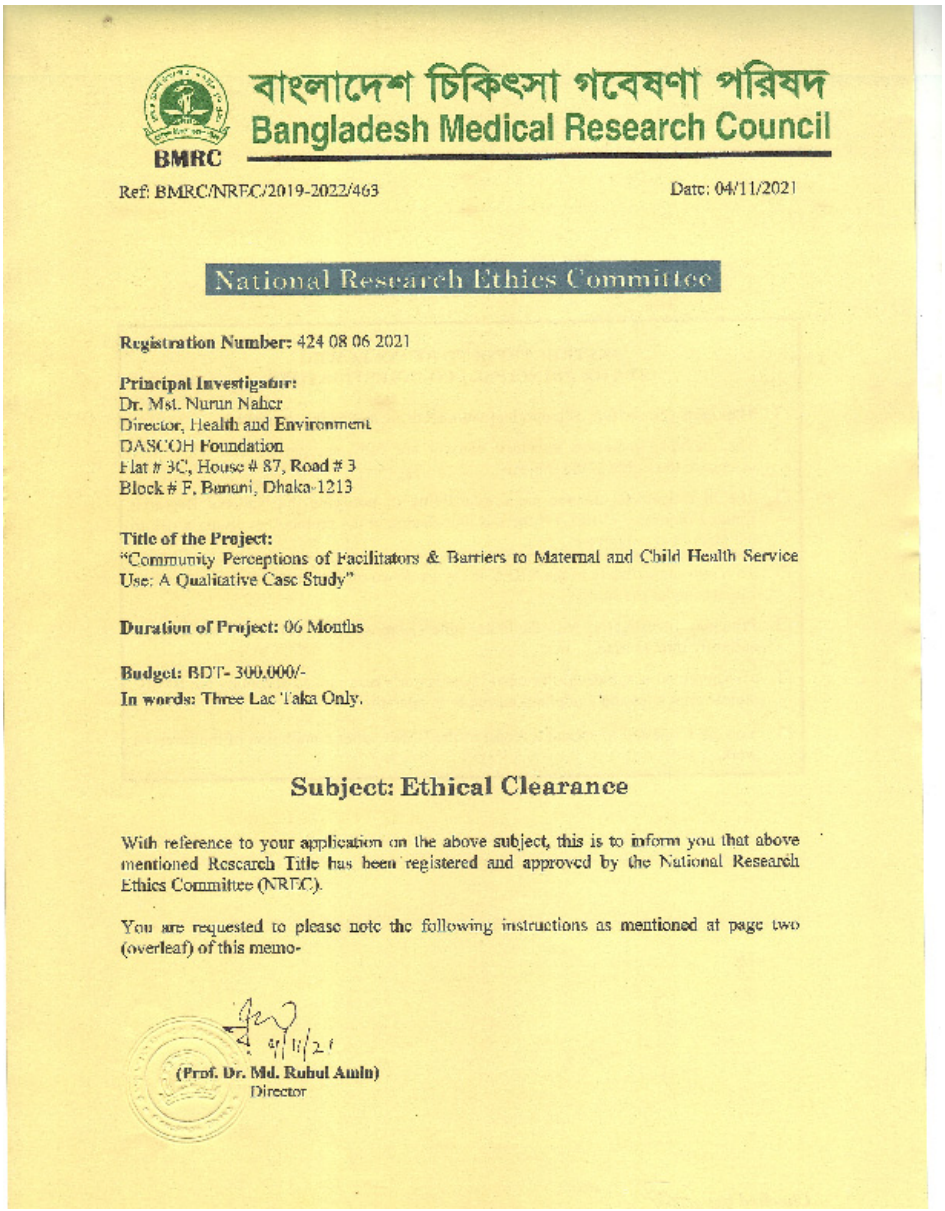
The study findings imply the importance to recognize the formal and informal health system, including Government and private sector health providers. Approaches which foster mutual appreciation, understanding of each other's competence and limitations, and development of quick links of referral need to be explored and put into practice in order to increase quality of care and reduce complications. An integrated approach of increasing family awareness on the in-laws houses as well as the "fathers house" including all the family members is important rather than addressing only individuals, such as the pregnant women and/or the husband. Appropriate awareness generation and effective behavior change communication to convert the knowledge to appropriate practice needs to be applied. Likewise integrating private and government facilities in the referral path, as well as extending and managing the pregnancy pathway of a woman before and after the "Shad" ritual in two different geographic locations requires innovative approaches and engagement. Educational and financial barriers are influencing at individual level for which we need to plan appropriate interventions which will not only increase show immediate outcome rather will generate sustainable impact to reach the long-term target.

There are several and important roles of the different levels of the health system at different tires that need to be functional, accessible and acceptable and reliable to the community. Improving quality of care is a pertinent issue, going along with improving the confidence of the service seekers in the reliability of the public health facilities. Lastly, adequate post-natal care needs to be addressed and institutionalized effectively to counteract complications and ensure the long-term wellbeing of woman and children.

References:

1. Trends in maternal mortality: 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization; 2019.
2. Bangladesh Maternal Mortality and Health Care Survey (BMMS 2016)
3. S Downe 1, K Finlayson, D Walsh, T Lavender. Weighing up and balancing out': a meta-synthesis of barriers to antenatal care for marginalised women in high-income countries, Journal of obstetrics and Gynaecology, February, 2009
4. Kenneth Finlayson 1, Soo Downe. Why do women not use antenatal services in low- and middle-income countries? A meta-synthesis of qualitative studies, PLoS Med, 2013;10(1): e1001373.
5. Bibha Simkhada 1, Edwin R van Teijlingen, Maureen Porter, Padam Simkhada, J Adv Nurs. Factors affecting the utilization of antenatal care in developing countries: systematic review of the literature 2008 Feb;61(3):244-60.
6. Zahid Memon 1, Shehla Zaidi, Atif Riaz. Residual Barriers for Utilization of Maternal and Child Health Services: Community Perceptions From Rural Pakistan, Glob J Health Sci. 2015 Nov 3;8(7):47-57.
7. Bangladesh Health Facility Survey, 2017
8. Moyer CA, Adongo PB, Aborigo RA, Hodgson A, Engmann CM, Devries R: “It’s up to the Woman’s People”: How Social Factors Influence Facility-Based Delivery in Rural Northern Ghana. Matern Child Health J. 2013
9. Bansari Shah,1 Nandita Krishnan, 2 Stephen R. Kodish et al. Applying the Three Delays Model to understand emergency care seeking and delivery in rural Bangladesh: a qualitative study;, BMJ Open. 2020; 10(12): e042690.
10. Shamsun Nahar, Morsheda Banu & Hashima E Nasreen. Women-focused development intervention reduces delays in accessing emergency obstetric care in urban slums in Bangladesh: a cross-sectional study;, BMC Pregnancy and Childbirth volume 11, Article number: 11 (2011)
11. Rubaba Anwar, Aneeka Rahman. PROGRAM BRIEF Towards a Child Benefit Scheme Bangladesh, Social Protection & Jobs Global Practice, World Bank, KWPF.
12. Shegufta S Sikder, Alain B Labrique,Ian M Craig. Patterns and determinants of care seeking for obstetric complications in rural northwest Bangladesh: analysis from a prospective cohort study, BMC Health Serv Res. 2015; 15: 166.
13. Michael A Koenig 1, Kanta Jamil, Peter K Streatfield. Maternal health and care-seeking behavior in Bangladesh: findings from a national survey, , Int Fam Plan Perspect, 2007 Jun;33(2):75-82.
14. Lumbini Roy , Taposh Kumar Biswas , Mahbub Elahi Chowdhury. Emergency obstetric and newborn care signal functions in public and private facilities in Bangladesh, , PLOS ONE, November, 2017

Annex i-: Ethical Approval from BMRC



বাংলাদেশ চিকিৎসা গবেষণা পরিষদ
Bangladesh Medical Research Council
BMRC

Ref: BMRC/NREC/2019-2022/463 Date: 04/11/2021

National Research Ethics Committee

Registration Number: 424 08 06 2021

Principal Investigator:
Dr. Mst. Nurun Naher
Director, Health and Environment
DASCOH Foundation
Flat # 3C, House # 87, Road # 3
Block # F, Banani, Dhaka-1213

Title of the Project:
"Community Perceptions of Facilitators & Barriers to Maternal and Child Health Service Use: A Qualitative Case Study"

Duration of Project: 06 Months

Budget: BDT- 300,000/-
In words: Three Lac Taka Only.

Subject: Ethical Clearance

With reference to your application on the above subject, this is to inform you that above mentioned Research Title has been registered and approved by the National Research Ethics Committee (NREC).

You are requested to please note the following instructions as mentioned at page two (overleaf) of this memo-

(Prof. Dr. Md. Ruhul Amin)
Director

Annex ii: Onboarding training topics:

- Research Introduction : Qualitative vs. Quantitative methodologies
- Problem Statement and Hypothesis
- Sampling and Study Design
- Data Collection Techniques
- Biases and Challenges in Conducting Research
- Kobo Toolbox Introduction
- Basic Techniques of developing & deploying mobile forms with Kobo
- KAP Survey
- Kobo Toolbox Practice
- End-line Questionnaire Introduction
- Topics and Questions on end-line Questionnaire
- Sampling Discussion on Village selection
- Practice asking questions with Kobo using tablets.
- Practice the end-line survey

Annex-iii: Informed Consent Form

Community Perceptions of Facilitators & Barriers to Maternal and Child Health service use: A Qualitative Case Study

Interviewer details
I am _____, a field research officer from DASCOH Foundation, a local NGO.

[Signature only required for Interviews; Information Sheet and key parts of this form to be read out before the start of group discussions, and verbal consent is implied for anyone who remains for the activity]

Invitation for participation
You have been selected as a participant for interview as part of the Bangladesh case study, which is being conducted by the Swiss Red Cross in order to understand community opinions and experiences of local maternal health care services for pregnancy and labour. We feel that you have valuable information to contribute towards improving our understanding of how decisions are made about maternal health care.

Purpose of the study
The aim of this research is to learn about community members' views on the MNCH services that are available, including their quality and usefulness. We would like to know how decisions are made during a woman's pregnancy, about whether she attends ANC or chooses to give birth in one of the facilities, particularly if something goes wrong and what she and her family does when complications arise.

Please read the information sheet about the study provided for you to keep.

Types of participation of the study respondents

For Group Discussion
We would like you to join a group discussion of about 8-12 people, which will last between 1 and 2 hours. We will conduct some activities that you can participate in with the others in the group to identify how women in this community decide whether to use maternal health services during pregnancy, birth and after, and what is your opinion about the different care options. Notes of the discussions and photos of any visuals produced such as map/diagrams during the discussion will be taken. We will not record

your name or private information during the activity, and everything that is said will remain confidential in the study. We would like to audio-record the interviews and to take notes in order to ensure we capture the information you provide accurately.

For Individual Interviews
We would like to conduct an interview with you that will last between 45-90 minutes. Topics that will be addressed are how you and your family members took decisions about care at different stages of your pregnancy and your experience and perceptions of health services during pregnancy and birth. You do not have to answer any questions that you do not want to and can leave the interview at any time. We would like to audio-record the interviews and to take notes to ensure we capture the information you provide accurately.

Risks, hazards and discomforts

For Group Discussion: None of the topics that we discuss will be personal, so the discussion should not pose any risks or make you uncomfortable. You can contribute as you wish, and there is no obligation to answer any question that you do not want to.

For Individual Interviews: Some of the topics we discuss will relate to what happens in case of complications or emergency situation during pregnancy and/or labour. This could be distressing for you if it brings up difficult memories or issues. We can stop the interview at any time, and you do not have to answer any question that you do not want to. I can also arrange for you to talk to a counsellor afterwards if you feel it could make you feel better.

Benefits /Compensation/Reimbursements
The study results will help us understand how to improve MNCH services here and in other places, and to learn what kinds of conditions make it easier for women to obtain the care they need. There are no immediate benefits to you as an individual. Taking part in the study will not cost you anything and we will not pay you to take part in the study.

[For GROUP: We will provide some refreshments during the activity]

Confidentiality
If you agree to take part in this study by signing this document, all information obtained will be stored using an ID number in computer files, with your name and other identifying information removed. No names of participants will be recorded, and we will treat all the information received confidentially. The only people who will hear the recording or see the notes are those who are working directly on this research project. In reports and papers about this research, we may use some of what you say in the interview as an example of local experiences, but your name will not be mentioned.

Voluntary participation/Termination/Rights to withdraw from participation
Involvement in this study is voluntary. If you decide not to take part in this study, your decision will not affect your future access to local services. You are free to withdraw your consent and assent and stop your involvement at any time. Before you sign this form, please ask any questions on any aspect of this study that is unclear to you.

Authorization
You are making a decision whether or not to take part in this study. Your signature shows that you have read and understood the information provided above, have had all your questions answered, and have decided to take part.

I have read the information sheet concerning this study and I understand what will be required YES/NO

I understand that at any time I can withdraw from this study without giving a reason YES/NO

I agree to take part in this discussion YES/NO

I agree for this interview to be recorded **YES/NO**

I agree that what I say may be included in reports and papers as anonymous quotes **YES/NO**

__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __ __ __ __ __	__ __ /__ __ /2021
Name of the participant	Signature/Thumb print	Date
_ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __ __ __ __ __	__ __ /__ __ /2021
Name of the witness	Signature/Thumb print	Date
__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __ __ __ __ __	__ __ /__ __ /2021
Name of the interviewer	Signature/Thumb print	Date

Duplicate copy of Inform Consent will be given to the participant.

Annex-iv: Guideline for Interactive Group Discussion and Individual in-depth Interview

Interactive Group Discussion Facilitation Guide

Introduction (10 minutes):

- Welcome the participants and introduce yourself.
- Explain the purpose of the assessment: read out the Informed Consent form about the aims and objectives, and how participation is entirely voluntary, and they can opt-out of any part of the discussion and are free to leave at any time.
- If the discussion will be audio-recorded, explain that this is to aid notetaking and so researchers can more accurately capture what was said.
- Explain that the research team will not record any names and will keep all information shared during the activity anonymous. However, because this is a group activity, confidentiality cannot be assured.
- Ask if there are any questions, and if anyone would like to leave right away.
- Ask everyone to introduce themselves briefly in case not everyone knows each other, and if appropriate, to say something about their interest in the topic of maternal health in their communities, or what they feel is a local priority. This will help break the ice and improve focus but keep it short – this is not the time to get into an in-depth discussion.

Part I: COMMUNITY MAPPING: ***What does your community look like?***

Part II: PREGNANCY PATHWAYS: ***What are common local experiences for pregnant women?***

Part III: HORSE & CART: ***Facilitators and barriers to health care seeking.***

Part IV: WRAP UP

Part I: COMMUNITY MAPPING: ***What does your community look like?***

(30 minutes)

Participants: 4-5. If you have a big group, divide them into smaller groups for the mapping activity. Hand out the flipchart paper and give 1 marker pen to each participant so that *everyone* has one. The aim is to encourage everyone to contribute – so try to avoid letting 2-3 dominant participants do all the work.

Materials: Flipchart paper; coloured pens

1. Ask the participants to draw a map of their local community, *however they would like to depict it*. They can decide how big "local" means. Ask them to first talk about it among themselves: what places they know, where they go, how much detail they want to use. There is no "right" or "wrong" way to draw a map – but the participants might have a lot of questions or concerns at the beginning. Explain that we are trying to understand daily life in their communities, as the background to decisions about maternal health care. The map will help "set the scene" and provide their perspective of their community. They can draw their map any way they like, but they should be encouraged to use *symbols* and *pictures* instead of writing in case some participants have lower literacy. Leave the group to draw their maps alone for 5-10 minutes. This helps groups interact with each other instead of looking to the facilitator for guidance.
2. Discuss the maps. Let each group explain their drawing to you and compare them. Ask questions about what is on the map and also what is *not* on the map. What are important places and persons why? Community or religious meeting places? a school? The police station? Shops? The residence of a community health worker? The groups can add places that they have forgotten, or they can explain why they did not include some things on it. Remember (and remind them) that it is *their* map, so they choose what should or should not be included.
3. Now ask groups to **mark all the places and persons where a pregnant woman would go to seek care during the pregnancy and at the time for labour and giving birth**. You can ask the following questions to help the group understand the task and prompt discussion for places and persons that can be marked on the maps. Encourage the group to think broadly, including formal health services as well as traditional or informal providers.
    - Which groups live where in a community? Do they access the health services differently?
    - Where do pregnant women go to stay healthy?
    - From what kinds of people do they seek advice and assistance? Where are these people located?
    - In a normal pregnancy, what formal and informal services can women go to?
    - During a normal delivery, where are all the possible places and persons a woman might go?
    - What happens if there is an emergency? Where could a woman go for help?

When the groups are finished marking their maps, briefly review them and probe to ensure the group has included all possible locations for health-care seeking and advise for pregnancy/childbirth.

Part II: PREGNANCY PATHWAYS: ***What are common local experiences for pregnant women?***

(30 minutes)

Participants: 8-12 (all together)

Materials: Flipchart paper; coloured pens

1. Put up a flipchart and draw a "timeline" across the bottom, from left to right. The far left represents the moment a woman suspects or realizes she is pregnant; the far right is the final outcome of the pregnancy (which could be miscarriage/ live birth or stillbirth), followed by a short postnatal period, once the woman has given birth (and may have returned home).
2. To start, suggest the group draw some time points (accompanied by pictorial illustrations) of each key step in the pregnancy (according to local perceptions). These can help the group think about their responses for the next questions for each stage of pregnancy.
3. Ask the group members to think to themselves for a few moments, maybe reminding themselves about their own previous experiences, or close family members/ friends, as well as stories they have heard from others. They should think about what happens to women in the local community from learning they are pregnant through to giving birth (or experiencing a negative outcome) – and they should think about "common" and "normal" experiences at each stage of the pregnancy, as well as those that are more rare, both for pregnancies that go as planned and for those that experience a complication, health problem or emergency.
4. Now ask the group to draw one or more pregnancy pathways across the timeline, indicating at what point of the pregnancy certain behaviours, experiences or health services occur (again, using symbols or picture if literacy is an issue). The group can draw 1 or more pathways but should include differences between social groups or individuals and also differences between routine and complicated situations. Some guiding questions could be:

    - What happens when a woman first becomes pregnant?
    - Whom would she tell? Where might she go for advice?
    - Does she usually seek health services? Why or why not? Who influences her decision?
    - Where might she go for advice and care as the pregnancy proceeds? How does she make these decisions? (PROBE: who might influence her? family members? friends? health providers?
    - What might cause a pregnant woman to seek care at different kinds of providers?
    - What might cause a pregnant woman not to seek care from any type of provider?
    - Where do women commonly choose to give birth? What does this depend on?
    - Are there some kinds of women who might have a different pathway during normal pregnancy and delivery? Why, and how are their pathways different? Why do these differences occur?
    - -What happens if a woman has a complication or poor health during her pregnancy? Would she have a different care pathway compared to a woman without any problems?
    - -What happens if there is an emergency at the time of giving birth? How will that affect a woman's pregnancy pathway?

- Among women experiencing complication or emergency, are there some who might have a different pathway? Why, and how are their pathways different? Why do these differences occur?
- How are different kinds of pregnant women influenced by family or other community members?
- What are the "triggers" for deciding to go to a certain provider or avoiding services?

1. Ask the participants to provide as much detail as possible. Leave the group to discuss and draw their pathways but ask enough guiding questions so that the group feels they have depicted all the possible health-seeking options taken by local women during both "normal" pregnancy/birth and at the onset of complications/emergencies. Really try to understand how the group sees the decision-making process across the whole pregnancy experience (through each type of "pregnancy pathway" they have drawn).
2. **Discussion**
   Bring out the maps that the groups drew earlier. Ask them to take a look at their maps.
   - How many of the places and persons that they identified on the maps were included in the pregnancy pathways?
   - Which types of services and persons are used for which kinds of situations during pregnancy and childbirth?
   - Do different types of women and families choose different places and persons on the map during their pathways? Why do their decisions differ?
   - Looking at the pathway diagrams and the maps, which services from the maps are most commonly featured in pregnancy pathways? Why?
   - Which are the least used services and why? How does this differ across groups of women and their families and communities?
   - Any other ideas you want to share?

Part III: HORSE & CART: ***Facilitators and barriers to health care seeking***

(30-45 minutes)

This activity works to analyse what is "driving change forward" and what is "holding change back."

In this case, we will ask the group to think about the challenges communities face in using available services for ANC and childbirth. We will also ask them to identify any factors or programmes that already exist (or could be introduced) to support higher use of these services.

Participants: 8-12 (all together)

Materials: Flipchart paper, coloured card, marker pens, tape or blu-tack.

Identifying Facilitators

1. Give a flipchart to the group and ask for 2 volunteers to draw a "horse and cart" in the middle of it. The cart should be empty. The group can decide what drives a cart – it doesn't have to be a horse. What is locally relevant – motorcycle? donkey? Person on a bicycle? Something needs to be pulling their cart forward.

2. Ask the participants to think about existing enabling factors for decision-making and the use of appropriate services during pregnancy and childbirth, considering the pregnancy pathways diagram and the maps. What are the internal or external facilitators of use of each kind of service they have highlighted as “common”?
3. For each facilitator, ask participants to talk about it, and to decide it if it is a small or large facilitator (e.g. really helps pregnant women access the services they need). They should draw and cut out a small picture and pin it to the “horse” to show it is pulling the cart forward. Facilitators can be physical (new roads/ ambulances); financial (shared saving schemes); or social (supportive spouse and family encouraging facility birth).
4. Several participants can work on different “facilitators” at the same time and add them to the picture.

Identifying Barriers

5. When the group has finished listing all the facilitators ask participants to think about existing barriers or factors that are likely to hold back pregnant women from receiving requisite care. What will restrain progress of the cart?
6. For each barrier, ask participants to talk about it, and to decide it if it is a small or large barrier (e.g. a serious threat to access or just a small hurdle). They should draw in a large or small rock/boulder (or any other heavy object) in the back of the cart, to demonstrate the “heavy load” that it will add.

Discussion

- Are there more boulders in the cart, or help on the horses? What is the balance of facilitators and barriers in the community (is the cart moving forward slowly, quickly, or not at all)?
- Which barriers do they feel are most significant?
- Do barriers and facilitators differ between individual women, families or whole social groups? Why?
- If there is a complication or obstetric emergency, how do these facilitators or barriers influence what happens?
- How do these facilitators and barriers affect decision-making by women and their families? When a woman (and family) are considering what care to seek or not seek, which information and perceptions affects their final decision?
- Are there any existing measures that help to overcome the barriers they have identified?
- How would they address these barriers if they could?
- Which are the best facilitators for improving health-care seeking and maternal health outcomes?
- What new facilitators might influence decision-making during pregnancy and at the time of giving birth?
- Are different facilitators needed for different individuals, families or social groups?
- Are there any projects in the area that helping to move the cart forward? Why or why not?
- Ask for specific examples from community experience, for example “ Do you know of cases in the community when a woman experienced a serious complication during pregnancy or an emergency? What happened? Can you describe what the facilitators and barriers were in those situations?”

Part IV: WRAP UP

Ask the group to look at all 3 of the visuals they have produced, and if there are any additional ideas or information they would like to share. Ask permission to photograph the diagrams/maps but leave the originals with participants to keep or dispose of as they wish.

Thank the group for their active participation. Tell them we appreciate their time and thoughts, which will be added to other information that is being used to better understand local perspectives on maternal health services in the area.

Inform the group that individuals might be approached to participate in an individual interview, where they could share more of their thoughts and experiences. In particular, the researchers may invite women who gave birth in the past 6 months in the community or at a health facility to share their individual experiences. Also, ask participants to suggest women in the community who experienced a complication/emergency during their pregnancy or birth and may be willing to be interviewed.

Anyone asked to participate in an interview can refuse to do so. They are under no obligation to agree to participate, but if they are asked and would like to be part of an interview, a time will be scheduled that is convenient for them, and the interview held somewhere in private.

Guideline for individual interviews

Women who gave birth in past 6 months (no complications)

Areas of Inquiry	Specific Topics	Suggested Probes	Subjects Suggestive answered
Introduction/ Background	Please ask the respondent to introduce herself and talk about herself and her family.	• Please can you describe your family and living situation? • How many children do you have, and what are their ages? • What kind of work is your family engaged in? What are your daily tasks?	
Pregnancy **Birth planning**	Now I would like to talk to you about your most recent pregnancy. Did you consider it to be a “healthy pregnancy”? Why or why not? Can you explain step-by-step about your pregnancy? When you first realised you are pregnant, Whom did you consult about your pregnancy? Can you tell me what kind of advice you received from	• What made you feel it was healthy or not healthy? • How did it compare to any previous pregnancy? [if relevant] • Describe in your family whom you informed. What was their reaction and advise? What about your husband or family members? [PROBE: spouse, parents, in-laws, siblings, friends, traditional healers, other community members	

Areas of Inquiry	Specific Topics	Suggested Probes	Subjects Suggestive answered
	different kinds of people? During the pregnancy, what (if anything) specific did you do to have a health pregnancy and birth experience? As your pregnancy progressed, what were your thoughts about care? What kind of informal or formal care did you receive during your pregnancy? Are there any other types of care that you wanted to have but were not able to obtain? As your pregnancy advanced, how were you feeling? What were your thoughts about where you wanted to give birth? With whom did you discuss your decision about where to give birth? Did you make any plans prior to the birth, such as where and with whom you wanted to give birth? Who else helped you plan?	• Did you care for yourself in specific ways? • Did you change any of your regular habits or behaviours? • Are there other things you wanted to do during your pregnancy to help make it healthy but that you found difficult? Please explain • Describe any providers or services that you consulted. • Can you describe how you decided whether or not to have care during your pregnancy and where? • With whom did you discuss these decisions? • Why? Can you give examples? • Did you disagree with anyone about what care you should have? Can you explain? [PROBE: spouse, parents, in-laws, siblings, traditional healers, other community members] • Can you explain how you made your decision? • What did they tell you? Did you agree or disagree with them? Did you consult anyone else?	
Giving birth	Please tell me about your birth experience. What happened step-by-step, from the time you went into labour? Please take your time to think about everything	• Where were you/ what were you doing at onset of labour? • Who else was around? • What did you do? Whom did you call or tell? • **Then what happened?** • **What happened next?**	

Areas of Inquiry	Specific Topics	Suggested Probes	Subjects Suggestive answered
	that happened and how your felt about it. How did your birth experience compare to what you had planned? Were here any decisions that had to be made during your labour and birth? If so, please describe. Do you feel you had a good birth experience? Why or why not? Looking back, what would you have liked to do differently or would do differently in future? What advice would you give to a friend or your sister who is pregnant about care during pregnancy and birth?	• Was anyone present at the birth? Who? • What did they do? • Anyone else? • Did anything unexpected happen? • What do you feel went well or poorly compared to your expectations? • Would you change the place you gave birth? • Would you change who was present? • What would you recommend for pregnancy care? Why? • Where would you recommend women to give birth? Why?	
After the birth	Tell me about any care you and your baby have received since you gave birth? Has anyone come to visit you in the home to check on your and the baby's health? Who and what do they do? How were decisions made about the kind of care you should receive after the birth? How are decisions about your baby's care normally made?	• What kinds of care have you received? • From whom? • Do any traditional providers or health workers visit? How often and for what purpose? • Who is involved? [PROBE: spouse, parents, in-laws, siblings, traditional healers, other community members] • What do other people advise? • Are there any disagreements about care? Please describe.	
Planning for complications/ emergency	Luckily your last pregnancy was healthy, and you had a routine	• Please explain? • Who would have made the decision about what to do?	

Areas of Inquiry	Specific Topics	Suggested Probes	Subjects Suggestive answered
	birth. But if you had experienced a health problem or complication during the pregnancy or at time of birth, what do you think you would have done? Where would you have gone for help? What kinds of barriers might have made it difficult for you to get good care in an emergency? Can you describe the kinds of challenges women in this community face during pregnancy and birth if they have a complication or emergency?	• How could help be obtained? [PROBE: means and costs of transport] • Why would you have gone there? • Please can you describe any situations you know or have heard about? • What happened?	
Wrap-up	Thank you for sharing your personal experiences with me. Is there anything else you would like me to know?	• Do you have any final questions for me about the study?	

Women with complications/obstetric emergencies during pregnancy

Areas of Inquiry	Specific Topics	Suggested Probes	Subjects Suggestive answered
Introduction/ Background	Please ask the respondent to introduce herself and talk about herself and her family.	Please can you describe your family and living situation? What kind of work is your family engaged in? What are your daily tasks?	
Experiences of complication/ emergency during pregnancy	Please tell me about your last pregnancy. I know this is a difficult subject and a sad and frightening experience for you. Please take your time and tell me in your own words what happened. You do not have to tell me about experiences that you do not want to	Whom did you tell when you first felt you might be pregnant? [PROBE: spouse, parents, in-laws, siblings, friends, traditional healers, other community members] Describe any providers or services that you consulted. Can you describe how you decided whether or not to have	

Areas of Inquiry	Specific Topics	Suggested Probes	Subjects Suggestive answered
Birth planning	share, or that make you upset. Maybe first you can tell me about the early stages of your pregnancy and how you felt? Whom did you consult about your pregnancy? Can you tell me what kind of advice you received from different kinds of people? During the pregnancy, what (if anything) specific did you do to have a healthy pregnancy? Before you experienced the complication, what kind of informal or formal care did you receive during your pregnancy? What were your thoughts about where you wanted to give birth? With whom did you discuss your decision about where to give birth? Did you make any plans prior to the birth, such as where and with whom you wanted to give birth? Who else helped you plan? If you feel ready, please tell me about your experience of what went wrong during the pregnancy/ labour. Take your time and tell me step-by-step about what occurred. [**Interviewer** should not interrupt too often if respondent is	care during your pregnancy and where? With whom did you discuss these decisions? Can you explain how you made your decision? [PROBE **only if respondent does not continue narrative in her own** way] How did you realise something was going wrong? Whom did you consult/ discuss the situation? How was the decision made about what to do next? Who made this decision? [probe: spouse, parents, in-laws, other family, other community members, health providers] Where did you go? Why was this particular prover or service chosen? Who made the decision? How did you get to the provider or service? How was transport arranged? What kinds of challenges were encountered when seeking care? What happened once you reached the provider? How do you feel about the care you received?	

Areas of Inquiry	Specific Topics	Suggested Probes	Subjects Suggestive answered
	comfortable describing her experience. Use probing questions only at the end to fill in any gaps OR if respondent gets "stuck" and seems unable to continue. It is good to regularly ask "And then what happened? What occurred next?] **IMPORTANT**: If respondent shows signs of becoming distressed, *pause* the interview and check she is willing to continue. Take a *short break*. If it is not feasible to continue, thank the respondent and *stop the interview*. *Referrals* for counselling should be made for any distressed respondent.		
Feelings about the experience	I am sorry you went through such a difficult and frightening experience. Can you tell me how you are feeling about what happened now? What advice would you give to other women who might experience the same thing, what would you tell them? How would you advise them to plan for possible complications or emergencies?	What would you recommend for pregnancy care? Why? Where would you recommend women to give birth? Why? What kinds of preparations do you think women and their families should make in advance? Please describe, Looking back, would you have done anything differently? Can you explain?	
After the birth	Tell me about any care you received afterwards? Has anyone come to visit you in the home to check	What kinds of care have you received? From whom?	

Areas of Inquiry	Specific Topics	Suggested Probes	Subjects Suggestive answered
	on your health? Who and what do they do? How were decisions made about the kind of care you should receive?	Do any traditional providers or health workers visit? How often and for what purpose? Who is involved? [PROBE: spouse, parents, in-laws, siblings, traditional healers, other community members] What do other people advise?	
Advice to others	Given your experience, what would you advise other pregnant women about care during pregnancy and childbirth? What makes it easier for you to get the care you wanted during the pregnancy at the time of the birth? What might make it more difficult?	What would you suggest pregnant women do to have a healthy pregnancy? Where do you think it is best for women to give birth? Can you think of any actions women and their families can take to increase chances of getting the care they need? What kinds of challenges might women face?	
Wrap-up	Thank you for sharing your difficult personal experiences with me. Is there anything else you would like me to know?	Check if respondent would like to be referred for counselling or further assistance. Do you have any final questions for me about the study?	

Women with complications/obstetric emergencies during labour

Areas of Inquiry	Specific Topics	Suggested Probes	Subjects Suggestive answered
Introduction/ Background	Please ask the respondent to introduce herself and talk about herself and her family.	• Please can you describe your family and living situation? • What kind of work is your family engaged in? What are your daily tasks?	

Areas of Inquiry	Specific Topics	Suggested Probes	Subjects Suggestive answered
Experiences of complication/ emergency during childbirth	Please tell me about your last pregnancy and delivery. I know this is a difficult subject and a sad and frightening experience for you. Please take your time and tell me in your own words what happened. You do not have to tell me about experiences that you do not want to share, or that make you upset.		
Pregnancy (See woman without complication) **Birth planning**	Maybe first you can tell me about the early stages of your pregnancy and how you felt? Whom did you consult about your pregnancy? Can you tell me what kind of advice you received from different kinds of people? During the pregnancy, what (if anything) specific did you do to have a healthy pregnancy? What were your thoughts about where you wanted to give birth? With whom did you discuss your decision about where to give birth? Did you make any plans prior to the birth, such as where and with whom you wanted to give birth? Who else helped you plan?	• Whom did you tell when you first felt you might be pregnant? [PROBE: spouse, parents, in-laws, siblings, friends, traditional healers, other community members] • Describe any providers or services that you consulted. • Can you describe how you decided whether or not to have care during your pregnancy and where? • With whom did you discuss these decisions? • Can you explain how you made your decision?	
Giving birth	If you feel ready, please tell me about your experience of what went wrong during the labour. Take your time and tell me step-by-step about what occurred.	[PROBE **only if respondent does not continue narrative in her own** way] • How did you realise something was going wrong?	

Areas of Inquiry	Specific Topics	Suggested Probes	Subjects Suggestive answered
	[**Interviewer** should not interrupt too often if respondent is comfortable describing her experience. Use probing questions only at the end to fill in any gaps OR if respondent gets "stuck" and seems unable to continue. It is good to regularly ask "And then what happened? What occurred next?] **IMPORTANT**: If respondent shows signs of becoming distressed, *pause* the interview and check she is willing to continue. Take a *short break*. If it is not feasible to continue, thank the respondent and *stop the interview*. *Referrals* for counselling should be made for any distressed respondent.	• Whom did you consult/ discuss the situation? • How was the decision made about what to do next? • Who made this decision? [probe: spouse, parents, in-laws, other family, other community members, health providers] • Where did you go? • Why was this particular provider or service chosen? • Who made the decision? • How did you get to the provider or service? How was transport arranged? • What kinds of challenges were encountered when seeking care? • What happened once you reached the provider? • How do you feel about the care you received?	
Feelings about the experience	I am sorry you went through such a difficult and frightening experience. Can you tell me how you are feeling about what happened now? What advice would you give to other women who might experience the same thing, what would you tell them?	• What would you recommend for pregnancy care? Why? • Where would you recommend women to give birth? Why? • What kinds of preparations do you think women and their families should make in advance? Please describe,	

Areas of Inquiry	Specific Topics	Suggested Probes	Subjects Suggestive answered
	How would you advise them to plan for possible complications or emergencies?	• Looking back, would you have done anything differently? Can you explain?	
After the birth	Tell me about any care you received afterwards? Has anyone come to visit you in the home to check on your health? Who and what do they do? How were decisions made about the kind of care you should receive?	• What kinds of care have you received? • From whom? • Do any traditional providers or health workers visit? How often and for what purpose? • Who is involved? [PROBE: spouse, parents, in-laws, siblings, traditional healers, other community members] • What do other people advise?	
Advice to others	Given your experience, what would you advise other pregnant women about care during pregnancy and childbirth? What makes it easier for you to get the care you wanted during the pregnancy at the time of the birth? What might make it more difficult?	• What would you suggest pregnant women do to have a healthy pregnancy? • Where do you think it is best for women to give birth? • Can you think of any actions women and their families can take to increase chances of getting the care they need? • What kinds of challenges might women face?	
Wrap-up	Thank you for sharing your difficult personal experiences with me. Is there anything else you would like me to know?	• Check if respondent would like to be referred for counselling or further assistance. • Do you have any final questions for me about the study?	

Areas of Inquiry	Specific Topics	Suggested Probes	Subjects Suggestive answered

Women with previous complications/ obstetric emergencies after delivery

Areas of Inquiry	Specific Topics	Suggested Probes	Subjects Suggestive answered
Introduction/ Background	Please ask the respondent to introduce herself and talk about herself and her family.	Please can you describe your family and living situation? What kind of work is your family engaged in? What are your daily tasks?	
Experiences of complication/ emergency	Please tell me about your last pregnancy and delivery. I know this is a difficult subject and a sad and frightening experience for you. Please take your time and tell me in your own words what happened. You do not have to tell me about experiences that you do not want to share, or that make you upset.		
Pregnancy **Birth planning**	Maybe first you can tell me about the early stages of your pregnancy and how you felt? Whom did you consult about your pregnancy? Can you tell me what kind of advice you received from different kinds of people? During the pregnancy, what (if anything) specific did you do to have a healthy pregnancy? What were your thoughts about where you wanted to give birth? With whom did you discuss your decision about where to give birth?	Whom did you tell when you first felt you might be pregnant? [PROBE: spouse, parents, in-laws, siblings, friends, traditional healers, other community members] Describe any providers or services that you consulted. Can you describe how you decided whether or not to	

Areas of Inquiry	Specific Topics	Suggested Probes	Subjects Suggestive answered
	Did you make any plans prior to the birth, such as where and with whom you wanted to give birth? Who else helped you plan?	have care during your pregnancy and where? With whom did you discuss these decisions? Can you explain how you made your decision?	
Giving birth	Please tell me about your birth experience. What happened step-by-step, from the time you went into labour? Please take your time to think about everything that happened and how your felt about it. How did your birth experience compare to what you had planned? Were here any decisions that had to be made during your labour and birth? If so, please describe. Do you feel you had a good birth experience? Why or why not? Looking back, what would you have liked to do differently or would do differently in future? What advice would you give to a friend or your sister who is pregnant about care during pregnancy and birth?	Where were you/ what were you doing at onset of labour? Who else was around? What did you do? Whom did you call or tell? **Then what happened?** **What happened next?** Was anyone present at the birth? Who? What did they do? Anyone else? Did anything unexpected happen? What do you feel went well or poorly compared to your expectations? Would you change the place you gave birth? Would you change who was present? What would you recommend for pregnancy care? Why? Where would you recommend women to give birth? Why?	
After birth complications	If you feel ready, please tell me about your experience of what went wrong during the labour and afterwards. Take your time and tell me step-by-step about what occurred.	[PROBE **only if respondent does not continue narrative in her own** way] How did you realise something was going wrong? Whom did you consult/ discuss the situation?	

Areas of Inquiry	Specific Topics	Suggested Probes	Subjects Suggestive answered
	[**Interviewer** should not interrupt too often if respondent is comfortable describing her experience. Use probing questions only at the end to fill in any gaps OR if respondent gets "stuck" and seems unable to continue. It is good to regularly ask "And then what happened? What occurred next?] **IMPORTANT**: If respondent shows signs of becoming distressed, *pause* the interview and check she is willing to continue. Take a *short break*. If it is not feasible to continue, thank the respondent and *stop the interview*. *Referrals* for counselling should be made for any distressed respondent.	How was the decision made about what to do next? Who made this decision? [probe: spouse, parents, in-laws, other family, other community members, health providers] Where did you go? Why was this particular prover or service chosen? Who made the decision? How did you get to the provider or service? How was transport arranged? What kinds of challenges were encountered when seeking care? What happened once you reached the provider? How do you feel about the care you received?	
Feelings about the experience	I am sorry you went through such a difficult and frightening experience. Can you tell me how you are feeling about what happened now? What advice would you give to other women who might experience the same thing, what would you tell them? How would you advise them to plan for possible complications or emergencies?	What would you recommend for pregnancy care? Why? Where would you recommend women to give birth? Why? What kinds of preparations do you think women and their families should make in advance? Please describe, Looking back, would you have done anything differently? Can you explain?	
After the birth complication	Tell me about any care you received afterwards? Has anyone come to visit you in the home to check	What kinds of care have you received? From whom?	

Areas of Inquiry	Specific Topics	Suggested Probes	Subjects Suggestive answered
	on your health? Who and what do they do? How were decisions made about the kind of care you should receive?	Do any traditional providers or health workers visit? How often and for what purpose? Who is involved? [PROBE: spouse, parents, in-laws, siblings, traditional healers, other community members] What do other people advise?	
Advice to others	Given your experience, what would you advise other pregnant women about care during pregnancy and childbirth? What makes it easier for you to get the care you wanted during the pregnancy at the time of the birth? What might make it more difficult?	What would you suggest pregnant women do to have a healthy pregnancy? Where do you think it is best for women to give birth? Can you think of any actions women and their families can take to increase chances of getting the care they need? What kinds of challenges might women face?	
Wrap-up	Thank you for sharing your difficult personal experiences with me. Is there anything else you would like me to know?	Check if respondent would like to be referred for counselling or further assistance. Do you have any final questions for me about the study?	

Individual In-Depth Interview with Health Care Providers

Areas of Inquiry	Specific Topics	Suggested Probes	Subjects Suggestive answered
Introduction/ Background	Please can you tell me about your role and work? What do you do on a day-to-day basis related to maternal health?	• Describe your job? • Where are you based? [PROBE: health facility, community or both] • What are all the different MNCH services provided in this facility, including clinical or other care support?	•
	Tell me about the local community's use of	• What do pregnant women do when they first realise	

Areas of Inquiry	Specific Topics	Suggested Probes	Subjects Suggestive answered
Local Health Seeking Norms **Decision Making for MNCH**	MNCH services, including ANC, giving birth and PNC? What are the differences in health behaviour and use of services between groups of people in this community? How do you think women and their families decide whether or not they will use MNCH care? How do you think women and their families decide where to give birth?	they are pregnant? Where do they get advice? • What kind of care do women normally get during pregancy? • Tell me about where women usually give birth? • What are the differences between groups? • Which women are more or less likely to use ANC (describe different characteristics) • Which women are more or less likely give birth in a facility (describe different characteristics) • Who is involved in the decision-making? Who has more influence? • What do community members base their decisions on? (e.g. available information, perceptions of care quality, previous experience, rumours, etc.) • Do you notice any patterns, i.e. what kinds of women/families are more likely to plan to deliver at home or in a facility?	
Complications/ Emergencies	Now think about when a women experiences a complication during pregnancy or an obstetric emergency in this community. Can you describe what commonly happens, step-by-step, when something suddenly goes wrong during the pregnancy or during labour at home?	• How do women, families or other community members recognise a problem? • Whom do they consult? • Where do they usually get help? • How do you think the decision is made? • Who makes decisions about seeking care in an emergency? • How are health workers contacted or involved? • What care is most commonly provided?	

Areas of Inquiry	Specific Topics	Suggested Probes	Subjects Suggestive answered
	If the woman it brought to your health facility during the emergency, what happens next?	• Do you feel there are any gaps in providing emergency care? If so, what are these and why do they occur? • When are referrals made? • How the decision to refer elsewhere is made?	
Facilitators and Barriers	In your opinion, what are the difficulties that women face in getting good MNCH care? Why do these barriers occur? In your opinion, what are the difficulties that women face in delivering in a safe facility? Why do these barriers occur? Are there any factors that make it easier for women to receive MNCH care, especially for giving birth? Please describe	• When do women face these barriers? • Are some groups more affected than others by these barriers • How can they overcome them? • What makes it easier for women to access ANC? • What makes it easier for women to give birth in a facility? • Is it easier for some kinds of women to access ANC and facility births compered to others? Please describe the differences.	
Specific Examples	In you experience as a health provider, you may have encountered situations where a woman has had an emergency or “near miss” during her pregnancy or labour/giving birth. Please can you describe some examples in detail and tell me what happened, step-by-step? What was your role in the situation? What was the outcome?	PROBE only after respondent provides detailed account first, if additional information required: • What happened? • How did the woman or family realise something went wrong? • What did they do? Who was involved? • Do you know how they decided to seek care? Who made the decision? • What arrangements were made? • What barriers were faced in the situation and were they overcome? How? • Were there any circumstances that helped	

Areas of Inquiry	Specific Topics	Suggested Probes	Subjects Suggestive answered
	Can you describe any other examples?	the woman reach care? What were these? • How were you involved? • What happened next? • How common or "typical" are these cases of what you feel happens in the community?	
Existing programmes (if relevant)	What efforts have been made in your facility to make it easier for pregnant women to obtain good services during pregnancy and at the time of birth? Please describe. Do you do anything specific in your work to improve pregnancy and birth care for women who need it most? What about community-level activities to improve health service use during pregnancy and birth? Please describe any projects or efforts you know about. What do you think about these programmes? If you could decide, what kinds of new programmes would you like for there to be in this area?	• What is successful and what is less successful about these efforts/ activities? • Do they reach most women who need them? Why or why not? • What is the quality of the programmes/ services offered? • What motivates people to participate in activities? • What reduces success of these programmes? • Who would they be for? What would they do? • Are there any activities that could help increase maternal health in the area?	•
Wrap-up	Thank you for sharing your experiences with me. Is there anything else you would like me to know?	• Do you have any final questions for me about the study?	

Individual In-Depth Interview with Local Representative/Authority/Manager

Areas of Inquiry	Specific Topics	Suggested Probes	Subjects Suggestive answered
Introduction/ Background	Please can you tell me about yourself, your role and work?	• Describe your work as a local authority/ Manager of Health Section.	•

	How does your work relate to maternal health?	• What are all the different MNCH services provided in this municipality? • What do you think about the situation of maternal health services utilization by the women in this municipality? • How does your daily work affect maternal health?	
Local Health Seeking Norms **Decision Making for MNCH**	Tell me about the local community's use of MNCH services, including ANC, giving birth and PNC? What are the differences in health behaviour and use of services between different groups of people in your municipality? How do you think women and their families of this municipality decide whether or not they will use MNCH care? Particularly facility delivery? How do you think women and their families decide where to give birth? How do you think women and their families decide where to give birth in case of emergencies/complications? In which situation women and their family have difficulty in taking decision; ANC, Delivery, PNC and any kind of obstetric complication?	• What do pregnant women do when they first realise they are pregnant? Where do they get advice? • What kind of care do women normally get during pregnancy and after delivery • Tell me about where women usually give birth? • What are the differences between groups in relation to utilizing MNCH maternal health services? • Which women are more or less likely to use ANC (describe different characteristics) • Which women are more or less likely to give birth in a facility (describe different characteristics) • Who are involved in the decision-making? Who has more influence? • What do community members base their decisions on? (e.g. available information, perceptions of care quality, previous experience, education, rumours, etc.) • Do you notice any patterns, i.e. what kinds of women/families are more likely to plan to deliver at home or in a facility? • Do you think women and their families make decision differently if they are facing emergencies/complications	

		during pregnancy or birth? How?	
Facilitators and Barriers	In your opinion, what are the difficulties that women face in getting ANC services? Why do these barriers occur? In your opinion, what are the difficulties that women face in delivering in a health facility? Why do these barriers occur? Are there any factors that make it easier for women to receive MNCH care from health facility, especially for giving birth? Please describe How do you see the quality of service delivery within this municipality and its utilization? Is there any relation?	• When do women face these barriers? • Are some groups more affected than others by these barriers • How can they overcome them? • Who can help them overcome these difficulties? • How can local government help women overcome them? • What makes it easier for women to access ANC specifically in this municipality? • What makes it easier for women to give birth in a facility in this municipality? • Is it easier for some kinds of women to access ANC and facility births compared to others? Please describe the differences. • What could be the reason for such difference? • How can it be solved from the level of local government?	
Existing and possible interventions	What efforts have been made by local government/health section to make it easier for pregnant women to obtain good services during pregnancy and at the time of birth? Please describe. Have you done anything specific in your work to improve pregnancy and birth care for women who need it most? What about community-level activities to improve health service use during pregnancy and birth by other stakeholders/partners?	• How do you think these efforts make it easier to obtain maternal services? • What is successful and what is less successful about these efforts/ activities? • What reduces success of these programmes? • Do they reach most women who need them? Why or why not? • Who would they be for? What would they do? • Are there any activities that could help increase maternal health in your area specifically?	•

	Please describe any projects or efforts you know about. What do you think about these project/programmes? If you could decide, what kinds of new intervention/project would you like to introduce in this area?	• What type of intervention would you like to be started? • To start these new intervention what do you think should be in place? Perquisites? Partners?	
Wrap-up	Thank you for sharing your experiences with me. Is there anything else you would like me to know?	• Do you have any final questions for me about the study?	•

Swiss Red Cross
Werkstrasse 18
CH–3084 Wabern
Phone +41 58 400 41 11
info@redcross.ch
www.redcross.ch

Post Finance
IBAN CH43 0900 0000 3000 4200 3

Swiss Red Cross