

The London School of Economics and Political Science

Care-Seeking for Birth in Urban India

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Abstract

The thesis examines care-seeking for first births in low-income settlements of urban India. Care-seeking is framed as a dynamic, social process. The thesis shifts the research focus from non-use of maternity services to a more holistic notion of care-seeking strategies, and examines how they are shaped by patterned social relationships and their content.

The study combines a prospective, qualitative design with multiple household perspectives. Seventy-seven in-depth interviews were conducted in 16 households. Matched data were collected for primiparous women and other household members, and interviews were conducted prospectively during pregnancy with a follow-up after birth. The study was conducted in Indore, a large city in the central Indian state of Madhya Pradesh, where a range of maternity care providers operate in a complex urban health system.

This population could be characterised as strategic care-seekers, aware and discriminating across the range of care options available. Managing perceived risks was central to strategies, but solutions differed due to variation in perceptions of risks and their management. The notion that childbirth requires medical management was dominant. Yet, health facilities were also regarded as a potential source of risk. Strategies were plural and contingent, combining different providers across and within sectors, giving households control and flexibility in dealing with unfolding circumstances.

Local narratives apportion responsibility for care-seeking to the household in which the woman is staying for the birth. The value placed locally on household-level 'responsibility' contrasts with the focus on women's autonomy in the literature on maternal health. A corollary of responsibility is blame in the event of an adverse outcome, which impels households to seek care that meets expectations among their social ties.

The thesis generates new insight on an issue that has previously been examined largely with static approaches, underpinned by individual rational actor assumptions. Findings reveal care-seeking strategies that go beyond a decision on whether or not to use a health facility. This partly derives from a complex urban health system providing choice, but it is also a response to the challenges households face in negotiating the health system to receive care they perceive to be 'safe.' The findings have implications for the policy goals of increasing births with a skilled attendant and improving quality of care.

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For my father, Gareth Jones

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Acronyms, glossary and translations

Acronyms

ANC	Antenatal care
ASHA	Accredited Social Health Activist
DLHS	District Level Household and Facility Survey
EAG	Empowered Action Group
IIPS	International Institute of Population Sciences
IMC	Indore Municipal Corporation
JSY	Janani Suraksha Yojana
LMICs	Low and middle income countries
MDG	Millennium Development Goal
MMR	Maternal mortality ratio
MP	Madhya Pradesh
NFHS	National Family Health Survey
NGO	Non-governmental organisation
NRHM	National Rural Health Mission
OBC	Other backward classes
SC	Scheduled caste
ST	Scheduled tribe
TFR	Total fertility rate
UHRC	Urban Health Resource Centre
UK	United Kingdom
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UN-Habitat	United Nations Human Settlements Programme
US	United States
USHA	Urban Social Health Activist
WHO	World Health Organization

Glossary and translations¹

Anganwadi centre	Anganwadi Centres provide health and nutrition services for pregnant women, new mothers and children from 06 years as part of the national Integrated Child Development Services programme
Accredited Social Health Activist (ASHA)	A community health worker selected from within the community to work as an intermediary between the community and the public health system in rural areas
<i>Bachche</i>	Children
<i>Basti</i>	Literally a ‘settlement,’ it is the term used locally to refer to a low-income settlement
<i>Dai</i>	Traditional birth attendant
<i>Ghee</i>	Clarified butter
<i>Godh Bharai</i>	A Hindu ceremony that usually takes place in the seventh month of pregnancy to bless the mother and unborn baby
<i>Gram panchayat</i>	Locally-elected, self-government bodies at the village level
<i>Gur</i>	Jaggery, an unrefined product of sugarcane
Jaggery	An unrefined product of sugarcane
<i>Jati</i>	Endogamous hereditary groups, communities, castes or sub-castes in Hindu society, of which there are thousands
<i>Jimmedari</i>	Responsibility
<i>Jokhim</i>	Risk
Janani Suraksha Yojana (JSY)	A major, centrally-sponsored conditional cash transfer scheme launched under the National Rural Health Mission (NRHM) in 2005 to promote institutional births
Janani Express Yojana	A scheme providing women with free, round-the-clock transport to public health facilities for childbirth

¹ From the local Hindi vernacular

<i>Kamzori</i>	Weakness
<i>Khun ki kami</i>	Literally a 'lack of blood,' it is the local term for anaemia
<i>Mayaka</i>	Natal home
<i>Nala</i>	Drainage channel
<i>Patta</i>	Leasehold land title
<i>Roti</i>	Bread
<i>Sasural</i>	In-laws' home
<i>Sava mahina</i>	The period of postpartum confinement for, literally, one and a quarter months
<i>Takat</i>	Strength
Urban Social Health Activist (USHA)	A community health worker selected from within the community to work as an intermediary between the community and the public health system in urban areas
<i>Varna</i>	The four strata into which Hindu society is divided. These are related but distinct from <i>jati</i>

Key to interview excerpts

Key to excerpt conventions

<i>[Text]</i>	Text within square brackets denotes my insertions, used largely to replace names with a more meaningful signifier for readers or to clarify where excerpts assume knowledge from earlier sections of the interview
(Text)	Text within round brackets provides clarification of the preceding text
[...]	Indicates that text has been omitted to shorten the quote, but the sequence remains unchanged
—	Denotes the sentence was cut off

Key to excerpt referencing

Household interview excerpts are referenced according to the following convention: (C#, core/additional participant, household category (only in Chapter 7), I#)

C#	Denotes the case code (cross-reference with Table 4.1)
Core/additional participant	For example, ‘woman,’ ‘husband,’ ‘mother,’ ‘mother-in-law’ or other. All kinship terms are used in relation to the woman. See Section 4.2.1 for a list of core or additional participants
Household category (only in Chapter 7)	‘Natal,’ ‘nuclear marital’ or ‘joint marital.’ Household category is only included for excerpts in Chapter 7 on social relationships and interaction. See Section 4.4 for a description of categories
I#	Denotes interview stage. I1 denotes interviews before birth and I2 denotes interviews after birth

For example, (C1, woman, natal, I1) indicates that the excerpt is from an interview before birth with a woman residing for the birth in her natal household, coded case number one.

Key informants are referenced by their role and, where relevant, this is followed by a slum code: e.g., (ASHA worker, B1)

1. Introduction

1.1 Background

Low and middle income countries (LMICs) account for 99 per cent of around 287,000 global maternal deaths per year (WHO, 2012) and more than 98 per cent of around 2.8 million neonatal deaths² (United Nations Children's Fund, 2013). Improving maternal and newborn health have been central goals on the international agenda for several decades. Millennium Development Goals (MDGs) 4 and 5 target a reduction in maternal mortality by three quarters and in child mortality by two thirds between 1990 and 2015 (United Nations, 2008), and women's and children's health are likely to remain a priority in the post-2015 global development framework (United Nations, 2013, 2014a). Along the continuum of care through pregnancy until after birth, care at birth is recognised as crucial in initiatives to improve maternal and newborn health (Ronsmans & Graham, 2006; WHO, 2005). Complications arise in around 15 per cent of births in any context and are largely unpredictable (White Ribbon Alliance et al., 2010). Maternal deaths are clustered in the period during and immediately following childbirth (Ronsmans & Graham, 2006). Moreover, the vast majority of neonatal deaths—around three quarters—occur in the first week of life and most have obstetric origins, as do a substantial proportion—around one third—of stillbirths (WHO, 2006).

There is international consensus on the importance of high-quality skilled care at birth for improving maternal and newborn health (Koblinsky et al., 2006; Martines et al., 2005; WHO, 2004). The proportion of births attended by skilled health personnel is one of two indicators used to monitor progress towards MDG 5's goal of improving maternal health (United Nations, 2008). A skilled birth attendant is an 'accredited health professional—such as a midwife, doctor or nurse—who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns' (WHO, 2004, p.1). The skilled attendant must have

² Deaths at less than 29 days

access to the necessary equipment and a functioning health system, including transport and referral facilities for emergency obstetric care. Yet, many births in LMICs take place at home without assistance by a skilled attendant, and even where births are assisted by a skilled attendant, women might not receive adequate quality of care (Koblinsky et al., 2006).

India is of particular concern because it accounts for around 19 per cent of global maternal deaths (WHO, 2012) and 27 per cent of global neonatal deaths (United Nations Children's Fund, 2013). Its maternal health care landscape has undergone significant change over the past decade. When the last National Family Health Survey (NFHS) was conducted in 2005–06, the proportion of births with a skilled attendant was low in India (International Institute for Population Sciences (IIPS) and Macro International, 2007). The majority of women had births at home assisted by a traditional birth attendant, family or friends: only 39 per cent of births nationally took place in a health facility and 47 per cent with a skilled attendant. There was also wide regional variation, and births with a skilled attendant ranged from 25 per cent to 99 per cent across states.

India has pursued a strategy focused on increasing institutional births. While a shortage of maternity care facilities and human resources has been a major obstacle to increasing births with a skilled attendant in many LMICs, demand for their use is not automatically generated even where they are available (Ensor & Cooper, 2004; Koblinsky et al., 2006). In 2005, large-scale national initiatives were launched in India focusing on the demand side as well as the supply. These included a conditional cash transfer scheme to promote births in health facilities, and a new cadre of community health volunteers to function as intermediaries between communities and the health system (Ministry of Health & Family Welfare, 2013a). By 2012, births in a health facility had increased to 73 per cent nationally, with even more dramatic increases in some states (Office of the Registrar General & Census Commissioner, 2012).

While this is a positive development, challenges persist. India has made substantial progress towards reducing maternal and newborn mortality in recent decades, but levels remain high nationally. It has a maternal mortality ratio (MMR) of 178 per 100,000 live births (Office of the Registrar General, 2013) and a neonatal mortality rate of 29 per 1000 live births (Office of the Registrar General & Census Commissioner, 2012). Moreover,

levels are much higher in some low-performing states. Large geographical and socioeconomic inequalities (IIPS & Macro International, 2007) along with uneven progress leave subgroups of the population behind. Lower socioeconomic groups in low performing states³ no doubt remain over-represented among those who do not access services (Lim et al., 2010).

Increasing uptake of services cannot alone resolve the problem of poor maternal and newborn health in India. Alongside the scaling-up of births with a skilled attendant, the low quality of maternity care services in many LMICs has become a major policy focus (Mathai, 2011; Mselle et al., 2013; Spector et al., 2013). As Hulton et al. (2007, p.2083) state, ‘a policy emphasis on increasing the rate of childbirth in hospitals inherently assumes that [they] provide an optimal level of care,’ but this is being increasingly questioned as evidence emerges showing that this may not be the case. Studies from India have repeatedly drawn attention to the low quality of care provision in both public and private sector institutions (Bhate-Deosthali et al., 2011; Chaturvedi et al., 2014; Hulton et al., 2007; Iyengar et al., 2008; Iyengar et al., 2009; Nair & Panda, 2011). Research has identified multiple concerns, including insufficient and low quality human and physical resources; poor referral links and information management systems; and care that fails to adhere to international standards for good practice (Hulton et al., 2007). A weaker than expected relationship between increasing institutional births and a decline in maternal mortality has been attributed at least in part to low quality of care (Goli & Jaleel, 2014; Randive et al., 2013). There has also been criticism of the focus on institutional births to the exclusion of other context-specific services and community-based strategies that may also achieve improvements in maternal health (Costello et al., 2006).

1.2 Literature on maternity care-seeking in India

Given the importance of care at birth in improving maternal and newborn health, the need to understand care-seeking behaviour has been recognised. An extensive and varied literature on maternity care-seeking in India has emerged in the past 15 years, largely

³ See Sections 3.4 and 3.5 for discussion of differences across states

focused on understanding patterns and reasons for non-use of services. The nature of the literature is briefly reviewed in this section in order to highlight what is lacking in current understanding of care-seeking for birth, contributing to the rationale for this study. The aim here is to provide a brief overview; a more detailed review of relevant literatures is woven through later chapters.

Maternity care-seeking is influenced by a complex interplay of economic, social, cultural, geographical and organisational factors (Gabrysch & Campbell, 2009), operating at the individual, household, community and health system levels (Stephenson & Tsui, 2002; Wild et al., 2010). By far the largest body of literature examining care-seeking for birth in LMICs focuses on the determinants of care outcomes, normally operationalised as binary variables representing use of a health facility or skilled birth attendant. Determinants studies on India have included a range of individual- and household-level explanatory variables, such as education, economic status, employment, urban/rural residence, female autonomy, household structure, caste, religion, age, birth order, experience of complications, and use of antenatal care (ANC) (Bhatia & Cleland, 1995; Jat et al., 2011; Kesterton et al., 2010; Matthews et al., 2005b; Navaneetham & Dharmalingam, 2002; Ram & Singh, 2006; Saroha et al., 2008; Thind et al., 2008). These studies demonstrate fairly consistently that higher levels of female education, higher economic status, urban residence, lower birth order, experience of complications, and use of ANC during pregnancy are independently associated with use of a skilled attendant or health facility for birth, while evidence for the other factors is weaker or mixed. Region is also a strong determinant of care at birth in India and studies using multi-level modelling approaches have found substantial unexplained community-level variation in use of maternity care services (Jat et al., 2011; Kesterton et al., 2010; Stephenson & Tsui, 2002).

Studies of determinants mostly use large-scale, cross-sectional surveys, such as the NFHS, to identify socio-structural factors that affect maternal health care utilisation. The NFHS also included a question on reasons for non-use of a health facility for the last birth. The most common responses included that it was unnecessary, as well as economic and geographical access barriers (IIPS & Macro International, 2007). Yet, such surveys provide little insight into the knowledge, beliefs and attitudes underpinning maternity care-seeking behaviour. A small body of qualitative research has examined the perspectives of women

and their families on maternity care services, focusing on barriers to use. Alongside cost and distance, these studies highlight the role of cultural factors. For example, ‘comfort’ emerged as a key reason for women’s preference for a home birth in studies from diverse Indian contexts: in contrast to hospitals, the home environment was attached with meanings of familiarity, support and being able to follow cultural practices (Griffiths & Stephenson, 2001; Matthews et al., 2001; Matthews et al., 2005b; Sharma et al., 2013).

Lay perceptions of risk and susceptibility do not always correlate well with biomedical discourse on risk in pregnancy and birth (Mumtaz & Salway, 2007). Studies on some Indian and wider South Asian contexts have found that birth was considered a natural process that did not require medical intervention, and it might take a complication to prompt care-seeking at a health facility (Brunson, 2010; Griffiths & Stephenson, 2001; Matthews et al., 2005b; Parkhurst et al., 2006). Nevertheless, perceptions are not fixed across time and space. In Shah More et al.’s (2009a) more recent study in Mumbai, slum residents did perceive a need for medical care during pregnancy and childbirth. When services are available and perceived necessary, households find ways to overcome barriers to using them (Griffiths & Stephenson, 2001; Parkhurst et al., 2006).

Perceived low quality of care has featured as a prominent theme in the narratives of women and their families on maternity care services. Section 1.1 discusses low clinical quality of care in LMICs, including India. Perceptions or user experiences of the quality of maternity services is a distinct dimension since lay people judge the quality of care through value systems that are different to those captured in clinical practice guidelines (Hulton et al., 2000). It is recognised as a crucial element to consider, however, not least because of its implications for the uptake of maternity care services (Griffiths & Stephenson, 2001; Matthews et al., 2005b; Moore et al., 2002). In particular, interpersonal elements are crucial to service users’ perceptions of the quality of care, and many women perceive or report experiencing disrespectful and even abusive interaction at health facilities (Bhattacharyya et al., 2013; Hulton et al., 2007; Jeffery & Jeffery, 2010).

India’s maternal health system encompasses a range of providers across the public and private sectors. Care in the private sector is perceived to be superior to care in the public sector, to the extent that even the poor opt for its use where possible in spite of the cost implications (Nair & Panda, 2011; Raman, 2014; Skordis-Worrall et al., 2011).

Although socioeconomic status increases the likelihood of birth in a private health facility (Bhatia & Cleland, 1995; Kesterton et al., 2010; Thind et al., 2008), use of the private sector has increased considerably among lower socioeconomic groups since the 1990s (Pathak et al., 2010). While maternal health care policy must therefore address both sectors (Shah More et al., 2009b), there has been little in-depth investigation of how populations engage with institutions across these sectors through pregnancy and birth.

Studies largely conceptualise care-seeking for birth as a discrete ‘decision’ that equates with the outcome, and most adopt static approaches. Despite frequent references in the literature to a care-seeking or decision-making ‘process,’ few studies have investigated maternity care-seeking in India as a process with a temporal dimension. There are exceptions. Matthews et al. (2001; 2005b) used a prospective design to collect data about care-seeking as women’s pregnancies unfolded in rural Karnataka, South India. Further, while Shah More et al.’s study (2009a) was cross-sectional, it traced pathways from antenatal to intrapartum care for women in Mumbai, India. Both studies’ findings are discussed in further detail in Chapter 6, but here it suffices to say that they reveal a non-linear care-seeking process. No study to the best of my knowledge has used qualitative methods specifically to conduct a more in-depth, holistic investigation of the process of seeking care for birth in India.

Finally, gendered household power structures play a prominent role in the literature on maternal health care in South Asia since young women in contexts across this region have low levels of autonomy (Jejeebhoy, 2000). A hypothesised link between women’s low autonomy and maternal health care outcomes has been examined in numerous studies of determinants, with mixed findings⁴ (Allendorf, 2007; Bloom et al., 2001; Furuta & Salway, 2006; Mistry et al., 2009). Qualitative methods have also been used to understand intra-household dynamics underpinning maternity care-seeking in more depth in some South Asian settings, which in some cases has led to critiques of assumptions underpinning theoretical links (Mumtaz & Salway, 2009; Simkhada et al., 2010). Yet, no study of this kind has been conducted in India to my knowledge.

⁴ See Chapter 7 for a more detailed discussion of findings

Despite a fairly extensive literature, this section has established numerous gaps in understanding of maternity care-seeking in India. In sum, studies of determinants have provided much insight into the characteristics of those who have poor access to maternal health care services, and qualitative studies have complemented this with analysis of the perspectives of women and their families on maternity care. However, a more holistic understanding of care-seeking for birth as a dynamic process that extends through time and is situated within a patterned household and wider social context is lacking. Despite recognition of the importance of the collective in decision-making in India, a shortcoming of most studies—particularly those using large-scale, cross-sectional surveys—is their focus on the individual. While low female autonomy has been a key research focus, there has been little in-depth examination of intra-household dynamics in care-seeking for birth.

Despite substantial increases in births with a skilled attendant over the past decade, the need to understand care-seeking behaviour remains paramount. The majority of past studies—for good reason—have focused on non-use of maternity care services, but the context has changed. In view of the array of maternal care providers, potentially major cost implications (particularly for private care), and widespread concerns regarding quality of care, there is a need to move beyond a binary understanding of use versus non-use of services to a more nuanced understanding of how populations engage with maternal health systems. This applies in particular to urban areas, where maternal health systems are especially diverse. Research examining maternal health in urban areas is limited in LMICs (Coast et al., 2012; Fotso et al., 2009a; Mberu et al., 2014). Examples are emerging in India, but these have tended to focus on the metropolises of Mumbai or Delhi (Devasenapathy et al., 2014; Matthews et al., 2005a; Raman, 2014; Shah More et al., 2009a; Shah More et al., 2011; Shah More et al., 2009b). A vast majority of India's population growth over the coming decades will be in urban areas (Office of the Registrar General & Census Commissioner, 2011b), and urbanisation will shift the geography of poverty by increasing the share of the poor living in urban areas (Ravallion, 2002). The need to develop understanding of how populations—particularly the poor—engage with urban health systems is urgent.

1.3 Research questions and outline

The overarching aim of this research is to understand care-seeking for first births in low-income settlements of urban India. Care-seeking for birth in India has largely been examined with static approaches, underpinned by individual rational actor assumptions. Chapter 2 critiques this perspective and outlines the alternative framework underpinning data collection and analysis in this study, employed with the aim of generating new insight. The framework is adapted from the work of Pescosolido (1991, 1992, 2006), which conceptualises care-seeking as a dynamic and interactive process. It shifts the focus from a binary care outcome of use versus non-use of a skilled attendant or health facility for birth to a more holistic and dynamic notion of ‘care-seeking strategies.’ Care-seeking strategies encompass sequences of decisions and actions that extend through time and cover the spectrum of available care options. The framework regards interaction within patterned social relationships not as an influence on the individual, but as the driver of the care-seeking process. In sum, the overarching aim of the research is:

- To understand care-seeking for first births in low-income settlements of urban India

The following three research sub-questions are derived from the study’s care-seeking framework and in combination address the overarching research aim. They respectively form the basis of the thesis’s three substantive chapters.

1. How is childbirth and care for birth perceived, and with what connections to inclinations towards different care options? (Chapter 5)
2. What care-seeking strategies are employed by households for childbirth and why? (Chapter 6)
3. How do patterned social relationships and interaction shape care-seeking for birth? (Chapter 7)

We know that birth order is a key determinant of care-seeking behaviour (see Section 1.2). Focusing on first births thus allowed a more in-depth investigation, which may serve as a foundation for future research with a broader focus.

Chapter 3 describes the study context. Data were collected in low-income settlements in Indore: a large city of 2.17 million people in the central Indian state of Madhya Pradesh. Indore is a setting in which use of maternal health care services has risen rapidly over the past decade, and 92.6 per cent now use health facilities for birth (Office of the Registrar General & Census Commissioner, 2013c). It presents an ideal site for developing understanding of how people engage with a complex urban health system for maternity care. Chapter 3 describes the economy and society, with a focus on life in an increasingly urban India. It also discusses the context of young women's lives and expands on this chapter's introduction of maternal and newborn health indicators, patterns of use of maternal health care services, and maternal health policy. The description focuses on Indore, but situates the city within the broader state and national context.

Chapter 4 describes the methodology. The methodological approach reflects the study framework's conceptualisation of care-seeking as a dynamic and interactive process. It combined a prospective, qualitative design with multiple household perspectives. Qualitative methods were used to obtain in-depth data on care-seeking for birth. Matched data were collected for primiparous women and their husbands, mothers and/or mothers-in-law, depending on household composition at the time of the birth. Interviews were conducted in the woman's third trimester of pregnancy, and households were followed-up after birth.

Chapters 5–7 present the study's empirical findings, addressing the three research sub-questions respectively. As such, each functions as a self-contained chapter answering a single question, but all three combine to address the overarching research aim. Each chapter opens with a separate review of conceptual and empirical literatures on which the findings build. Key concepts in the current literature on maternal health care are discussed and scrutinised, including 'birth preparedness' in Chapter 6 and women's 'autonomy' in Chapter 7. The empirical chapters also draw extensively on concepts from the sociocultural literature on 'risk,' including 'uncertainty,' 'trust,' 'responsibility' and 'blame.' The conceptual literature on risk is introduced in the empirical chapters rather than in the opening chapters because its contribution to understanding the data emerged inductively during analysis, rather than *a priori* as part of the study's framing.

Chapter 5 addresses the question of how childbirth and care for birth are perceived, and with what connections to inclinations towards the different types of care available for birth in Indore. I use the term ‘inclination’ to capture the complexity of considerations that preclude the notion of a ‘preference’: for example, a participant might prefer to receive care in the best private hospital available, but when discussing the type(s) of care to seek, economic or other considerations may be factored in. The chapter establishes that households in this setting now process childbirth as a risk event and efforts to manage these risks are central to their care-seeking strategies. Following a review of the sociocultural literature on risk, particularly in relation to childbirth, the chapter presents analyses of data. It first considers how the process of childbirth and its risks are constructed locally. It proceeds to consider the integration of different discourses on managing risk. Finally, it examines how the different care options available for birth in Indore are perceived and their interconnections with perceptions of how to achieve a ‘good’ or ‘safe’ birth outcome, as participants themselves defined it. This investigation of perceptions serves as a foundation for the next chapter focusing on actual care-seeking strategies.

Chapter 6 addresses the question of what care-seeking strategies are employed by households for childbirth and why. It is the chapter that places the spotlight on the dynamic, temporal process of care-seeking. Care-seeking strategies refer to sequences of decisions and actions towards care at birth, including intentions or actual contact with providers and other preparatory actions. The site, type and characteristics of providers, and purposes for which they are consulted are considered, across the spectrum of options available. The chapter opens with a review and critique of the way in which the care-seeking process is conceptualised in the maternal health literature, particularly on India. The findings section speaks to these issues, as analyses are presented of the nature of care-seeking strategies and actions towards care at birth. Patterns are explained with reference to the context within which care-seeking takes place.

Chapter 7 addresses the question of how patterned social relationships and interaction shape care-seeking for birth. The framework regards interaction within social relationships as the driver of care-seeking strategies. The chapter begins with a review of the literature linking relationship dynamics, including ‘female autonomy,’ with maternity care-seeking in South Asia. The findings section discusses relationships and interaction

within the household and with wider social ties, and presents an analysis of how they shape care-seeking strategies.

Chapter 8 concludes. This final chapter pulls together findings from the three chapters to address the overarching research aim of understanding the care-seeking process for first births in low-income settlements of urban India. It discusses issues raised by the research and considers them in relation to policy debates. Both the limitations of the research and the insights generated by adopting a dynamic, social process-oriented health care-seeking framework, along with the methodology that emerged from it, are discussed. Finally, the chapter suggests avenues for future research.

2. Health Care-Seeking Framework

2.1 Introduction

A dynamic, social process orientation to health care-seeking frames data collection and analysis, adapted from the work of Pescosolido (1991, 1992, 2006) and Pescosolido and Levy (2002). The approach differs from dominant health care utilisation or care-seeking models. This chapter describes the dominant approaches and their critiques, leading to the rationale for using a different framework to generate new insight on an issue that has thus far largely been investigated with static approaches, underpinned by an individual rational actor perspective. The chapter introduces the alternative framework guiding this research, before ending with a discussion of how it has been adapted for the purposes of this study.

2.2 Dominant models of health care-seeking

Understanding people's interactions with health systems both in high and low income countries has long been of interest to researchers across disciplines, including sociology, anthropology, psychology and economics. Originally aimed at investigating problems of underuse or inequitable use of health services in the United States (US), several models were developed in the 1960s and 1970s to explain how and why people make different types of health care decisions, which are still influential today—explicitly or implicitly—in the way studies of health care-seeking or health care utilisation are framed (Babitsch et al., 2012; Pokhrel & Sauerborn, 2004; Ricketts & Goldsmith, 2005). Theoretical models that have dominated over the past half century include Andersen's behavioural model (Andersen, 1968, 1995) and the Health Belief Model (Hochbaum, 1958; Rosenstock, 1966; Rosenstock et al., 1988).

Andersen's behavioural model was developed in the late 1960s in response to concerns over inequitable access to health care in the US (Andersen, 1968), and has since undergone several revisions (Aday & Andersen, 1974; Andersen, 1995; Andersen & Newman, 1973). It is a determinant model that organises a range of factors that influence utilisation of health services. The outcome refers exclusively to use of modern medical

care, and is understood in terms of the type, site, purpose and unit of analysis, the latter of which refers to contact, volume or continuity measures (Aday & Andersen, 1974; Andersen & Newman, 1973). The relative importance of each influencing factor varies depending on the dimension of health service utilisation or type of service examined (Aday & Andersen, 1974; Andersen & Newman, 1973). Individual determinants are categorised as those which predispose people to use services, those which enable or impede use, and the person's need for care.

The model's 'predisposing' characteristics are those that affect the propensity of individuals to use services, and comprise demographic factors, such as age and sex; social structural factors that indicate location or status in society, such as education or occupation; and attitudes and beliefs regarding health, illness and healing. As well as a predisposition to use health care services, there must be the means to do so, and these are defined in the model as 'enabling' conditions (Andersen & Newman, 1973). 'Enabling' factors may act at the family level, such as income; or at the community level, such as health care costs or the ratio of health personnel and facilities to population. 'Need' for care is considered the most immediate cause of health service use, and includes a self-perception component as well as a clinically evaluated component. In the revisions of the 1970s, societal determinants, such as norms and technology, and health system characteristics, such as resources and organisation, were added to the model (Aday & Andersen, 1974; Andersen & Newman, 1973). A recent systematic literature review of usage of the behavioural model between 1998 and 2011 indicated substantial variation in the way variables are categorised into predisposing and enabling factors, with only a small set of common variables included in applications of the framework (Babitsch et al., 2012).

For Andersen (1995), enabling and need characteristics better explain variation in health service use than health beliefs. In contrast, the Health Belief Model developed by a group of investigators from the US Public Health Service in the 1950s and 1960s is derived from social-psychological theory and places the focus on variables that deal with individuals' subjective worlds to explain preventive health behaviour and the behaviour of a person who feels ill towards defining the condition and identifying a remedy (Hochbaum, 1958; Rosenstock, 1966, 1974). More specifically, the model focuses on individuals' knowledge, beliefs, attitudes and values in order to understand the mechanisms underlying

associations between personal characteristics and health behaviour and to shed light on ‘why’ people use health services, (Rosenstock, 1966).

The Health Belief Model includes variables that represent psychological readiness to take action and the extent to which a particular course of action is believed to be beneficial in reducing the threat. Both the individual’s perceived vulnerability to a particular health condition and perceived seriousness of the consequences of a health condition determine the individual’s readiness to take action. When ready to act, however, the specific action taken is determined by the individual’s beliefs regarding the effectiveness of different known courses of action. These beliefs are influenced by norms and pressures within the social network. Where an action perceived to be effective also has costs, the tension between perceived benefits and barriers to action must be resolved. Finally, the model proposes that, even when an individual is ready to act and a preferred course of action is known, an internal or external cue is still required to trigger action. The model was later expanded to include self-efficacy among the explanatory variables, which refers to a feeling of competence in implementing action (Rosenstock et al., 1988). Health decision-making is regarded by Rosenstock (1966, p.107) as a ‘process in which the individual moves through a series of stages or phases in each of which he interacts with individuals and events.’ However, health beliefs in this model are assumed to relate to a specific point in time, acting as the context for responses at the next stage. In sum, the dominant frameworks all constitute determinant models that elucidate a set of explanatory variables for health care utilisation (Kroeger, 1983; MacKian et al., 2004), albeit derived from different analytical approaches and organised in different ways.

2.3 Frameworks in studies of maternity care-seeking

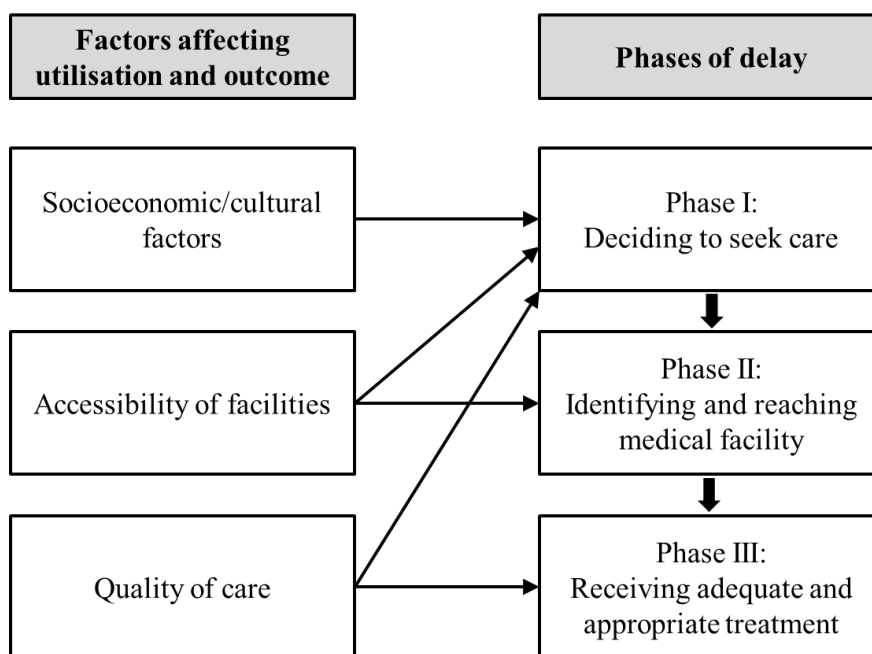
Few studies on maternity care-seeking in LMICs explicitly employ one of these dominant theoretical models to frame their research (e.g., Stephenson & Tsui, 2002; Thind et al., 2008; Wild et al., 2010). Nevertheless, the literature is dominated by studies using determinant models to analyse the association between a set of explanatory variables and various maternal health care outcomes (Kesterton et al., 2010; Matsumura & Gubhaju, 2001; Navaneetham & Dharmalingam, 2002; Singh et al., 2012a). This may, at least in part,

be a result of the data available. A large portion of the quantitative research on this topic in India uses large-scale survey data from the NFHS (IIPS, 2014b) or District Level Household and Facility Survey (DLHS) (IIPS, 2014a), which collect extensive data on socio-structural factors and health care outcomes. Accordingly, the data steers the research output in this direction.

Thaddeus and Maine's (1994) three delays model (see Figure 2.1)—perhaps the most influential conceptual framework in research on maternal health care utilisation in LMICs—is also a determinant model. The model sets out three phases of potential delay between the onset of an obstetric complication and its outcome. Thaddeus and Maine (1994) conducted a literature review to identify obstacles to the receipt of high quality and timely obstetric care, and the model illustrates the links between the (categories of) factors identified and the three phases of delay. The first phase of potential delay is the decision to seek care on the part of the individual, family or both. After a decision is made to seek care, reaching an adequate health care facility is a second phase of potential delay and receipt of adequate care once at the facility is a third phase of potential delay. Influences on the first phase of decision-making encompass a range of demographic, socioeconomic and cultural factors, as well as perceived need, perceived physical and economic accessibility and perceived quality of care.

The model focuses exclusively on use of modern medical care because it is concerned with the period following the onset of an obstetric complication, when other forms of care are considered inadequate (Thaddeus & Maine, 1994). Nevertheless, it has often been used more flexibly as a conceptual framework for routine or preventive use of a skilled attendant at birth (e.g., JHPIEGO, 2004; Morrison et al., 2014). In recognition of behavioural theory's contention that the importance of different factors changes depending on the type of health need or service, Gabrysch and Campbell (2009) more recently reviewed the literature on routine use of a health facility for birth. They identified 20 determinants and grouped them into four categories: sociocultural factors, perceived need/benefit of skilled care, economic accessibility, and physical accessibility. The factors included in the three delays model (Thaddeus & Maine, 1994) and in Gabrysch and Campbell's review (2009) parallel many of those included in the behavioural model and Health Belief Model.

Figure 2.1 The three delays model



Source: Thaddeus and Maine (1994)

2.4 Critiques of dominant health care-seeking models

The dominant determinant models of health care utilisation are subject to critique on several fronts relevant to this study. Underlying each of the dominant models is an individual rational actor orientation. The portrayal of purposive individual decision-makers, reviewing what is known on the costs and benefits of different courses of action within their particular circumstances, in a social structure that offers both facilitating opportunities and impeding barriers, in order to make a discrete decision on 'modern' versus 'traditional' forms of care, is problematic (MacKian et al., 2004; McKinlay, 1972; Pescosolido, 1992; Pescosolido & Kronenfeld, 1995; Ricketts & Goldsmith, 2005; Zola, 1973). Pescosolido (1992) suggests that this is a symptom of the overextension of ideas relevant to economic behaviour into wider domains. The dominant models fail to acknowledge that individuals are 'rooted in social contexts that affect, in a far more complex manner, the way we process and act on information' (MacKian et al., 2004, p.139). They reveal characteristics of users versus non-users of care, but provide little insight into the process of care-seeking.

First, the dominant models present a static view of health care-seeking as a discrete, isolated decision-making event. This downplays the dynamic process of care-seeking with its multiple influences and feedback loops that operate through time. There is a need to shift from the conceptualisation of ‘a’ decision to seek care to more of an emergent, multi-stage care-seeking process that is patterned and contingent (Kroeger, 1983; McKinlay, 1972; Pescosolido, 1992). Ricketts and Goldsmith (2005, p.279) focus in particular on the neglect of the “dynamic axes” of learning and adaptation, a temporal, experiential process whereby people change as a result of their use of services. Individuals may become more adept at navigating and negotiating the health system through their interactions with it, or may not make this transition at all (Ricketts & Goldsmith, 2005). This challenges frameworks that view each health care-seeking event in isolation. Addressing such critiques, a dynamic dimension was added to the behavioural model in the form of feedback loops showing a potential effect of the outcome on subsequent predisposing factors, perceived need and thus health behaviour (Andersen, 1995). Yet, this addition to an otherwise static model does not preclude the need for frameworks that better capture the dynamic nature of care-seeking processes (Pescosolido & Kronenfeld, 1995). Although such critiques have a long history (Kroeger, 1983; McKinlay, 1972), they remain a weak element of studies on health care-seeking behaviour (MacKian et al., 2004).

The need for a dynamic, process-oriented perspective on care-seeking is pertinent in regards to the topic of this study. The circumstances of pregnancy leading to the birth unfold over nine months and can be extremely unpredictable (Matthews et al., 2005b), continuously changing the context of decision-making. Care-seeking for birth cannot therefore be understood through static conceptualisations involving a linear course of action. Further, conceptualisations in the current literature largely view care-seeking during pregnancy and for birth as two separate processes, sometimes including ANC as an explanatory variable for use of a skilled attendant at birth. This conceptualisation downplays their interconnectedness as elements of one pregnancy and childbirth episode, with potential for learning and adaptation through on-going contacts with the health system. There is a need to develop frameworks that conceptualise care at birth as the culmination of a dynamic process that unfolds through time in response to evolving circumstances. These

frameworks should be more cognisant of the continuum of care through pregnancy to birth (e.g., Shah More et al., 2009a).

Second, health care decision-making is largely conceptualised in the dominant models as an individual-level process. It is the individual who converts knowledge into beliefs or weighs up the benefits of different courses of action. There is a place for social interaction in these models, but only as influences on individual cognitive processes: as ‘additional items on an individual’s checklist,’ in Pescosolido’s words (1992, p.1102). For example, social norms are included in the behavioural model as societal factors that influence health care-seeking indirectly through their influence on individual-level determinants. Acknowledging criticism of the disregard for social networks, relationships and interaction, Andersen (1995) responded that social networks and interaction may fit in with social structure as ‘predisposing’ characteristics, and the extent and quality of social relationships may fit in with ‘enabling’ characteristics that facilitate or impede health care utilisation. Similarly, in the Health Belief Model, norms and pressures of social groups are considered to influence individual-level beliefs (Rosenstock, 1966). The downplaying of the central role of the family has been further challenged (e.g., Bass & Noelker, 1987). The behavioural model originally focused on the family as the unit of analysis (Andersen, 1968), but was later revised for methodological reasons to focus on the individual as the unit of analysis with family characteristics attached (Andersen, 1995; Andersen & Newman, 1973).

This perspective, in which social relations merely facilitate action, has been critiqued for overlooking the socially embedded nature of care-seeking, giving rise to the alternative perspective that interaction within social networks is the driver of processes to define a situation and identify a solution (MacKian et al., 2004; McKinlay, 1972; Pescosolido, 1992). As Pescosolido and Kronenfeld (1995, p.18) suggest, ‘it is quite different conceptually to say, on the one hand, that social networks are a contingency of choice in a systems model and, on the other, the engine of action in a dynamic model of utilization.’ MacKian et al. (2004) promote approaches investigating health care-seeking behaviour as a product of the inter-relationships of individuals within containing social systems, cultural norms and system constraints, rather than a product of an internal process.

Concern about the role of social interaction in the care-seeking framework is especially relevant to this study. Notwithstanding a more general point about the need to view care-seeking as a socially-driven process, frameworks must pay due regard to the key role of household and family dynamics in South Asia and other cultural contexts where an ideology of interdependence among key relations prevails (Furuta & Salway, 2006; Mumtaz, 2002) and female autonomy is low (Jejeebhoy, 2000; Mason, 1986). Care-seeking frameworks developed in western contexts that focus on individual cognitive processes are particularly problematic in such settings (White et al., 2013). Determinant approaches in the maternal health literature convert gendered household power structures into an individual-level characteristic via the concept of autonomy (Allendorf, 2007; Bhatia & Cleland, 1995; Bloom et al., 2001; Furuta & Salway, 2006; Mistry et al., 2009). While this may reveal whether or not women's level of autonomy within the household affects service use, it tells little about how the care-seeking process is embedded within a patterned system of household relationships.

Finally, determinant models tend to conceptualise care-seeking in terms of use versus non-use of health services, usually entailing a distinction between modern medical care and anything else. Studies on care at birth often distinguish only between home birth and facility birth, or between use and non-use of a skilled attendant at birth (e.g., Navaneetham & Dharmalingam, 2002; Stephenson & Tsui, 2002). These binary variables overlook the complexity of care-seeking. Medical pluralism, wherein different types of providers are consulted sequentially or simultaneously, has been documented in diverse contexts, but is particularly relevant in LMICs, where health systems may be relatively more complex (Kroeger, 1983; Nichter, 1980; Pescosolido & Kronenfeld, 1995; Scott et al., 2014). Studies indicating pluralism within maternity care in South Asia (Parkhurst et al., 2006; Shah More et al., 2009a) and the existence of a range of care providers in urban areas of India (Das & Hammer, 2007) render this an important dimension for consideration in this study. In order to better understand how populations engage with health systems to seek care at birth, a multidimensional understanding of care is required—encompassing the purpose as well as the site, type and characteristics of the provider—across the spectrum of potential options. Moreover, since individuals may interact with more than one (type of) care provider as part of the care-seeking process for birth, investigation of the number,

timing, combination and sequence of interaction with different providers through pregnancy and birth is necessary.

In sum, as MacKian et al. (2004, p.144) suggest: ‘What seems to be missing in much of the literature is a sense of how the process of “seeking” extends over physical and social space, time and the health system in complex ways, and cannot be picked out as something intrinsic to the individual.’ Thaddeus and Maine’s (1994) three delays model and the approaches seen in most studies of care-seeking for birth in LMICs are subject to the same critiques as the dominant health care utilisation models. Such critiques raise the question of alternatives.

2.5 Alternative health care-seeking approaches

Dominant models of health service utilisation can all be considered examples of determinant models. An alternative to these would be ‘pathway’ models, which break decision-making down into steps (Kroeger, 1983; MacKian et al., 2004). For example, Young (1981) describes a cognitive-ethnographic decision modelling approach that uses formal techniques to elicit the criteria considered by individuals to make a choice between alternatives, as well as the principles by which this information is used in the decision-making process. This approach has been tested in studies of maternal health care utilisation in LMICs. For example, Edmonds et al. (2010) used the decision-tree modelling approach in a study of choice of birth attendant in Bangladesh, in order to assess the predictive power of women’s self-identified criteria. Although this approach is more concerned with process, it still tends towards a fairly linear conceptualisation of the process. The focus also remains on the individual rational actor, which is problematic for the reasons discussed in the previous section.

In an altogether different approach to dominant models with an individual rational actor orientation, Pescosolido’s (1992, p.1102) social organisation strategy framework presents ‘an explicitly dynamic, network-centered, event-based approach’ to the study of health care-seeking. It provides a more dynamic, process-oriented perspective, which frames decision-making in terms of an ‘episode’ that encapsulates decisions and actions surrounding an ‘event.’ The key phenomena to be explained are the strategies of action and

how they are socially organised, rather than ‘a’ decision (Pescosolido, 1992). ‘Strategies’ here refer to the patterns, combinations, or sequences of decisions and actions through time. At its core is the notion that the system of social relations provides the foundation for decision-making. Pescosolido (1992) argues that it is insufficient to regard social relations as an influence on individual-level processes; rather, she offers the alternative perspective that it is through social interaction within networks that situations are defined, issues resolved and outcomes evaluated.

The social organisation strategy framework does not deny rationality, however, since a combination of affect and rationality is considered to drive action (Pescosolido, 1992). Action is underpinned by cultural routines, which are produced through interaction and depend on affective reactions—or acquired instinct for what to do without knowing why. Yet, when these fail to provide an effective course of action, individuals are compelled to think through situations. The key difference is that affect and rationality are conceptualised as tied to interaction within a social network, rather than residing within the individual. Moreover, Pescosolido (1991) considers rationality ‘bounded,’ taking into account few factors seen as crucial. In the social organisation strategy framework, the theoretical explanation of decision-making episodes lies in the overarching pattern of structured interactions or networks in which those surrounding the event operate (Pescosolido, 1992). The framework reconceptualises the mechanisms underlying associations between the factors included in dominant theoretical models and health service utilisation to be a function of their effect on network ties. In sum, in Pescosolido’s (1992, p.1105) framework, ‘decision-making itself is a dynamic, interactive process fundamentally intertwined with the structured rhythms of social life.’ It is considered complementary because it leads to a different, but not contradictory, set of questions: it shifts the emphasis from who uses services to the strategies of action and how they are socially organised.

The network episode model is a conceptual model to understand how individuals recognise and respond to health and illness, based on principles of the social organisation strategy framework (Pescosolido, 1991, 2006). The network episode model ‘presents a dynamic view of key health care decision stages and specifies how the structure, content and function of network ties (and how they change over time) interact to influence the course and treatment of medical problems’ (Pescosolido, 1991, p.178). The model

combines insights from the ‘illness career’ perspective, predominantly used in qualitative traditions to study pathways to care, with insights from social network theory. The illness career and the social support system are presented as the two key strands in the model, with their interaction influenced by elements of the social context, such as personal characteristics and the nature of the health problem (Pescosolido, 1991, 2006). The illness career strand provides a dynamic conceptualisation of a series of decisions and actions that extend through time (the strategies of action described in the social organisation strategy framework), allowing for individual change in response to the consequences of previous decisions (Pescosolido, 1991).

Pescosolido (1991, p.171) proposes that social networks ‘determine how individuals evaluate need, gather access information, and perceive the sociocultural fit of medical options.’ The model’s social support system is made up of three network-related dimensions: the structure of network ties, their functions and their content. Social networks are considered neither randomly distributed nor egalitarian: they can be supportive, but they can equally be hierarchical or coercive (Pescosolido, 2006). Examples of structural elements would be the size, density or strength of network ties, and types of functions might include the provision of information, advice, and emotional, material or practical support. Both are considered to interact with ‘cultures of information, beliefs and action scripts’—themselves a product of social interaction—to influence health care decisions (Pescosolido, 2006, p.194). It is network structure that determines the level of social influence, but it is ‘cultural content’ that determines the direction this takes in terms of the different options for care (Pescosolido, 2006). A later revision to the model elaborated on the ‘treatment system’ as a specific social network. The nature of the bond between patient and provider, or between the health system and communities, were understood to shape the care encounter and reactions to it in ways that could either reframe or reinforce the cultural content of social networks (Pescosolido, 2006).

An application of the network episode model in Bangladesh aimed to examine the influence of socio-structural context on care-seeking for birth (Edmonds et al., 2012). The rationale provided by the authors for the choice of approach was that women exchange information on the accessibility and quality of health services, and assess their families’ and peers’ approval of the use of health services, all within their social networks. The study

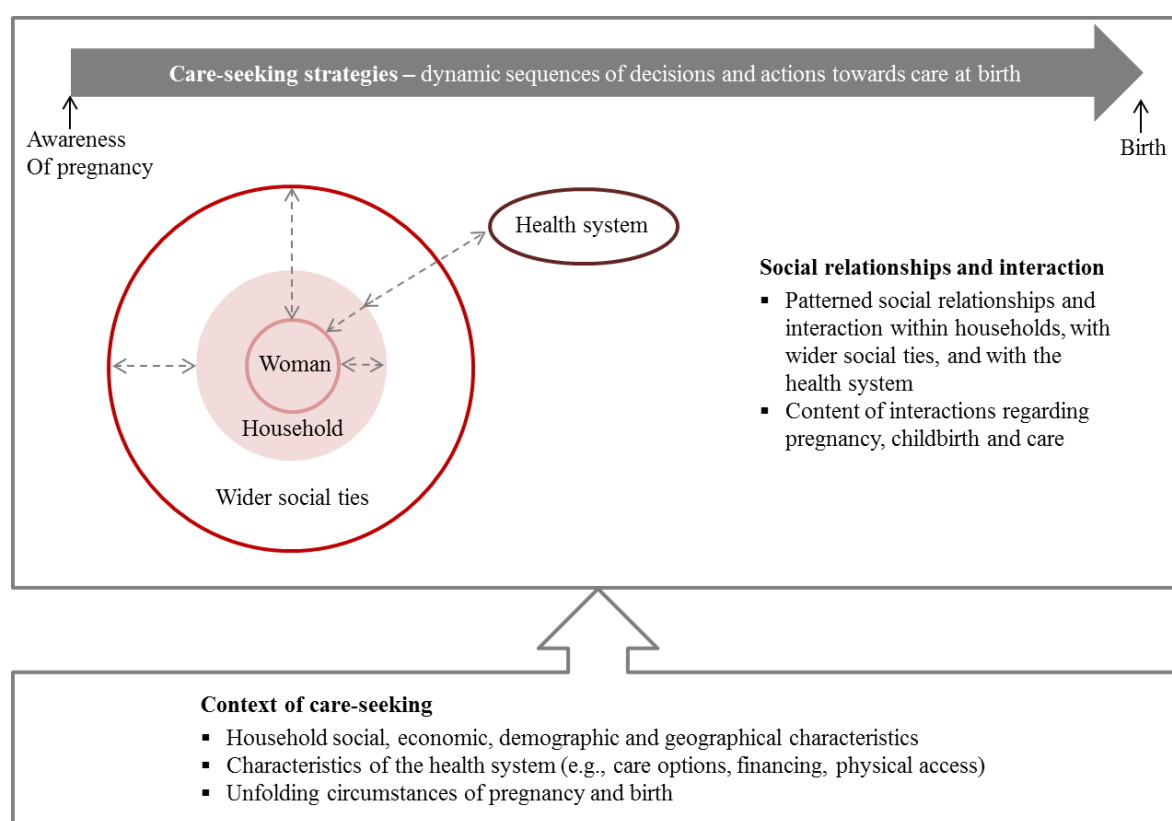
examined the hypothesis that network structure variables (density/kinship homogeneity/strength of ties) together with network content (endorsement for or against a particular type of birth attendant) explains the type of birth attendant beyond the variance explained by women's individual-level attributes. A possible critique is that the cross-sectional design does not reflect the dynamic, process-oriented perspective of the network episode model (and social organisation strategy). In addition, the framework may have needed adaptation for the Bangladesh context. Although the authors acknowledged that women have little decision-making autonomy in Bangladesh, they used an egocentric model that may not have provided an apt conceptualisation of how decisions are made in this context. Edmonds et al.'s (2012) findings are discussed further in Chapter 7.

2.6 The study's care-seeking framework

The framework for this study is adapted from Pescosolido's (1991, 1992, 2006) network episode model and the social organisation strategy framework from which it is derived. Care-seeking for birth is conceptualised as a dynamic, social process, with patterned interaction as the mechanism through which meaning is attached to health events and care options, and actions are determined. In adopting this framework, the study seeks to generate new insight on an issue that has thus far largely been investigated—explicitly or implicitly—with static approaches, underpinned by an individual rational actor perspective. The study does not reject the contribution of more traditional approaches. Rather, through employing a lens that is more focused on the dynamic and interactive process of care-seeking, it is concerned with building on the knowledge that has already been gained through these approaches. Indeed, the study investigates social-psychological concepts, such as beliefs and attitudes. However, signifying its departure point from the Health Belief Model, it does so from the perspective that these are a product of interaction with social ties, rather than internal processes partially influenced by social norms. As Pescosolido (1991, 1992) notes, these different approaches are not contradictory and the questions they address can be complementary, producing a more comprehensive understanding of health care-seeking.

Figure 2.2 illustrates the study's framework. The care-seeking process for birth is framed as in Pescosolido's approach (1992), in terms of an 'episode' that encapsulates decisions and actions surrounding an 'event' that requires them. In this study, childbirth is the event, which requires decisions and actions regarding care. The corresponding episode is one that could be considered to begin with awareness of pregnancy and end after birth. In this sense, a pregnancy and birth episode entails a relatively more defined time period than many 'illness' episodes.

Figure 2.2 Care-seeking framework for birth



Notes: Dotted lines represent types (but not the number) of social ties

Source: author's own, adapted from Pescosolido (2006)

The analytic focus is care-seeking strategies, or dynamic sequences of decisions and actions towards care at birth. The notion of care-seeking strategies encompasses the number, combination, sequence, timing and duration of decisions and actions towards care at birth, including consideration or actual contact with different types of care providers, as well as preparatory actions. It is concerned with a more holistic notion of care than is

captured in most studies of maternal health care utilisation, which largely focus on use versus non-use of modern medical care. It considers the site of care, type of provider, and purposes for which they are consulted, across the spectrum of options available. ANC may form part of care-seeking strategies for birth, which opposes conceptualisations of discrete decisions on care during pregnancy on the one hand and for birth on the other. Preparatory actions may include registration at a facility and financial or transport arrangements.

Interactions within patterned social relationships act together with the content of these interactions to drive care-seeking strategies in the framework. The agent in Pescosolido's (1992, p.1103) social organisation strategy framework is the 'individual in patterned interaction with others,' which represents a shift from the 'individual' focus in traditional approaches. In this study, the relevant 'individual' refers to largely young, primiparous women in India. To conceptualise the agent as the woman 'in patterned interaction with others,' and the household simply as part of her social network, would be problematic. In view of the numerous studies on Indian contexts highlighting interdependence within households, the household's critical role in health care-seeking and young women's low autonomy, this study adapts the framework to bring the household to the fore. The adaptation entails a shift from Pescosolido's (1992, p.1103) 'individual in patterned interaction with others' to 'household members in patterned interaction with each other, with wider social ties, and with the health system.' The study borrows here from the notion of the 'household production of health' in developing countries (Berman et al., 1994). Adopting a collective rather than unitary notion of the household (Alderman et al., 1995), members' perspectives are regarded as not necessarily identical and patterned social relationships and interaction determine how they are reconciled. A 'household' is usually defined in surveys according to living arrangements (e.g., IIPS & Macro International, 2007). This is the way in which it is conceptualised in this study, although a critical approach is taken (see Chapters 4 and 7), acknowledging that the household is not a straightforward concept (Randall & Coast, 2014; Randall et al., 2011).

Finally, the context of care-seeking encompasses household characteristics, health system characteristics and the unfolding circumstances of pregnancy and birth, all of which may be dynamic through the episode. They influence the interplay between interaction within social relationships on the one hand and care-seeking strategies on the other.

The three research sub-questions derive from the framework. ‘Scripts’ of knowledge, beliefs and attitudes regarding pregnancy, childbirth and care are a product of social interaction. These perceptions are the focus of research sub-question 1 and are examined in Chapter 5. They provide the foundation for care-seeking strategies, but do not equate with decisions and action in the framework. Actual care-seeking strategies, or dynamic sequences of decisions and actions towards care at birth, are the focus of research sub-question 2 and are addressed in Chapter 6. Essentially, Chapters 5 and 6 examine the care-seeking strategies component of the framework—the analytic focus. Interaction within patterned social relationships is conceptualised as the driver of these care-seeking strategies. The social relationships and interaction component of the framework is the focus of research sub-question 3, and is addressed in Chapter 7. The context of care-seeking is discussed across Chapters 3, 5, 6 and 7.

2.7 Summary

Table 2.1 Summary of the study framework’s distinguishing features

	This study’s maternal health care-seeking framework¹	Traditional maternal health care-seeking approaches
Nature of approach	Dynamic, interactive, process-oriented approach, focusing on an event that requires decisions and action	Static, discrete decision-oriented approaches underpinned by an individual rational actor perspective. Dominated by determinant models
Analytic focus	Care-seeking strategies, encompassing the number, combination, sequence, timing and duration of decisions and actions towards care at birth	Care outcomes
Dimensions of care	The site of care, type and characteristics of provider, and purpose for which the provider is consulted, across the spectrum of options available	Use/non-use of a skilled attendant or a health facility for birth
Agent	Household members in patterned interaction with each other, with wider social ties, and with the health system	Individual
Role of social relationships and interaction	Driver of decisions and action	Factor(s) influencing the individual
Basis of action	Combination of affect (culturally acquired instinct for what to do without knowing why) and ‘bounded’ rationality (taking into account a few factors regarded as crucial), driven by social interaction	Individual rational action

¹Adapted from Pescosolido (1991, 1992, 2006)

The study's data collection and analysis are framed by a dynamic, social process orientation to health care-seeking, adapted from the work of Pescosolido (1991, 1992, 2006) and Pescosolido and Levy (2002). Table 2.1 presents a summary of features that distinguish the study's care-seeking framework from other approaches.

3. The Study Context

3.1 Introduction

The study was conducted in households of primiparous women residing in low-income neighbourhoods in Indore, a large city in the central Indian state of Madhya Pradesh (MP). This chapter describes multiple layers of relevant contextual information. It discusses the economy and society, with a focus on life in an increasingly urban India. It considers the context of young primiparous women's lives, including marriage, the household and childbearing, and progresses to discuss the maternal health, health care and policy scenario. Finally, it describes the Indore field site. The chapter situates Indore within the broader state and national context.

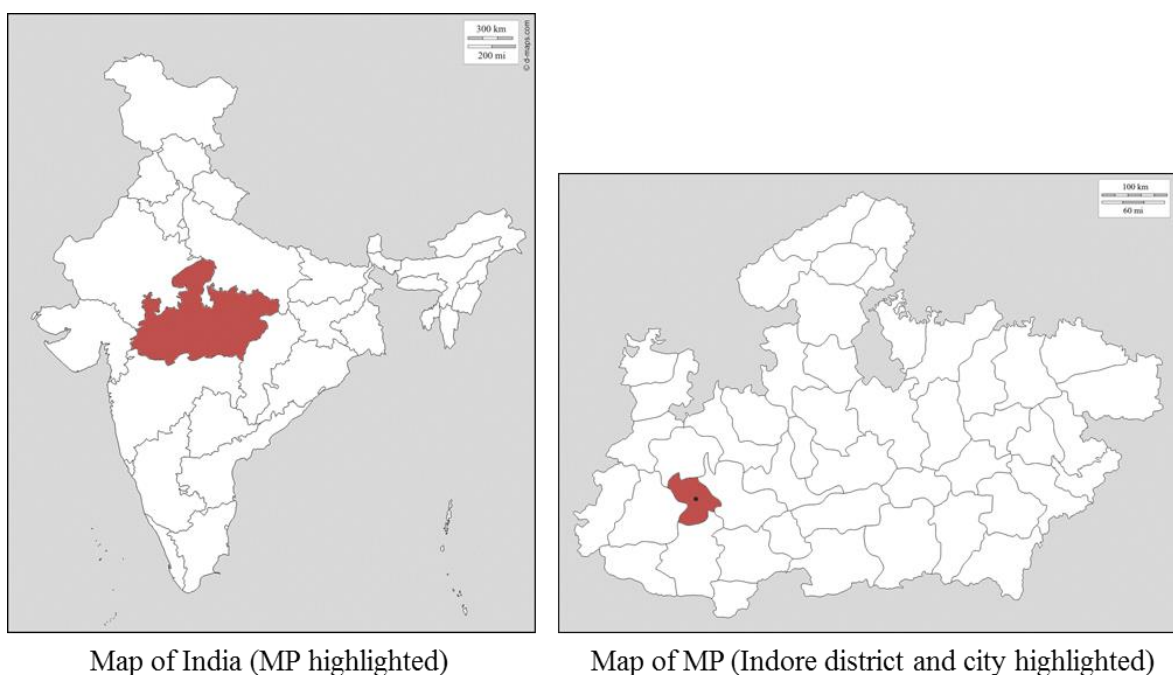
3.2 Socioeconomic context

With a total population of 1.21 billion in 2011, India is the world's second most populous country (Office of the Registrar General & Census Commissioner, 2011b). It is a federation of 29 states (28 at the time of data collection) and seven union territories, across which there is considerable diversity in economic, social, cultural, demographic and health characteristics. MP is located in central India (see Figure 3.1) and is the sixth largest of India's states by population size, which stood at 72.6 million in 2011 (Office of the Registrar General & Census Commissioner, 2011b). The state encompasses 51 administrative districts (50 at the time of data collection) across 10 divisions, and includes 376 towns or cities (Government of MP, 2014). Indore refers to both a city and a district located in the south-western corner of the state on the Malwa plateau. Data collection focused on the city, which is the largest in MP with a population of 2.17 million (Office of the Registrar General & Census Commissioner, 2011b).

India has gained status over the past two decades as one of the world's major emerging economies. With high annual economic growth rates through most of the 2000s, Gross Domestic Product per capita in current US\$ increased from US\$ 457 in 2000 to US\$ 1503 in 2012 (World Bank, 2014b), propelling India from a low to a lower-middle income

country (World Bank, 2014a). Gains are not equally distributed across the population, however, and widespread poverty persists. According to estimates for 2011–12, 21.9 per cent of the total population and 13.7 per cent of the urban population were below the national poverty line⁵, which represents a substantial decline from the poverty estimates of 2004–05 (Planning Commission, 2013). However, the methodology has been criticised for providing estimates that are too low (Planning Commission, 2014). The World Bank’s \$2 a day (purchasing power parity) poverty line yields estimates as high as 68.8 per cent for India in 2010, declining from 75.6 per cent in 2005 (World Bank, 2014b).

Figure 3.1 Map of India and MP locating the study setting



The United Nations Development Programme (UNDP) places India at 135th of 187 countries on the Human Development Index, which combines measures of income, life

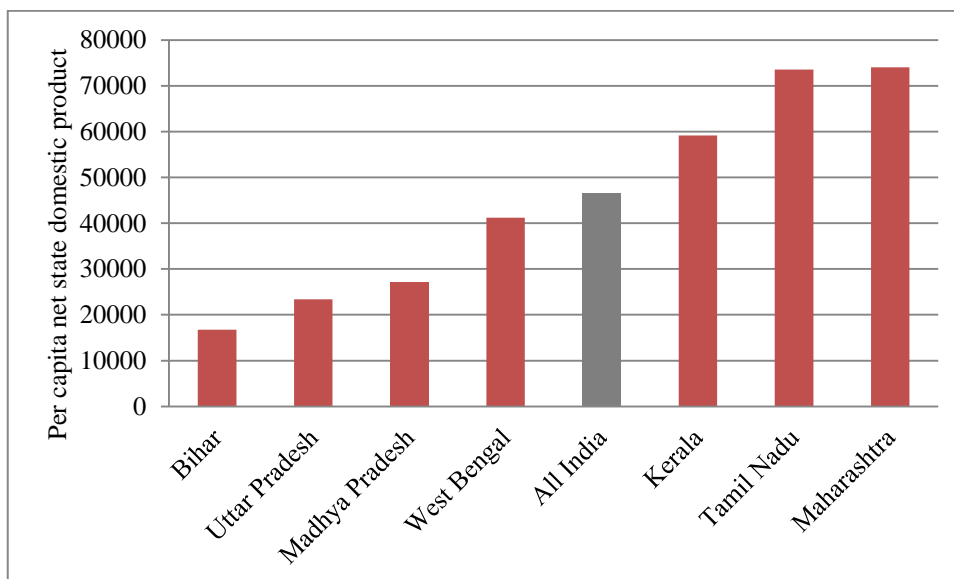
⁵ The national poverty line is computed according to the Tendulkar Committee methodology, which uses implicit prices derived from quantity and value data collected in household consumer expenditure surveys. The state poverty line for MP in monthly per capita consumption expenditure is INR 771 in rural areas and INR 897 in urban areas, in comparison to an all India poverty line of INR 816 in rural areas and INR 1000 in urban areas. The all India poverty ratio is the state-population weighted average poverty ratio, and the all India poverty line is the monthly per capita consumption expenditure that corresponds to the all India poverty ratio (Planning Commission, 2013). (US\$ 1 = INR 53.0 on 01 January 2012)

expectancy and education (UNDP, 2014). Access to education has expanded in India in recent decades, so levels are higher among the younger age groups. Nevertheless, 21.7 per cent of women in the age group 15–19 have no education and a further 7.7 per cent have fewer than five years; and a substantial proportion of men also have low levels of education, albeit higher on average than women (IIPS & Macro International, 2007). There are large socioeconomic differentials, with the lowest levels of education in the lowest wealth quintiles and among scheduled castes, tribes and other backward classes (IIPS & Macro International, 2007).

Socioeconomic development varies widely across states, and MP falls within the band of states with the lowest levels of development (see Figures 3.2–3.4). Its per capita state domestic product is around 40 per cent below the national level, and has fallen further behind over time (Ministry of Statistics and Programme Implementation, 2011; Planning Commission, 2011; UNDP, 2012). Poverty estimates are also higher: 31.7 per cent of the total population and 21.0 per cent of the urban population fall below the national poverty line, placing MP seventh highest on this indicator across India's states (Planning Commission, 2013). Moreover, UNDP ranks MP at 20th of 23 states on the Human Development Index (UNDP, 2012).

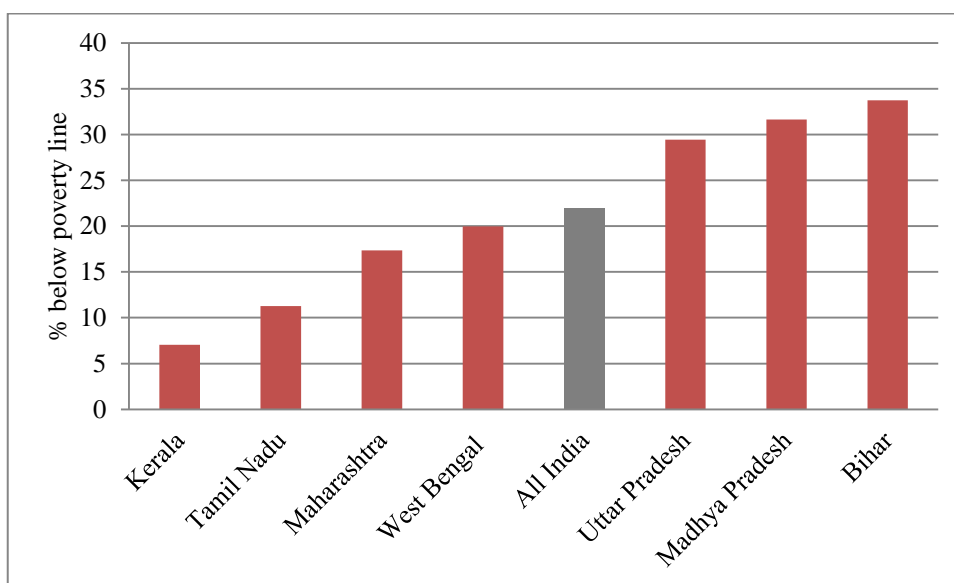
India's caste system encompasses a large number of endogamous hereditary groups, communities or castes (*jati*), which were traditionally divided into four strata (*varna*) while others fell outside the system altogether. The Constitution of India recognises scheduled castes (SC), scheduled tribes (ST) and other backward classes (OBC) as disadvantaged populations. SCs make up 15.6 per cent of the population in MP, which does not differ substantially in rural and urban areas, and is marginally lower than the national average (Office of the Registrar General & Census Commissioner, 2011b). MP's ST population (21.1 per cent of the total) is much larger than the national average, but it makes up only a fairly small proportion of the urban population (5.2 per cent) (Office of the Registrar General & Census Commissioner, 2011b). With OBCs also accounting for almost 40 per cent of the population, SCs, STs and OBCs collectively make up around 80 per cent of MP's total population (IIPS & Macro International, 2007).

Figure 3.2 Per capita net state domestic product in selected states⁶ and India



Provisional estimates for 2009–10 at current prices (INR). US\$ 1 = INR 46.6 on 01 January 2010
Source: Ministry of Statistics & Programme Implementation (2011)

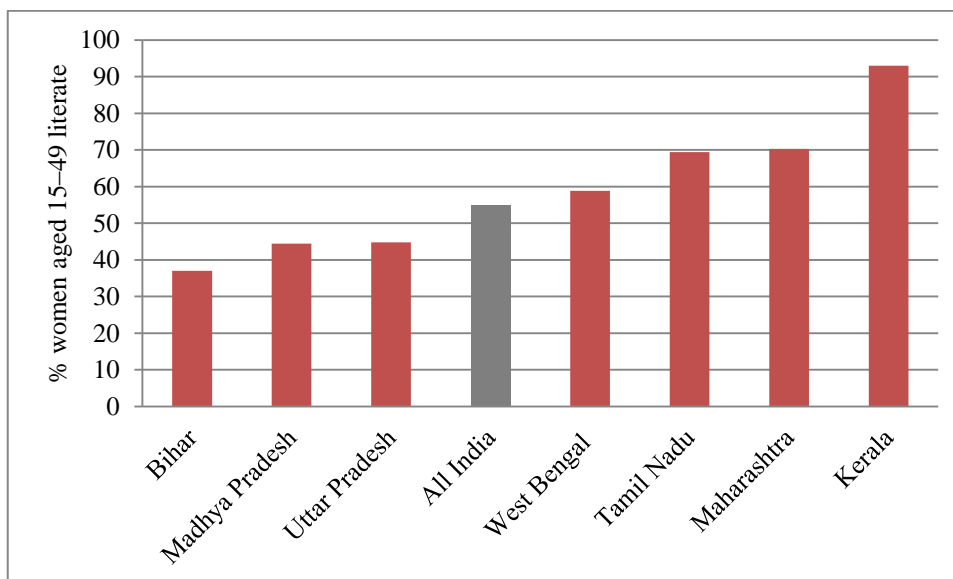
Figure 3.3 Percentage of population below poverty line in selected states and India



See note on methodology on p.42
Source: Planning Commission (2013)

⁶ Selected states comprise the six largest in India by population size, which include MP. Kerala, renowned as a superior health achiever relative to income (Caldwell, 1986), is also included. The seven states are distributed across India's regions.

Figure 3.4 Percentage of women aged 15–49 literate in selected states and India



Source: IIPS (2007)

India is still overwhelmingly rural: only 31.2 per cent of the population lived in urban areas in 2011 (Office of the Registrar General & Census Commissioner, 2011b). However, it is becoming increasingly urban and is projected to reach 50 per cent urban by 2050 (United Nations, 2014b). MP is more rural than the Indian average, with only 27.6 per cent living in urban areas in 2011. Growth in India's urban population in absolute numbers is remarkable. It increased from 222 million to 410 million between 1990 and 2014, and is projected to double again to 814 million by 2050 (United Nations, 2014b). Despite widespread perceptions to the contrary, rural-urban migration contributed a fairly small (but rising) portion of around 24 per cent to urban growth from 2001–2011. Natural growth accounted for the major portion of around 44 per cent, followed by reclassification and urban boundary expansion (Indian Institute for Human Settlements, 2011). Among around 8000 urban centres in India, there are currently three megacities with a population of more than ten million and 53 cities with a population greater than one million (Indian Institute for Human Settlements, 2011). Indore is the 15th largest Indian city (Office of the Registrar General & Census Commissioner, 2011b). Million-plus cities currently account for around 13 per cent of India's total population (Indian Institute for Human Settlements, 2011).

Urban living can provide opportunities, including greater availability of health care and other services, and urban populations accordingly fare better on average than their rural counterparts on many economic and social indicators (UN-Habitat, 2011). Yet, aggregate figures conceal large intra-urban inequalities (Indian Institute for Human Settlements, 2011; Kumar & Singh, 2014). A substantial proportion of India's urban residents are poor and, although this proportion may be declining, absolute numbers remain high because of rapid urban growth. Vast slum areas are a physical and spatial manifestation of urban poverty in LMICs (UN-Habitat, 2003). Slums have been defined in various ways, but the term is generally used to describe a diverse range of low-income settlements or poor human living conditions, often characterised by a lack of basic services, inadequate housing and living conditions, overcrowding and insecure tenure (UN-Habitat, 2003). While not all the urban poor live in slums and not all slum-dwellers are uniformly poor, they do contain the highest concentration of urban poor residents (Montgomery & Hewett, 2005; Subbaraman et al., 2014; UN-Habitat, 2003, 2011). Million-plus cities account for a smaller share of the urban poor (less than 20 per cent) than smaller urban settlements, but a larger share of slum populations (more than 40 per cent) (Indian Institute for Human Settlements, 2011).

Official figures estimate a total of 33,510 slums across urban India, housing 8.8 million households⁷ (Ministry of Statistics and Programme Implementation, 2013). Yet, India is reported to have made strides in improving slum conditions since 2000 (UN-Habitat, 2011) and slum dwellers as a proportion of the urban poor may have declined (Chandrasekhar & Mukhopadhyay, 2012). Notification of slums by government authorities gives legal recognition that is often necessary for receiving municipal services (Subbaraman et al., 2014; Subbaraman et al., 2012), and notified slums tend to have more permanent housing structures and better access to public facilities (Ministry of Statistics and Programme Implementation, 2013). Slum notification and improvement is normally the remit of urban local bodies (National Resource Centre). MP sets good practice as the only state to regularise tenure of squatters on government land (National Resource Centre). The Madhya Pradesh Nagariyon Kshetra Ke Bhumihin Vyakti (commonly known as the Patta Act) was introduced in 1984 to grant leasehold land titles (or *Pattas*) to landless persons or

⁷ Slum populations are notoriously difficult to estimate

residents of squatter settlements (Indore Municipal Corporation, 2006). Accordingly, MP has the largest proportion of notified slums of any state: 81 per cent in comparison to an all India figure of 41 per cent (Ministry of Statistics and Programme Implementation, 2013).

3.3 The context of marriage and childbearing

Marriage is almost universal among women in India: in 2005–06, only 0.6 per cent of women aged 45–49 had never married (IIPS & Macro International, 2007). Despite a legal minimum age at marriage of 18, enforcement of the law is weak and the actual age at first marriage is low, albeit rising. Age at marriage is youngest among the lowest wealth quintiles (IIPS & Macro International, 2007). It is also younger in MP than the national average (IIPS & Macro International, 2007). In 2011–12, 46.1 per cent of women in MP aged 20–24 were married before they were 18 (see Table 3.1). Although age at marriage is higher on average in urban areas, a substantial proportion of women (27.0 per cent in Indore) nonetheless are married by the age of 18 (Office of the Registrar General & Census Commissioner, 2013b).

Kin and village exogamy is the norm in many Indian states, including MP, whereby families customarily arrange marriages between sons or daughters who are unrelated in kinship and by place of residence (IIPS & Population Council, 2010a; Rahman & Rao, 2004). The traditional family in India is patriarchal, patrilineal and patrilocal (Freed & Freed, 1982). Joint households, in which a married couple lives with unmarried children as well as married sons and their families, are commonplace, but plurality in household structures has always existed (D'Cruz & Bharat, 2001). Allendorf (2013) suggests that the proportion of young women aged 15–29 living in nuclear households in India showed a steady increase from 1992–3 to 2005–6, mirroring the findings of other studies (Niranjan et al., 2005). However, the majority of young married women still live in joint households: 59.8 per cent of women aged 15–29 lived in joint households in 2005–06 (IIPS & Macro International, 2007), and the proportion living in joint households is particularly high in the youngest age groups (aged 15–19) (Allendorf, 2013).

Marriage and kinship patterns contribute to the low status of women in Indian society. Despite laws against dowry, the practice continues unabated (IIPS & Population

Council, 2010b). Women largely transfer from the natal to the marital household upon marriage. They enter as a stranger at the bottom of the household's age and gender hierarchies, although status in the household tends to increase with age as women bear sons (Das Gupta, 1995). Following marriage, access to natal kin is controlled by the marital family (Dyson & Moore, 1983). The bond between mother and son is said to affect the son's relationship with his wife, reinforcing the woman's subordination within the household (Das Gupta, 1995). It is in the interests of the mother-in-law to ensure her son remains loyal to her, and allowing a close bond to develop between the son and his wife poses a threat to sustaining a joint household (Vera-Sanso, 1999). The ideal marital relationship is therefore regarded as one of respect and distance, although there are growing aspirations for 'companionate marriages' among young people (Allendorf, 2012a). Relations between a dominant mother-in-law and submissive daughter-in-law are typically portrayed as strained, and reports of neglect and abuse of young married women by the marital family, particularly the mother-in-law, are common (Raj et al., 2010; Sarkar, 2013; Vera-Sanso, 1999).

Unequal gender relations mean young married women have little agency, rendering them dependent on their husbands and/or in-laws. Within the household, they have little authority over decisions pertaining to themselves or their families, limited opportunities for employment, and limited access to or control over household financial resources (Jejeebhoy, 2002). Norms of semi-seclusion also mean that women have little freedom to move around independently outside the home (IIPS & Population Council, 2010b; Vera-Sanso, 1999). There are regional differences in patterns of kin and gender relations, however, and MP performs relatively poorly on indicators of gender equity (IIPS & Macro International, 2007). UNDP (2012) ranks MP at 33rd of 35 states on the gender-related development index.

Childbearing in India occurs almost exclusively within marriage and almost all women have children: only 3.4 per cent of women aged 40–44 in 2005–06 had never given birth (IIPS & Macro International, 2007). Young women are under pressure to demonstrate their fertility soon after marriage. In a study on married adolescent girls in Maharashtra, India, Barua et al. (2001, p.60) found that, 'mothers-in-law strongly objected to any delay [in childbearing] and the girls were willing to have a child in their first year of marriage to

meet this social expectation, which husbands usually had to go along with.’ Contraceptive prevalence is thus extremely low between marriage and the first birth (IIPS & Population Council, 2010b), and age at first birth is correspondingly low. The median age at first birth for women aged 25–29 in 2005–06 was 19.9 years—younger in the lowest wealth quintiles—and had changed little since previous cohorts (IIPS & Macro International, 2007).

The total fertility rate (TFR) in India has declined rapidly from 5.2 in 1971 to 3.6 in 1991, and further to 2.4 in 2012 (Office of the Registrar General & Census Commissioner, 2012). Fertility in urban areas is lower than overall and is already below replacement level nationally at 1.8. However, there is wide variation across states. In MP, the TFR remains relatively high at 3.1 overall and 2.3 in urban areas (see Table 3.1) (Office of the Registrar General & Census Commissioner, 2013b). Childbearing tends to occur within a short window at early ages, following which permanent contraceptive methods—particularly female sterilisation—are used (IIPS & Macro International, 2007; Padmadas et al., 2004).

A pervasive preference for sons has been widely documented in India (Das Gupta et al., 2003; Pande & Astone, 2007). Son preference is recognised as a major issue and skewed sex ratios at birth seen across the country—particularly in northern and central states—are explained by sex-selective abortions, facilitated by access to prenatal sex-determination technologies (Arnold et al., 2002; Kulkarni, 2007). The sex ratio at birth in MP is 904 females per 1000 males, and is particularly low in Indore at 856 (see Table 3.1) (Office of the Registrar General & Census Commissioner, 2012).

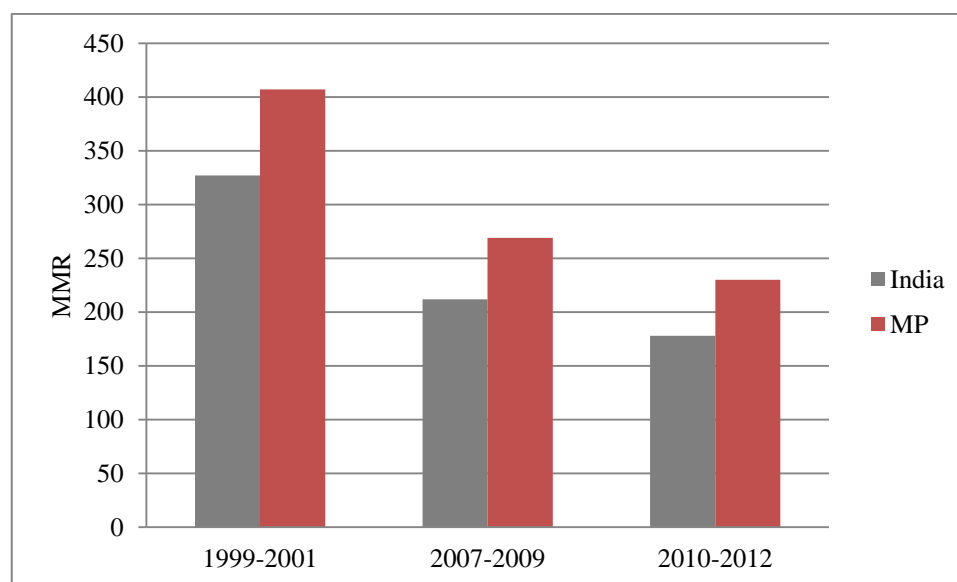
3.4 Trends in maternal health, health care and policy

India has made substantial progress towards improving maternal health, evidenced by a reduction of 66 per cent in the MMR between 1990 and 2010 (WHO, 2012). Yet, levels remain high (see Figure 3.5). For India as a whole, the MMR was estimated to be 178 per 100,000 live births in 2010–12 and national averages mask considerable variation across states (Office of the Registrar General, 2011). The MMR for this same period in MP was high at 230, in comparison to 66 in Kerala, the state with the best maternal health (Office of the Registrar General, 2011). The neonatal mortality rate in MP was also estimated to be

the highest of all states in 2012 (Office of the Registrar General & Census Commissioner, 2012) (see Figure 3.6). MP falls within the Empowered Action Group (EAG) of eight states concentrated in the north, centre and east of the country, prioritised by the government for their low performance on health and demographic indicators.

The proportion of births taking place in a health facility or with a skilled attendant increased only marginally throughout the 1990s and early 2000s in MP and India more generally (see Figure 3.7). In MP, the proportion of births in a health facility was extremely low at 22.0 per cent in 1998–99 and increased by only 7.7 percentage points through to 2005–06 (IIPS & Macro International, 2007). In the ensuing six years or so until 2011–12, however, a dramatic shift took place: births in a health facility increased by a remarkable 50 percentage points in MP to reach 79.7 per cent. Increases were seen both in urban and rural areas, but were relatively smaller in urban areas, where levels were higher at the starting point. Although the trend in MP mirrored the national pattern, relatively greater increases saw it overtake the national average over this period (see Figures 3.7 and 3.8). Use of ANC also increased in MP over the same time period, albeit more modestly (see Figure 3.9).

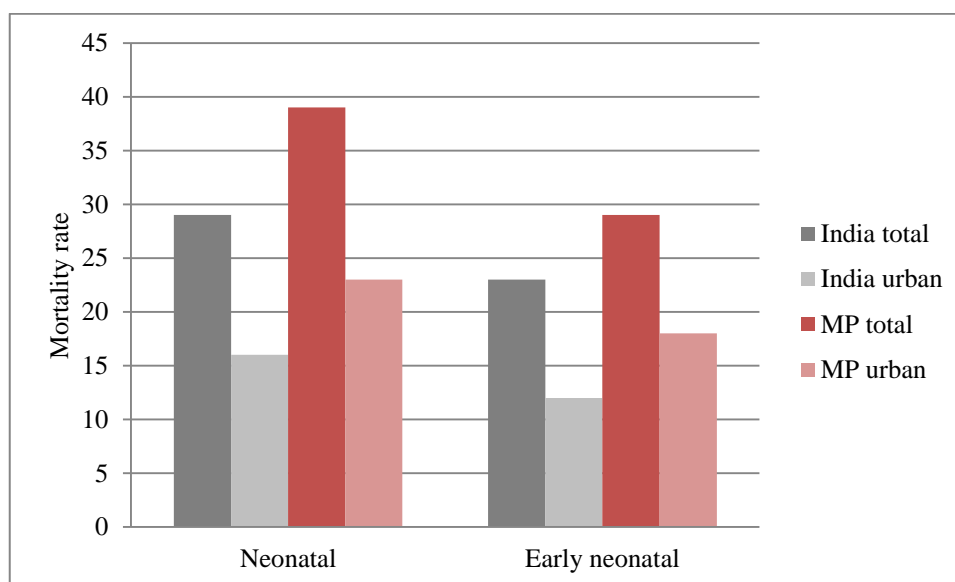
Figure 3.5 Trends in the MMR in MP and India, 1999–2012



MMR – maternal deaths per 100,000 live births

Source: Sample Registration Survey, Office of Registrar General, India (2006, 2011, 2013)

Figure 3.6 Neonatal and early neonatal mortality rates in MP and India, 2012

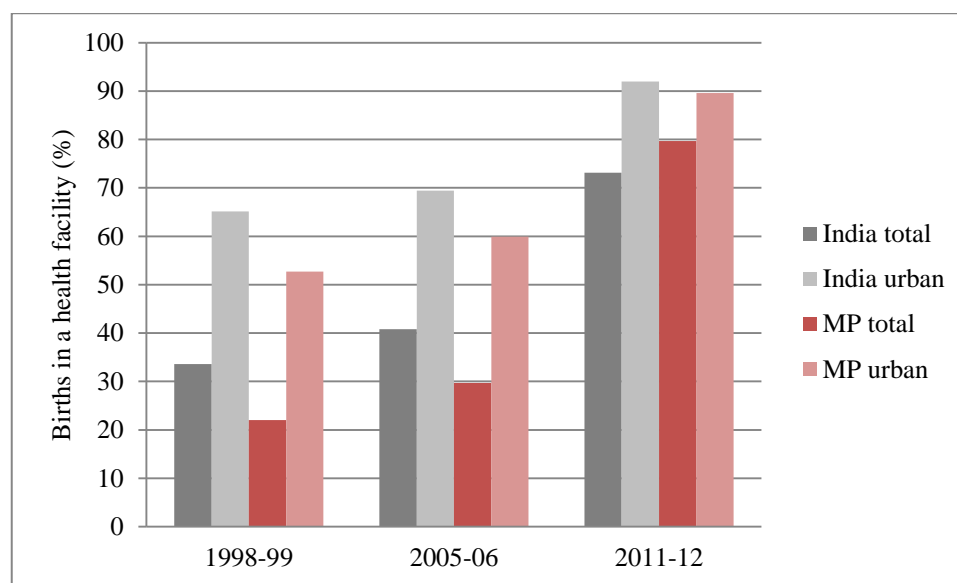


Neonatal mortality rate – deaths at less than 29 days per 1000 live births

Early neonatal mortality rate – deaths at less than 7 days per 1000 live births

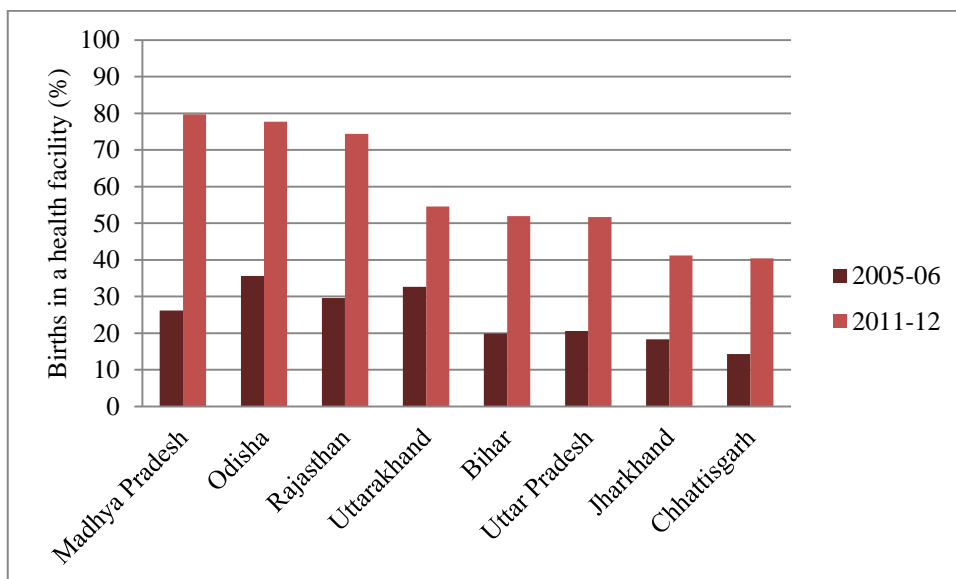
Source: Sample Registration Survey statistical report (Office of the Registrar General & Census Commissioner, 2012)

Figure 3.7 Trends in births in a health facility in MP and India, 1998–99 to 2011–12



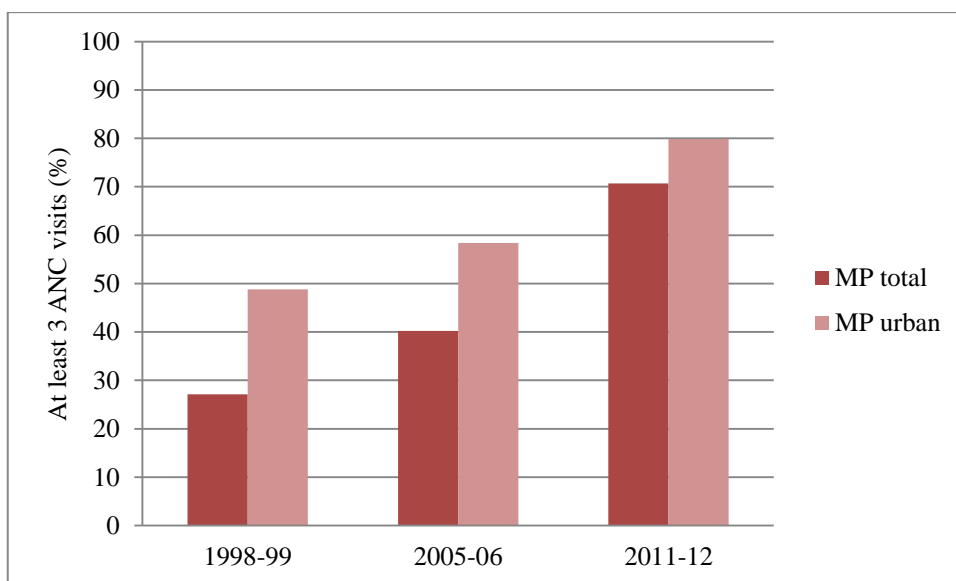
Sources: 1998–99 and 2005–06 – NFHS (IIPS & Macro International, 2007, 2008); 2011–12 – Annual Health Survey, MP (Office of the Registrar General & Census Commissioner, 2013b) and Sample Registration Survey (Office of the Registrar General & Census Commissioner, 2012)

Figure 3.8 Trends in births in a health facility in EAG states, 2005–06 and 2011–12



Source: 2005–06 – NFHS (IIPS & Macro International, 2007); 2011–12 – Annual Health Surveys (Office of the Registrar General & Census Commissioner, 2013a)

Figure 3.9 Trends in ANC in MP, 1998–99 to 2011–12



Sources: 1998–99 and 2005–06 – NFHS (IIPS & Macro International, 2008); 2011–12 – Annual Health Survey, MP (Office of the Registrar General & Census Commissioner, 2013b)

This major shift in use of maternity care services in India in the late 2000s coincided with a period of intensified efforts to tackle poor maternal and newborn health, particularly in the low-performing EAG states. Maternal and newborn health had certainly

been on the international agenda for some time with the launch of the Safe Motherhood campaign in 1987 and their subsequent inclusion in the MDGs. They were also included in India's domestic policies, including the National Population Policy 2000 (National Commission on Population, 2000) and National Health Policy 2002 (Ministry of Health & Family Welfare, 2002). The Government of India launched the Child Survival and Safe Motherhood Programme in 1992 followed by the first phase of the Reproductive and Child Health Programme in 1997, which aimed to address the supply-side through improving the availability of emergency obstetric care and strengthening institutional capacity. However, progress at this stage was uneven across states and slow at the national level.

Shiffman and Ved (2007) suggest that safe motherhood became a greater priority on the national political agenda in the mid-2000s. Major change came with the launch of the National Rural Health Mission (NRHM) in April 2005, aiming to provide equitable, affordable and quality health care to the rural population (Ministry of Health & Family Welfare, 2013a). Key elements of the approach included decentralisation, community participation, flexible financing, capacity building, monitoring progress against standards, and innovations in human resource management (Nandan, 2010). The NRHM incorporated the second phase of the Reproductive and Child Health Programme, and improving maternal and child health were key targets. With its focus on rural populations, the needs of the urban poor were largely neglected at this stage (Bhaumik, 2012), and this did not change until May 2013 (after data collection for this study), when the Government of India approved the National Urban Health Mission (Ministry of Health & Family Welfare, 2013a). Despite its focus on rural areas, some major initiatives that emerged under the NRHM umbrella included, or were imitated in urban areas.

Increasing institutional births has been a key policy focus of the NRHM. Janani Suraksha Yojana (JSY) is a major, centrally-sponsored conditional cash transfer scheme launched under the NRHM in 2005 to promote institutional births. It is underpinned by an assumption that financial barriers prevent women from using health facilities for childbirth (Randive et al., 2013). While it is a national scheme, criteria and conditions are differentiated for low- and high-performing states, and for urban and rural areas. In MP, an EAG state, all pregnant women who have a birth in a public health facility or accredited

private institution are eligible for a cash benefit of INR 1400 (approximately US\$26⁸) in rural areas or INR 1000 (approximately US\$19) in urban areas. A smaller cash amount is also available to meet the costs of home birth on a targeted basis for women aged 19 and above who have below the poverty line status, for up to two live births. In higher performing states, the scheme is more targeted and the cash amount lower⁹. Payments should be made after birth from health facilities, and immediately upon discharge for those who have institutional births. There is also a provision for transport costs and incentive payments to community health volunteers for aiding women's access to maternity services. JSY is the largest programme of its kind in the world. With a budget allocation of US\$ 342 million in 2009–10, it was expected to provide cash transfers for 36 per cent of 26 million births in India that year (Lim et al., 2010).

JSY has been credited—at least in part—with propelling the major increase in institutional births in India since 2005 (UNFPA, 2009). However, programme uptake and the magnitude of increases in institutional birth has differed across states (Randive et al., 2013). In MP, implementation has been particularly successful. 69.3 per cent of women having births in 2011–12 received JSY assistance (Office of the Registrar General & Census Commissioner, 2013b) and the increase in institutional births in MP since 2005 was the largest of all the high-focus EAG states (see Figure 3.8) (Office of the Registrar General & Census Commissioner, 2013d). Overall, women who lack prior knowledge of JSY are more likely to have a home birth (Sidney et al., 2012), but a vast majority of women in MP are aware of the programme (Sidney et al., 2012; UNFPA, 2009). There are indications, however, that the scheme may not be reaching the most vulnerable (Lim et al., 2010; Santhya et al., 2011b). In Lim's study (2010), uptake was highest among the middle levels of wealth and education, and among primiparous women.

Whilst acknowledging its successes, some have urged caution. Although maternal and neonatal mortality have decreased since JSY was launched, they do not appear to be straightforwardly correlated with increases in institutional birth (Lim et al., 2010; Randive et al., 2013). Low quality of care is a factor that may moderate effects (see Section 3.5 for

⁸ At 1 January 2012 exchange rate

⁹ Conditionalities associated with parity and minimum age of the mother for institutional births in high performing states and for home births in all states/union territories have been removed since the time of data collection (Ministry of Health & Family Welfare, 2013b).

discussion of quality of care). While JSY may have increased births in health facilities, this does not in itself guarantee skilled care, and ensuring an increase in supply of quality services to match the rapid increase in demand is imperative for future progress in improving maternal health (Paul et al., 2011; Randive et al., 2013; UNFPA, 2009). Some also question the focus of JSY exclusively on care for childbirth, arguing instead for a greater focus on the continuum of care from prenatal through to postpartum and neonatal care (Gopalan & Durairaj, 2012; Sri et al., 2012).

A further initiative of the NRHM was to introduce a new cadre of community health worker—the Accredited Social Health Activist (ASHA). The intention was to train a woman from every village across the country to work as an intermediary between the community and the public health system (Ministry of Health & Family Welfare, 2014a). In regards to safe motherhood, they are expected to provide health information and promote good health practices within their communities, counsel women on birth preparedness, and facilitate women's use of skilled maternity care (Ministry of Health & Family Welfare, 2014a). JSY provides a cash incentive to ASHAs for facilitating women's use of maternity care services (Santhya et al., 2011a). While ASHAs were largely instituted in rural areas, they are discussed here because local schemes to develop similar cadres of community health workers emerged in several large cities, including Indore (see Section 3.6), even before the National Urban Health Mission was launched, through efforts of externally-funded projects and local non-governmental organisations (NGOs) in collaboration with urban authorities.

3.5 Current maternal health care scenario

In view of the rapid increase in use of maternity care services in the late 2000s, the vast majority of women in MP (79.7 per cent) now have births in a health facility (see Table 3.1). A small proportion (6.2 per cent) of births are assisted by skilled health personnel outside a medical facility, but most home births are assisted by a traditional birth attendant (*dai*), family or friends. An even higher proportion of women (91.1 per cent) seek ANC, although fewer (70.7 per cent) have three or more ANC visits. 80.3 per cent also receive postnatal care, which is likely a result of the increase in institutional births since women

typically receive postnatal care before leaving hospital. Although use of maternity care services in MP is now among the highest of the high-focus EAG states, maternal and neonatal mortality remain relatively high (see Table 3.1).

Table 3.1 Health and social indicators for MP, urban MP and urban Indore, 2011–12

	Range in EAG states	MP total	MP urban	Indore urban
Care at birth				
Birth assisted by skilled health personnel (%)	51.8–85.9	85.9	93.9	96.8
Birth in a health facility (%)	40.4–79.7	79.7	89.6	92.6
Birth at government institution (%)	19.0–68.7	68.7	65.6	53.9
Birth at private institution (%)	9.3–21.4	10.9	23.8	38.4
Caesarean out of total births at government institutions (%)	3.9–11.9	4.3	7.2	10.0
Caesarean out of total births at private institutions (%)	21.1–43.4	31.2	33.2	32.4
Mothers who received JSY assistance for institutional birth (%)	36.6–85.4	85.4	72.3	51.1
Mothers who received JSY assistance for birth (%)	19.9–69.3	69.3	65.2	47.6
Antenatal care				
Mothers who received any ANC (%)	83.2–97.0	91.1	95.5	96.9
Mothers who received 3 or more ANC (%)	32.5–78.5	70.7	79.9	89.3
Mothers who had ANC in 1 st trimester (%)	46.5–70.0	70.0	80.0	86.8
Mothers who had full ANC check-up (%)	5.0–20.2	15.3	22.0	33.4
Postnatal care				
Mothers who received postnatal care within 1 week of birth (%)	62.2–83.9	80.3	90.3	94.7
Mortality indicators				
MMR (per 100,000 live births)	162–300	277	–	215 ^a
Neonatal mortality rate (per 1000 live births)	24–50	43	31	20
Other				
Currently married women aged 20–24 married before legal age (18 years) (%)	22.7–54.1	46.1	31.2	27.0
TFR	2.1–3.6	3.1	2.3	2.3 ^b
Sex ratio at birth (F/M)	866–951	904	876	856
Female literacy (%)	57.6–74.0	66.2	83.1	88.3
Male literacy (%)	77.1–90.6	84.3	93.8	94.8

All India figures are unavailable since Annual Health Surveys were carried out only in EAG states + Assam

^aFigures available for Indore division only, which includes five adjacent districts, rural and urban

^bUrban and rural

Source: Annual Health Surveys 2011–12 (Office of the Registrar General & Census Commissioner, 2013a)

Use of maternity care services is typically higher in urban areas in India. Table 3.1 shows this urban advantage in MP, along with an even greater advantage in Indore¹⁰. Aggregate figures conceal intra-urban differentials, however. Matthews et al. (2010) classify India as a country with large urban inequalities in use of maternal health care, in which the urban rich have a substantial advantage over poor and marginalised urban populations, but the urban poor nonetheless compare favourably with the rural poor. Thus, lower socioeconomic groups are likely to remain over-represented among the urban population who do not use maternity care services.

Multiple therapy frameworks coexist in India in a pluralist health landscape, from allopathic practitioners to ayurvedic, homeopathic and folk practitioners (Nichter, 1980). Shah More et al. (2009b, p.9) suggests we need ‘to conceive health systems in terms of chaotic composites of (informal and formal) private and public providers.’ Despite the intent in India on gaining independence in 1947 to build a health system fully financed and delivered within the public sector, the health system is by now among the most privatised in the world (de Costa & Johansson, 2011). Indeed, the private sector accounted for 76.7 per cent of total health expenditure incurred in India in 2004–05 (Ministry of Health & Family Welfare, 2009). The private sector is unregulated and diverse, encompassing the organised private sector, not-for-profit organisations, and the informal ‘unorganised’ sector (Shah More et al., 2009a). It comprises a range from world-class, well-resourced hospitals to unqualified providers (de Costa & Diwan, 2007). De Costa and Johansson (2011) claim that expansion of the private sector has not been deliberate in India; rather, a large and popular private sector emerged spontaneously in response to a weak public health sector.

This raises a question of how the overall system and patterns of use translate into the realm of maternal health care. The private sector is largely preferred in India to the extent that even the poor sometimes opt for its use where possible, despite the higher costs involved (Nair & Panda, 2011; Raman, 2014; Skordis-Worrall et al., 2011). In MP as a whole, the vast majority of births in a health facility (86.2 per cent) take place in government institutions (see Table 3.1), although many women seek ANC in the private sector (Office of the Registrar General & Census Commissioner, 2013b). Greater use of the

¹⁰ Indore is discussed more specifically in Section 3.6

public sector for births relative to other areas of health care may be a result of the inpatient nature of care at birth, which requires certain types of facilities and may entail high costs in the private sector. Also, cash transfers under JSY are largely provided for births in government institutions, although private institutions may also be accredited. The private sector is more prominent in provision of care at birth in urban than in rural areas, and particularly in Indore, where 38.4 per cent of births take place in private sector institutions. The density of private physicians is higher in urban areas, bolstered in part by greater economic means to pay for private care than in rural areas (de Costa et al., 2009).

Public spending as a share of total health expenditure is very low in India at 20 per cent, and is lower still in MP (Ministry of Health & Family Welfare, 2009). This means that the lion's share of 71.1 per cent of overall health expenditure is out-of-pocket, borne by households themselves. Costs of care are widely considered to be a barrier to the use of maternal health care services (Skordis-Worrall et al., 2011). Services are free at the point of care for routine and non-routine births in public hospitals. Under the Janani Shishu Suraksha Karyakaram launched in 2001, drugs, diagnostics and food are free for women and newborns up to 30 days in public hospitals and free transport is provided (Ministry of Health & Family Welfare, 2014b). In practice, this does not eliminate all charges. Some expenditure on medicines and medical supplies remain (Leone et al., 2013), and not all use the free transport scheme (Santhya et al., 2011b). Indirect costs, such as subsistence, loss of earnings for the woman and/or companion, and informal payments to hospital staff can also reach substantial amounts (Skordis-Worrall et al., 2011). Costs for maternal care in the private sector are generally higher than in the public sector, although they vary widely between hospitals and depend on complications and the type of birth (Mohanty & Srivastava, 2013).

Several studies estimate household expenditure on maternal health care in India. Skordis-Worrall et al. (2011) found that expenditure on birth represents just over a half of expenditure on maternal health care overall. Using data from the 2004 National Sample Survey, Leone et al. (2013) quantify expenditure on direct and indirect costs associated with maternal health care. Across India, they estimated expenditure on birth to be INR 1198

(approximately US\$ 26.30¹¹) at home, INR 2468 (approximately US\$ 54.10) in a public health facility, and much higher in the private sector at INR 6720 (approximately US\$ 147.40). Mohanty et al. (2013) showed a fairly similar pattern using DLHS data, and also found large differentials by type of birth, with expenditure on a caesarean birth six times higher than for a normal birth. Several studies find wide state-level variation (Leone et al., 2013; Mohanty & Srivastava, 2013).

Skordis-Worrall et al. (2011) found that expenditure increased with economic status in line with increased use of the private sector. The poorest were found to rely more heavily on wages and borrowing rather than savings to finance care (Skordis-Worrall et al., 2011). Several studies have highlighted the high prevalence of ‘catastrophic’ expenditure on maternal health care in India, whereby a household must reduce its basic expenditure to cope with health costs (Bonu et al., 2009; Skordis-Worrall et al., 2011). This can occur across wealth quintiles because households’ use of different types of care depends on their economic means (Skordis-Worrall et al., 2011). Mohanty et al. (2013) found that out-of-pocket expenditure had declined over time, which they attributed at least in part to the NRHM. However, mean expenditure is significantly higher than the cash benefit received under JSY (Leone et al., 2013; Mohanty & Srivastava, 2013).

The quality of health care available both in public and private facilities remains low overall in India, and while the availability of health services and geographical access is a lesser barrier in urban areas, this does not necessarily denote access to good quality services (Das & Hammer, 2007; Harpham & Molyneux, 2001). An assessment of the quality of maternal health care in a slum area of urban India identified numerous quality issues, including a lack of medical supplies, users being left unsupported or without a health professional in attendance, the use of inappropriate procedures that are not evidence-based and abusive interaction between service providers and users (Hulton et al., 2007). Information provided to women during pregnancy and birth is also limited and there are socioeconomic differentials in the quality of care women receive during pregnancy (Rani et al., 2008). The rapid rise in use of maternal health care services following the launch of NRHM has raised concerns that increased pressure on services may have had a negative

¹¹ Based on 1 January 2004 exchange rate

effect on service quality (Chaturvedi et al., 2014; Randive et al., 2013; Sri et al., 2012). Despite a widespread preference in India for private health care, this sector has burgeoned with little regulation or accountability. While some private hospitals offer world class care, the assumption that the private sector is always superior is not supported by the evidence (Bhate-Deosthali et al., 2011; Hulton et al., 2007). Bhate-Deosthali et al.'s (2011) study raised major concerns regarding poor standards of care in small, private maternity care facilities.

Alongside the rise in institutional births, concerns have emerged regarding over-medicalisation of birth. While the World Health Organization (WHO) now states that the optimum rate of caesarean section is unknown, they do state that very low and very high rates can be dangerous and tentatively suggest a range of 5–15 per cent to be acceptable (WHO, 2009). Leone (2014) describes India as a country with a double burden, combining under-medicalisation wherein many women do not receive the medical care they need at birth, and over-medicalisation in other settings wherein medical interventions are used beyond what is necessary for medical reasons. Several studies have noted high rates of caesarean births in some states and in the private sector in particular (Padmadas et al., 2000; Sreevidya & Sathiyasekaran, 2003), and Leone (2014) suggests that this is driven more by supply than demand. In Indore, caesarean births account for only 8.1 per cent of all births in public health facilities, but this figure rises to 32.2 per cent in private institutions (see Table 3.1). Aside from the potential risks of caesarean births, their use in non-emergency cases may entail a shift in resources towards non-essential interventions and an increase in out-of-pocket expenditure (Leone, 2014).

3.6 The field site: Indore

I set out to identify an urban field site in a state with relatively large socioeconomic inequalities in access to maternal health care, and it was crucial to identify an organisation that could facilitate my access to communities. The decision to locate data collection in Indore was based on these criteria. Indore fulfilled the first two criteria. Moreover, the Urban Health Resource Centre (UHRC), an Indian, non-profit organisation working on health issues in slum communities in Indore, agreed to assist me with access to

communities (see Section 4.3 for further detail on this arrangement). The following description of Indore is informed by a situation analysis of the city conducted in 2002 (Taneja & Agarwal, 2004), data from large-scale surveys that disaggregate for the city or district (IIPS & Macro International, 2008; Office of the Registrar General & Census Commissioner, 2013b) and other reports and official sources. These are supplemented with information collected from the field site, including field notes, informal discussions and key informant interviews (see Chapter 4 for further detail on methods).

Indore is the largest city and a major industrial and commercial centre in MP (albeit not the state capital) (Indore Municipal Corporation, 2006). Seven major urban towns and 946 villages surrounding the city have also been designated as an Indore influence region (Indore Municipal Corporation, 2006). Indore district—dominated by the city—has the highest per capita income of the state's 50 (now 51) districts (Planning Commission, 2011). Its economy is supported by manufacturing and service industries both within the city and in surrounding areas. Cotton textiles have traditionally been a major industry in Indore, but new manufacturing industries such as automobile, engineering, pharmaceutical and food processing industries are also increasingly prominent, as is software development (Indore Municipal Corporation, 2006). Along with a flourishing economy, levels of human development in Indore are higher than the state's urban average (see Table 3.1) (Office of the Registrar General & Census Commissioner, 2013b).

There is a wide income distribution in Indore, however, and a sizeable urban poor population does not benefit equally from the city's opportunities. As its traditional industries are gradually replaced by an industrial base that is largely high tech, and capital- rather than labour-intensive, employment opportunities for the unskilled and semi-skilled are limited (Indore Municipal Corporation, 2006; Taneja & Agarwal, 2004). Slums are numerous, but estimates of the size of its slum population vary widely. According to the 2001 census, only 16 per cent of Indore's population were slum dwellers (Office of the Registrar General & Census Commissioner, 2011a), but there is consensus that it is a gross underestimate (National Resource Centre, 2012). A situation analysis conducted in 2002 suggested that more than 40 per cent of the population live in slums and urban poor settlements (Taneja & Agarwal, 2004), and an Indore Municipal Corporation slum census in 2009 counted a population of 788,619—around 36 per cent of Indore's 2.17 million

population—across 592 slum settlements (National Resource Centre, 2012). Most of Indore's SC and ST population are slum residents (Indore Municipal Corporation, 2006).

Slums in Indore are diverse, varying in size, density, environment, infrastructure and employment (Agarwal & Taneja, 2005). The average slum size in MP is only 215 households (Ministry of Statistics and Programme Implementation, 2013)—somewhat smaller than might be expected from representations of slums in the media. In Indore, they include some that are established, as well as newer settlements on the roadside, in construction or industrial sites, and those on the city periphery. They often cluster together in groups, although some are single and isolated (Indore Municipal Corporation, 2006), and are largely located in low-lying areas along the canal banks, close to work places or on the periphery (National Resource Centre, 2012). They have a high population density of 33,742 persons per sq. km on average, in comparison to 12,290 per sq. km across the city as a whole (Taneja & Agarwal, 2004). However, some settlements are notably dense while others are sparse, particularly on the periphery. The built-up area is growing faster than population size in nearly all of India's largest cities, resulting in the expansion of low-density sprawl (Indian Institute for Human Settlements, 2011).

Housing in Indore's slum areas is largely in single-story, one or two room constructions, and most housing is durable (National Resource Centre, 2012). Slum residents are largely dependent on the informal sector for their livelihoods (Indore Municipal Corporation, 2006). Most engage in unskilled daily wage labour and around 20 per cent engage in semi-skilled or skilled labour (UN-Habitat, 2006). Slum-resident women are much more likely to be in the labour force than in non-slum areas (UN-Habitat, 2006).

The city is administered by the Indore Municipal Corporation; 130 of the city's 165 sq. km fall within its boundaries (Taneja & Agarwal, 2004). Such local urban bodies are given powers by the state to levy specific taxes, duties and tolls; and slum improvement, public health, sanitation, water supply and poverty alleviation all come under their remit (Taneja & Agarwal, 2004). The municipal area is divided into 12 zones and 69 wards of various sizes and populations (Indore Municipal Corporation, 2006). The administration of some peripheral slums still falls under village authorities since city expansion tends to precede administrative changes. The Indore City Development Plan 2021 is a document that sets out the Indore Municipal Corporation's plan for slum areas (Indore Municipal

Corporation, 2006). Multiple projects have aimed at slum improvement in Indore, but the city's growth has been too rapid for these projects to keep up (National Resource Centre, 2012).

A situation analysis in 2002 indicated that births in a health facility or with a skilled attendant were much lower in Indore's slum areas than in other parts of the city (Taneja & Agarwal, 2004). Moreover, not all slums were equal on health indicators. A health vulnerability assessment in Indore considered 156 of the 539 slums identified to be 'health vulnerable' based on multiple criteria, including social conditions, poverty levels, infrastructure, access to health and nutrition services, health status and the presence of community-based organisations (Taneja & Agarwal, 2004), although these may have since followed diverse trajectories. Only 31 per cent of mothers had births in a health facility in vulnerable slums in comparison to 62 per cent in less vulnerable slums (Taneja & Agarwal, 2004). Moreover, public sector agencies and NGOs were only reaching 30 per cent of the urban poor, and largely in slums that were comparatively better off (Taneja & Agarwal, 2004). Although births with a skilled attendant have increased across the city since then, intra-urban differentials in access to quality maternal health care services no doubt remain.

The maternal health system in Indore is complex and extensive. A plethora of public and private providers offers care for birth and an even wider array offers ANC and postpartum care. The public sector health system, administered by the District Health Department, is multi-tiered and organised around administrative zones and wards. A zonal officer is responsible for service delivery in each zone, supported by a doctor and an auxiliary nurse midwife for each ward (Taneja & Agarwal, 2004). Public sector health facilities include a large regional institute linked with the medical college, which functions as a tertiary referral centre serving populations far beyond the city's boundaries. Further health facilities include a district hospital that serves the district's urban and rural population, four general hospitals, two nursing homes, one maternity home, two polyclinics and 23 dispensaries (and urban family welfare centres) (Taneja & Agarwal, 2004). At the time of the study, key informants reported that public sector intrapartum care was provided only at the tertiary hospital, the district hospital and in the four general hospitals. These facilities also provided ANC with a doctor, including a range of diagnostic tests, such as ultrasound and blood tests. Polyclinics and dispensaries provide outpatient services

including some ANC and immunisation, and auxiliary nurse midwives obtain supplies from these centres for community outreach (Taneja & Agarwal, 2004). There is no public sector provision of home-based skilled birth attendance in Indore.

The national Integrated Child Development Services scheme was launched in 1975 and is a key provider of health and nutrition services for pregnant women, new mothers and children from 0–6 years (Ministry of Women & Child Development, 2014). The scheme is implemented by the Ministry of Women and Child Development, with the health component supported by the Ministry of Health and Family Welfare. Services are delivered through an extensive network of Anganwadi centres across the country, staffed by Anganwadi workers and helpers. Health-related services are delivered in association with auxiliary nurse midwives, who use the Anganwadi centres as a base for community outreach work. Services for pregnant women include provision of supplementary nutrition, immunisation against tetanus toxoid, health checks, and nutrition and health education (Ministry of Women & Child Development, 2014). A situation analysis identified 301 Anganwadi centres operating across 110 slums in Indore in 2002, but most slums were not covered (Taneja & Agarwal, 2004). Between 2002 and the time of data collection, the number of operational Anganwadi centres across India had more than doubled (Ministry of Women & Child Development, 2014), which was reflected in their expansion in Indore, but they still did not cover all slums.

Maternity care services in Indore are also offered by a multitude of private institutions. Private providers with intrapartum care facilities include a range from small maternity clinics to large private hospitals, including one linked with a medical college. Costs vary widely and do not appear to be closely correlated with size. A range of qualified and unqualified practitioners also offer intrapartum care services at home. The range of providers offering ANC is even wider. Numerous private doctors provide ANC services through home offices or other small clinics with no diagnostic facilities or facilities for intrapartum care. Some doctors working in government health facilities also practice on a private basis alongside their work in the public sector.

JSY had been operational in Indore since its launch in 2005. On paper, women falling within the urban administrative area received INR 1000 and women falling within the rural administrative area received INR 1400 for births in public sector health facilities.

In practice, key informants and households reported that the mode of payment had changed to account payee cheques in the beneficiary's name. This appears to have been prompted by a government order (Chaturvedi, 2007). Since a large proportion of young women in low-income groups did not have bank accounts and did not open one upon receipt of the cheque, they did not convert cheques into a cash amount to benefit from the scheme.

While ASHAs were instituted in rural areas, they were nonetheless active in some slums on the city periphery that remained under the administration of village authorities. In addition, a scheme to train and accredit an equivalent cadre for urban Indore, called Urban Social Health Activists (USHAs), was initiated through the collaboration of NGOs and local authorities in the late 2000s. Similar schemes had emerged in several cities prior to the launch of the National Urban Health Mission in 2013, which introduced a national scheme to expand the role of USHAs to urban areas across the country. MP state authorities had also initiated Janani Express Yojana, a scheme providing women with free, round-the-clock transport to public health facilities for childbirth.

Civil society plays a key role in the maternal and child health landscape across India. Various NGOs operate in Indore, with programmes that either directly or indirectly pertain to maternal and newborn health. Activities include implementation of health camps that may target pregnant women among others, provision of reproductive health services, health education, facilitation of self-help groups, advocacy, capacity building and slum upgrading projects (Taneja & Agarwal, 2004). Indore also has a plethora of community-based organisations operating independently or in association with NGOs, many of which emerged around savings groups (Taneja & Agarwal, 2004). UHRC received funding from USAID from 2003–2009 to implement a large maternal and child health and nutrition programme across 75 slums in Indore in partnership with government agencies, other NGOs and community-based organisations (UHRC). At the time of data collection in 2012, UHRC's work continued with a narrower geographical focus and a broader programme focus on integrated development, with community empowerment as a key principle.

3.7 Summary

The research was conducted in low-income settlements in Indore, a million-plus city in the central Indian state of MP. It was an ideal site to conduct this research because MP is one of the states prioritised by the Government of India for its poor performance on demographic and health indicators, and low-income groups have generally had poor access to maternity care services. Yet, it is also one of the front-runners among these prioritised states in effecting a remarkable increase in utilisation of skilled maternity care services over the past decade, and thus provides a window on care-seeking behaviour within this rapidly changing maternal health landscape. Indore's performance on health indicators is among the highest in the state on average, but it also has a substantial poor population who do not have equal access to health services. The diversity of providers operating in the city presents an opportunity to improve understanding of how people engage with a complex urban health system for maternity care. India's urbanisation along with rapid urban growth means that million-plus cities, already numerous, will become even more so in the coming decades. It is crucial to improve understanding of maternity care-seeking in these understudied settings.

4. Methodology

4.1 Introduction

Qualitative interviews with households about the care-seeking process for a first birth formed the major component of this research. Two distinct features of the study included a prospective design and multiple household perspectives. In each household, interviews were conducted with primiparous women and other specific household members, and these were conducted prospectively during pregnancy with a follow-up after birth. This chapter explains the methodology, connecting the study design with the research questions and health care-seeking framework. The methods of sample selection, data collection and analysis are then described, and the chapter ends with a discussion of ethical considerations and reflexivity.

4.2 Research design

The study aimed to develop understanding of care-seeking for birth, underpinned by a framework that regards health care-seeking as a dynamic process driven by social interaction (see Chapter 2). Methodological approaches must be tailored to the framework, but Pescosolido (1992) highlighted the lack of appropriate existing data for this type of framework. Although a range of approaches may provide complementary insights (Pescosolido, 1991), I opted for qualitative methods in this study for two reasons. First, qualitative methods have strengths in viewing social life in terms of processes (Bryman, 2008). I initially considered combining qualitative methods with secondary analysis of quantitative data. However, despite common references in the literature to a decision-making or care-seeking process, the large-scale, cross-sectional surveys that dominate in studies on maternity care-seeking provide limited insight into processes. Second, many concepts in the literature on maternal health are applied across LMICs with insufficient regard for the situated meanings and lived experience of care-seeking for birth in different contexts. Uncovering these nuances requires investigation of care-seeking from the perspectives of those taking decisions and actions, and a holistic, in-depth approach with

attention to the social, cultural, economic, physical and institutional context within which care-seeking takes place.

Distinct features of this qualitative study include multiple household perspectives and a prospective design. Within each household, two or three members were interviewed on two occasions: once before birth and once after birth. These features provided data tailored to answering the research questions within the health care-seeking framework described in Chapter 2. The next two subsections respectively describe the two design features and explain the rationales underpinning them.

4.2.1 Multiple household perspectives

Households in this study comprise of residential units in which a primiparous woman was staying for the period around the birth, regardless of whether this was her usual residence. In each household, individual interviews were conducted with the primiparous woman and one or two further household members selected according to criteria detailed below. The study's health care-seeking framework regards social interaction as the driver of the process of defining a health event and identifying a solution. In view of the household's central role in maternity care-seeking, the agent in Pescosolido's (1992) framework was redefined in this study as 'household members in patterned interaction with each other, with wider social ties, and with the health system' (see Chapter 2). Eliciting multiple household perspectives was thus central to the study's investigation of intra-household dynamics and household members' interactions with wider social ties.

Most quantitative and qualitative studies on maternity care-seeking across LMICs focus exclusively on women's accounts (e.g., Bedford et al., 2013; Griffiths & Stephenson, 2001; Kesterton et al., 2010; Parkhurst et al., 2006; Some et al., 2011). In view of the household's importance, however, several qualitative studies in South Asia have included interviews with husbands and mothers-in-law (e.g., Allendorf, 2012b; Mullany et al., 2005; Mumtaz & Salway, 2009; Simkhada et al., 2010). Yet, few qualitative studies—with some exceptions (e.g., Mullany, 2006)—have made analysis of the similarities and differences between multiple perspectives within each household a specific analytical strategy. Some quantitative studies on South Asia have examined matched husband and wife survey data

on household decision-making and reproductive health behaviour to determine the extent of (dis)agreement (Allendorf, 2007; Becker, 1996; Jejeebhoy, 2002; Story & Burgard, 2012). One study expanded the scope to include the mother-in-law (Kadir et al., 2003). These studies reveal a high level of discordance between couples (and other household members), and some studies have found the level of (dis)agreement itself to have implications for care outcomes (Allendorf, 2007; Story & Burgard, 2012), reinforcing the analytical value of examining multiple household perspectives.

Studies on a range of other topics from different contexts have highlighted the analytical contributions of separate qualitative interviews with more than one household member (Hertz, 1995; Milburn, 1995; O'Rourke & Germino, 2000). Stories about households can be woven out of the differing and competing accounts of individual household members (Valentine, 1999). The approach can illuminate the negotiated, and often conflictual reality of decision-making (Milburn, 1995), and it can reveal the influence of power processes (Milburn, 1995; Valentine, 1999).

This study sought to collect data from the following household members, referred to as core participants and differentiated by the type of household in which the woman resided for the birth. Core participants were limited to two or three members in each household in order to allow a sufficient sample of households within resource constraints.

- Natal household—primiparous woman, mother
- Joint marital household—primiparous woman, husband, mother-in-law
- Nuclear marital household—primiparous woman, husband

Section 4.4 discusses the rationale for the three household categories. Within these categories, criteria for core participants were based on research evidence highlighting the key role of older female household members and husbands in care-seeking for pregnancy and birth in South Asian contexts (Brunson, 2010; McPherson et al., 2010; Mumtaz & Salway, 2009; Parkhurst et al., 2006). Husbands were not included in criteria for natal family households since they typically did not accompany wives who returned to their natal households for the birth. The primiparous woman is hereafter referred to as the 'woman,' with all kinship terms used stemming from the woman. For example, 'mother,' 'mother-in-law' or 'husband' are always used in relation to the woman, unless specified otherwise.

The emergent nature of qualitative research allows researchers to take advantage of new or unforeseen sample opportunities during fieldwork (Patton, 2002). Thus, additional interviews were conducted with further members of the household or wider family—referred to as additional participants—where core participants’ accounts indicated their influential role in care-seeking for birth. For example, the maternal uncle of one woman was interviewed because she discussed his extensive involvement in care-seeking and her respect for his advice.

4.2.2 Prospective design

Two interviews were conducted with each core participant. The first interview was conducted during the woman’s third trimester of pregnancy to examine perceptions, interactions, decisions and actions towards care at birth to date. The second interview was conducted within eight weeks postpartum to investigate how these progressed through time until the birth. Qualitative studies on care-seeking for birth have typically conducted a single stage of retrospective interviews (e.g., Griffiths & Stephenson, 2001; Parkhurst et al., 2006; Sychareun et al., 2012). As Lewis (2003) states, a single stage of research is appropriate if current state is the focus and it is expected to be relatively stable, but a single stage may not be sufficient if ‘process’ is an important aspect of the research. Temporality was incorporated in the design of this study in line with the dynamic, process-oriented perspective on care-seeking. Interviews during pregnancy and after birth provided a superior platform for examining care-seeking strategies, or sequences of decisions and actions towards care at birth.

Prospective, longitudinal surveys have been used in a small number of studies on maternal health care in South Asia (e.g., Karkee et al., 2014; Matthews et al., 2005b). Limitations notwithstanding, the strength of qualitative prospective designs vis-à-vis the quantitative equivalent lies in their capacity to examine in-depth the interaction and interplay between multiple variables through time (Saldaña, 2003). To my knowledge, no study has examined care-seeking for birth in South Asia using a prospective, qualitative design. The approach has, however, been used to examine decisions for birth in high income countries (Coxon et al., 2014) and to examine a range of other phenomena linked

with pregnancy, childbirth and early motherhood across contexts (Carolan, 2003; Doherty et al., 2006; Earle, 2002; Miller, 2000; Moffat et al., 2007; Pothisiri, 2010; Vincent, 2012). For example, Moffat et al. (2007) explored prospectively women's decision-making regarding mode of delivery after a previous caesarean section in the United Kingdom (UK). Pothisiri (2010) also used a prospective design to examine patterns of continuity and change between women's intentions for postpartum care and outcomes in Thailand.

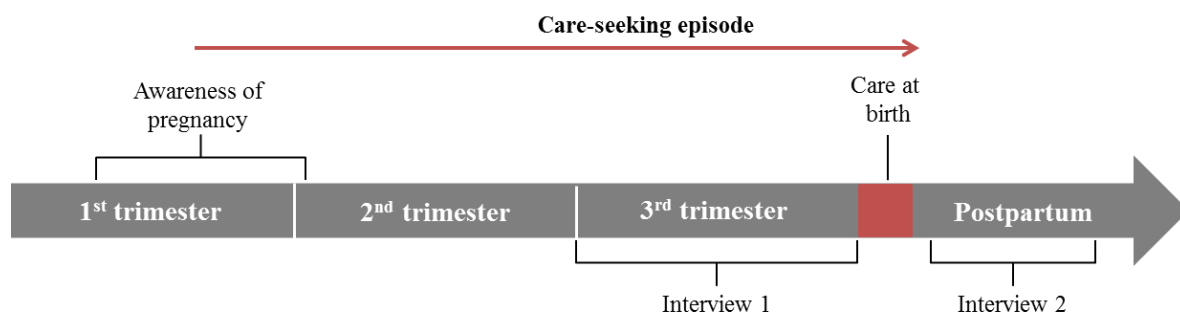
Continuity and change are a central focus of qualitative approaches that incorporate temporality (Saldaña, 2003). In this study, two stages of interviews provided a stronger foundation for examining sequences of decisions and actions from awareness of pregnancy through to the birth. Intentions may be formed and followed through to the birth in a relatively linear manner, or the opposite may be true, with one or more changes arising at any stage of the episode. Studies have already highlighted frequent switching between intentions for care at birth and outcomes due to events following the onset of labour (Matthews et al., 2005b). The methodological approach in my study sought to uncover in greater depth the interplay between sequences of decisions and actions through time on the one hand, and social interactions, the unfolding pregnancy and birth, and other contextual and intervening conditions on the other.

Figure 4.1 illustrates how the prospective design connects with the conceptualisation of care-seeking for birth as an unfolding episode that begins with awareness of pregnancy and ends with childbirth. In order to capture the whole care-seeking process, the ideal scenario would be to follow households through the entire care-seeking episode. The more feasible alternative was to conduct interviews at specific points in the episode, with the aim of building a picture of the care-seeking process, acknowledging limitations. Although several stages of interviews would have been ideal, two stages were conducted due to a combination of practical and ethical considerations.

The rationale for conducting first interviews in the third trimester was a reasonable assumption that decisions and actions are more likely to be explicit at this point than during earlier stages of pregnancy, thus increasing the potential for obtaining rich data on care-seeking strategies. The timing of first interviews was flexible within the third trimester since the month of pregnancy was often unknown to participants: some women had not received ANC, while others had attended ANC but were not given an estimated date of

delivery verbally, could not read written reports, or had been given conflicting dates by different providers. Second interviews were conducted after birth because the unpredictable nature of childbirth means that events in the latter stages are critical in understanding care at birth. The precise timing of second interviews was arranged in accordance with participants' preferences and plans as well as fieldwork logistics, but all were conducted between one and eight weeks after birth.

Figure 4.1 Prospective design



There were further advantages to conducting two stages of interviews. Retrospection raises potential problems with recall errors, distortion and post-event rationalisation (Lewis, 2003; Stanton, 2004). Longitudinal designs do not overcome all issues of retrospection since each interview may gather data on events prior to the interviews (Plumridge & Thomson, 2003; Saldaña, 2003). Certainly, both interviews in this study enquired about sequences of decisions and actions to date. Nevertheless, the issue of participants imbuing actions with a rationality they did not have at the time was minimised by a prospective design because the first interview predated the birth—the event of interest—and there was a record of what was said earlier on the same topic (Farrall, 2006). Reducing the influence of post-event rationalisation was particularly important for the primiparous women in this study, whose vantage point on childbirth was vastly different after a first experience. Recall errors were also kept to a minimum in this study because second interviews were conducted within eight weeks of the birth.

Limitations of a prospective design are acknowledged, however. One inevitable concern is the potential influence of the research process itself on the course of events, with

implications for findings. Being asked to participate in in-depth interviews is not a normal part of lives and this impact should be considered during data collection, analysis and interpretation (Thomson & Holland, 2003). In this study, potential effects arose from encouraging reflection on care options and increasing the salience of various issues through discussing issues to a depth which may not have occurred otherwise. The limitation is an unavoidable element of the design, but the interviewer used open, neutral questioning techniques to minimise its influence. Multiple household perspectives also provided a source for cross-reference and triangulation, albeit from a weak social constructionist position (see Sections 4.8.1 and 4.10). Further considerations of the prospective design are discussed in relevant sections of this chapter: the inability to sample for diversity in care at birth and the challenge of attrition in Section 4.4; the capacity to tailor second interviews to each participant in Section 4.5; and reflection on the design's implications for the researcher-participant relationship in Section 4.10.

Trade-offs between breadth and depth are inevitable in the design of any research. This applies not only to the distinction between qualitative and quantitative approaches, but also within a qualitative approach (Patton, 2002). There was a trade-off in this study between the depth to which each case (or household) could be investigated and the size of the household sample. Opting for depth with a combination of a prospective design and multiple household perspectives was fundamental to the contributions of this research. Yet, it also raised limitations—in constraining the number of cases, for example. The concluding chapter (Chapter 8) discusses in further depth the research design's implications for findings.

4.3 Fieldwork

Accessing slum communities in India as a stranger can be extremely challenging, so affiliation with an organisation with knowledge of the local context and links with communities was essential. During project planning, I approached Dr. Siddharth Agarwal, Director of UHRC, to discuss such an arrangement. UHRC is a non-profit organisation that conducts research and implements programmes to address health and nutrition needs of slum communities in Indore amongst other cities. Through their work in the city over

several years, UHRC staff members have expansive knowledge of the city's health system and low-income settlements as well as an extensive network of contacts in both. I conducted fieldwork in affiliation with UHRC. I coordinated data collection from the UHRC office in Indore. UHRC staff members were a crucial source of contextual knowledge for the research. They assisted in the development of fieldwork plans and tools, and the research benefited from their extensive experience of working and conducting research in the field site. They facilitated access to slums (*bastis*¹²) through their network of contacts (see Section 4.4), and a UHRC staff member provided research assistance for part of each week.

I was based in Indore for almost eleven months during 2011–12, a period which comprised three key phases:

1. Initial phase (September 2011–January 2012)
 - Developed further Hindi language skills
 - Developed understanding of the context
2. Preliminary phase (January–February 2012)
 - Trained research assistant
 - Piloted and refined fieldwork plans and tools
3. Main data collection phase (February–July 2012)
 - Conducted household interviews and collected supplementary contextual data
 - Conducted key informant interviews¹³

During the initial phase from September 2011 to January 2012, I focused on developing my Hindi language skills. I also used this phase as an opportunity to begin developing my understanding of the context through visits to *bastis*, informal discussions and attending a consultation organised by UHRC on health issues in the city's slum settlements, bringing together stakeholders from government, non-governmental and community-based organisations. I also took an active role in a small qualitative study on migrant adolescent girls in Indore's *bastis*, some of whom were recently married (Agarwal

¹² The term used for slum in Indore is *basti*. I gleaned that it is a more neutral term for referring to low-income, informal settlements. I hereafter use the two terms interchangeably, but I largely use 'slum' to discuss slums in a more general sense and *basti* to refer to such settlements specifically in the field site.

¹³ With the exception of one group interview conducted during the preliminary phase

& Jones, 2012; Montgomery et al., Forthcoming). While this study was completely separate from my own, it provided an excellent opportunity to reflect on and develop my own fieldwork plans.

During a short preliminary phase in January–February 2012, I focused on piloting and refining fieldwork plans and tools. I conducted a key informant group interview with female residents (n=5) from one *basti* cluster, who all worked as USHAs and were active community-based organisation members. I used the interview to seek information that would inform my research plans. In particular, I sought feedback on practical and ethical considerations of my research from an ‘insider’ perspective. I also provided training for the research assistant. After introducing the research background, aims and methods, I provided training in qualitative methods, covering topics such as principles of qualitative research, qualitative interviewing skills, and ethics. I discussed the first interview guide with the research assistant in depth, including the content of each section and question wording, and I practiced interviews with her through role play. We subsequently conducted three pilot first interviews in one household with a woman, husband and mother-in-law. This provided an opportunity both to test and practice using the research tools, following which we discussed issues and I made minor amendments to the tools. Since these amendments were minor, I did not exclude pilot interview data from the analysis (Arthur & Nazroo, 2003).

The main data collection phase took place over five months between February and July 2012. This phase involved collecting the major part of the data set, which encompassed two stages of interviews with core participants in each household as well as interviews with additional participants. The household sample and interviews are discussed further in Sections 4.4 and 4.5 respectively. During this phase, I also conducted key informant interviews (see Section 4.6) and collected supplementary data on the context (see Section 4.5).

4.3.1 Research assistant

A UHRC staff member, Shabnam Verma, provided research assistance. My developing Hindi language skills were not at a sufficiently advanced level to conduct qualitative interviews. She accompanied me to all interviews and conducted all except two interviews

under my guidance. The exceptions were two key informant interviews I conducted in English. Having one research assistant conduct all household interviews maintained consistency both across households and the two stages. Shabnam also provided support in identifying and negotiating access to *bastis* and key informants.

Shabnam was ideal for the role of research assistant for several reasons. Having worked on maternal and child health issues in *bastis* across the city, she was familiar with the topic and context, and experienced in working with the study population. She provided valuable insight in post-interview reflection sessions, drawing on her cultural and contextual knowledge. Although not previously trained in qualitative research, she had considerable experience of survey data collection and some experience of conducting focus groups. As a woman in her thirties with a child, I also considered her profile to be suitable for interviewing this study's participants. It is likely that women in this cultural context would be uncomfortable discussing childbirth with a male interviewer. For an interviewer with whom both younger and older women would feel comfortable discussing, a female located between them in age was the most appropriate. I was also advised that participants may be suspicious of the intentions of a childless interviewer.

Although having one research assistant was optimal in terms of consistency, an earlier concern was how male participants would respond to discussing pregnancy and childbirth with a female versus a male interviewer. Mumtaz (2002) employed a male research assistant to access men in Pakistan, but still found that difficulties in developing rapport with male participants led to a lack of depth. Informal discussion with others working in the Indore field site indicated potential advantages of a female interviewer because pregnancy and childbirth were not normally discussed between men. I tested the response of male participants to a female interviewer during the early stages of data collection and satisfied with the response, I proceeded with one female research assistant.

4.4 Household sample

I recruited households from low-income settlements within and on the periphery of Indore, all of which were either included among the 539 slums identified in a situation analysis of the city conducted in 2002 or were identified as slums by the relevant authorities (Taneja &

Agarwal, 2004). Eligible households were those in which a resident woman was in her third trimester of pregnancy for a first birth and intended to stay in the city for the birth. This included both marital households in Indore in which women intended to stay for the birth and natal households in Indore to which women had returned for the birth, regardless of the location of their marital households. It excluded marital households in Indore in which women intended to return to natal households outside the city for the birth.

In keeping with the logic of sampling in qualitative research, I used a purposive sampling approach to recruit information-rich cases (Patton, 2002). Due to a key focus on the ‘household’ and hypotheses in the literature of differences in care-seeking across household types (Bloom et al., 2001; Saikia & Singh, 2009), I purposively included a range of household types in which a woman might reside for the birth. I categorised households according to theoretically-relevant distinctions in the literature between marital and natal households (Dyson & Moore, 1983), and between nuclear and joint marital households (Bloom et al., 2001; Saikia & Singh, 2009). Natal households were crucial because of the custom for women to return to them for the first birth in many Indian subpopulations. Essentially, I focused on three broad categories¹⁴:

- Natal households—Households comprising natal kin to which the woman returned for the birth, regardless of composition
- Nuclear marital households—Households normally comprising the woman residing with her husband without parents-in-law or the husband’s elder siblings, and in which the woman stayed for the birth
- Joint marital households—Households normally comprising a woman co-residing with parents-in-law or the husband’s elder siblings, and in which the woman stayed for the birth

In reality, households are often more complex and dynamic than simple categorisations convey (Randall et al., 2011). For example, in the study context, mothers or mothers-in-law sometimes stayed with couples that remained in a nuclear marital household for the birth.

¹⁴ These household type categories refer exclusively to the time of birth, since birth was the focus event. Definitions of nuclear and joint marital households do not conform to standard survey definitions (IIPS & Macro International, 2007), since they were operationalised for the purposes of this study in ways that were theoretically-relevant to the topic of interest.

The above categories were thus applied for the purposes of sample selection while complexity is addressed as findings in Chapter 7.

Due to reported community-level effects on maternal health care outcomes (Kesterton et al., 2010; Stephenson & Tsui, 2002), the original aim was to select the sample from three or four slums, allowing investigation into influences on care-seeking arising from the neighbourhood. This proved unfeasible. Many *bastis* in Indore were substantially smaller than anticipated, and thus did not have a sufficient number of households in which a primiparous woman was in her third trimester of pregnancy at any one time. In some *bastis*, no eligible household was identified, and in others, only one or two households were eligible. The alternative option was to select the sample from across a larger number of *bastis*. It remained feasible nonetheless to contextualise household data at the neighbourhood level since data were collected on each *basti* in the sample (see Sections 4.5 and 4.6). The sample was eventually recruited from across 11 *bastis*, selected purposively to include diversity in factors relevant to the topic, including reported level of birth at a health facility; presence of an Anganwadi centre; and presence of an USHA or ASHA (see Section 4.4.1 for further detail).

The study sought to investigate the range of care-seeking strategies. It was known through survey reports and informal discussions in the study setting that births among *basti* residents took place in diverse locations, including at home, in public and in private institutions. A prospective design precluded the possibility of purposively selecting the sample to include a range of types of care at birth. A concern arose based on reports of intentions during earlier first interviews that I might have insufficient data on women who subsequently had a home birth. Thus, I opportunistically conducted a single stage of retrospective interviews in one additional household in which a primiparous woman had a recent home birth in a neighbourhood where a high proportion of home births were reported but no households met the eligibility criteria during the study period. Although several households in the original sample subsequently had a home birth, data from this household were included in analysis and reporting, acknowledging possible issues with data comparability.

Time is a sampling issue as well as an important context for a study (Patton, 2002). Of particular relevance to this investigation were climatic patterns in MP, which has a

monsoon weather pattern with three distinct seasons: summer (March–June), rainy (July–September) and a cool, dry winter. Births in the study took place between March and July 2012. The clustering of births over a period of a few months was inevitable since time and resource constraints did not allow data collection to extend for a whole year. The implication for findings was that potential seasonal influences on care-seeking could not be fully examined. In particular, transport links with medical facilities may become challenging during the rainy season in slums with poor infrastructure. For example, during the rainy season in 2011, a (non-sample) *basti* was observed in which access to the nearest road would have involved wading through a waterlogged drainage channel (*nala*). In this study, although all births eventually took place during a hot and dry period due to the delayed start to the rainy season in Indore in 2012, the rainy season may have been a consideration in sample households where a birth was anticipated towards the end of the data collection phase.

I recruited sample households through UHRC's wide network of contacts in *bastis* across the city, including USHAs, community-based organisation members, Anganwadi workers and NGO staff. I selected sites in discussion with UHRC staff and their contacts, in accordance with criteria described earlier in this section. To avoid the potential bias of selecting only from *bastis* in which such contacts were active, I had intended to include at least some sites that we approached independently. However, I was advised against this strategy because communities tend to distrust outsiders, which raised access issues as well as risks; a mutual, even distant, connection put potential participants at ease. To minimise potential bias, the alternative strategy I adopted was to include some *bastis* in which contacts were familiar to residents, but in which they did not actively work. In practice, these included sites nearby contacts' place of residence or work, or ones in which they had previously worked. I selected the pilot household from a *basti* in which UHRC was currently actively working; otherwise, I deliberately avoided these sites to minimise bias.

The aim was to recruit from the most complete sample frame possible for each sample *basti*. Anganwadi workers are present in most, but not all, *bastis* in Indore, and are expected to keep records of all pregnancies in their catchment area, including information on birth order and the stage of pregnancy. This was used as a starting point where possible, but I took measures to avoid potential limitations of relying exclusively on this strategy.

First, not all *bastis* in Indore have an Anganwadi centre. Second, where there are Anganwadi centres, not all women are registered and there are inaccuracies in some registers. Addressing this limitation, where USHA workers were available, we asked them to suggest any further households that might meet eligibility criteria. We also made door-to-door enquiries in some sites and/or followed-up where residents informally identified other women who were pregnant in the neighbourhood. This was a strategy through which I identified eligible participants who might otherwise have been missed. However, the possibility remains that I missed some households whose members, for various reasons, might have hidden the pregnancy.

Sample attrition is a risk in all longitudinal designs (Lewis, 2003). Within this study, potential risks included attrition of either a whole household or individual core participants within a household, of which the former would have the greatest implications. The study's short timeframe minimised this challenge since participants largely knew their likely whereabouts over the next three or four months, and the study population was not particularly mobile. Many women in this context also observe a period of postpartum confinement for more than a month following the birth, during which women—and sometimes mothers and mothers-in-law supporting them—stay at home. A greater risk in this study was the potential attrition of women moving between the marital and natal households following the birth. For example, some women stayed at their marital households in the city until the birth because of the greater availability of health services, but returned to their natal households outside the city immediately after the birth. To prevent this type of attrition, women were asked about their likely whereabouts in the postpartum period during the initial visit and second interviews were arranged to fit in with participants' plans where possible. To avoid the exclusion or attrition of women who intended to leave the city immediately after birth, I made a decision to conduct second interviews with these women by telephone (see Section 4.5 for further detail).

4.4.1 Sample summary

Table 4.1 presents a summary of interviews. I opted for a maximum sample size of 16 households for feasibility given the two stage interview design with multiple household

members. I approached a total of 20 eligible households¹⁵, of which three declined participation after full information was given (see Section 4.9). I excluded (and replaced) another household after conducting first interviews because the woman unexpectedly returned to her natal household outside the city for the birth (see Section 4.4 for eligibility criteria). There was no further attrition of a full household from the sample although I conducted only a single stage of retrospective interviews after birth in one household (see Section 4.4 for explanation). Across all other households, I conducted two stages of interviews with all except two core participants. I also conducted interviews with seven additional participants (see Section 4.2.1 for an explanation of the distinction between core and additional participants). In total, I conducted $n=77$ interviews with household participants, including 37 before birth and 40 after birth.

Table 4.2 presents data on a selection of relevant characteristics of sample *bastis* (see Section 4.5 for method of data collection). The sample was selected for diversity in levels of facility birth, presence of an Anganwadi centre, and presence of an USHA or ASHA (see Section 4.4). *Bastis* also varied in size and age, although a limitation of the sample was a lack of very new or temporary settlements. Their absence was due to difficulties in identifying and accessing these settlements. Slum formation is a dynamic process and new slums emerge continuously. Yet, there is usually a delay in updating information in official records, and these settlements may be hidden, not yet well integrated in the city, or they may exist one day and be gone the next. In new or temporary settlements, residents may face different or additional vulnerabilities in relation to care-seeking. A health vulnerability assessment of Indore's slum areas was conducted in 2002–03 (see Section 3.6) (Taneja & Agarwal, 2004). Since the relative position of slum areas appeared to have changed considerably over the ensuing decade, I abandoned initial intentions to include their assessed 'health vulnerability' as a criterion for selection, although I note this information in Table 4.2. Finally, differences in governing body are due to the continued administration of *bastis* on the periphery by rural administrative bodies; they are sometimes reclassified but this is often a slow process.

¹⁵ This number includes one household in which a single stage of retrospective interviews was conducted after birth (see Section 4.4 for explanation).

Table 4.1 Summary of interviews

Household	<i>Basti</i> ¹	Household type ²	1 st stage interview	2 nd stage interview
C1	B1	Natal	Woman	Woman Grandmother ³ <i>Additional: Maternal uncle</i>
C2	B1	Natal	Woman Mother	Woman Mother
C3	B2	Joint marital	Woman Husband Mother-in-law	Woman Husband Mother-in-law
C4	B2	Natal	Woman Mother	Woman Mother
C5	B3	Natal	Woman Mother	Woman Mother
C6	B3	Nuclear marital	Woman Husband <i>Additional: Mother</i>	Woman (t) Husband <i>Additional: Mother (t)</i>
C7	B4	Joint marital	Woman Husband Mother-in-law	Woman Husband Mother-in-law
C8	B4	Joint marital	Woman Husband Mother-in-law	Woman Husband Mother-in-law
C9	B5	Nuclear marital	Woman Husband ⁴	Woman <i>Additional: Mother-in-law</i>
C10	B6	Joint marital	Woman Husband Mother-in-law	Woman Husband Mother-in-law
C11	B7	Nuclear marital	Woman Husband <i>Additional: Mother-in-law</i>	Woman (t) Husband <i>Additional: Mother-in-law</i>
C12	B8	Natal	Woman Mother <i>Additional: Husband</i>	Woman Mother
C13	B9	Natal	Woman Mother	Woman Mother <i>Additional: Mother-in-law</i> ⁵
C14	B10	Natal	Woman Mother	Woman Mother
C15	B10	Natal	Woman Mother <i>Additional: Husband</i>	Woman Mother
C16 ⁶	B11	Natal		Woman Mother

¹ See Table 4.2 for details of *bastis*

² Household type refers to the time of birth. Core participants refer to this household. Women interviewed by telephone may have been in a different household to the core participants at the time of the second interview

³ Since the woman was staying with her natal grandparents and her mother was absent, I regarded the grandmother as the core participant. However, the birth took place before I was able to conduct a first stage interview with the grandmother as she was unavailable on three occasions when I arranged to visit

⁴ Since the husband had only one day of leave from work per month, during which he had other tasks to complete, I was unable to conduct the second interview

⁵ This mother-in-law was interviewed because she also lived in the city and retained influence on care-seeking for birth (see Chapter 7)

⁶ Single stage retrospective interviews only

(t) Telephone interview

Core participants are shown in regular font; additional participants are shown in italics

Table 4.2 Summary of sample *basti* characteristics

<i>Basti</i> ¹	Population ²	Approximate age of <i>basti</i>	Governing body ³	Reported level of facility birth	Anganwadi centre	USHA currently active	Health vulnerability assessment (2002–03) ⁴	UHRC intervention status
B1	~1000	~15–20 years	<i>Gram panchayat</i>	Low	No	No	Extremely health vulnerable	Intervention until 2009
B2	950	~25–30 years	IMC	High	Yes, complete coverage	Yes	Less health vulnerable	Intervention until 2009
B3	~1000	>40 years	IMC	Medium	Yes, complete coverage	No	Moderately health vulnerable	Intervention until 2009
B4	~600	~20 years	IMC	Very high	No ⁵	No ⁶	Not included in assessment	No intervention
B5	~240	<10 years	<i>Gram panchayat</i>	Very high	No	Yes	Less health vulnerable	No intervention
B6	>1000	>40 years	IMC	Very high	Yes, incomplete coverage	Yes	Extremely health vulnerable	Current intervention
B7	1300	~25–30 years	IMC	Medium	Yes, near complete coverage	Yes	Less health vulnerable	No intervention
B8	~6000	~10–12 years	<i>Gram panchayat</i>	Medium	Yes, incomplete coverage	Yes	Not included in assessment	No intervention
B9	~240	~10–12 years	<i>Gram panchayat</i>	Very high	No	No	Not included in assessment	No intervention
B10	>4000	>50 years	IMC	Low	Yes, incomplete coverage	No	Moderately health vulnerable	No intervention
B11	1000	~17–18 years	<i>Gram panchayat</i>	Low	Yes, complete coverage	No	Extremely health vulnerable	Intervention until 2009

Data collected from a combination of Anganwadi workers, USHAs and *basti* residents. Accuracy of some responses could not be verified.

¹ *Bastis* are not named in order to preserve participants' anonymity because in most *bastis*, few women had a first birth during the data collection period

² Mostly estimated by informant(s). Those without a preceding ~ or > sign are estimates based on official records or a survey

³ IMC – Indore Municipal Corporation. The gram panchayat is responsible for development in *bastis* that continue to fall under a rural classification.

⁴ Health vulnerability assessment of Indore's slum areas conducted in 2002–03 (see Section 3.6) (Taneja & Agarwal, 2004)

⁵ No Anganwadi centre but residents were invited to auxiliary nurse midwife outreach sessions at a nearby Anganwadi centre

⁶ USHA workers covering a nearby *basti* provided assistance if requested

Table 4.3 presents data on characteristics of sample households. Nine women had returned to natal kin households for the birth and seven remained in their marital households, of which four were joint households and three were nuclear households. Most women in the sample were recently married; only one woman had been married for more than two years. All except this one woman had conceived within the first year of marriage (see Section 3.3 for discussion of this phenomenon).

Table 4.3 Characteristics of sample households (N=16)

Characteristic	N
Household type (at time of birth)	
Natal	9
Nuclear marital	3
Joint marital	4
Time since marriage (at time of 1st interview)	
< 1 year	11
1–2 years	4
> 2 years	1
Age of woman¹	
18–20	5
20–22	11
Education of woman	
None	3
1–5 years	3
6–12 years	10
Woman's employment status	
Employed since marriage	2
No employment since marriage	14
Religion	
Hindu	14
Muslim	2
Caste grouping	
SC or ST	6
OBC	9
General caste	1

¹ Five women reported the given age to be an estimate

All women in the sample were reportedly between 18 and 22 years of age (although five women gave an estimated age since they had no official documents). Despite survey evidence indicating widespread early marriage and childbearing in MP (IIPS & Macro International, 2008), no eligible women were identified in sample *bastis* who reported their age to be less than 18 years. This may simply be due to chance. Alternatively, it might be in part a result of rapid change in age at first marriage and first birth, or misreporting—deliberate or otherwise—due perhaps to a recent political focus on preventing early marriage and childbearing in India. As expected in this population, only two women had been employed since marriage, both from the same caste (*jati*).

While six women had little or no education, ten had at least some secondary education—a higher proportion than in probability samples from recent surveys (IIPS & Macro International, 2008). Households were mostly Hindu, except two in a predominantly Muslim neighbourhood. All except one household belonged to a SC, ST or OBC.

4.5 Household interviews

I first visited households identified for potential inclusion to ascertain they met eligibility criteria, provide information on the study and seek informed consent (see Section 4.9). I made arrangements for interviews in person, by telephone or indirectly via the contact person who linked us to the household initially. Frequent rescheduling was required when participants were unexpectedly unavailable, but such visits were not wasted as they provided a useful opportunity to keep up-to-date with households' circumstances and collect data informally (Knight, 2010).

Identifying and negotiating a suitable interview setting or conditions proved a continuous challenge. Privacy, participants' comfort and convenience, and minimising distraction were priorities, but trade-offs were unavoidable. It was necessary to conduct interviews at participants' homes because most young married women's movements outside the home are very limited in this setting and few older women habitually spent time outside the neighbourhood, other than for work. Moreover, a custom of postpartum confinement is observed in a large segment of the population, whereby women largely stay within the confines of the home for more than a month after birth. Conducting interviews at home was the only feasible option and is common practice in population and health research with households (e.g., IIPS & Macro International, 2007; Simkhada et al., 2010), but this presented challenges.

Privacy is a somewhat neglected issue in the methods literature—most likely because it is an unquestioned notion in many western contexts. Yet, perceptions of privacy differ across contexts. In this study setting, where a strong sense of togetherness and interdependence binds households, the notion of privacy or private information within households was largely alien. Households can also be wary of young women interacting privately with non-household members. Moreover, overcrowding is a defining characteristic of slum areas (UN-Habitat, 2011): it is common for a large

household to live within one or two small rooms, making privacy impracticable, particularly in the hot summer months when being outside is not an option. Finally, as strangers in the neighbourhood, we attracted interest from curious neighbours, who frequently came to enquire about the purpose of our visit, hoping to join in the discussion. Several other studies in South Asia have noted similar challenges (Kaphle et al., 2013; Raman et al., 2014; Sharma et al., 2013).

Whilst others' participation was accepted in some studies on this topic (Raman et al., 2014), obtaining individual, separate household perspectives was central to this study's methodological approach (Taylor & de Vocht, 2011; Valentine, 1999). Ensuring interview privacy for young women—particularly in marital households—was also important for ethical reasons. Seeking these conditions required careful consideration, flexibility, continuous (re)negotiation, but also, at times, compromise. In general, households responded positively to the explanation that a first time mother, first time father and grandmother's experience of pregnancy and birth is different and that we wanted to hear and give time to all their different views separately. Yet, this frequently required renegotiation when someone else arrived, who was absent at the initial explanation. It was also important to balance seeking optimal interview conditions with minimising inconvenience to other household members arising from our visit.

Overall, efforts to negotiate interview conditions were fairly successful. Since there was a particular concern about both ethical and representational issues in failing to ensure privacy for young women at their marital home, I avoided compromise on interview conditions for this subgroup. In contrast, it was imperative in some instances to accept limitations of the young woman's presence (following her own interview) in her mother or mother-in-law's interview, where she could not be expected to leave the home. The authority of elder women in the household in the domain of pregnancy and childbirth means that participants to whom this applied appeared to talk openly, although potential representational implications are acknowledged.

In order to maximise convenience for household members, I invited them to decide on the sequence of interviews themselves, but it involved interviewing the woman first in most cases. Efforts were made within the first stage to conduct interviews with all participating members of a household as closely as possible in time in order to capture the same stage of pregnancy. This was usually, albeit not always, possible because many working participants—largely husbands—were available either

only on a Sunday or only one day per lunar cycle. I visited households as many times as necessary to complete all interviews, which typically entailed one to three visits for each stage of interviews.

I attended all interviews with the research assistant. Visits began with general conversation with any household members present, with the aim that participants would become comfortable with our presence before progressing to interviews. Individual qualitative interviews were conducted by the research assistant in Hindi using a semi-structured interview guide to help structure the dialogue. My developing Hindi language skills enabled me to provide prompts to the research assistant on topics to probe further—a strategy similar to that used by other researchers (e.g., Hemmings, 2007). This was selected in preference to conducting interviews with a translator (e.g., Wild et al., 2010), which has greater implications for the flow of interviews.

Interview guides were developed based on the research questions and referring to interview guides used in research on a similar topic in South Asia (Mullany et al., 2005; Parkhurst et al., 2006), obtained via personal correspondence. The original intention was to use an interview guide translated into Hindi, but this was abandoned in favour of using an English version, which allowed easier monitoring and refinement. The research assistant reported no difficulties in using the English version since the guide was mainly used as a prompt and we discussed question wording in Hindi on a regular basis. First interviews covered the care-seeking process; beliefs, attitudes and norms; social relationships and interactions; contacts with the health system and birth preparedness (see Appendix A). The first interview guide was largely the same for all participants, notwithstanding minor revisions made as the research progressed and small differences depending on perspective (i.e., woman, husband or elder female).

Second interviews covered care for birth; the care-seeking process; birth preparedness; as well as sections tailored for each individual. A master version of the second interview guide (see Appendix B) was adapted for each participant on the basis of the first interview. Wide ranging benefits of using participants' earlier interviews to tailor their subsequent interview/s have been reported by researchers using qualitative longitudinal designs and other repeat interview strategies. It provides an opportunity to seek clarification and follow-up lines of enquiry missed in the first interview (Vincent, 2012). It demonstrates that the interviewer listened and took interest (Vincent, 2012). Incorporating points raised in previous interviews also reminds participants of the way

in which they previously constructed their accounts and allows them to reflect on this (Farrall, 2006; Miller, 2000; Moffat et al., 2007), contributing to interpretations of change.

All interviews were audio recorded using an Olympus DS-40 handheld digital voice recorder. Interviews lasted between 20 minutes and 1 hour 20 minutes, with most lasting between 40 minutes and 1 hour. Interviews lasting less than 40 minutes were shorter than I had originally intended. Many of these participants reported having work to complete and this was certainly the case for some. Yet, I also felt that sitting down for a longer period reflecting on life's experiences and/or challenges was considered a lavish use of time for some in this low-income population. I opted for flexibility in this regard, particularly since the two stage interview design and multiple household perspectives invariably provided me with rich data for each case overall.

I conducted three second-stage interviews by telephone using a Beitel speaker phone, which enabled recording of the interview (see Section 4.4 for explanation). Aside from mode, the same format was followed as for interviews in person. Telephone interviews are rarely used in qualitative research, which appears to stem from concerns about quality (Novick, 2008). A review of telephone interviews by Novick (2008), however, found little evidence of data loss, distortion or compromised quality. Sturges and Hanrahan (2004) claimed that telephone interviewing successfully substituted for face-to-face interviews in their study when practical constraints made this necessary. Other studies on care-seeking for birth have used telephone interviews where this was the woman's preference (Coxon et al., 2014). Telephone interviews in this study were of satisfactory quality, and did not differ noticeably in depth or duration than interviews in person. The exception was one telephone interview cut short by a sudden interruption¹⁶. An interruption was more difficult to manage by telephone than it might have been in person. Previous contact in person during first interviews meant rapport had already been built with participants interviewed by telephone, but potential implications for rapport may be a greater consideration in research where single or first interviews are conducted by telephone.

Following the woman's first interview, I administered a brief questionnaire to obtain background information on the household, participants and the pregnancy (see Appendix C). The questionnaire took no longer than 5 minutes to administer. Questions

¹⁶ The interview duration was 35 minutes, but this would likely have been longer without the interruption.

to which answers were already known from the interview were omitted and any missing information was filled with other household members. Administering the questionnaire after the interview prevented setting a short answer pattern for the qualitative interview.

Further, I completed a *basti* background information form with a combination of residents and those working in the neighbourhood for each *basti* in the sample. The form collected data on characteristics of the *basti*, its residents and the physical environment; patterns of use of maternal health care; and details of services and organisations operating in the neighbourhood (see Appendix D). These data enabled me to contextualise the household data at a neighbourhood level.

Following each household visit, I had a reflective discussion with the research assistant. Discussions covered observations and possible interpretations of the physical and social environment; participants and others within the household; rapport during the interview; and themes arising in interviews. Discussions proved useful, not least in combining insights from the very different backgrounds we brought to the research (see Section 4.10 on reflexivity). I wrote field notes following each visit, summarising observations, reflections on discussion points with the research assistant, analytical ideas, and implications for further fieldwork plans. These provided supplementary data for analysis.

4.6 Key informant interviews

Alongside collecting household data, I conducted 12 key informant interviews with various service providers who came into contact with households during pregnancy and/or childbirth in the capacity of their paid or voluntary work. I selected the sample purposively to include a range of maternal health care providers that participants might use as well as service providers of any type based in sample *bastis*. Table 4.4 provides a summary.

Key informant interviews were subsidiary to the household data and served three main functions:

- Informed household data collection plans

A group interview with five USHAs and/or community-based organisation members conducted during the preliminary phase sought feedback on research plans, including practical and ethical considerations

- Provided data to contextualise findings

A key purpose of the key informant interviews was to obtain data on the context. In particular, they provided essential data on the health system in a setting where it is difficult to access official information on the local health system through print or online resources. Moreover, this enabled me to uncover differences between how services work on paper and in practice. With service providers based in sample *bastis*, I also collected data to supplement the *basti* background information form in order to contextualise findings at a neighbourhood level. In particular, I used key informant interviews to explore any themes or patterns that appeared distinctive to a particular *basti*.

- Provided complementary data on care-seeking for birth from key informant perspectives

Household interviews provided the main source of data on care-seeking for births. However, I also asked key informants about their observations of maternity care-seeking behaviour¹⁷ through their work or in their settings. In particular, I raised salient themes emerging from preliminary analyses of household data to elicit reflection on these themes from their perspectives. In this regard, key informant interviews served mainly to inform my thinking rather than as data that I report directly, with the exception of Sections 7.2.5 and 7.2.7 in which these data play a role because the sections focus on interactive processes within community-based social networks.

Table 4.4 Key informant interviews (N=12)

Key informant interviews	
	N
Group interview	
USHAs/Community-based organisation members (n=5)	1
Individual interviews	
Government doctor	1
Private doctor	1
Auxiliary nurse midwife	2
Anganwadi worker	3
<i>Dai</i>	1
NGO worker	1
USHA	2

¹⁷ Among households in low-income urban settlements in general, rather than the specific households participating in this research

In sum, key informant interviews contributed to the development of my research plans and informed both Chapter 3 on the study context and my developing analysis and interpretation of household data for the empirical chapters. I conducted the group interview during the preliminary phase, but I conducted all others on an on-going basis throughout the main data collection phase. I tailored interview guides to each key informant, depending on their role and work setting as well as continuously emerging findings of preliminary analyses. I attended all key informant interviews along with the research assistant, and conducted the two interviews with medical doctors in English while the research assistant conducted all others in Hindi. We conducted the interviews at a location convenient for the key informant—usually at their workplace or at the UHRC office. I sought verbal informed consent from all key informants and audio recorded all interviews.

4.7 Data preparation

All Hindi audio recordings were transcribed verbatim into Hindi and then translated into English for coding. Two English key informant interviews were transcribed directly into English. Limitations of cross-language research are acknowledged. Translation is not a neutral, objective act, involving merely technical issues (Temple & Young, 2004). It introduces a subjective, interpretive element into the preparation of data: ‘the translator always makes her mark on the research’ (Temple & Young, 2004, p.171). The identity of the translator is thus an important consideration. My original intention was to identify a research assistant who could transcribe and translate alongside conducting the interviews. However, the research assistant had other commitments that made combining all these tasks impossible, so I used a professional agency based in India for transcription and translation. Despite their technical capacity and previous experience of working with clients conducting qualitative research, their lack of involvement with data collection and the inability for engagement on choices made in the act of translation is acknowledged as a limitation (Temple & Young, 2004).

A study by Twinn (1997) found that similar categories and themes were found whether coding was done in the original language or in the English translation. Yet, subtleties in the meaning of local dialogues can be lost or difficult to convey when qualitative data are translated into English (Simkhada et al., 2010). Words, metaphors

and phrases may have no exact equivalent in English or they may seem to have English equivalents, which actually have subtly different meanings (Hemmings, 2007; Twinn, 1997). In this study, I read early transcriptions and translations, and discussed issues with the agency. Before coding, I took a thorough but pragmatic approach to quality assurance of transcriptions and translations, in which meaning was the key criterion. I listened to a 5-minute section from the Hindi audio recording for each interview, cross-checking with the transcription, and then cross-checked with the same segment of the English translation. I used the criteria below to identify problematic transcriptions or translations that required further action:

- High or fair quality (limited issues, which largely do not change meaning) → No action required
- Low quality (frequent and/or major issues that change meaning) → Check and revise whole transcription, with the assistance of a fluent speaker where necessary and/or send for retranslation

Three translations fell into the latter category: two were re-translated and I revised the other with the assistance of a fluent speaker. In addition, I read through all translations with the Hindi transcription open for comparison and, where necessary, clarification. I also kept the Hindi transcription open whilst coding. Where subtleties in local words or phrases appeared conceptually salient or emerged repetitively in the data, I noted and discussed them with a native speaker.

4.8 Analysis

I imported all data into QSR International's NVivo 10 qualitative data analysis software (2012), including household interview translations, household background information forms, *basti* background information forms and key informant interview translations.

4.8.1 Case analyses of household data

Analysis comprised of both within-case analysis and cross-case analysis. When both are conducted, the initial focus should be on thoroughly analysing each individual case, following which cross-case analysis can be conducted to search for patterns and themes that cut across cases (Patton, 2002). Within-case analysis involved coding and analysis

of all data relevant to each case (care-seeking episode) in turn, including first and second interviews with each household participant; household background information; field notes concerning the household; and data on the relevant *basti* from the background information form and, if relevant, key informant interviews. Following the steps described below, I analysed each case and wrote up a case summary before moving on to the next case.

I initially coded all data for each case descriptively, providing an organisational grasp of the data as essential groundwork for further stages of analysis and interpretation (Saldaña, 2009). Coding the data by topic in the first instance was essential in this study to enable comparison of accounts on the same topic for individuals across time and from different household perspectives. I developed the coding system through an iterative process. First, I selected a sample of eight household interviews purposively to use for developing the system. I selected the sample for diversity in household type, household role, interview stage, location of care at birth and level of continuity or change in care-seeking strategies. Having read these eight interview transcripts once for an overview of issues raised, I drafted a coding system based on this preliminary reading as well as issues identified in the literature on the topic and addressed in the research questions (Ritchie & Spencer, 1994). The draft underwent several iterations as it was tested on the sample of interviews, revised and re-tested until the point I was satisfied that it captured the scope of the data. I coded household background information forms, key informant interviews and *basti* background information forms using the same coding system, but I added further codes for the contextual information only covered in these data. Appendix E presents a list of descriptive codes.

I extracted coded data from NVivo 10 software (QSR International, 2012) for further analysis. I transferred summaries of all coded household data points for each case into a set of matrices (see Appendix F for template). Matrices corresponded with the descriptive coding system in structure and content, with matrices representing categories, and columns representing (subcategories of) descriptive codes. Each household interview was represented by a single row, so there were typically 4 or 6 rows for 2 or 3 core participants respectively as well as further rows for additional participants. This allowed comparison across interview stages and multiple household perspectives. The matrices provided a distilled but comprehensive summary of data for

each case, keeping close to the language of the original translation at this stage (Ritchie et al., 2003). I numbered turns in the dialogue in the raw data and entered these with the corresponding summary in the matrices to facilitate movement back and forth between the raw data and analysis.

The next step entailed thematic analysis. Within the matrices, I attached a thematic label to all dimensions of the summarised information in the column adjacent to each cell (Ritchie et al., 2003). This step marked the beginning of abstraction from the original data and the search for patterns. It provided the foundation for further within-case analyses as well as the later stage of cross-case analysis. Subsequent steps described below included further analytical methods that reflected the study's dynamic, social process orientation to health care-seeking, and used to its potential the corresponding prospective design with multiple household perspectives. I tailored these methods specifically for the purposes of this study, drawing on strategies described in the literature.

To examine how social context—particularly relationships and interaction—shape care-seeking, I first developed a summary of the social context of care-seeking which drew on the range of coded case data, including household interviews, household background information forms, relevant key informant interviews and *basti* background information forms (see Appendix G, Table 1a for template). Second, I coded actors in the matrices using a colour scheme to represent the woman, husband, natal household members, marital household members and others. This supplemented specific descriptive and thematic coding of social relationships in the matrices. Third, I analysed the multiple household perspectives. The aim of analysis was not simply to aggregate data from each household perspective to present one 'valid' story, which would conflict with the study's weak social constructionist position (see Section 4.10). Rather, the analytical process was designed to identify, describe and interpret similarities and differences in household constructions (e.g., Perlesz & Lindsay, 2003; Warin et al., 2007). As Perlesz and Lindsay (2003) note, this type of research too often falls into the trap of aggregating linked data in a way that conflicts with the ontological and epistemological foundations of the research.

Nevertheless, there is little guidance in the literature on methods of conducting analysis of multiple household perspectives (Ribbens Mccarthy et al., 2010). I designed a tool for this purpose comprised of a table with columns representing matrices, and

rows to elicit similarities and differences between perspectives on care-seeking for birth as well as their interpretation (see Appendix G, Table 1b for template). One similarity, for example, might be a woman and her mother both expressing a preference for birth at home. A difference might be in the strength or certainty of the intention: for example, the mother might express unwavering intent for a home birth while the woman might be more ambivalent. Alternatively, they might express different reasons for wanting a home birth: the woman might highlight fear of disrespectful treatment by hospital staff while the mother emphasises economic barriers. I analysed similarities and differences by reading repetitively across household perspectives within each column of the matrices. A final row provided space to reflect on potential influences and interpretations of these patterns.

The separation of first and second interview data for each core participant into individual rows in the matrices provided a foundation for analysis of constructions through time. To examine temporality in care-seeking for birth, I used a combination of two analytical methods that I again tailored for this study. First, to understand the ‘process’ of care-seeking, I chronologically assembled decisions, actions, interactions as well as unfolding circumstances contained within the matrices (Corbin & Strauss, 2008; Saldaña, 2003, 2009). I assembled them in a table with three columns representing the pre-pregnancy¹⁸, pregnancy and perinatal periods respectively (see Appendix G, Table 2a for template). Second, to investigate continuity and change in the care-seeking process in greater depth, I adapted a tool used by Saldaña (2003) for analysing longitudinal qualitative data (See Appendix G, Table 2b for template). A set of descriptive questions concerning continuity and change sought to elicit systematic answers from the household data and Appendix G, Table 2a for each case:

- What increases or emerges through time?
- What is cumulative through time?
- What kinds of significant events occur through time?
- What decreases or ceases through time?
- What remains constant or uneventful through time?
- What is idiosyncratic through time?
- What is missing through time?

¹⁸ Pre-pregnancy here referred largely to experiences before the pregnancy episode that were reported to have a key influence on care-seeking.

Answers provided the foundation for answering further analytic and interpretive questions regarding inter-relationships between observations and the factors influencing continuity or change.

Finally, I prepared a summary of each case drawing on all the case data and analyses described, before moving on to the next case. The aim in these case summaries was to tie together the various threads to present a brief, but holistic, narrative of the care-seeking episode. These case summaries began with thick description, but became increasingly interpretive as the analysis progressed. After completing all cases individually, I brought all the within-case analyses together to consider emergent themes and patterns across cases.

Figure 4.2 Process of analysis

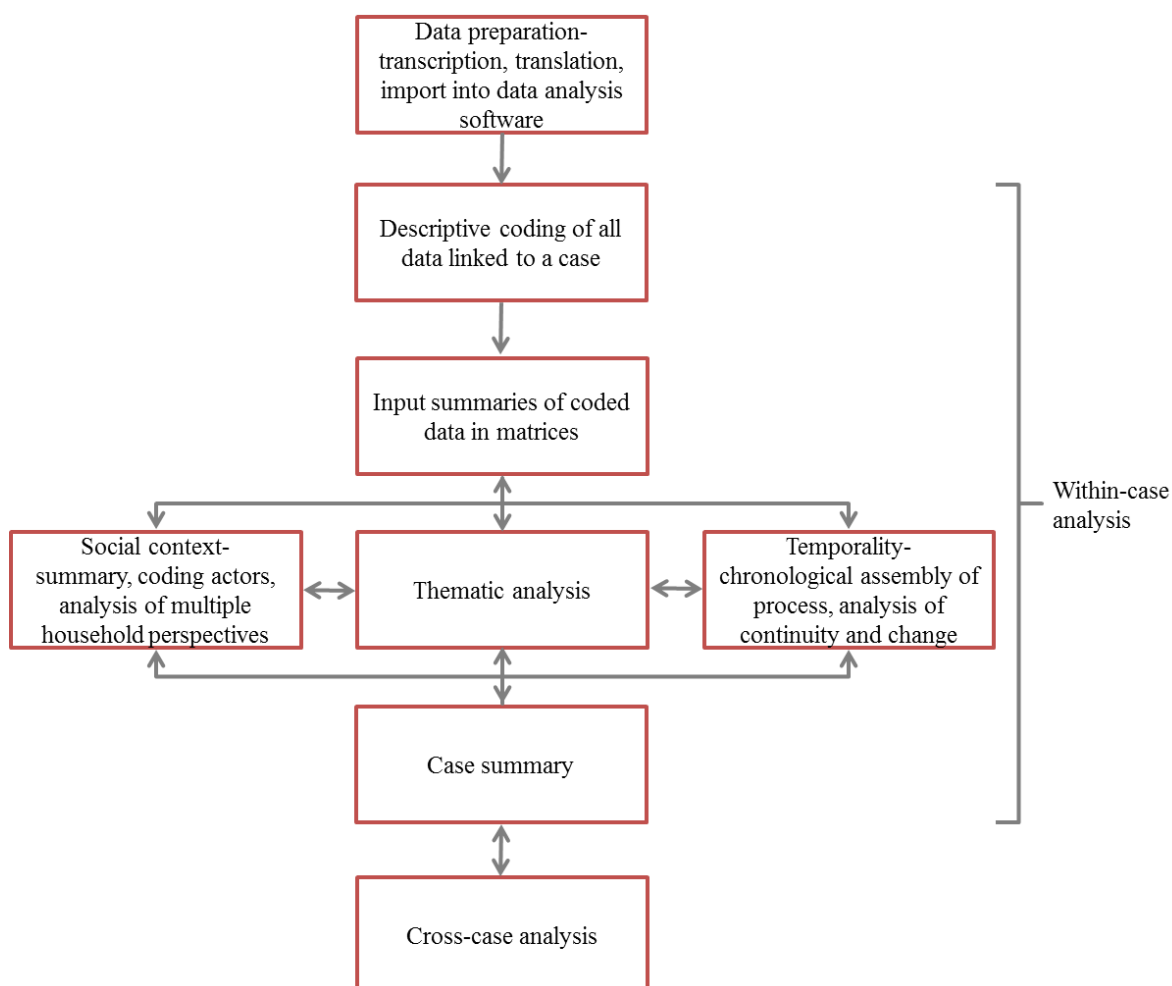


Figure 4.2 illustrates the process of analysis. The actual process was more iterative than the simplified linear process described. For example, insights gained from

one element of the analysis informed other elements, and often led to a review of previous elements of the case analysis. I also wrote notes on themes and patterns as coding and analysis proceeded, so this was not a discrete step. Similarly, cross-case analysis was a cumulative task that proceeded alongside within-case analysis, although it took centre stage only towards the end of the process.

4.8.2 Analysis of key informant data

I coded key informant interviews with the same coding system as household data, albeit with additional codes for the contextual information covered in these data (see Appendix E). To summarise analyses of key informant interviews, I coded interviews with community-based key informants linked to sample *bastis* as part of within-case analyses (see Section 4.8.1) and they contributed to analyses of the social context of care-seeking for some cases. I coded all remaining key informant interviews—those not linked to a specific sample *basti*—after completing the case analyses. Aside from the contributions discussed in Section 4.8.1 to examining the social context of care-seeking for specific cases, key informant data were coded descriptively but did not undergo further stages of analysis. Rather, I read coded key informant data on the maternal health care context and care-seeking behaviour in the latter stages of analysis and during the writing-up process and they informed my developing analysis and interpretations.

4.9 Ethical considerations

I obtained ethical approval for the study from the London School of Economics, in accordance with its research ethics policy. I conducted the research in affiliation with UHRC, a non-profit organisation that conducts research and programmes on health in Indore—and in other cities—in collaboration with Indore’s Department of Health and Family Welfare. Because the research was approved by the London School of Economics and was being conducted under the auspices of UHRC, advice I received in country was that affiliation with a local academic institution specifically for ethical approval was not needed. I discussed ethical considerations of my research plans and tools with staff at UHRC, who regularly conduct research on maternal and child health in Indore’s slum areas. In addition, I discussed ethical considerations with a group of

female *basti* residents who worked as USHAs and were members of community-based organisations (see Sections 4.3 and 4.6).

I sought verbal informed consent from all participants. Due to low literacy levels in this context, information on the study was given verbally and consent to participate was sought verbally. This is common practice in studies on a similar topic with poor populations in LMICs (e.g., Shah More et al., 2011; Simkhada et al., 2010). We gave information to all present in the household during the initial visit and sought consent from a household member with authority (e.g., head of household, mother, mother-in-law or husband). In view of the cultural context, if the husband, parents or parents-in-law were absent during the initial visit, we invited the woman to discuss participation with other household members before confirming. Informed consent was also sought individually from each potential participant. We gave explanations to each participant of who we were; the nature of the research; what participation entailed; as well as audio recording, confidentiality and voluntary participation. This was presented in a conversational manner, encouraging dialogue. In particular, it was crucial to explain in a more concrete way abstract concepts such as ‘confidentiality’ and ‘anonymity’ that might be taken-for-granted in (some) western settings, in order to ensure that consent really was informed.

Ethical considerations in this study centred on conducting research with young, recently-married women whose low status, particularly in their marital homes, made them a vulnerable subgroup. To begin, informed consent with young women who typically have little decision-making authority required sensitive judgement that went beyond what was verbally conveyed. In one household, for example, the husband consented to participate, and while the woman concurred with him, her non-verbal communication conveyed discontent. I made a decision to interpret this as non-consent. Three households declined participation largely on the woman’s wishes. It may be that young women’s vulnerability makes them particularly cautious of situations they feel might compromise their position.

I also decided to exclude any households in which there were concerns—at the outset or arising during the research process—that participation may compromise the woman’s position in her household (e.g., Brunson, 2010). Signs or disclosure of abuse within the participating household was a major potential issue, although this situation was not encountered. Discussion with key informants also indicated that marital

families might not permit us to talk with the woman in private and I had decided to exclude any such household, but the situation did not arise. The large proportion of women in the sample staying in natal households for the birth may partially explain the absence of such encounters. I also discuss in Chapter 7 how marital households in which women stay for a first birth may be self-selecting in ways that are biased towards positive relationships. Further, households may have been put at ease because we wanted to discuss with several household members, not only the woman.

A further ethical consideration given the topic was how to deal with substantial risks of maternal and neonatal mortality and morbidity in slum contexts. I had decided in advance not to proceed with second interviews in households that experienced a stillbirth, or maternal or infant death following the first interview. Fortunately, there were no such outcomes in the sample. A situation that did arise, however, was that infants in two households appeared malnourished when we visited for the second interview. I judged that we had an ethical obligation to raise this as a concern and to advise households to consult a medical professional, which had already been done in both cases. I also decided that failing to mention specific concerns relating to feeding practices observed in these households would be unethical—particularly since this was an element of the research assistant's normal work.

An anticipated potential situation in which households expressed a wish to access maternal health care but did not have the means to do so did not arise because government services, free at the point of care, are widely available in this urban setting and were known to all participating households, even if not used. Due to the nature of the interview, however, we did encounter requests for advice on which (type of) provider or health facility to use for birth. In such situations, we provided details of sources of information and advice in the local area, such as an Anganwadi worker or USHA. Whilst we were concerned not to overstep our role as researchers with sample households and avoided initiating an advisory role, we did respond to requests for factual information within the domain of the research assistant's normal work at the end of the interview (e.g., how to access a benefit or entitlement).

Steps were taken to ensure confidentiality and anonymity for participants. Digital recordings and transcripts were assigned a code and stored securely with password protection. Names and contact details were stored securely, separately from the recordings and transcripts. The agency employed for transcription and translation

services have confidentiality procedures in place for all clients, and signed an additional confidentiality agreement for their work on this study. For anonymity, I do not name or provide information in this thesis by which households or sample *bastis* could be identified.

I offered a small gift to participants after the interview to thank them for their participation and as a compensation for their time. We did not make participants aware of this in advance to avoid providing a material incentive to participate for these low-income households. Examples of small gifts given following first interviews include soap, a toothbrush or toothpaste. After the second stage interviews, a small gift was left with households for the newborn baby, such as baby soap, lotion and powder.

4.10 Reflexivity

My research is conducted from a weak social constructionist position, which accepts the notion of an objective social reality, but considers it only possible to know through people's representations (Lupton, 1999). Representations are constructed through value systems. My research seeks to interpret these representations, which provide a window on reality and have implications for maternity care-seeking. The position is similar to that referred to by others as 'subtle' or 'critical' realist (Hammersley, 1992; Snape & Spencer, 2003). Given my stance, I was concerned with the validity of my interpretations (Hammersley, 1992; Snape & Spencer, 2003). From a weak constructionist position, however, I purport to present my interpretation of participant constructions, derived through research in which I strived for rigour and transparency; I do not equate this with representing an objective reality. Acknowledging that the findings are a co-construction produced through the act of research, this section reflects on the implications for findings of my own presence and subjectivity, as well as those of the research assistant and participants.

Given that this is a piece of social policy research, by nature often motivated by social problems, I frequently reflected on what I conceived as 'problems' in my research and on what basis. I concluded that these encompassed problems as defined by medical experts, international policy-makers and researchers; problems as defined by the research participants; and problems that I perceived based on my own assumptions. A policy problem—in this case, poor maternal health indicators—provided the motivation

for this research. Problems as defined in the research and policy literature on global maternal health care thus influenced the research from its inception, while problems as defined by the research participants in this site were those that I uncovered via the data. They overlapped in some places and conflicted in others. As I make clear in Chapter 5, I avoid the position that scientific-medical knowledge is objective or ‘rational’ in contrast to subjective or ‘irrational’ local knowledge; I conceive them both as constructions that are the product of different types of value systems. I seek to represent participants’ perceptions of maternal health, health care and decision-making patterns without judgement in the findings sections and discuss them in relation to expert knowledge and policy debates in the discussion sections.

I also sought to reflect on what I brought to the research in terms of thinking through ‘problems,’ aside from these categories. Although childless and not influenced by personal experience of childbirth and maternal health care, I am nonetheless immersed in a social context largely influenced by British public discourses surrounding pregnancy and childbirth. This is perhaps best characterised as a context where a medical model of childbirth is dominant, but there has been increasing focus both within the National Health Service and in some popular—certainly white, middle-class—discourses on promoting a social model of childbirth. I strived during the research to question and reflect on the basis of my assumptions, and how they mesh both with participants’ and (my understanding of) expert perspectives. To give one example that I assessed to be derived solely from my own assumptions, several women reported that they travelled to hospital following the onset of labour on a motorcycle. Not one participant presented this as a problem; indeed, low-income groups in this setting might feel fortunate to have this option available to them. I am also not aware of any evidence on this from a scientific-medical perspective, but my reaction was to perceive it as a problem or a risk, particularly given the poor road infrastructure within many *bastis*. This—no doubt—is influenced by my own sociocultural context where this would be regarded as unsafe and inappropriate.

I came to the research as an ‘outsider,’ albeit with a fair amount of previous experience (two years) living in an Indian city, working in non-profit organisations. In contrast, the research assistant was an ‘insider’ in some respects and an ‘outsider’ in others. She was relatively local, shared many elements of cultural background and had worked in Indore’s *bastis* for a number of years. Yet, she was also more educated than

most participants and belonged to a different socioeconomic stratum. The post-interview discussions I had with the research assistant were invaluable. Similarities and differences in our representations of the same interview were a source of material for my reflections on the way in which my own positionality as an ‘outsider,’ and hers, affected the research.

But how did participants perceive us as researchers? Certainly, the way in which we were introduced to households is noteworthy in this regard. UHRC’s *basti*-based contacts facilitated our access to communities and households. These gate-keepers proved invaluable in neighbourhoods where there is a tendency to distrust strangers and where it takes time for new workers entering the setting to become accepted. The trusted position of our contacts in many communities appeared to assure households that we as researchers were worthy of their trust. As such, it is likely that we received a more open reception from the outset than we would otherwise have had. In particular, this might have influenced households’ willingness to allow us to speak with young women, who are often ‘shielded’ from strangers.

As one of very few foreigners passing through this city, I was a focus of interest for some time, but this seemed to ebb fairly quickly, particularly since the language barrier placed me at the periphery of interaction during household visits. We made the participants aware that the research assistant worked for a non-profit organisation carrying out social work in *bastis* in the city, and that in this instance she was helping me with my research. Alongside the trust afforded us through our links with the mutual contact, it is likely that participants perceived us as ‘outsiders,’ who may be on-side but still had some ‘official’ identity. In this regard, despite efforts to remain neutral in interviews, it is possible that participants assumed that we would support ‘modern’ medical care for birth, which could have influenced how they represented their strategies (Scott et al., 2014). Participants nonetheless appeared fairly open about intentions for a home birth as I discuss in Chapter 5. I also gleaned that households sought to represent their behaviour towards the woman in a positive light. I looked at data beyond an individual’s narrative to assess these claims, of course, but they provided valuable insight into how ideals are constructed regardless of their closeness to ‘reality’ (see Chapter 7).

Participants had little or no previous exposure to research, and the experience of strangers coming to the house to ask in depth about their lives and views was certainly

unfamiliar. It was important to put people at ease and develop trust, which required flexibility. We respected people's time and space, which at times involved steps such as discontinuing an interview and returning on another day if necessary. We also spent time talking with participants and their households informally before or after interviews, which sometimes involved giving basic information about ourselves. In a longitudinal design, the researcher also becomes less of a stranger as the study progresses (Miller, 2000; Vincent, 2012). This was particularly the case in this study because we interviewed not only one, but two or three household members, sometimes requiring several household visits. Participants appeared to be more at ease with us and the research process in the second stage of interviews, and accordingly discussed more openly and in more depth.

This applied to young women, in particular. Older women by and large appeared comfortable with expressing their views openly from the outset. While several young women enthusiastically discussed their experiences and views, some were more reserved. Four first interviews (including two in natal and two in marital households) stand out as such. These were more challenging interviews: the women required much prompting because responses tended to be short, and they appeared to be shy and somewhat guarded. Second interviews with two of these women were very different: they appeared more at ease and spoke much more openly and in depth than in first interviews. Alongside increased familiarity with the research process and with us as researchers, women appeared more confident in discussing childbirth after a first experience (see Chapter 7). Moreover, childbirth may bring excitement that is motivating to discuss after the event has passed with a positive outcome. However, the other two women were similar in both interviews. Household members spontaneously described these women as quiet more generally. For example, some described hospitals insisting that women see the doctor alone during ANC visits, but the woman would not speak to the doctor. This may arise from a combination of cultural norms, limited experience of interaction with strangers (see Chapter 7) and young women's vulnerability leading to cautiousness.

Finally, I pondered for some time the question of how to refer to the household members I interviewed. Did I refer to them as respondents, informants or participants? I felt 'respondents' evoked the question-answer format of a questionnaire, which did not adequately capture the nature of this study's data. 'Informants' had an impersonal air. I

settled for 'participant' on the basis that the interviewees took part in my research, acknowledging the imperfection of this term also.

4.11 Summary

The study employed a prospective, qualitative design with multiple household perspectives. In-depth individual interviews (n=77) were conducted in households (n=16) in Indore in which a primiparous woman was staying for the birth. In each household, matched data were collected for women, husbands, mothers and/or mothers-in-law, depending on household composition at the time of the birth. Interviews were conducted prospectively in the third trimester of pregnancy with a follow-up after birth. These features were designed specifically in response to the goal of answering the research questions with a dynamic, social process orientation towards health care-seeking. I developed methods and tools for further analysis—building on the thematic analysis—to use these innovative features of the design to their potential. I also conducted key informant interviews (n=12) and collected supplementary data, largely with the aim of understanding the context of care-seeking for birth.

5. Perceptions of Childbirth and Care for Birth

The centrality of risk

5.1 Introduction

This chapter addresses how childbirth and care for birth are perceived, and with what connections to inclinations¹⁹ towards the different types of care available for birth in Indore. Perceptions refer to constructed knowledge, beliefs and attitudes, which are a product of social interaction (see Section 2.6). Perceptions and inclinations provide the foundation for decisions and actions, but they do not equate with actual care-seeking strategies (discussed in Chapter 6) in the framework. The remainder of Section 5.1 introduces key literatures on which the analysis draws, with a focus in particular on the concept of ‘risk,’ before the findings are developed in Section 5.2.

5.1.1 *The centrality of risk*

Households in this study demonstrated knowledge of the range of care options available for birth in the city. Yet, they were inclined towards (and eventually used) different types of care. Some were more inclined towards birth at home assisted by a *dai* or family member, some towards various types of public hospitals and others towards private health facilities. Chapter 1 reviewed the qualitative literature on perceptions of care for birth in India. The literature focuses on reasons for non-use of skilled maternity care and highlights economic and geographical access barriers, strong cultural norms of home birth, differences between lay constructions and biomedical discourse on risk, and perceived low quality of maternity care services. The literature also suggests that maternity care in private health facilities is regarded as superior to care in public health facilities, but is unaffordable to a large segment of the population.

In this urban setting, where a range of care options are available to a population that has access both to public and increasingly to private forms of transport, geographical barriers were not a prominent theme in narratives²⁰. Economic considerations were a more prominent theme for this low-income population, especially

¹⁹ See Section 1.3 for an explanation of the term ‘inclination.’

²⁰ Some participants reported better physical access to be the reason for the woman being in the city for the birth, rather than at a natal or marital household outside the city.

in regards to inclinations towards public versus private sector care. Yet, they played a secondary role in narratives to themes linked with how to achieve a ‘good’ birth outcome, as participants themselves defined this. Indeed, several participants—women, husbands and elder females—explicitly downplayed economic considerations relative to perceptions of how birth is best managed. Further, with women unable to convert their JSY cheques into cash (see Section 3.6), this scheme was not reported as an incentive to use health facilities²¹. Economic considerations essentially formed part of the context that participants negotiated to reach care goals.

Birth is not only a physiological event, but also a social event (MacKenzie Bryers & van Teijlingen, 2010). It is imbued with meanings that affect perceptions of how it is best managed. Perceptions of risk and its management are fundamental to decisions on care during pregnancy and childbirth (Miller & Shriver, 2012). When data were collected for a study on care-seeking for birth in rural South India in 1996, women expressed their preference for a home birth partly in terms of a perception that birth is a normal phenomenon that does not require medical management in an institutional setting (Matthews et al., 2001; Matthews et al., 2005b). A close reading of the data collected in this study 16 years later in an urban Indian context highlighted considerable fear and anxiety regarding perceived risks of pregnancy and childbirth, and active attempts to manage them were central to participants’ narratives on care for birth. Inclinations towards different types of care reflected variation in constructions of how to minimise risks to the life and health of the woman and baby as well as other potential negative consequences they associated with childbirth—albeit within specific contexts of resources and constraints. This finding inductively guided the framing of this chapter’s analysis around the concept of ‘risk.’

The analysis draws on sociocultural concepts and theories of risk as well as insights from empirical research on risk and childbirth. A fairly substantial body of empirical literature has examined lay perceptions of risk in pregnancy and childbirth along with responses to them in western contexts (Coxon et al., 2014; Lindgren et al., 2010; Mitchell & McClean, 2014). Fewer studies investigate risk perceptions specifically as a foundation for understanding sociocultural influences on care-seeking for birth (Kaphle et al., 2013; Miller & Shriver, 2012). Such studies have been

²¹ Of course, this thesis examines participants’ constructions and cannot say whether or not JSY did impact behaviour. Section 3.4 describes studies which have sought to evaluate the scheme’s impact.

especially limited in LMICs (Eckermann, 2006; Obermeyer, 2000b; Smith-Oka, 2012) and, to the best of my knowledge, there has been no study of this kind on India, although there are several relevant studies that inform the analysis (Chatterjee & Fernandes, 2014; Sharma et al., 2013; Van Hollen, 2003).

5.1.2 Sociocultural perspectives on risk

According to Jaeger et al. (2001, p.17), an ontological risk is ‘a situation or event in which something of human value (including humans themselves) has been put at stake and where the outcome is uncertain.’ From a technical-scientific perspective, risk refers to the knowable probability of a specific outcome, along with the value of potential losses or gains. This perspective holds that experts can identify and manage objective risks through calculations of probability (Lupton, 1999). It is intrinsic to a biomedical framework for managing pregnancy and birth. Experts seek to establish causal relationships between various behaviours, such as care-seeking, and maternal or newborn outcomes, in order to advocate the ‘safest’ practices. In many contexts, this expert knowledge is central to societies’ constructions of risk, mediated through mass communication and embedded within institutions, including the formal health system (Lupton, 1999). The technical-scientific perspective is underpinned by an individual rational actor philosophy in which expert knowledge is regarded as objective and neutral, positioned in contrast to the subjective knowledge of lay people. Such a distinction gives rise to a view of lay people’s deviation from expert wisdom as ‘irrational’ (Zinn, 2008).

From this study’s weak constructionist position (see Section 4.10), an objective reality of risks associated with childbirth is considered to exist, but is impossible to know because risk knowledge is mediated through social and cultural processes. Perception of risk is essentially an epistemological, rather than ontological entity (Jaeger, 2001). Humans process experiences and information about the world embedded in social, cultural, political and historical contexts that lead them to perceive and prioritise some risks but not others, and act on them in different ways (Bailey & Hutter, 2006; Lupton, 1999). As Miller and Shriver (2012) state in relation to childbirth, women in different societies act in ways they believe will maximise safety and minimise risk, but they do so within a specific context that shapes their perceptions and

responses. From this perspective, biomedical knowledge is regarded as one type of risk rationality, rather than a representation of objective reality. Expert and lay perceptions of risk are a product of social interaction, and vary because they are mediated through value systems with different assumptions and concerns (Douglas, 1992).

‘Risk society’ is a term coined to refer to the conditions of late modernity (Beck & Ritter, 1992). It is argued that risk has pervaded public consciousness in western societies in the contemporary era to the extent that it has become a central concept of human existence, and its active management a key objective of daily life (Beck & Ritter, 1992; Beck et al., 2000; Giddens, 1991). Whether or not objective risks have increased, the process of modernisation has unleashed a greater sense of uncertainty and anxiety about threats (Beck & Ritter, 1992; Giddens, 1990). The notion that risks are calculable and under human control signifies a shift from pre-modern societies, in which threats were more likely to be attributed to supernatural causes or fate (Giddens, 1990; Jaeger, 2001). This shift took place alongside scientific advancement and the emergence of ideas of rational thinking during the period of enlightenment (Lupton, 1999).

Increasing focus on risk is also linked with the process of individualisation, in which the traditional institutions that structure people’s decisions and behaviour weaken (Lupton, 2012). This process brings human agency to the fore. People are expected to take personal responsibility for the decisions they make, and means that they may also be blamed by themselves or others for choices that lead to negative outcomes (Lupton, 1999). Whereas decisions in earlier eras were underpinned by local knowledge and tradition, the individualisation of modern societies requires continuous reflexivity. This entails active and critical responses to conditions that lead to fear and anxiety through negotiation of risk discourses and constant monitoring of action and its contexts, including increasing questioning of expert knowledge (Lupton, 1999). ‘Trust’ is a key dimension of these theories since the shift towards a risk society entails increasing contact with abstract systems (Beck & Ritter, 1992; Giddens, 1991).

5.1.3 Risk and childbirth

Alongside the increasing pervasiveness of risk discourse in western contexts during the Twentieth Century, there was a shift from a social to a medical model of childbirth

(MacKenzie Bryers & van Teijlingen, 2010), with obstetric science promising to identify and manage its risks (Chadwick & Foster, 2014). This is not to say that childbirth was dissociated from danger earlier. Rather, the emerging dominance of a biomedical discourse emphasising human action to manage risks diminished the notion of pregnancy and birth as a natural event (Rothman, 2014). Where birth is embedded in a biomedical discourse, actions to minimise risk become a moral necessity. Many women now engage in preconception care; seek and adhere to extensive medical advice about what to do and what not to do during pregnancy and birth; and undertake a comprehensive schedule of tests and foetal imaging during pregnancy (Lupton, 2011; Smith-Oka, 2012). Pregnancy and childbirth are ‘safer’ in these settings than they have ever been, so a pervasive sense of anxiety about risk is paradoxical (Mitchell & McClean, 2014; Smith et al., 2012).

Studies in western settings have overwhelmingly found that the vast majority of women display commitment to medical management of birth. Despite attempts in settings such as the UK to introduce less medicalised options for ‘low risk’ births, a powerful historical discourse compels the majority of women to opt for birth in an obstetric unit (Coxon et al., 2014). Biomedical risk discourse is not unquestioned, however. Some grapple with competing discourses and a minority opts for an alternative, such as home birth, underpinned by a view that medical management entails its own set of risks. For example, women who opted for a home birth in Sweden associated hospitals with risks related to loss of autonomy, including being in the hands of strangers and routines, and unnecessary interventions (Lindgren et al., 2010). Women who planned home births in a study in South Africa²² sought to negotiate risks to a safe birth with other perceived dangers, including effects on emotional well-being (Chadwick & Foster, 2014). Obermeyer (2000b) suggests that one reason for divergent evaluations of biomedical risk discourse is the different weights given to risks to life and health associated with reproductive events on the one hand, and to biomedical birth’s negative consequences for women’s knowledge and power on the other. Nonetheless, even those who challenge aspects of medical authority still tend to negotiate this within a biomedical risk frame. For example, even where women in Australia sought a midwife-led birth centre, they wanted this to be connected to a

²² Although South Africa is an upper-middle income country and not ‘western,’ the study is mentioned here because it focused specifically on a middle-class population.

hospital because they believed in the inherent risk of childbirth (Possamai-Inesedy, 2006). In a study in the UK, women were also much more likely to discuss the need to determine which hospital would provide them with the best care than home birth (Coxon et al., 2014).

This raises a question regarding the perceptions of risk surrounding childbirth we might expect in non-western contexts such as India. India differs from western contexts on features such as individualism that are central to notions of a ‘risk society,’ as conceived by Beck and Giddens. Yet, in an era of globalisation, there are unprecedented opportunities for societies to be exposed through mass communication technologies to other risk discourses. Moreover, international efforts have brought maternal and child health onto the political agenda of governments across LMICs. Focusing on dangers to the life and health of women and newborns from birth in settings with underdeveloped health systems, these efforts are largely underpinned by a biomedical risk framework. How does exposure to such discourses affect lay perceptions of risk and in turn influence care-seeking for birth in these settings?

Research has identified considerable variation in definitions of risk and perceptions about what is a normal, healthy and wise course of action for birth across global contexts (Miller & Shriver, 2012). Certainly, in several studies conducted in LMICs over the past two decades, birth was framed as a normal event that did not require medical management (e.g., Matthews et al., 2001; Obermeyer, 2000b; Parkhurst et al., 2006). Nevertheless, scholars have cautioned against the assumption that traditional constructions of childbirth are devoid of a notion of danger. Perceptions of potential negative consequences and their causes may differ from biomedical notions of risk (Dako-Gyeke et al., 2013; Eckermann, 2006; Kaphle et al., 2013), but cultural practices demonstrate that traditional societies have always taken actions to protect women and children from perceived dangers of pregnancy and birth (Obermeyer, 2000b).

Diversity in constructions of childbirth brings different solutions for ensuring safety to the fore. For example, Capelli (2011) describes how, in her study in Morocco, conceptions of risk were embedded in the symbolism of blood from parturition and delivery of the placenta, which placed the ability to deal with these elements at the heart of a safe birth, legitimising the role of a traditional midwife. Studies on lay perceptions of risk also highlight concern with different types of threats, including spiritual ones and

those arising from witchcraft and sorcery, which call for different types of care (Dako-Gyeke et al., 2013; Denham, 2012; Kaphle et al., 2013). Moreover, obstetric calculation of risk by rates of potential pathology ignores the more complex range of negative outcomes that can occur (Kaphle et al., 2013). Whilst biomedical discourse focuses on risks of morbidity and mortality arising from obstetric complications, lay representations may consider a broader range of negative consequences.

In some non-western settings, biomedical risk discourse has already become authoritative, however, with reports of over-medicalisation of birth in some contexts (Buekens, 2001; Leone, 2014; Smith-Oka, 2012), alongside under-medicalisation in others. Interestingly, even where biomedical discourse is not yet pervasive, it is permeating and changing local discourse. In Ghana, Denham (2012) showed how public health campaigns and improved access to community health resources had changed community members' understanding of maternal and infant outcomes, resulting in a model that integrated biomedical notions of causation with traditional frameworks. Women within the same societies may hold different rationalities, some more closely ascribing to biomedical discourse and others aligned more closely to traditional discourses (Dako-Gyeke et al., 2013; Denham, 2012). Assumptions in the sociological literature that women's preferences are polarised between 'natural' or 'medical' birth therefore fail to capture the nuances of women's experiences, or the breadth of contextual influences on their decisions (Coxon et al., 2014).

In sum, studies on perceptions of care for birth in LMICs have noted differences between lay constructions of risk and biomedical discourse. However, few have examined this area in depth. The need for further investigation of the linkages between perceptions of risk and maternal health care decisions in LMICs has been acknowledged (Chadwick & Foster, 2014; Mumtaz & Salway, 2007). By examining perceptions of care options within a frame that also considers how participants understand the birth process and a 'good' or 'safe' outcome, the chapter reveals multiple interconnections. The study is of particular relevance to maternal health interventions seeking to change behaviour.

5.2 Findings

Findings in this chapter draw largely on thematic analyses of data from all cases, and are exemplified with quotes (see p.13 for key to interview excerpts). The focus here is the range of perceptions in the data, as well as the interconnections between them. I do not make distinctions between first and second interviews since temporal dynamics are discussed in Chapter 6²³. I also do not examine how these connect with specific household members or households, which is discussed in Chapter 7. The emphasis is on situated meanings of risk and its management, forging the starting point that adherence to an authoritative biomedical risk discourse is the rational course of action. Conceptualisation of risk in this chapter is therefore broad, encompassing risks of morbidity and mortality as well as other potential negative consequences that might be associated with childbirth in participants' narratives.

5.2.1 *Constructions of childbirth and its risks*

Considerable fear and anxiety was expressed in this study regarding the uncertainty of pregnancy and birth outcomes. As one mother stated, *'When a baby comes out from the mother's womb, there is a human inside a human. Who knows what will happen?'*²⁴ Participants of all generations, female and male, regardless of their inclination towards a home or health facility birth, viewed birth as an event imbued with potential dangers to the life and health of both the woman and baby. Obermeyer (2000b) suggested that people may know personally of few or no birth-related deaths because mortality outcomes are statistically rare events, even where mortality rates are high. Participants in this study, however, expressed their fear through retelling stories of 'cases' (deaths or near misses) they heard of within their families or communities. Anxiety was particularly profound among primiparous women, amplified by their self-perceptions as lacking in knowledge and experience of birth. The following excerpt conveying one woman's fear was mirrored in similar narratives of anxiety—albeit to different extremes—across the sample.

²³ However, I do note where reported perceptions differ substantially from the participant's other interview.

²⁴ C4, mother, I2

'Those who I tell, they encourage only, but I'm scared on my own about what will happen [...] Even if there's the slightest problem, I feel very worried and scared. That's why I called them (family) here in advance, so that there's someone with me [...] Sometimes I feel pain in my abdomen, or I get dizzy, then I feel worried' (C6, woman, I1)²⁵

In the study setting, the construction of an ideal birth is one that progresses rapidly. Labour extending beyond a specified or predicted number of hours was described as a cause for alarm. It is understood that pain, synonymous in this context with contractions, must build up for birth to progress. This echoes findings of anthropological studies from other regions in India. In Van Hollen's study (2003, p.57) in Tamil Nadu, South India, western biomedicine's focus on suppressing the pain of birth was regarded as akin to reducing contractions, and 'conjured up the specter of prolonged labor and the very tangible associated dangers to both mother and baby.' The woman's capacity to 'bear pain' is thus at the heart of understandings of risk in childbirth. A '*woman has to bear pain if a child is to be born,*²⁶ and problems accordingly arise or surgical births become necessary when the woman is unable to tolerate the pain. Essentially, birth progress largely depends on the woman's strength ('*takat*'); complications do not simply happen to her. As one pregnant woman stated, '*it depends on how much effort we can make from our side at that time.*²⁷

The local illness category of '*kamzori*' (weakness) is pervasive in this discourse. A study in Mumbai, India, found that adverse reproductive histories were understood as a key contributor to 'weakness' (Ramasubban & Rishyasinga, 2001), and this study further shows how it is understood to affect childbirth. Women are understood to vary in their threshold for bearing the pain of childbirth, and a woman who is weak is inherently at risk. One meaning attached to weakness is a delicate constitution. In contrast to the perceived explanatory factors in Ramasubban and Rishyasinga's (2001) study, a ubiquitous narrative in this setting was that the condition is largely a contemporary phenomenon: women nowadays are weak because '*times are bad.*' Young, primiparous women are reported to be particularly susceptible. Participants claimed that diet and food quality have deteriorated; new diseases have emerged; and women in the past were stronger because they engaged in hard labour in the fields even in late pregnancy, contrary to the sedentary lifestyles of young women nowadays. An

²⁵ See p.13 for key to referencing of interview excerpts

²⁶ C12, mother, I2

²⁷ C3, woman, I1

almost identical discourse has been noted previously in other sites across time and place (Capelli, 2011; Obermeyer, 2000b; Van Hollen, 2003). The question then is not the extent to which the discourse reflects an objective reality, but the way in which it fits within local constructions of danger in childbirth. While danger is said to arise from a woman's lack of strength, this narrative allows blame to be diverted towards societal change. Van Hollen (2003) interprets it essentially to be a criticism of modernity. A perceived increase in weakness is framed as the reason for contemporary fear and anxiety regarding childbirth, and a key factor driving a shift towards acceptance of medical management of birth. The following quote illustrates elements of this cultural narrative:

'That practice (home birth with a dai) has changed because people don't want to take a risk²⁸ any longer. People in earlier days were very hard working. The women used to work in the fields during the day plus do work at home. They used to deliver easily and no one would even come to know. But the girls nowadays are very delicate. That is the difference [...] See, many spurious things are mixed into foods nowadays. We used to get pure ghee (clarified butter) to make food earlier but now it is not that good. Even fruits and vegetables are artificially ripened. So all of this makes a difference to the mother and the child' (C13, mother-in-law, I2)

A further meaning attached to weakness is a 'lack of blood' ('*khun ki kami*')—the local understanding of anaemia. Many pregnant women in this study were told during ANC visits that they lacked blood, in line with the high proportion of young women in India who are anaemic (Toteja et al., 2006). Women who lacked blood were considered weak. Essentially, linkages between the nature of the biomedical category of anaemia and the local distinction between women's strength and weakness have enabled the condition to become integrated within local constructions of pregnancy and birth. This illustrates the way in which new discourses may be reconciled with existing ones as they come into contact. Increased use of foetal imaging technologies has also enabled the local category of weakness to be applied to the unborn baby, in relation to reports of a 'weak' foetus at ANC visits. The growing awareness and diagnosis of anaemia and low birth weight in India as maternal, newborn and child health programmes have expanded over recent decades may have served to produce or reinforce local perceptions that weakness has

²⁸ The English word 'risk' was commonly used in Hindi narratives.

increased, making birth in general more risky, and thus impelling the shift towards birth in a health facility.

Participants also reported other types or sources of danger in childbirth that did not relate to constructions of weakness. Abnormal presentation or bleeding were discussed in particular, as well as specific complications that participants heard of within their families or communities, such as the cord being wrapped around the baby's neck. Nonetheless, the process of childbirth was constructed in a similar way across the sample, and narratives on danger were largely located within constructions of pain and weakness, as described. The construction of childbirth and its intrinsic risks did not vary substantially across participants inclined towards different care options. What differed was how households positioned themselves and their communities in relation to perceptions of increasing risks. Some households deflected the notion of increased risk away from themselves by positioning themselves in contrast to other communities, thereby providing a rationale for their continued inclination towards a home birth, despite *'times being bad.'* For example, one mother reported that *'our people²⁹ are so tough, [...] we are calm about [childbirth],'³⁰* and this narrative was mirrored in the following quote by her daughter:

'There are no problems except pain during delivery. Mummy had told me that this pain all ladies have to face [...] In our people, such things (i.e., problems with bearing pain) don't happen' (C16, woman, I2)

In low-income urban settlements, childbirth was imbued with meanings of danger and risk, which were perceived to have increased in contemporary times, and underpinned a high level of fear and anxiety regarding the uncertainty of birth outcomes. Van Hollen (2003) suggested that perceptions in her study on South India that childbirth is dangerous were not a result of the advent of a biomedical discourse 'pathologising' childbirth. This study suggests a middle ground. Local constructions of childbirth certainly include notions of potential danger. Yet, increased exposure to biomedical discourse and greater use of medical technologies which bring previously unknown risks to people's attention are likely to have intensified anxiety:

²⁹ *'Hamare log,'* translated here as 'our people,' appeared to be used by this mother, as well as her daughter in the next quote, to refer to their caste (*jati*).

³⁰ C16, mother, I2

'We're constantly told to give fruit if there is less blood in the body [...] We follow everything. But was this the norm in earlier days? [...] People did not even know that such things happen. But now we are told that she does not have enough fluid in her body so she needs to be taken to the hospital; medicines and injections are pumped in; bottles of glucose are put. There is so much that is done' (C13, mother, I2)

Moreover, improved access to an array of care options for birth in urban areas, such as Indore, places increased pressure on decision-making. This connects with the sociocultural literature on risk highlighting a paradoxical increase in anxiety concomitant with societies' greater focus on managing risk (Beck & Ritter, 1992; Coxon et al., 2014; Giddens, 1991; Lupton, 1999).

5.2.2 Medical management of risk in childbirth

In view of this cultural construction of childbirth and its inherent dangers, questions arise regarding narratives on how birth is best managed, and what role is ascribed to medical management. Certainly, protecting the woman and baby from morbidity and mortality was a key theme across narratives, and inclinations regarding care for birth were framed in these terms. For example:

'There is one daughter-in-law and God forbid if something were to happen to her. Then what would happen? Her life gone, her husband's life also spoiled, so better get it done where there is safety' (C12, husband, I1)

Perspectives on how to achieve a safe outcome differed across participants, however. In regards to reported perceptions of the role of medical management, at one end of the range was the notion that health facilities are the safest place for birth. This was certainly the dominant narrative in the data in the context of a rapid increase in use of health facilities for birth prior to the study (see Chapter 3). Biomedical risk discourse was prominent in this perspective. Hospitals were represented as better equipped to manage the birth *'in case something happens'* because they have doctors and nurses with expertise, medicines, and *'scientific machines.'*³¹ The following quote from a husband shows how he constructed the medical technologies of hospital settings as imperative for managing the risks of birth.

³¹ C8, woman, I1

'Home birth is very risky so should not happen [...] There are no facilities at home—I mean no equipment and all. For that we have to run to [the public tertiary hospital³²]. We should stay in such a place that all medicines are available [...] It can't happen at home—there's no guarantee. Anything can happen anytime. There's tension all the time so that's why it's risky' (C8, husband, I1)

The following quote from a pregnant, relatively educated woman, who had completed secondary school, shows further how biomedical discourse was invoked in narratives emphasising that health facilities are a safer place for birth.

'While a doctor does everything in such a hygienic manner, here we feel we are so clean but don't know how many micro-organisms are actually to be found. That's why it's better to go to a hospital' (C12, woman, I1)

Sharma et al. (2013) raised a question based on a study with tribal communities in Gujarat, India, of whether increased hospital births was a result of the deskilling of *dais* or whether deskilling of *dais* was the result of increased hospital birth. The latter interpretation is implicated, at least in part, in this setting because expectations for care from this perspective could not be fulfilled by even the most skilled *dai*, since they rely on access to medical expertise and technology. Participants whose narratives fell at this end of the range reported that home birth was risky because lay people or *dais* might not identify complications and could not provide the type of care necessary to deal with them. The following quote—focusing on the newborn in this instance—demonstrates how this uncle considered the management of birth-related uncertainty to be crucial and perceived this possible only via the medical route.

'I very much recommend a hospital because it's safe for babies. The mother is also looked after well. If there's a problem, the hospital will know. If the baby's weak, we won't know at home. In the hospital, they weigh the baby—whether it's 2.5 kilos or 3 kilos. At home, we can't find this out. They simply bathe the baby and put it to sleep. They can't find out if the baby has any sickness, whether it's weak. In a hospital, they check the baby and its mother' (C1, uncle, I2)

In view of improved access to health facilities for birth, combined with the perceived increase in risk, the dominant narrative was that it would be unwise to forgo their use. From this perspective, use of a hospital was imperative for first births because women's inexperience amplified uncertainty. Some young women could not even conceive of a home birth. This discourse did not preclude the notion of birth

³² All health facility names have been replaced with such descriptions.

fundamentally as a normal rather than a medical event. As one common narrative goes, pain is the same wherever the birth takes place. Rather, perception of heightened risk surrounded childbirth by uncertainties that called for being in an appropriate place to identify and manage problems in case they manifested. Essentially, medical expertise and technologies represented a solution for alleviating some of the anxiety around the uncertainty of birth that some communities now felt ill-equipped to manage.

At the other end of the range was the view that childbirth largely does not require medical management. Common to this perspective was reported faith in ‘their’ *dai*’s expertise, gained through experience rather than qualifications, with many claiming never to have seen a case mismanaged by their *dai*. Not even the extreme end of this range, however, was untouched by biomedical discourse on childbirth. The need to shift to a hospital in case of a complication was a universally reported imperative. The difference between this end of the range and the other was thus a matter of confidence in a *dai*’s ability—or their own—to handle a normal birth and judge when the case required a shift to hospital for medical intervention.

‘It’s not as if, no matter what, [the dai] would do it at home only. She keeps trying her best for delivery, but if she can’t do it, she tells that she can’t do it, so take her to hospital’ (C2, mother, I1)

‘We mostly do [birth] at home, but if [my daughter] faces more trouble then we’ll take her to the hospital. That way, delivery in us is normal, so our people³³ mostly do it at home only. But now the atmosphere is like-... now the world is like, because of weakness they go to hospital’ (C15, mother, I1)

‘If it can happen in a simple manner at home, then what is the need to go to the hospital? It’s simple work, and if there’s some problem, then we have to run for the hospital [...] If the baby’s position is not proper, or if the uterus mouth is not opening, then in such situations one has to go to the hospital. That way, until now in our people³⁴ it has happened at home’ (C16, mother, I2)

However, risk discourses were not homogeneous across all participants inclined towards a home birth. The far end of this range comprised those whose constructions more closely resembled the perceptions reported in Matthews et al.’s (2001; 2005b) earlier study in India—that birth is a normal event that does not require medical management in an institutional setting. While these participants stipulated the importance of a safe outcome, they conveyed a perception that childbirth complications

³³ *Hamare log*, ‘translated here as ‘our people,’ appeared to be used in a caste (*jati*) sense.

³⁴ *Hamare log*, ‘translated here as ‘our people,’ appeared to be used in a caste (*jati*) sense.

were minimal in their communities and medical input was unnecessary unless a complication arose. In contrast, other participants also inclined towards a home birth conveyed more anxiety about birth-related risks. Their constructions drew more on biomedical discourse and delineated a greater role for medical expertise and technology during pregnancy in order to identify and address birth-related risks to ensure they could ‘safely’ pursue birth at home.

5.2.3 Integrating medical knowledge within existing constructions of childbirth

Despite the broad distinctions set out in Section 5.2.2, representations on managing birth-related risks precluded simple categorisation. An over-riding theme in the data was the integration of different and sometimes contradictory discourses within the same narratives. The last section introduced the notion that medical expertise and technologies were at least in part embraced as a solution to risk and uncertainty surrounding childbirth even by participants inclined towards a home birth. Yet, they were never embraced unambiguously even by those who were inclined towards birth in a health facility. In the same way that inclinations towards a home birth did not entail complete rejection of a role for medical expertise, a belief that birth in a health facility is the safest option entailed neither complete commitment to the doctor’s authority nor to biomedical knowledge. Indeed, alternative discourses were perceptible in the narratives of even the strongest advocates of birth in a health facility, suggesting that exposure to the authoritative knowledge of medical experts entailed a process of integration rather than replacement of existing knowledge.

One example is the selective acceptance of biomedicine depending on its coherence with local constructions of childbirth and risk. Some medical technologies were accepted by all, regardless of inclinations for care at birth, suggesting that a generalised fear of biomedicine was not the key issue underpinning rejection of maternity care services³⁵. For example, even those who rejected all other contact with health services sought tetanus toxoid injections:

‘People say that [tetanus toxoid injections] help to prevent fits during delivery. But I don’t know since I didn’t take any such thing. It’s to avoid any

³⁵ The average number of visits to a doctor per year in India exceeds the number in some western contexts (Das et al., 2008).

complications. That's why it's important to take it [...] After taking the injections there's no danger and everything is normal' (C15, mother, I2)

There was also widespread acceptance of the use of injectable uterotonics for labour augmentation. Extensive research highlighting the regular, even routine, use of oxytocin injections in the second stage of labour in India and other countries is of concern to public health experts because the WHO advises against their use in this way, based on evidence that it increases risks such as uterine rupture, foetal distress and postpartum haemorrhage (Iyengar et al., 2008; Iyengar et al., 2009; Jeffery et al., 2007; Mirzabagi et al., 2013; Sharan et al., 2005). Recent findings of an association with autism are also undergoing further investigation (Gregory et al., 2013). Guidelines stipulate that oxytocin should be used for labour augmentation only in case of need, administered in a carefully controlled way, and in a facility where there is access to emergency obstetric care (Jeffery et al., 2007; Sharan et al., 2005).

The research literature suggests that oxytocin injections have been embraced in India because they fit with local constructions of birth that place value on facilitating rapid progress. They are accepted so readily in part because they are viewed as a more efficient means of achieving the same end as the folk methods traditionally used to stimulate pain or contractions and accelerate labour, such as concoctions of tea with black pepper and *gur* (jaggery³⁶) (Van Hollen, 2003). In this study, households welcomed injectable uterotonics as a way of relieving anxiety over the woman's strength to bear the pain of birth. Uterotonics were revered for their perceived reduction of risks for the woman and baby within local constructions. Even some participants who perceived no need for an institutional birth were sufficiently persuaded of their benefits to seek their use at a home birth. Studies have also noted the widespread use of oxytocin injections in health facilities in spite of WHO guidelines to the contrary (Iyengar et al., 2008; Iyengar et al., 2009; Jeffery et al., 2007; Mirzabagi et al., 2013; Sharan et al., 2005). Their apparent use in some (but not all) health facilities even persuaded some participants of the virtues of an institutional birth:

'Those who are weak, who don't have enough blood [are going to hospitals]. My daughter is very thin, maybe she will be unable to deliver without help [...] In a hospital, she will get medicines for pain (i.e., for labour augmentation), and they might take care of her in many other ways' (C14, mother, I2)

³⁶ An unrefined product of sugarcane

Studies have indicated that use of oxytocin is more common for first births (Jeffery et al., 2007; Sharan et al., 2005). This study suggests an explanation grounded in the greater perceived uncertainty and anxiety regarding a primiparous woman's strength to bear pain. Attitudes towards oxytocin demonstrate a more general pattern in which people seek to negotiate their use of biomedicine in ways that allow them to take up aspects they consider important and reject aspects that do not fit with their constructions of childbirth. Van Hollen (2003) argues that, as birth becomes increasingly medicalised around the globe, modern medical technologies may be used in different ways and given different meanings in different contexts.

Alongside widespread acceptance of these medical technologies, elements of medical management that were counterintuitive within local constructions of a safe birth were rejected. Fundal pressure (i.e., exerting manual pressure on the abdomen during labour) is reportedly applied in home births to stimulate labour progress. Although Iyengar et al. (2008) found that fundal pressure was also common in health facilities in Rajasthan, India, some participants in this study reported concerns about the safety of institutional births because fundal pressure was not used. The following quote shows how one mother processed this distinction between home and hospital practices within a local construction of childbirth.

'[The dai] will push the baby downwards by pressing on the stomach [...] But if you are in hospital, they will just say, "Push, push," and do nothing else, even if you are trembling in pain. They will just say, "Push, push harder." From where will the woman push harder if she doesn't have the strength? It requires a little effort from you and a little effort from them'³⁷ (C12, mother, I2)

Other practices, especially those perceived to hold back birth progress, were subjected to the same scrutiny over their safety. These concerns demonstrate how traditional practices do not persist merely because they are customary; rather, they may be imbued with meanings related to ensuring the well-being of the woman and baby. Where medical practices are at odds with local constructions of childbirth and risk, they raise potential implications for attitudes towards the use of health facilities. This is evident in the following quote. Medical practices experienced during a previous household birth, which were perceived to be counterintuitive, were presented as the

³⁷ Despite all household members expressing a strong inclination towards birth in a health facility in the first interview, the woman had a home birth. This mother's narrative accordingly conveyed a more positive attitude towards birth at home in this second interview than in the first.

reason underpinning the household's inclination to stay at home for the forthcoming birth:

'After putting [my daughter-in-law] on saline [at hospital], her pains subsided because saline cools the body. Instead, when we had gone there, they should have given her some injections to increase the pains so they could facilitate the proper delivery of the baby, isn't it? And not only this, they put her on the drip for the whole day and she kept sleeping on the bed [...] Therefore we think that nobody attends properly to poor people in hospital [...] I told her, "I won't let you go inside that theatre." I gave her courage and mental strength. I told her, "Now if you get pains, you let it build up. We are here to take care of you and provide you strength." So she said, "Yes mummy, I'll do as you say." So then we made her sit on the bed, and when she experienced pains, we pushed her abdomen [...] Even then we were calling the doctor, "Madam, please come and check the patient." So she told us to leave her in that condition. Now the baby is coming down—how can we leave her in that state? That's why I pray to God that it would be good if [this] delivery happens at home' (C2, mother, 11)

Caesarean births were another unwelcome element associated with birth in a health facility in this study, regardless of inclinations for care. Caesareans are embraced by some populations as a method of controlling the perceived risks of birth (Chadwick & Foster, 2014). In contrast, normal birth was valued in this setting and caesareans were viewed with fear and dread, mirroring the findings of some other studies in South Asia (e.g., Parkhurst & Rahman, 2007). Caesareans were reported to have negative implications for women's health—particularly weakness, as in Ramasubban et al.'s (2001) study in Mumbai, India. Fear of caesarean birth was a key element in narratives of participants who were resistant to an institutional birth. Narratives were somewhat contradictory among those who viewed hospital as the safest place for birth, however. Access to a caesarean in case there was no other option was welcomed, but doctors were perceived to conduct them too readily. Perceptions of danger centred on the woman's ability to bear the pain of birth; yet, even where a birth was not progressing as expected, women were perceived to need more time and assistance for a normal birth. In the following quote, the mother-in-law expresses how the apparent rush to intervene surgically at health facilities is at odds with her construction that babies have a time to be born, determined by God:

'In hospital they don't give any time. They just bring out their scalpels and knives and deliver the baby by surgery in no time. It destroys [the woman's] life forever. I believe that the baby will be born only when God wills. [At home] we try for 5–10 minutes and see. Everybody has to sustain that pain. But if it's

really not possible, then all options are open [...] Nowadays doctors only deliver babies by operation. They hardly wait for half an hour. If they see the woman is in too much pain, they just get their instruments and conduct the surgery' (C10, mother-in-law, I1)

A caesarean birth was perceived to necessitate future caesareans, which generated fear of a long-term cycle of weakness. Risks to health were not the only concern in relation to caesarean birth. In view of reports that only two caesareans were permitted because a third would be dangerous, it left producing the desired son, in a context of son preference, to a gamble with only two chances³⁸. Other reported negative consequences included economic risks since costs become more unpredictable when a caesarean is conducted. Mirroring findings in Parkhurst et al.'s (2007) study in Bangladesh, the following excerpt shows how concerns regarding caesarean birth connect with attitudes towards care options.

'I feared that if I took her to the hospital for delivery— With this being the first baby, some people say that in hospital they will not take the responsibility [for a normal birth], and even if there's a little more pain they do the operation [...] Normal delivery is always good; with an operation, you face problems' (C16, mother, I2)

5.2.4 Reconciling alternative discourses

A further example of competing discourses was the preservation of spiritual, fatalistic or supernatural beliefs on birth-related danger and its management alongside beliefs derived from biomedical discourse. The increasing pervasiveness of risk discourse in western settings occurred concurrently and in connection with the rise of secularism. Jaeger et al. (2001) contend that all modern conceptions of risk exclude the possibility that events occur with predetermined certainty, since anticipating future outcomes to improve present choices becomes futile in fatalistic views of danger. However, lay perceptions do not adhere to such rational actor assumptions. In this study, biomedical risk discourse was combined routinely with spiritual, fatalistic or supernatural beliefs to

³⁸ Son preference is a major issue in parts of India, including MP (see Chapter 3). Son preference was alluded to by several participants, including by some women who were concerned about their marital families' reaction to a daughter. Other women and husbands were reportedly happy to have a daughter. Discussion of son preference is minimal in the thesis because the data did not suggest it to be a salient issue in care-seeking for a first birth. Even where participants explicitly stated that they wanted a son, there was no suggestion in any narrative that they knew the sex before birth.

produce narratives that weave the two discourses in ways that participants did not perceive to be contradictory. For example:

'There wasn't a single day that I felt I could not have [the iron pill] [...] I thought it was important to have it because the [health] camp doctors said that our blood increases and we won't get any problems during delivery. They also said that the child would be normal. I used to keep all this in mind [...] Also I thought that if I took this pill then by God's blessings I wouldn't have any problems. Thinking of this, I used to take the pills, and that's why God ensured that I didn't have a problem' (C14, woman, I2)

The woman reconciles the two discourses by constructing the act of taking iron supplements as one endorsed by God to minimise risk. A similar phenomenon was noted in a study in Morocco, in which Obermeyer (2000b) suggested that affirming God's will did not necessarily entail ignoring the possibility that actions could alter the course of events; it merely acknowledged the limits of human control. Indeed, even before people accessed health facilities for birth, they took actions in anticipation that it would increase the likelihood of a safe outcome, such as folk methods for speeding up labour or food regimes to promote strength. In a US setting, Miller and Shriver (2012) described a religion-centred lifestyle habitus centred on religious ideas about the body, childbirth and motherhood that directly countered the dominant biomedical framework of mainstream society. Miller and Shriver's (2012) findings contrast with the weaving of discourses found in this study, which is perhaps a result of the centrality of religion in India, allowing the advent of a compelling biomedical risk discourse to be integrated alongside, rather than positioned in conflict with religious beliefs.

For some, superstitious beliefs and belief in supernatural dangers also ran alongside a biomedical discourse on risk, and called for different kinds of actions to protect the woman and baby, simultaneously with medical management. For example, this quote by a mother who perceived medical management necessary for a safe birth shows how this co-existed with an alternative discourse on protective actions.

'Sometimes women even die while giving birth. So I tied some mustard seeds in [my daughter's] sari. But [at hospital] she had to take it off, so I said, "Keep the mustard seeds in a glass"' (C4, mother, I2)

Another practice that arose in several narratives entailed refraining from or delaying informing others of labour pain. Informing others, particularly the husband, might lead to the suppression of pain, and thus slow down the progress of labour. In addition,

others' knowledge that the birth was in progress raised the possibility they could use supernatural powers to harm the woman and/or baby. Such messages were passed down through generations and internalised as practices to be followed.

'Tying of pains is that the 5–6 pains³⁹ that are there, someone can tie those pains. Here there are a lot of people who practice black magic ("phoonk karne vale"), who practice sorcery ("jadu-tona karne vale"), and are also our enemies. And a lot of people are jealous too. So if she shouts and shrieks then people will come to know that she's getting labour pains and tie her pains. After tying the pains the pregnant woman dies. What I mean to say is that if she is unable to give pains, then the baby will suffocate to death and that poison spreads into her, and then both of them will die' (C14, mother, I2)

5.2.5 Perceptions of care options for birth

The discussion of care for birth is so far incomplete in two ways. First, previous sections have largely focused on the role ascribed to a biomedical framework in managing birth-related risks, but have not discussed narratives on the maternity care services that implement this. Second, the focus so far has been exclusively on risks of morbidity and mortality, but the broader potential negative consequences attached to different types of care at birth are still to be considered. This section describes perceptions of the array of different types of care available, while the next section examines how meanings of risk, danger or safety are attached to these in ways that influence inclinations for care at birth.

Most qualitative studies on perceptions of care for childbirth in India are based in rural contexts or small urban areas where options for care are few. The large city setting of this study provides a different perspective. Participants in this study were aware of the range of care options available and demonstrated strong views on the differences between them. Distinctions were made in particular between care for birth at home and in a health facility; in private versus government health facilities; but also between different types of public and, to a lesser extent, different types of private health facilities.

The costs of birth even in a modest private health facility were high for the low-income households in this study. Although many were inclined towards the public sector as a result, the narrative that quality of care is superior in the private sector was

³⁹ Used synonymously with contractions (see Section 5.2.1)

pervasive⁴⁰, echoing findings of studies from across India (Bhattacharyya et al., 2013; Griffiths & Stephenson, 2001). Frequency of contact with staff was reported to be inadequate in government hospitals. Statements such as, ‘*They just put you like that and don’t take care of you,*’⁴¹ were common. Doctors were described as too busy to give a personalised service. One husband described ‘*assurance, sympathy and peace of mind*’⁴² as the ideal in terms of interpersonal care. Yet, many reported that staff at all levels in government hospitals had little time or inclination to provide them with sufficient information, and ignored rather than listened to questions or pleas to check the woman or baby. Women were frightened of being left alone since family members were by and large not allowed to accompany them during birth in government hospitals. Participants also described hospital staff regularly scolding and shouting at service users, particularly the poor, and some reported experiencing such behaviour personally during ANC visits. Moreover, young women expressed considerable fear regarding stories that circulated of women in labour being beaten by nurses or attendants if they became ‘too distressed.’

Government hospitals were also portrayed as daunting and uncomfortable environments. They were criticised for being crowded and full of strangers and, although some suggested they were cleaner now than in the past, poor cleanliness was still raised by some as a concern. Another frequent complaint centred on having to ‘*run around*’ to carry out administrative tasks and to purchase medical supplies when accompanying a woman for birth at a government hospital. Procedures were reportedly not always clear to service users, making the process confusing, difficult to navigate and time-consuming. In addition, household members reported a necessity to accompany the woman throughout her stay at hospital because these settings were perceived to be unsafe. For example, many described hearing from others or from media reports that babies are sometimes stolen from government hospitals. Accompanying the woman throughout her stay had implications for household or other work responsibilities.

⁴⁰ This was in spite of research identifying problems with clinical quality of care in private as well as in public sector health facilities (see Sections 1.1 and 3.5). A private sector gynaecologist interviewed in this study claimed that she advised her low-income clients to use government rather than private health facilities for birth, since she reported that the type of small private clinics this population might use lacked the facilities and capacity of public hospitals. Nevertheless, it is lay constructions that matter for the purposes of this study.

⁴¹ C1, woman, I1

⁴² C6, husband, I1

Variation was also reported between health facilities within the public sector. Participants were aware that referrals are sent to the largest hospitals, which have the whole range of medical facilities and specialists to deal with complications. Yet, the largest hospitals were also the most feared. They were reported to have the poorest interpersonal care. They were also perceived to be the most daunting, unsafe and difficult to navigate, and the most crowded since users travelled from throughout the region. Perceptions of better interpersonal care drew many towards smaller public hospitals, although some narratives conveyed a tension with the superior medical facilities in larger hospitals.

'I met one person who told us that, "[...] although there's a lot of carelessness in [the public tertiary hospital], it's still the best option for good treatment." All these private places [also] send risky cases there only, as no one takes a risk'⁴³
(C6, husband, I2)

The nature of care at birth in the public sector was contrasted with care at home or in private health facilities. Participants described how, at home, women can birth in their own familiar environment in the presence of known and trusted people, who never leave their side and provide support and encouragement. Households are able to follow the practices they perceive to be important. In contrast, the unknown of a hospital birth was viewed by some as a daunting experience. The following quote conveys a woman's perception of the isolation she would experience at hospital, and contrasts this with care at home.

'Until you deliver on your own, they don't come to attend to you [at hospital]. [At home] everyone can explain everything, but nobody would be there [at hospital] to explain or comfort you' (C1, woman, I1)

Such perceived advantages of a home birth were raised only where the notion of a home birth could be conceived, but were not uncommon in narratives, even among those who reported inclinations towards an institutional birth.

Although private care still entailed leaving the comforts of home, it was positioned in contrast to care in government health facilities. An expression that frequently arose in interviews was, *'Private is private, government is government.'*

⁴³ This excerpt likely captures post-hoc rationalisation since, in the first interview before his wife used the tertiary hospital, the husband's narrative focused on the perceived negative elements of the tertiary hospital and conveyed inclinations for birth in a private health facility

Private health facilities were described as more client-centred, with a nurse assigned to the woman's care, ensuring a more personalised service and more frequent checks. Family members were typically allowed to stay with the woman during birth at a private facility, and care providers were reported to speak more gently and reassuringly. Use of private health facilities, essentially, was understood in terms of buying both means and entitlement to better care. One mother-in-law stated, *'They take that kind of money to give that kind of service,'*⁴⁴ meaning that private facilities have the means to provide more attentive care, regular checks or a cleaner hospital, for example. However, there was also a sense in comparisons of care in the public and private sectors that free care effectively limited leverage over the service received, placing the woman at the mercy of hospital staff. This is captured in the claim that, in private health facilities, *'if there is more pain, then we can give money and get anything done,'*⁴⁵ or that *'it is money power: if you spend money, your work is done faster.'*⁴⁶ In the following quote also, the woman conveys the power imbalance she perceives in government facilities where no payment is made for services.

'In a private hospital, since they get money, they do the work better and more quickly. In a government hospital, they work at their own convenience. They work as in any government office [...] I mean if you get pain, then it depends on them when they want to check or see to the well-being of patients' (C11, woman, I2)

5.2.6 Interconnections between perceptions of care options for birth and risk

A question remains regarding the meaning attached to these representations of different types of care for birth within local risk knowledges. Low perceived quality of care has been addressed in several studies (see Section 1.2), but few studies place the analysis within a frame that extends the discussion to the implications attached to perceptions of poor quality care. By addressing perceptions within a risk frame, this chapter reveals interconnections between perceptions of poor quality care and constructions of a safe birth.

Health service delivery, as distinct from biomedicine, was certainly considered to have implications for life and health. Participants referred to 'spoilt cases,' often in

⁴⁴ C8, mother-in-law, I2

⁴⁵ C6, mother, I1

⁴⁶ C12, mother, I2

government hospitals, they knew or heard of within their families, neighbourhoods or in the media. Those inclined towards a home birth contrasted this with their *dai*, who never mismanaged cases according to their narratives⁴⁷. In narratives on ‘spoilt cases’ at hospital, blame was attributed to the actions or inaction of care providers, rather than accidental causes.

‘I am thinking of [a small public hospital for the birth]. [My sister] said, “Go to a private hospital instead.” She said, “We don’t want any problems, there shouldn’t be any complications during her delivery” [...] There was a friend of mine. He took his wife to a government hospital. The baby boy was born, but the case became very complicated afterwards in the hands of the government doctor [...] The baby was alright, but the poor lady didn’t survive’ (C3, husband, I1)

In particular, problems were attributed to neglect at hospital. In the following quote, the mother-in-law explains the rationale for her inclination towards the private sector in terms of the threat posed by perceived neglect in public health facilities.

‘I did not want my child (daughter-in-law) to have any complications and so decided against [the public tertiary hospital] [...] Patients get admitted in government hospitals but there’s no one to take care of them. They don’t take care even when the patients are in pain’ (C13, mother-in-law, I2)

The following excerpt conveys similar meaning, but this time it underpinned inclinations towards a home birth.

‘We think we’re in such difficulty and rely so much on the doctor. We think we’re going [to hospital] and he will give us medicine. So the doctor is like God to us. But even a doctor isn’t God if he doesn’t attend to us... then how could he be God to us?’ (C2, mother, I2)

This mother reported her understanding of the doctor’s role fundamentally to be about protection from risk, but questions how this is possible if the doctor is not physically present. The quote hints at the view in this setting that ensuring safety requires the attendant to be actively involved in facilitating the birth process. This again reinforces the finding presented earlier that local constructions of childbirth shape understandings of risk. Linked with a belief that danger in childbirth is centred on the woman’s strength to bear the pain, a comfortable environment with a supportive attendant actively facilitating the birth was seen to help ensure safety. This is illustrated

⁴⁷ Of course, these narratives capture constructions rather than an objective reality.

in the next quote, in which the mother explains how the way in which the *dai* talks to the woman can boost her strength to endure the pain.

'It would be good if the delivery happens at home. We call the dai. She talks nicely—it gives strength and courage to the patient. We also talk nicely at that time' (C2, mother, I2)

Constructions of the way in which private and government health facilities differ focused less on technical competence than on interpersonal care. Indeed, some indicated this explicitly—claiming that the same doctors are employed in both institutions, but the context in which they work affects either their behaviour or capacity to provide adequate care. Nevertheless, there remained some who reported a difference in the technical competence of doctors employed by private and government health facilities. For example, one mother-in-law conveyed that, *'It is just better in private hospitals. People are not ready for emergencies in a government hospital.'*⁴⁸ Another excerpt conveys a husband's belief that doctors in government health facilities are more junior.

'In a private clinic the doctors are all well-trained and educated, but in a government hospital they are all trainee doctors who are still learning, so they are not fully ready for all this [...] If the baby and mother have some trouble then it becomes very difficult' (C11, husband, I2)

A study of trustworthiness in health care in Pakistan suggested that interpersonal competence was in reality a proxy for technical competence (Ahmad et al., 2013). This study suggests, rather, that technical elements of care and interpersonal behaviour both contribute to the broader notion of capacity to protect women and babies from birth-related risks to life and health.

The data suggest a more generalised mistrust of the formal health system, particularly the public sector. This was especially prominent in the narratives of those who were inclined towards a home birth, but was also implicated in the anxiety expressed by participants inclined towards birth in a health facility. In writings on the shift to a risk society, trust emerges as a key issue as lifestyles begin to rely on abstract institutions at a greater distance from the person concerned, rather than long-established social relations within personal networks (Giddens, 1990). Faith in abstract systems—in this case the health system—can diminish when challenged by negative experiences (Zadoroznyj, 2001). Mistrust was explicit in examples where participants described

⁴⁸ C13, mother-in-law, I2

avoiding medicines prescribed or provided through the public health sector because they had little faith in it. It was also explicit where participants described challenging or going against the doctor's advice, which served to reinforce their position when vindicated. The following excerpt provides such an example.

'So now, you tell me, do I trust the doctor, or do I trust the dai? [...] When [my daughter] was taken for a check-up, the doctor said that she too was carrying twins. But there was only one [...] They simply put the stethoscope and said there were two babies. They tell any nonsense. That's why I don't trust the doctors much. I have delivered four babies at home' (C1, grandmother, I2)

Such mistrust may be (re)produced not only through personal negative experiences with government health services, but also through a wider cultural narrative of mistrust in authorities with a long history (e.g., Basu, 1990; Parkhurst & Rahman, 2007). But trust is continuously negotiated. In this study, poor interpersonal behaviour fuelled mistrust of government providers, mirroring Zadoroznyj's (2001) findings that there is a clear link between the quality of interaction with maternity care providers and trust. Where established, trust offers reliability in times of uncertainty, and thus minimises concern about potential risks (Lupton, 1999). It was clear in this study that generalised mistrust in government institutions served to increase anxiety and a sense of uncertainty about the birth. It led to concern about surrendering complete control of the woman's body and birth outcome to the doctor's authority. The doctor's authority is distinguished from medicalised authority here to show that opposition in these narratives was less to biomedicine, and more to the vehicle of medical authority within this setting.

Finally, biomedical discourse focuses on the reduction of maternal and neonatal morbidity and mortality, but local constructions encompassed a broader range of potential negative consequences. Certainly, narratives indicated concern with the perceived threat of the formal health system to emotional well-being and dignity. The following narrative conveys one mother's perception that hospital is a place that increases certain anxieties.

'When you go to the hospital, everyone says something or the other. The doctors will say something and the nurses will say something else and that will frighten me, and my daughter will also take tension' (C12, mother, I2)

There were countless examples of narratives that focused on fear of hospital, rather than fear of birth per se. In the next quote, the mother describes how a fear of hospital partly underpinned her inclinations towards a home birth.

'We feel very scared madam. What kind of patients are there? Those we have never seen. And if we see the scene there once, then I can't sleep for the whole night. The scene keeps hovering in my mind and in front of my eyes. That's why we don't go there' (C2, mother, I1)

Participants described fear of loss of dignity at health facilities. For example, one woman described witnessing a birth in the corridor of a hospital in sight of male visitors. Other concerns arose from the effects of the perceived power imbalance entailed in the use of free care. As Ricketts and Goldsmith (2005) state, competencies that promote effective use of care compete with competencies to avoid interactions that negatively affect people's sense of self-worth.

'I'd gone there to write her name (i.e., register). But that doctor is making a fool out of me there. All the time she keeps saying, "Don't come now; come next month."' (C3, husband, I1)

Such concerns with use of the public health sector can be understood largely in terms of meanings related to loss of control. Government hospitals were perceived to be unfamiliar and uncomfortable places providing inadequate care. Since it was free, however, participants perceived themselves to have little leverage over it, leaving them vulnerable and at the mercy of providers. Diverse meanings were attached to these threats, from risks of morbidity and mortality to other negative consequences such as loss of dignity. Where households were inclined to opt out of public sector care, a theme of maintaining control over the manner in which birth was conducted and birth outcomes was detectable in narratives. For those leaning towards a home birth, this theme outweighed any perceived compulsion to seek medical management. In effect, choosing a home birth allowed the household to maintain absolute control. Those leaning towards private sector care could also be understood, however, to be seeking to maintain control. Whilst these households were sufficiently immersed in a biomedical risk discourse to impel their use of a hospital for the birth, they sought leverage over the care they received through paying for services. They were sufficiently concerned about the threats they perceived of birth in public sector health facilities to risk potentially serious economic consequences. On the other hand, there remained another group who

also reported medical management to be imperative, but who constructed care in a government hospital as something that simply had to be endured in order to achieve a safe outcome within the constraints of their economic circumstances.

5.3 Summary

In this chapter, I have taken the perspective that people understand childbirth and its appropriate management through interactions embedded in specific social, cultural, political and historical contexts, steering away from a starting point that biomedical discourse on pregnancy and childbirth is the rational course of action and any deviation from it irrational. This perspective has revealed the logics of affect and rationality connecting people's own constructions of childbirth and care with their solutions for managing the event. In demonstrating these interconnections, the chapter has built on a body of literature that largely discusses perceptions of 'modern' versus 'traditional' forms of maternity care in isolation from broader understandings of childbirth (see Section 1.2).

Residents in these low-income urban neighbourhoods processed childbirth as a risk event, demanding the 'right' decisions from the range of care options in Indore to ensure a 'safe' birth. Exposure to biomedical knowledge was certainly changing local discourse, but its integration within existing constructions of childbirth and care shaped the way in which elements were understood (Denham, 2012; Van Hollen, 2003). The chapter has contended that exposure to biomedicine has contributed to a ubiquitous perception that risks in childbirth have increased. For some, this compelled a shift towards medical management, while others constructed themselves and their communities in contrast to the general population in ways that supported a narrative that medical management was, for them, unnecessary. As Zinn (2004) suggests, greater certainty emerges not only from protective action in response to perceived risk, but also from the (re)interpretation of situations.

While this population shared with biomedical discourse a central focus on minimising risks of morbidity and mortality, concerns encompassed a broader set of risks arising from the management of childbirth. Maternity care services were seen as both a solution and a source of risk. On the one hand, medical management offered technologies and expertise to identify and manage risks of childbirth. On the other,

quality of care in the public health sector was perceived to be poor (Matthews et al., 2001; Raman, 2014; Skordis-Worrall et al., 2011). Examining perceived quality of care in relation to constructions of a ‘safe’ birth, this chapter has shown that poor interpersonal care, in particular, is seen as a source of risks to the life and health of the woman and baby, as well as broader negative consequences for dignity and emotional well-being.

I have highlighted how birth in a health facility—specifically in the public sector in this case—was attached with meanings of loss of control or autonomy, replicating narratives from other settings across time and space (Kempe et al., 2013; Lindgren et al., 2010). Inclinations for a home birth were underpinned by narratives prioritising complete control over the birth process as well as confidence in the ability to manage this. Use of the private sector was presented as another way of retaining some control. Although several studies have identified poor quality clinical care in private as well as public health facilities in India (see Section 1.2), this population associated paying for care with leverage over the care they received. Yet, the costs of care in private health facilities were high and unpredictable, which raised potentially catastrophic financial risks for this low-income population.

Households in low-income urban settlements in Indore seek maternal health care from a socioeconomically vulnerable position within a complex, challenging maternal health system. The assimilation of an authoritative biomedical discourse is transforming childbirth into a risky event that requires medical management. Yet, with little trust in the health system, health facilities are not necessarily regarded as ‘safe’ places, compelling consideration of how to ‘manage the risks of medical management’ (Rothman, 2014). In this chapter, I have highlighted how these conditions and tensions exacerbate a high level of fear and anxiety surrounding pregnancy and childbirth.

This chapter has examined the range of perceptions relevant to care for birth. It has shown that inclinations towards different types of care at birth were connected with variation both in constructions of the different options for care and in how people positioned themselves in relation to risks and their management. Perceptions and inclinations underpin, albeit do not equate with actual care-seeking strategies, which are discussed in the next chapter.

6. The Care-Seeking Process for Birth

Plural, contingent and flexible strategies in a context of uncertainty

6.1 Introduction

This chapter addresses what care-seeking strategies are employed by households for childbirth and why. Care-seeking strategies refer to sequences of decisions and actions towards care at birth, including intentions or actual contact with providers and other preparatory actions. The chapter considers the site, type and characteristics of providers, and purposes for which they are consulted, across the spectrum of options available. The framework conceptualises care-seeking for birth as a process that extends through pregnancy until after birth (see Section 2.6), and it is this chapter that focuses on its dynamic character. This is an area that remains profoundly under-researched. The chapter begins with a review of how the care-seeking process has been conceptualised in the literature, particularly in India, and what we currently know about the process. This is followed by the findings in Section 6.2, which discuss patterns in sequences of decisions and actions, the meanings attached to them, and their interconnections with perceptions of care discussed in Chapter 5. These patterns are considered with reference to the context within which care-seeking takes place.

6.1.1 The care-seeking process for birth

The ‘process’ of maternity care-seeking in India—and in LMICs more generally—is under-researched. This is surprising given the importance of understanding how people engage with health systems for supply- and demand-side programmes aiming to improve the use and quality of maternity care services. By far the largest body of literature on maternity care-seeking in India analyses the statistical association between care outcomes and a range of explanatory variables (see Section 1.2). With a focus on structural factors, this literature tends to overlook the role of agency and emphasises the final care outcome. This outcome is often assumed to be synonymous with a ‘choice’ or ‘decision’ (e.g., Devasenapathy et al., 2014; Sarma & Rempel, 2007; Thind et al., 2008), implying a discrete and static decision which is made and then followed through to the birth in a linear fashion. Those who have a home birth are conceptualised as those

who made a decision to have a home birth, and vice versa. These models pay little attention to the process leading to care outcomes, and group together all those who share the same end-point outcome, regardless of how they reach this point.

Although models simplify reality, there is a need for complementary research to scrutinise the assumptions of these models. This is currently lacking in relation to care-seeking for birth in India. This static characterisation of care-seeking may serve relatively well in some contexts. For example, Miller and Shriver (2012) examine care decisions for childbirth in a US context and show how intentions for birth provider during pregnancy are acted upon and largely followed through to the birth, particularly where a hospital birth is planned. Limited research on the care-seeking process in India suggests that this characterisation does not adequately reflect the complexity of care-seeking strategies in this context.

Studies have shown that intentions for care at birth evolve as the unpredictable circumstances of pregnancy and birth unfold (Matthews et al., 2005b). Intentions are not fixed and outcomes do not always correspond with intentions. Moreover, studies in South Asian contexts with low use of skilled attendants at birth suggest that decisions to use a skilled provider were often made in response to complications after the onset of labour (Matthews et al., 2005b; McPherson et al., 2006; Parkhurst et al., 2006). Parkhurst et al. (2006) contrasted such findings in Bangladesh with those in Uganda, where intentions to use a skilled provider tended to be established earlier during pregnancy, with implications for actions taken to prepare for this outcome, such as saving money. Conversely, Matthews et al. (2005b) found that some households intended to use a skilled attendant at birth, but they were unavailable when needed. Whilst it is a positive sign that the women in Parkhurst et al.'s (2006) study in Bangladesh did reach a health facility in an emergency, this outcome might be considered substantively different from planned or routine use of a skilled provider, with implications for policy and programmes. Yet, the focus of large-scale surveys in India (e.g., NFHS or DLHS) on the final care outcome fails to distinguish this diversity.

Studies in South Asia have documented that households may engage with a number of different care providers simultaneously or sequentially during pregnancy and birth, either within the biomedical system or across systems (Parkhurst et al., 2006; Shah More et al., 2009a). The scenario in which medical care is sought as a last resort, suggests the possibility of pluralism even during the intrapartum period itself. A study

in Morocco showed how women may perceive no contradiction in seeking care from both ‘modern’ and ‘traditional’ providers, and birth practices may also blur the boundaries between the models associated with these different providers, creating ‘hybrid’ types of care (Obermeyer, 2000a). Indore’s complex urban health system also raises the issue of pluralism across sectors and types of maternity care services.

The focus in the maternal health literature has largely been on birth with a skilled versus non-skilled provider, or at home versus a health facility. Research investigating how people engage with different types of health providers through pregnancy to birth is limited. An exception is an insightful study by Shah More et al. (2009a), which traced the care pathways followed by women living in low-income areas in Mumbai, India, from pregnancy to birth. It distinguished not only between home and health facility, but also between different health sectors and types of institutions. Clients generally stayed within the same sector for ANC, registration and birth, although there was some movement from the private to the public sector. Within the public sector, there was also movement from smaller hospitals for ANC towards tertiary hospitals for birth, for reasons reported to include distance to services and medical indication prompting referral. Moreover, the study showed that it was not uncommon for respondents to receive ANC and register at a health facility, but then have a home birth. Whilst Shah More et al.’s (2009a) study provides insight into the trajectories of contact with the health system between pregnancy and birth, the quantitative methods allowed little insight into the meanings and motivations underlying the observed patterns.

There is evidence from studies examining determinants of maternal health care utilisation that women who have (more) ANC are more likely to use a skilled provider for birth, even after controlling for confounding factors (Bhatia & Cleland, 1995; Bloom et al., 1999; Ram & Singh, 2006). Whilst this may be intuitive, there is little understanding of the mechanisms underlying the association. There may certainly be a self-selection issue: women who are at higher risk may be more likely to seek ANC and birth with a skilled attendant. Further suggested mechanisms are that ANC may bring complications to the woman’s attention (Ram & Singh, 2006) or that women may be acting on health advice imparted during ANC visits (Bloom et al., 1999). Experience may be another mechanism: ANC may increase knowledge of health facilities or women may grow more comfortable with professional care through progressive exposure (Bloom et al., 1999; Ram & Singh, 2006). This latter point connects with

Ricketts and Goldsmith's (2005) emphasis on the importance of the temporal, experiential process of how people change as a result of their use of health services, with implications for the transition through the health system from one element to another. This is an important dimension that is rare for studies to consider, which is addressed in this chapter.

6.1.2 Birth preparedness

Birth preparedness is the main rubric under which actions taken during pregnancy towards care at birth are conceptualised in LMICs. 'Birth preparedness and complication readiness' refers both to a concept and an intervention approach developed in the early 2000s by JHPIEGO, an international, non-profit organisation affiliated with John Hopkins University (2001) to address the 'three delays' in women receiving timely and adequate obstetric care following the onset of a complication (Thaddeus & Maine, 1994) (see Section 2.3). It is predicated on the notion that women who are more 'birth prepared' are more likely to birth with a skilled provider (JHPIEGO, 2004). It has been used widely as an approach to community mobilisation and behaviour change interventions in the decade since it was introduced (Soubeiga et al., 2014), becoming a key component of community-oriented Safe Motherhood programmes in LMICs. Being birth prepared entails having identified a place for birth and a skilled provider; saved money for the birth and arranged for transport; and having knowledge of the danger signs that may indicate a life-threatening complication (JHPIEGO, 2004). Some usages of the approach include ANC, while others separate the two (cf., Karkee et al., 2013; Moran et al., 2006).

JHPIEGO acknowledged that the approach was rooted in theory rather than evidence (2004). Some problems with both the conceptualisation and the research base that has developed around the approach are noteworthy. The 'three delays' model on which it is based focuses on delays in receiving obstetric care when a complication arises away from a medical facility. Yet, birth preparedness approaches often focus on the routine use of a skilled provider for all births (JHPIEGO, 2004), in which the notion of preparing to avoid 'delays' loses its potency. Further, analyses of cross-sectional surveys show a positive association between being 'birth prepared' and use of a skilled provider at birth (Kabakyenga et al., 2011; Karkee et al., 2013; Moran et al., 2006;

Nawal & Goli, 2013). This is regularly interpreted to mean that being birth prepared 'motivates' women to use services. Yet, intuitively, the relationship is more likely to signify that those who intend to use a skilled provider at birth are more likely than those who do not both to eventually use those services and to prepare for using them in advance. Those who have used skilled providers are also more likely to know how to answer questions about birth preparedness than those who have not used services.

An assumption inherent in birth preparedness approaches is that women do not use a skilled attendant at birth because they are not prepared or have insufficient knowledge. However, a study in Indore found that higher proportions of women reported identifying a skilled attendant and a health facility, and saving money for birth and obstetric emergencies than actually used a skilled provider at birth (Agarwal et al., 2010). In this context, the success of a birth preparedness intervention in increasing routine use of a skilled attendant at birth would rest on its ability indirectly to generate demand. Soubeiga et al.'s (2013) intervention study in Burkina Faso found greater effects on use of a skilled attendant at birth from preparedness messages provided during ANC visits in areas where institutional births are low, leading them to conclude that it is important to adapt the content of messages to the context. Essentially, the issue of context is crucial.

A recent systematic review and meta-analysis of randomised studies of birth preparedness interventions in LMICs did find a statistically significant reduction in neonatal mortality risk, but not an increase in births with a skilled attendant (Soubeiga et al., 2014). Developing understanding of the mechanisms through which interventions may or may not impact various outcomes in different contexts is imperative in order to inform the design of better targeted interventions. There is also a need for much greater understanding of local care-seeking strategies through pregnancy to birth as well as the contexts within which these play out as a foundation for programmes. Research in this area remains profoundly limited given the widespread use of birth preparedness approaches, which suggest that planning and action towards care outcomes is considered to be an area of programmatic need. It may be that the focus on a specific notion of what preparing for birth entails, with its assumptions on the process and challenges, has contributed to the narrow view of care-seeking strategies currently seen in the maternal health literature.

In sum, the current literature on care-seeking for birth largely portrays a static and discrete decision along with a linear course of action. Little attention has been afforded to the dynamic process of care-seeking for birth and to the strategies that are developed and implemented by households and their members to negotiate the health system in different contexts. This chapter aims to move the research agenda on maternity care-seeking forward in this direction. It builds on the current literature that largely focuses on the role of structural factors by providing a more in-depth understanding of the process of care-seeking and the role of household agency. It informs both policy and programmes that seek to engage with communities and those that seek to make health services more responsive to user needs in order to facilitate use of services and improve their quality.

6.2 Findings

Findings in this chapter draw in particular on longitudinal analyses and thematic analyses of data from all cases. Patterns in care-seeking strategies for birth and their meanings are presented and discussed. More specifically, these include patterns in decisions and actions taken during pregnancy towards care at birth, with a focus on engagement with the health system; actions taken after the onset of labour; and the interconnections between these and the care received. These are illustrated with quotes and short case examples. While the sample is non-representative, the aim where numbers are presented is to contextualise the patterns identified within the larger data set.

6.2.1 Plural, contingent and flexible strategies

Households in this study actively engaged in care-seeking for birth, displaying agency in managing the birth in the way they perceived best within the constraints of their material and social circumstances. All households formed intentions; this was evident from the concordance of narratives within households on intentions for place of birth, which suggested that at least some discussion had taken place (see Chapter 7 for analysis of intra-household dynamics). In a complex urban health system, unlike in rural areas where there might only be one facility within reach, forming intentions involved

considering not only birth at home versus a health facility, but also the type of provider and the specific institution. Findings in this study contrasted with those from earlier studies in India and other South Asian contexts which indicated that contact with maternity care services was largely initiated in response to problems during a home birth (e.g., Matthews et al., 2005b; Parkhurst et al., 2006). In view of the rapid increase in use of health facilities for birth in recent years in the study setting, underpinned by widespread anxiety regarding first births and exposure to biomedical discourse (see Chapter 5), all households reported engaging to some extent with the formal health system as part of care-seeking for birth. Yet, constructions of risk and inclinations towards different care options had implications for the nature and patterns of engagement.

While strategies played out in diverse ways and at different stages of the episode across households, they were nevertheless patterned. A key theme was that intentions for care at birth tended to be plural, contingent and flexible. The intentions of many households for care at birth (ten of 16 in this study) could be characterised as ‘contingency strategies.’ That is, they were not expressed as a single, fixed ‘decision’ or ‘choice’ of a provider or institution, even in the third trimester of pregnancy. Rather, they were plural and filled with ‘ifs’ and ‘buts.’ This ambiguity should not be interpreted as passive ambivalence on the part of households; in this context, it was strategic. Such strategies kept several options on the table, compelling or allowing them to be (re)assessed in view of the unfolding circumstances of pregnancy and birth, and a final decision to be made after the onset of labour. Attached to each option were circumstances, more or less clearly articulated, which would prompt or prioritise its use. These circumstances might include, for example, prenatal reports on the woman’s health or the foetus; complications following the onset of labour; being informed at hospital of the need for a caesarean section; referral from a hospital; the timing of onset of labour; or the ability to mobilise resources.

The options included in contingency strategies were connected with perceptions within the household of the diverse care options available (see Chapter 5), reconciled through patterned intra-household relationships (see Chapter 7). For those whose intention was first to ‘*see whether it is possible at home,*’⁴⁹ a health facility was

⁴⁹ C3, woman, I1

recognised as a contingency option in case there was a complication or the *dai* reported that she was unable to manage the birth:

'We have got her name registered at [a small private clinic]. [The private tertiary hospital] is also there. And I also arrange for someone to check her at home [...] As the circumstances demand, we'll do accordingly. If there's need, we'll take her to hospital. But before that I get her checked. If [the midwife⁵⁰] says, "There is time, you can take her to hospital," then we'll take her. But if she says, "Wait for 5–10 minutes, I'll get the delivery done here," then we'll get it done at home [...] And the doctor is also nearby, we call her also. She does whatever is necessary like giving injections⁵¹ and all. That is, we don't want the child to be at any risk, we've arranged for all facilities [...] We got her name registered⁵² [at the private tertiary hospital, not only the small private clinic] so that the option is open for us. If there's an emergency at night or there is need to go to a big hospital, we can go there anytime' (C10, mother-in-law, I1)

The quote is from an interview with a mother-in-law who was inclined towards a home birth. Yet, anxious about birth risks, the household developed elaborate, strategic plans to address contingencies. Contingency plans involved not only one but two health facilities: a small private clinic that was nearer, where the household had built rapport over several household pregnancies with the doctor in whom they had '*faith*,' as well as a larger hospital that they perceived to be more daunting, but which had greater obstetric facilities in case of need, including a neonatal intensive care unit. Although not all contingency plans for households whose primary intention was a home birth were as well-developed, and not all households acted on these intentions to the same degree (see Section 6.2.2), all identified one or more specific hospitals that they would use in case of need.

The combination of home birth with private health facilities was commonplace in this subgroup. Negative perceptions of government hospitals underpinned efforts to bypass the public sector, which Chapter 5 discusses in terms of maintaining (at least some) control over the way in which birth is conducted. These households favoured a home birth to realise this objective, but they remained willing in case of need to find a way to mobilise sufficient resources to seek care in the private sector and endure its economic consequences in order to avoid birth in a government hospital. Those who

⁵⁰ I refer to a midwife rather than a *dai* in this case since she was described as someone who was retired from working at a hospital, but I was unable to verify whether or not she was a skilled attendant

⁵¹ I.e., injectable uterotonics for labour augmentation (see Section 5.2.3)

⁵² See Section 6.2.2 for further detail on registration

reported private hospitals to be their contingency option did not necessarily have greater financial resources than others.

Plural intentions were also commonplace among households intending a hospital birth. Typical combinations were small and large public hospitals, or small public hospitals with private health facilities. The following quote demonstrates the former combination:

'As we used [this small public hospital] at the time of my sister-in-law's delivery, we know it's good. She was there for three days and she said it's good. So mummy got me registered there and also in [a larger public hospital], as one cannot be sure whether it will be a normal or caesarean delivery, although I've been told it will be a normal one. Even then we haven't taken any chance and got registered⁵³ in [both hospitals]. We won't have to run about at the last minute' (C12, woman, I1)

Both options pursued by this household were within the public sector. They perceived interpersonal care to be better in the smaller public hospital, which they were therefore more inclined to use (see Chapter 5). However, they retained the larger public hospital as an option in case the woman needed a caesarean section due to its greater obstetric facilities.

In combinations of small public hospitals with private health facilities, the small public hospital was intended if all was 'normal' and the private facility was a contingency option in case of a complication. A larger public hospital was bypassed because of a perception that more thorough and attentive care as well as greater expertise is required for dealing with complications, which these households perceived to be more likely in the private sector (see Chapter 5):

'We've decided on [this small public hospital]. If it doesn't happen there (i.e., if referred), then we'll get it done at a private hospital. [The small public hospital] would tell us to go to [the public tertiary hospital]. [The public tertiary hospital] isn't good. Rather than go there, we would go to private' (C11, husband, I1)

The contingency planning attests to the high level of strategising that households engaged in to negotiate the complex urban health system in the study context, with the aim of ensuring a 'good' outcome, as they defined it. Participants developed complex strategies, combining the perceived strengths of one option with the strengths of another to adapt to different types of circumstances, and taking into account social and

⁵³ See Section 6.2.2 for further detail on registration

economic constraints. There were exceptions, however. These were largely households that intended birth in a large public or private hospital with a whole range of facilities, which gave them confidence that there would be no need to use any other hospital. For example, one woman explained with regards to such a strategy that it is best to ‘*go to a hospital that is good, where all facilities are there, so there is no need to go from there to any other hospital.*’⁵⁴

Intentions as well as actions towards realising them were also dynamic, evolving in response to influences through time. Households formed intentions but these were re-evaluated as the context changed in ways that had implications for perceptions. Interaction with social ties during pregnancy influenced intentions. For example, family, friends or acquaintances offered advice or shared their own experiences, which led households to view options in a new light (see Chapter 7). Interaction with the health system during pregnancy was also a major influence, reinforcing Ricketts and Goldsmith’s (2005) statement that more attention must be paid to the temporal, experiential process of how people change as a result of their use of health services. The perceived quality of experiences during prenatal contact with health care providers was one key element:

‘When I first came here, my parents took me to this other [small public hospital]. I got a sonography there and sought other information about delivery. But the doctor there asked me to get admitted 15 days in advance and my delivery hasn’t happened until now [...] My mother pleaded not to get me admitted. She said she had small children, “Who will look after them?” [...] I was feeling scared over there. There was no one with us, it was only my mother and me [...] They took our thumb prints on paper—mine and my mother’s⁵⁵. Then they said, “You come for delivery anytime, it won’t be our responsibility.” Then I said, “I won’t get delivery done at this hospital.” I didn’t register my name also there and we left [...] I felt scared with all this’ (C1, woman, I1)

This woman subsequently registered at a private tertiary hospital, but eventually stayed at home for the birth.

Health facilities might also refuse to register a woman or refer her elsewhere if reluctant to take on the case for various reasons. Perceptions of the unfolding circumstances of pregnancy and one’s risk status—which may or may not have been

⁵⁴ C9, woman, I2

⁵⁵ A thumb print was an alternative to a written signature since the woman and her mother were not literate. It appears that the woman and her mother were asked to ‘sign’ to clear the hospital of responsibility for an adverse outcome because they had not followed advice for immediate admission.

informed by contact with the health system—also evolved in ways that affected intentions. Problems or complications identified during pregnancy led some households to eliminate options in favour of others they perceived to be better able to deal with complications. In one household, the woman’s increasing weakness was perceived to pose risks for a home birth, prompting the balance to tilt towards one of the health facilities already in their contingency strategy:

‘Earlier everybody was of the view that a home delivery is better, but later on they thought that it would be better to get the child delivered at the hospital, in case anything is required [...] Because every now and then something keeps happening to me, they think that I won’t be able to manage anything on my own, so they feel that it would be better to take me to hospital’ (C10, woman, II)

6.2.2 Contact with the health system and other preparatory actions

All households engaged with maternity care services to some extent during pregnancy, regardless of intentions for care at birth. Many also engaged with traditional providers, including some households planning birth in a health facility. Different health system contacts served different (combinations of) purposes. Some contacts were directly intertwined with care-seeking for birth, such as those initiated predominantly to ‘test’ different facilities in order to inform intentions, as well as those aimed at acting on intentions through registering or maintaining contact with specific health facilities in preparation for care at birth. Other purposes for contact with the health system during pregnancy were indirectly linked to care-seeking for birth. Such examples included checking or monitoring the woman and foetus in order to identify any risks that might influence intentions for care at birth, or seeking medical technologies that might minimise risks at birth.

The interconnections between ANC, registration at a facility and care-seeking for birth were complex. ANC in the study setting was predominantly sought and provided through public or private health facilities that also offered care at birth. Yet, some small private clinics or sole practitioners offered ANC without provision for care at birth. Some basic elements, such as iron supplements and tetanus toxoid injections, were also available through auxiliary nurse midwife outreach visits. Each public hospital with provision for care at birth conducted separate registration. Advance registration was imperative for birth in public health facilities other than the tertiary

hospital. If a woman arrived at one of these facilities for birth without advance registration, she would be advised to go to the tertiary hospital. The tertiary hospital also pre-registered women, but admitted women for birth regardless of registration status. Women were able to register in any and as many government hospitals as they wished, but registration in one facility did not carry over to any other facility. Advance registration was also required in most private health facilities; without it, women would be turned away. However, some private hospitals—particularly larger ones—did admit unregistered women, mostly on an ad hoc basis.

Registration and ANC were interlinked. Households and key informants reported that registering at a facility necessitated completing an ANC visit with an array of tests, regardless of whether the woman was pursuing ANC and had undertaken such testing elsewhere, even if this was at another public health facility in the city. This highlights inefficient linkages between facilities within the public sector. Similarly, attending a facility for ANC tended to lead automatically to registration; thus, registration did not necessarily signify an intention to use the specific facility for birth.

A household might consider a specific hospital to be an option for birth and act on this through registering. Fifteen⁵⁶ of 16 cases in this study were registered at least at one hospital. They received ANC as part of the registration process, with some accepting this as a one-off and others returning for regular appointments. Where intentions for birth were uncertain or changed during pregnancy, and/or involved contingencies that were acted upon, a scenario emerged in which households might register and receive ANC at multiple facilities both within and across different sectors. It was a deliberate strategy of some households to register at several facilities in order to keep options open, allowing greater flexibility to make decisions in response to unfolding circumstances. For example, the following interview excerpt shows how this woman sought ANC regularly at two health facilities to keep both options open for the birth. Incidentally, this was a household in which the intention at the time of this interview was to try first for a home birth.

Woman: *'I am taking treatment from two places. We go to the private clinic every 15 days and get checked up. But in [the private tertiary hospital], it is only possible about once a month.'*

Interviewer: *'And why are you going to the two places?'*

⁵⁶ In one case, it was unclear whether they had eventually managed to complete this process since household members' narratives contradicted each other (see p.158)

Woman: *'Because if the delivery happens at night, this private place is nearer. Who will take me to [the large] hospital?'*
(C10, woman, I1)

Some households identified health facilities included in their care-seeking strategies based either on previous experiences within the household or on information shared by family, acquaintances or community health workers (see Chapter 7). They might alternatively or additionally visit multiple health facilities in order to assess options for care at birth in a strategy of 'shopping around.' This entailed setting out deliberately to identify maternity care services that they perceived to be acceptable. Whilst this 'consumerist' approach is perhaps not surprising in Zadoroznyj's (2001) study in Australia, it is more unexpected in low-income areas of a state in India where the proportion of births with a skilled provider was low until recently. Yet, a quarter of households adopted this strategy. They might visit hospitals both across and within different sectors as part of their search for the 'best' facilities for birth. The following quote demonstrates one household's strategy of seeking information and testing different maternity care providers in order to assess them against their criteria for at least the minimum expectations of a facility for birth.

'We wanted to go to [name of hospital] because it was a private hospital and a good one. Then we had gone to [a small public hospital] also. We had gone here and there. So we were looking for a facility where we could go, where there are good facilities and where we could get ourselves admitted quickly. That's why we had taken out information about various hospitals' (C6, woman, I2)

Reflecting characteristics of others who also adopted this strategy, this woman and her husband had a relatively high level of education, having both completed high school. As a nuclear household in which both the woman and her husband were migrants to Indore, they also had little previous experience with the city's health care services to inform intentions.

Other contacts with maternity care services during pregnancy were less directly related to care-seeking for birth. Some households weighed out one set of priorities and constraints for ANC, and a different set of priorities and constraints for care at birth. Prominent in this group were households that were particularly distrustful of the public sector and sought to bypass it wherever possible. Costs of birth in private facilities were both higher and more unpredictable than the costs of ANC in these facilities. As a result, some households elected to pursue ANC in the private sector for check-ups and

treatment, sometimes in clinics that did not have a provision for care at birth, and then register at a government health facility as part of the care-seeking process for birth, which necessitated further ANC and another round of tests.

Some households had a very high level of contact with the formal health system during pregnancy, attending regular ANC appointments at one or multiple hospitals, perhaps visiting other health facilities to check their services or to register, another facility for diagnostic tests that were unavailable in all facilities, as well as visiting the auxiliary nurse midwife at the Anganwadi centre for injections, iron supplements or advice. A further motivation observed for visiting multiple hospitals was to cross-check reports given from one hospital with those given at another, with the aim of verifying or questioning the accuracy of information provided. For example, one woman who was told of abnormal presentation following ultrasound in a public hospital followed up with another in a private clinic to cross-check, since the household was anxious to avoid an unnecessary caesarean section⁵⁷. Another husband reported that, *'People were telling us to get a check-up done in private once.'*⁵⁸ Similar actions were taken in another household, but in this case all within the private sector:

'In the beginning, [one private hospital] was saying the child is weak. They gave injections but still said the child is weak [...] [My mother-in-law] was tense and said, "Now I'll go to another [private] hospital" because she didn't understand. Then she, my husband and I went to this hospital and said we'll do it here. Here they said everything's fine' (C13, woman, I1)

Some women also visited health facilities frequently in response to symptoms, complications or worries during pregnancy:

'I've been [to see the doctor] many times. I go there twice in every eight days or so [...] because my health doesn't remain good. Like recently I had pain, or my BP becomes low. See, with the slightest tension, my BP becomes low. I can't take any load on my mind. Then when my health becomes bad, I have to rush to hospital' (C6, woman, I1)

Interviewer: *'From her seventh month (i.e., when she returned to the natal household), how many times did she go to the doctor?'*

Mother: *'We took her 10–15 times. They used to call for her once in every 7 or 8 days [...] because the fluids were less in her body. Apart from that she didn't have any problems [...] It was important because her stomach used to pain her.'*

⁵⁷ C8

⁵⁸ C11, husband, I1

I was nervous because the baby had problems and she also used to get pains quite often' (C13, mother, I2)

Although a biomedical risk discourse was becoming increasingly dominant, this population had limited access to medical information, and anxiety about unexplained symptoms or risks was sufficient to prompt many to go to the hospital immediately. Far from the portrayal of a poor population in India with limited use of maternity care services, many households in this study demonstrated frequent use, and strategically negotiated the complex urban health system to manage pregnancy and birth.

Use of such a plethora of ANC has implications for continuity of care. Only in three households was continuity of care described as a deliberate element of their care-seeking strategy for birth:

'It's good to get [all] treatment done in one place; that's what people say. They know everything about your case, and also other doctors don't really take any interest in you if you go to them later. [People] say that we should continue going to the same hospital we go to from the beginning' (C8, woman, I2)

Continuity of care refers to provision by the same caregiver or small group from pregnancy through to the postnatal period (Hodnett, 2000). In this study, the lack of continuity of care emerging from the use of several health facilities and providers had a range of implications. One woman, for example, was given an estimated delivery date that differed by as much as two months in two different health facilities she attended for ANC.

Frequent use of maternity care services and intentions to birth in a health facility did not preclude contact with traditional providers during pregnancy. Whilst some households were entirely opposed to this, other households were not averse to calling a *dai* during pregnancy, even if they perceived a hospital birth to be the only safe option. The *dai* might be tasked specifically with massaging the abdomen to '*set the baby straight*' or to relieve pain. While their advice was valued, they were called for a specific purpose rather than for general checks:

'That dai has a lot of knowledge; she tells everything. Whether [the delivery] will happen at home or one will have to go to hospital, she tells everything [...] Last Sunday, the hospital was closed and my madam (doctor) wasn't there, and my abdomen was paining a lot. I couldn't even sit because of the pain. So [the dai] came and massaged my abdomen. Then I told her that madam (doctor) said my baby's weak. She said, "No, your baby's absolutely fine." She said it's not getting space to move inside the womb [...] Like she told me everything is

normal, so when one has no problem, then she can be called at home' (C6, woman, I1)

The quote is from a woman who was in general strongly inclined towards a biomedical risk discourse, but called the *dai* as a fall-back when these services were unavailable. Although she intended birth in a health facility, the quote shows how the *dai*'s advice was nevertheless taken seriously. A further example shows how naturopathic treatments were sought by one household when allopathic treatment was perceived to have failed to produce results.

'[My family] believe in naturopathy. Because I didn't feel much relief [when unwell during pregnancy] with the medicine my brother had bought from [the doctor], my husband bought medicine from some other baba⁵⁹ who was renowned and told me to take that medicine and I would get relief quickly [...] He gave some herbs, some medicinal plants and there was a white powder, and he said that if I ate those with milk or water, then I would feel relief in three days' (C12, woman, I2)

Conversely, even households that reported intentions for a home birth engaged selectively with maternity care services to varying degrees during pregnancy. For example, they might register at a health facility as a contingency strategy. They might also seek medical technologies perceived to be beneficial in identifying or managing birth-related risks. These were constructed as actions that would assist the household in realising its primary intention for a home birth. For example, prenatal checks and testing provided reports on the health status of the woman and foetus, which would inform the evolving care-seeking strategy for birth; and certain medical technologies, such as tetanus toxoid injections, were sought as a way of minimising birth risks. The following quotes demonstrate these strategies. The first describes an intention—subsequently enacted—to register at a health facility so that the woman could be admitted in case of need.

'We will register [the woman's] name in the last month [...] In the same hospital we'll get her check-up, we'll get her sonography done, we'll get her blood group test done, so we'll have that hospital's papers⁶⁰, (C15, mother, I1)

The second concerns the uptake of tests to check the woman's health status and monitor the pregnancy to ensure that a home birth would be 'safe.'

⁵⁹ Wise and respected elderly man, sometimes associated with spiritual powers

⁶⁰ To 'have that hospital's papers' refers to being registered.

'We took treatment with [a doctor at a private nursing home]. When she checked she said that the baby is normal and so the delivery will also be normal. She had told us that if she has any problem, bring her to the hospital, but we didn't have any such problem [...] [The purpose of ANC is that] you get to know if the baby is weak or there is a problem with the baby, and whether the lady is weak, and they write for the tetanus injection and give' (C16, mother, I2)

Responses to such reports were sometimes contradictory, however. 'Normal' reports reinforced intentions for a home birth, but reports of health concerns did not always prompt the household to reconsider a home birth.

Contact with the health system during pregnancy among households whose primary intention at the first interview was a home birth varied in accordance with the distinct risk discourses discussed in Section 5.2.2. Some of these households' contact with maternity care services amounted to a single visit to fulfil only what they perceived to be absolutely necessary, and that often in late pregnancy. Yet, others attended ANC regularly throughout pregnancy—in one case reportedly three times a month⁶¹—with the aim of managing risks that would allow them to safely pursue a birth at home, as they perceived it.

Finally, in terms of other preparatory actions, households were unconcerned with preparing for transport in advance because they did not perceive this to be a challenge. Participants described several public and/or private transport options available to them in first interviews, but were largely confident that *'arrangements can happen when the time comes.'*⁶² Households did make some financial arrangements in advance, albeit largely in late pregnancy. This tended to be more focused on ensuring access to funds that might be needed than on saving since costs were unpredictable within these households' contingency strategies. For example, one husband described keeping a small amount of money aside anyway, but reported that he had also made an arrangement with a friend to borrow INR 5000 in case they eventually used a private health facility. Borrowing from friends, family or money lenders, sometimes on interest, was described across the sample, and some participants described household members taking an advance on their salaries. Some households also pawned valuable items and others belonged to different forms of savings groups.

⁶¹ C10

⁶² C9, husband, I1

In sum, contact with the health system during pregnancy was complex, but in all cases strategic. Answers to questions on the pathways of influence between prenatal contact with maternity care services and care-seeking for birth are unlikely to be straightforward. However, these data suggest that they should not be conceived as discrete care-seeking episodes. Although ANC visits do not necessarily signify an intention for a hospital birth or to use a specific health facility, they are intertwined with care-seeking for birth. First, some prenatal visits to health facilities were made specifically to register for birth at that facility, whether this was a primary or a contingency option. In these cases, it could not be said that ANC motivated the household to seek a health facility birth, since it was already an intrinsic part of their care-seeking strategy for the birth. Nevertheless, there was evidence that such ANC influenced or reinforced intentions for a hospital birth for some households, through processes including reports that drew the household's attention to risks, such as 'a lack of blood' or a 'weak baby'; through crystallising an intention or contingency plan; or through the influence of exposure to medical care or a specific provider. Nonetheless, a minority of households in this sample conversely perceived their use of ANC to mean they were taking precautionary measures that would allow them to proceed 'safely' with a home birth.

6.2.3 Actions following the onset of labour

Regardless of intentions during pregnancy, options were reassessed after the onset of labour. Circumstances led households to take action towards a particular option among their intentions or to an option not previously considered at all, and strategies might be revised further as circumstances continued unfolding. The point of contact with the health system following the onset of labour was a critical stage at which the course might change. In effect, sequences of evolving circumstances and actions in response continued until after birth, with implications for the care pursued.

Certainly, some households received care in accordance with their reported primary intentions, but several also pursued a different option or were diverted while pursuing a primary intention. Focusing on home versus hospital births initially, five women had a home birth and two stayed at home following the onset of labour until a problem arose that led them to seek care in a health facility. Yet, home birth was a

reported intention beforehand of only four households. Three of these households reported that home birth was not under consideration in first interviews, but intentions for a hospital birth were side-tracked after the onset of labour and they eventually stayed at home.

Pathways after the onset of labour for some households were of particular concern in terms of their potential implications for the notion of a ‘safe birth,’ as defined by the international community. The following case example describes the care-seeking process narrated by a woman and her mother in one such case (C14), and traces some of the influences on the pathway following the onset of labour. This woman’s household was in a neighbourhood with strong norms of home birth and both she and her mother discussed the advantages of a home birth. Nonetheless, members of her family were used to engaging with public health providers, having been employed in roles linking them with their community, and she and her mother reported an intention for the birth to take place at a public health facility. She was seemingly ‘birth prepared.’ During the third trimester, she had identified, sought ANC and registered at a health facility. Unusually for this study, both she and her mother reported saving money for the birth. She had also apparently taken the telephone number for the intended hospital’s ambulance service.

Nonetheless, when labour pains started, intentions for a hospital birth were initially abandoned and a *dai* was called. Both the woman and her mother claimed that it was the woman’s own decision. The woman reported fear that the birth would take place on the way to hospital and her mother reported that she was concerned by the effort required to seek care at a hospital. The mother followed a common—but unsafe—practice in this context of calling a doctor to their home to administer injectable uterotonics for labour augmentation (see Section 5.2.3), following which the doctor left. In the early hours of the morning, after two injections were administered, concerns arose regarding what the woman reported to be a lack of progress, and her mother reported to be the woman’s inability to ‘bear the pain.’ At the woman’s request, a decision was made to shift to a hospital.

Realising that the contact details they had taken from the small public hospital at which the woman was registered were printed in an English script they did not understand, they called the widely known number for the general ambulance scheme for births (see Section 3.6), which took them to the public tertiary hospital. The ambulance

could only come as far as the entrance to the neighbourhood and with the woman by now reportedly in the advanced stages of labour, she struggled to reach the ambulance. When she did, the drivers raised concerns that the birth would take place during the journey to the hospital in the absence of a skilled provider, and reportedly encouraged the dangerous practice of binding her lower limbs with the aim of halting the birth until she reached the hospital⁶³. She eventually had a normal birth immediately upon being admitted to the hospital.

Aside from being an example of ‘unsafe’ practices, this is an illuminating case because it illustrates several patterns that are shared with other households. First, the care received in this case cannot be understood in the singular since the woman received multiple types of care between the onset of labour and birth. While she was at home, a relative, who was also a *dai*, was the main care provider, but the mother called a doctor to the house to administer oxytocin injections, combining both traditional and medical forms of care. This mirrors the findings of Obermeyer’s (2000a, 2000b) studies in rural Morocco in the early 1990s, which found that the boundaries between a home and hospital birth were fluid, and elements of both were combined in many cases. Also, there was a shift from a predominantly ‘traditional’ home birth to medical management at a hospital as the circumstances of labour unfolded. Circumstances continue unfolding through labour in ways that have implications for care-seeking strategies, so the type of care received may evolve throughout the intrapartum period. A singular notion of outcomes is oversimplified since the outcome itself may be plural. As in this case, some households combined elements of traditional and medical care. However, care at birth may also involve pluralism within the formal health system where care shifts between multiple providers across different sectors or institutions.

The case is also illustrative of the non-linearity in some cases between reported intentions for care at birth and the actions taken following the onset of labour. There is no straightforward explanation for this phenomenon as narratives were complex and somewhat contradictory. Two households in which the reported intention for a hospital birth was not acted upon at all following the onset of labour were in neighbourhoods with strong norms of home birth, resulting in less social pressure to use a health facility (see Chapter 7). Within each narrative in these households also, particularly

⁶³ Only two women used an ambulance service to reach a first health facility, although several others travelled by ambulance when referred from a first health facility to the public tertiary hospital. More positive experiences were related in other cases.

contradictory perceptions of biomedical and traditional management of birth were conveyed (see Chapter 5): on the one hand, the greater safety of a hospital birth was espoused, but on the other, perceived risks of medical births were described as well as greater comforts of home birth. The combination of these elements allowed intentions for a hospital birth to be abandoned with little hesitation. Both women's constructions of events related fear that the birth would take place on the way to hospital, but in both cases, the *dai* was called immediately, suggesting a more complex underlying explanation.

A somewhat different case was a household in which some actions were taken towards a hospital birth in the early stages following the onset of labour, but a sequence of events led to their abandonment (C12). This was a household in which both the woman and her mother were unwavering on intentions for a hospital birth in first interviews, and had developed strategic contingency plans for different eventualities. Following the onset of labour in the early hours of the morning, the woman's mother encouraged her to stay at home until the pain increased. When the pain intensified, they called the ASHA to accompany them to the hospital but, despite agreeing, she did not arrive. Six hours reportedly passed between calling the ASHA and the birth. Rather than go themselves to hospital, they called the *dai*, the purpose of which the woman reported was *'to manage until the ASHA came and took me to the hospital.'* The woman reported:

'I was having problems in the delivery [...] [The baby] wasn't able to come out as she was entangled. The [dai] was trying to push her out but she was going inside instead and, as it was my first delivery, I wasn't able to get those pains which are required' (C12, woman, I2)

Despite the woman reporting that her family became increasingly worried and suggested that they shift to hospital, the *dai* advised them to continue with the home birth, and her mother reported: *'[The dai] said that she would take the responsibility and I told her that, if she was so confident, then there was no need for me to take her to hospital.'* Eventually, despite conveying strong negative attitudes towards a home birth in first interviews, the woman stayed at home for the birth. The case was underpinned by a different explanation to the previous cases. The explanation seems to lie largely in a sequence of social interactions both within the household and between the household, the ASHA and the *dai* following the onset of labour.

Among the three women who did not fulfil—at least until crisis point—their reported intention for a hospital birth, two were seemingly ‘birth prepared’ and the other had made some preparations⁶⁴. They identified and registered at one or more hospitals; sought ANC; either saved for the birth or identified how they would mobilise resources; and identified transport options they could use. Moreover, of the four other households whose primary intention was to have a home birth, three had identified and registered at a health facility as a contingency option; managed to mobilise resources for the birth, which they prioritised for a special postpartum diet; and had identified transport they could use if need be. Indeed, the uncle of one woman who had a home birth was reported to have called an auto-rickshaw at the time of the birth to wait in case of need. In none of these cases could a lack of ‘birth preparedness’ be understood to underlie non-use of a skilled attendant. Being ‘birth prepared’ was intrinsic to the contingency planning that was common in this sample. Understanding non-use of care in such a context requires engaging with a more complex combination of reasons than is offered by a ‘birth preparedness’ approach.

Among households that took action towards birth in a health facility following the onset of labour, as intended, the relationship between intentions and actual care at birth was scarcely more predictable. No household reported difficulties in reaching a health facility. Critical points that altered courses of action were centred on the period once a woman had reached the first health facility. Of the eleven cases that visited a health facility at some point during the intrapartum period, six received care in the facility they intended when they set off from home. These were largely households that sought care at large public or private health facilities where they had previously registered. The remaining five households were refused admission or checked by a health professional and referred to a larger hospital. Whilst all eventually reached a health facility before the birth, participants described a stressful experience. The following interview excerpt presents one woman’s narrative of her experience between reaching the first health facility and getting to a health facility where she was finally admitted.

‘[At the private hospital], we couldn’t meet a doctor or nurse, and when we asked them (administrators) to check, they said, “She’ll come in 10 minutes; she’ll come in 15 minutes” and so on. We waited there in that way for 30, 40, 45

⁶⁴ See case discussed on p.158

minutes, but the doctor didn't come, and we thought the pains that were coming shouldn't become less, so that's why we left [...] We had got a card done (i.e., registered) at [a small public hospital] [...] We went [there] and got very good doctors, but in my sonography [done there earlier], they had reported that the baby was weak and, after seeing that report, they said, "Here you can have a normal delivery but we can't take care of children as there's no children's doctor here." So that's why they sent us to [the public tertiary hospital] [...] Everyone got scared as I wasn't getting admitted to any hospital. My mother was scared [...] because I was feeling so weak, and after seeing my condition, she was getting all unnecessary thoughts [...] I was getting so much pain and because of fear, I wasn't able to grasp things at all. I was telling all my people, "Wherever you want to take me, take me soon"' (C6, woman, I2)

Having adopted a 'shopping around' approach to determine which health facilities met expectations and eliminate those that did not (see Section 6.2.2), this household had registered at a minimum of four health facilities, including private and public health facilities. Nonetheless, they experienced a difficult pathway to care after the onset of labour. Initially, the household had tried to contact the private doctor they had seen at her home clinic throughout pregnancy, who had earlier agreed to come to the private hospital to assist the birth. Unable to make contact after the onset of labour, they proceeded to the private hospital anyway, where she was still not seen by a doctor after waiting for some time. Scared of the implications for the progress of labour of waiting any longer to see the doctor, the family felt compelled to discuss and decide where to try next. Anxious to avoid the public tertiary hospital, where they perceived services to be 'careless,' they next visited a small public hospital. Yet, this hospital referred her to the tertiary hospital as they were reportedly unwilling to take the risk of managing the birth because of previous ultrasound results. She eventually did reach the tertiary hospital and had a normal birth soon after arrival. With considerable time passing before she received care; failing to get admission at two hospitals; and the prospect of having to use the tertiary hospital she feared and had strived to avoid, this had been a stressful experience.

Participants and key informants reported that referral of first births from small public hospitals to the public tertiary hospital was common practice in the study context. The purpose here is not to examine indications for referral since this was beyond the scope of this study. Certainly, in some ways, it could be conceived as a positive point that health providers act cautiously in referring to facilities with access to emergency obstetric care. Nevertheless, the admission of primiparous women in small public hospitals seemed to be more the exception than the rule, even if they were registered

and had been advised to come for the birth beforehand. This can be a stressful experience for young women in labour and their families. The findings replicate those in Shah More et al. (2009a), which show shifts from small to large hospitals between ANC and birth, although shifts in this study were all related to referral or its anticipation, rather than distance. Moreover, large hospitals were often part of households' contingency strategies.

This leads to a further issue that arose in relation to 'birth preparedness.' Section 6.2.2 describes how the tertiary hospital was the only public sector facility that admitted women who were unregistered, and many private facilities also turned away women who were not registered there. Thus, the 'registration' element of 'birth preparedness' was crucial for securing admission to the health facility. This point is reinforced by the experience of one household that intended a home birth. They had made monthly visits to a private clinic for ANC, albeit one which had no provision for care at birth. The woman had attempted to register at a small public hospital as a contingency option on more than one occasion in the last trimester, but they reported problems with registration⁶⁵. They reportedly decided to pursue registration at a private facility instead, but they never did so. Since they were unwilling to go to the public tertiary hospital and had not registered at a private facility as a contingency option, they faced extreme difficulty at crisis point, travelling from one private facility to another, being refused admission, until one doctor finally agreed to accept the case.

Finally, a noteworthy element of reported care-seeking strategies, even among some who intended a hospital birth, was to delay admission to hospital. For example:

'They mentioned that the heartbeat of the baby was quite faint. It was already 24 hours since she was in pain. If we had brought her in earlier it would have been better. We are the ones who delayed taking her to the hospital. Then the madam (doctor) scolded us as to why we had brought her in so late' (C5, mother, I2)

When two women visited health facilities for ANC in late pregnancy, the doctors advised immediate admission until the birth due to concerns about the pregnancy. In both cases, the households reported refusing to accept admission. Explanations reported by these households included a fear of the inconvenience, but it was also a strategy to avoid a caesarean section owing to the fear that being at hospital would increase the

⁶⁵ It was not clear whether they had eventually managed to complete this process since household members' narratives contradicted each other on this issue.

likelihood that doctors would push for this procedure (Parkhurst & Rahman, 2007). This latter reason in part also underpinned the strategy of postponing admission to the hospital following the onset of labour. A further reason was a superstitious belief that ‘pains’ would slow down if others came to know of the labour.

6.2.4 A context of uncertainty

Analysis indicates that ‘uncertainty’ is a central element underpinning the plural, contingent and flexible care-seeking strategies for birth found in the study context. Uncertainty is inextricably linked to the notion of risk: attempts to manage risk are essentially attempts to make the future more certain. Modernity is characterised by the view that certainty in the future is mutable through human control, contrasting with pre-modernity when the world was simply given (Jaeger, 2001; Zinn, 2004). Traditional social structures that shape norms and behaviour afford certainty, but as these institutions weaken, certainty increasingly depends on making the right decisions (Lupton, 2012; Zinn, 2004). Zinn (2004) suggests that greater certainty can be achieved through protective actions and belief in their effectiveness, but also by reinterpreting situations and changing reality constructions.

Uncertainties relevant to birth in this context were manifold. Physiological uncertainty is inherent to childbirth. Medical knowledge and technologies may place women in categories of high or low risk, but obstetric complications arise in around fifteen per cent of births in any context and are largely unpredictable (White Ribbon Alliance et al., 2010). Another type of uncertainty relates to (perceptions of) management of childbirth, which is dependent on context. Chapter 5 examines perceptions of both childbirth risks as well as risks arising from the management of birth, and suggests that anxiety regarding these is increasing. However, these perceptions do not fully explain the plural and flexible care-seeking strategies for birth and extensive contingency planning discussed in this chapter. To understand these, they need to be combined with uncertainties external to the birth experience itself.

These may be characterised as the uncertainties of daily life and institutions. A subcategory particularly relevant to the topic of this study is uncertainty in the health system. The types of uncertainty grappled with by households in the study setting included whether the hospital would be open; whether the doctor or health worker

would be available; what referral criteria were in operation; whether they would be admitted to the hospital; or what the charges would be. Even within this study's small sample of births, countless such experiences were related. For example, when one woman arrived in labour, the hospital was closed because it was a festival day; a doctor was unavailable to check and admit another woman; there were differences between the timing of services on paper and in practice; women were frequently refused admission or referred; households had to negotiate transport after being turned away; and women were charged fees inconsistent with expectations:

'We took her [to a small public hospital] but they refused to treat her. They kept saying that the senior madam was going to come and she would take the decision, but when the senior madam came she just made out the papers and asked us to go to [the public tertiary hospital] [...] I believe that they don't admit people who are coming for their first delivery' (C5, mother, I2)

'Nobody was here [at the small public hospital] for delivery; even madam (doctor) wasn't there. Had we come a night before, then we could have had the delivery here [...] We had come on [name of festival] night only [...] They said, "No, today is [also the doctors' festival]; they will not come today." So they said, "Go to [the public tertiary hospital]"' (C4, woman, I2)

'When we went to [this hospital for ANC], it is a government hospital, but the total expense was Rs. 400 [...] Sonography, blood, urine test, we had to pay for all [...] My brother's daughter got it done in [another government hospital] and nothing was taken' (C5, mother, I2)

Such uncertainties were common across the public and private sectors. These are examples of uncertainties that were directly experienced, but they affected actions through the anticipation that they might be faced and the anxiety this generated.

The aim here is not to make comparisons of the extent of such uncertainties between different settings, nor to suggest that they are unique to the study context or even to under-developed health systems. The data do not allow such comparison, and stories of women being turned away from hospital during labour because of a lack of beds, for example, are not unheard of even in settings such as the UK⁶⁶. However, it has been suggested that there are more numerous and more effective institutions in western contexts to reduce uncertainty, and through habitual experience of a relatively certain

⁶⁶ For example, the Guardian reported on this in November 2013: <http://www.theguardian.com/society/2013/nov/08/nhs-maternity-services-overstretched-watchdog>

state of affairs, people develop trust and expectations that their actions will be effective (Johnson-Hanks, 2005).

These uncertainties at least in part explain the discordance in many cases in this study between care-seeking intentions, actions and eventual outcomes. These uncertainties also call for different kinds of strategies. Little has been written about the influence of uncertainty on maternity care-seeking strategies, but it has been discussed in the literature on reproductive decision-making (e.g., Johnson-Hanks, 2005; Timæus & Moultrie, 2008) and life courses more generally (Bledsoe, 2002). In Johnson-Hanks's (2005) study in southern Cameroon—a context of reportedly profound uncertainty—informants refrained from expressing imagined reproductive futures, effectively avoiding the 'future perfect' tense. They engaged in action only in the moment, seizing opportunities as they arose, which Johnson-Hanks (2005) referred to as 'judicious opportunism.' This strategy was interpreted to be a consequence of repeated experience of uncertainty and sudden change:

'Under extreme uncertainty, when all the rules are changing, what works is not the best strategy but the most flexible one—the one that takes every present in the subjective, that keeps every alternative open as long as possible, and that permits the actor to act rapidly and flexibly to take advantage of whatever opportunities arise' (Johnson-Hanks, 2005, p.377)

This study's context, topic and timescale are very different to Johnson-Hanks's (2005); yet, the findings on care-seeking strategies for birth resonate with elements expressed in this excerpt from her paper. Certainly, households in this study did plan and take action in pregnancy towards the forthcoming birth; this was imperative for those hoping for birth in any hospital other than the public tertiary hospital, which necessitated registration. Yet, a single 'best strategy' might simply have reflected the inclinations towards different care options discussed in Chapter 5. Households largely relinquished developing a single best strategy in favour of a more flexible one of contingency planning, which left options on the table until the birth, allowing households to respond to unpredictable or unexpected events as they arose. In effect, households were hedging their bets. They might still have a favoured option, but they simultaneously acted on other options. Plans for birth were essentially expressed in the 'subjunctive mood' (Johnson-Hanks, 2005).

The following quote from a mother demonstrates explicitly the link between uncertainty and care-seeking strategies for birth:

I liked [the small public hospital], but we don't know. If they refuse to handle the case at the end time—. That's why I have made papers (i.e., registered) at [the public tertiary hospital as well as the small public hospital], so that if we have to go there at the end time, they won't refuse us. We are going for check-ups at both places and, at the end time, we'll go wherever is conducive' (C7, mother-in-law, 11)

If this household were confident in the public health system as an institution—confident that it would ensure that the woman would reach and receive appropriate treatment—this type of plural, flexible and contingent strategy would be unnecessary. Inconsistency and unpredictability in the health system is a dimension that is unlikely to be criticised directly by lay people, but its traces were discernible throughout narratives in this study—increasing anxiety and shaping strategies—and certainly should be an object of greater attention.

It was not only uncertainties of the health system, but their combination with perceptions of physiological uncertainties and uncertainties in the management of birth that ultimately defined the nature of contingency strategies. Contingency strategies provided flexibility, but there was a limit to the flexibility of some households. Through actions towards contingency plans during pregnancy, these households essentially drew boundaries around what was acceptable to them, underpinned by their attitudes towards different care providers. For example, when some households incorporated a private hospital in their contingency strategy in case they were refused admission at a small public hospital, they were essentially seeking to eliminate the possibility of having to use the public tertiary hospital, which they associated with greater risk (See Chapter 5).

6.3 Summary

In this chapter, I have focused on the largely neglected element of 'process' in maternity care-seeking or decision-making. Attention to the sequences of decisions and actions towards care at birth has challenged the assumptions of traditional static approaches that equate care-seeking with 'a' choice or decision. The chapter has shown that, in low-income urban settlements in Indore, care-seeking strategies are anything but static. Households identified and followed up plural options during pregnancy, keeping them open for flexibility. Options were attached with contingencies which would prioritise their use. Moreover, strategies evolved through time as the context of pregnancy and

labour unfolded. Indeed, care for birth itself might be plural as households pursued one option and then re-evaluated the strategy, or combined different types of providers simultaneously (Obermeyer, 2000a). Shah More et al.'s (2009a) study in Mumbai, India, described the phenomenon of discordance between the sectors and types of facilities used for ANC, registration and birth. In contrast, this study found that strategies—including intentions, prenatal contacts with the health system and registration—were largely plural through pregnancy in Indore.

In this chapter, I have emphasised that ambiguity and fluidity should not be interpreted as ambivalence on the part of households. Households displayed agency in negotiating the complex urban health system with its array of care options, and plural, contingent and flexible strategies were strategic. They were partly a phenomenon of a complex urban health system, providing choice, which in some ways is a positive development. But the other side to this coin is the very real challenges that households face in negotiating the health system to receive care they perceive to be adequate for ensuring a safe outcome. The chapter has shown that households' flexible strategies encompassed efforts to manage a combination of childbirth risks and risks arising from medical management discussed in the last chapter, as well as broader uncertainties and unpredictability in the health system and in daily life. Households deliberately combined care options across and within sectors according to their perceived strengths in addressing these risks and uncertainties, acknowledging that different circumstances call for different measures.

This chapter challenges approaches that conceptualise care-seeking during pregnancy and for birth as two separate episodes, in which the former simply influences the latter (Bloom et al., 1999; Ram & Singh, 2006). They may be better conceptualised as different components of the same episode. Contacts with health providers during pregnancy were directly intertwined with care-seeking for birth when used as an opportunity to gather information or test health facilities for birth or to register. Further, some ANC visits were indirectly intertwined with care-seeking for birth: for example, when aimed at identifying and/or minimising risks with implications for care intentions at birth. This study has shown that, for some, ANC was even used to check that risks were low or to treat problems in order to pursue inclinations for birth at home. ANC should establish confidence in the care provider (Matthews et al., 2001), but this study

has shown that negative experiences may also divert some potential service users away from using maternity care services for birth.

Registering at a health facility was crucial since women were turned away from most facilities without having done so, except at the large hospitals many sought to avoid. Yet, as in other studies in urban India in which a large proportion of women who had a home birth had attended ANC and registered (Agarwal et al., 2010; Devasenapathy et al., 2014; Shah More et al., 2009a), lack of preparation was not a key factor in home births in this setting. Being birth prepared meant keeping multiple options to deal with uncertainty, reiterating the importance of context for birth preparedness (Soubeiga & Sia, 2013). As well as registering at one or more facilities, households were confident with knowing that transport options were available rather than fixing on one certain option, and on knowing how they would access the funds needed for different options rather than saving a specific amount.

This chapter has examined actual care-seeking strategies for birth (see Section 2.6). Their content reflects perceptions discussed in Chapter 5, but strategies are more complex and responsive to multiple influences through time than is conveyed by an assumption that inclinations translate directly into 'a' decision, a decision into action, and action into the outcome. The next chapter discusses the way in which interaction within patterned social relationships acts together with the content of interactions to shape care-seeking strategies.

7. Social Relationships and Care-Seeking for Birth

Autonomy, responsibility and blame

7.1 Introduction

This chapter examines how patterned social relationships and interaction shape care-seeking strategies for birth. It does so from the perspective that it is through interactive processes that situations are defined and solutions identified (Pescosolido, 1991, 1992) (see Section 2.6). Pescosolido's network episode model (1991, 2006) advocates a form of social network analysis to examine how interaction within social networks drives care-seeking. Two studies on maternal health care decisions in Bangladesh have adopted such an approach (Edmonds et al., 2012; Gayen & Raeside, 2007), but certain assumptions are questionable in South Asian settings. The studies capture social ties of women who had a birth, assuming that they assess families' and peers' approval of the use of health services within these social networks. In effect, they inherently assume an autonomous agent. Yet, a large literature from this region suggests that young, recently-married women have little decision-making autonomy. This study employs a different approach, using a qualitative in-depth methodology to reveal nuances in the patterning of social relationships and interaction underpinning care-seeking for birth, tapping into local constructs.

The chapter begins with a review of the literature linking relationship dynamics with maternity care-seeking in South Asia. Findings focus especially on the 'household' given its importance for this process in India (see Section 7.1.1), and proceed to examine the role of household members' wider social ties. Finally, the implications of these patterned social relationships and interaction for the content of care-seeking strategies are discussed. 'Female autonomy' is a key concept that is addressed in view of its prominence in the literature. The chapter also draws on the concepts of 'responsibility' and 'blame' from the sociocultural literature on risk, which are invoked in local perspectives on this topic. Few studies in LMICs to date, and none in South Asia to the best of my knowledge, apply these concepts in analyses of maternity care-seeking.

7.1.1 Gendered household power structures and care-seeking for birth

The household encompasses a crucial layer of social relationships for maternity care-seeking. Across diverse South Asian settings, studies have highlighted an ideology of interdependence within households, with primacy of collective over individual identity (Furuta & Salway, 2006; Mumtaz & Salway, 2009). Section 3.3 described the kinship structures along with gender and age-based hierarchies which sustain young married women's subordinate position within households in this setting. Household power structures are of central importance because they shape the way in which decisions are made and actions are taken towards care for childbirth.

'Female autonomy' within the household is a key concept used in analyses of factors influencing women's health-related outcomes in LMICs. The concept has overlaps with women's 'status,' 'power,' 'agency' and 'empowerment' (Kabeer, 1999; Mason, 1986). Definitions of female autonomy have in common the notion that it concerns women's capacity to exert control over their private concerns (Basu, 1992; Dyson & Moore, 1983; Jejeebhoy, 2000). It is widely considered to encompass multiple, closely related dimensions, including women's voice and authority in decisions on matters affecting themselves and their households; access to knowledge and information; control over material resources; and freedom of movement outside the home (Bloom et al., 2001; Jejeebhoy, 2000). Low female autonomy has been highlighted as a concern in many global settings (Fotso et al., 2009b; Morrison et al., 2014; Sychareun et al., 2012), but levels in (parts of) India are reported to be among the poorest in the world (Jejeebhoy, 2000). This has implications for women's ability to acquire information about maternal health and health care services; to make decisions on maternal health care; and to take independent action in seeking care⁶⁷ (Blanc, 2001).

In the 2005–06 NFHS survey, only 27.5 per cent of women in urban MP reported having the final say on their health care and a further 33.5 per cent reported making these decisions jointly with their husbands (IIPS & Macro International, 2008). Figures are substantially lower for younger married women. However, no questions are asked in the NFHS specifically about decision-making for maternity care. Some qualitative studies have examined intra-household dynamics underpinning maternity care-seeking in South Asian settings, although few have done so in any depth in India.

⁶⁷ See Section 7.1.2 for studies of the links between autonomy and maternal health care utilisation

While there may be differences across contexts, studies from diverse settings in the region have suggested that matters relating to pregnancy and birth fall within the domain of authority of older females, particularly mothers-in-law (Das Gupta, 1995; McPherson et al., 2010; Mumtaz & Salway, 2009). Husbands' involvement in pregnancy and birth is reported to be limited in many South Asian settings, aside from contributing towards financing care or making arrangements in an emergency (Brunson, 2010; McPherson et al., 2010; Mumtaz & Salway, 2007; Raman et al., 2014; Simkhada et al., 2010). However, role expectations might be changing, with knowledge, interest and support from husbands reportedly becoming more accepted in some contexts (Barua et al., 2004; Mullany et al., 2005).

Studies on maternity care-seeking have also emphasised the importance of the household as a collective. For example, Mumtaz and Salway (2009) highlighted a norm in their field site in Pakistan for household discussion and opinion, and a cooperative and consensus based decision process. Where young women lack direct influence in decisions on care for birth, they may still seek influence in indirect ways. Some women in a study in Pakistan drew upon their natal families or other elder women in their clan to influence the prime decision-maker (Mumtaz & Salway, 2007). Roles are also not uniform across households (McPherson et al., 2010; Simkhada et al., 2010). Household composition and the woman's place within it influence her level of autonomy (Bloom et al., 2001). In particular, a multitude of studies indicate that women's autonomy is lower in joint marital households and higher when they have closer proximity or relationships with natal kin (Bloom et al., 2001; Dyson & Moore, 1983; Jejeebhoy, 2000; Matthews et al., 2005a).

People's reports on decision-making authority within their households tend to be normative, however, and may not necessarily capture what occurs in practice (D'Cruz & Bharat, 2001; Mullany et al., 2005; Story & Burgard, 2012). For example, in a qualitative study in Nepal, even where husbands were reported to have the final say, women and husbands described a higher level of consultation than would be implied by the woman having no say (Mullany et al., 2005). Jejeebhoy (2002) also found no more than loose agreement between women and their husbands on the woman's level of autonomy, with husbands portraying a relatively more liberal picture. As Kabeer (1999, p.447) states, statistical perspectives on decision-making are 'simple windows on complex realities [...] they tell us little about the subtle negotiations.'

7.1.2 Links between autonomy and maternal health care outcomes

Low autonomy has been hypothesised to negatively influence use of maternal health care, and the link has been examined in numerous studies. Some empirical evidence from South Asia provides tentative support for the hypothesis (e.g., Bloom et al., 2001; Matthews et al., 2005a; Mistry et al., 2009). However, other studies find no association (Allendorf, 2007; Bhatia & Cleland, 1995), and others find only a weak association (e.g., Furuta & Salway, 2006; Kesterton et al., 2010). Moreover, not all dimensions of autonomy are found to be associated with care outcomes even among studies evidencing a link (e.g., Bloom et al., 2001; Furuta & Salway, 2006; Matthews et al., 2005a; Mistry et al., 2009). Compounding attempts to draw conclusions is the different ways in which autonomy has been operationalised. Autonomy was earlier measured largely with proxies, such as education or employment (Jejeebhoy, 2000). Direct measures are now more often used, but differences persist. For example, some use sole decision-making as a measure (e.g., Allendorf, 2007) and others use joint decision-making (e.g., Allendorf, 2012c; Furuta & Salway, 2006), both representing different autonomy goals.

Along with these mixed results, the ideal of individualism inherent in the concept of autonomy has been critiqued as culturally incongruous in South Asian settings (Mumtaz & Salway, 2009). Where an ideal of togetherness is pre-eminent, autonomy is not necessarily an aspiration for women, and being autonomous may be attached with meanings such as isolation and a lack of support (Furuta & Salway, 2006; Mullany et al., 2005; Mumtaz & Salway, 2009). Some have suggested that constructs such as ‘centrality’ within the household, focusing on relationships rather than notions of individualism, may be more appropriate in such settings (Mumtaz & Salway, 2009).

Although the mechanisms for a hypothesised link between female autonomy and use of maternal health care are not well defined, the implication is that other household members play a negative role, constraining women’s use of services. Where women have low autonomy, household members are said to stand between women’s perceptions of care and actual decisions (Das Gupta, 1995; Simkhada et al., 2010). The suggestion is that, if women had greater say, they would make different—better—decisions on their own care. Some qualitative studies have suggested that women do have more positive perceptions of the formal system that cannot be realised due to the prevailing gendered household power structures. In Nepal, one study found that others

obstructed women's partial embrace of the biomedical system (Brunson, 2010), and in another study, women expressed frustration with household members regarding decisions on maternal care (McPherson et al., 2006). Given the mixed results on autonomy, these ideas require further scrutiny in different contexts.

An additional hypothesis in the literature is that living in a joint household negatively affects women's health because of their lower autonomy in these households. Yet, evidence of such a link is also tenuous. Saikia and Singh (2009) reported a weak negative association between living in a joint household and birth with a skilled attendant in India. In contrast, another study in India found that, after adjusting for selection into household type, women in 'patrilocal extended families' were more likely to receive ANC and birth with a skilled attendant than women in nuclear households (Allendorf, 2013). Similarly, Matsumura and Gubhaju (2001) found no association between living in a joint household and care at birth in Nepal, and a positive association for ANC. The implication is that there may be potential advantages for maternal health care utilisation from living in a joint household that counteract its negative effect on women's autonomy, such as greater economic status (Allendorf, 2013) or greater availability of support and sharing of tasks (Matsumura & Gubhaju, 2001).

Finally, a key problem with analyses using large-scale surveys such as India's NFHS (IIPS & Macro International, 2007) and DLHS (IIPS, 2010) is that the household captured in explanatory variables may not coincide with the household in which the woman stayed at the time of the last birth. Responses regarding household structure or autonomy likely capture the situation in the woman's marital household, but a substantial proportion of women in India return to their natal households for births, particularly the first (Hutter, 2001; Matthews et al., 2005a; Shah More et al., 2009a). The question on place of birth provides response options for the woman's marital home or parents' home if the woman had a home birth, but there is no way to distinguish whether the woman was staying at her natal or marital household at the relevant time for those who report birth at a health facility. Household processes may be very different for young women in marital and natal households, which may serve to dilute any effects we might expect to see. This highlights a need to further understanding of dynamics within different household structures in which women might stay at the time of the birth, as well as between natal and marital households, and of their implications for maternity care-seeking.

7.1.3 Social relationships and maternity care-seeking

In contrast to a fairly large literature on women's autonomy, few studies have examined the links between broader dimensions of intra- or extra-household relationships and maternity care-seeking. This is surprising given the large body of literature linking social relationships with a range of health behaviours and outcomes (Stansfeld, 2006). Dimensions of social relationships that might be considered include structural characteristics of the social network, such as size, density and range; or functional characteristics, such as the type and quality of (specific) relationships or support (House & Kahn, 1985; Stansfeld, 2006).

There are exceptions to the literature's neglect of social relationships. Some studies find evidence of a link between measures of poor quality marital relationships, such as domestic violence, and non-use of a skilled maternity care provider (Sarkar, 2013). Allendorf (2010) highlights the need for complementary efforts examining potential benefits of high-quality relationships. Her study in MP found that women in joint households who had better relationships with in-laws were significantly more likely to use ANC, and women in nuclear households who had better relationships with their husbands were more likely to use both ANC and have births in health facilities, reinforcing the importance of household structure (Allendorf, 2010). A qualitative study by the same author suggests that high quality relationships may motivate family members to act to ensure women's health, but cautions that the link is not straightforward since it is moderated by knowledge and beliefs on how this is best achieved (Allendorf, 2012b).

Greater 'male involvement' in maternal and reproductive health has been promoted in recent decades, particularly since the International Conference on Population and Development in Cairo in 1994. Gender-based power inequities contribute to a lack of communication between spouses (Blanc, 2001) and Mullany et al.'s (2005) study indicated a positive association between communication about health and joint decision-making. Women whose husbands accompanied them for health care were also found to be more likely to report sharing problems (Mullany et al., 2005), and their husbands demonstrated greater knowledge about maternal health (Barua et al., 2004). Several studies also report an association between measures of communication with husbands and use of maternal health services (Furuta & Salway, 2006; Mumtaz &

Salway, 2007). Furuta and Salway (2006) suggest several possible pathways: openness to modern ideas, a more open relationship or women's greater influence in these relationships, which may either act on pre-existing demand or generate demand through the exchange of information and support.

Few studies have examined the influence of relationships with wider social ties on use of maternity care. Non-household ties may play direct roles in care-seeking. For example, in a Bangladesh setting where medical care was largely sought only at crisis point, community members and informal health practitioners gave advice and helped with transport and financial arrangements (Parkhurst et al., 2006). Non-household members may also play indirect roles. For example, Basu's (1990) study comparing two distinct regional groups residing in the same locality in India with different care-seeking behaviour highlighted the importance of cultural norms. There is a question, however, of which norms matter for migrants in urban settings: those of their new surroundings or their village of origin (Matthews et al., 2005a; Raman et al., 2014). In Edmonds et al.'s (2012) application of the network episode model in Bangladesh (see critiques in Section 2.5 and Section 7.1), women's networks were predominantly comprised of dense, relatively strong tie, kinship-based relations. The study found no association between network structure variables (density, kinship homogeneity, and strength of ties) and facility birth, but did find an association with network content (endorsement for or against a particular type of birth attendant).

The current body of evidence on relationship dynamics in relation to maternity care-seeking is limited and complex, with mixed results. Initial assumptions often appear flawed and culturally incompatible when subjected to greater scrutiny and, even where links are found, understanding of mechanisms remains limited. The need for greater understanding of how maternity care-seeking is shaped by patterned social relationships and interaction has been recognised (Furuta & Salway, 2006; Mullany et al., 2005; Mumtaz & Salway, 2009). This study addresses the gap by examining social relationships and interaction surrounding care-seeking in depth during and immediately after the care-seeking process via multiple perspectives in a small number of households, which provides a unique platform for understanding these dynamics as they play out in the relevant households.

7.2 Findings

Findings in this chapter draw in particular on a combination of thematic analyses and analyses of multiple household perspectives for all cases. Patterns in social relationships and interaction relevant to care-seeking as well as the meanings attached to them are presented, discussed and illustrated with quotes. Again, while the sample is non-representative, the aim where numbers are presented is to contextualise the patterns identified within the larger data set. The findings focus on situated meanings; these are considered in relation to normative debates and the international policy agenda in the discussions in Section 7.3 and in Chapter 8.

7.2.1 Constructions of primiparous women and household responsibility

To what extent do roles in care-seeking in these low-income neighbourhoods in urban central India reflect characterisations in the literature from diverse South Asian settings? A more nuanced analysis of how women engaged with the care-seeking process for first births in different types of households is presented in subsequent sections. Here it suffices to say that young primiparous women were not constructed as managers of their own maternal health care, mirroring findings of studies from other settings where women have low levels of autonomy (e.g., Mumtaz & Salway, 2007; Simkhada et al., 2010). While these women might be involved in discussions on care for birth, they were largely not regarded as decision-makers. With cultural restrictions on both employment and unaccompanied mobility for recently-married women, they also lacked the resources for independent action towards care goals. This raises a question of the local meanings attached to these phenomena, and how they compare with the concept of ‘autonomy’ dominant in international discourse on maternal health.

As actors, young women often took ‘theme’ rather than ‘agent’ semantic roles in narratives on care-seeking, as exemplified in such statements as ‘*We’ll take her to hospital*’⁶⁸ by a mother-in-law or ‘*Mummy will register my name...*’⁶⁹ by a woman. This phenomenon is produced by, and in turn reproduces, constructions of young primiparous women in this setting. They were widely characterised in the data as

⁶⁸ C0, mother-in-law, joint marital, I1

⁶⁹ C5, woman, natal, I1

children (*'bachche'*), lacking in capacity to manage the care-seeking process because of limited knowledge and experience. As the excerpts below demonstrate, their husbands were similarly portrayed as inexperienced in these matters. This discourse underpinned reported perceptions of the need for elders to manage young women's journey through pregnancy to the first birth. This discourse was not limited to the narratives of elders; such meanings were echoed in the self-representations of young women and their husbands:

'They (i.e., the couple) are just children; what do they know?' (C10, mother-in-law, joint marital⁷⁰, I1)

'Since this was her first pregnancy, she had no idea about anything' and 'He still has a lot of childhood instinct in him [...] He doesn't have any knowledge of how children are born, he doesn't know anything' (C8, mother-in-law, joint marital, I2)

'The elders should take care of her if it's her first time and she doesn't know anything, and she should listen to what elders say [...] I'm small for all these things and just listen to what the elders say. I'm not able to think what is right or wrong' (C12, woman, natal, I2)

'If some elderly ladies are there in the house, they know what to do and what not [...] She was in pain, and even I didn't know what to do because for me also everything was new, so when she was in pain I used to get scared [...] So I felt that elderly ladies who are experienced have a major role to play in this' (C6, husband, nuclear marital, I2)

Pregnancy and childbirth are events deeply embedded in ritual and tradition across contexts. Local norms represent this as a time when women need to be surrounded by supportive structures and cared for by other household members, and this seems to be taken particularly seriously for first births. This is manifested in the custom of *'sava mahina,'* a period of confinement for around one and a quarter months after birth. Whether or not adhered to in a household in reality, the pregnancy episode was constructed across cases as a time when women should ideally be allowed to rest more than usual and take leave from normal household chores, and when a special diet should be provided for them:

⁷⁰ The type of household in which the woman resides at the time of the birth is referenced for all quotes in this chapter (see p.13 for key to referencing of interview excerpts).

'You have to take care of their food, and bring medicines, fruits and all, bottles and all for good health. I used to bring fruits daily' (C7, husband, joint marital, I2)

'The wife should get full support from us; whatever possible should be done; there should be no problem of any kind [...] [We] should take care of her eating and food; whether she is taking medicines on time or not; in work also that she does not do this or that' (C8, husband, joint marital, I1)

'Since I am her mother and she is at my home, it is my duty to look after her. Give her a bath, wash, massage, this and that for eating. I only am taking care of her' (C14, mother, natal, I2)

Linked with constructions of primiparous women as inexperienced and the pregnancy episode as a vulnerable time when women should ideally be lavished with support, it is the household that is charged with responsibility (*'jimmedari'*) for managing pregnancy and birth. While a first birth may bring the construct of 'responsibility' into sharp focus, it is likely an extension of one that applies more widely to the lives of young women. The notion of household responsibility contrasts with the individualism of western contexts, where responsibility for the woman's care and well-being during pregnancy and birth is largely deemed to be centred on the woman to whom the outcome pertains (Lupton, 2012). Household responsibility is understood to entail fulfilling obligations or duties through pregnancy to the birth, according to local perceptions of how to ensure a good outcome for the woman and baby.

Imbued with the meaning of others deciding and acting on behalf of the woman, the notion of household responsibility stands in contrast to the concept of autonomy prioritised on the international agenda. When other household members sought to portray their role in the woman's pregnancy and birth as a positive one, it was not the language of autonomy they espoused; rather, it was the fulfilment of their responsibility for the woman's care. Through such a lens, for a household to allow a primiparous woman to manage the birth independently would be regarded not as the promotion of women's rights, but as the neglect of a culturally prescribed duty, leaving members open to reprimand from those around them. Of course, this does not mean that these obligations were in fact fulfilled by all households; only that this was how ideals were constructed through local value systems.

7.2.2 *The household context for pregnancy and birth*

The centrality of the household to the care-seeking process for first births in this setting has been established. It is known that women live in different types of households and that there is a custom of returning to the natal household for first births in India. Yet, investigations of the implications of household context for the care-seeking process are extremely limited. In this section, the diverse household contexts of women in this study are briefly described to contextualise subsequent discussions of the dynamics between and within natal and marital households during the care-seeking process⁷¹.

Twelve of 16 women in this study were married for less than 15 months at the time of the first birth, conceiving within six months of marriage. Marriages were largely ‘arranged,’ but two women had ‘love marriages.’ This was a taboo in the context of this study, and one set of parents reluctantly endorsed the match while the other woman married without her parents’ involvement, although they remained in contact. Reflecting patterns demonstrated in large-scale surveys (IIPS & Macro International, 2008), most of the recently-married women in this sample lived in joint marital households with their in-laws (*sasural*). All others lived in nuclear marital households, either in close proximity to their parents-in-law or in the place to which their husbands had migrated. However, nine of the 16 women returned to their natal households (*mayaka*) for the birth⁷², reflecting a widespread custom in India for the first birth. Women typically returned to their natal households after *Godh Bharai*, a Hindu ceremony to bless the mother and unborn baby that normally takes place in the seventh month of pregnancy⁷³, and stayed until they had completed *sava mahina*, the period of confinement after birth.

Seven women stayed in their marital households for the birth: four in a joint and three in a nuclear household. Various reasons were reported for eschewing the custom of returning to the natal household, most often concern over access to health facilities in the natal village. Other reasons reported in joint marital households were a perceived insufficiency of financial or social resources for care in the natal household, or because the in-laws wanted to keep the celebrated event in their home. In view of the

⁷¹ Section 3.3 discusses the context of marriage and childbearing in India more generally. See also Table 4.3.

⁷² One woman stayed in her maternal relatives’ household rather than her parents’.

⁷³ For various reasons, one woman returned in the fifth month of pregnancy; another in the ninth month; and another stayed at her natal household intermittently for extended periods throughout pregnancy. All others returned after *Godh Bharai*.

construction of couples having a first birth as too inexperienced to manage independently and the cultural imperative of surrounding the woman with female-led supportive structures during this period, staying in a nuclear marital household was largely presented not as an ideal, but a result of prioritising greater access to health facilities in the city. To mitigate perceived problems with such circumstances, elder females came to stay in two of these households in the lead up to the birth⁷⁴. In sum, the sample was not representative and household structure was a sampling criterion; nevertheless, the range of household contexts demonstrates the complexity and fluidity of the notion of a ‘household’ over the care-seeking episode for birth.

7.2.3 The baton of responsibility

The ‘household’ has special meaning in local constructions since it forms the boundaries of ‘responsibility’ (see Section 7.2.1). When the woman was in her marital household—whether joint or nuclear—her care was constructed as their responsibility. However, in cases where the woman returned to her natal household for the birth, the shift also signified the transfer of responsibility to *‘their hands.’* At any one time, the locus of responsibility was either in one household or another. In effect, the local construct of ‘responsibility’ as it relates to a first birth might be characterised as a baton that is held by the household in which the woman is staying and transferred with her when she moves between households, as illustrated in the following quotes:

‘Since she was with us (i.e., at our household), it was our responsibility’ (C8, mother-in-law, joint marital, I2)

‘We normally leave our wives at their mother’s place for the delivery of the first child. So they (her parents) will come here and take her there; then I will place her in their hands. It’s in their hands then’ (C15, husband, natal, I1)

As a result, natal and marital households rarely engaged in shared or collaborative efforts, although different stages of the care-seeking episode might be the responsibility of different households. For example, the marital household might initiate ANC in early pregnancy to check on and manage risks, while the natal household might

⁷⁴ A mother and grandmother came to stay in one household, and a mother-in-law in the other. They were defined as nuclear here since they remained in their nuclear marital residence, to which meaning was attached despite elder females’ presence. See Section 7.2.4 for further detail.

have responsibility for care at birth if the woman were to return for the birth. ‘Responsibility’ for the birth entailed accountability for the birth outcome and encompassed all elements of care-seeking, including taking decisions and actions towards care for birth, overseeing the woman’s health and health care, full financing of care, and accompanying the woman during the birth:

‘If they (marital family) bring her to the house, it’s like you take care of her, she’s your daughter. Now you get the delivery done in the hospital or at home, do whatever you want to do. They’ll come to see the baby, that’s all’ (C15, mother, natal, I1)

‘It depends on them where they get it done. I can’t say where to get it done. See, I know the situation in my house but I don’t know about them. Had it been in my house then I would have said [...] It’s on her mother where she wants to get it done [...] At the time of the second child, we’ll do everything, everything will be on us’ (C12, husband, natal, I1)

The clear lines of responsibility underpinned inter-household tensions between natal and marital households during the care-seeking episode. For example, households having to bear the whole costs associated with the perinatal period might express some disgruntlement. Simultaneously, however, involvement when the woman was staying at the other household chanced being interpreted as interference from one perspective or a result of shirked responsibility on the part of the ‘baton-holder’ from the other perspective. For example:

‘My mother used to stay [with me at hospital] at night, but she didn’t really have to since it was my in-laws’ responsibility’ (C3, woman, joint marital, I2)

Who would hold the baton of responsibility in the perinatal period involved a process of negotiation. Since returning to the natal household is a custom for the first birth, parents reportedly had a duty to offer to undertake responsibility. However, kinship structures afford the marital household greater power in the inter-household dynamic because the woman ultimately becomes a member of their household following marriage. This could be used to veto the return or influence the natal household in negotiations. For example, in one case, the mother-in-law reportedly made the woman’s return to the natal household conditional on the parents agreeing to use a specific private hospital—where the woman had attended ANC—for the birth. Despite being ill-able to afford the expenses, the parents acquiesced because they considered the first birth to be their responsibility:

'They told me not to think that they wanted me to spend money and get it done in private just because I was taking her for the delivery. They said they would be willing to take up the responsibility instead of sending her to me. But then I said that, regardless of where they wanted me to get it done, I would take the responsibility since it was her first delivery' (C13, mother, natal, I2)

7.2.4 Intra-household dynamics of care-seeking and household structure

In several, but not all cases where women returned to their natal households for the birth, the narratives of women and particularly their mothers distinguished between the level and quality of support a woman would receive at a natal and a joint marital household⁷⁵. Some were critical of the in-laws' behaviour towards the woman, describing the stress this caused, and they accordingly expressed relief that she was at her natal household for the birth. Others talked in general terms, invoking a cultural narrative differentiating the quality of mother-in-law/daughter-in-law and mother/daughter dyads and its implications for the woman's care. Contrasting with mothers-in-law, mothers' relationships with their daughters were characterised as ones of unbounded love and sacrifice.

'Your in-laws' house is after all your in-laws' house, but at your natal house, you get a lot of care' (C12, mother, natal, I1)

'There is a difference between your mother taking care—. In the in-laws' house you have to do the household chores too [...] There is a difference between [my mother-in-law's] care and my mummy's' (C12, woman, natal, I1)

'We do everything from washing her clothes to taking care of her diet. Then we see to it that she doesn't put her hands in cold things. Who would take so much care at the in-laws' house? After some days they would ask her to do all the household work [...] She has all the freedom here. She takes a walk, then if she feels like she cooks rotis (bread), or else she just sits, then she asks for this or that. But it's different at the in-laws' place: who would let her rest there?' (C4, mother, natal, I1)

'[My mother-in-law] thinks they (daughters-in-law) are machines to work [...] She favours her daughters, she's mad about her daughters, and thinks of her daughters-in-law just as daughters-in-law' (C5, woman, natal, I1)

Nevertheless, in most cases in this study in which women stayed in marital households for the birth, reports and observations of the quality of relationships were

⁷⁵ Of course, most mothers in this study were also mothers-in-law to other women.

strikingly opposite to this depiction. These women reported close relationships and extensive support from their in-laws. Women and their mothers-in-law emphasised the quality of their own relationship by characterising their dyad as akin to that of a mother and daughter, implicitly acknowledging a cultural narrative to the contrary:

'I don't have a daughter, so I regard her as my daughter' (C8, mother-in-law, joint marital, I1)

'She's our daughter-in-law; we have responsibility towards her. We treat her like a daughter and we don't let any problem come to her' (C7, mother-in-law, joint marital, I1)

'In our family there's no shyness; everybody sits together and discusses freely about issues. My father-in-law doesn't regard us as daughters-in-law; he treats us as his daughters [...] I don't feel like I'm at my in-laws' place; it seems the same as my parents' home. We can talk or joke with everybody in the family' (C10, woman, joint marital, I1)

Of course, these excerpts capture the way in which women and their mothers-in-law opted to represent their household relationships in the context of interviews held at the marital home. Yet, concordance in narratives across multiple household members, not only on the relationships but also on behaviours described supporting these statements, gave them credence as a reflection—in part at least—of an objective reality that differs from the way in which relationships were depicted in the narratives of women staying in natal households. A possible explanation is that cases in which women stay at their marital households for the first birth are self-selecting. For example, it was reportedly these marital households' concern about the adequacy of arrangements for care if the women were to return to their natal households that underpinned decisions for them to stay. For example, one mother-in-law stated of the natal household, *'There are facilities there, but she has a very young brother, so there's nobody to take care of her.'*⁷⁶ The marital households must also have been willing to incur costs in place of the natal households. Moreover, were the women unhappy with the arrangement, they might have put pressure on their natal kin to negotiate with the marital households for their return. In effect, these marital households may encompass a subgroup in which women had relatively higher quality relationships and support from their in-laws. Certainly, they were a group especially concerned with care arrangements.

⁷⁶ C8, mother-in-law, joint marital, I1

Replicating the findings of other studies in South Asia (see Section 7.1.1), intra-household roles in care-seeking for first births in this setting were underpinned by cultural norms that accord responsibility and authority along lines demarcated by age and gender. Constructions of pregnancy and birth as feminine matters along with the value attached to experience combined to designate the management of young women's journey through pregnancy to birth as the domain of elder household females. Depending on whether the woman was staying in the natal or marital household, the mother or mother-in-law was largely constructed as the authority figure, although other older females—grandmothers or elder sisters(-in-law), for example—were also regarded as competent advisors:

'Who else other than mother is there to take the decisions? Papa doesn't know about these things' (C5, woman, natal, I2)

'Well, it would depend upon my mother [...] The decisions are normally made by the older women in the house—the mother-in-law or the grandmother-in-law' (C3, husband, joint marital, I2)

'In my house I take care [of the pregnancy and birth]' (C10, mother-in-law, joint marital, I1)

Decisions on care for birth were not made by elder females in isolation from the rest of the household, however. Participants often described discussion within the household. Close concordance in narratives on intentions across household perspectives lends support to these reports since it evidences communication. Despite their construction as feminine matters, some husbands, fathers and/or fathers-in-law reportedly did show interest and discussed care with females, and were certainly expected to contribute to financing care. Moreover, other household members might be involved in arrangements for transport and might also accompany the woman at a home birth or to the hospital, although it was the mother or mother-in-law who usually stayed at the hospital for the whole period of admission.

Beneath narratives largely side-lining primiparous women as agents in care-seeking both in natal and joint marital households, there were indications that they had some influence. Women might share their health concerns or fears with other household members. They were also involved in the co-construction of prenatal contacts with the health system along with the person—usually a household member—who accompanied them. These processes were potentially influential, whether or not they were used

intentionally as vehicles to influence care-seeking strategies. For example, one woman reported that her joint marital household was re-evaluating intentions for a home birth in light of increasing concern that she would be *'unable to bear the pain.'*⁷⁷ Although mothers were similarly constructed as the decision-makers in natal households, there were indications that young women's capacity for direct influence may be greater in natal than in joint marital households. Descriptions of care-seeking also revealed that young women may have more direct influence—particularly in natal households—than they explicitly acknowledged, reinforcing Mullany's (2005) findings in Nepal. For example, there is a discrepancy between the former quote in which the woman stated that she had no say in care decisions and the latter quote in which she described refusing her mother's wishes to register for birth at a second hospital. A similar narrative was noted in the mother's interview.

'I didn't take any decisions [...] Mummy only takes decisions; we have to say yes to what the mother is saying' (C5, woman, natal, I2)

'I said no, we will go only to that hospital where we have registered my name' (C5, woman, natal, I2)

Still, young women in general displayed low levels of autonomy on any direct measure of the concept in relation to care-seeking for birth in natal and joint marital households. This did not preclude their characterisation as positive relationships, however. Where strong bonds were emphasised, young women constructed the authority of elder women in a positive way. In their narratives, they portrayed it as something that gave them relief at a time when they felt scared or uncertain, and they reported feeling confident that competent elders would act in their best interest.

'I've left everything up to mummy (mother-in-law) since she knows everything and would do her best for me' (C8, woman, joint marital, I1)

'I didn't have much knowledge about the delivery but my mother and bhabhi (sister-in-law) had the knowledge and were there to help me' (C12, woman, natal, I2)

Essentially, from a situated perspective, strong bonds were linked with others' concern and prioritisation of the woman's well-being and birth outcome, and with their responsiveness to her fears and needs. Women did not seek the capacity to push through

⁷⁷ C10, woman, joint marital, I1

an independent agenda; they sought and achieved subtle influence through being able to raise and discuss problems and fears within open and receptive household relationships.

Husbands' role in care-seeking was minimal where women stayed at their natal households for the birth. Their involvement was also marginal in joint marital households although they might provide practical support and contribute to financial or transport arrangements. They might also participate in household discussions, but their say in decisions was delimited by constructions that locate these matters within the domain of authority of elder females. Situated meanings emphasised young men's lack of knowledge (see Section 7.2.1), but also the inappropriateness of a man, junior in the age hierarchy of the household, speaking out on these matters.

'Men are not involved much in this process [...] Most men keep quiet; they can't say anything in front of their mothers' (C3, husband, joint marital, I2)

'[My husband] talks [with family] about other issues, but not this issue. He might feel that I'm the youngest, so it won't be taken well if I talk about these things' (C10, woman, joint marital, I1)

'As they (parents) are more experienced, elder to me—. That is, they're the owners of the house; they're the heads of the family. They have the right to think about everything. If something has to be decided, then they only will decide it' (C8, husband, joint marital, I1)

'Our son didn't tell us what to do or where to take her. He left it up to us [...] because he thought his parents and brother are there to take care of him and his family and to do all the work required [...] It's always better when the son respects his parents and takes our permission to do things. My son always listens to what we say so that feels good' (C8, mother-in-law, joint marital, I2)

The issue was also framed in terms of men being too busy with work for involvement, drawing on notions of masculinity. In these households, women and husbands largely reported their communication about pregnancy and birth to be fairly limited and general, with all important issues addressed through the mother-in-law:

He doesn't talk much [...] he listens but then goes out to work [...] he doesn't tell me anything (C7, woman, joint marital, I1)

'He wasn't with me. It was mostly my mother-in-law who was with me. My husband didn't have that much time as he had to go to work' (C8, woman, joint marital, I1)

Narratives suggested that interpersonal dynamics and the role of women and their husbands in care-seeking for birth were quite different in nuclear marital households. In all three cases of this type, women and husbands were central in managing the care-seeking process, although family members were involved to some, albeit different extents. In effect, these were exceptions in terms of women's autonomy, male involvement, and the sharing of efforts between households, including the collaboration of natal and marital families in some cases. At one end of this range was a case in which the woman, her husband and mother framed the decision to stay at the nuclear marital residence as a sacrifice of prioritising access to the city's health facilities for the birth, ascribing strongly to the cultural narrative that couples lack the necessary experience to manage a first birth independently. Accordingly, the woman's parents were invited to undertake responsibility for the birth, albeit from the marital residence, where they joined the couple from the eighth month of pregnancy. Yet, even in this case, in practice it was the couple that gathered information on different options for care, visited hospitals for ANC and to register, and made decisions on which one(s) to follow up, although the natal family financed care, and accompanied and coordinated arrangements at the birth alongside the husband. In the other two cases, the couples emphasised their independent responsibility for the birth. They reported that decisions and financial arrangements were made within the boundaries of their household, although they drew on family support for certain tasks, such as accompanying the women at hospital⁷⁸.

These primiparous couples defied cultural narratives of their inability to manage the care-seeking process for a first birth. In particular, the women displayed remarkable agency. They identified their own priorities and goals, and found ways to address them in collaboration with their husbands. In some cases, they overcame cultural norms to take action towards care-seeking outcomes. For example, although even these women did not normally travel outside their neighbourhoods unaccompanied by a family member, they did so in response to a perceived imperative when their husbands were unable to take leave from work. One travelled alone by bus to the hospital for ANC appointments and the other went with a non-family neighbour.

⁷⁸ In one household, the mother-in-law came to stay in the final week of an overdue pregnancy, and both the mother-in-law and mother accompanied the woman at hospital. The other household shared a compound residence with the husband's parents, but they emphasised their separate functioning (in terms of cooking, budgeting and decision-making). They drew minimally on assistance from the in-laws at hospital.

Although the woman in one case and the husband in another at times fell back on the cultural narrative of husbands' authority in the dyad, the care-seeking processes that all three couples described were most certainly collaborative. They reported extensive discussion and joint action to juggle competing priorities of an inclination towards private care in all three cases with its potential economic implications for their household. Together they ploughed energetically into identifying a place of birth that met their expectations, harnessing social resources to gather information on the options available in view of a lack of previous experience to draw upon. Both women's agency and male involvement were amplified in these cases.

'He supports me on all issues, discussing things with me, giving me medicines. He supports me in everything, he takes me to hospital whenever required [...] Until now he wanted me to go to [name of private hospital] only. Then I asked him to go and check out [name of government hospital] because the Anganwadi madam was quite positive about it. He's like I shouldn't face any problem at the end time' (C6, woman, nuclear marital, I1)

'[An USHA] helped us with the decision and we both finally decided what to do [...] My parents, we live in one house but separately and I knew they couldn't help me, so we (the couple) made our own decisions about the delivery [...] I didn't have anyone to share this with; it was just us two' (C11, husband, nuclear marital, I2)

'We both, husband and wife [decided on this hospital]. We both want it there; if I say something he agrees to it and vice-versa' (C9, woman, nuclear marital, I1)

Yet, this is a self-selecting group among nuclear marital households as well as households more generally. They may over-represent those with greater experience and personal resources for managing independently already, as well as higher quality relationships in which women had faith in their husbands' support. Certainly, narratives suggested strong companionate bonds. For example, in an earlier conflict between one woman and her in-laws, she was reportedly supported by her husband, leading to the dissolution of the joint household. Another woman relished her relative freedom in the city with her husband and their self-sufficiency: *'My husband and I stay happily, so I don't miss anybody here.'*⁷⁹ The question remains, however, of whether there was self-selection into nuclear households in the first place, or whether residing in a nuclear household allowed these bonds to develop, as the following quote suggests:

⁷⁹ C9, woman, nuclear marital, I1

'She can freely share any problem when we're alone, but she can't do the same when five people are sitting (i.e., in a joint household). Here we're alone, so she can say freely this is my problem and this is not' (C6, husband, nuclear marital, I2)

Nevertheless, staying in a nuclear marital household for the birth may also be attached with more negative meanings of loneliness and fewer sources of support. This cultural narrative is exemplified in the following excerpt from the case in which natal family members were asked to join the couple at their residence:

'I feel those who live in a joint family, they're better-off. I feel very lonely at times [...] Had we been living together [as a joint family], then I would have somebody to talk to. And it's a totally different thing being with elders; they would give me advice and suggestions [...] Like now, even for very small things, I get so tense. The elders handle these issues in a more mature manner and get less worried' (C6, woman, marital non-joint, I1)

7.2.5 Interaction with wider social ties regarding maternity care

Intra-household dynamics are embedded within a web of wider social relationships. In a context where women have low decision-making authority and the household is so prominent in care-seeking, it is vital to consider household members' social ties beyond the woman's. Households in this study were not recent migrants, having been in the city for periods ranging from six years to those in which even the woman or husband was born there. Households were largely based near relatives—often within the same neighbourhood—since migrants tend to join kin connections on arrival in a new city, providing them with social networks from the time they arrive (Agarwal & Jones, 2012). Since these households rarely moved their base within the city once settled, this pattern ensured a sustained network in close proximity⁸⁰. For example, a mother-in-law in one household that had migrated to the city eight years earlier stated: *'We never felt that we had left the village coming here [...] People in around eight houses here are our relatives.'*⁸¹

Relatives were a key group with whom women interacted in the city and extra-household interactions they described regarding pregnancy and birth were

⁸⁰ Other studies in low-income urban areas in India have indicated a more mobile population (Shah More et al., 2009b). Since this sample was non-representative, it is not possible to ascertain whether this study's population was actually different in this regard.

⁸¹ C8, mother-in-law, joint marital, I2

predominantly with family members. Some acknowledged either taking advice or learning from the experiences of these family members. Narratives nonetheless often emphasised actual decisions being made within the household, behind closed doors.

'I do what I feel is right, I don't listen to anybody' (C4, mother, natal, I1)

'We had already decided that we were going to take her to the hospital. So we didn't say anything to anybody. Who helps us? Nobody does. We have to do things ourselves' (C1, grandmother, natal, I2)

Previous care experiences within the household were drawn upon to inform the care-seeking strategy. Although it was the woman's first birth, there may have been multiple previous births within the same generation in the household and they provided a template for the current birth.

Relatives might be called upon for practical assistance. For example, female relatives might accompany the woman for ANC, or for the birth at home or hospital along with the mother or mother-in-law. They might also lend money for costs related to pregnancy and birth as part of a reciprocal understanding, or help with transport arrangements.

'The first Rs. 10,000 we gave, and then relatives had come [to visit] and they gave (i.e., lent) us [the rest]' (C3, mother-in-law, joint marital, I2)

'Though almost everyone has a vehicle here, it's better to call your own people (i.e., family)' (C13, mother, natal, I2)

Elder women's non-kin relationships and interactions were geographically concentrated within their immediate neighbourhoods because their time was mostly spent in or near the home, aside from work outside the *basti*. As the latter quote suggests, however, the notion of non-kin involvement in care-seeking was rejected and discussion of decisions outside the family was constructed as off-limits, with a pervasive narrative of appropriate distance and proscription of meddling in each other's affairs. A theme of mistrust was detectable and some participants expressed concern about supernatural powers that might be used for harmful purposes (see Section 5.2.4), which compelled the defence mechanism of keeping matters close within trusted kin-based relationships.

'I didn't speak to anyone else about this [...] People just start spreading rumours' (C8, mother-in-law, joint marital, I2)

'Whatever happens in my house, I can tell you. I don't even think of what is there in others' houses, what is going on in their houses' (C16, mother, natal, I2)

The distinction between kin and other community members is exemplified in the following excerpt from a case which was unusual because the household had no relatives in the city:

'I only know that mostly people go to [this or that hospital]. I don't know many people out here, and this is the first delivery in our home. If I ask, they'll ask me why I'm asking so many things. Had our people⁸² been here, we would have asked them everything' (C7, mother-in-law, joint marital, I1)

In rural Bangladesh, Parkhurst et al. (2006) identified community involvement as key in the experiences of those who sought professional care for birth. In this study, direct community involvement was largely restricted to kin relationships. Nevertheless, references to more general discussions and picking up information from wider, often neighbourhood-based contacts were commonplace:

'As I used to go for work, during lunch time, when all the ladies had food, they used to discuss that [this place] is good, [that place] is good [...] I started getting knowledge that here it is like this and there it is like that' (C7, mother-in-law, joint marital, I2)

'All these people from our locality talk. When they go and come back from [hospital], they say that we have taken the injections' (C15, mother, natal, I1)

Moreover, some participants reported exposure to information about pregnancy and birth through television or news media. Some read negative reports about government hospitals in newspapers in a climate of increasing public surveillance of the health system. Although information and advice imparted by health professionals during ANC visits was often reported to be limited, some did refer to discussion of care options. Access to information through community health workers had also increased substantially as the network of Anganwadi centres expanded and new roles for community health volunteers, such as ASHA or USHA workers, emerged⁸³. While the neighbourhoods of 13 of 16 women in this study were served by an Anganwadi centre,

⁸² *'Apne wale,'* translated here as 'our people,' appeared to refer to kin in this case, but similar phrases (e.g., *'hamare log'*) appeared to be used in some interviews to refer to one's own caste (*jati*).

⁸³ See Section 3.6 for a discussion of Anganwadi centres and USHAs

contact varied widely—from households that had no contact to those that used them as a valuable resource for information and advice on place of birth, as well as other services. In five cases, an USHA worker accompanied the woman for at least one ANC visit, but assisted the household at the time of the birth in only two cases because they were unavailable at the relevant time. Both Anganwadi workers and USHA workers reported that their assistance with care-seeking was rarely sought by households in which elder women considered themselves experienced and self-sufficient, which was echoed in the narratives of elder women. However, nuclear marital households drew on these social resources extensively in their quest to identify an appropriate place of birth in the absence of prior experience: two visited the Anganwadi centre on several occasions specifically to discuss options for care, and two drew extensively on the assistance of USHA workers.

The narratives of husbands suggested much less concern with distinctions between those with whom they could discuss birth and those with whom they could not. In contrast to elder women, husbands might refer to discussion among ‘friends,’ usually linked with their employment, about different care options. Cultural norms marginalising husbands in care-seeking decisions for first births in joint marital households obscured their relevance. However, in nuclear marital households in which husbands were attributed with much greater responsibility in the care-seeking process, women and their husbands reported drawing extensively on the advice of husbands’ friends alongside the advice of kin and community health workers:

‘Here in Indore, my husband’s friends’ wives had their deliveries at these places [...] Then my aunt who lives in our neighbourhood, she told us about it. Then my husband’s aunt, she is a resident of Indore. Her three children were born after operations in [name of hospital]. She had asked me that if possible, go and see [there] also’ (C6, woman, natal, I1)

Sociocultural norms isolate young women from independent information sources about pregnancy, birth and maternal health care services. Women’s engagement with issues related to maternal health was limited before marriage, and with pressure to conceive soon after marriage, this left a short window within which to acquire knowledge. Patrilocality means that women largely move to new, unfamiliar physical and social surroundings upon marriage. However, norms restricted recently-married women’s employment and movement outside the home, and they were discouraged from developing independent, non-household social relationships. In effect, despite

being in a large city, the worlds of young women remain small (Agarwal & Jones, 2012).

Young women largely reported that it was not a custom to go out or they were forbidden from doing so at their marital households, although it was rarely framed as a problem because it was a cultural norm. There were differences between households and between *bastis*, but this was a matter of degree. Even when women were outside near their homes, interaction with non-family members beyond casual conversation crossed a line of acceptability and peer friendships were largely absent in these early days of marriage. The wider world was constructed as a threatening place for young women, and narratives of suspicion that people would seek to lead them astray were commonplace. Some women made contrasts with their natal household where they might know more people and be *'allowed to go around here and there'*⁸⁴ within the neighbourhood. Yet, interaction was still largely with kin and close neighbours.

'I don't go anywhere. It's not like I would go to their (i.e., neighbours') place to talk, but I interact with them when they come over to our place. Otherwise I sit alone at home' (C10, woman, joint marital, I1)

'When I go to put clothes out, then we just have casual interaction (i.e., with neighbours). My mother-in-law doesn't let us go anywhere, and nobody comes to our place [...] Someone might brainwash⁸⁵ me, so I don't go [...] My mother-in-law says people (i.e., the neighbours) are not good' (C4, woman, natal, I2)

'Friends may misguide you. They might make you do things that are wrong [...] so we stay away from them' (C5, woman, natal, I1)

'In this colony, not all people are of the same mind-set; people think differently. Some talk like this and that (i.e., gossip), so we don't like it' (C3, woman, joint marital, I1)

Women's movement outside the neighbourhood in either type of household was rare, framed in terms of need and virtually always accompanied:

'If there is something urgent, then we finish it off. Or sometimes if madam (i.e., the doctor) calls us then we go. Like this card was to be made (i.e., registration), then I went; after that I haven't gone out' (C3, woman, joint marital, I1)

⁸⁴ C1, woman, natal, I1

⁸⁵ The notion that people might try to introduce young women to new, alternative ideas or lead them astray was commonplace. In the phrase *'Aise koi sikha de,'* the literal 'to teach' was translated as 'to brainwash.' 'To brainwash' was a phrase that I heard used frequently in English informal conversations about this phenomenon.

Added to this, women reported that *'it doesn't look good'*⁸⁶ to be seen outside in late pregnancy, restricting even further women's access to information sources during the pregnancy episode.

With no prior personal experience of pregnancy and birth, the implication of young women's isolation from independent social networks was that their knowledge of pregnancy and birth, maternity care and the city's health system was largely constructed either directly through information provided by elder women in the household or family, or was at least mediated by them since they regulated young women's social relationships. This served to consolidate women's dependence on other household members. The following quote demonstrates implications of limited access to information:

'I didn't know what all would happen during delivery. I didn't even know from where the baby comes out. I used to wonder that, since the stomach was becoming so big, they might operate and take out the baby from the stomach. So I was actually wondering how the dai would operate on me. I was looking at her wondering what she would do' (C15, woman, natal, I2)

7.2.6 Congruity within households

But how do these patterned social relationships interact with the content of interaction to shape care-seeking strategies? In regards to intra-household relationships, one of the most striking findings of analyses of multiple perspectives was the close concordance between the constructions of young women and their mothers or mothers-in-law of childbirth, risk and the different care options available. The explanation must lie in part in young women's isolation from independent information sources that might inform alternative views on maternal health care. Were women to have wider access to independent social relationships, one could imagine a situation in which they might convey different perceptions of care from elder women in their households even if they had not the authority to carry this through. Yet, in this study, there was little explicit reference to conflicting views or disagreement with those in authority. The positions of elder women in the household vis-à-vis birth at home versus a health facility or in the public versus private sector—as well as reported perceptions underpinning these—were largely mirrored in young women's narratives. The process through which limited

⁸⁶ C3, woman, joint marital, I1

access to information rendered young women dependent on knowledge, beliefs and attitudes shared with them by other household members is explicitly captured in the following quotes:

'I also think the same, what else do I see? It's like I'm ok with the decision of other family members' (C10, woman, joint marital, I1)

Interviewer: *'In your in-laws' village, where do most of the deliveries happen?'*
 Woman: *'I don't know. I've just recently got married [...] They don't let me go out. Only to my mother-in-law's [...] They don't allow me to talk to anybody'*
 (C1, woman, natal, I2)

Woman: *'I don't want an operation'*
 Interviewer: *'Why do you feel that there should be no operation?'*
 Woman: *'I don't know. Everyone [in the household] said that the delivery should be done without an operation, so I also feel that there should be no operation'*
 (C8, woman, joint marital, I1)

Perspectives or agendas within the wider household were not always congruous, however. Young women's isolation from independent social relationships left them open to manipulation of their limited knowledge and fear by household members with different agendas as a strategy of influence. In one such case, the woman reported consensus within the household on intentions for birth at a private tertiary hospital in the first interview. However, she reported eventually refusing to go, defying her grandmother's and uncle's wishes, because her uncle's wife had frightened her about what would happen at hospital:

'One is alone over there (i.e., at hospital). My uncle's wife told me so [...] She said, "Deliver at home [...] You have to cry a lot over there. Until you deliver on your own, they don't come to attend to you. Here [at home] everyone can explain everything, but nobody would be there to explain or comfort you." [...] She told me this recently when everybody went [out]' (C1, woman, natal, I2)

Since the aunt herself had two births at the hospital, this example raises the issue of complex intra-household dynamics and potentially different household agendas, and their implications for care-seeking.

Findings of concordance in perspectives for the most part between women and authority figures in the household provided little support for the notion that household power structures obstructed access to care for young primiparous women with more positive views of the biomedical system in this setting, as Brunson (2010) describes in

Nepal. Nor that young women were frustrated with others' decisions, as McPherson et al. (2006) describe. This is not to say that unequal power structures do not matter for care outcomes; only that the analyses do not suggest that these women experienced them in terms of being held back from achieving a different set of priorities or preferences by those around them. Women's passive conformity may certainly have contributed in some cases, but stops short of a complete explanation. Some women were seen to actively construct the landscape of maternal health and care, but they did so through a narrow lens that was largely limited to close-kin based networks, and these were also—in this study at least—ones in which they expressed considerable faith. Essentially, women's low autonomy influenced the process in more subtle ways.

Many young women in this setting returned to their natal households for the first birth and indications were that those who stayed in marital households were self-selecting in ways that suggested a bias towards positive relationships with in-laws or husbands. The woman's and baby's well-being were reported to be the priority of care-seeking strategies across all types of households. For example, women in both natal and marital households expressed confidence in elders' or husbands' commitment to a good outcome, with statements such as: *'They (parents and parents-in-law) say for my benefit only,*⁸⁷ *'Whatever they (parents-in-law) do for me would be the best'*⁸⁸ or *'A mother would not do wrong for her child.'*⁸⁹ Some women staying in natal households did describe hostile relationships with their in-laws, however, and processes may be very different where women stay in such households or for higher order births for which they may be more likely to stay in their marital household. Nevertheless, although this young woman's aim was to criticise her in-laws' apparent neglect, her quote conveyed the perceived incentive for marital households to seek a good birth outcome:

'Even if my mummy feeds [the child] from a gold plate, will s/he⁹⁰ be of any use to her? Your family blood will ultimately be useful for you. Today, even if they don't do anything for her/him, s/he will stand by them and not my parents, isn't it? After all, s/he will be their son's child' (C14, woman, natal, I1)

⁸⁷ C13, woman, natal, I2. Refers to parents and parents-in-law because both had input in the care-seeking strategy for birth in this case (see Section 7.2.3)

⁸⁸ C8, woman, joint marital, I2

⁸⁹ C5, woman, natal, I2

⁹⁰ There is no distinction between masculine/feminine pronouns in Hindi.

Where natal or joint marital households opted to use maternity care services, this was necessarily sanctioned or even encouraged by elder women given their authority in these matters. A biomedical discourse was dominant across generations in most households in this study. In many cases, elder women leaned towards medical management in spite of their own and sometimes the births of their elder daughters(-in-law) earlier taking place at home. Perceived changes in context underpinned constructions of the need to use health facilities for birth nowadays, even where these co-existed with constructions of home birth as the ideal (see Chapter 5). The data suggest that elder women and men were agents of change in this setting and that a period change in ideas was taking place, not only a cohort change.

Nevertheless, non-use of maternity care services was not necessarily a reflection of a lack of commitment to a safe outcome. As Chapter 5 indicates, there was diversity in perceptions of birth-related risks and how they are best managed. Some elder women in both natal and joint marital households expressed inclinations towards a home birth underpinned by reported perceptions of greater risks at hospital. Thus, even where a safe birth outcome was presented as the priority, this did not necessarily lead automatically to use of maternity care services. The isolation of young women from wider information sources meant that, where elder women in the household held negative perceptions of the formal health system, this was mirrored in expressions of fear of hospitals by young women. These findings reinforce those of other studies indicating that links between strong household relationships and maternity care outcomes are moderated by perceptions of different care options (Allendorf, 2013; Mumtaz & Salway, 2005). As Allendorf (2013) suggests, high quality relationships may ensure commitment to a safe outcome for the woman, but strategies reflect what they believe will be beneficial.

7.2.7 Networks, norms and the spectre of blame

Section 7.2.6 discussed the implications of intra-household dynamics for care-seeking strategies, but leaves a question regarding how they are shaped by the wider interactive context. Here the chapter revisits the concept of ‘responsibility’ introduced in Section 7.2.1 as well as its corollary of ‘blame.’ Chapter 5 established that childbirth was regarded as a risk event in the study setting. Risk discourse is powerfully connected

with the notions of responsibility and blame. In modern societies, risk is seen to be under human control (Lupton, 1999) and an adverse outcome is no longer attributed to fate or accidental causes, but to ‘mismanaged risk’ (Coxon et al., 2014). In these circumstances, people are expected to take responsibility for the decisions they make, and may be blamed if they are perceived to have made the wrong decision. This places much greater pressure on decision-making and attaches worry, anxiety and guilt to childbirth, which was once conceived as a natural process (Lupton, 2011, 2012).

‘Responsibility’ and its corollary of ‘blame’ emerged inductively as key constructs in situated meanings attached to care-seeking for birth in this setting. The individualism of western societies means that accountability for decisions during pregnancy and birth is largely constructed as the woman’s (Lupton, 2012). Even studies in LMICs have found the locus of accountability to be increasingly centred on the woman (e.g., Denham, 2012; Smith-Oka, 2012). Yet, with the construction of responsibility for (first) births in this setting as the household’s rather than the individual woman’s (see Section 7.2.1), guilt and blame for a negative outcome would fall on the household, and on those regarded as authority figures in the household in particular. For example:

‘My sister had three deliveries. One happened at her in-laws’ place, but then it went out of hand because her mother-in-law didn’t take care of her, so her daughter was born very weak’ (C3, woman, joint marital, I1)

‘My elder brother’s wife was sent to her mummy’s place in her seventh month after Godh Bharai⁹¹ but her parents didn’t take good care of her. She [fell] and the baby died in the womb’ (C12, woman, natal, I1)

‘If anything went wrong, her husband and her mother-in-law would blame us⁹². They would say, “You people brought her so far, and you didn’t take care of her”’ (C1, uncle, natal, I2)

The latter quote arose in reference to a renegotiation of the decision on place of birth after the onset of labour pains. While all three household participants reported that the woman refused to be taken to a hospital, the uncle expressed concern regarding the guilt and blame that would have befallen their household for making the wrong decision in case of an adverse outcome. The natal-marital household dynamic plays a key surveillance role. Since the birth outcome is the exclusive responsibility of only one of

⁹¹ A Hindu ceremony to bless the mother and unborn baby

⁹² I.e., the natal household in which the woman was staying at the time of the birth

the households, it is in effect accountable to the other. Simultaneously, households need to be seen to be doing the right thing among their wider social ties.

In effect, whether or not it is followed through, the ‘spectre of blame’ exerts pressure to act on risk events, such as childbirth, in ways that conform to expectations within the social network. Expectations are closely tied with norms. If childbirth ends in an adverse outcome for the woman or baby, blame surrounds behaviour that contravened norms (Coxon et al., 2014; Smith-Oka, 2012). In western societies, being seen as a ‘responsible’ mother entails seeking to minimise risk through accepting the authority of medical expertise (Miller & Shriver, 2012). As Chapter 5 discusses, a biomedical risk discourse on pregnancy and birth now coexists in local discourse alongside more traditional frameworks. The international community’s prioritisation of maternal and newborn health has intensified pressure on LMICs with poor indicators in this area to respond. In India—and across the globe—initiatives have flourished that aim to increase births with a skilled attendant or in a health facility (see Chapters 1 and 3). Regardless of the other mechanisms through which these initiatives might operate, they have certainly brought into people’s communities an authoritative message that birth is a risky event, best managed by medical experts. As Chapter 5 states, this is reinforced through contact with maternity care services, which brings to people’s awareness risks about which they might not otherwise have known.

Section 7.2.5 indicated that many participants reported exposure to such messages within their communities, through the health system and in the media. Biomedical discourse on pregnancy and birth is underpinned by strong moral meanings (Lupton, 2011). This is conveyed in the following excerpt referring to public health messages and the latter excerpt from a key informant illustrating a mechanism through which this might operate via contact with the health system:

‘The doctors have told people that new deliveries can’t be done at home. Tomorrow, if anything goes wrong, can you take the responsibility or risk⁹³? Lots of things have gone wrong seriously; someone’s baby was born weak, someone’s baby was born paralysed [...] The doctors assure us that, “If anything goes wrong, we are here to help you out, we take the responsibility”’ (C14, mother, natal, I1)

‘Sometimes when they (people in general) do this thing and something goes wrong, we catch hold of this point and tell them that you didn’t listen to us, so it

⁹³ ‘Jokhim’

happened like this. Then from the next time they start listening to us'
(Community nurse midwife)

These authoritative and moral messages change the context of care-seeking. Where a household had access to medical facilities and members of their social networks endorsed their use, households were fearful of blame were they not to use them or follow medical advice:

'Had we not taken her [to the public tertiary hospital for a caesarean section], then it was our responsibility. We would be liable if anything were to happen to the mother or child. Who wanted to take such a risk?' (C5, mother, natal, I2)

The following quote from an USHA worker is noteworthy because it suggests that fear of blame from family members was sufficient to ensure the compliance of elders in authority, even where this co-existed alongside an otherwise strong inclination towards traditional frameworks:

Interviewer: *'Are there families who decide to get the delivery done at home?'*
USHA: *'...Definitely not in this area. They don't want the delivery to be done at home because they're afraid. The elderly mother-in-law would want the delivery to be done at home; she would have delivered her children at home. But then she is also scared nowadays that, in case something happens, her son and daughter-in-law will curse her forever [...] That's why even the elders nowadays want to go to the hospital'* (USHA worker, B6)

The influence of the spectre of blame on care-seeking strategies did not necessarily stop at the issue of whether or not to use a hospital, but extended to the type of hospital used. Chapter 5 discusses the widespread perception that quality of care is superior in private hospitals and risk concomitantly lower. Even within the low-income neighbourhoods in this study, those who were relatively more financially able were reportedly under social pressure to conform to the expectation that they would prioritise the woman and newborn's well-being above money. Not to do so similarly invoked the spectre of blame:

'They (people with greater financial resources in the basti) have pride [...] They think, "I'll take the ladies of my house to some good place; if I take her to the government hospital, people will laugh at me that he's taking his wife to a government hospital in spite of being rich"⁹⁴' (USHA worker, B2)

⁹⁴ 'Rich' here refers to relatively rich within the *basti* since the context of the quote was a discussion of why some people in the *basti* did not take up the services offered by USHA workers.

The following household was reportedly content with using a government hospital and ill-able to afford the costs of using a private hospital. Yet, the mother's narrative suggests they felt compelled to opt for the private sector through fear of blame by the in-laws if something were to happen:

'She (i.e., the mother-in-law) had already warned us about complications. And the way the world is today, if anything untoward were to happen then we would be blamed for it. People would say that we brought our daughter home and got her delivery done [at a government hospital] where we wanted just to save money, which is why all this happened. Instead we just went [for a private hospital] as per their wishes' (C13, mother, natal, I2)

Finally, this section has described a mechanism embedded in social interaction that, in tandem with the perceptions discussed in Chapter 5, compelled many households' use of health facilities for birth in spite of reservations. Yet, it still fails to account for variation in care-seeking strategies: how or why did some households retain opposition to the biomedical system when it had become so compelling for others in these low-income urban neighbourhoods? Pescosolido (1992) conceptualises affect and rationality as tied to interaction within a social network. In effect, the study's care-seeking framework (see Section 2.6) suggests that the answer lies in the patterning of social relationships and interaction.

Section 7.2.5 indicated that for the households in this study, most of which had long been in the city, social ties and interaction were geographically concentrated within the neighbourhood. This brings to the fore the content of interaction in the diverse *bastis* within which these households resided. Of the four households in which the primary intention reported in first interviews was a home birth, two were in *bastis* in which most births by this point took place at a health facility. They comprised the households referred to in Sections 5.2.2 and 6.2.2 that, despite inclinations towards a home birth, sought considerable contact with private maternity care services during pregnancy, which was constructed as an effort to identify and manage risks. Further, the women in both cases eventually had normal births in private health facilities, suggesting a low threshold for turning to medical expertise when concerns about risk arose. Essentially, despite retaining resistance to birth in a health facility, these households were embedded in social networks that expected use of health facilities for birth and would attach blame for their non-use if an adverse outcome ensued.

The two other households inclined towards a home birth in first interviews were located in *bastis* where most births took place at home, as was the woman interviewed only retrospectively after a home birth⁹⁵, as well as two of three households who had a home birth despite reporting intentions for birth in a health facility in first interviews. Households across all sample *bastis* had low incomes; these households were not necessarily distinct in this regard. Yet, household and key informant data suggested that these *bastis* in particular were made up of a small number of particularly low status and stigmatised castes or tribes⁹⁶, who were even less integrated in wider social networks than the residents of other *bastis*. Although there were Anganwadi centres in two of the three *bastis*, key informants described them as difficult places to enter due to mistrust of outsiders, and also suggested that these groups might face greater interpersonal difficulties with health workers when accessing health care services. Their relative marginalisation may have rendered these communities less penetrable to new norms than others more open to diverse influences. These households encompassed those that were aware of the wider trend towards greater use of hospitals, but positioned themselves in contrast to other communities, as tough and capable of managing home birth. They made minimal use of maternity care services throughout the care-seeking episode (see Sections 5.2.1, 5.2.2 and 6.2.2). At the time of this study, cultural norms or content among these households' social ties minimised the spectre of blame for pursuing a home birth.

7.3 Summary

In this chapter, I have examined patterns in social relationships and interaction surrounding pregnancy and birth in low-income urban settlements in Indore, and considered their implications for care-seeking strategies. While the chapter has reiterated the importance of the household in maternity care-seeking in this region, it has offered an alternative perspective on intra-household dynamics. The chapter mirrors other studies from South Asia which find that matters relating to pregnancy and birth fall within female elders' domain of authority, and that young women by and large are not autonomous, independent maternity care-seekers (Bloom et al., 2001; Jejeebhoy,

⁹⁵ See Section 4.4

⁹⁶ I do not list these castes or tribes, since the aim in this final section is to suggest mechanisms requiring further investigation rather than to draw attention to specific groups.

2000; McPherson et al., 2010; Simkhada et al., 2010). By focusing on local constructions of ideal and actual household roles in care-seeking, however, the study has uncovered the conflicting meanings attached to the same phenomena from a local perspective on the one hand and from the perspective of the discourse on autonomy on the other.

The chapter reinforces other studies which bring the quality of women's relationships within the household to the fore (Allendorf, 2012b; Mumtaz & Salway, 2009), building on these by developing links with the concept of responsibility. Taking adequate 'responsibility' for the young woman and newborn's care was constructed as the ideal in both natal and joint marital households, and a woman managing pregnancy and birth independently was attached with meanings of evaded responsibility on the part of the household. Strong relationships and taking responsibility went hand in hand. Responsibility entailed providing care and support; being responsive to the woman's needs; and acting in her best interest. Where relationships were strong, women had faith in female elders' decisions and actions. Moreover, primiparous women's perceptions were largely constructed through information shared by household members since they lacked independent information sources. In effect, findings in this study differed from those in Nepal which found that women experienced low autonomy in maternity care decision-making in terms of being held back from a different set of preferences (Brunson, 2010; McPherson et al., 2006). Of course, not all households have good relationships and not all fulfilled cultural ideals for taking adequate 'responsibility,' and a context of low female autonomy renders these women particularly vulnerable.

This investigation adds weight to the critique introduced in Section 7.1.2 of studies using large-scale surveys such as the NFHS and DLHS to examine variables relating to the household as determinants of maternal care outcomes since they fail to capture the full complexity, diversity and fluidity of the relevant household unit during the care-seeking episode for (first) birth. Intra-household dynamics differ across household types. In this study, women in natal households characterised intra-household relationships as open and responsive. Women remaining in marital households were also self-selecting in ways that suggested a bias towards positive relationships. Negative characterisations of marital household relationships among some women interviewed in natal households, however, suggest that patterns may differ substantially in some

marital households, with particular implications for later births when women are more likely to stay in their marital households.

Since childbirth was viewed as a risk event, accountability for an adverse outcome was attached to the household responsible at that point in time. The spectre of blame impelled households to adhere to norms among their social ties. Variation in care-seeking strategies arose in part because the content of interaction on how birth is best and most safely managed varied across geographically-concentrated social networks. Assumptions that non-use of maternity care services is necessarily a reflection that other concerns are prioritised over women's or newborns' safety are flawed.

This chapter has examined how interaction within patterned social relationships shapes care-seeking strategies for birth, from the perspective that it is the driver of action. It has shown that decisions and actions in this context of strong household interdependence and low female autonomy depend on intra-household dynamics. Households are embedded in a wider interactive context, however, which also shapes their strategies. Knowledge, beliefs and attitudes are a product of social interaction (Pescosolido, 1992), which contributed to diversity at the neighbourhood level in this context of geographically-concentrated social networks. Further, social ties provided the surveillance function that regulated care-seeking behaviour during pregnancy and birth.

8. Conclusion

8.1 Introduction

The overarching aim of this research was to improve understanding of care-seeking for first births in low-income settlements of urban India, underpinned by a framework that conceptualises care-seeking as a dynamic and social process. The empirical chapters respectively addressed three research sub-questions which placed the spotlight on different elements of the framework (see Section 2.6). Chapter 5 considered the range of perceptions concerning care for birth. These provided the foundation for actual care-seeking strategies, or sequences of decisions and actions towards care at birth, examined in Chapter 6. Finally, the patterned social relationships and interaction driving care-seeking strategies were examined in Chapter 7. In this concluding chapter, I pull together findings from the three empirical chapters to address the overarching research aim. I discuss issues raised by the research and consider them in relation to current policy debates, particularly concerning the key goals of increasing births with a skilled attendant and improving the quality of maternity care services. Finally, I reflect on limitations of the research as well as the methodological approach's implications for findings, and suggest avenues for future research.

8.2 Care-seeking for birth

The thesis has shown maternity care-seeking among this low-income urban population to be highly strategic. This characterisation more closely resembles the 'sophisticated' care-seekers described in Matthews et al.'s (2005a) study of slum-dwellers in Mumbai, India, than the characterisations of poor populations typically seen in the literature. This may be a result of the changing context or differences across settings, but it may also be a result of the study's methodology placing greater emphasis on human agency. First, this population was aware of the array of maternity care options available and was highly discriminating across this range. Considerations went far beyond the decision to use a skilled birth attendant or health facility, or not, which has been the focus of most studies in India to date. Second, the study has challenged the static view of maternity

care-seeking seen in much of the literature, building on others that show it to be a dynamic process (Matthews et al., 2005b; Shah More et al., 2009a). Households' care-seeking strategies for birth were plural, contingent and flexible. They could be characterised as contingency strategies that combined different providers across and within sectors to allow flexibility in dealing with unfolding circumstances. Moreover, strategies changed through pregnancy to birth in response to the evolving context.

This population viewed childbirth as a risk event wherein their decisions and actions had implications for a 'safe' outcome, as they defined it. The thesis accordingly harnessed insights from the sociocultural literature on risk in analyses of themes and the connections between them. Managing perceived risks to a safe birth was central to this population's care-seeking strategies. Yet, since people are embedded in contexts which shape the way in which they perceive and respond to risks, solutions for maximising safety vary across populations and may not coincide with biomedical knowledge (Lupton, 1999; Miller & Shriver, 2012).

Research on care-seeking behaviour often overlooks interconnections between the ways in which people define situations and the ways in which they act in response. Conceptualisation of a singular, rational, biomedical model of a safe birth has led some researchers to interpret home births as a signal that people prioritise other concerns rather than (or over) a safe birth (e.g., Devasenapathy et al., 2014). It also underpins assumptions that, where levels of female autonomy are low, home births indicate others' failure to prioritise the woman and baby's safety. This study's examination of interconnections between how people themselves constructed the birth process, their priorities for care at birth, and their care-seeking strategies, revealed that a safe birth was presented as a primary concern regardless of care-seeking strategies. Where solutions differed from biomedical knowledge, they were either attached with meanings of safety or at least of no harm.

Households perceived and sought to manage multiple birth-related risks and uncertainties, including physiological risks, risks of medical management, and institutional uncertainty in the health system. The view that biomedicine offers solutions for physiological risks was dominant in this setting, and was reflected in care-seeking strategies. This differs from findings in other Indian contexts across time and space, including in some contemporary urban areas (Devasenapathy et al., 2014; Matthews et al., 2005b). Indore's low-income neighbourhoods represent a setting where the

proportion of births taking place in a health facility has risen rapidly in the past decade (see Sections 3.4 and 3.5). While an explanation for this shift was beyond the scope of this research, the study does offer insight into the meanings attached to it locally. The need to use a health facility for birth in contemporary times was constructed as a response to a perceived increase in childbirth risks. This underpinned high levels of anxiety regarding childbirth, motivating efforts to identify and manage risks. Lay knowledge was largely no longer considered adequate for this purpose; identifying and managing risk required medical expertise and technologies.

As Lupton (1999) states, risk knowledges are not static; they change constantly in response to changes in personal experience, local knowledge networks and expert knowledges. Certainly, in this setting, people have become increasingly exposed to authoritative biomedical discourses. Increasing institutional birth has been prioritised on the national and state political agendas in the past decade (Jat et al., 2013; Shiffman & Ved, 2007). Media coverage of maternal and newborn health issues has increased (Jat et al., 2013). JSY has achieved widespread coverage in MP (Office of the Registrar General & Census Commissioner, 2013b) and such programmes convey an authoritative message that birth should take place in a health facility. Anganwadi centres, USHAs and perhaps health camps might promote institutional births within neighbourhoods. Moreover, contact with maternity care services is to some extent self-reinforcing since it increases awareness of risks that may otherwise remain unknown.

Transport and costs are regarded as key barriers to accessing maternity care services in LMICs (Gabrysch & Campbell, 2009). Since care options were available and physically accessible in this urban centre, transport barriers did not play a prominent role in narratives. Although economic considerations arose in narratives on inclinations towards different types of health facilities, they were not raised as a prominent barrier to use of a health facility for birth, mirroring findings of a study in urban Delhi, India (Devasenapathy et al., 2014). They were certainly secondary to themes relating to perceptions of how to ensure a safe birth. This is perhaps surprising given that several studies have shown that out-of pocket costs remain despite services being free at the point of care in the public sector, even after deducting JSY benefits (Leone et al., 2013; Mohanty & Srivastava, 2013). (At the time of data collection, there were also difficulties in accessing the JSY cash benefit in Indore—see Section 3.6.) Where a health facility was regarded as the safest place for birth, this low-income population

found ways to mobilise financial resources—through their work or family, for example—in spite of the financial consequences. Other studies in India have similarly noted that people overcame barriers where they perceived a need to use a health facility (Griffiths & Stephenson, 2001; Matthews et al., 2005a). JSY is credited at least in part with the rapid increase in institutional births in some states in India over the past decade (UNFPA, 2009). Aside from the direct impact of reducing financial constraints, the scheme may indirectly instil a message that births should take place in a health facility and, once this perception has taken hold, people are likely to continue using maternity care services.

Although medical management was to a varying extent regarded as a solution to childbirth risks, maternity care services were also seen as a source of risk. Low perceived quality of care in public health facilities was highlighted as a threat to a safe birth, and poor interpersonal care was at the centre of these narratives. The literature sometimes makes a distinction between caring and curing, or interpersonal and technical elements of care (Moore et al., 2002). From a local perspective, however, disrespectful interpersonal care—particularly neglect—was a fundamental source of risk to life and health. Participants questioned how health providers could identify and manage risk if they paid insufficient attention to service users. Since local narratives associated paying for care in the private sector with superior interpersonal care, it was understood as a safer place for birth. Perceptions of more respectful interaction in the private sector also minimised fear of broader risks, such as loss of dignity. Households not only distinguished between sectors, but also between facilities within the public sector. For example, contrary to Shah More et al.'s (2009a) findings in Mumbai, India, avoidance of large public hospitals was noted in spite of their more advanced medical facilities because the study population associated them with greater risk than smaller hospitals, largely as a result of differences in interpersonal care.

Maternity care-seeking took place in a context of considerable (perceived) institutional uncertainty in the health system. Rules and procedures were often unpredictable, unclear or at least unknown to participants. The frequent, but unpredictable referral of primiparous women to larger hospitals was a source of particular anxiety. Although this study focused on lay perspectives, it lends tentative support to other studies which suggest a 'disorganised' referral system between public health facilities in urban areas (Devasenapathy et al., 2014; Shah More et al., 2009a).

For example, a large proportion of women in Shah More et al.'s (2009a, p.75) study in Mumbai, India, were referred before admission, sometimes 'from the gates of the institution.'

Care-seeking strategies reflected efforts to negotiate (perceptions of) these three types of risks within the constraints of households' economic means, in response to the unfolding context of pregnancy and birth. Options pursued depended on perceptions of care options combined with the type of care the woman's situation demanded, both of which might be dynamic through pregnancy. Variation in the content of care-seeking strategies thus reflected differences in how people positioned themselves in relation to physiological risks and their management, and in constructions of the different care options. Plural, contingent strategies combining two or more options served to retain households' flexibility and control over the course of action in response to evolving circumstances, in a context of distrust in an unpredictable health system.

Increased consciousness of risk and a weakening of traditional institutions that buttress human behaviour places greater pressure on decision-making (Lupton, 2012; Zinn, 2004). This carries with it responsibility for making the right decisions and its corollary of blame when things go wrong (Coxon et al., 2014; Lupton, 2012). The fear of blame places pressure, albeit does not guarantee, that those responsible pursue maternity care-seeking strategies that meet expectations for minimising risk among their social ties. For example, a view among a household's social ties that birth is safer in a health facility impelled their use, lest the household be blamed in case of an adverse outcome, even where they were anxious about using them. Yet, since the content of interaction varies across social networks, the spectre of blame does not necessarily yield the same strategy.

It is the construct of 'responsibility' and associated fear of blame that connects intra-household dynamics with care-seeking strategies in local narratives. 'Responsibility' is linked with 'autonomy' because responsibility for maternity care is centred on the household—particularly older females who usually hold authority in these matters. Household level responsibility is a product of cultural norms, and differs from many other contexts where responsibility is centred on the individual woman. The notion of 'responsibility' was pervasive in local narratives on maternity care-seeking. Ideal household roles were understood in terms of taking adequate responsibility, which entailed deciding and acting on behalf of the woman. Essentially, the constructs of

responsibility and autonomy differ because similar behaviours are attached with different values through these two lenses. Findings on the incongruity between principles promoted in a focus on women's autonomous, independent action and those implicated in situated understandings of ideal household roles in maternity care-seeking—for first births at least—are a key contribution of this research. The findings build on other research which has challenged assumptions of the autonomy discourse (e.g., Mumtaz & Salway, 2009)—in this case, developing insights from the sociocultural literature on risk to add to this debate.

Primiparous women's autonomy was low in natal and joint marital households, albeit not so in nuclear marital households. In a context prioritising ideals of household responsibility, young women's influence arose through open and responsive household relationships. The emphasis on strong relationships mirrors a small number of other studies (Allendorf, 2012b; Mumtaz & Salway, 2009). Strong relationships meant that those responsible sought to act in the best interests of the woman, but a household's commitment to act in the best interests of the woman may also foster strong relationships. Recently-married, primiparous women's lack of independent information networks or previous experience of childbirth meant that their perceptions were unlikely to conflict with those around them. The thesis cautions against the assumption that non-use of a skilled attendant at birth signals that women are being held back from realising a different set of preferences, or that it is a reflection that other issues are prioritised over the woman and/or baby's safety. This may be the case, but is not necessarily so. Of course, not all relationships are positive and not all households respond in the same way to responsibility. Low levels of autonomy render women particularly vulnerable in these situations.

The focus on first births in this thesis calls for reflection on the implications of primiparity for maternity care-seeking. Determinants studies suggest that women are more likely to use health facilities for first (or lower order) births (Bhatia & Cleland, 1995; Navaneetham & Dharmalingam, 2002). This thesis suggests an interpretation deriving from the belief that first births are inherently more risky. Younger cohorts in general were constructed as 'at risk' owing to contemporary lifestyles, and primiparous women's inexperience exacerbated perceptions of uncertainty. This view was apparently reinforced through messages from the health system that primiparous women were 'high risk,' including through patterns of referral.

Primiparous women were constructed as lacking in capacity to manage the care-seeking process because of limited knowledge and experience, which was connected with constructions of household responsibility. Household context is a further feature that distinguishes first births due to the custom for primiparous women to return to their natal households for the birth. While informal observations in the field site suggested that some women may also return to natal households for later births, and other studies in South India have noted the same (Hutter, 2001; Matthews et al., 2005b), the proportion is likely to be smaller. Intra-household dynamics may be very different in these households. Moreover, this thesis has suggested that marital households in which women stay for the first birth may be self-selecting in ways that lean towards positive relationships. Some women staying in natal households for the birth described negative relationships in their marital households, which may have implications for maternity care-seeking for later births. There were also indications that the dynamics of surveillance between natal and marital households may intensify the pressure of responsibility and accountability for first births, demanding concerted effort to minimise risk. While the association between maternity care-seeking and household context at the time of birth as well as its interaction with parity merits investigation, large-scale surveys do not currently collect information on household at the time of birth. Perceptions of greater uncertainty, differences in household context and the dynamics of responsibility are all potential explanations for findings of higher use of health facilities for first births.

While—given the nature of the study—I generalise to concepts and theory rather than wider populations, an important question nevertheless concerns what the Indore setting brought to the findings. In particular, I highlighted in Chapter 1 the limited research on maternity care-seeking in urban areas. In Indore, a range of health providers across different sectors (see Section 3.6) are both available and physically accessible, as in other large urban centres (Shah More et al., 2009a). The range of health providers offers a greater range of options, including referral centres, but this adds to the complexity of care-seeking. This does not mean that such strategising on the type of care used is not possible outside urban areas. For example, a study in rural Tanzania found that more than 40 per cent of women bypassed the nearest health facility, often due to concerns about quality of care (Kruk et al., 2009). However, the extent of

pluralism and flexibility in care-seeking strategies noted in this study was made possible by the complex urban health system.

I also highlighted in Chapter 1 that Indore is a city that has witnessed a rapid shift in maternity care-seeking during the past decade. Accordingly, the study had less to say specifically about non-use of maternity care services than many other studies conducted in India. The findings provide a good example of how perspectives produce and are shaped by a rapid shift in care-seeking behaviour, however, and provide insight into considerations for improvements in maternal health beyond the stage of encouraging women into health facilities.

8.3 Policy implications

The thesis has implications for the key policy goals of increasing births with a skilled attendant and improving the quality of maternity care services. A synthesis report on the post-2015 agenda indicates that universal health care coverage, access and affordability as well as preventing maternal and newborn deaths will become targets within the Sustainable Development Goals (United Nations, 2014a). A manifesto put forward by the Maternal Health Task Force for maternal health post-2015 called for greater emphasis on reaching the unseen women who are socially excluded (Langer et al., 2013). Certainly, as Indian settings reach the point where most women birth with a skilled attendant, the focus will increasingly be drawn to minorities who do not access care. Given that less than eight per cent of births now take place at home in Indore (Office of the Registrar General & Census Commissioner, 2013b), households in this study that pursued a home birth provide insight into such populations in an urban area. The thesis distinguished two groups: one of households in *bastis* where most births took place in a health facility and the other in *bastis* where most births took place at home. For the former, childbirth was risky and medical expertise and technologies had a role in identifying and minimising these risks. They framed inclinations towards a home birth in terms of a fear that medical management potentially generated more risk than it resolved, as long as there were no complications. Since the content of interactions in these households' neighbourhoods—where their social ties were concentrated—was inclined towards medical management, they demonstrated little hesitation in using health facilities during pregnancy or in response to perceived complications.

The other group encompassed households in *bastis* where few births took place in health facilities. While they shared perceptions of an increase in childbirth risks, they positioned themselves as minimally susceptible to them. These households perceived little need for medical involvement to identify and manage risks, unless there was a complication that they (or the *dai*) felt unable to manage. The content of interaction with these households' social ties shaped their inclinations towards a home birth, and also sanctioned them because norms of a home birth excluded a moral obligation to use the biomedical system. These *bastis* seemed to be particularly marginalised and less integrated in the city's wider networks than others. A study in Mumbai, India, revealed socioeconomic gradients in use of maternity care services within low-income neighbourhoods (Shah More et al., 2009b). This thesis builds on research that highlights community-level effects (Jat et al., 2011; Stephenson & Tsui, 2002), by showing how differentials between low-income neighbourhoods may be produced or reinforced through interactive mechanisms. Differentials at a regional or district level have long been shown (Kesterton et al., 2010), but this study suggests that the concentration of social ties within neighbourhoods may produce differentials between them that go beyond the socioeconomic status of its residents. Contrary to assumptions that slums represent a homogeneous group, the study reinforces an important point about inequalities across (as well as within) low-income urban neighbourhoods (Agarwal & Taneja, 2005). The differences discussed between groups that pursue a home birth highlight the need for a tailored approach to promoting use of a skilled birth attendant, even within low-income urban neighbourhoods.

The strategy prioritised on the international agenda and on India's national agenda for improving maternal health has been the promotion of birth with a skilled attendant. Thus, one might reasonably ask whether we should be concerned about the nuances of care-seeking strategies discussed in this thesis as long as health facilities are used. This thesis makes a case for greater attention to these issues since they may have a broad range of consequences. Among low-income populations that perceived medical management to be the only option for a safe birth, economic constraints on their ability to use a health facility in which they anticipated adequate quality of care generated considerable stress and anxiety. And for low-income households that were able to mobilise sufficient resources, use of the private sector had economic consequences. Moreover, plural, contingent and flexible care-seeking strategies themselves were both a

solution and a source of uncertainty, and consequently anxiety. They relied on lay judgement of what course of action was required for different circumstances, which may differ from biomedical knowledge.

Further, while some households do not reach the WHO's recommendation of at least four ANC visits, others reported this many visits per month as well as countless diagnostic tests, sometimes across several health facilities, and not necessarily in response to complications. Plural care-seeking strategies, as well as the uncertainty and distrust underpinning them, contributed to the high use of maternity care services among some households as they sought to hedge their bets. Weak linkages within the public health system allowed or compelled repetition in procedures across health facilities. Poor access to information combined with high levels of fear and anxiety regarding risks also led households to consult doctors frequently to quell uncertainties. Meanwhile, participants described over-stretched services, long waiting times and short appointment times, all of which have consequences for satisfaction, quality of care, pressure on resources, as well as opportunity costs for service users. Preventing these consequences of care-seeking strategies requires improvements in quality of care and better linkages between and within sectors of the health system.

Moving forward, addressing quality of care will be critical to further improvements in maternal health (Langer et al., 2013). Interpersonal care should be at the forefront of these efforts, alongside technical elements. In Indore, an authoritative biomedical discourse compelling the use of health facilities has taken hold. However, improving the quality of care provision is critical if this strategy is to mean ensuring safe births for women (Hulton et al., 2007). It is also critical to avoid the trap that policies to reduce morbidity and mortality expose women to a broader set of risks that arise from disrespectful care. As Windau-Melmer (2013, p.1) states, 'safe motherhood must be expanded beyond the prevention of morbidity and mortality to encompass respect for women's basic human rights,' which should include a focus on women's autonomy, dignity, feelings, preferences and choices, including their choice of companionship. This study suggests that improving interpersonal care would not only reduce reluctance or anxiety about using maternity services, but would also have positive implications for the way in which people engage with the health system.

Addressing institutional uncertainty and unpredictability as part of broader quality improvements is also recommended. For example, this might include addressing

changeable opening times, closures without warning and an unpredictable referral system. This may increase trust and reduce anxiety, with implications for use and patterns of use of maternity care services, as well as satisfaction with these interactions. Essentially, if the health system operated with more certain rules and procedures, and households had greater trust in the health system, they may feel less need to hedge their bets. Discussion of the negative effect of perceived low quality of care—as distinct from clinical quality of care—on use of health facilities for birth has been extensive in the literature (Bowser & Hill, 2010; Moore et al., 2002), but discussion of its broader implications for care-seeking strategies has previously been limited.

A caveat is important here. Maternity care services are assessed within local constructions of the birth process and its management. While poor interpersonal care requires change in the health system, some elements of local constructions driving negative attitudes towards health facilities may conflict with elements of medical practice for which there is compelling evidence. One example is the criticism noted of health facilities for not using fundal pressure, which arose from its important role in some constructions of the birth process. Overcoming these issues requires sharing of information with service users regarding medical practices and why they are used, which currently appears to be limited (Rani et al., 2008).

Finally, what do this thesis's findings mean for debates on intra-household dynamics in maternity care-seeking? Certainly, it suggests a need to engage more with locally-meaningful constructs. Women's rights and empowerment remain fundamental, but the thesis reiterates Mumtaz and Salway's (2009, p.1351) caution against 'undue attention on women's independent and autonomous action.' There is a need to move beyond this focus of the autonomy discourse, and to pay more attention to the quality of women's relationships and support within marital households. Strategies might promote supportive household relationships and harness local discourses around responsibility, whilst simultaneously striving to strengthen women's personal and social resources, for example through promoting access to information sources. Women with poor household relationships are in a vulnerable position (in relation to maternity care-seeking as well as more generally) and should be a priority for attention.

8.4 Limitations

Limitations of this research are acknowledged. The balance between breadth and depth was an important consideration. Given the research gaps identified in Section 1.2, I prioritised in-depth and holistic understanding of care-seeking for birth, to which the combination of a prospective, qualitative design with multiple household perspectives was fundamental. However, conducting between four and six interviews in each household constrained the feasible size of the household sample. Eliciting the range of perspectives and experiences is important in qualitative research, and a larger number of cases may have aided this objective. I strived to achieve the same range with a smaller number of cases by narrowing the population parameters only to first births in one city's low-income urban settlements and undertaking careful purposive sampling (see Section 4.4). Simultaneously, there were constraints on depth. If one were to take the methodological approach to its limit in order to understand the dynamic and interactive process of care-seeking, more than two stages of interviews starting from early pregnancy would be ideal, as well as further interviews with a broader range of household members or other key figures in care-seeking. I opted for a balance combining a concern with both depth and the range of perspectives, within pragmatically feasible limits. Potential gaps on either element are acknowledged as a limitation.

Caveats and limitations of the sample should also be noted. First, in Section 4.4.1, I referred to the absence of new or temporary settlements in the sample, arising from challenges in identifying and accessing these areas. Moreover, in the relatively more well-established *bastis* in the sample, I identified (and included) only two eligible households that had migrated to the city in the past 10 years. Rural-urban migrants may face different or additional vulnerabilities in relation to care-seeking. For example, they may have less knowledge of the health system and/or lack the social resources to access this information (Stephenson & Matthews, 2004), particularly if based in new or temporary settlements. They may also constitute a relatively more socioeconomically vulnerable group, and being a recent migrant may exacerbate economic insecurity. A study in Mumbai, India, found that rural-urban migrant women's use of health facilities for birth was nearer the level of rural non-migrants than urban non-migrants (Stephenson & Matthews, 2004). A study on urban India using NFHS data also found

that the combination of being poor and a migrant rendered women least likely to birth with a skilled attendant when comparing with others that shared none or only one of these characteristics (Singh et al., 2012b). Thus, the absence of recent migrants—a particularly vulnerable group—was a limitation of this research.

Second, I focused on a population based in low-income settlements since I was more concerned in this study with social context than economic means. Yet, I made the point in Section 3.2 that slum-dwellers are not uniformly poor, and there were clearly differences in economic resources across the sample. While I did collect background socioeconomic information in each case (see Appendix C), I prioritised eliciting participants' own perspectives on the financial aspects of care-seeking over collecting data on objective measures of economic resources.

Third, all women in this study reported their age at the first interview to be over 18. I suggested reasons for this in Section 4.4.1 given survey results showing a fairly high proportion of early marriages and first births in this region of India, particularly in lower socioeconomic groups (IIPS & Macro International, 2008). If first births under the age of 18 do indeed persist on a large scale among the population I sampled from, their actual or presumed (due to misreporting) absence is a limitation of this study since they constitute an important group from a policy and health perspective.

Interaction with the health system was addressed to some degree in all empirical chapters (see Figure 2.2), but the data I present reflect the study's focus on community perspectives. This caveat should be noted in readings of how the health system and interactions with it are represented.

8.5 Methodological implications

The combination of a prospective design and multiple household perspectives was a distinguishing element of this qualitative study of maternity care-seeking behaviour, warranting reflection on these methodological decisions. I focus here on implications for findings since more general considerations were discussed in Chapter 4. The prospective, qualitative design provided rich insight into the process of seeking care for birth, allowing the thesis to challenge the static conceptualisations dominant in the literature. In particular, interviewing during pregnancy revealed ambivalence in attitudes towards different care options as well as the plural, contingent and flexible

nature of care-seeking strategies discussed in Chapter 6. Traditional retrospective designs may miss uncertainty and fluidity as interviews after birth imbue care-seeking with a concreteness and conviction afforded by post-event rationalisation. The prospective design also captured thoughts and feelings as they were experienced—such as fear and anxiety about childbirth and its management—which may be forgotten or distorted after the event. For example, where women had a home birth, its advantages were conveyed with more conviction after the birth than during pregnancy. Moreover, those who used public sector health facilities largely conveyed a more positive attitude towards them after birth than during pregnancy. The prospective, qualitative design essentially captured nuances of the process, overcoming limitations arising from post-event rationalisation and recall issues (Lewis, 2003; Stanton, 2004).

Due to the prospective design and timing of interviews, I interviewed women and household members largely in the context in which the woman stayed at the time of the birth⁹⁷. In doing so, I overcame the issue I problematised in studies that take observations from the woman's current—usually marital—household and apply them in analyses of care for birth, which may have taken place in a different—most likely the natal—household. This was the first study from India to my knowledge that collected empirical data from natal households specifically to examine the dynamics of care-seeking in different types of households. Moreover, even where women stayed at their marital household for the birth, this design had greater capacity to examine intra-household dynamics underpinning care-seeking than a design involving interviews removed in time.

An inevitable drawback of longitudinal designs—as I note in Section 4.2.2—is the risk of influencing the course of events through the act of research, with potential implications for findings. Reflecting on the issue in this study, it seems likely that the research encouraged more reflection than would be typical. Yet, I did not get the impression that participants deviated from strategies in response to the research process. As I commented in Section 4.10, it is likely that participants assumed that we would advocate 'modern' medical care and if there was a direction in which the research process would have influenced households, it would be this one. Yet, most participants in this study had already developed strategies and acted on them by the time we visited

⁹⁷ That is, aside from second interviews I conducted by telephone

for the first interview and those who were most certain about a home birth pursued this strategy regardless of pre-birth interviews.

Most studies on maternity care-seeking focus only on women's accounts, including those that use NFHS and DLHS data (e.g., Griffiths & Stephenson, 2001; Kesterton et al., 2010). In view of women's low autonomy, some studies—particularly qualitative ones—have included husbands and mothers-in-law (e.g., Matthews et al., 2005b; Mumtaz & Salway, 2009). This design allows comparison between the perspectives of women, husbands and/or mothers-in-law, as groups. Few, however, have obtained matched qualitative data within each household specifically for the purpose of within-case analysis. It was this element that distinguished my approach and its value lay in the rich understanding it yielded of each case. An alternative approach might have been to interview the whole household together—an approach which some studies have adopted, not least because it is more practicable given the challenges of space and cultural norms around privacy (e.g., Raman et al., 2014). Such an approach has the capacity to yield some data on intra-household dynamics via observation during interviews, but it would be problematic to ask questions about these dynamics. Moreover, my own observations from household visits suggest that it is elder females' voices that would predominantly be heard with this method.

Talking to household members individually, as I did, provided me with insight into individual perspectives and allowed me to weave stories about intra-household dynamics 'out of the often differing and competing accounts of individual members' (Valentine, 1999, p.72). In the early stages, I was surprised and somewhat disappointed that analysis did not uncover 'differing and competing accounts' to the extent I had anticipated. However, this quickly gave way to the realisation of a key finding in Chapter 7—that primiparous women's lack of independent information networks means that perceptions of maternal health care are constructed almost exclusively through their households. This finding provided insight into linkages between low female autonomy and maternity care-seeking, and challenged assumptions in the literature that women necessarily experience low autonomy in terms of being held back from realising a different set of preferences.

An unanticipated advantage of both design elements concerned implications for the researcher-participant relationship. Since the design involved spending more time with the household than might be typical with a traditional design, participants became

more comfortable with our presence. As I noted in Section 4.10, this partially explained the observation that participants in general, but particularly young women, tended to discuss issues in more depth in the second interview (Miller, 2000; Vincent, 2012). To some extent, the second interviews yielded richer data than the first interviews, although in the analysis and supporting evidence, I strived not to place undue emphasis on one stage over another.

While new insights in this thesis emerged through examining accounts of the same event from different vantage points—be it a different time point or participant—this nevertheless came at an expense. As I discussed in Section 8.3, it constrained the number of cases that I could include. Moreover, it inevitably meant some repetition in the data. The implication for future research is that such a design should be considered when researchers set out specifically to maximise the insights obtained through a prospective design and/or multiple household perspectives, using analytical methods tailored for this purpose.

8.6 Future research

The thesis raises methodological considerations as well as avenues for future research. Methodological considerations concern, in particular, the use of data from retrospective, cross-sectional surveys to examine the statistical association between variables relating to the household and utilisation of maternity care services. Such results should be treated with caution given that a substantial proportion of women in parts of India return to their natal households—particularly, but not only for first births—and this study found that responsibility for care transfers with the woman. This applies to indicators of household structure, female autonomy and social relationships as well as, for example, place of residence and indicators of household economic status. Future surveys should seek to distinguish in which household the woman was staying at the time of the birth.

The thesis has also challenged a static conceptualisation of care-seeking and assumptions that care outcomes reflect ‘a’ choice or decision. Care-seeking is influenced by multiple influences through time. Those who use health facilities for birth are not necessarily those who intended to do so, and vice versa. Moreover, implications arise from the way in which people engage with the health system (as I discuss in Sections 8.2 and 8.3). Future research should clarify whether its aim is to say something

about care outcomes or about care-seeking (or decision-making). The latter refers to a process and, where this is the analytic focus, methodological approaches should reflect this.

This study's methodological approach offered valuable insight into care-seeking for first births in low-income settlements in urban India, but prioritising depth necessitated narrow population parameters. Studies with a similar focus and/or approaches are warranted, albeit with broader or different populations. These might consider care-seeking for higher-order births, in rural areas or in different types of urban areas, and/or in contexts with different levels of progress in improving maternal health.

The focus in this thesis was care-seeking strategies for birth, although I considered the care-seeking episode to extend through pregnancy until the birth. Given the complex interconnections I revealed between ANC and care for birth, future research using a similar approach might broaden the analytic focus to care-seeking strategies for the continuum of care through pregnancy, birth and after birth. Such research might seek to extend this study's examination of the way in which interaction with different types of care providers connects with subsequent decisions and actions throughout this continuum.

By shifting the focus from use versus non-use of maternity care services to care-seeking strategies, this thesis has provided evidence of considerable complexity in the health system and in how people navigate or use it. There is a growing global research literature drawing on complex systems theory to examine health care systems (Kannampallil et al., 2011), which should be considered for its potential contribution to developing understanding of this topic in view of these findings. In relation to more specific health system issues, this study among others tentatively suggests weak linkages and a 'disorganised' referral system between public health facilities in urban areas (Devasenapathy et al., 2014; Shah More et al., 2009a), warranting future research specifically to examine how these operate and their implications.

The thesis examined social relationships and interaction underpinning care-seeking for birth, with a focus on the household. Reinforcing Allendorf's (2010, 2012b) earlier contention, much more research is needed on the complex connections between multiple dimensions of social relationships and maternity care-seeking. These have received surprisingly little attention to date in comparison to female autonomy. Studies should abandon the assumption that low female autonomy is necessarily a sign of poor

social relationships, which this study among others has suggested is not always the case. Research would benefit from a foundation situated in the vast conceptual literature connecting social relationships and health behaviour or outcomes.

In this qualitative study, multiple household perspectives allowed me to examine the wider social ties of different household members and understand how these shaped the care-seeking process. In Chapter 7, I critiqued the focus exclusively on women's social ties in social network analyses of maternity care-seeking behaviour in Bangladesh (Edmonds et al., 2012; Gayen & Raeside, 2007). Future research using social network analysis approaches is warranted, but it is critical that these are adapted to take account of intra-household dynamics in these settings, which differ from western contexts. Finally, this thesis has discussed the issue of differences in maternity care-seeking behaviour between low-income neighbourhoods within the same city, in particular highlighting how these may arise through interaction in social networks concentrated within neighbourhoods. Neighbourhood-level dynamics certainly warrant further investigation.

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Appendices

Appendix A. First interview guide template

HOUSEHOLD INTERVIEW GUIDE 1: WOMAN

1. Introduction

- Repeat info on purpose, confidentiality, voluntary participation, recording
- Check whether participant has any questions and whether willing to proceed

2. Personal circumstances

This is an opportunity to reduce anxiety by asking questions that are simple to answer and non-threatening. Collect simple contextual information. Use an approach that sets the scene for conversational in-depth interview style.

- Tell me about your family here. Probe if necessary (e.g., living arrangements, occupations)
- Marriage (inc. when married, how arranged)
- Migration history, if applicable
- Other household (inc. where based, frequency and type of contact)
- *Pregnancy (inc. when baby due, health and well-being during pregnancy, thoughts/feelings about birth (indirectly))

3. Care-seeking process

Use bullet points as a guide only. Questions and their order should be responsive to participants' narrative.

- Intentions/plans for delivery
e.g., "What are your thoughts so far on what to do for delivery?"
 - Reasons for natal/marital household for birth
 - Place(s) of delivery, birth attendant
 - (*If more than one option mentioned*), clarify status of each
 - What participant knows about the (type(s) of) facility/birth attendant
- Reasons for intentions
(Note: Explore in-depth. Probe all elements of intentions)
 - All reasons underlying intentions/contingencies (*e.g., beliefs, attitudes, barriers etc.*)
 - Other options considered, reasons
 - Quality and barriers/challenges of options
 - How learned about the facility/birth attendant
 - Own/acquaintances' experiences with facility/birth attendant
 - Participants' own views (*if not the main decision-maker. Listen for clues and probe*)

- Whose views, any agreement/differences in views in household (*Indirectly*)
- How decisions on intentions made
(*Note: Explore in-depth. Seek to move beyond normative responses*)
 - E.g., I'm interested in how decisions on pregnancy and delivery are made by families. How would you describe how the decision was made in your family? Who was involved in deciding? How? Why?
 - E.g., I'm interested in finding out about your role in decisions and planning for pregnancy and delivery. How would you describe your role? Why?
 - Description of discussions, conflict or problem solving in decision process
 - Any differences between views on role norms and roles in practice, why, situations in which it would be different (*Indirectly*)
 - Similarities/differences with decisions on other important issues in household. Why?
- Process/temporal aspects
 - Timing and sequence of decisions and actions
 - Changes over time
 - Reasons for any changes

4. Beliefs, attitudes and perceived norms

- I understand that people choose different options for delivery here. You're thinking of (place/provider). i/What other options are there for delivery in this area? ii/What are your thoughts about these options?
 - List options for delivery
 - Views on each delivery care option (*inc. quality, challenges*)
 - Own/acquaintances' experiences with different options
 - Views on home birth (*if not raised spontaneously*)
- What do (most) other women you know of do for delivery?
 - Description of norms
 - Reasons for norms
 - Who are the women they are referring to (*e.g., relatives, basti, village*)
 - Exceptions, why
- Does everyone think the same on what to do for delivery? I'm thinking of 1/men and women; 2/people of different ages; 3/different communities
 - Gender, intergenerational, community similarities/differences
 - Reasons
 - Issues arising from differences and how addressed
 - Any other subgroups

- Are practices here different to practices in the village? How? (*Note: If marital/natal home in a village*)
- Are practices changing?
 - Changes in norms over time
 - Reasons
 - Views on any changes
- What do you usually do when you have a general health problem?
 - Type of health care used, why x/why not x (*e.g., why not government hospital?*)
 - Experience of hospitals
- Complications- do not raise directly, but probe perceptions if complication/ problem/ emergency raised by participant

5. Social relationships and interactions

Any relevant people/discussions/experiences mentioned should be probed throughout interview.

- Interaction with family/household members
(*Unless discussed in-depth already*)
 - What each family/household member thinks (*“What does x think about delivery?”*)
 - Reasons
 - Discussion (*e.g., “Tell me about the conversations you’ve had”*), when
 - How influenced decisions
 - Any differences in views, how managed (*Indirectly- Note differences mentioned in description of discussions and probe if relevant*)
 - If anyone with whom does not discuss, why
- Interaction with non-household members (*e.g., natal family, other relatives, neighbours, friends/colleagues if relevant*)
 - Which places participant goes (*Prompt as necessary*)
 - Which people participant meets at/outside home (*Prompt as necessary*), frequency
 - Nature of relationship
 - What x/y/z thinks about delivery
 - Reasons
 - Discussion (*e.g., “Tell me about the conversations you’ve had”*), when
 - Any influence on decisions
- Antenatal care or any other contact with health providers during/regarding pregnancy and delivery (*e.g., USHA, ANM, AWW, doctors, TBA*). (*Note: cover each contact separately*)

- Context (*e.g., who, where, when, how initiated, who present, who did they talk with*)
- Reasons for contact
- Frequency of contact
- Detailed description of encounter
- What health provider said about delivery
- Views on health provider, encounter, info (*e.g., "Tell me your thoughts about x"*)
- Any influence on views/decisions
- Reasons for contact with >1 ANC provider (*if applicable*)

- Where she hears information about health.

What about pregnancy and delivery?

(*Prompt if necessary: 1/who she would ask/who would advise her; 2/events, TV, radio, posters*)

- Who/where
- Content
- Any influence on views/decisions

6. Birth preparedness

Probe preparations anytime raised during interview e.g., registering, cost, saving, distance, transport, seeking information, planning for emergencies

- Are there any arrangements (**vyavastha*) you or your family/household has made or will need to make for delivery at (intended place/provider)?
 - What, who, when, how

7. End of interview

- Brief background information questionnaire
- Ask to see papers from hospital if applicable
- Thank the participants, explain contribution and discretely leave gift
- Provide contact details for women's group, USHA or support service as necessary
- Arrange how participant will be re-contacted for 2nd stage of interviews

Appendix B. Second interview guide template

HOUSEHOLD INTERVIEW GUIDE 2

1. Delivery care, decisions and actions

- Background
 - Mother and baby's health and well-being since delivery
 - Date of delivery
 - Where delivered, birth attendant
- Care outcome and influences (*e.g., tell me the story leading up to the birth*)
 - Description of circumstances and events leading up to birth
 - Reasons for care outcome
 - (*If >1 option considered in interview 1*), reasons for this outcome from other options considered. Any other options considered after interview 1, why
 - (*If delivery care outcome is different from intentions in interview 1*), reason for change
 - How was the decision made about where to deliver?
 - Process/temporal aspects of decisions and actions in relation to circumstances, events, interactions, why
 - Views and feelings regarding circumstances, decisions and actions leading up to birth
- Full description of delivery care experience
 - What happened at the facility (*for each facility visited*)
(*e.g., Tell me what happened after you arrived. Was there any administration required? What happened then? How long was it until you were seen?*)
 - The birth (inc. type of birth, length of labour, any problems)
 - Who attended the birth?
 - How would you describe the services and care you got in the facility. Why?
- How decisions are made

Tailor section for each participant, to build on first interview
--

- Care during pregnancy and birth (*as necessary to build on first interview*)
 - Beliefs on care for woman's health during pregnancy and delivery. Why?
 - Actions to take care of woman's health during pregnancy and delivery? Who initiated?
 - Any medicines or injections given/taken during pregnancy? Why/why not?
 - Any health issues during pregnancy? When? How addressed? Why? Who decided?
 - Tell me about ALL the check-ups or hospital visits you had during pregnancy.
 - Where did you go altogether?

- Where first? When? Why?
- Then? When? Why?
- When did you go for the last time?
- How many times/how often did you go? Why?
- What did you view as the benefits of going for check-ups?
- What happened when you went for check-ups (What did they do? What did they tell you? Any advice or information they gave about pregnancy or delivery? Advice on where to deliver? Any reports)
- At which hospital registered altogether. Why?
- Were there any other people you saw or got advice from related to pregnancy and delivery? (*Tailor to build on first interview*)

2. Knowledge

Probe thoughts about risks, fears, health problems, health care, and complications as they arise throughout interview

- What possible pregnancy related problems have you heard of? What are the signs? What should someone do about this? Where heard of this?
- What were your thoughts before birth about how to deal with any problems if they happened? (inc. any plans made in case of an emergency)
- I'm interested in where couples having a first birth learn about things to do with pregnancy and delivery. From which people or places did you get information about pregnancy and delivery? What learned from x,y,z?

3. Birth preparedness and barriers

- Financial
 - Total expenditure on delivery (inc. delivery, equipment or medicines, informal costs, transport costs, opportunity costs)
 - How did this compare with expectations before delivery? Why?
 - Financial arrangements made (inc. who, when, how).
 - Any help from others outside the household
 - Any plans in case needed any more
 - Any challenges with planning or meeting costs
 - Any influence of cost of care on decisions for delivery care
- JSY
 - Had you heard of any schemes for giving money to women for delivery? What heard? From where from? When?
 - What were your thoughts about using this scheme? Why?
 - Did this scheme in any way affect your thoughts about where to deliver? Why?
 - Tell me about your experience with obtaining this money (*if used*)
 - How did you use the money? (*if used*)
- Transport (if relevant)

- Transport used to get to (and between) hospitals for delivery?
- How was this arranged? When? By whom?
- Any challenges related to transport? What? Why?
- Had you heard of any schemes providing transport to hospital for delivery? What heard? From whom/where? When? What were your thoughts about the scheme?
- Time commitments (if relevant)
 - Who went with you to hospital?
 - How was this managed with work and other household tasks? (inc. effect on income)
- Tell me about any things that were bought/brought ready for delivery. When? Who? Why?
- Probe any mention of son preference

4. Follow-up on first interview

Tailor section for each participant, to build on first interview

5. **Reflection** (as appropriate, depending on participant's skills in abstract/reflective discussion)
- What were the supportive elements around you which helped with making decisions and plans about care during pregnancy and delivery? Are there any challenges for families like yours in deciding where to deliver? What? Why? How did you manage this?
 - Are there any potential challenges in using hospitals? What? Why? How did you manage this?
 - How prepared did you feel for pregnancy and delivery? In what way? Why? What helped you prepare for pregnancy and delivery?
 - What advice would you give to another woman like you having a first birth?

Appendix C. Household background information form template

HOUSEHOLD BACKGROUND INFORMATION

Note: ask questions only where answers are unknown from preceding interview(s)

HOUSEHOLD	
Household #	
Basti	
Head of household	
Religion	
Migration	
Since when has the family lived in Indore?	
From where did the family migrate? (if <15 years) (<i>State, district, rural/urban</i>)	
Socioeconomic	
Own land	
Own house	
Own colour TV	
Toilet facility in the house	
Access to safe drinking water (<i>at home/ <150m/ >150m</i>)	
Regularly employed persons in the household	
Chronically ill or disabled household member	
Caste	

Household composition			
#	Relationship to woman <i>(Note woman or husband's position in sequence of resident siblings)</i>	Name <i>(that we should use for the household member. Only note if required)</i>	M/F
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

WOMAN	
Participant #	
Name <i>(that we should use for the participant)</i>	
Age	
Marriage	
When were you married? <i>(month and year)</i>	

Migration	
<i>If at marital household</i>	
Where is your natal family based? (<i>State, district, rural/urban</i>)	
(If migrated from outside Indore), when did you come to Indore?	
What was the reason for coming to Indore? (<i>e.g., marriage, employment</i>)	
From where did you migrate? (<i>if not for marriage</i>)	
Since you arrived in Indore, have you only lived in this basti? If no, when did you come to live in this basti?	
<i>If at natal household</i>	
When did you return to your natal household?	
Where is your marital household? (<i>State, district, rural/urban</i>)	
Natal family contact	
How often have you seen your natal family in person in the past 6 months?	
How would you travel between your marital and natal household? How long would this take?	
How often have you had telephone contact with your natal family since marriage?	
Education	
Have you ever attended school? If yes, what is the highest grade you completed?	
Employment	
In addition to housework, do you do any other work	

for which you are paid in cash or in kind?	
Pregnancy	
When is your baby due? <i>(Note: Check ANC report if available)</i>	
Is this your first pregnancy? <i>(If no, ask brief details of previous pregnancy outcomes if appropriate)</i>	
Have you seen anyone for antenatal care during this pregnancy? If yes, list who, where, when, how many times <i>(Note: only if clarification of details required following interview)</i>	1.
	2.
	3.
	4.
	5.

OTHER HOUSEHOLD PARTICIPANT	
Participant #	
Relationship to woman	
Name <i>(that we should use for the participant)</i>	
Age <i>(only for husband)</i>	
Education	
Have you ever attended school? If yes, what is the highest grade you completed?	
Employment	

Do you do any work outside the home for which you are paid in cash or in kind? If yes, what work do you do?	
---	--

OTHER HOUSEHOLD PARTICIPANT	
Participant #	
Relationship to woman	
Name (<i>that we should use for the participant</i>)	
Age (<i>only for husband</i>)	
Education	
Have you ever attended school? If yes, what is the highest grade you completed?	
Employment	
Do you do any work outside the home for which you are paid in cash or in kind? If yes, what work do you do?	

Notes:

Appendix D. Basti background information form template**BASTI BACKGROUND INFORMATION****BACKGROUND**

Basti name/#

Cluster

Approximate total population

AND/OR Number of households

Information on age of basti and growth in recent years

UHRC health vulnerability assessment

Status of basti (e.g., notified, security of tenure)

Governing body (e.g., IMC, gram panchayat)

BASTI RESIDENTS

Main religion, caste (as appropriate)

Main occupations

Estimated % who have a BPL card

Notes on population/social conditions

LIVING ENVIRONMENT

Road infrastructure (e.g., main road in basti/main road near basti but poor roads within basti/no main road nearby)

Toilet (e.g., no facility/ public toilets (unusable)/ public toilets (functional)/ mostly private)

Water (e.g., mostly private taps/ communal water supply)

Drainage (e.g., covered drainage, open drains, no facility)

HEALTH AND HEALTH-RELATED SERVICES

Estimated % births in a health facility (+ note change over time)

Main care for birth used by basti residents

Anganwadi centre (e.g., presence, coverage, use of services, change over time)

ANM outreach (e.g., frequency, coverage, services, use of services, change over time)

USHAs (e.g., level of activity, services, use of services, change over time)

Any maternal health care providers in basti (e.g., type, nature of services)

Community-based organisations (e.g., presence, strength, activities, maternal health related activities, change over time)

NGOs (e.g., name, time since intervention, activities, maternal health related activities)

Any other notes

Completed with:

Appendix E. List of descriptive codes

Background information

- HH for time of birth
- Living arrangements and household composition
- Employment, income, socioeconomic status
- Education
- Migration
- Marriage
- Conception
- Delivery date
- Baby's gender
- Other

Care-seeking for birth

- Status of options and contingencies
- Timing
- Change
- Reasons for home versus hospital
- Reasons for private versus government
- Within government or private reasons
- Unfolding perinatal events

Perceptions of maternal health and health care

Administrative, physical or organisational

- Birth certificates
- Cleanliness
- Facilities
- Family involvement
- Food
- Other service users
- Referral
- Registration
- Safety
- Waiting
- Other

Interpersonal care

- Attention and care
- Environment
- Interaction
- Influence of contacts
- Other

Interventions

- Clinical skill
- Obstetric interventions

Risk

- Managing pregnancy/birth risk
- Managing other risks
- Perceptions of pregnancy/birth risk
- Traditional beliefs
- Religious references

Other

- Past experience

Social relationships – natal/marital household

- Woman's character
- Woman's relationships
- Husband's character
- Husband's relationships
- In-laws' characters
- In-laws' relationships
- Natal characters
- Natal relationships
- Natal contact
- Decision-making authority, capacity, experience

Social relationships, interactions and contact – non-household

- Non-household exposure and relationships
- Non-household influence on care-seeking
- Community norms for maternal health care
- Media/programme exposure or influence

Birth preparedness, economic and physical access

Economic access and preparation

- Costs, influence on care
- Financial arrangements
- JSY and other schemes

Physical access and transport

- Physical access
- Transport arrangements

Other

- Other preparation

Health and care during pregnancy

- Antenatal care
- ASHA contact
- AWC contact
- Health status during pregnancy
- Self-care
- Other

Key informant and supplementary data specific⁹⁸

Key informant role

- Key informant role
- Career path

Social context

- Bastei economic and social context
- Community response to key informant services

Differences within population

- First births
- Socioeconomic
- Migration
- Other

⁹⁸ All codes were used for key informant and supplementary data, but this section includes additional codes only relevant to these data

Appendix G. Further analysis tools template

Table 1a: Social context

Wider social and economic context
Household social and economic context
Household/family relationships

Table 1b: Analysis of multiple household perspectives

HX	Care-seeking for birth	Social context/influences	Views of health care	Access issues and birth preparedness	Health and care during pregnancy	Other
Similarities in themes/ constructions						
Differences in themes/ constructions						
Influences on similarities or differences						

Table 2a: Chronological assembly of care-seeking process

Pre-pregnancy	During pregnancy	Perinatal

Table 2b: Analysis of continuity and change

Increase/Emerge	Cumulative	Significant event	Decrease/Cease	Constant/Uneventful	Idiosyncratic	Missing
Inter-relationships between continuities and changes						

Factors influencing continuity or change						

