

**Healthy Women,  
Healthy Families:  
Insights and  
Opportunities Report**

**Co-created by:**



# Background.

In **2016** Scope, then known as M4ID, collaborated with Management Sciences for Health (MSH) team to co-create and customise Group Antenatal Care (GANC) model for Uganda by applying co-design methods with communities in Mbale and Bududa, Uganda.

In **2017** Scope adapted the model to the Kenyan context in Kakamega county, co-designing key elements with a diverse set of stakeholders using Human-Centred Design (HCD) approach.

In **2019** Scope further adapted key elements of the GANC service model and linked tools from Kenya and Uganda to suit the context of Guatemalan Highlands while leveraging HCD.

In 2021, building on the previous work done in Uganda, Kenya and Guatemala, Scope was tasked to help MSH to co-design a user-centric service delivery model inclusive of ANC and Postnatal Care (PNC) for married first-time parents living in the informal settlements of Gazipur, Bangladesh, as part of the Healthy Women, Healthy Families (HWHF) initiative. This report contains the key findings of formative design research conducted in June 2021 in the Tongi and Morkun areas of Gazipur.





## What we learned from previous and other iterations.

Through our collective work, as well as that of others testing GANC models around the globe, we have learned about what experience women are seeking and the service components that can help to create that experience. We build from this work by thinking about this from the perspective of scaling as adaptation. We need to retain the core functions of the experience that make it effective, but change their service to meet the specific needs and expectations of women - and in this case parents - and the context. While we have focused predominantly on pregnant women in the past, our work in Gazipur brings in expectant husbands, potentially other family members and extends through to the postnatal period. It also involves an urban population, while the other projects were based in rural areas. Therefore, we need to innovate and try new elements for the model in this project.

### Key characteristics of the experience.



#### WELCOMING

Arrive and feel like there is a good/warm reception



#### RESPECTFUL

Feel that they are treated like others, provider listens and values them



#### EMOTIONALLY SUPPORTIVE

Feel that they can share their joys, concerns and fears with others



#### KNOWLEDGE IS POWER

Feel knowledgeable about how to have a healthy experience and newborn and to cope with the challenges that arise



#### FUNCTIONAL SUPPORT

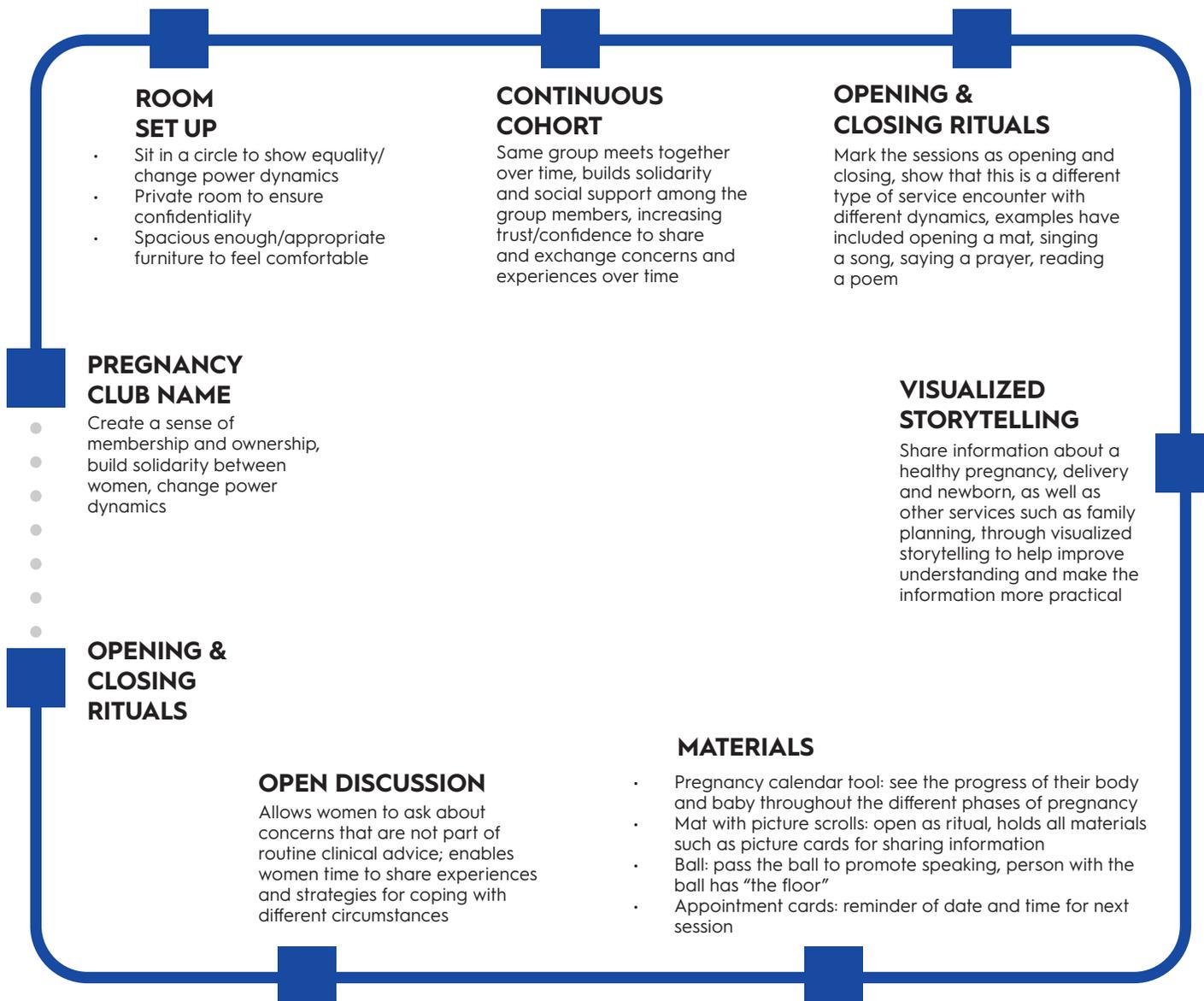
Feel that there are people who can be called upon to help with tasks or issues such as finance or transport as needed



#### SELF-EFFICACY

Feel that they are able to take the actions needed to have a healthy pregnancy and delivery and care for their newborn

# Key components of the service.



## Operational challenges.

- Need to shift provider mindset for a very different type of service
- Scheduling is difficult because this service differs from other types of primary care and aligning women's and providers needs with transport, work, etc.

## What we did.

Prior to conducting research sessions with users, rapid desk research was carried out by Scope to gain a better understanding of the context and the target population, building on foundational documents provided by MSH. These documents included a wide range of materials such as government guidelines and standard operating procedures for ANC/PNC/maternal health, national health and demographic surveys, NGO reports, journal articles and online content. BRAC also added their expertise and experience working in the context. Together, Scope, BRAC and MSH refined the initial research questions, areas of inquiry and participant profiles. The primary research activities were carried out by BRAC supported by training in HCD methods and remote guidance from Scope.

The objectives of the formative design research were to explore the current reality of life and experience of services, both existing and ideal, from the perspectives of first-time pregnant women, recent first-time parents, community influencers as well as facility- and community-based providers of ANC and PNC. To this end, altogether 19 sessions were carried out including 11 in-depth interviews and 8 focus group discussions. To stimulate richer dialogue and insight generation, a set of design research tools were created, consisting of service journey maps, picture cards and facilitation prompts.

After the data collection, Scope, BRAC and MSH engaged in a collaborative research synthesis process. The data was systematically organised and analysed to create emerging themes which were then jointly reviewed and, through ongoing discussions, further developed into the insights presented in this report.



# Who participated.

Altogether **52 people** participated encompassing both service users and providers.



**19 sessions**, IDIs and FGDs exploring current reality and ideal experiences:

## Focus Group Discussions on Current Realities

- Recent first-time mothers
- First-time pregnant women
- Recent First Time Fathers
- Shasthya Shebikas
- Shasthya Kormis

## In-Depth Interviews on Current Realities

- Recent first-time mother with 4+ ANC visits
- Recent first-time mother who made no ANC visits
- First-time mother-to-be (2 interviews)
- Recent First Time Father
- Midwives (2)
- Shasthya Shebika
- Shasthya Kormi
- Leader of women's group
- Member of the MNCH Committee

## Focus Group Discussions on Ideal Experiences

- First Time pregnant women
- Recent First-time Mothers
- Shasthya Kormis

# What we learnt.

## PARENTHOOD

- 1 First-time parenthood is a complex emotional journey.\*
- 2 First-time pregnant women seek sister-like connections with providers.\*\*

## BUILDING CONNECTIONS

- 3 Some providers' scare tactics can create stress and unnecessary fears.\*\*
- 4 Young expectant women have limited social connections in the city.\*

## BRINGING MEN INTO THE JOURNEY

- 5 Husbands want to feel included in the perinatal journey.\*\*
- 6 Parenthood is increasingly seen as a joint venture with husbands taking a more active role.\*

## OTHER FAMILY MEMBERS MATTER TOO

- 7 Mother-in-law is considered the family expert, which can limit her daughter-in-law's agency.\*

## COMMUNICATION

- 8 Both providers and first-time parents(-to-be) feel uncomfortable to discuss sexual interactions.\*\*
- 9 Service changes can create misunderstandings.\*\*

## COVID

- 10 'Money problem is the main problem'.\*\*
- 11 Compassion and connection is needed more than ever between providers and the community.\*\*

\* Refers to insights that relate to the quality of ANC/PNC services for young first-time parents(-to-be) in the Tongi region as per HWHF project objectives.

\* Refers to insights that relate to the practice of perinatal health behaviours among young first-time parents(-to-be) in the Tongi region as per HWHF project objectives.

## PARENTHOOD

### 1 **First-time parenthood is a complex emotional journey.**

*"I heard the news from my wife and I lost myself in happiness. Really, this is not something which is expressible."*

**Recent first-time father**

*"Yes, I have some fear. Anything can happen anytime. People also die during delivery."*

**Recent first-time mother**

*"I cannot much take my child on my lap as it is so small. I feel a bit uneasy, that's it."*

**Recent first-time father**

First-time parenthood signals a completely new life stage and thus is marked by strong emotions and governed by social norms around expected behaviour and emotions. In general, pregnancy news among married first-time expecting parents seemed to be warmly welcomed, even if not always planned. Both men and women as well as their family members expressed great joy upon learning about the pregnancy -- a joy that was so special in nature that it was often difficult to express in words. Nevertheless, the approaching transition to parenthood was also marked by increased emotional strain for both men and women alike. Anxiety about delivery, worries related to the wellbeing of the baby, changes in employment, and pressure to take care of the family were just some of the concerns expressed by expectant first-time parents-to-be.

In some ways the approaching transition to parenthood seemed even more pronounced for men who felt a radical shift from a care-free lifestyle to one marked by increased responsibilities. They felt expectations to be more family-oriented in their behaviour as well as increased pressure to provide for the family. At the same time, there were indications that men do not always receive the support they need to navigate through this transition smoothly. For example, not knowing how to handle small babies hindered interaction with their newborns and increased feelings of uneasiness.

There is a need to acknowledge and normalize that negative emotions accompany the joy of transitioning to parenthood for both men and women. Information and emotional support go hand in hand in preparing first-time expecting couples for this transition to ensure physical and mental wellbeing and both should be made available for them. Increased awareness around the challenges associated with becoming a parent can also serve to decrease the stigma related to postpartum depression and alleviate feelings of inadequacy. At the same time, there is a tremendous opportunity to leverage the positive attitudes around approaching parenthood expressed by both women and men alike to pursue improved health outcomes for the whole family.

**“Yes. a lot has changed since then. Before I became a father it was mostly about me and my wife. We were able to roam around according to our own will and after being a father now things have changed and costs went up. Now there is added tension as I want a better future for my child no matter how much hardship I go through.”**

**Recent first-time father**



**HMW** create a safe space to have an open conversation about the emotional experience of first-time parents(-to-be)?

**HMW** leverage the positive emotions related to the first pregnancy and the high value ascribed to having children?

**HMW** better support first-time expecting couples in their emotional journey and make room for discussion around negative emotions and difficulties?

## BUILDING CONNECTIONS

### 2

## First-time pregnant women value and seek personal connections with health providers: sister-like support is key to building long-term trusting relationships.

*"It was great. In short, like my elder Apa. She used to give all types of advice."*

**Recent first-time mother**

*"I feel great. I get acquainted with the families of the pregnant mother and I feel like they are my relatives. I know everyone by name and can recognize them over the phone."*

**Shasthya Kormi**

*"They never get bored. When I don't understand or get something, I can ask them twice or thrice. But they don't get bothered and answer me clearly."*

**First-time pregnant woman**

First-time pregnant women value and seek personal connections with their health providers. They seek sister-like guidance when navigating through the many physical, psychological and social changes that approaching motherhood entails. Such trusting relationships convinced expectant women about the good quality of services thus encouraging them to continue to access care.

First-time pregnant women seemed to value two-way interactions: women appreciated the opportunity to ask questions and that the provider listened in addition to receiving advice. The trusting relationship was often reciprocated by providers, at least community-based ones, as demonstrated in testimonials of some Shasthya Kormis who likened their clients to their relatives, always remembering their clients' names and even recognizing them by voice when receiving a phone call.

The findings speak to the need for ensuring continuity of care in the provider - patient relationship as trust does not tend to result from single interaction but is rather established over time. In addition, providers need support to enhance their communication and interpersonal skills. There is an opportunity to build personal relationships early on and thereby communicate pregnancy-related information prior to conception, setting the stage for a healthy pregnancy. Moreover, first-time parents who have a positive service experience are also more likely to return in subsequent pregnancies.

Building these personal connections between providers and young women over the long-term may also turn out to be a good strategy for increasing the desirability of the services. In addition, meaningful connections with clients can also contribute to the wellbeing of health providers, increasing staff retention.

A background image showing several women in a community setting. The central focus is an older woman with grey hair, wearing a colorful headscarf and a dark top with a red and yellow border. To her left, a younger woman with dark hair and a colorful patterned shawl is visible. To her right, another woman is partially visible, looking towards the camera. The setting appears to be an indoor community space with some furniture and other people in the background.

## BUILDING CONNECTIONS

**“I trusted her as she was familiar to me. She used to support me, and because she used to listen to me. That’s why there was no question in my mind like I’m not getting good service.”**

**Recent first-time mother**



**HMW** build and capitalize upon trusted relationships, especially those of Shasthya Shebikas/Kormis?

**HMW** build trust between health providers and women even before pregnancy?

**HMW** foster a more sister-like relationship between women and providers?

## BUILDING CONNECTIONS

### 3 Some providers' scare tactics can create stress and unnecessary fears.

*"We inspire them saying that, "if you follow these guidelines, the delivery will be normal without any complications," so that they (husband and MIL) get the importance of mothers' healthcare. Pregnant mothers need the ultimate care and utmost concern. Also, ANC is important for newborn babies."*

**Shasthya Kormi**

*"And if they are feeding the baby from one breast and from the other one milk is falling away, that means the baby is getting the water. But the main ingredient remained in the breast. It can cause the breast to get hard and later breast cancer can occur. "*

**Shasthya Kormi**

Good provider-patient interaction is of increased importance when catering to first-time parents-to-be as any shortcomings may adversely influence the uptake of services post-birth as well as in subsequent pregnancies. Currently, there are indications that the counselling offered is at times suboptimal, with some community health workers utilising scare tactics and inaccurate information when interacting with their clients to get them to avail services and products. In contrast, other community health workers take a more positive approach, focusing on messaging around the health of the baby to motivate their clientele to adopt recommended behaviours.

At the moment, counselling in general may not be receiving the focus it deserves from health providers even if first-time expecting couples appear to value it highly. It appears that it is at times provided for free with the aim of convincing pregnant women to pay for the clinical tests that are perceived to be more worthy of monetary compensation.

To ensure that first-time parents(-to-be) get the best possible service experience, there is a need to support the development of interpersonal and counselling skills of providers – paying particular attention to the two-way nature of communication. Active listening (which will play an even more pronounced role in the group-format) coupled with demonstration of warmth and care through words, body language and tone of voice are all important components of good counselling which should be further fortified to facilitate the forming of trusting relationships between health providers and first-time parents(-to-be). Instead of relying on scare tactics, utilizing positive pregnancy stories that make the link between positive health behaviour and good pregnancy outcomes more visible is likely to yield better results in getting first-time expectant couples to follow the current ANC guidelines.

## BUILDING CONNECTIONS

**“We ask them if they feel any burning sensation in their vagina after the delivery. If they say yes, then we tell them that due to the home delivery their vagina has been torn. So, that will create issues. They need to stitch their vagina or else their husbands will remarry. (...) Also, they should take iron tablets and be fine and their husbands will be happy. Or else their husbands will marry someone else.”**

**Shasthya Kormi**



**HMW** make counselling a central part of the service experience in the eyes of both health providers and first-time parents?

**HMW** enhance counselling and interpersonal skills, building on positive tactics?

**HMW** involve peers from their network to share their positive pregnancy stories to serve as a source of information and inspiration for first-time parents?

## BUILDING CONNECTIONS

### 4

#### Young expectant women have limited social connections in the city.

*"We ask them why do you want to go to the village (to give birth)? They reply, nobody is here to take care of me. We assure them, we are with you. You may depend on us."*

**Shasthya Shebika**

*"During the pandemic, many people are in crisis, some lost their job. The working people like rickshaw-puller or van-pusher are in grave crisis. Many mothers also not being able to work at the garments or other workplaces during the pregnancy."*

**Leader or Women's Group**

Social interaction with friends and people outside of family appears to be limited for many first-time pregnant women living in urban slum settings. At times the disintegration of young women's extra-familial social networks is caused by leaving paid employment prematurely, either due to pregnancy related symptoms or to COVID-related layoffs. At other times, young women face pressure to end their friendships after marriage to focus more on their new family, as demonstrated by secondary literature<sup>1</sup> stemming from urban slums of Dhaka. In addition, increased household responsibilities that generally accompany marriage often keep first-time pregnant women tied to the private sphere, limiting the opportunities to interact with friends.

Becoming a mother for the first-time often triggers radical physical, psychological and social changes and thus tends to go hand in hand with increased worries and concerns. Consequently, first-time pregnant women/recent mothers have a heightened need for social support. Considering the typical living arrangements in the Gazipur context, the need for extrafamilial support networks becomes more pronounced: unlike in rural environments, many first-time pregnant women in Gazipur informal settlements live without their extended family with husbands working long days outside home.

The group model offers an ample opportunity to strengthen extrafamilial social support networks by facilitating friendship building and sharing of experiences among the first-time pregnant women/recent mothers and bonds with facility and community-based providers. In doing so, a key consideration will be to institutionalize group norms that respect confidentiality as pregnancy and pregnancy related difficulties are generally considered private matters. In addition, it will be important to stay cognizant of the different cultural and social backgrounds that may limit spontaneous connections among first-time pregnant women.

<sup>1</sup> Anaise Williams, Malabika Sarker & Syeda Tahmina Ferdous (2018) Cultural Attitudes toward Postpartum Depression in Dhaka, Bangladesh, *Medical Anthropology*, 37:3, 194-205

## ANTENATAL OPD

### BUILDING CONNECTIONS

“My husband and I only live here and there is no other help that we have.”

First-time pregnant woman



**HMW** form a community within the ever-changing urban space to better support first-time pregnant women?

**HMW** set the stage for good group dynamics and build strong relationships especially given the more heterogenous cultural make up of urban slums?

**HMW** facilitate discussions around pregnancy and other sensitive topics with people outside of one's family while ensuring confidentiality?

**HMW** facilitate informal support networks or other sources of support?



## BRINGING MEN INTO THE JOURNEY

### 5

#### Husbands want to feel included in the perinatal journey.

*"It would have been better as I could have reminded her of a few things as remembering everything is often not possible. While discussing it I could have asked or added a few things."*

**Recent first-time father**

*"If the husband comes along, we request him to feed the mother healthy food and suggest not to involve in sexual intercourse during the first three months and the last three months of pregnancy. We also suggest keeping a vehicle managed for emergencies and keep saving."*

**Midwife**

Currently, some husbands feel excluded from health consultations as their role is limited to accompanying their pregnant wife to the facility. Typically, they are expected to wait outside the consultation room for the appointment to be finished. This prevents them from better understanding what their pregnant wife is going through and preparing for their upcoming responsibilities to help care for the newborn. Moreover, when husbands are counselled, the information tends to focus on a rather limited set of topics - mainly covering maternal nutrition, the importance of abstinence during pregnancy, as well as arranging technicalities for the approaching delivery such as money and transportation.

The husbands who participated expressed interest to be more involved. They tended to greatly value the counselling, albeit limited, and expressed the desire to learn about pregnancy related matters. In addition, some husbands expressed interest to pass on the information to educate others on matters related to pregnancy.

The findings speak to a need for husbands to feel more included in the perinatal journey. There is an opportunity to rethink the counselling and linked materials directed towards husbands for them to feel more part of the service experience, enabling them to better understand and support their wife throughout the pregnancy and postnatal period. When exploring the possibility of doing so further, it is essential to keep in mind the context-specific gender norms that may restrict open conversation on sensitive subject matters between people of opposite sex.

A close-up photograph of a man with dark hair and a mustache, looking slightly to the right. He is holding a young girl in his arms. The girl is wearing a bright orange jacket with a white fur-lined hood and a blue floral headband. The background is blurred, suggesting an outdoor setting.

## BRINGING MEN INTO THE JOURNEY

**“I was not mostly allowed inside, I was only waiting outside. The patient and the doctor used to have the discussions and the consultations. They used to have their conversations and consultations while I was waiting outside.”**

**Recent first-time father**



**HMW** rethink counselling and linked materials for husbands to make them feel more part of the service experience?

**HMW** facilitate communication between couples on pregnancy and parenthood?

**HMW** create a space for men to learn and share their experiences?

## BRINGING MEN INTO THE JOURNEY

6

**Parenthood is increasingly seen as a joint venture with husbands taking a more active role.**

*“Whenever I came back from my work I did try to help her as much as possible. I helped her with the daily chores, cutting vegetables and preparing rice and cooking.”*

**Recent first-time father**

*“I have to care of my baby when I return home. Also, I help my wife in her household tasks. Like washing clothes of baby, make my baby clean after its pooping. Helping my wife when she needs.”*

**Recent first-time father**

Traditionally pregnancy is perceived as a woman’s domain, which the husband is expected to support financially, but largely remain uninvolved. A potential trend emerged that indicated approaching parenthood to be increasingly discussed by young couples and viewed as a joint-venture with more equal sharing of preparation and parenting responsibilities between the husband and wife. Some husbands follow through with actions, taking an active role in supporting their wife throughout the pregnancy and post-delivery by helping out with household chores, preparing for the birth, and caring for their newborn.

This sentiment of parenthood as a joint venture can also be seen at times in the realm of family planning: some husbands described joint discussions around contraception, sometimes before the first child but more so afterwards given the increased financial, physical and emotional strains that become evident once the baby has arrived.

The same joint mentality was at times also visible in relation to care-seeking with husbands using their status to counterbalance the more traditional views of mothers-in-law to allow their wives to go for check-ups and other appointments.

The findings present an opportunity to leverage the emerging trend of co-parenting to expand the role that is currently ascribed to husbands. In doing so, it is important to encourage critical reflection of prevailing gender norms to facilitate positive change in couple dynamics. Moreover, to set the stage for equitable co-parenting, there is a pronounced need to strengthen couple communication and joint decision-making, preferably as early as possible.

A photograph of a woman and a baby in a slum setting. The woman is on the left, wearing a pink sari, looking directly at the camera. The baby is on the right, wearing a white shirt and a red skirt, smiling. The background shows a dense urban environment with makeshift structures and a city skyline in the distance.

## BRINGING MEN INTO THE JOURNEY

**“Mainly I’m depending on him (her husband). He will manage everything. As the baby is not mine alone, we both have duties to perform. We will have to take care of our newborn baby together.”**

**First-time pregnant woman**



**HMW** utilise progressive men that want to share parenting responsibilities to act as role models for others?

**HMW** foster gender-equitable attitudes and expand the support functions of a husband, beyond the typical financial and material support?

**HMW** equip first-time expecting husbands with all the relevant skills they need to be able to take on a more active role pre and post delivery?

**HMW** facilitate couple communication and joint decision-making?

## OTHER FAMILY MEMBERS MATTER TOO

7

### **Mother-in-law is considered the family expert which can limit her daughter-in-law's agency.**

*"They gave birth to 6, 7 children and they hadn't faced problems. So, they don't feel it's important to do check-ups regularly and other tests."*

**Member of the MNCH Committee**

*"It is pretty common for the mothers-in-law to never understand their daughters-in-law's situation. They never think how they would feel if their daughter was being treated the same way."*

**First-time pregnant woman**

*"Sometimes, when my mother-in law doesn't allow me to take services by going to hospitals, my husband makes her understand."*

**First-time pregnant woman**

Although there can be many different people who influence the behaviour of first-time expectant women, both in positive and in negative, the women we talked to emphasised the relationship with the mother-in-law as a priority one in need of extra attention.

Due to their lower social standing and lack of previous pregnancy experience, young first-time pregnant women tend to have limited agency to follow the behaviours promoted for modern antenatal/postnatal care if it conflicts with the beliefs held by their mother-in-law. Having gone through a pregnancy and childbirth elevates the mother-in-law to the role of an expert, a position that lends her the authority to typically dictate what her pregnant daughter-in-law should and should not do. Moreover, particularly those mothers-in-law who do not have their own experience of ANC/PNC, tend not to fully understand the value of modern medicine. They also don't seem to grasp the connection between the wellbeing of their pregnant daughter-in-law and that of their future grandchild which is reflected in their advice and treatment of daughters-in-law.

The findings highlight the need to improve mothers-in-law's understanding of advances in knowledge about pregnancy and the benefits of modern ANC/PNC. The examples of mothers-in-law that are more progressive-thinking, believe in modern medicine, and invest in the health of their daughters-in-law show the opportunity that others might be able to change also. Furthermore, first-time pregnant women themselves held the view that such re-education of mothers-in-law would be possible if exposed to appropriate messaging; however they were hesitant to include them in the ANC sessions as it might inhibit their ability to talk and discuss freely.

Given their role in influencing the pregnancy, it is necessary to acknowledge and incorporate mothers-in-law into the new service model. There is an opportunity to clarify how supporting the wellbeing of the daughter-in-law in pregnancy contributes to the wellbeing of the future grandchild.

## OTHER FAMILY MEMBERS MATTER TOO

“This kind of thing almost everyone says as there were not many doctors or medicines or medical innovations. The times have changed. Now the medical services are available. When they were pregnant, the elders say that they used to do all their work and do all the household chores. They have carried water from the ponds then why do we need all the help?”

**First-time pregnant woman**



**HMW** simultaneously acknowledge MILs' status and promote adoption of evidence-based practices?

**HMW** leverage the connection between a pregnant woman's health and the baby's well-being?

**HMW** get MILs to treat their daughters-in-law more like their daughters?

**HMW** find ways to connect and share information with MILs?

**HMW** create a space to address the concerns of MILs?

## COMMUNICATION

8

### Both providers and first-time parents feel uncomfortable to discuss sexual interactions.

*"I have seen so many women suffering because of the husband are not understanding. I have done deliveries here at the BRAC and because of the husbands the women are in misery, I have seen such things."*

**Recent first-time mother**

*"(Un)like other men, he doesn't force me to have sex every day, rather we do it once in a week."*

**First-time pregnant woman**

*"If there will be male medical officers, it will be better. Because, we will not be able to tell everything sometimes."*

**Midwife**

Many women find sexual interaction during pregnancy challenging to negotiate with their husbands, with indications of sexual mistreatment by some husbands. First-time pregnant women stressed how this was something that should be better addressed in the counselling as it had far reaching consequences for their wellbeing. Currently, it seems that there is a mismatch between the needs of first-time pregnant women and the way in which ANC counselling approaches intercourse: providers tend to focus exclusively on discussing appropriate timing of intercourse, bypassing the importance of consensual sex and other forms of intimacy altogether. Moreover, pregnant women are not given advice on how to initiate such conversations with their husband. In addition, there seems to be a misalignment between the national ANC guidelines and recommendations passed on by providers when it comes to the safety of intercourse during a normal pregnancy.

Furthermore, both community and facility-based providers often struggle to communicate around sensitive topics, in particular intercourse, due to prevailing social norms. There are indications that gender-related barriers restrict open conversations around sensitive subject matters between people of opposite sex.

There is a need to shift from abstinence focused messaging to discussing the meaning of consensual sex and other forms of intimacy besides intercourse. Given the desire expressed by some husbands for increased involvement in pregnancy and ANC in general, there is an opportunity to increase male involvement in such discussions. This would further lend itself to building the agency of first-time pregnant women by addressing communication and decision-making around the subject matter. This change is predicated upon having the correct information, training, and tools in place for health providers that would enable effective and stress-free communication on sex.



COMMUNICATION

**“Apa, as you have said to her that she should refrain from having sex with her husband it should also be notified to her husband as some of them are not very willing to understand, so it should be explained to them as well.”**

**First-time pregnant woman**



**HMW** equip health providers with the necessary skills and tools to be able to better communicate about sensitive subject matters with both sexes?

**HMW** shift from having abstinence as focal point of counselling to conversations around consensual sex?

**HMW** facilitate couple communication and joint decision-making around sex?

**HMW** expand the understanding of sexual wellbeing to include not just physical but also mental aspects?

## COMMUNICATION

9

### Service changes can create misunderstandings

*"They sometimes blame us for saying BRAC works for free but we are the ones stealing their money."*

**Shasthya Shebika**

*"They say we (Shasthya Shebikas) only go for taking their money."*

**Shasthya Shebika**

*"Our messages are not sent to everyone properly."*

**Member of the MCH Committee**

Currently, accurate information about BRAC service offerings (especially regarding recent changes) has not completely permeated the public awareness. The lack of clarity around service offerings, particularly around pricing, has become a fertile breeding ground for misconceptions and suspicions curtailing the uptake of services. For many first-time pregnant women and their family members, the user-fees that were introduced came as a complete surprise, leading them to think that the service fee would end up in the community health worker's own pockets.

To increase the uptake of services, intensified community sensitization efforts around BRAC service offerings can help to communicate changes in a clear and timely manner. This is important when thinking about the changes the new group-based service model will entail and how to communicate about the service and its associated costs. There is also an opportunity to rethink the channels through which the messages are delivered to households to optimize the information flow.



**HMW** identify and leverage trusted community-based channels for timely communication of upcoming changes in the BRAC service offering to increase the uptake of the future service model?

**HMW** present a unified service offering across the perinatal journey?

## 'Money problem is the main problem'.

*"My husband's office got closed because of this pandemic. So, we are badly in financial crisis. Nothing is like before. We can't buy a thing if we like, we have to think of money. Even sometimes, we have to think twice before going to hospitals."*

**First-time pregnant woman**

*"Bhai, money problem is the main problem. Think about how much price one KG rice is now? It would be better to buy rice for 100 TK and eat together if we need the same amount to do a single checkup. There are more needy people than me who beg in the street, they don't get the service as they don't have enough money. With 100 TK, they can live two days. So, it would be better both for us and more needy people, if the test fees will be reduced or no fees at all."*

**First-time pregnant woman**

COVID has had drastic effects on livelihoods with many first-time pregnant women and their husbands having lost their jobs or having taken a lower paying job. Additionally, the cost of basic necessities, goods, and services has increased, further tightening budgets. In this situation, many families must prioritize and are cutting back on services out of necessity, thus cost considerations have gained prominence as a defining factor for access to care. Due to the loss of a substantial income, regular health check-ups during pregnancy are not the highest priority for everyone and/or people lack money to access services even if they perceive them to be important.

In response to these financial difficulties, some health providers voluntarily gave information and counselling out of the kindness of their hearts and sought different ways to reduce costs for first-time pregnant women; however, there seemed to be a lack of clarity about what financial support/discounts are available and about the exact terms for availing them. At times first-time expecting parents resorted to taking private loans to pay for the delivery, and had difficulty with repayment to further financial stresses.

Given the financial hardship and subsequent compromises to accessing care, it is vital that providers maintain an understanding approach towards clients as any scolding can further discourage first-time pregnant women and recent first-time parents from attending and creates a bad reputation. It is also essential to make sure that available financial support is communicated clearly and reaches the most needy. When moving from individual consultations to the group-based model, there is an added opportunity to restructure the financial model by leveraging economies of scale to lower the user fees.

COVID

“I couldn’t even go to hospital and take services when I had fever as I didn’t have much money to afford and hire CNG or other vehicles. It was suggested to eat healthy foods, fruits, hot water and other stuffs which we couldn’t even think of, let alone do these.”

**First-time pregnant woman**



**HMW** make sure that available financial support/discount reaches the most needy?

**HMW** leverage the financial argument for postponing pregnancy and start the conversation about family planning early?

**HMW** connect first-time parents to financial or other support services?

**HMW** create an affordable financial model for group-based services?

11

## Compassion and connection is needed more than ever between providers and the community.

*"It was a matter of concern and fear to allow them coming; whether they're coming with virus or not, when Apa used to come to our houses."*

**First-time pregnant woman**

*"If there were a system where it would allow us not to go for Thana visits if we show any symptoms, that would be better"*

**Shasthya Kormi**

The pandemic has profoundly affected the ANC/PNC service experience for both health providers and care-seekers. Families were reluctant to let health workers (especially those with limited PPEs) enter their homes for fear of contracting the virus, which meant that at times community health workers had to counsel women from outside with limited privacy, over the phone, or forgo the service provision altogether.

Several health providers spoke about having to work in an atmosphere of increased fear due to limited IPC protocols, lack of PPEs, and the uncertainty of not knowing whether they would contract the virus and pass it to their own family. There seemed to be differences in the IPC measures adopted between different providers with community health workers particularly affected by the lack of PPEs. Some of them had resolved the issue by refusing to conduct household visits altogether, while others were trying to appeal for risk allowance albeit with limited success.

To address the fear and increase both provider and care seeker confidence in services, there is a need for standardized IPC protocols. However, with heightened safety measures, it is increasingly important to pay attention to a compassionate manner of conduct when interacting with first-time expecting parents(-to-be) to counterbalance any potentially alienating effects of face masks and physical distance. In addition, increased emphasis should be placed on supporting the psychological wellbeing of both first-time parents(-to-be) and health providers to optimise the service experience.

COVID

**“I am not only staking my life but also my family members’ lives because when I come from outside I might bring the virus home.”**

**Shasthya Kormi**

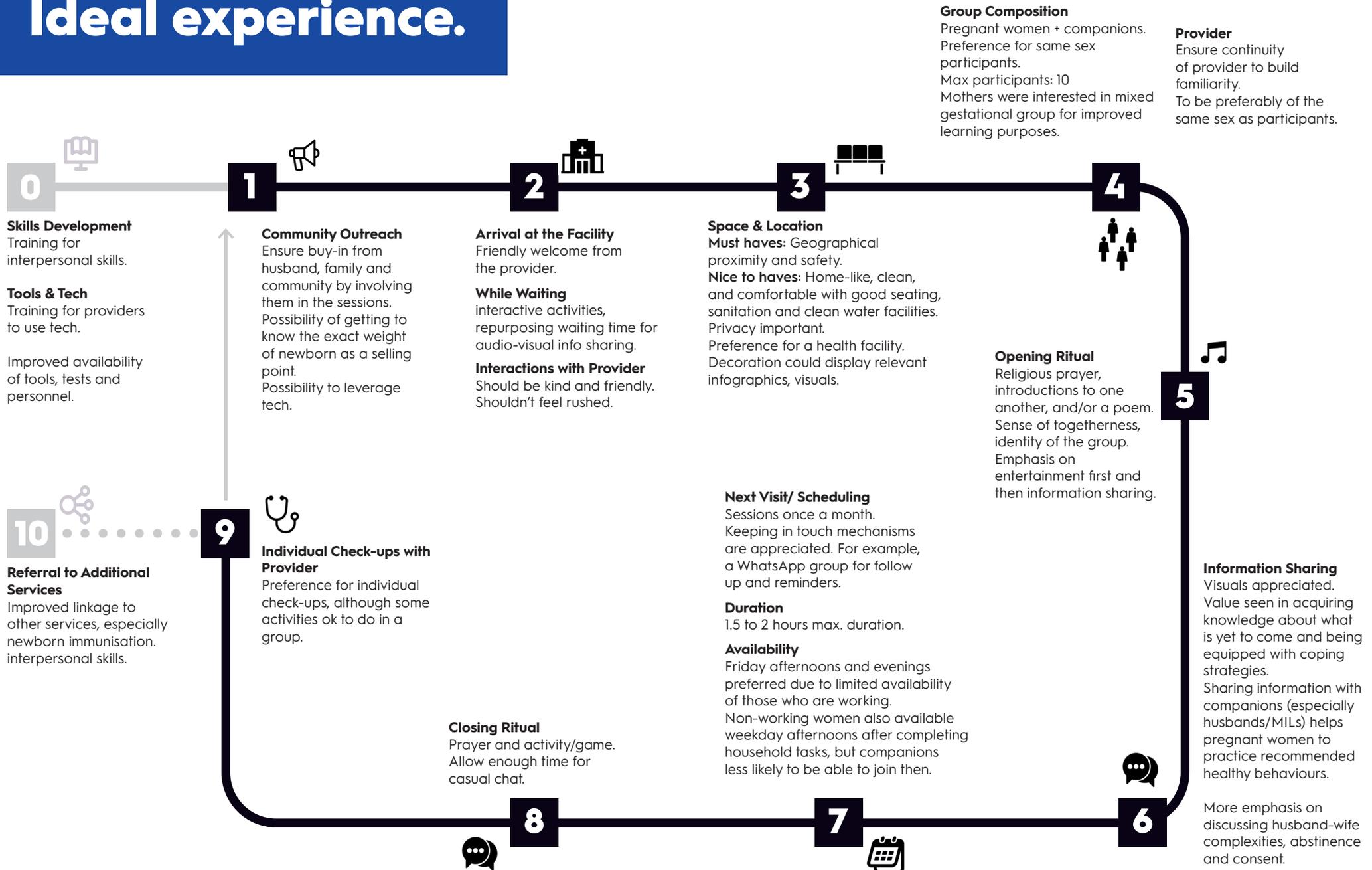


**HMW** maintain close and compassionate interaction between providers and first-time parents(-to-be) during the pandemic?

**HMW** best equip providers to safely conduct and provide services during the pandemic situation?

**HMW** best support the emotional wellbeing of both first-time parents(-to-be) and health providers in a general atmosphere of increased fear?

# Ideal experience.





**IDEAL EXPERIENCE**

**“Everyone may not get a topic when Madam discusses it in a group discussion, but it would be easier when everyone will talk about it with each other. Thereby, they can understand things well and also, we can provide them services properly. But when we provide service one to one, we can’t know much and one can’t know about others.”**

**Shastya Kormi**

# Snapshots of HMWs

Across all of these insight areas we have identified key opportunities with which to respond to the needs, challenges and difficulties. We have used 'How Might We...' questions to positively reframe the challenges into actionable opportunity statements. Rather than being solutions or ideas themselves, they open the solution space to multiple possibilities which we can explore, test, and iterate. Here is a summary of the main HMW questions from the previous insight areas:

## PARENTHOOD

**HMW** better support first-time parents-to-be in their emotional journey, including negative emotions?

## BUILDING CONNECTIONS

**HMW** build trust between health providers and women even before pregnancy?

**HMW** enhance counselling and interpersonal skills, building on positive tactics?

**HMW** form a community within the ever-changing urban space?

## BRINGING MEN INTO THE JOURNEY

**HMW** create a space for men to learn and share their experiences?

**HMW** facilitate communication between couples on pregnancy and parenthood?

## OTHER FAMILY MEMBERS MATTER TOO

**HMW** simultaneously acknowledge MILs' status and promote adoption of evidence-based practices?

## COMMUNICATION

**HMW** foster conversations about sexual well-being and consensual sex?

**HMW** leverage trusted channels to communicate the new model of care?

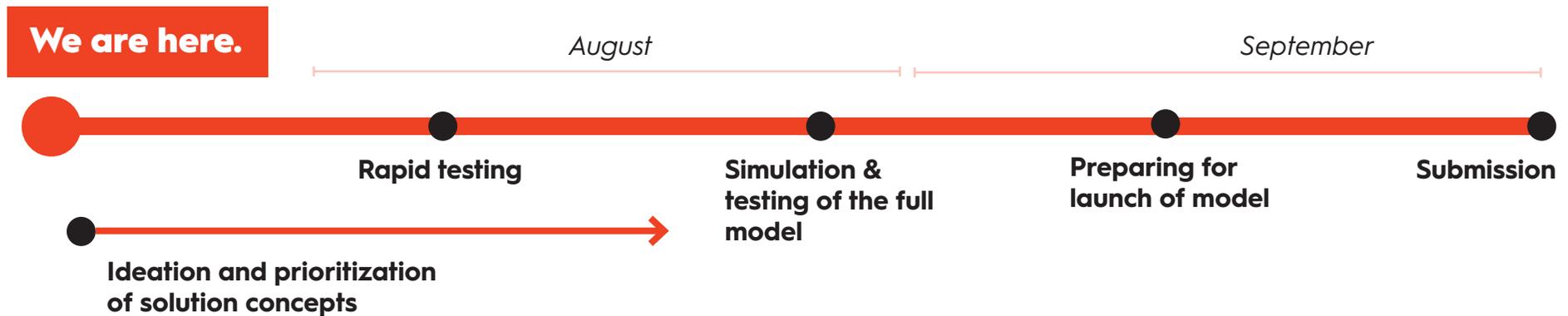
## COVID

**HMW** create an affordable financial model for group-based services?

**HMW** foster compassionate and safe interactions between providers and parents?

# Next Steps

Based on these findings we will engage in early concepting and co-creation with a variety of stakeholders, including at least young first-time parents and CHWs. Through repeated rapid prototyping and iteration cycles we will gather feedback to better tailor the solution(s) to respond to the users needs and realities.



In addition to the above insights and HMWs, we also see gaps in the research which can be covered during the **co-creation phase**:

- Explore further the role of other family members and companions, including sisters, sisters-in-law, mothers, neighbors, and colleagues as supporters during the pregnancy journey and specifically during group sessions.
- Probe the topic of birth spacing and family planning and how to approach it during the pregnancy journey and during group sessions.
- Explore the specific challenges of working women beyond availability and timing of the sessions.
- Extend the scope of the service journey beyond the perinatal period to include potential interventions during the pre-marriage and/or pre-pregnancy period.

# Annex.

The following info-boxes present the findings related to the handful of topic areas identified in need of further exploration. These findings are a combination of data stemming from research conducted during the Discover and Co-create phases.



**INFO-BOX 1****Working First-time Pregnant Women**

*"I told them that I'm feeling sick (...) My vision is fuzzy and my head spinning. I'm unable to work. As they did not allow me two days leave, I left the job."*

**Recent first-time mother**

In general, working first-time pregnant women tend to have considerable challenges in combining demands of work life with those of being pregnant. As a result, some of the women missed out on essential health information and services. Paid employment not only limited their availability for ANC, but pregnancy related symptoms also increased the likelihood of having to quit their job due to limited support received from the employers who tended not to pay for sick leaves or outright disapproved women taking time off from work to recover. At times working pregnant women also faced pressure from other family members to quit their jobs because of being pregnant.

On the whole, Fridays were cited as the most convenient times for ANC checkups, and for some working women these were the only time they could make it to the facility since they were off work then. However, even then women seemed to be in a hurry, perhaps given their household responsibilities, expressing interest for the group sessions to be concise with minimized waiting time.

To accommodate the busy working schedules of working pregnant women, some of the Shasthya Kormis opted for conducting home visits outside of their normal working hours. The community health workers also pointed out that working first-time pregnant women in their first trimester were challenging to recruit for our group-based ANC mock sessions due to their competing work priorities. There were also indications that some of these women only become aware of their pregnancy later, further hindering timely uptake of ANC.

From the Shasthya Kormis we also learned that working schedules of first-time parents at times interfere with immunization schedules of their infants, increasing the likelihood of the baby missing out on important vaccines. There were also indications that for some first-time pregnant women, the ANC visits offered a unique opportunity to be able to interact with their peers as in their work and neighborhood women tended to be older.

The findings speak to the importance of carefully determining the correct timing and duration of the group sessions so that they are compatible with the busy working schedules of first-time pregnant women. There is also a need to think through how to best support Shasthya Kormis in getting first-time pregnant working women to take up ANC already in the first trimester once the group sessions are launched. At the same time the group format will offer an important opportunity to connect first-time pregnant women with their peers for improved social support.



ANNEX

**“After fieldwork and returning home,  
I remain available to respond to  
pregnant mother for the sake of  
humanity and love. Whenever needed,  
I visit the pregnant mother”**

**Shasthya Kormi**

**INFO-BOX 2****Postnatal Care Experiences  
of First-time Mothers**

*“Why don’t you give baby’s vaccines here? It would be more helpful.”*

**First-time pregnant woman**

When it came to the number of PNC visits done, there was considerable variation among the recent first-time mothers interviewed with some having made just a single visit whereas others had been to the facility five times. The factor increasing the number of PNC visits and their perceived value tended to be ill health of the baby.

It became apparent that there is still room for improving the awareness about the available PNC services and their purpose in the community as some of the recent mothers had thought postnatal care to be only for newborns, thus being completely unaware of its importance for maternal health. Moreover, not being aware of existing services was also cited as one of the key reasons why some women in the Tongi area were not taking any PNC, in addition to poverty, lack of transport and unavailability of companion to escort them. Furthermore, mothers-in-law were at times also described as barriers to uptake as they failed to see the importance of the services for their daughter-in-law. In general, recent first-time mothers appeared to have the permission to leave the house post-delivery if required to go for a health check-up, however, for some young mothers, socio-cultural practices around perceptions of purity hindered them from following the recommended PNC schedule as they were not allowed to interact with people outside of their household for some time after delivery.

That there is a need for increasing the uptake of PNC services became evident from the brief interactions we had during the mock session: some of the mothers were not following the recommended breastfeeding advice in relation to feeding frequency and duration, and there were notable gaps when it came to maternal and newborn nutrition. Moreover, some of the women felt left alone with the newborn and perceived there to be limited support available from other family members, which increased their anxiety about the infant’s health. There were also indications that information retention in connection to individualized PNC sessions was far from optimal with some of the recent first-time mothers being able to recall messages only about breastfeeding and iron tablets.

The wish that was expressed by several recent first-time mothers had to do with adding immunization to services offered at BMC. Women complained about having to go to multiple places to get their child immunized which at times was very time-consuming given the long waits at public facilities. Moreover, there were indications that gaps existed in the referral practices for immunization services as some of the recent mothers were not aware how to access these services and hence had not gotten their baby immunized.

The findings speak for intensifying community sensitization efforts around PNC that clarify the services available and their purpose not only to pregnant women but also to their family members. There is a clear need for improving knowledge and practices especially around breastfeeding and maternal nutrition, as well as increasing the support recent mothers get when it comes to looking after the newborn. In addition, there is a need to improve the existing referral system for immunization services to minimize the risk of infants being left out of life saving vaccines.

ANNEX

**“After the session I realized that PNC is not just for the baby but also for me.”**

**Recent first-time mother**



## INFO-BOX 3 Family Planning

*“Family planning is forbidden before first baby.”*

**First-time pregnant woman**

The findings suggest that there exists a great deal of variation when it comes to couples discussing and/or using family planning before their first pregnancy. Whereas some couples had had such conversations straight after marriage, others had not yet approached the topic nor seemed to have received much information on contraceptives prior to conception. Moreover, there were indications that at times also other family members, notably the mother-in-law, initiated such discussions, expressing the desire for the couple to “complete the family” by having a baby.

When as a couple considering the available options for family planning, personal fit of the method was cited as a factor by some. However, it was evident that misconceptions around hormonal contraception influence at times such decision-making as contraceptive pills were believed by some to lead to infertility if utilized before the first child. Others went as far as stating that family planning was forbidden before the first pregnancy, indicating that cultural norms around parenthood might make it challenging for some couples to adopt contraceptives prior to becoming parents themselves. Additional cited barriers to contraceptive use ranged from side effects to cost and availability of some products. Moreover, there were also indications of inconsistent use of family planning methods, as several women reported getting pregnant although condoms had been in use.

*“We discussed with a gynecologist after our marriage and took family-planning “*

**Recent first-time father**

The need for planning the subsequent pregnancy was in general recognized by both men and women, and at times also by mothers-in-law, especially given the financial hardships brought about by the current pandemic. At times such planning was seen to include consultations with health provider to achieve the desired result, whereas other times left solely for husbands to take care of by means of condoms.

The above findings highlight the need to build awareness of contraceptives and of their appropriate utilisation among newlyweds as well as to correct misconceptions around family planning methods, particularly in relation to perceived effects on fertility, as these can act as barriers to informed decision-making. The data also draws our attention to the importance of involving husbands and other family members in outreach efforts, as these can influence considerably the family planning uptake by young women. Moreover, the desire to postpone the subsequent pregnancy expressed by both women and men alike presents an ample opportunity to facilitate couple communication and improved planning for the next pregnancy.

ANNEX

**“If she takes the pill, she does not feel good and feels like her head is spinning. From some other people I have heard that it gets difficult to get a second child if they use the pill method.”**

**Recent first-time father**



## INFO-BOX 4 Community Outreach

*“Most mothers need to take permission from the in-laws. Many request us to convince their in-laws, mostly mother-in-law, who prohibit them from taking ANC services”*

**Leader of Women’s Group**

When it came to increasing community support for uptake of ANC and PNC services, both community and health system representatives stressed the importance of directing efforts towards husbands and mothers-in-law. Mothers-in-law, although not always living permanently with the young couple, at times moved in with them temporarily during pregnancy and post-delivery or alternatively exercised their influence from a distance. In fact, for first-time pregnant women, mother-in-law was perceived to be more influential in terms of pregnancy advice than their own mother, at times dictating the appropriate place of delivery from a far, or in case of extended families, restricting the interaction between the daughter-in-law and people outside of the household.

Regarding the messaging used by Shasthya Kormis for convincing community members of the importance of regular ANC, several of the health workers seemed to be improvising on the spot rather than following any standardized script. Describing pregnancy as a period of heightened need for care and improved nutrition as well as making the link clear between pregnancy and the health of the future grandchild were some of the ways in which Shasthya Kormis tailored the messaging for mothers-in-law specifically. For the pregnant women themselves, the community

health workers promoted the services by explaining how the various tests would enable the young mothers-to-be to get to know important things about their pregnancy not visible to the naked eye such as hemoglobin or blood pressure as well as by highlighting the iron and calcium tablets the women would be receiving. The cost of services was an additional selling point when compared against other service providers.

Several community representatives also highlighted the importance of ensuring visual representation of family members in posters used for ANC/PNC outreach as achieving healthy pregnancy was understood to require the support of husbands and mothers-in-law alike. Spaces attracting a lot of people such as schools, mosques, and busy roads, were seen as best places to display the posters within the community. Moreover, given the considerable illiteracy levels especially among the elder generations, face-to-face communication was perceived to be particularly important in disseminating health messages. In addition, utilizing leaders of women’s support groups was noted as an effective strategy for increasing early uptake of services as they were seen to play an important role as trusted mediators between the health facility and the community – not only by contributing to the promotion of appropriate pregnancy care and institutional delivery but also by offering information on available financial support and helping to access it as well as at times accompanying pregnant women to the facility.

The above findings highlight the need for targeted messaging directed not only towards first-time pregnant women but also towards their family members, especially mothers-in-law, to facilitate timely uptake of services and to aid in the creation of an enabling environment for the practice of positive health behaviours during pregnancy and post birth. At the same time there is an opportunity to standardize the outreach messages utilized by community health workers to improve effectiveness of messaging across the different cadres.



ANNEX

**“I tell them that they don’t know how much blood they have in their bodies. So, we can help her understand that by measuring it. The same goes for diabetes, blood pressure, urine infection and bilirubin.(...) They cannot know these by themselves. So, they need to take the service..”**

**Shasthya Kormi**



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