

A Framework for a Multi-Sectoral Index on Quality of Services: Women's Perspectives

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By Ritika Sebastian and Indu Poornima

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3D Program for Girls and Women

Contributing to the implementation of the Sustainable Development Goals (SDGs), the 3D Program for Girls and Women advances gender equality and girls' and women's empowerment by facilitating convergent action across stakeholders and sectors to increase economic opportunities for girls and women and address their health, education and safety needs. The 3D Program is currently working with partners in Pune City and rural Pune District, Maharashtra State, India to identify priority issues and link stakeholders to provide cross-sectoral, coordinated solutions to meet the multiple, intersecting needs of girls and women. The Program is deriving lessons learned and developing tools for global application of a scaled-up convergent response for gender equality by demonstrating a convergent approach to programming in India and East Africa.

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Leadership for Equity is a systems change and research organization that aims to help strengthen the effectiveness of public education systems. At LFE, the fundamental belief is that Public Education Systems are by definition 'gatekeepers' of equity; and effective and sensitive public education systems will ensure that quality education is provided to every child. The team works across hierarchies within the public education system to:

Consult: Provide strategic and implementation consulting at a policy level to improve effectiveness of educational programs

Enable: Build capacity and support existing officials to operate with increased effectiveness and sensitivity

Scale: Support high potential innovations to scale and institutionalize within the system

Acknowledgments

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Abbreviations

BPL	Below poverty line
CAT	Coding Analysis Toolkit
FGD	Focus group discussion
INR	Indian Rupee
KKPKP	Kagad Kach Patra Kashtakari Panchayat
LFE	Leadership for Equity
MaNaPa	Mahanagar Palika
MASUM	Mahila Sarvangeen Utkarsh Mandal
NGO	Non-governmental organization
PAN	Permanent account number
PCMC	Pimpri Chinchwad Municipal Corporation
PMC	Pune Municipal Corporation
QoS	Quality of services
RCV	Resident community volunteers
RTE	Right to Education Act
SMC	School management committee
SHG	Self-help group
UCD	Urban Community Development department

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Introduction

Public and civic bodies exist, in theory, as agents of the state for the benefit and welfare of the people they serve through policies, services and benefits. However, there is abundant evidence to show that gender, class, caste and other social stratifiers intersect to determine an individual's knowledge, access and experience of public services and benefits. Holding public systems accountable for the delivery of quality services to all potential beneficiaries, particularly the most marginalized sections of society, is an essential component of good governance. In keeping with this deeply felt need to ensure that public and civic bodies actually fulfill the purpose for which they exist, this report recommends a conceptual framework for a Quality of Services (QoS) index to map efficiency, impact and effectiveness of public services for girls and women.

As a first step towards this, the 3D Program for Girls and Women, in partnership with Leadership for Equity (LFE) in Pune, India, has developed a conceptual framework for a QoS index to ensure that public and civic bodies better understand the dimensions of quality for public services from the user perspective, specifically, the perspectives of girls and women.

The framework was developed based on qualitative research, including key informant interviews with civil society leaders, service providers and community members and focus group discussions with women in both rural and urban communities, as well as a multi-disciplinary literature review. Rather than arriving at the notion of quality by focusing only on impact or outcomes of services as many studies tend to, the objective here was to understand from women's experiences what it takes for them to access these services and avail their benefits. The

Index captures the multiple dimensions of service quality from a user's perspective to assess the quality of services provided by different institutions across different sectors. This understanding can help strengthen existing programs, identify and fill gaps, and ultimately improve service outcomes, while also strengthening our understanding of what is important to girls and women to inform planning, monitoring and evaluation of both new and existing services.

The preliminary framework elaborates five dimensions of quality: availability, access, affordability, acceptability and accountability. Components of each dimension are elaborated, as are specifications to guide measurement. The process to develop the framework and the framework itself are described in this report. The framework will be used to develop a tool, which will be tested for its reliability and validity in the next phase of work.

Scope and Approach

This study examines services that directly impact the quality of life of girls and women in three sectors - education, health and financial inclusion. While we further narrowed our enquiry to services in primary education, maternal health care, and banking, it was observed that various aspects of a particular sector and service are often linked and overlap. Thus, the data collection, analysis and the resulting conceptual framework are not limited to these.

The methodology combined findings from literature across various disciplines with viewpoints of women on what they would consider to be 'quality' in services. Operationally, we set about understanding quality in layman terms, as defined in the Oxford dictionary (2018): 'The standard of something as

Table 1: Dimensions of Quality

Health	Education	Financial Inclusion
Those services that enable women to achieve and enjoy the highest attainable standards of health, as a fundamental human right indispensable for the exercise of other human rights which is conducive to living a life in dignity (CESR, 2000).	Those services that enable girls to achieve free and compulsory primary education as envisioned under India's Right to Education Act (2009) and services that provide opportunities for quality higher education for women in environments that are healthy, safe and gender sensitive (UNICEF, 2000).	Those services that ensure women's access to appropriate financial products and services at an affordable cost in a fair and transparent manner (Joshi, 2011).

measured against other things of a similar kind; the degree of excellence of something'. This study thus takes an exploratory approach to define quality and identify key dimensions that influence experiences of service quality in order to establish the conceptual framework.

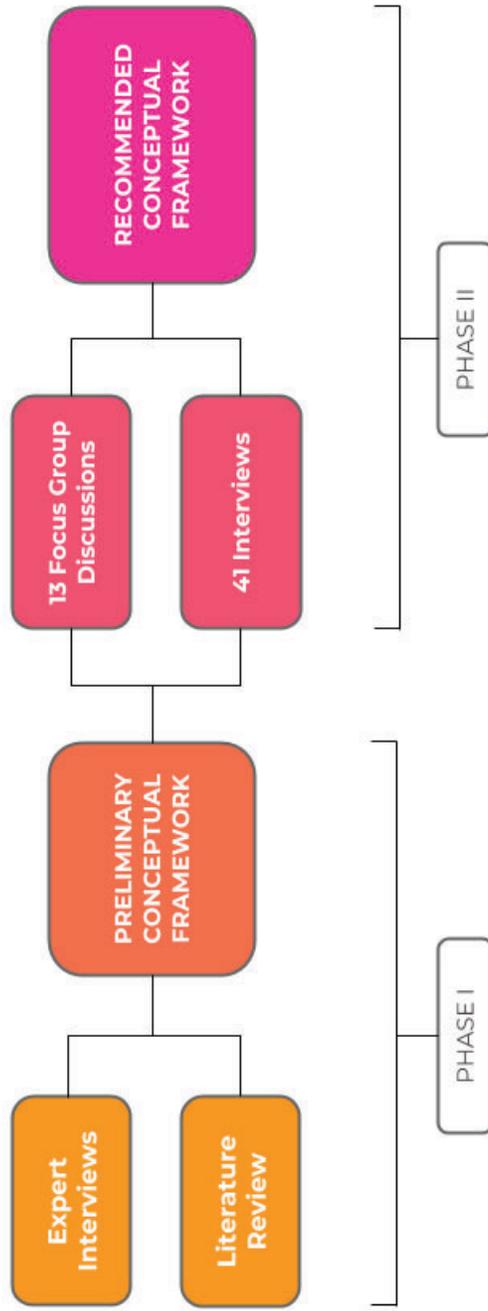
To formulate the conceptual framework and develop the QoS index, we identified six key dimensions of quality and then tested these for their relevance and usefulness through interviews and focus group discussions (FGDs) with women. Thus, the study progressed in two distinct phases:

Phase 1: Combining insights from a literature review and key informant interviews to develop a preliminary conceptual framework.

Phase 2: Findings from interviews and focus group discussions with women users of services, to inform the development of the recommended QoS framework.

Interviews were conducted in Pune District in the state of Maharashtra, India. The district has a population of 9,429,408 (Census Report, 2011), accounting for 8.39% of the total state population. Administratively, Pune district is divided into 15 talukas (blocks) and two municipal corporations - Pune Municipal Corporation (PMC) and Pimpri Chinchwad Municipal Corporation (PCMC).

Figure 1: Process to Develop the Conceptual Framework for Quality of Services Index



Preliminary Conceptual Framework

Methodology

In Phase I, to develop the preliminary conceptual framework, we reviewed the existing literature on service quality measurement across different sectors and geographies, with a focus on methods used to capture user narratives and transformed them into measurable indices. Concurrently, we interviewed key informants working with non-governmental organizations (NGOs) and social enterprises in and around Pune District to include their perspectives on 'service quality' (see References for literature reviewed and Appendix I for list of key informants).

Findings

Literature Review

A range of studies were examined to review different frameworks and indicators by analyzing 'service quality' across multiple sectors, including business, health, education and social services. Among the various studies, recurring dimensions of quality from the user's perspective included:

- Accessibility and convenience;
- Accountability, reliability;
- Empathy, attention, interpersonal relations, attitudes and behavior of the staff;
- Respect for dignity, privacy;
- Reliability and responsiveness of the care workers;
- Skills and performance of the staff;
- Assurance and trustworthiness of the staff;
- Communication and information quality;
- Effectiveness of the service;
- Time duration of the benefit;
- Meeting client needs and demands;
- Tangibles received, quality of facilities and services

These dimensions of quality are insightful, and helped to create a preliminary analytical conceptual framework based on the 3As of quality - accessibility, appropriateness, accountability. In addition, dimensions of quality included in the SERVQUAL index (Parasuraman et al. 1985, 1988), an existing measure of service quality, were included in the preliminary conceptual framework.

Accessibility is defined as the ability of beneficiaries to reach, understand and use a particular service, regardless of age, disability, ethnicity, geographical location or any other factor (ECOSOC, 1999).¹ In measuring this dimension, we considered physical, economic and social access. Physical access is defined as the ability to avail the benefits of a government service in a timely manner especially in the case of women with disabilities, migrants, and those living in remote, conflict-prone regions. Economic access includes the affordability of the service in terms of the direct cost, as well as other indirect costs associated with accessing a particular service, such as the cost of transport. Social access refers to administrative obstacles, either in the form of language, logistical or any other complexities, that systematically exclude a beneficiary from accessing those services that she is entitled to, including whether or not she is aware that a service or benefit exists.

Appropriateness examines whether the service in question is relevant for the immediate, as well as future, needs of the user and whether the services provided are sensitive to the gender and life-cycle requirements of women (UNICEF, 2000). In terms of user experience, appropriateness includes respecting confidentiality wherever applicable and the medical appropriateness of services, especially in health care.

1. As cited in Committee on Economic, Social and Cultural Rights, CESCR, 2000.

In the context of education, appropriateness refers to the flexibility with which the services respond to the needs to girl students across diverse settings, over and above financial assistance and scholarships.

Accountability explores the efficiency of service delivery in responding to the needs of users, as well as the existence and effectiveness of various grievance redressal and accountability mechanisms available to girls and women (Accountability and Voice for Service Delivery at the Local Level, UNDP, 2008, Rabie & Towfighian, 2017). While different forms of corruption affect both men and women, there is evidence that women face additional risks in accessing services, including violence, verbal abuse and sexual exploitation, if they are not ready to offer graft (Transparency International India, 2018).

SERVQUAL (Parasuraman et al. 1985, 1988) has been applied across service sectors including health, banking, education and telecommunications. This tool captures the gaps in service quality between the customer's perception of service quality received to that of expected service quality. It includes five dimensions of quality: reliability (ability to deliver the promised service effectively), assurance (trust and confidence from the part of the service provider), tangibles (physical and human resources), empathy (care and attention) and responsiveness (proactive to the customer needs). Each dimension has items measuring both expectations of consumers and the perceived level of service receive. For each item a 'gap score' is calculated as the difference between 'perception of performance' score and the 'expectations of performance' score. The SERVQUAL instrument also invites the customer to allocate weights to dimensions that are important according to them. SERVQUAL therefore, allows an organization to determine, in a quantifiable and rigorous manner, if

its resources are well focused on the dimensions that are important to the customer. Despite having attracted a certain degree of criticism, SERVQUAL has been successfully applied and adapted to different settings where dimensions of quality are modified to suit the needs of the context which is evidence of its utility as an overarching quality framework across sectors (Tan and Kek, 2004). SERVQUAL, however, was not developed to assess girls and women's perceptions of quality of services.

Key Informants and Experts

The team interacted with key informants and experts from grassroot organizations that have worked with women in Pune City and District (See Appendix I for full list). During Phase I, these discussions focused on how women access public services through government program or schemes. The relevance of SERVQUAL and 3As for this study was reaffirmed through these discussions, and key learnings are summarized below.

Awareness of Government Schemes

Girls and women are generally not aware of government programs and entitlements that could benefit from. If aware, those most in need have limited access to services, due to lack of information, lack of documents, narrow eligibility criteria, and income cut-offs.

Nonexistent or Partial Coverage

While government programs may exist on paper, they may not be implemented, may be extremely taxing for women to access, or only partially cover related costs, limiting their impact. For example, a health scheme may cover only the cost of medical procedures, not pre- and post-medical care, equipment and supplies, medicines, or logistical support.

Inadequate infrastructure and Women's Mobility

Lack of mobility by girls and women, combined with lack of adequate infrastructure can hamper access to services, especially with respect to the higher education of girls. Lack of schools in communities and lack of adequate transportation impact girls' access to school, particularly secondary school. The lack of safe, well-scheduled public transportation is another barrier. Girls have less freedom to travel after dark and may forego classes because of inadequate transport and the potential for sexual harassment either waiting for, or on buses. Many young women do not report the harassment they experience to their families, fearful that their families may force them to stop their education altogether.

Mismatch Between Service Provision and Women's Needs

There is a mismatch between services that the state provides and the needs of women. State delivery mechanisms fail to acknowledge the patriarchal structures that shape the everyday realities of women's lives. This failure of government schemes to address the social and structural challenges that women face impedes women's ability to utilize public services.

Role of Middlemen as Facilitators and Barriers

The team interviewed resident community volunteers (RCVs) or *samooch sangatikas* in urban areas, women from the community who serve as links between the PMC's Urban Community Development (UCD) department and city residents. They are trained by UCD to raise awareness and help community members access scheme benefits. The success

of various schemes under UCD can be attributed to the efficient role played by *Samooch Sangatikas*. These discussions highlighted the role of facilitators in easing access to schemes. It is general practice for the agent to take a share of the benefits that women receive. In fact, the chances are low that women will receive a benefit without involving an agent. According to the RCVs, the whole process is a business in itself run by people who have information and social connections within the bureaucracy.

Sometimes, political representatives take on the role of an intermediary, helping beneficiaries when they do not have all the required documents or the means to apply for a scheme, in return for votes or political support. This kind of patronage, as well as graft, is seen as a necessary part of accessing services and benefits for those who do not have the capacity to successfully apply for them on their own. For example, the application for the pension scheme for widows and single mothers, *Sanjay Gandhi Niradhar Yojana*, is tedious and requires multiple documents to prove eligibility. However, even once those are produced, there is no guarantee that the benefit will be awarded. A committee at the taluka or block level or the *aamdar*² and *tehsildar*³ decides who receives scheme benefits. They usually segregate applicants according to political affiliations rather than eligibility criteria, favoring one over the other. Since it takes multiple trips to process the documents, applicants feel that it is better to pay a sum of money as a graft and get the work done. The cost of forgoing a day's wage is higher than paying the graft. However, even if the graft is paid there is no assurance that the document will be processed.

2. Aamdar is a member of the Legislative Assembly (Vidhan Sabha) or Legislative Council (Vidhan Parishad).

3. Tahsildar is a Group A gazetted official in Maharashtra government. He is a taluka-level officer and head of Tehsil office and acts as an Executive Magistrate of the taluka.

Lack of Documents

Across schemes and services accessed by women, lack of adequate documents to prove eligibility is a major barrier to accessing services. Despite efforts by NGOs to raise awareness about the need to possess identification documents like the Aadhar and PAN (personal account number) cards, many women do not have them and often show little or no interest in getting them.

Direct Benefit

Schemes with direct benefits are seen to be more valuable than schemes that provide an indirect service or aim to change behavior over a longer period. Thus, schemes that entitle a beneficiary to a direct and immediate benefit, such as cash transfers, books, bicycles, and equipment, are more sought after than training or awareness-raising programs.

Attitude of Government Officers

The attitude of government officers at different levels of service delivery can sometimes be problematic. Most often, users are seen as 'begging' for a free service and not as rightfully entitled to it. Accessing benefits and services usually requires multiple trips to a government office.

Preliminary Conceptual Framework

The literature review and information from key informants and experts confirmed that (a) quality is multi-dimensional, and (b) women's experiences of services are shaped by their intersectional position based on gender, caste, class, age and other social stratifiers. Based on these understandings, a preliminary conceptual framework was developed that assesses quality across six dimensions:

Availability

Quality of service can only be understood if services are available. The Oxford Dictionary (2018) defines availability as the presence of resources able to be used or obtained; at someone's disposal'. In our enquiry we began by understanding if a particular service was available to the participants, the range of physical and human resources within points of service and whether they matched the needs of users accessing the services.

Physical Accessibility

Physical accessibility can be defined as the ability of beneficiaries to reach a particular service, irrespective of age, ethnicity, geographical location or any other factor.⁴ The ability to avail the benefits of a government service in a timely manner is an important determinant of quality, especially for women with disabilities, migrants and those living in remote, conflict-prone regions. Distance, convenience and mode of transportation were identified as key factors affecting physical accessibility of services for girls and women.

Affordability

This dimension measures quality in terms of monetary access to services, including both direct and

indirect costs associated with availing a service. Affordability is defined as one's willingness and ability to pay. To this end, it is important to note that although many government services are designed to be delivered free of cost for the users, they are often found to be lower in quality than private services received by those who pay for the service. Therefore, affordability becomes an important measure of quality, especially in the health and education sectors.

Acceptability

Services meet quality standards only if they are acceptable to their user, that is, if the service provided meets the users current and future needs and that the service provider is sensitive to those needs. Acceptability is used as a measure of quality in this context to evaluate how women perceive their interaction with service providers and others at the point of service delivery.

Safety

The Declaration on the Elimination of Violence Against Women defines violence against women as 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion, arbitrary deprivation of liberty, whether occurring in public or private life' (Whitzan, 2013). In the context of this study, women's perception of their own safety often affects their decisions to either access or use basic services. Therefore, safety in relation to service use is a key dimension of quality of service.

4. Adapted from the definition of 'accessibility'.

Accountability

Accountability is best understood as the nature of the relationship between two sets of actors: rights holders and duty bearers who are obliged to account and take responsibility for their actions (Brown, et al. 2008). To be accountable, service providers must be answerable for their actions; they must explain to the users or justify what they do and why they do it. In this study, we attempted to understand the grievance redressal mechanisms that are available to women and their effectiveness (Accountability and Voice for Service Delivery at the Local Level, UNDP, 2008).

Each of the six dimensions were further broken down into their functional components to guide our discussions while collecting data and were subsequently refined based on insights from interviews with girls and women using the service (See Table 2).⁵

5. Beyond the six dimensions mentioned above, social structures and gender roles within which women operate also create asymmetries of power that place women at a disadvantage in accessing services. While framing the preliminary conceptual framework we were cognizant of this reality that adversely impacts access and therefore women's experience of quality. However, we chose not to include 'social access' as a dimension of quality since it remains outside the purview of service provider's operations.

Table 2: Preliminary Conceptual Framework: Dimensions of Quality

Dimensions	Components
Availability	<ul style="list-style-type: none"> • Availability of specialized and/or advanced services: referral care/ grades of institution • Infrastructure and human resources: Quality and quantity of physical infrastructure and human resources • Timing: Convenience and reliability • Documentary requirements as barrier to eligibility and use
Physical Accessibility	<ul style="list-style-type: none"> • Distance traveled to access the service • Availability of transportation • Convenience of service and time taken to reach
Affordability	<ul style="list-style-type: none"> • Direct cost of service and supplies • Indirect cost of services • Opportunity cost: Loss of other potential benefits from time and money spent on service
Acceptability	<ul style="list-style-type: none"> • Assurance in the skill of service provider • Empathy, dignity, privacy • Efficacy of service: Outcome of service as expected
Safety	<ul style="list-style-type: none"> • Perceived safety • Financial security • Safety in traveling to reach the service • Normalized indignities
Accountability	<ul style="list-style-type: none"> • Formal grievance redressal structures • Community/informal support structures

Developing the Quality of Service Framework

Methodology

Having constructed the preliminary conceptual framework in Phase I, in Phase II we set out to test its relevance and completeness using qualitative methods. The study included women and girls from lower income households in urban and rural Pune. Data from rural areas was collected from Vanpuri village in Purandar Taluka and Tikona village in Maval Taluka. The urban section of our data collection covered Patil Estate, Mahanagar Palika area (MaNaPa) and Gultekdi within PMC area and Kasarwadi within PCMC area (see Figure 1).

To capture women's experiences across urban and rural Pune, we examined the following:

- Whether the components identified in the preliminary conceptual framework were relevant to the participants;
- Whether there are other dimensions of quality that had not been included in the conceptual framework; and
- What could be suitable indicators to measure the different components?

For this, our discussions with participants and key informants explored the following questions:

- How are services accessed by girls and women?
- What are the major problems faced by them in accessing services?
- On what factors did the participants base their choice of institutions for service delivery?

Data Collection

We used semi-structured interviews⁶ and focus

Figure 2: Study Areas in Pune City and District



The map shows taluka boundaries within Pune District. The colored sections indicate areas covered under this study.

group discussions (FGDs)⁷ to gather data. The interviews and FGDs were conducted in Marathi and Hindi and later translated into English during transcription. The semi-structured questionnaire allowed us to capture the diversity in narratives coming from women of varied backgrounds while ensuring that the discussion did not stray too far from the primary objectives of the study. FGDs allowed us to probe data regarding the same topic from different vantage points at the same time. Through FGDs we were able to explore the differences and/or similarities in experiences that different women from the

6. Semi-structured interviews are used in cases where the objective of the research is to explore the respondent's view towards a particular topic. While there is a list of predetermined frameworks, there is flexibility in how they are asked to each respondent. The follow-up questions vary according to the initial response received from each participant (Given, 2008).

7. Focus group discussions as a qualitative research tool is used in cases where there is a need to collect data from a purposely selected group of individuals rather than from a statistically representative sample of a broader population (Sutherland et.al, 2018).

same geographical area might have had while accessing the same service. (See Appendices for interview and FGD guide.)

Sampling and Participant Profile

Since the aim was not absolute generalizability, but in-depth learning from a few women's experiences, we used convenience⁸ and snowball⁹ sampling.

We were introduced to the participants through organizations working with women in rural and urban Pune, such as Mahila Sarvangeen Utkarsh Mandal (MASUM), Jeevan, Kagad Kach Patra Kashtakari Panchayat (KKPKP) and Forbes Marshall Department of Social Initiatives. Through them we gained access to service users and providers. In total, 69 women and girls participated in 41 semi-structured interviews and 13 FGDs. (See Table 3 for details.)

Operational Realities

While the plan was to have structured spaces for one-on-one interviews and group discussions, we found the operational realities to be different. The time of the year and the daily activities of women influenced the structure of data collection. Data collection was undertaken subject to the following:

- For each session, two or more sectors were discussed with key informants, service users and service providers
- Semi-structured interviews were largely conducted with a single participant. However, in certain cases, two or three women were present and the interview included responses from all of them
- Data collection was conducted in the monsoon months of June - July, which in rural areas are also the main sowing months in this region. Due to this, many village residents were unavailable to speak to us. Women respondents were therefore those who could not work in the fields due to their age or health
- Data collection was conducted in the monsoon months of June - July, which in rural areas are also the main sowing months for agriculture in this region. Due to this, many village residents were unavailable to speak to us. Women respondents were therefore those who could not work in the fields due to their age or health
- During data collection, we found that women did not immediately respond to questions about their overall experience. For most of the participants, accessing education, healthcare and banking services were mundane aspects of their daily life. When asked how they liked a particular service, their initial responses were mild and indifferent, indicating that women often may not have distinct opinions about the quality of services, or may not think that their opinions are important. In these cases, we asked women to rate services, or compare two or more service providers, in order to understand which aspects of service were important to them. Our assumptions were challenged, in realizing that the women we spoke to were often not able to clearly articulate their opinions, and that they had little or no awareness about the various aspects of the services they were entitled to.

8. Convenience or availability sampling is a type of non-probability sampling method that relies on data collection from people who are available to participate in study. There are no inclusion criteria identified for the population of the study prior to the selection of participants (Saunders, Lewis & Thornhill, 2012).

9. Snowball sampling is a technique for gathering samples through the identification of an initial participant who is used to provide the names of other actors. These actors may themselves open possibilities for an expanding web of contact thus opening up a credible set of samples for research study (Beck, Bryman & Liao, 2004).

Table 3: Semi-structured interviews and FGDs conducted

Sector	Region	SI*	FGD	Key Informants	Service Providers	Service Users
Education	Rural	12	3	Anganwadi Sevika; Anganwadi Maddatnis; MASUM karyakarta	School Headmaster; (3) School teachers	SMC members, parents, grandparents, school girls
	Urban	5	2	-	-	SMC members, parents, grandparents, school girls
Health	Rural	8	3	Nurse at sub-health center; ASHA worker	Village sarpanch	Service users for minor ailments, maternal healthcare and operations
	Urban	5	1	-	-	Service users for minor ailments, maternal healthcare and operations
Financial Services	Rural	7	3	MASUM karyakarta; trainer with Maharashtra Joyti Abhiyan	-	Members of SHGs and banking service users
	Urban	4	1	-	-	Members of SHGs and banking service users
Total		41	13			

Analysis

The process of data analysis began with the transcription of the interviews. The transcripts were coded using the software Coding Analysis Toolkit (CAT).¹⁰ A list of predefined codes was selected based on the preliminary conceptual framework, and new codes were added during the process as necessary. Once the coding was done for all the transcripts, the generated set of codes were arranged into larger themes and subthemes. For example, the

theme ‘availability’ had several codes under it, such as grades (in a school), timing and barriers faced during access to service.

After clustering the codes into themes, the data was analyzed to identify recurring patterns across different interviews with respect to each theme. Efforts were made to understand these patterns across services provided by different sectors but within the socio-economic context of each participant. The

10. Coding Analysis Toolkit, <https://cat.texifter.com/>

identified patterns across the length and breadth of the data took the form of components of each dimension of the framework. These components and their specific indicators would eventually be used to develop the recommended index that measures quality.

Findings

Overview

Having developed the preliminary conceptual framework, we sought to test it by capturing women's experiences in availing services in primary education, maternal healthcare and banking. This study included a range of participants, such as service providers, key informants and service users. Given their unique perspectives, each of them highlighted different factors as determinants of quality. While for service providers like teachers, ASHA workers and nurses, the quality of service delivery was impeded by inadequate monetary and human resources, the key informants highlighted gendered barriers as an important hurdle. As cited by one of the key informants, most often, lack of documents with updated addresses and names post-marriage of women impede their accessibility to certain services. This is most commonly seen when young pregnant women availing services at public health centers are denied cash benefits since they are unable to produce adequate documents. Therefore, barriers such as these rooted in existing gender norms obstruct the quality of services delivered to women. They also in-turn shape women's experiences and leave them ill-equipped to negotiate for the better services they are entitled to.

Our discussions with service users also revealed that those services they accessed themselves, of their

own accord, such as health care or education for their children, were assessed more in terms of quality, than those such as banking, that were triggered by an external party (the government or an NGO). In contrast, the latter were seen as cumbersome and of lesser value. In most cases, women did not open bank accounts until they felt it was absolutely necessary to do so. Further, their overall experience at the point of service and the final outcome of the service were also important determinants of quality across sectors.

Based on an analysis of the detailed findings from the field, the preliminary conceptual framework was revisited. The sub-sections below present findings along each of the six dimensions and their relevance to women's experience of service quality.

Availability

Availability as a dimension of quality within the conceptual framework gauged whether or not a particular service was available for use to girls and women. The key findings regarding availability of institutions of service delivery and the factors upon which users make their choice are discussed below.

Availability vs. Use

Institutionalized services in all three sectors were never completely unavailable to women. In the case of the health and education sectors, it was observed that women did not always choose the nearest available health centre or school. They were willing to travel if they believed that a better-quality service was available elsewhere.

Consumption of a particular service depended on a range of factors, some intrinsic to the individual (like perception of quality), while others were external

(such as service timings). Most often, the women respondents were in a position to choose the services that best satisfied their requirements, from a range of schools, hospitals and banks, regardless of proximity. Women chose those institutions which they believed would deliver the highest possible service quality. In the health sector, the most important factor that influenced such a choice was the availability of specialized infrastructure and service staff in a given hospital. Unreliable service timings often meant that a woman sought out services further away. In the education sector, choice of institution was informed by aspirations for English medium schools and better opportunities for their children. In the banking sector, however, proximity was important, and women almost always accessed the nearest available bank. Additionally, women's choice of a banking service was primarily guided by a third-party facilitator - like an NGO or other family members.

Infrastructure and Human Resources

Women refrained from using the nearest available school or hospital if it lacked the kind of physical infrastructure and human resources that they required. In schools, service providers confirmed that lack of adequate funds and recruitment of teachers make it impossible to meet proper standards of teaching. Further, various government programs are introduced and then changed or withdrawn before teachers are able to see proper results from them. In the health sector, a variety of factors influenced women's choice of institution, such as doctors with specialized training for surgeries and infrastructure like sonography equipment and private rooms. The presence of these in a hospital was often correlated with higher standards of quality. Distance was not an impediment in availing a service at a hospital with better infrastructure and care facilities. *'If complica-*

tions during a cesarean arise, then we have to move the patient to some different facility. So, in the first place itself, we prefer going to a hospital with all these facilities'.

Timing

Limited service schedules or timings, for example at a bank, were accepted as a norm, necessitating multiple trips to get work done in both urban and rural areas and significant opportunity costs. *'Visiting banks means spending the whole day on it. So, you cannot work in fields. That's wasting time'.* Erratic timings at a sub-health center at Vanpuri, led to uncertainty about availability of the service, leading to lower reliance on that service and a quest for an alternative. Overall however, service timings did not hinder the availability of services among our participants. Instead, for most women the amount of time spent at the service center in availing the service was an important factor in determining the quality of service itself. The quicker the service, the better it was for the women, particularly in the banking sector.

Social Capital

Many participants leveraged their social networks to ensure better services by accessing higher education for their children, availing higher quality of care in public hospitals and receiving adequate attention by service providers in the banking sector. For many women, the quality of healthcare services received, especially at a government hospital, was directly proportional to their own social ranking or the relationship they had with influential people. A village *Sarpanch* (local government head) observed, *'See, I am the elected representative. I know many people now. My husband also knows many people. So, whenever I go to a government hospital they pay full attention to me. This is not the case for ordinary*

people. An ordinary person does not get the same treatment that I get in government hospital.' This is also the case in the banking sector - 'If you know someone in the bank only then will you get proper guidance. Otherwise, they won't even listen to you.' Women also find that in a bank people with power and money often cut queues and are catered to faster by the bank staff.

Role of the Facilitator

Several organizations play an important role in enhancing women's access to basic services by raising awareness of existing services or the processes required to access them. These facilitators also support women to be assertive in their interactions with service providers. This is especially so in rural areas, where NGOs like MASUM conduct awareness campaigns to enhance women's access to healthcare institutions and form self-help groups (SHGs) in multiple villages that enable women to act collectively. Women's participation in SHGs creates a pathway to institutional banking facilities in rural areas, while also raising other important issues for women and their families. For example, 'MASUM conducts health camps for their SHGs, so now lots of women talk openly about their health issues. Even those who never talked to anyone before'. In another instance, a MASUM karyakarta ensured that children belonging to the *Dhangar Samaj*¹¹ were integrated into the formal education system.

In urban areas of Pune, NGOs, such as the waste pickers trade union KKP, play an important role in making English medium private schools accessible to children from below the poverty line (BPL) households through the Right to Education (RTE) Act. 'Our Sanghatana does everything; they tell us to fill the form online and if our members are not able to

pay the fees or have to give a donation, the sanghatana pays. They provide everything, books and notebooks. They help get scholarships. If the children get grades of 65%, they also get prizes.'

Eligibility

Proving eligibility for benefits of certain services within these sectors requires personal identification documentation such as the PAN card, Aadhar card or bank account details. Most women do not have these documents. This acts as a barrier to accessing services, which was most evident among women accessing financial empowerment schemes within the banking sector. Eligibility criteria and required documents needed were fewer to access basic health care and education facilities. Women and children from vulnerable communities, such as nomadic tribes, had to depend on a facilitator to help them obtain basic documents, such as ration cards or birth certificates. Sometimes, these groups were denied benefits of a particular scheme. For example, when asked whether she received any financial assistance for her daughter's delivery, one participant replied, 'We applied for the scheme but required the signature of the head of village signature. Our sarpanch refused to sign the documents'.

Recommended Components: Availability of Services

Our understanding of availability as a dimension of service quality evolved as the study progressed from reviewing literature to understanding the perception of women on the field. The resulting changes in the components of Availability are summarized in Table 4. The preliminary components as derived from literature and key informant interviews have transformed to the recommended components after analysis of data.

11. Dhangar Samaj is a community of sheep herders classified under Nomadic Tribes.

Table 4: Recommended Components: Availability of Services

Dimension	Preliminary Components	Recommended Components
Availability	<ul style="list-style-type: none"> • Grades of institution • Physical infrastructure and human resources • Timing • Eligibility of requirements 	<ul style="list-style-type: none"> • Physical infrastructure • Human resources • Eligibility requirements • Presence of a facilitator

Unlike in the preliminary framework, physical infrastructure and human resources are separated into two separate components in the recommended framework. This is due to the individual importance accorded by women to both. Basic physical infrastructure included both facilities such as clean classrooms and buildings and equipment, such as sonography or ultrasound machines. Human resources included an adequate number of teachers and doctors in schools and medical facilities, respectively.

Similarly, eligibility requirements, particularly documentary compliance is another important component of availability established by both the literature and participants in the field. However, the availability of a higher grade of institution (for example, a specialty hospital as opposed to the nearest sub-health center) was not a matter of concern for women in the field. This is because most women first visited institutions that offered higher level services rather than visiting a lower level institution and then moving to a higher-level institution. Therefore, the component did not hold meaning while measuring quality from the user's perspective and was consequently omitted in the final recommended framework.

Timing as a component of availability was seen as

important in the initial phase but was removed since women did not base their choice of an institution upon its working hours. The component that was not foreseen in the preliminary framework but was revealed as a component of quality during interactions with women was the role of a facilitator or third-party organization in helping women access services.

Physical Accessibility

The distance one has to travel to reach service delivery points was most often perceived by women in terms of both time taken and cost of travel. Although the relative distance that an average rural woman travelled to reach the service was higher than that of her urban counterpart, the travel was not perceived as cumbersome. On the contrary, rural women saw it as an inevitable step in accessing quality services of one's choice. Moreover, while urban women almost always hired auto rickshaws to go for prenatal checkups or delivery, in rural areas women depended on public buses that run every hour or ambulances in case of emergencies.

In the education sector, lack of good quality education in the vicinity was cited as a problem by some rural participants - *'If education had been good here*

in the village school, then my son won't have to suffer unnecessarily. He has to go so far.' In one village, when asked why girls did not pursue education beyond tenth or twelfth grade, one participant said, *'It gets a little far for them. Now two girls have been fighting with their father to send them to college in Talegaon, which is 22 kilometers away.'*

Recommended Components: Physical Accessibility

In the initial phase of the study, it was assumed that the distance women had to travel to access a particular service, mode of transport used, and the time taken to reach service delivery points were all important determinants of quality. However, the analysis of data from the field revealed that distance travelled was measured in terms of time and cost of the transport. These were the factors that determined quality rather than the mode of transport used. Therefore, the revised framework has proximity as a component of physical accessibility which refers to proximity of the service in terms of time and cost. An additional component that was mentioned by women during discussions around physical accessibility was safety. Participants almost always mentioned instances of 'feeling unsafe' or 'catcalling' or instances

of harassment in relation to mobility, especially while using public transport. Therefore, it has been included as a component of physical accessibility in the recommended framework.

Table 5: Recommended Components: Physical Accessibility

Dimension	Preliminary Components	Recommended Components
Physical Accessibility	<ul style="list-style-type: none"> • Distance traveled to access service • Mode of transport • Convenience of service and time taken to reach 	<ul style="list-style-type: none"> • Proximity (time and cost) • Safety

Affordability

Affordability or the cost of availing a service, had varying degrees of importance as a determinant of service provider across the three sectors. It was of higher importance to women when making decisions regarding choice of schools, as opposed to accessing services at a hospital or a bank.

In the education sector, cost of service served as a deterrent when deciding where children would be sent to school. A private education is often associated with quality. However, the affordability of school fees was the primary factor in determining if a child should attend English medium private schools or not. Wherever they could not afford the fee, parents resorted to different ways of covering the cost like applying for financial support through the Right to Education act or paying the fee in instalments - *'The school fees are around 2,500 to 3,000 rupees a year...If I find it difficult then we pay in bits (installments). If we have money, we pay in one go'*.

While the education in public schools is free of cost, indirect costs increased with higher education. This adversely impacts girls from economically challenged families. For instance, one participant,

a student, will find it difficult to pursue education beyond ninth grade as her family cannot afford the associated costs. When asked how much she had already spent, her mother replied, *'It cost me 1,500 rupees and since ours is a joint family, so expenses of my cousins also add up...it was given until 8th then we have to buy, from 1st to 8th we did not have to spend even five paise, but it be expensive from here on now'*.

In contrast, cost was not a major deterrent for women accessing hospitals which they thought of as having the 'best' quality services. Except in a few cases, women generally do not compromise on quality in healthcare services due to lack of money, even if it means borrowing the amount from elsewhere. One participant who had a successful surgery in a private hospital described how she paid for it - *'My aunt, my sister, my brother all helped me and Damale ji gave 2 lakh rupees on loan...My family and I have pawned all our jewelry. I have spent a total of about 4 lakh rupees so far. But, the operation was successful'*. While women would prefer not to spend large amounts on health care, Notably, a higher amount spent was always equated with a higher perception of the quality of service received. *'Why wouldn't we want*

Table 6: Recommended Components: Affordability

Dimension	Preliminary Components	Recommended Components
Affordability	<ul style="list-style-type: none"> • Direct cost of service and supplies • Indirect cost of services • Opportunity cost 	<ul style="list-style-type: none"> • Cost of service (direct and indirect)

treatment at lower costs in government hospitals? In fact, the lower the cost the better it is for us. But they won't admit us quickly. And they make us run... In private hospitals, even though they are costlier, doctors are available for us. They come immediately and treat us quickly and give medicines'.

Recommended Components: Affordability

The preliminary conceptual framework had listed direct and indirect costs as separate components of service affordability. Based on the narratives of the participants, there was no clear distinction between cost as being direct or indirect. Therefore, in the recommended framework, both have been absorbed into one component - cost of service. Furthermore, opportunity cost was removed from the recommended framework since none of the women viewed the time or money they spent on accessing services as resulting in forgoing use of the same.

Acceptability

While all the dimensions mentioned so far explore components that determine the user's choice of service, acceptability evaluates service quality components that are important to women during their interactions at service delivery points.

Skill of the Service Provider

Service provider skills are a key determinant of quality, particularly in the case of health care and education.

The assurance that doctors and nurses are skilled enough to treat ailments in the most effective manner is an important determinant of quality. Trust in the service provider and reliability that the expected service will be delivered are associated with this. If women feel that service providers are not skilled

enough, they are quick to change service providers. One participant even changed hospitals after an unsuccessful surgery at a government hospital.

In the education sector, the skills of teachers, particularly their ability to impart English-language education, is an important factor that determines perceived quality. One participant plans to move her younger son from the public school he attends, concerned that, *'Now they have started semi-English in the school. But appointing a teacher trained in Marathi to teach English does not make any sense. How will they teach in English?'* Although more a phenomenon of the rural than the urban, this component of quality is linked to the aspiration of parents for English-medium education for their children.

Empathy and Care

Based on the responses of women, it is evident that the empathy with which service providers treat service users was an important marker of quality across all three sectors. In the health sector, this empathy translated to compassion during interactions about ailments and care given throughout the treatment by both doctors and nurses. Most users associated higher empathy and more empathic care as being more available in private hospitals than public hospitals. *'The only reason we go to private hospitals is because the care and attention we get in a private hospital is absent in a government hospital. Also, in a private hospital, if a medicine doesn't work, they check and change the medicine to find one more effective. But in a government hospital, this is absent, they keep giving you the same medicine'.*

In the education sector, empathy was seen as the approachability of teachers to discuss the performance of their students and the individual attention

given to students. These were decisive factors in rating the service quality of a school. A participant with a son with special needs appreciated that, *'His teachers at the government school personally went to the hospital and got the disability certificate for him. Teachers from that school are very helpful. They tell us all the information. They talk to us nicely'*.

In the banking sector, the presence of empathy meant patiently listening to one's queries regarding the formalities at the bank, approachable staff and respectful treatment. For women, it also meant equal treatment vis-a-vis their male counterparts at the bank. Additionally, it translated as confidence felt during their dealings in the bank and increased comfort levels arising from familiarity with officers in the bank. All the respondents identified these features in a high-quality experience in the banking sector but did not always experience them. For example, according to focus group participants, *'If there is a mistake in the check, we have to go again and submit a new one. Every time we go they tell us where to sign, but by the time we have to do it again we forget and we end up asking the same thing. They get angry with us for asking the same things and shout at us.'*

Outcome

The efficacy of the service was an important marker of quality from the perspective of women. In the case of healthcare services, women rated a service higher if they received a positive outcome at the end of their treatment. Even if the whole experience at the hospital was not satisfactory, if their illness was cured or they delivered their baby successfully, women still rated the hospital higher on quality. Similarly, in the education sector, an increase in the merit of the student and scholarships or other academic and co-curricular achievements received by the student improved a participant's overall perception of service quality.

Value Added Services

The presence of infrastructure over and above the basic necessities enhanced the perception of service quality. For example, a deluxe room with air conditioning in a hospital or a school with facilities for extracurricular activities are accorded higher standards of quality by the users than those without them.

Crowding and Waiting Time

Crowding from the user's perspective includes both

Table 7: Recommended Components: Acceptability

Dimension	Preliminary Components	Recommended Components
Acceptability	<ul style="list-style-type: none"> Assurance in the skill of the service provider Empathy, dignity, privacy Efficacy of service: outcome of service 	<ul style="list-style-type: none"> Value added services Assurance in the skill of the service provider Crowding and waiting time Empathy and care Outcome

inadequate physical infrastructure and personnel at a service delivery point to accommodate and attend to all users at any given time, as well as long waiting hours before receiving services. For example, when asked how long it takes to get their work done at the bank, women responded, *'It all depends on the crowd. Sometimes it even takes one whole day. We set aside other household work to get this done'*.

In the education sector specifically, crowding also refers to a higher pupil to teacher ratio and the consequent lack of attention one's child receives. Greater individual attention at school was seen as a higher quality of service by the parents. *'The teachers here care for the children and also teach properly. So, the children are disciplined well and attended to. There are fewer children in this school, so the teachers can give individual attention and time to each child. In big schools there are a lot of children in the class, with different intelligence levels, and there is no individual attention'*.

Recommended Components: Acceptability

The components of acceptability in the preliminary framework - assurance in the skill of the service provider, empathy and care received from service provider and service outcome - were verified by the

participants of the study and included in the recommended framework as well. The presence of value added services and crowding and waiting time were added, based on the inputs from women.

Safety

During the initial phase of the study, experts and key informants raised concerns about safety in public spaces and transportation. However, none of the women we spoke to during data collection perceived safety as a factor that influenced their assessment of the quality of a particular service. In the education sector, it was mentioned as a concern by some respondents, for girls to attend (or access) school but not as a major determinant of quality of education.

Recommended Components: Safety

Consequently, safety was removed as a separate dimension of measuring quality as elaborated in the preliminary conceptual framework and included as a component within physical accessibility in the recommended framework (see Table 5).

Accountability

Accountability in the health sector often took the form of a community grievance redressal mecha-

Table 8: Recommended Components: Safety

Dimension	Preliminary Components	Recommended Components
Safety	<ul style="list-style-type: none"> Perceived safety Financial security Safety in traveling to reach the service Normalized indignities 	<ul style="list-style-type: none"> None

Table 9: Recommended Components: Accountability

Dimension	Preliminary Components	Recommended Components
Accountability	<ul style="list-style-type: none"> Formal grievance redressal structures Community/informal support structures 	<ul style="list-style-type: none"> Grievance redressal mechanisms

-nism, especially in rural areas where the gram panchayat or the community resolution platform, the junsunvayi (organized by MASUM) resolved issues related to the efficient functioning of the sub-health center. In the education sector, accountability translated into the facilitation of parent-teacher meetings and the existence of school management committees (SMC) that address parents' complaints. Community platforms like SMC at schools and women's SHGs, provide service users with the opportunity to learn more about services and to discuss and make decisions about service provision. This has increased accountability and created platforms for grievance redressal for most women.

Recommended Components: Accountability

Although participants mentioned various grievance redressal mechanisms, they did not identify them as a component of service quality. However, accountability as a dimension of measuring quality was established through literature and was identified as one of the 3A's of quality. Quality service provision requires that service providers like teachers and healthcare providers ensure that community members receive the services required to meet their needs. Mechanisms that monitor how services are actually provided and finding ways to increase provider effort is critical to the quality of service delivery. To

ensure quality delivery of services, it is important to have adequate accountability mechanisms in place (Rabie & Towfighian, 2017) and thus, accountability has been retained as a dimension of quality in the recommended framework.

Conclusion

Findings from the second phase of the study were consistent with the six dimensions of service quality identified in the first phase, although some of their components were revised. Speaking to girls and women highlighted their understanding of service quality and patterns of service use. The presence of an institution in their own vicinity did not always translate to its use. Rather, women were willing to travel longer distances to avail the service from an institution of their choice. In other words, they had an informed understanding on the specificities of services that they required or the quality they expected and chose institutions of service delivery accordingly. In doing so, the physical distance or higher cost did not hold them back from accessing a service. Women would prefer services offered free of cost in public hospitals and schools that matched their perceptions of quality. However, since that does not often happen, women believe that if they pay more, they can receive a relatively higher quality of service.

Recommended Quality of Service Framework

The recommended QoS framework and service quality components were developed based on the analysis in the previous section. Keeping the perspectives of girls and women at its center, each component has been further defined and appropriate measures for each component have been elaborated. The indicators of each component measure user's perceptions rather than score the service provider on any predefined standards.

The framework has been developed to serve as the basis of an instrument to measure quality of a particular service as perceived by a single user. It is recommended that the final index should contain questions requiring yes or no answers, responses over a Likert-type scale or multiple choice responses. Some suggested questions are provided below.

Based on a cumulative score assigned by individuals of a representative sample population, this instrument can indicate a user's perception of service quality for any given service provider on a spectrum ranging between high quality and low quality.

While indicators have been developed keeping in mind all the three sectors, analysis of the data clearly suggests that each indicator varies across sectors. For instance, while availability of human resources is a determinant of quality in health and education services, it seems to be less important to a user of banking services. It remains to be seen whether weights should be attached to some indicators to reflect their relative importance over others.

Limitations

- The study was situated within Pune district, and included a small non-representative sample of participants. Additionally, Pune District and Pune City are among the more developed regions in Maharashtra. For most participants, services already existed and were fairly accessible, which may not be the case in other locations across Maharashtra or elsewhere in India. Therefore, the findings should only be considered as relevant to derive the recommended conceptual framework. The Quality of Service tool developed using this framework would need to be tested for its reliability and validity before being used.
- The sample included more rural than urban participants. While data from only two rural settlements were included, data from four urban settlements were covered during data collection. This may have biased the framework toward issues relevant for urban users.

Table 10: Recommended Quality of Services Framework

DIMENSION	COMPONENTS	SPECIFICATIONS
AVAILABILITY	Physical infrastructure	<ul style="list-style-type: none"> Defined as: Minimum physical infrastructure (facilities, equipment, supplies) required to obtain a given service outcome Measured as: Presence of «basic infrastructure» as perceived by the user Key Variables: Basic infrastructure (facilities, equipment, supplies) Suggested questions: Was there adequate infrastructure at the institution to cater to your needs? (Yes/No)
	Human resources	<ul style="list-style-type: none"> Defined as: Minimum human resources required to obtain a given service outcome Measured as: Presence of «necessary human resources» as perceived by the user Key Variables: Necessary human resources Suggested question: Was there an adequate number of qualified staff at the institution to address your needs? (Yes/No)
	Eligibility requirements as barriers to entry	<ul style="list-style-type: none"> Defined as: Presence of any documentary compliance as a barrier to use of service Measured as: Difficulty in accessing a service due to eligibility requirements and required documents Key variables: Documents required to access services Suggested question: Were you asked to produce documents at any stage when accessing the service? a) if yes, how difficult was it for you to procure those documents? (On a scale of 1 to 5, 1 most difficult and 5 being least difficult)
	Presence of a facilitator	<ul style="list-style-type: none"> Defined as: Third party intervention that enables and enhances availability of services Measured as: Percentage of users unable to access services without a third-party facilitator; Percentage of visits requiring a facilitator for a given user over a given period of time Key variables: Facilitator; facilitator interventions Suggested questions: <ul style="list-style-type: none"> a) How often have you resorted to using a facilitator? b) Has any NGO/ organization helped you in accessing services from this institution? (Yes/No) c) [If Yes] Without that intervention do you think you would have been able to access the service? (Yes/No) d) [If No] Would the presence of a facilitating NGO/ Organization have made it easier for you to access the services from this institution? (Yes/No)
Physical ACCESS	Proximity to point of service	<ul style="list-style-type: none"> Defined as: Physical distance to point of service delivery as measured in time, cost or distance Measured as: Distance between place of residence and point of service; average time taken to reach; average cost of reaching/travel Key variables: Distance, cost, time taken Suggested question: Do you experience any difficulty in reaching the point of service due to <ul style="list-style-type: none"> a) Distance (Yes/No) b) Time (Yes/No) c) Cost of transport (Yes/No)
	Safety	<ul style="list-style-type: none"> Defined as: Harm perceived by the user while accessing services Measured as: Number of instances of avoiding service due to perceived/experienced threat Key variables: Perceived/ experienced threat of harm Suggested questions: <ul style="list-style-type: none"> a) I do not feel safe while travelling to this point of service. Do you strongly agree, agree, disagree or strongly disagree? b) I do not feel safe when I am using the service. Do you strongly agree, agree, disagree or strongly disagree?

DIMENSION	COMPONENTS	SPECIFICATIONS
AFFORDABILITY	Cost of service	<ul style="list-style-type: none"> Defined as: Ability and willingness of the user to pay for a particular service Measured as: Degree of perceived affordability Key variables: Perceived affordability Suggested question: For the quality of service received at this institution, I think the expense incurred is fair. Do you strongly agree, agree, disagree or strongly disagree?
ACCEPTABILITY	Value added services	<ul style="list-style-type: none"> Defined as: All services enhancing user's overall experience over and above basic infrastructure Measured as: Number of additional/value added services; level of satisfaction with value added services Key variables: Value added services (e.g.. air-conditioned facilities; extra-curricular activities in school) Suggested question: How satisfied are you with the [insert value-added service here] available at this institution? (1 to 5, indicating least to most levels of satisfaction)
	Skill of the service provider	<ul style="list-style-type: none"> Defined as: User's perception in ability of the service provider to obtain the desired outcome Measured as: Degree of satisfaction with skill of service provider Key variables: Skill of the service provider Suggested question: On a scale of 1- 5, 1 being least satisfied and 5 being most satisfied, how satisfied are you in the skill of the service provider?
	Outcome	<ul style="list-style-type: none"> Defined as: Expectation of result as defined by the users in availing a given service Measured as: Ratio of positive to negative outcomes Key variables: Expected outcomes Suggested question: On a scale of 1-5, 1 being least satisfied and 5 being most satisfied how satisfied were you that your expected outcomes were met at this institution?
	Waiting time	<ul style="list-style-type: none"> Defined as: Insufficient resources per user Measured as: Average wait time per user; User to service provider ratio Key variables: N/A Suggested questions: Do you strongly agree, agree, disagree or strongly disagree with the statements given below? <ol style="list-style-type: none"> I had to wait for a very long time to receive the service I feel that there are too many people at the point of service at any given time
	Empathy and care	<ul style="list-style-type: none"> Defined as: Expected conduct and behavior of the service provider as defined by the user. Measured as: Number of instances of discrimination; Degree of sensitivity of the service provider Key variables: Discrimination; sensitivity of the service provider Suggested question: <ol style="list-style-type: none"> Are you satisfied with the attitude and behavior of the service provider while receiving your treatment? Did you feel you were treated with dignity?
ACCOUNTABILITY	Accountability	<ul style="list-style-type: none"> Defined as: Presence of a grievance redressal mechanism and its effectiveness when used Measured as: Presence of grievance redressal; Ratio of positive to negative grievance redressal outcomes Key variables: Grievance redressal Suggested questions: <ol style="list-style-type: none"> Are you satisfied with the grievance redressal mechanisms at the institution? Have you used it to resolve any of your complaints?

The Way Forward

Having arrived at the indicators based on conversations with women about their understanding of quality, it is proposed that a questionnaire containing easy to answer questions on a Likert-type scale or with yes/no responses be created. This will serve the purpose of practically evaluating a service at the service delivery point.

A rapid prototyping of the tool would need to be carried out to assess its usability and feasibility in the field. This phase would entail a revision and finalization of the tool. The reliability and validity of the tool would then need to be established. This would help in ascertaining weights, if any, to be applied to some dimensions over others, and for coming up with a reliable, feasible and easy-to-use scoring system that can be applied to services in multiple sectors.

The ultimate success of the tool will depend on its use by government officials to assess girls' and women's perception of the quality of a range of services, and apply that feedback to improve those services.

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Appendices

Appendix 1: Field Experts and Key Informants

During Phase I of the study, the team interacted with the following field experts:

KKPKP

www.kkpkp-pune.org

Poornima Chikarmane
Lakshmi Narayanan

Yardi

www.yardi.com

Bharti Kotwal

Gyan Prakash Foundation

gyanprakash.org

Anita Tai
Kalpana Tai

MASUM

www.masum-india.org.in

Joyti Tai
Malan Zagade
Manisha Gupte
Meena Shendkar

RCV, Market Yard

Usha Chitre
Chhaya Gaikwad

Haqdarshak

haqdarshak.com

Aniket Doegar

During Phase II of the study, the team interacted with the following key informants:

KKPKP/SWaCH

swachcoop.com

Mangal Jadhav
Saru Waghmare

MASUM

Kavita Jagtap
Vaishali Tai

Forbes Marshall Department of Social Initiatives

www.forbesmarshall.com/fm_micro/csr/

Bina Joshi

Jeevan

Shantabai Varve

Appendix 2: Interview Guide

Section A: Introduction

- Introduction to LFE
- Introduction participants (name, occupation, age, level of education)
- Brief overview of the research project, and announcing the disclaimer, ask participants to sign the consent form.

Section B: Definitions

- When you think about primary education/maternal health/banking what comes to your mind? How would you define it? Do you think that 'primary education/maternal health/banking' is a service? What would you call a service? How do you define a service? (Elicit responses that gives us an idea as to how they define any sector.)
- In terms of primary education/maternal health/banking, what would you call good service? What do you expect from the school/hospital/bank (information about service benefits)? Why should one go to school/hospital/bank? (Goal is to gauge the outcome/expectations from the service and long term aspirations.)

Section C: Structure and process

- Where do you avail the service?
- How do you become part of it? What is the process of using the service?
- Who do you interact with in availing the service?
- What expenses do you have to incur while availing the service?
- Have you accessed any schemes while availing benefits?

- Overall how is your experience in availing the service? (Goal is to elicit responses that reflect the life cycle of the service and access, and to get basic information on institutions involved, the personnel involved and the money spent in the process.)

Section D: Discussion and debate

- What about the service works for you? What aspects of it are you happy with?
- Is the service fulfilling your requirements and helping you? Are you satisfied with the outcome?
- What would you say are the major roadblocks and problems with accessing the service? what aspects of the service are negative and do not work for you?
- What aspect do you think do not work for women in particular? Do you think women have it particularly difficult in accessing these services? How do you think your experience as women is different?
- What aspects of it would you like to change?
- If none of the critical aspects identified before have been touched upon, at this stage we can prompt the group asking if components of the framework were the most difficult? (Keep a copy of the framework available)
- If one would make a report card for the service, what are the five things you would rate it on, how much would you rate it and why? (We can repeat the various issues that were mentioned up till now and ask women to prioritize according to importance and include rating scale)

Appendix 3: Focus Group Discussion (FGD) Guide

A. FGD Questionnaire: Education

Date:

Place:

Number of participants:

- Introduction to LFE
- Introduction to group members (name, occupation, age, level of education)
- Brief overview of the research project, and announcing the disclaimer, ask members to sign consent form

Questions

1. Do you have children? If not, do you know of children going to primary schools or anganwadi?
2. Which school does your child go to? Where is it, how do you commute? How long has the child gone to this school?
3. Why did you choose this school over the others?
4. How does your child commute to the school?
5. Are you satisfied with the services of the school? Why/Why not?
6. Will you go continue to put your child (or other children) in the same school?
7. On a scale of 1 to 10 (ten being the highest mark) how much would you mark it? Why did you give that score?
8. If not this school, what are alternative options?
9. Has your child availed any benefits related to an education scheme? (Including scholarships specifically for girl students?)
10. What were the biggest problems you/your child faced while trying to access the service? Was it difficult to collect all the required documents? Was the eligibility criterion difficult? Did you have to make multiple visits? Is it difficult to commute there? Is safety an issue for women here? Was there any instance where your child felt lack of safety as a girl in class? Does she have adequate access to toilets etc?
11. What were the positive aspects about the service at school?
12. Has your girl child told you about any 'bad' experiences she has had to face at school- from teachers, fellow students girls/boys) or anybody else?
13. Do you feel that the safety of your girl child is taken care of at school- why or why not?

Appendix 3: FGD Guide (continued)

B. FGD Questionnaire: Health

Date:

Place:

Number of participants:

- Introduction to LFE
- Introduction to group members (name, occupation, age, level of education)
- Brief overview of the research project, and announcing the disclaimer, ask members to sign consent form

Questions

1. Where do you go to the hospital? When was the last time you went? For what?
2. Do you have any children? Where did you give birth ?
3. Why did you choose that hospital for delivery?
4. Where did you receive pre- and ante-natal care? Who informed you of these?
5. Are you satisfied with the service you received? Why/Why not?
6. Will you go back to the same doctors and hospitals? If not this hospital, what is the alternative option you have?
7. On a scale of 1 to 10 (10 being the highest score) how much will you rate the service? Why would you give that score?
8. Did you receive any benefit from any maternal health related scheme?
9. What were the biggest problems you faced while trying to access the service? Was it difficult to collect all the required documents? Was the eligibility criterion difficult? Did you have to make multiple visits? Is it difficult to commute there? Do you have to wait a lot for the doctor to attend to you? Was there any instance where you felt lack of safety as a woman? Was the treatment by service personnel not very nice?
10. What were the positive aspects about the service that you accessed?
11. Do you think your experience of accessing the hospital service would have been different if you were a man? How?

C. FGD Questionnaire: Banking

Date:

Place:

Number of participants:

- Introduction to LFE
- Introduction to group members (name, occupation, age, level of education)
- Brief overview of the research project, and announcing the disclaimer, ask members to sign consent form

Questions

1. Are you part of an SHG? If yes, for how long?
2. Who introduced you to the SHG? How did you become a part of it? How many members? Which bank is it registered with?
3. Have you accessed banking services before being a member of the SHG? If so, for what? Can you describe the experience of using a bank? What are the difficult aspects of it? What changed after becoming an SHG member?
4. Have you taken loans from a bank or SHG? Why? and what for?
5. Are you satisfied with the services of the bank? Why or why not?
6. Do you see yourself going to a different bank in the future? Why or why not? If not this bank, what are the other options that you have access to? Why?
7. On a scale of 1 to 10 (10 being the highest score) how much will you rate the service? Why would you give that score?
8. Are you informed by the bank of new schemes? Have you accessed benefits from any schemes related to banking?
9. What were the biggest problems you faced while trying to access the service? Was it difficult to collect all the required documents? Was the eligibility criterion difficult? Is it difficult to commute there? Did you have to make multiple visits? Is the wait time long? Was there any instance where you felt lack of safety as a woman? Was the treatment by service personnel not very nice?
10. What were the positive aspects about the banking service that you accessed?
11. Do you think your experience of accessing the hospital service would have been different if you were a man? How?

Partnerships lie at the heart of the 3D Program.
We are grateful for the support we receive from
our partners to help us advance our work.

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Kagad Kach Patra Kashtakari Panchayat (KKPKP) • SWaCH

Pune Smart City Development Corporation, Limited

The Movement for Community-Led Development

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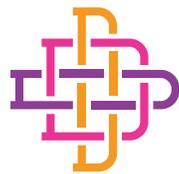
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