USAID's Community Nutrition & Health Activity

Report on

Consultation Meetings with Stakeholders, Households & Community People to Understand Information Sources, Media Access and Habits of CNHA Primary Target Groups to Inform CNHA SBC Strategy

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Submitted to

Visual Communication Ltd.
Level 3, House 4, Road 24
Block K Banani, Dhaka-1213

Submitted by

Dot Consulting
House 12, Road 14, Block C, Section 6, Mirpur, Dhaka 1216

Table of contents

Abbreviations

ANC	Antenatal Care
AHI	Assistant Health Inspector
CARE	Cooperative for Assistance and Relief Everywhere
CC	Community Clinic
CG	Community Group
CHCP	Community Health Care Provider
CNHA	Community Nutrition and Health Activity
CSG	Community Support Group
DNCC	District Nutrition Coordination Committee
FE	Field Enumerator
FGD	Focus Group Discussion
FP	Family Planning
FPI	Family Planning Inspector
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
HI	Health Inspector
IDI	In-depth Interview
KII	Key Informants Interview
MCH	Maternal and Child Health
NGO	Non-Governmental Organization
NNC	National Nutrition Council
ORS	Oral rehydration solution
DNCC	District Nutrition Coordination Committee
GoB	The Government of Bangladesh
P&LW	Pregnant and Lactating Women
PNC	Postnatal Care
SBC	Social and Behavior Change
UDCC	Union Development Coordination Committee
UH&FWC	Union Health and Family Welfare Centers
UH&FPO	Upazila Health and Family Planning Officer
UNCC	Upazila Nutrition Coordination Committee
UNO	Upazila Nirbahi Officer
UFPO	Upazila Family Planning Officer
VISCOM	Visual Communication Ltd.
ZOI	Zone of Influence

Executive summary

Background and objective: The USAID's Community Nutrition and Health Activity (CNHA) is a 5-year (2023-2028) project that aims to improve the nutritional status of women and children within the first 1,000 days of life, from pregnancy to the child's second birthday, among the most vulnerable communities in Bangladesh. The project is implemented in 50 Upazilas across 14 districts in four geographical regions: Haor, Coastal and Northwest (Char), and Padma Basin, which are part of USAID's Zone of Influence (ZOI) regions in Bangladesh. It is managed by CARE-Bangladesh in collaboration with Jhpiego, mPower, icddr,b, and Visual Communication Ltd. (VISCOM).

The CNHA collaborates with existing Government of Bangladesh (GoB) health structures, including Community Clinics (CCs) and Union Health and Family Welfare Centers (UH&FWCs), to enhance service delivery at the lowest tier of the public health system. The project employs the Core Team model to improve service quality and efficiency while implementing a robust Social and Behavior Change (SBC) strategy to catalyze demand for services and foster the adoption of family planning (FP), maternal and child nutrition, and healthy practices among its target population of around 4 million direct and 10 million indirect participants. The purpose of the stakeholder consultations by DOT is to better understand the information sources, media access, and habits of CNHA's primary target groups to inform CNHA's SBC strategy.

Methodology: The consultation was conducted through a hybrid approach, combining individual-level consultation (IDI and KII) and group consultation (FGD) to get information on media access, information sources, and media habits of the target audiences from February 12, 2024, to February 29, 2024. We have conducted 90 group consultations with pregnant and lactating mothers, adolescents, and mothers-in-law and 180 individual-level consultations with different stakeholders including husband, mother-in-law, and community-level health service providers; CHCP, HA, FWA, and FWV from 28 unions of CNHA implementing 14 districts of Bangladesh. Quantitative data were collected on household communication assets; information sources related to FP, nutrition, mother and child health and hygiene practices; trustable media, and media habits from the project beneficiaries earlier through individual and group consultation; and experience and opinion related to the barrier and challenges of getting information explored qualitatively. A stratified random sampling approach was used to select one Upazila from each district considering the poverty situation. SPSS was used for quantitative data analysis whereas qualitative data were organized using MS Excel and analysed manually.

Key findings:

Respondent's SES:

- The majority of household heads belong to primary level (class I-V) followed by secondary level (Class VI-X) education. However, one-fifth of the household heads do not have formal education, especially in the Haor (32.7%) followed by Padma Basin (22.0%).
- Most of the pregnant and lactating women (4 out of 5) had some sort of formal education (Primary: Class I-V, and Secondary: Class VI-X equivalent), though more than half of the mother-in-law did not have formal education.

Nutrition and health service-related information sources:

- Every 4 out of 5 pregnant and lactating mothers and their husbands were exposed to family planning, maternal and child health, nutrition, breastfeeding and child rearing related

information. The information receiving status was relatively lower among mother-in-law (around 3 out of 4) and very low among adolescent girls (around 1 out of 4) for all services. Across the study cluster, a higher percentage of the respondents from Padma Basin received information on the above-mentioned services compared to other regions, and the lowest percentage was identified in Char areas.

- The most common sources of information were community-level health service providers; CHCP and FWA, private clinics/ doctors followed by friends and family members.
- Participants identified community-level health facilities especially CC, satellite clinic as their information hub, and got information mostly from CHCP, FWA and materials displayed inside the health facility.
- However, some of the information related to CNHA target behavior was unavailable or merely available among pregnant and lactating mothers of reproductive age (18-49 years) i.e. healthy spacing for pregnancy, 4 times PNC (when to and what purpose), and importance of children age-specific food supplement, frequency of food intake for pregnant women, as well as children under 2 years, zinc supplement of children after diarrhea.
- The study participants who received information regarding above services, less than half of them from Padma Basin and Haor zone mentioned the information is sufficient for meeting their health and nutrition needs whereas around three-fifths of the Char and Coastal region mentioned the information as sufficient.

Consultation with medicine shopkeepers, pharmacies, and village doctors is common practice for addressing general health problems like fever, cough, stomach pain, colds, diarrhea, and acidity across all areas. People only go to hospitals for severe and critical diseases or health problems, such as severe illness in children (e.g., diarrhea with vomiting) and injuries.**Trustable sources of information for nutrition and health services:**

- Across various service components, CHCPs, FWAs/FWVs, friends and family, private clinics or doctors, and NGO workers were identified as the most trusted sources.. The highest percentage of the participants mentioned CHCP for 4 service components followed by friends and family for hygiene service (menstrual and personal hygiene).
- The weighted value of the two most trusted sources shows that respondents had different trusted sources across groups and services. However, three sources were commonly identified: friends and family members were ranked 1st by 4 out of 5 groups, with the CHCP ranked 1st by the husband group. Community health workers, particularly CHCPs, were commonly mentioned as the 2nd most trusted source, while FWAs were ranked as the 3rd most trusted source.It was also observed that almost none of the respondents mentioned new media like social media platforms- Facebook and mobile SMS as the most trustworthy sources of information.

Information receiving channel and preferred channel:

- People of the project implementing areas are mostly getting information from two channels: the most traditional way - friends and family, and through community health care providers - FWA and CHCP.
- The most preferred channel for receiving information is the courtyard meeting. Many pregnant and lactating mothers across all zones described this method as effective, particularly those with limited access to other media and poor communication with health facilities.The second important channel mentioned by the respondents was community

health workers especially FWA who visited the community on a regular basis, and CHCP where people visit for common health problems.

- Consultative meeting participants also highlighted community-focused, entertainment-based channels, such as folk songs, street dramas, and game shows, as effective for engaging and involving community members, particularly children and mothers.Information dissemination through other community institutions like mosques is also preferred by many of the informants from where emergency health information or national priority message is broadcast. Some respondents were also interested in getting information through mobile phone, health programs on television, and NGO workers.

Media access and media habits:

- Though around one-third of the households had their own Television, a lower percentage (10.6%) of households had cable connection with their television and none of them had a radio. However, almost all households had mobile phones, 4 out of 5 had basic phone and 3 out of 5 had smartphones and 1 out 3 had an internet connection with their mobile phone. The ownership of TV (39.0%) and smart phone (79.9%) was found to be higher in Padma basin compared to other regions.
- A large portion of pregnant and lactating women were not exposed to mass media as well as social media. The majority of the pregnant and lactating women spent their leisure period gossiping with neighbors and playing with children and those who had mobile phones spent time watching Bangla Natok, serials (Indian Bangla), videos, etc.
- Around one fourth of the pregnant women and lactating mother had been exposed to Television (TV). It was also observed that very few (less than 5%) of the study participants were exposed to radio and newspapers during the mentioned period (January 2024).

Social media access and habits:

- Half of the respondents had access to social media, with usage rates higher among males compared to females. However, less than two-thirds of social media users did not have their own account and primarily used family members' account.
- Exposure to Facebook was highest among husbands (55.4%), followed by pregnant women (26.4%), adolescent girls (23.8%), and lactating mothers (21.3%).Adolescent girls had the highest exposure to YouTube and TikTok, followed by husbands and lactating mothers. Very few of the mothers-in-law were exposed to social media.
- In general, pregnant and lactating women who owned smartphones spent 2 - 3 hours daily on social media and it was less than one (1:00) hour who didn't own smartphone.
- Many of the lactating mothers mentioned checking Facebook and YouTube at least 3 to 4 times a day, with and 8:00 – 9:00 pm being the most preferred time time as phones are more available to women during that time.

Materials used in counselling and its effectiveness:

- The most common counselling practice involves verbal communication and providing information and instructions to service receivers during door-to-door visits and at community clinics.. In addition, many of them used visual aids such as flipcharts, leaflets, flash cards, poster, banner and demonstration tools like plate, bowl, measurement tape, depending on the counselling topics such as nutrition, antenetal care, and breastfeeding.

- All the service providers, including CHCPs, FWAs, HAs, AHIs, and FPIs mentioned that pictorial information sheets (messages with picture) were the most effective tool for capturing the attention of the service seekers and making information easily understandable..

- Many CHCPs found demonstration plates and bowls very effective for mothers to help them visualize and understand quantity of food needed to provide to children between the age of 6 to 23 months.

Barriers and Challenges to obtaining accurate and appropriate information:

Many of the respondents mentioned that they had no problems getting the information related to health services, they had easy access to CC and obtained information from CHCP. However, not all the information is harmonized across all age segments, especially young adolescent mothers (18-24 years) and mothers aged 25-49 years. Many of the problems hindering them from obtaining appropriate and accurate information were also addressed by the participants.

- Firstly; many of them had no formal literacy and didn't know about their information needs, creating barriers to accessing nutrition and health-related information and messages.
- Secondly, there was a lack of information flow to the community from the service facility. People mostly received information when they visited the health facility with health problems.
- Thirdly, the health service-seeking behavior of the participants was discussed. Very few community members visited health facilities for children's growth check-ups until they became sick. Nutrition was a less important and less prioritized issue in the community, resulting in inadequate information on children's nutritional requirements and care by age segment.
- Fourth, poor communication and transportation were noted. Many participants from Haor and Coastal zones visited CC less due to the location of the facility, road communication, and inadequate transportation. Transportation costs were also a significant issue preventing visits to CC or health facilities which further worsened during the rainy season.
- Fifth, there was a lack of awareness and movement restrictions for pregnant women during pregnancy hindering their ability to visit health facilities.
- Sixth, some of the women were not interested in accepting new information, preferring to trust information available in the community, traditional knowledge and advice from elders regardingpregnancy care, mother and child feeding, food taboos and health-seeking behaviors.
- Seventh, respondents had limited access to and exposure to mass media such as TV, newspapers and radio.
- Eighth,although half of the households had smartphones, females had less access because smartphones were mostly held by male members. Additionally, many households did not use internet packages for the entire month.
- Ninth, there was a misconception about male engagement in family planning services. Since m field workers were female and targeted females for FP services, many males believed FP methods were exclusively for females, leading to reduced interest in FP methods. Additionally, female health workers felt uncomfortable providing FP counselling to eligible male groups.
- Tenth, there were inadequate supporting materials, insufficient time, and a lack of proactiveness among service providers regarding information dissemination. In general, the

pick time was 10 AM to 12 PM when patients came toCC for medicine. Managing patient flow made it difficult to provide appropriate counselling services within the time frame.

Recommendations:

- Recognize the diverse literacy levels and information needs across different demographic groups and geographical context. Develop age-appropriate communication materials and methods through a participatory approach, suited to each group's literacy level, ensuring that messages are relevant and easily understandable.
- Increase community awareness and promote the importance of regular health check-ups, particularly for children's growth monitoring and maternal health during pregnancy. Implement community mobilization activities to encourage proactive health-seeking behavior and emphasize the significance of nutrition in overall well-being.
- Diversify information dissemination channels beyond traditional methods to reach a wider audience. Explore the use of community-focused entertainment-based channels, such as folk songs, street dramas, game shows, multimedia projection, etc., to engage the community, particularly children and mothers. Incorporate health messages into these entertainment activities to make them more impactful. Additionally, leverage mobile phones, television programs, and NGO workers to expand the reach of health messages.
- Collaborate with community institutions like mosques to broadcast emergency health information and national priority messages. Utilize existing community networks for effective dissemination of information.
- Capitalize on trust in community-level health workers, friends, and family members by empowering them to disseminate accurate health and nutrition related information. Provide training and resources to these trusted sources, i.e., CHCP, FWA to ensure they are equipped with accurate and up-to-date information and effectively communicate key messages on family planning, maternal and child health, and nutrition.
- Targeted behavior-specific communication materials could be developed that community healthcare workers and other local-level platforms can use to inform, make aware and mobilize community people. Encourage regular community visits and door-to-door communication to reach those who may not have easy access to health facilities.
- Stocktaking of existing message and martials and continue using visual aids and demonstration equipment during counseling sessions, as they have proven to be effective in conveying messages, especially for nutrition-related topics. Ensure these materials are culturally appropriate and easily understandable.
- Promote internet access and digital literacy to empower individuals, especially women, to use smartphones for accessing health information.
- Strengthen counseling sessions by incorporating visual aids such as flip charts, leaflets, posters, and demonstration equipment to improve understanding and retention of key messages. Emphasize the use of pictorial information sheets and practical demonstrations to effectively convey complex health concepts, especially related to nutrition and child care.

1.0 Introduction

1.1 Community Nutrition and Health Activity (CNHA) Project Background

As part of supporting Bangladesh in becoming self-reliant, USAID's Community Nutrition and Health Activity (CNHA) project will address the inequitable nutrition and other health outcomes of the most vulnerable segments of the population through a targeted community-health system-strengthening approach. A consortium of five organizations is implementing this project, where Cooperative for Assistance and Relief Everywhere (CARE) leads as the prime recipient of the CNHA project with sub-awardees Jhpiego, mPower, ICDDR, B, and Visual Communication Ltd. (VISCOM).

The USAID's CNHA project aims to improve women's and children's nutritional status within the first 1,000 days of life, from pregnancy to the child's second birthday. The interventions will strive to achieve its goal by contributing to the following results:

Result 1: Strengthened community health system to deliver nutrition, family planning, and health services.
Result 2: Improved household nutrition and health behaviors.
Result 3: Enhanced leadership and governance for improved nutrition.
Result 4: The resilience of communities and households to potential nutrition shocks increased.

1.2 Project Intervention Area

CNHA closely aligns with the Government of Bangladesh's (GoB) efforts to improve the nutrition of the most vulnerable segments of the population. CNHA has selected 14 target districts from the Haor, Coastal, Northwest (Char), and USAID's Zone of Influence (ZOI) regions of Bangladesh. The districts were chosen through a thorough evaluation of various factors, including 16 indicators related to health, nutrition, gender, and WASH, as well as socio-economic data on poverty, gender-based violence (GBV), child marriage, presence of marginalized or hard-to-reach populations, and vulnerability to climate change. These 14 districts are divided into four clusters: Padma Basin (ZOI/USAID), Char, Haor, and Coastal covering 50 Upazilas (sub-districts) and 443 Unions.

1.3 Project Approach and Target Audiences

CHNA plans to work with existing Government of Bangladesh health structures to sustainably improve service delivery at the lowest tier of the public health system of Bangladesh. The project defines the GoB community health systems as Community Clinics (CCs), Union Health and Family Welfare Centers (UH&FWCs), and satellite/outreach services as public. CCs are well distributed in all rural areas of the country and offer comprehensive nutritional, primary health care, FP, and health education services from a single center.

CNHA program approaches include addressing the quality, effectiveness, and efficiency of community health systems using the Core Team model to improve the supply and quality of services. Secondly; using an effective Social and Behavior Change (SBC) strategy to increase demand for services and adoption of optimal health, nutrition, and family planning practices. It is expected that a positive behavior change will happen among the direct (around 4 million) and indirect participants (about 10 million) of the CNHA project area's different audience segments. CNHA's target groups are as follows:

Table 1.1 CNHA's target groups

Priority groups	Stakeholders
Primary target groups • Pregnant and lactating women (PLW) 15-49 years and adolescent girls • Children under two years **Secondary target groups** • Household members, caregivers, in-laws, and male spouses of households with children under two or PLW (1000-day households) • Newly married couples, and • Children between two and five years	• Core Team members (District and Upazila) • Frontline Health and Family Planning Workers and Supervisors (CHCP, HI, FWA, HA, FPI, FWV) • Community group (CG) • Community support group (CSG) • Union Development Coordination Committee (UDCC) • Upazila and District Nutrition Coordination Committee (UNCC, DNCC) • Civil society organizations or the private sector • Other government-level stakeholders: District Civil Surgeon, DD Family Planning, District Nutrition Officer, UNO, UH&FPO, UFPO

1.4 Purpose of the Consultative Meeting

The USAID's CNHA aims to increase the adoption of critical, priority nutrition, FP, sanitation hygiene, and other health behaviors through targeted and tailored innovative SBC activities that reach households and communities. An SBC strategy is essential for a tailored SBC including target audience-specific intervention design, identify appropriate channel of communication, implementation, and monitoring of SBC activities. As a partner, VISCOM is responsible for co-creating the SBC strategy with CARE. VISCOM leads the design of communications activities, while CARE leads the implementation of community-level interpersonal communications across the project. Consultation with key stakeholders at the Upazila and Union levels is an important approach to developing a comprehensive SBC strategy. VISCOM appointed DOT Consultancy to conduct the consultation session with different stakeholders of the CNHA project. The purpose of the stakeholder consultations by DOT is to understand information sources, media access, and habits of CNHA's primary target groups in a better way to inform CNHA's SBC strategy.

1.5 Objectives of the Consultative Meeting

The overall objective of the consultation is to understand information sources, media access and habits of CNHA's primary target groups to inform CNHA SBC strategy. The outcomes of the consultation will be used for designing the SBC strategy, more likely to be relevant to a substantial portion of the target population.

2.0 Methodology

2.1 Consultative Meeting Approach

The consultation was conducted through a hybrid approach combining individual and group consultations for getting information on media access, information sources, and media habits of the target audiences. During individual consultation, quantitative information on socio-demography, communication resources, existing sources, and preferred sources was collected whereas group consultation explored their understanding regarding current service, cause of selection of service facility, causes of not using community health service facility, reasons for choosing particular channel and media as information sources for FP, MCH, mother, and child nutrition and hygiene practice. We have conducted 90 group consultations with Pregnant and lactating mothers, adolescents, and mothers-in-law and 180 individual-level consultations with different stakeholders including husband, mother-in-law, and community-level health service providers.

2.2 Selection of Study Areas

The consultation meeting covered all 14 districts of 4 Zone of CNHA. A stratified random sampling approach was used to select one Upazila from each district considering the poverty situation. As poverty is one of the considerable issues, half of the Upazilas were taken from high-poverty Upazilas, which were ranked by the Poverty Map of Bangladesh -2016[1]. In the third stage, we selected two unions from each Upazila, totalling 28 unions. For the selection of these unions, we discussed with the local implementing partner of CNHA to select a union in each Upazila that is hard to reach and one that is more general. In the selection of Unions, we also considered the population size (at least one-third of the Unions having more than 25000 population) as well as hard-to-reach areas (1 from each Upazila).

Table 2.2. Distribution of study Unions by Upazila and District

[1]

Zone	District	Upazila	Union	Population	Poverty Level
Padma Basin (ZOI)	Shariatpur	Bhedarganj	South Tara bunia	16,934	Moderate
			Char Census	18,132	
	Madaripur	Shibchar	Kanthalbari	19,612	Very Low
			Char Janajat	17,234	
	Faridpur	Nagarkanda	Charjoshordi	30898	Very Low
			Ramnagar	25000	
Char	Kurigram	Nageshwari	Narayanpur	27,437	Very High
			Nunkhawa	14,260	
	Joypurhat	Akkelpur	Rukindipur	26,117	Moderate
			Sonamukhi	16,266	
	Gaibandha	Sundarganj	Dhabondo	26210	Very High
			Belka	38900	
	Rangpur	Kawnia	Haragach	23401	Very High
			Balapara	45292	
Haor	Kishoreganj	Mithamain	Khatkhal	15,139	Very High
			Bairati	11,955	
	Sunamganj	Derai	Charnarchar		Very High
			Karimpur	26,255	
	Netrokona	Durgapur	Gaonkandia	16,638	Very High
			Durgapur	23,618	
	Habiganj	Ajmiriganj	Shibpasha	33474	Moderate
			Jolshukha	16061	
Coastal	Patuakhali	Dashmina	Chorborhan	12,560	Very High
			Alipura	19,842	
	Barguna	Amtali	Atharogachia	23,444	High
			Chawra	20,802	
	Bhola	Manpura	Manpura	18,267	High
			Sakuchia South	17,386	

2.3 Selection of Meeting Participants

The slection was made considering the consultation objectives which included CNHA primary target groups i.e pregnant and lactating mothers, husbands who are direct beneficiaries of the primary health care services; and mothers-in-law who create an enabling environment or barrier for FP, MNCH, nutrition, and hygiene services received at household level. We also included community-level health care service providers; CHCP, HA, FWA, and FWV for individual consultation in the form of Key Informants Interviews (KII) to understand the supply side availability of communication resources, existing information sources, use of existing information for delivery of FP, MCH, Nutrition service, etc., effective material and channel as well as required channel, message, and materials for effective communication.

Table 2.3: Selection criteria for CNHA target groups

Group	Inclusion of participants	Remarks
Pregnant and lactating women	Must respond **yes** to all of the questions below • Are you Currently pregnant or lactating Or Do you have a child under the age of two years? • Are you between the ages of 15-49 years? • Do you live in the CNHA target unions?	Split into groups based on **younger group** (15-24) and **older group** (25-49) for consultation
Mothers-in-law of Pregnant and Lactating Women and/or Children under two (living in the same household)	Must respond **yes** to all the questions below: • Do you have a daughter-in-law living with you between the ages of 15-49 years who is currently pregnant or lactating? **Or** • Do you live with a daughter-in-law between the ages of 15-49 years who has at least one child under the age of two years? • Do you live in the CNHA target unions?	
For Husbands of Pregnant and Lactating Women and/or Children under two (living in same household)	Must respond yes to ONE of the questions below: • Do you live with your spouse between the ages of 15-49 years who is currently pregnant or lactating? Or • Do you live with your spouse between the ages of 15-49 years who has at least one child under the age of two years? • Do you live in the CNHA target unions?	If the husband is a migrant and not living at home for more than 8 months of the year, please note.
Unmarried Adolescent Girls 15-19 years of age	Must respond **yes** to all of the questions below: • Are you female and between the ages of 15-19? • Are you currently unmarried? • Are you live in the CNHA target unions?	

2.3.1 Steps for Selection of Group Consultation

In consultation with the local implementing partners of the CNHA, DOT consultancy trained staff to recruit eligible participants based on the inclusion criteria from each union. This was done two days before the consultation. The CNHA cluster teams helped facilitate access for DOT's teams to liaise with CHCPs, HAs, and FWAs to identify beneficiaries who align with the CNHA's target groups. For rich discussion, we kept the group size to about 10 participants. Following the 10-10 rule helps with planning and quality: no more than 10 questions and no more than 10 participants. During group formation for each consultation, we purposively included 2-3 persons out of the 8-10 participants from the lowest wealth quintile. For the KIIs with government-level participants, the team can purposively interview at least one female representative per cluster.Steps followed for group consultation and IDI participants recruitment:

- One Field Enumerator (FE) recruited from the Community (selected Unions) to conduct an eligibility survey [residence status, 'Yes' and age between 15-49y or and pregnant or having one or more children].
- FE collected the information of pregnant and lactating women following the inclusion criteria [Initially list might be collected from FWAs]

- After getting oral consent from the interviewee, the FEs uploaded the list of eligible participants to the respective field supervisor and uploaded it to the OneDrive folder.
- From the DOT office, follow-up communication was made to ensure their participation at the venue.
- During the day of consultation, the Moderator further checked their eligibility criteria and asked them to participate.

2.4 Distribution of Sample

Further, the distribution of consultations was done based on the population of the selected unions. We have allocated 2 consultations per primary target group for the unions that have more than 25,000 population and one consultation for the unions with less than 25,000 population. We have selected 19 unions with a population of less than 25,000 and 9 unions that have more than 25,000. This is how we arrived at the number of 37 (14*1+9*2) consultations (Annex 2: Distribution of the participants):

Table 4: Consultation Breakdown

	Category	Group Consultations	Individual level Consultation		Comments
			IDIs	KIIs	
Household Level	Pregnant and Lactating Women (15-24) younger	37			Consider targeting 1 group consultation with younger PLW women (15-24) in unions with <25,000 population and 2 consultations in unions >25,000
	Pregnant and Lactating Women (25-49) older	37			Consider targeting 1 group consultation with older PLW women (25-49) in unions with <25,000 population and 2 consultations in unions >2,000
	Mothers-in-law		32		02 group consultations from each zone and 02 IDIs from the rest 16 Unions
	Husbands	8	32		02 Consultation meetings from each zone, 02 IDIs from the rest 16 unions
	Unmarried Adolescent Girls (15-19)	8	32		02 Consultation meetings from each zone and 02 IDIs from the rest 16 unions
Health Provider Level	CHCP (consider at least one female provider per cluster)			28	Each Union 1; considered representing all unions
	HI/FPI/FWA/HA/FWV			56	Each Union 2. (Consider at least 1 female provider per cluster)
Total		**90**	**96**	**84**	**270**

2.5 Methods and Tools Used for Consultations

Considering the consultation objectives; to better understand information sources, media access and habits of CNHA's primary target groups to inform CNHA's SBC strategy, DOT in consultation with VISCOM and CARE, developed group consultation, IDI, and KII guidelines and shared it with all consortium partner of CNHA for feedback. The tools were pretested and finalized after several meetings with CARE and VISCOM, and translated into Bangla for final use (Annex-1). The data collection was split into two parts: quantitative (short interviews 5-10 minutes for each participant) and qualitative (group discussion or in-depth interview). For FGD participants, half of the quantitative data were collected before group discussion, and the rest half of the interviews after the completion of FGDs using KoboToolbox. A total of 748 interviews were performed for quantitative data collection.

2.6 Consultation Team and Field Implementation

We deployed seven (07) teams consisting of three members in each team (01 field Supervisor, 01 Moderator, and 01 Notetaker) and each team was responsible for conducting two districts. Besides, we locally deployed 01 Field Enumerator from each union for the recruitment of the participants. The team was led by an SBC expert supported by DOT consultancy. As part of field preparation, 04-day long training was organized for field teams that discussed study tools, and interview techniques through a participatory approach i.e question answer, mock interview, field testing, etc. During the training session project management team members including DCoP, Equity Advisor, SBC Technical lead from CARE, and SBC Advisor and SBC specialist from VISCOM were present and provided feedback. The consultation was conducted from February 12, 2024 to February 29, 2024

2.7 Data Quality Control, Data Management and Analysis

The consultative meeting discussion was recorded with the permission of the participants. Besides, verbal and written consents waretaken from each participant during their recruitment and before group consultation or interview . For the management of quantitative data, the dashboard was monitored regularly, and the data was downloaded regularly. To survey participants, they were rechecked with the eligibility survey ID# to ensure accuracy. To ensure data consistency, a unique file name was used for audio recording. Field notes,transcription and code sheet were developed with definitions and examples from the transcripts to ensure multi-coder reliability. Quantitative analysis was performed by study zone and participant category whereas thematic analysis was performed for quantitative data. The meaning units from Bangla transcripts were organized thematically in MS spread sheet and coded manually. Finally, the finding was presented followed by a mixed method approach.

3.0 Socio-demographic Profile of the Participants

The study participants were mostly female, i.e., pregnant and lactating (P&L) women, and mothers-in-law of P&L women. Table 3.1a shows that the mean age of the pregnant and lactating women was 24 and 25 years, most of them (4 out of 5) had a formal education; belonged to secondary (Class VI-X) and Primary (Class I-V) grades and had own mobile. However, more than half of the mothers-in-law had no formal education and one-third had no mobile phone.

Table 3.1a: Age, sex, education, and mobile phone use status by participant types

SES	Category	Participant by groups				
		Pregnant women (n=178)	Lactating mother (n=357)	Husband (n=56)	Mother-in-Law (n=94)	Adolescent girls (n=63)
Age	Mean (Years)	24	25	32	53	16
Sex	Female	100.0	100.0		100.0	7.5
	Male	-	-	100.0	-	92.5
Education level	Primary Level (1-V)	30.3)	32.5	35.7	33.0	6.3
	Secondary (VI-X)	51.7	47.9	33.9	10.6	77.8
	Higher Secondary (11-12)	11.2	7.6	10.7	0.0	14.3
	Graduate and above	2.8	4.8	10.7	0.0	0.0
	Religious (no grade)	0.0	0.3	0.0	1.1	0.0
	No Formal Literacy	3.9	7	8.9	55.3	1.6
Mobile phone use	No/Don't share	13.5	15.4	1.8	29.8	38.1
	Had personal phone	86.5	84.6	98.2	70.2	61.9

Table 3.1b illustrates that most of the household heads were male ranging from 91% to 96% across the zone and on average 6.1% of households were found to be female-headed, the highest 9.1% in Padma Basin. It was also observed that the majority of household heads belong to primary level (class I-V) followed by secondary level (Class VI-X) education. However, a remarkable number of the respondents do not have formal education, especially in the Hoar (32.7%) followed by Padma Basin (22.0%). Agriculture is reported as the main income source by the respondents across all regions (except Padma Basin) followed by day labor and small business. In the Coastal zone, fish capturing or firming was reported as the 3rd highest (12.8%) source of income.

Two-thirds of the study participants mentioned having children (<=2 years) in their households. Furthermore, only one out of ten pregnant mothers reported having under 2 children in the house which indicates that the majority of the pregnant women were primiparous women or had at least 2 years of birth interval from the previous birth.

Table 3.1b: Socio- demographic information of study households by cluster/Zone

SES	Category	Name of Zone				Overall
		Padma Basin(n=164)	Char (n=246)	Haor (n=205)	Coastal (n=133)	
HH head's Sex	Male	90.9	95.1	92.2	95.5	6.6
	Female	9.1	4.9	7.8	4.5	93.4
Highest education of HH head	Primary Level (1-V)	44.5	29.3	35.6	58.6	39.6
	Secondary (VI-X)	23.8	35.8	26.8	14.3	26.9
	Higher secondary (11-12)	6.7	10.6	1.5	3.0	5.9
	Graduate and above	3	6.9	2.9	13.5	6.1
	Religious (no grade)	0	0.0	0.5	0.0	0.1
	No Formal Literacy	22.0	17.5	32.7	9.8	21.4
House Hold main income sources	Agriculture/Farming	22.0	40.7	31.2	36.1	33.2
	Fisherman/ fish farming	1.8	0.0	1.5	12.8	3.0
	Laborer/Day laborer	25.0	17.9	22.9	13.5	20.1
	Rickshaw/van/ boatman/ cart puller	3.0	2.8	2.4	32.3	2.7
	Bus/truck/car/CNG driver	6.1	1.6	42	5.3	3.3
	Government/non-government Job	12.8	13.0	3.9	12.0	10.3
	Small/medium business	16.5	12.6	26.3	9.8	16.7
	Large business	1.8	0.4	1.0	0.0	0.8
	Teaching	0.0	0.0	0.0	2.3	0.4
	Remittance	8.5	3.7	2.9	4.5	4.7
	Others	2.4	7.3	5.9	1.5	4.8
Household having children	No children	39.0	34.1	25.4	42.1	34.2
	Have children <=2	61.0	65.9	74.6	57.9	65.8

4.0 Findings

4.1 Household Communication Asset and Resources

In regards to ownership of Television (TV), there was a difference across the regions which was higher in the Padma Basin (39.0%) and Char region compared to the Haor (25.4%) and Coastal zone (17.3%). Less than 10% of the households had cable connection with their TV in three areas, except the Padma basin. Almost none of the households have a Radio in their house. The data also indicates that almost a similar number of households across the region had basic phones (feature phones) ranging from 79.9% to 86.5%. However, more than half of the households had smartphones and it was higher in the Padma Basin (79.9%) compared to others. Similar trends were found for mobile data (internet) use across the regions.

Table 4.1: Availability status of the communication equipment at the house by study zone

Communication equipment available at the House	Name of Zone				Overall
	Padma Basin (n=164)	Char (n=246)	Haor (n=205)	Coastal (n=133)	
TV	39.0	37.0	25.4	17.3	30.7
Cable	19.5	6.9	9.8	7.5	10.6
Radio	0.0	1.2	0.0	0.0	0.4
Computer	4.9	0.4	1.0	2.3	1.9
Internet	14.0	4.5	19.3	3.8	7.8
Internet-mobile	44.5	33.7	32.2	31.6	35.3
Basic phone	81.1	85.4	82.0	86.5	83.7
Smartphone	79.9	47.6	55.1	54.1	57.9

4.2: Exposure to FP, MCH, Nutrition and Hygiene

Table 4.2a shows that most of the pregnant women (around 85%), lactating mothers (around 80%) and husbands (around 80%) received information related to family planning, nutrition, maternal and child health, breastfeeding and child rearing and caring. The information receiving status was relatively lower among adolescent girls for all services except hygiene services (menstrual, personal hygiene).

Table 4.2a: Information receiving status on different service components by respondent groups

Service component	Types of respondents				
	Pregnant women (n=178)	Lactating mother (n=357)	Husband (n=56)	Mother-in-Law (n=94)	Adolescent girls (n=63)
Family Planning	85.4	80.4	80.4	73.4	22.2
Nutrition	84.8	80.1	83.9	70.2	38.1
Maternal and child health services: ANC, PNC, NNC etc. treatment	86.0	81.0	78.6	72.3	27.0
Breastfeeding and child-rearing and caring	86.5	82.1	80.4	74.5	30.2
Hygiene service (Menstrual, personal hygiene)	86.5	76.8	58.9	69.1	68.3

Considering the project cluster, a higher percentage of the respondents from Padma Basin getting information on the above-mentioned services compared to other regions. **Table 4.1b** shows that the highest information receiving status regarding family planning was found in Coastal (84.2%) and lowest in Char (69.1%) whereas nutrition, maternal and child health services, breastfeeding and hygiene service (Menstrual, personal hygiene) related information was found highest (88.4%, 87.2%, 92.1% and 92.1%) in Padma Basin and lowest in Char (71.5%) Haor (70.2%, 69.8%) and coastal (69.9%) respectively).

Table 4.2b: Information receiving status on different service components by study zone

Service component	Zone			
	Padma Basin(n=164)	Char (n=246)	Haor (n=205)	Coastal (n=133)
Family Planning	82.9	69.1	72.7	84.2
Nutrition	88.4	71.5	71.7	79.7
Maternal and child health services: ANC, PNC, NNC etc. treatment	87.2	72.0	70.2	80.5
Breastfeeding and child rearing and caring	92.1	72.4	69.8	82.0
Hygiene service (Menstrual, personal hygiene)	92.1	72.8	71.2	69.9

4.3 Sources of Information/way of Getting Information

The study participants were getting information mainly from 4 sources across all service components which were CHCP, FWA/FWV, friends and family and private clinics or doctors. The highest percentage of the participants mentioned CHCP name as the main source of information for 4 service components whereas friends and family were mentioned for hygiene services (menstrual and personal hygiene). Table 4.1c also indicates FWA/FWV, who works in the primary health care setting, especially in the community as an important source of information to many of the participants.

Table 4.1c: Sources of information of various service components

Sources	Service component				
	Family Planning (n=567)	Nutrition (n=574)	Maternal and child health services (n=571)	Breastfeeding and child rearing and caring (n=581)	Hygiene service (Menstrual, personal hygiene)
CHCP	32.6	34.3	28.7	31.8	19.9
FWA/FWV	31.2	20.4	23.6	26.0	21.1
Friends and Family	15.7	11.8	10.9	20.8	40.8
Private clinic/Doctor	3.7	13.8	18.2	5.7	3.3
Health Assistant	4.9	6.6	6.1	6.7	3.7
NGO workers	4.8	6.1	7.5	5.0	6.5
Medicine shop	0.7	0.3	0.2	-	0.2
Group meeting	1.1	0.9	1.1	0.3	0.4
TV	0.4	0.2	-	0.2	0.7
Facebook	0.5	0.7	-	-	0.4
Others	4.4	1.0	3.7	3.4	3.2

However, most of the adolescent girls mentioned school books and family members, especially thier mothers as a source for health and hygiene-related information. It was also observed that a remarkable percentage of respondents mentioned private clinics/doctors as an information source for nutrition and maternal and child health services. A large number of lactating mothers mentionedthat while visiting doctors or their clinics they received information about children's nutrition, especially the feeding of the children as well as

mothers' diet during pregnancy and child illness. According to a first-time mother from Kishoreganj:

> *"I several times visited MBBS doctor from early pregnancy and followed their advice – avoid heavy work, eat additional meals, take rest, drink adequate water, take iron supplements, etc., and have regular check-ups for the whole period. By the blessing of the almighty Allah, I born a baby boy safely".* FGD-PL-18-24-K1- P#1.

However, NGO health workers in the community are also important sources of maternal and child health-related information who link them to the health service points at the Upazila level. One FGD participant from Gaibandha describes the situation as:

> *"SKS (local NGO) health workers made door to door visit for checking the health condition of pregnant women in our area. They made physical examinations and advice for the iron supplement, as well as information related to mothers' nutritional needs, the importance of additional meals for pregnant women, preparation for institutional delivery and needs of regular check-up during pregnancy period".* FGD-PL-18-24-G1- P#4.

Very few mentioned internet and social media as sources of family planning related information though some of the participants use this platform for getting general health tips, care during pregnancy and for children. One FGD participant from young mother groups (18-24 years) of Madaripur district said:

> *"I use an Android phone and follow some doctor's page on social media. I also regularly scroll down the health tips-related YouTube videos and follow their advice. Get a lot of information regarding the importance of cleanliness, and child health care guidance for treatment".*

To describe the source of family planning-related information, many of the respondents across the zone mentioned CC, UH&FWC and satellite clinics as their information hubs from where health workers provide different method related information such as providing temporary methods like pills and condoms. FWA was the most common source who are contracted by women of reproductive age either at the facility or satellite center or in the community, even through mobile phone communication. Some of the lactating mothers also mentioned community clinic from where they are collecting pills. According to an FGD participant from Patuakhali:

> *"I collect pills from FWA (family planning Apa) mostly from the satellite clinic or from home during her visit. I have the phone number of FWA Apa and called her over the phone for the pill"* FGD-PL-25-49-P1- P#4

The following institutions and persons were identified from the qualitative from where participants, especially pregnant and lactating women got health-related information and services including FP, MNCH, nutrition and hygiene:

Table 4.1c: Matrix of information source

Service facility/Institutional settings	Family members and neighbors
○ Community Clinic (CC) ○ Union Family & Welfare Center (UH&FWC)	○ Neighbor *Vabi*, aunt, ○ Peers- Friends (sister-in-law called *Jaa, nanod etc.)*

○ Materials [Poster, chart, calendar] inside the CC ○ Center [EPI center] ○ Flowcharts in UHC, wall writings at CC and UH&FWC ○ Signboard of CC ○ Bill board inside the health facility (UH&FWC, UHC) ○ NGO clinic and School	○ Family members [mother, elder sister] ○ Elder person from the family (grandmother, mothers-in-law) ○ Knowledgeable persons in the village ○ Relatives works in the health sector/ pharmacy business
Govt. health service providers	**NGO/ private service providers**
○ Family Welfare Assistant (FWA) ○ Community Health care provider (CHCP) ○ Family Welfare Visitors (FWV) ○ SACMO in UH&FWC ○ Doctor in Upazila Health Complex (UHC)	○ Gynecological Doctor at a private clinic ○ Village doctor's ○ Homeopathy Doctors ○ NGO clinic ○ Courtyard meeting organized by NGO ○ Training from NGOs (BRAC, Shushilan, SKS, Care Bangladesh etc.) ○ Private clinic ○ Pharmacy/Medicine shop ○ Adolescent (Kishore Kishore) club
Mass media and print media	**New media and social media**
○ TV/ TV news ○ FM radio ○ Different newspaper sources ○ Books/ school books	○ YouTube ○ Facebook/ Facebook news ○ Internet browsing ○ Mobile

The group consultations also had similar information to individual experiences where community-level health facilities specially CC, satellite clinic were identified as their information hub, got information mostly from CHCP, FWA and materials displayed inside the health facility.

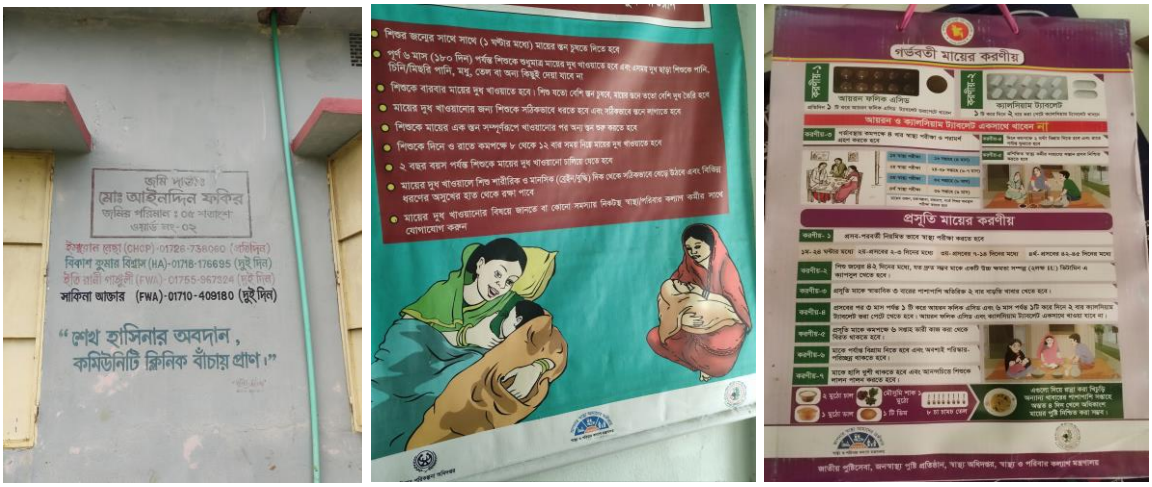

Photo: Different information and materials available in community clinic

Table 4.1d: Matrix on service specific sources of information

Family planning	Mother and child health
○ Union Health and Family Welfare Center (UH&FWC) ○ FWA ○ FWV ○ Community Clinic (CC) ○ Satellite clinic Center ○ Blue Star Pharmacy ○ Family member (Husband, in laws) ○ Neighbor Vabi, sister-in-law ○ Peers- Friends ○ NGO health workers ○ TV advertisement ○ Booklet, poster, and banner inside the FP corners at UHC and UH&FWC	ANC, Delivery and PNC service: • Private doctor • Community clinic • Health workers (FWA, CHCP) • Center [EPI center] • Union Health and Family Welfare Center (UH&FWC) • Mobile/TV • NGO health workers • Materials- poster, chart, Roman Banner displayed in health facility (CC and UH&FWC) Neonatal and Child Health: • Family member (Mother and Mother- in- law, husband) • TBA or Skilled birth Attendant • CHCP • FWA, FWV • Materials- poster, chart, Roman Banner displayed in health facility (CC and UH&FWC) • Center [EPI center] • Advise of village doctor’
Mother and children’s nutrition	**Hygiene**
○ Doctor ○ Community Clinic (CC) ○ Materials- poster, chart, roman Banner displayed in health facility (CC and UH&FWC) ○ Wall painting inside the CC ○ Health workers who visit the house (FWA) ○ CHCP ○ NGO health workers ○ Union Health and Family Welfare Center (UH&FWC) ○ YouTube ○ watching nutrition related program on TV ○ Miking (vaccination and Vitamin-A day)	○ NGOs Workers (Courtyard meeting/Community meeting) ○ Training from NGOs, BRAC, Shushilan, Care Bangladesh ○ Private clinic ○ YouTube ○ Textbooks ○ Peers-school friends ○ School and teachers ○ Poster inside Community Clinic, UH&FWC

4.4 Types of Information Received

Pregnant and lactating women across all regions had partial scenarios of community clinic services, which provide some medicine for fever, diarrhea, acidity, and physical check-up of

pregnant women. Considering CNHA targeted behavior and service, good portion of pregnant and lactating mother had information on pregnancy care, specially the information of visit during pregnancy for physical check-up; i.e., weight and blood pressure measurement, provide oral iron supplement and advise for additional meal and take rest, importance of eating nutritious foods- egg, local fruits and vegetables as well as care of children; must provide first breast milk (*shal milk*), exclusive breast feeding, vaccination, during illness, specially diarrhea- provide ORS several times, along with breast milk, provide extra food (complementary) after 6 months of age, and moderate level information on 4 times ANC, danger sign of pregnancy, visit doctors for any danger signs, Feeding during diarrhea: provide liquid foods to children adequately during diarrhea, poorly informed regarding avoid intercourse in first few months and last 2 months of pregnancy, must visit health facility at 3, 5 and 7 months for check-up, postnatal check-up, need to provide nutritious food for lactating mother, frequency feeding of children (6 times daily).

Most of the unmarried adolescent girls and young mothers (18-24 years) got menstrual hygiene management-related information from textbooks. Overall all participants described it as private and an issue of shyness. Many of them were informed about sanitary napkins use from TV advertisements, some of them had no affordability, and some of them had the ability but less access to sanitary napkin (pads). The problem is explained as:

> "*We have less access to sanitary napkin (pad), can't buy it from shop individually-as girls because most the medicine shop keepers are male*" FGD-AG-BA1.
>
> "*not available in grocery shop within or nearby villages"* FGD-PL-25-49-HA2.
>
> *"husband doesn't want to spend money"* FGD-PL-25-49-KI2

The available information is categorized by service types (Table 4.4a) based on the information mentioned by respondents.

Table 4.4a: List of information received by the participants

Maternal and child health (MCH)	**Mother and child nutrition**
ANC, Delivery and PNC service: ○ Pregnant women should go to the hospital (CC/UH&FWC/UHC) for regular check-up and act according to the doctor's advice. ○ Have to take iron tablets regularly basis to avoid anemia ○ Iron tablet is free and available in CC and UH&FWC ○ Physical check-up is free at the CC level ○ Take adequate, food and rest during pregnancy ○ Avoid sex with husband in the first few months (second trimesters of pregnancy) ○ Must visit health facility in 3, 5 and 7 months for check- ups ○ Avoid heavy work, especially after 6 months of pregnancy ○ Other family members should take care of pregnant women	○ Importance of giving nutritious food for mother & child. ○ Don't provide any food within 6 months age of the baby ○ Along with breast milk, children should be given extra food after 6 months. ○ Baby can eat soft food like milk, semolina, soft rice, boiled eggs, fruit juice after 6 months

Maternal and child health (MCH)	Mother and child nutrition
○ Drink adequate water, and eat local fruits and vegetables . ○ Importance of eating iron enrich foods like, spinach, green banana, tomato etc. ○ Mother should eat nutritious food like fish, egg, fruits, and vegetables to stay healthy for health outcome (baby) ○ Importance of eating nutritious food during pregnancy and lactating period ○ Provide the number of FWA for emergency call ○ Information about the importance of institutional delivery and the risk of home delivery ○ When must go to the hospital (Danger sign during pregnancy). ○ Maintain advice of the doctor. Child Health: ○ Must provide first breast (sal milk) ○ Exclusive breastfeeding: Must be fed the baby only breast milk birth at six months of age. ○ Vaccination: vaccinate all doses from CC or vaccine center, BCG vaccination should be given after birth ○ Taking her/him to the doctor without delay if he/she is sick ○ Feeding during diarrhea: provide liquid foods to children adequately during diarrhea ○ Diarrhea treatment and zinc supplement: If baby suffers from diarrhea, must provide ORS after every time of defecation ○ Go to a physician if symptoms of pneumonia or severe stage of diarrhea	○ Have to prepare and provide hotchpotch (*khichri*) after 6 months. ○ Have to increase food quantity with the growth of child. ○ Provide food to baby at least 6 times daily after 6 months ○ During the lactating period, mothers should be given nutritious food, meat, milk, egg, fish, and vegetables because if the mother is healthy, the baby will get sufficient breast milk ○ Provide nutritious food like eggs, hotchpotch, noodles etc. to the children.
Family planning (FP)	**Hygiene**
○ Different family planning methods ○ Advise for long-term method use- injection ○ Benefits of using long-term methods ○ Importance of completion of the full course of pill ○ Source of pills and other methods ○ Side effects of using long term methods ○ Information about no more than two children ○ For advance support ask to visit FWC or UHC ○ Health risk for un expected or unplanned pregnancy ○ Healthy spacing (2 years gap) between two babies	○ Always wash hands before preparing baby foods and serving the foods to babies ○ Wash your hands with soap before eating and after toilet use and clean the stools of children ○ Clean clothes should be used for menstrual hygiene management ○ Importance of using sanitary napkin

Note: Good (majority from each group), moderate (some from each group), poor (some groups or very few from each group).

However, some of the information related to CNHA target behavior was not available or merely available among pregnant and lactating mothers of reproductive age (18-49 years). Healthy spacing for pregnancy, 4 times PNC (when to and what purpose), and importance of children age specific food supplement, frequency of food intake for pregnant women as well as children age under 2 years, zinc supplement of children after diarrhea.

4.5 Perception on the Adequacy of Information Received from Different Sources

Table 4.5 shows the availability and appropriateness of FP, maternal and child health, nutrition and hygiene-related information based on exposure to messages and individual experiences. The study participants who received information regarding above services, less than half of them from Padma Basin and Haor zone mentioned the information is sufficient for meeting their health and nutrition needs whereas around three-fifths of the Char and Coastal region mentioned the information as sufficient. The table also shows that the lowest percentage of the respondents (36% and 37%) in the Padma basin found the nutrition and maternal and child health service (ANC, PNC, NNC etc.) related information sufficient for them followed by Char; 44.2% and 44.4% respectively. The findings indicate the need for adequate and appropriate information to participants across all regions, especially the Padma Basin and Haor regions.

Table 4.5: Sufficiency of received information on different service components by study zone

Service component	Zone			
	Padma Basin	Char	Haor	Coastal
Family Planning	51.5	63.5	44.3	60.7
Nutrition	35.9	58.5	44.2	59.4
Maternal and child health services: ANC, PNC, NNC etc. treatment	37.1	59.3	44.4	57.9
Breastfeeding and child rearing and caring	46.4	62.4	44.8	64.2
Hygiene service (Menstrual, personal hygiene)	49.0	62.6	48.6	58.1

* Sample size varies; based on 'Yes' response of service status

4.6 Service Seeking Health Facility

The choice of health facility is contextual, depending on transportation facility, distance of the facility, availability of health care providers, etc., and especially the health problem for whom service is needed. Many of the participants of Haor and coastal zones less visited CC due to the location of the village and transportation challenges. Some of the participants especially in the Kurigram, Netrokona, Bhola, Patuakhali, Kishoreganj identified short duration opening of the facility and unavailability of health workers in CC as cause for seeking service to other places. Consultation with the medicine shop keepers, pharmacy, and village doctors is common practice for taking service for general health problems like fever and cough, stomach pain, cold, diarrhea, and gastrological problems across all areas and people go to hospitals for severe and critical disease or health problems, severe illness of children, i.e., diarrhea with vomiting, injury case etc. However, some respondents from all districts also

mentioned community clinics (CC) for treatment of general diseases i.e., fever, diarrhea, itching, check-ups and iron supplement during pregnancy and most of the respondent mentioned UH&FWC, CC and Satellite clinic for getting family planning services. On the other hand, Health workers (FWA) visit houses and provide different information related to family planning methods, pregnancy care, and immunization. Almost none of the participants remember about visiting CC for seeking nutrition counselling and services.

Table 4.6: Availability of service in health facility by service types

Service	CC	UH& FWC	Satellite /EPI center	UHC	Private Chamber /Clinic	Village Doctor	Pharmacy
FP							
Short method	√√	√√	√√	√	-	-	√
Long methods		√	-	√	-		-
Counseling for methods selection	√	√√	√√	√	-	-	√
MCH							
ANC	√√	√	-	-	-	-	-
Normal delivery	-	√	-	√	√	-	-
Delivery- Caesarian case	-	-	-	√			
Exclusive BF counselling	√	√	√	√	√	-	-
PNC	-	√	-	√	√	-	-
Nutrition							
Counselling for P&L mother	√	√√	√√	√	-	-	-
Counselling for child nutrition	√	√	√	√	-		
Growth Monitoring	√	-					
Counselling for supplementary food children	√√	√	√	√√	-	-	-
Hygiene	√√	√√	√√	√√	-	-	√

4.7 Trusted Sources for Service and Reason for Trusting

The study participants identified 5 sources across all service components which were CHCP, FWA/FWV, friends and family, private clinic or doctors, and NGO workers as first (1st) ranked trustable sources. The highest percentage of the participants mentioned CHCP name for 4 service components (see table 4.7a) followed by friends and family for hygiene service (menstrual and personal hygiene). A significant percentage of pregnant and lactating mothers mentioned FWA/FWV whereas private doctors by husband, friend, and family by mother-in-law and CHCP and NGO workers by adolescent girls. It was also observed that almost none of the respondents mentioned social media platforms like Facebook and mobile SMS as the most trustworthy sources of information.

Table 4.7a: Most trusted (1st) source of information by inclusion characteristics

1st trusted source	Inclusion characteristics				
	Pregnant women (n=178)	Lactating mother (n=357)	Husband (n=56)	Mother-in-Law (n=94)	Adolescent girls (n=63)
CHCP	38.8	25.5	25.0	31.9	22.2
FWA/FWV	23.0	24.1	17.9	12.8	7.9
Friends and Family	12.4	16.0	10.7	20.2	41.3
Private clinic/Doctor	15.7	15.4	19.6	12.8	1.6
Health Assistant	2.8	7.3	8.9	7.4	1.6
NGO workers	3.4	5.9	5.4	5.3	17.5
Medicine shop	0.0	0.8	0.0	0.0	0.0
Mobile SMS	0.0	0.3	0.0	0.0	0.0
TV	0.0	0.0	5.4	1.1	0.0
Facebook	0.0	0.0	1.8	0.0	0.0
Group meeting	0.0	1.1	3.6	7.4	7.9
Others	3.9	3.6	1.8	1.1	0.0

As the 2nd most trustable source of information, the highest percentage of the participants mentioned Friends and Family by all groups followed by CHCP and FWA/FWV. It was also observed that almost none of the respondents mentioned social media platform like Facebook and mobile SMS or Voice messages (recorded call) as the 2nd most trustable sources of information (Table 4.7b).

Table 4.7b: Trusted source (2nd) of information by inclusion characteristics

2nd trusted source	Inclusion characteristics				
	Pregnant women (n=178)	Lactating mother (n=357)	Husband (n=56)	Mother-in-Law (n=94)	Adolescent girls (n=63)
CHCP	20.8	16.0	25.0	16.0	22.2
FWA/FWV	19.1	11.5	12.5	19.1	0.0
Health Assistant	3.9	8.1	1.8	9.6	3.2
NGO workers	3.9	6.4	7.1	9.6	23.8
Private clinic/Doctor	7.9	10.9	12.5	11.7	6.3
Medicine shop	1.1	1.1	1.8	0.0	0.0
Friends and Family	34.3	35.9	26.8	30.9	25.4
Mobile SMS	0.0	0.0	1.8	0.0	0.0
Voice call	0.6	0.0	0.0	0.0	0.0
TV	0.0	0.6	0.0	2.1	0.0
Facebook	2.2	0.3	3.6	0.0	0.0
News paper	0.0	0.0	0.0	0.0	1.6
Group meeting	4.2	6.2	3.6	1.1	6.3
Others	3.9	3.1	3.6	0.0	11.1

The weighted value of the two most trusted sources indicates different group of respondents had different trustable sources but three are more common, among them friends and family members ranked as 1st by 4 groups out of 5 and the rest one CHCP by husband group whereas community health workers, especially CHCP was commonly mentioned as the 2nd most and FWA as the 3rd most trustable source.

Table 4.7c: Trusted source (overall) of information by inclusion characteristics

Trusted sources weighted	Inclusion characteristics				
	Pregnant women (n=178)	Lactating mother (n=357)	Husband (n=56)	Mother-in-Law (n=94)	Adolescent girls (n=63)
CHCP	29.8	20.7	25.0	23.9	22.2
FWA/FWV	21.1	17.8	15.2	16.0	4.0
Health Assistant	3.4	7.7	5.4	8.5	2.4
NGO workers	3.7	6.2	6.3	7.4	20.6
Private clinic/Doctor	11.8	13.2	16.1	12.2	4.0
Medicine shop	0.6	1.0	0.9	0	0
Friends and Family	23.3	25.9	18.8	25.5	33.3
Mobile SMS	0	0.1	0.9	0	0
TV	0.3	0.3	2.7	1.6	0
Facebook	0	0.1	2.7	0	0
Group meeting	1.1	3.6	3.6	4.3	7.1
Others	4.2	3.5	3.6	0.5	6.3

In general, community health workers and friends and family including neighbors came to the fourth front as trustable sources among the participants in group discussions and in-depth interviews. Many of the participants described that a trustable relationship has developed between community people especially women of reproductive age, even with mother-in-law and community level health workers especially the FWAs, who visited door to door on a regular frequency for a long period and kept updated pregnant and lactating mothers with FP, child-care, vaccination and other health services. Respondents had multi-dimensional justification for trusting different sources, sometimes it depends on the relationship with health service providers, education and skills of the providers, types of health problems, access to the health service facility, social norms etc. One FGD participants from Joypurhat said:

> *"Family planning apa is most trustable because I had a good relationship with her and she always visits me and our village, provide contraceptive pills and information regarding the care of pregnant woman, child vaccination, etc."*

Most of the pregnant and lactating women mentioned FWA for family planning and pregnancy care related information. The reason behind trusting FWA is her current attachment to the govt. health services. Respondents also believe that she is always updated with contemporary information and services and is closely attached to the community.

Pregnant and lactating women also mentioned that all the information is available from CC. According to an FGD participant:

> *"Health workers (FWA) from community clinics make door to door visit every month, they tell us where to go for pregnancy service, when to go the health facility, what medicine is needed for pregnant women as well as advice for eating vegetables."* FGD-PL-25-49Y-BA1.

However, the majority of the unmarried adolescent girls mentioned family members, mothers and elder sisters, who are the most trustworthy for getting menstrual hygiene management-related information and some of them also mentioned schools, and textbooks. One FGD participant described the issue as:

> *"… because socially, menstrual hygiene is not openly discussed and in the first stage of puberty-we can't share this information with others except close family member specially mom. She passed the stage and has vast experience."* FGD-AG-FA1.

In many group discussion participants, the doctor was identified as most trustable for curative service of children, mother health as well as for nutrition service. One respondent from Gaibandha district describes the reason for trusting doctors:

> *"Doctor is most trustable because s/he advises us considering all pros and cons. They got training and orientation, updated regarding current issue of nutrition and mother child health etc. Almost all mentioned doctors as the most trustable source of information.* FGD-PL-18-24y-GA1.

Another FGD participant from Barguna said:

> *"When consulting with an MBBS doctor, I trust on their expertise, as they possess specialized knowledge and diagnostic skills which is essential for accurate identification of diseases through diagnostic tests"* FGD-PL-25-49y-BA2.

Another FGD participant from Habiganj said:

> *"When seeking advice from a doctor, it is considered reliable. The guidance provided by a doctor is aimed at improving our health. Following such advice typically leads to well-being and ensures adequate nutrition." FGD-PL-25-49y-HA2.*

Another IDI participant (husband) from Faridpur said:

> *"We trust the doctor because we can always consult them. If we encounter a problem, we can seek the doctor's advice and explain our concerns. They can prescribe medication as well as advise to address the issue."* IDI-H-FA-2.

4.8 Barriers and Challenges to Getting Accurate and Appropriate Information

There are lots of information on family planning methods, maternal health, pregnancy care, delivery and infant and lactating mothers care, and child care during diarrhea but all the information is not harmonized to all age segments especially young adolescent mothers (18-24 years) and mothers having age 25-49 years. The barriers mentioned by the respondents were contextualized but had a common instinct, lack of information flow to the community from the service facility. People get most of the information when they visit the health facility

with some health problems. Many of the respondents mentioned they had no problems getting the information, if they ask, government health workers provide the information, even if they get the information from private doctors. The gaps addressed by the respondents are about information dissemination, which is demand driven, not proactively disseminating to make the community aware. The second important issue addressed by the mothers is that very few of the people in their community visit health facilities for growth check-ups of their children until and unless they are sick as a result they are not getting appropriate information on children's nutritional requirements and their care by age segment. But almost all mothers have the information children should provide complementary food from 6 months of the baby. We have listed down some challenges and barriers to getting appropriate information regarding above mentioned health services:

- ✓ Lack of formal education and health literacy. Don't know about their information needs
- ✓ Lack of information flow to the community from the service facility. People were getting most of the information when they visit the health facility with some health problems.
- ✓ Much of the information related to pregnancy is available but not reached to the participants, especially to the first-time pregnant woman.
- ✓ Lack of awareness and movement restriction of pregnant women during the pregnancy period. Even the physical condition does not permit women to visit the health facility.
- ✓ Some of the women were not interested in accepting new information, keep trust in information available in the community, traditional knowledge and advice of elder people related to pregnancy care, mother and child feeding, food taboos and health seeking etc.
- ✓ Influence of mothers -in-law, mothers, and grandmothers.
- ✓ misconception about the engagement of males in family planning service. Most of the field workers are female and targeted female in the community for FP services. It is established to many of the males that FP will take FP methods, so they become less interested in the FP methods.
- ✓ Female health workers don't feel better to provide FP counselling to eligible male groups.
- ✓ Poor communication and transportation. Many of the participants of Haor and Coastal zones less visited CC due to the location of the facility, road communication and lack of adequate transportation.
- ✓ Transportation cost (financial) involvement, is also considerable issue of not to visit CC or health facility. The situation became actuate in the rainy season.
- ✓ Information regarding health service gets less importance and less priority compared to curative services
- ✓ Inadequate visit to the community by Health workers and thus community people keep trust in elder people's advice regarding pregnancy care

- ✓ Less visited to the facilities where several materials are displayed
- ✓ Attitude of the health service providers at health facility specially in the UHC
- ✓ Movement for pregnant women is difficult to seek facility-based services and in many cases, they don't visit the facility
- ✓ Information is available on the internet but many of them had no smartphones
- ✓ Though half of the households had smartphone females had less access because smartphones were mostly hold by male members. On the other hand, many households do not use internet packages for the whole month.
- ✓ There is a clinic, but doctors [CHCP] do not come regularly due to poor roads in Char
- ✓ Lack of proactiveness of the service providers at facility
- ✓ had less access and exposed to mass media like TV, newspaper and Radio and many of them had no access to cable TV connection.

4.9 Media Habit of the Study Participants

Considering study groups around one fourth of the pregnant women and lactating mother had been exposed to Television (TV) though the rate was higher among husbands (39.3%) and adolescent girls (41.3%). It was also observed that very few (less than 5%) of the study participants were exposed to radio and newspapers during the mentioned period (January, 2024). Moreover, the exposure to Facebook was found higher among husband (55.4%) followed by, pregnant women (26.4%), adolescent girls (23.8%) and lactating mother (21.3%) whereas adolescent girls had the highest exposure of YouTube and TikTok followed by husband and lactating mother. A very few of the mothers-in-law were exposed to social media.

Table 4.10: Media exposure of respondents in the last months (before the survey) by inclusion characteristics

Media	Inclusion characteristics					Overall
	Pregnant women (n=178)	Lactating mother (n=357)	Husband (n=56)	Mother-in-law (n=94)	Adolescent girls (n=63)	
TV	27.5	25.2	39.	30.	41.3	28.9
Radio	1.7	1.1	1.8	0.0	1.6	1.2
Newspaper	2.2	0.6	5.4	0.0	3.2	1.5
Facebook	26.4	21.3	55.4	2.1	23.8	22.9
YouTube	36.0	31.4	46.4	4.3	52.4	32.0
TikTok	24.7	27.5	44.6	2.	60.3	27.7

* 'Yes' response of particular media

The findings indicate that a large portion of pregnant and lactating women were not exposed to mass media as well as social media. The qualitative data explain that the majority of the pregnant and lactating women spent their leisure period gossiping with neighbors and playing to children's and those who had mobile phone spent time on them to watch Bangla Natok, serial (Indian Bangla), videos, etc. However, a large portion of participants mentioned they didn't have a leisure period. Some of the FGD participants from each area, especially from

Sunamganj, Kurigram, Netrokona, Kishoreganj, Bhola, Patuakhali and Rangpur district had no access to cable TV and merely watched television channel broadcast through cable network. However, one IDI participant from Sunamganj mentioned about new habit related to television:

> *"I have no cable connection and can't watch the news on TV, we use the memory card to watch Natok (drama) and Cinema on our TV… I loaded videos from the local market."*

The consultative meeting participants also noticed changes in their media habits based on the rainy season in the Haor area and Char and Padma Basin area along with winter and summer. However, respondents from all areas also mentioned their busyness during agricultural production and harvesting which was also responsible for changes in their media habits.

> *"I don't get any leisure time during the paddy harvesting season. Then for 15-20 days, we have to work very hard, if we don't work hard for those 15-20 days then we will not get this peace this whole year."* IDI-ML-JO-2.

In general, Haor people get more time from the May to October period as most of the areas became water-logged and movement became challenges, even land or boat communication with health facilities and growth centers. During this time, both males and females spent more time watching TV, and people who had smartphone increased their tendency to use social media sites like Facebook, YouTube, TikTok etc. Many of the participants mentioned about watching fun videos, short cut videos, Islamic songs, Hadiths and the Quran on their smart phone. According to a husband from Netrokona district:

> *"During the rainy season, we cannot go out, we sit at home and chat with family members, watch dramas on mobile phones."* IDI-HU-NE-3.

Another habit mentioned by respondents was playing games on the smart phone. Many of the male participants mentioned especially Ludo, where 3 to 4 people can play together as well as spend time playing *Pabji*. Whereas, women mentioned watching Natok and drama serials using memory cards. Pregnant and lactating women, even mothers-in-law also spend some time on smart phone, especially for watching Indian drama serials, folk songs, and *waz-mahfil*, and many of them use it as an alternative to the cable TV.

4.10 Social Media Habits

Table 4.11a shows that more than half of the respondents had access to social media though the rate was high among males compared to females.

Table 4.11a: Access to social media by the sex of the respondents

Access to social media	Sex of the respondents	
	Male	Female
Yes	58.9	54.8
No	41.1	45.2

The findings also show that study participants who had access to social media, less than two-thirds did not have their own social media account whereas about two-thirds (ranging from

71.6%- 80.0%) of the participants had other family members who had social media accounts. Table 4.11b shows that ownership of social media accounts varied across the zones; which was highest in the Padma Basin (42.6%) and lowest in Haor (27.9%).

Table 4.11b: Ownership of social media accounts by study zone

Social media account	Zone			
	Padma Basin (n=122)	Char (n=109)	Haor (n=111)	Coastal (n=70)
Self	42.6	34.9	27.9	40.0
Family member	74.6	71.6	77.5	80.0

Among the study participants, who had their own social media accounts or family members, the majority of them had multiple accounts, especially Facebook, messenger and *imo* accounts. Table 4.11c illustrates that Facebook was dominant account both for self and household members across all zones which was found highest in coastal and char areas.

Table 4.11c: Type of social media usage of the respondents by study zone

Social media	Zone			
	Padma Basin (n=52)	Char (n=38)	Haor (n=31)	Coastal (n=28)
Self				
Facebook	78.8	94.7	77.4	96.4
Imo	88.5	81.6	83.9	75.0
WhatsApp	59.6	55.3	45.2	60.7
Viber	3.8	0.0	0.0	7.1
Messenger	69.2	81.6	51.6	82.1
Other	0 .0	50.0	38.7	0.0
Family member	***(n=91)***	***(n=78)***	***(n=86)***	***(n=70)***
Facebook	87.9	91.0	88.4	94.6
Imo	87.9	78.2	69.8	73.2
WhatsApp	41.8	35.9	15.1	46.4
Viber	3.3	0 .0	0.0	3.6
Messenger	69.2	84.6	53.5	76.8
Other	1.1	19.2	31.4	0.0

* Multiple response

Among the social media users, 80% of the respondents regularly use social media across all zones but it was found lower in Haor (64.1%) and Char area (73.6%) areas. There were no differences among male and female for regularly using social media (Annex table 2).

4.10.1 Preferred Content in Social Media

Facebook is most popular social media platform in Bangladesh and it was also used for promotion of other social media like TikTok and YouTube where link was shared to get attention of the viewers. Study participants mentioned a long list of content watched on social media especially on Facebook, YouTube and TikTok. The contents were grouped into three categories, complete entertainment (funny videos- reels, music videos, Natok, drama serials), inter-educative (pictures, advertisements, quizzes, puzzles, cartoons, songs, thematic Natok,

games, etc. news and information (paper news, viral news, TV news), business and online market place (Live on different online page). However, the majority of the participants mentioned watching videos on YouTube which includes Bangla Natok, Indian serials (Bangla), Indian Bangla Cinemas, *Waz-mahfil*, and music videos whereas photo posts, short videos and reels, and news on Facebook and funny videos on TikTok. The list of contents mentioned by respondents were:

- Bangla Natok
- Bangla Natok-Indian mega serial
- Indian Bangla Cinema
- Bangladeshi Cinema
- Music videos
- Cutting of Bangla and Hindi cinema
- Quran, Islamic *waz*, Islamic song
- Short videos
- Reels
- Funny videos
- Bangla comedy drama
- Friends post, picture
- Cooking
- News-Bangladeshi channel
- Ukraine/Gaza war news
- Business-related contents (online marketing)
- Videos and picture on Facebook
- Pages related to health and advice by doctors
- Cartoon
- Comic etc.

In general, pregnant and lactating women spend 2 to 3 hours on smart phones watching social media who have self-smartphone and less than one hour who have smart phones in their house. The group findings also illustrate the flexibility of using smart phone for the women having smartphones, whereas others have access when husbands stay at home and it is mostly at night. The ranges of time mentioned by different groups are 15 minutes to 5 hours depending on household economic status, family members living abroad and the education and age of the participants. Many of the lactating mothers mentioned revisiting Facebook and YouTube at least 3 to 4 times a day. Respondents also mentioned that 8:00 – 9:00 pm is the most preferable time for watching Facebook and YouTube because the phones became available to women at that time. YouTube was the most common social media platform for watching different content. One informant's -Husband from Patuakhali district said:

> *"I don't spend time on Facebook regularly. I listen to the news on Facebook when I go to the market at night… because, I had no ability to purchase an internet package. I got free Wifi connection from the market during that time" IDI-Ha-PA-2.*

4.11 Preferred Information Channels

People are mostly getting information from two channels: the most traditional way - friends and family and secondly through community health care providers - FWA and CHCP. However, some of the people mentioned NGOs health workers who visited the community, organized group sessions, and made interpersonal communications. Some of the respondents also mentioned mobile phone-based communications.

However, mostly mentioned preferred channel of getting information is the courtyard meeting, many pregnant and lactating mothers across all the zones describe this method as effective, especially the people who had less access to other media and poor communication with health facilities. Along with discussion in the meeting they suggest to use of different audio-visual tools in the meeting will be most effective to retain the message for a longer time. The second important channel mentioned by the respondents was community health workers especially FWA who visited the community on a regular basis, and CHCP where people visit for common health problems. FWA had a good relationship with women and even elder people in the community, and as a health worker, she was trustable to them. Information flow from both channels might be effective to information and make aware of the community. Community people also referred to community focus entertainment-based channels, especially folk songs, street dramas, game shows to engage and involve them, especially the children's and mothers. Information dissemination through other community institutions like mosques is preferred by many of the informants from where emergency health information or national priority message like immunization day, the Vitamin-A capsule campaign, etc. can be broadcast. Some of the people also emphasize that miking from mosque is also a source of information. Moreover, some respondents were also interested in getting information through mobile phone, health programs on television, and NGO workers.

Table 4.11a: Views from service receivers and serviced providers regarding effective channel of information for community people

Service Receivers (PL, Husband and Mother in Law)	Health care Providers (CHCP, HA, FWA)
• Courtyard meeting • One-to-one sharing by FWA (IPC) • Involved voluntary cadre for disseminating information • Inter-educative media (game show, street theater in the village) • School level quiz competitions • Use mosque/ religious institutions to sensitize male groups regarding institutional delivery • Folk song for nutrition (live show) • Video show of the nutrition related documentary and materials (Pot song, folk song, jingle, etc.) • Video show	• Courtyard meeting/ group session with community • Group session in the CC with service seekers • Street drama or community level game shows, video shows • Leaflet and poster displayed in the health facility with key message • Display board in the health facility, schools • Use local cable channel for ANC and PNC service promotion and nutrition related information dissemination

• Street drama	• Community meeting with husbands and parents to sensitize them about maternal health care, FP services • Mobile base communication with the community and sharing information through mobile • School based quiz program

4.12 Other platforms for maternal, and child health information

Consultative meeting participants mentioned different NGOs name in different districts who are working in their areas regarding FP, nutrition, maternal health and hygiene issues including PSTC, Saint Bangladesh, BRAC, ESDO, Dhaka Ahasania Mission, Shusilan, SUS, Save the Children, CARE, LAMB, SKS, icddr, b working in their area with a focus on family planning, mother and child health and WASH in their area. But very few mention specific project name and detailed activities. Many of the service providers and community people also mentioned SHOUHARDO, MaMoni, Nabajibon, Suchana project and BRAC nutrition program names that were implemented in their areas. However, for maternal and child health, in few districts' participants mentioned BRAC health services and in one district participants mentioned LAMB and, in another district, SB3 project, and SKS health care services at community level. One community health care provider from Rangpur district said:

"I can't recall, the exact name, but there is a project in our area implemented by SKS, where they used mobile apps to provide information regarding foods and nutrition, even they also provide SMS"

Very of the pregnant and lactating women mentioned the name CG and CSG, but they know there is a committee for a community clinic headed by a ward member. Service providers had different perspectives regarding role of CG and CSG members for connecting people with the community clinic. One CHCP from Habiganj described the involvement of CG and CSG as:

> *"not all members are active and supporting. I found 2-3 women community members very supportive, who always provide the information of pregnant women in their locality and seek advice from me"*

Another CHCP from Durgapur, Netrokona described as CG groups had a positive role for functioning the CC. According to him:

> *"CG helps us to keep the facility (CC) open. For example, our BP machine was not working. Then CG support us to buy new BP machine. This is hilly and flood prone area, our committee support us to cope up with the situation."*

The positive role of CG also mentioned by another CHCP from Sunamganj:

> *This area became under water for above six months. CG supported us to raise the connecting road of CC so that people can come to the CC smoothly" "*

However, negative experiences also shared by many of CHCP regarding CG and CSG, they came to CC to take medicine and create pressure to provide medicine to them. According to a CHCP:

> *"Do not have a trustable relationship. Rather supporting for CC, they always blame us that we get many things from govt. but don't share it with them."* KII-CHCP- Habiganj.

4.13 Providers Perspectives: Availability of Service (message/ information provide) related to Mother and Child Nutrition and Health in CC

Service providers mentioned broadly three types of services in community clinic counselling, physical examination and medication for common diseases as per guidelines of DGHS. The counselling service includes individual-level counselling sessions by FWA and CHCP, group counselling with service seekers to CC by CHCP, and door-to-door visits by FWA. However, at the community level FWA conducts courtyard meetings with mothers and mothers-in-law and focused on two types of behavior (1) Two hours rest- sleep sleeping on the left side after taking a mid-day meal and (2) eating locally available nutritious food. According to an FWA in Faridpur:

> *"I tell them that you should eat rice at noon and take at least 2 hours of rest on the left side and eat this thing, it has nutrients, eat eggs, fish, meat, vegetables and curries."*

The following services are available in the community clinic mentioned by the CHCP, FWA, HA and AHI:

- Child growth monitoring
- Vaccination (EPI, TT, etc.)
- Supply iron tablets, calcium tablets
- Check-up (weight and pressure monitoring)
- Special program for child nutrition (SB3)
- counseling and services related to maternal and child health, nutrition
    - Respondents emphasized the importance of counseling and awareness-raising activities in promoting safe delivery practices, breastfeeding, vaccination, and proper nutrition for mothers and children.
    - Instructions for pregnant mothers' care
        - 4 ANC and 4 PNC visits
        - Activity and diet plans
        - Preparation for safe delivery
    - Exclusive breastfeeding, breastfeeding strategy
    - Vaccination for child
    - Dieting strategy for child and pregnant mothers
    - Age-specific counseling (6-8, 9-11, 12-24 months)
- Counseling to mothers, children, pregnant mothers, lactating mothers, fathers/husbands, mothers-in-law

4.14 Material Used in Counselling at CC

The practice of using communication materials for counselling differs among the service providers based on persons who are seeking services. The most common counselling practice is verbal communication and provide information and instructions to the service receivers at door-to-door visit as well as in CC. The necessity of using communication materials during counselling described by a CHCP:

> *"We are local, daughter of this village or wards and almost all people are known to me. Most of the cases, I need not to use any materials, they have trust on my words."* KII-CHCP-Madaripur-23Feb2024

Similar insights were found from many of the CHCPs and FWAs. Another FWA from Patuakhali said:

> *"Don't need to use any materials for counselling pregnant women, they are well known to me -provide instruction about eating and when and where go for check-up"* FWA-Patuakhali 14FEB 2024

One FWA described the current counselling practice at community level. According to her,

> *"People are more aware, over the period changing their behavior regarding use of other FP methods especially injections instead of taking oral pills. But not all the people are aware adequately, some of the people are adamant, don't accept verbal advice or don't go to the facility after verbal counselling. In that case, visual materials like poster or chart is effective… one to one counselling is very effective for FP methods"* IDI-FWA-Barguna-13FEB 2024.

But many of them also using visual aids like flipchart, leaflet, flash cards, poster, banner and demonstration equipment's like plate, bowl, measurement tape etc., based on the counselling issues like nutrition, ANC care, breastfeeding etc. To describe the child nutrition related counselling of lactating mother, one CHCP from Habiganj said:

> *"Based on the child age, I always counsel lactating mothers using food chart and food bowl for care of their children. I show chart about food types and quantity, number of frequencies for providing food, etc. Some times I also use plate and bowl that is used for measurement of food quantity providing for the children"*

He also mentioned that:

> *"I also use 'Sonali Alo'* [a set of 26 pieces of flash card] *leaflet for maternal and child health (includes ANC check-up, delivery, child care etc.) counselling. There are two written pictures in it, which shows when pregnant mothers will go for checkups, and when they will have a baby."*

However, we have documented the materials types used by the service providers and the following materials are as follows:

- Roman Banner
- Leaflet/Flash cards (*Sonali Alo*)
- Demonstration tools like plate, and bowl

- Color-coded weight measurement tools
- Growth charts for monitoring child development
- Banner for list of age-specific (6-8, 9-11, 12-24 months) child foods and nutrition
- Children's food chart
- Plates with pictures of food portions
- children's food chart
- Bowl to show the measurement of foods for children
- Demonstration plate for food quantity and food types
- Show banner and advice for 4 antenatal care service
- Leaflet/flipchart/chart on 5 danger signs for pregnant mothers
    - Danger signs for pregnant mothers [CHCP]
    - Danger signs for infants [CHCP]
- Chart/Picture of cervical cancer [recent govt. program on this]
- Information sheet on Zinc tablet consumption of children after diarrhea
- Picture chart on breastfeeding for lactating mothers
- Pregnant Women's food chart
- Growth monitoring chart, growth measurement cards
- EPI banner
- Handwashing poster

4.15 Effective tools for counselling

It was found common from all the service providers, i.e., the CHCP, FWA, HA, AHI, FPI that pictorial information sheet (message with picture) is most effective to create attention of the service seekers, make them understandable showing this chart or pictures. Many of the service providers agreed that people became interested when we show something in front of them like leaflet, chart etc. However, All the CHCP mentioned demonstration plate and bowl was very effective to make understandable about quantity of foods that needs to provide for children after 6 months to 23 months. We have documented the name of the tools found effective during counselling session with mothers, mother-in-law, husband and service seekers in the community health clinic.

- Child growth charts
- Plates with pictures of food portions
- "Visual aids like flip charts and color-coded weight measurement tools help in better understanding and retention of information
- Leaflet/flipchart/chart on 5 danger signs for pregnant mothers
- Mothers are more interested on demonstration materials like plate and bowl

The danger sigh of pregnant women chart was found most effective by an FWA. She said:

"… I always showed the chart of 5 danger signs of pregnant women during group meetings with pregnant women and mother-in-law because it creates an interest among the mothers regarding risk". KII-FWA-Kurigram-23 FEB 2024.

However, demonstration equipment's like plate, bawl for children nutrition and doll for breast feeding position was found most effective. According to an informant:

"We had a doll in our CC that were used for gives hands on training about breast feeding positioning for newly mothers. It's very effectives" KII-CHCP-Faridpur-28 FEB 2024.

4.16 Challenges for Counselling on Maternal and Child Health and Nutrition

The service providers identified the broader challenges for counselling service, which were inadequate time, non-availability of supporting materials and willingness of the service providers. In general, the pick time is 10 AM to 12 PM and patients came to the CC for medicine. To manage the patient flow, many of the cases they don't provide counselling service though in their job, there was an option of group counselling with service seekers in the CC. To explain this situation one CHCP said:

"The is only one CC in this union, most of the people came for service with 10-11 am and it is difficult for managing them and most of the cases couldn't possible to provide nutrition related counselling for children and pregnant women". CHCP-Patuakhali 13FEB 2024.

Another Service provider from Rangpur said:

"mothers don't want to stay for advice, they want some medicine of nutritious foods that is a big challenge for counselling them". HA-Rangpur-24FEB 2024.

Another challenge mentioned by the service providers was lack of interest by service seekers when they were advised to take iron tablets ever after several counselling.

"many of the women are not interested to continue the IFA for the whole pregnancy period. Many of the stars the course but not take it regularly.

We documented the challenges for counseling mothers listed below:

• Time constraints for counselors

• Reluctance of patients to give time for counseling

• Reluctance from community members to participate

• Supply of adequate takeaway materials for service receivers, such as leaflets

• Resistance from family members, like mothers-in-law

o Resistance from some mothers regarding vaccinations and new information

o Influence of mothers-in-law with opposing childcare practices and care for pregnant mothers

4.17 Ways of Overcoming these Challenges

To make people inform and aware regarding mother and child health nutrition, both community people and service provider mentioned the following suggestions:

Develop and positioning maternal health and mother and child nutrition related massages and materials

- Develop pictorial materials on nutritious foods as it is easy to make the message understandable to the service receivers
- Ensure supply materials for satellite clinic organizing and EPI centers
- Ensure availability of charts regarding 5 danger signs of pregnancy, child growth and banner for positioning of baby during breast feeding
- Display adequate festoons, poster, banner in the CC
- Develop audio-visual content related to maternal and child nutrition and make available for android phone. Smartphone is the easiest (easy access) way to get information for many of the households as well as service providers. Service providers can use the materials during counselling
- Many of the community people are also interested to search information on child care, health issues etc., on mobile phone.

Service provider skills development for counselling service

- Initiatives for skills development of CHCP so that they can assess the service seeker's needs and apply effective communication strategies (which one will be suitable for him/her) considering socio-demographic status.
- Show materials during counselling- flipchart, leaflet etc. because flip chart is most effective as there is picture that describes the context
- Patience of service providers during counseling
- Training for service providers [CHCP, HA, FWA] who work on the community to enhance their motivational skills

Community engagement and mobilization

- Enhance door-to-door visit activities and provide case-by-case counseling/consultation.
- Increase connectivity with the community to develop a trustworthy relationship. Therefore, make frequent visits (weekly or several times a month) to the catchment areas.
- Provide information through courtyard meetings.
- Use promotional materials focusing on nutrition-related messages.
- Use banners during courtyard meetings and provide leaflets as takeaway materials to each of the participants.
- Implement school-based programs for adolescent girls and provide IFA (Iron and Folic Acid) support.
- Increase awareness among community members through community-level programs.
- Reassure the well-being of mothers and children.

4.18 Recommendation from the Participants

- Use the existing formal health facility channel (Community Clinic, UH&FWC) to establish a hub for information because currently displayed materials are not adequate for all the services.

- Develop inter personal skills of the service providers specially CHCP and FWA who are working closely with the community. This training will sensitize the service providers to prioritize the information needed for the community and provide appropriate counselling

- Along with strengthening the facility service needs demand from the community regarding services.

- IDI respondent mentioned that for emergency information, the mosque is an important hub for getting information, this platform might be useful to inform and aware male segment of the population

- Target behavior focus communication measures need to be promoted which includes creating attention to the whole community through multiple channels of information. This channel should work strategically with periodic interventions, multiple interventions in the same topic or behavior, etc.

- Need to involve community leaders to create ownership of intervention and make it trustable to the community people. Sensitization meetings with community leaders would be an effective approach to address the target behaviors.

- FWA is one of the most effective sources of information to the community, equipping them with adequate and appropriate information if possible digitally (more audio-visual materials developed and provided to them) to disseminate information to the community

- Need to ensure the opening and service closing of the CC followed by government order; from 8:00 AM to 3:00 PM.

5.0 Conclusion and Recommendations

As consultative meeting participants have different perspectives, such as a lack of appropriate knowledge on FP, maternal and child health, and mother and child nutrition-related health behaviors, it is suggested to develop audience-specific messages through a participatory approach. On the other hand, community health workers (CHCP, FWA) and family members are the main sources of information. Considering this, all stakeholders should be engaged in developing appropriate messages.

- Diversify information dissemination channels beyond traditional methods to reach a wider audience. Explore the use of community-focused entertainment-based channels, such as folk songs, street dramas, game shows, multimedia projections, etc., to engage the community, particularly children and mothers. Incorporate health messages into these entertainment activities to make them more impactful. Additionally, leverage mobile phones, television programs, and NGO workers to expand the reach of health messages.
- Health workers have a demand for materials for communication with the community, especially materials for group-level counseling and individual counseling. Targeted behavior-specific communication materials could be developed that community health-care workers and other local-level platforms can use to inform, raise awareness, and mobilize community people.
- Capitalize on trust in community-level health workers, friends, and family members by empowering them to disseminate accurate health and nutrition-related information. Provide training and resources to these trusted sources, i.e., CHCP, FWA, to ensure they are equipped with accurate and up-to-date information and can effectively communicate key messages on family planning, maternal and child health, and nutrition.
- Targeted behavior-specific communication materials could be developed for community healthcare workers and other local-level platforms who can use these to inform and create awareness and mobilize the community. Encourage regular community visits and door-to-door communication to reach those who may not have easy access to health facilities.
- Most adolescents have ambitions that need support for school continuation. Therefore, prioritize target behaviors for adolescents and develop interactive approaches to engage them in the program, such as games, quizzes, reading competitions, and essay competitions.
- Stocktaking of existing messages and materials should continue, using visual aids and demonstration equipment during counseling sessions, as they have proven effective

in conveying messages, especially for nutrition-related topics. Ensure these materials are culturally appropriate and easily understandable.

- All CHCPs and community health workers have smartphones. Short videos or spot advertisements on specific issues could be developed and circulated through proper channels, which might be effective materials for counseling service seekers. The behavior of loading Natok in their mobile or memory card is a way of transferring these audio-visual materials to community people.
- There is a need for skills development of the CHCPs who provide one-stop services to the community, especially on counseling approaches and techniques, as well as refreshers within the project period (how to use materials for effective communication with service receivers).
- More than half of the respondents have access to social media, and Facebook is the most used social media platform across the zones, though more than two-thirds of them access it via family members' accounts. Pregnant and lactating women with smartphones tend to use them for 2-3 hours a day, compared to less than one hour for those without their own smartphones. This presents an opportunity to reach a certain portion of pregnant and lactating women through smartphones. To effectively reach the target audience through social media, the campaign must concentrate on Facebook and audio-visual content with appropriate messages.
- Very few respondents mentioned social media as a trustworthy source of information, so the use of this medium for disseminating maternal health and nutrition-related information needs to be reconsidered.

Annex 1: Consultative Meeting Tools

Guideline 1: Group Consultation For pregnant and lactating women

Instruction: Split into groups based on younger group (15-24) and older group (25-49)

Consultation Setting

- Identify a quiet, private place with enough space for all participants to gather comfortably, preferably in a circle
- Thank participants for coming and read the consent script
- Ask women to introduce themselves and the age of their child
- Ask all questions listed in the guide
- Take notes [Use annex 1 format]
- End the consultation by giving clear indication that it is coming to a close.

Informed consent: Important to not record any personally identifiable information of participants
[Read the informed consent statement below aloud in front of a witness who will sign their acknowledgement that the informed consent was given and accepted by participants.]

Hello! My name is _____ and I will be facilitating today's group discussion. Thank you for joining us. I am working with a group of organizations working to improve health and nutrition outcomes in your community. You are being asked to participate in this study to to understand how you get information to make decisions about nutrition and health for your family. You are free to say no now or leave at any point without negative consequences to you or anyone else. I expect the discussion to last for about one hour. The discussion will be audio-taped and *[notetaker's name]* is taking written notes; these will be used internally and confidentially for analysis only. You do not have to answer any questions that make you feel uncomfortable. While we require that all participants in this room keep the conversation confidential, it is possible that fellow participants here could violate this agreement by telling others in the community what you said. This is a risk you must consider. However, we will not record your surnames and your responses will be anonymous. The audio recordings and any notes will always be stored either in locked boxes or on a computer protected by passwords.

Do you have any questions?
Do you agree to participate in the study?

Witness of Oral Consent
I confirm that the elements of informed consent, the purpose of the research, the study procedures, and the possible risks and benefits have been explained to the participants. All questions have been answered. The participants have agreed to participate in the study, and to be audio-taped.

_____ Witness signature
_____ Date

Ground rules

Thank you very much for agreeing to talk with us. Now I will explain some ground rules to protect the privacy of everyone and to ensure we all have equal opportunity to share our thoughts in a respectful environment.

1. During this discussion today, please turn off your mobile phones to help us ensure confidentiality. We will do so too.
2. We are interested in all your ideas and experiences, so please feel free to speak openly. We would like to have many different points of view. However, please respect each other and do not criticise opinions that conflict with your own.
1. We want this to be a group discussion between yourselves, so you need not wait for me to call on you. But please speak one at a time. And please make sure to give others a chance to speak up so we can hear from everyone. Again, it is critical that you do not discuss anything from today's discussion with anyone once you leave here. This means that you should not tell anyone outside of this group who was here or what was said. This will protect everyone's right to confidentiality.

Would anyone like to add or clarify anything?

Objectives: to understand information sources, media access and habits of CNHA primary target groups to inform CNHA SBC strategy

Instruction to the Moderator: *We have made an individual exercise about media habit, information sources as well as trustable sources. Now we will explore it in the group and identify the reasons of choosing it.]*

A) Access to Services

[Note for the moderator: explore each issue separately FP, nutrition, Maternal and child health services: *ANC, PNC service, NNC etc. treatment*, Breastfeeding and child rearing and caring (*Immunization etc.),* and hygiene services (Menstrual and personal hygiene etc.)

1. How do you get information on FP, nutrition, and hygiene services for you and your child?

2. Who do you trust to give you information on FP, nutrition, and hygiene services for you and your child? (e.g. health care provider, family member, friend, media/ Internet).
   2.1 Why do you trust these sources?

3. From where [What plat form do you use] do you seek maternal health, child health, nutrition service? Have you received any counselling/advice from health workers at these facilities? [Moderator note: Count the response like hand raising count]
   3.1 What kind of advice did you receive or seek from health facility? [please explore all the component FP, nutrition, maternal and child health, hygiene practice etc.] Please share in detail.
   3.2 How useful were the information for you? Please share your experiences.
   3.3 How often do you access them? prob: frequently, when required etc. If not visited, why don't you visit?

4. Who makes the decisions in your household about health care (prob: where to go, when to go, spending money etc.)? [Please explore in general and issue specific, i.e. FP, EPI, breast feeding, child health, maternal health, health checkup during pregnancy and post-delivery period etc.]
   4.1 If your husband is away for work for much of the year, who makes the decision while he is gone?
5. What are the **barriers** and **challenges** for getting accurate and appropriate information related to FP, nutrition, maternal health, child health and hygiene practice? What measures are needed to remove the barriers?

B) Media Exposure and Sources of Information

6. How do you spend your leisure time? (Prob if required: watching TV, reading news paper, social media use-facebook, Youtube, Tiktok, gossiping with neighbors etc.

6.1 Is there any seasonal differences regarding leisure period and time? What are the changes in different seasons?

7. What content do you prefer to watch in social media through mobile? How often do you use social media in a day? What is your preferred time to watch social media?

7.1 In general, how many times you are using social media [Please count the number by respondents] ?

7.2 What are the predferred time for you to use social media

8. What do you know (What kinds of information do you have?) about maternal and child health and nutrition? please describe? From where you learnt this or from where you received these messages?

9. For you, what is the best way/channels to receive messages (probe to identify preference the visual, non-visual, written and verbal ways)? Why do you prefer those channels? Please provide some examples.

C) Other platforms for receiving Maternal, Neonatal and Child Health information

10. Behind the community clinic, are there other people or NGOs who advise about health and nutrition in your community? Have you ever exposed with any program organized by them or have taken any service or advice from them? Was this useful? If not, why not?

11. Are there people in the community to speak against adopting new health or nutrition ideas? Who are they? Why do you think they feel this way?

Moderator Note: Ask the participants if they have any suggestions. Close the discussion through vote for thanks. Acknowledge for their time and active participation. Remind them, we will not disclose any information outside them room, discussed here.

Thank You

Guideline 2: In-Depth Interviews for Mothers-in-Law of Pregnant and Lactating Women and/or Children under two (living in same household)

Consultation Setting

- Identify a quiet, private place
- Thank respondent for coming and read the consent script
- Ask all questions listed in the guide
- Take notes [Followed by note taking format] and use recorder
- End the consultation by giving clear indication that it is coming to a close.

Informed consent: Important to not record any personally identifiable information of participants
[Read the informed consent statement below aloud in front of a witness who will sign their acknowledgement that the informed consent was given and accepted by participants.]

Hello! My name is _____ and I will be facilitating today's individual interview. I am working with a group of organizations working to improve health and nutrition outcomes. You are being asked to participate in this study to to understand how you get information to make decisions about nutrition and health for your family. You are free to say no now or leave at any point without negative consequences to you or anyone else. I expect the discussion to last for about one hour. The discussion will be audio-taped and *[notetaker's name]* is taking written notes; these will be used internally and confidentially for analysis only. You do not have to answer any questions that make you feel uncomfortable. The audio recordings and any notes will always be stored either in locked boxes or on a computer protected by passwords.

Do you have any questions?
Do you agree to participate in the study?

Witness of Oral Consent
I confirm that the elements of informed consent, the purpose of the research, the study procedures, and the possible risks and benefits have been explained to the participants. All questions have been answered. The participants have agreed to participate in the study, and to be audio-taped.

_____ Witness signature

_____ Date

Objectives: to understand support for key practices for PLW and children under 2, media access and habits, participation in key platforms

A) Health and Nutrition Care and Support

1. Are you involved or were you involved in your daughter-in-law seeking antenatal care from a health provider or health facility during pregnancy?

1.1. If yes, how were you involved in this process? Please describe. How many times did your daughter-in-law seek antenatal care during pregnancy?

1.2 Why you were involved in taking health of you daughter in laws health checkup? What issues motivated you or compel you to be involved?

1.3. If no, please list the reasons you are not involved? and

2. Are you involved or were you involved in ensuring your daughter-in-law had three full meals during pregnancy?

2.1. If yes, how were you involved in this process? Please describe.

2.2what would enable you to be involved? probe: motivate you or compel you to be involved.

2.3. If no, please list the reasons you are not involved

[Note: If the respondent is mother-in-law of first-time mother or pregnant women, or the age of grand child is less than 6 months skip the question 3 section]

3. Are you involved or were you involved in complementary feeding of your grandchild under two years of age?

3.1. If yes, how were you involved in this process? Please describe the types of foods given and frequency of food given by age 6-8 months, 9-11 months, and 12-24 months.

3.2what influenced you to be involved? probe: motivate you or compel you to be involved.

3.2. If no, please list the reasons you are not involved

4. [Note: If the respondent is mother-in-law of first-time pregnant women, skip the question 3 section]Are you involved or were you involved in child feeding during illness for the child under two years of age? (e.g. diarrhea)

4.1. If yes, how were you involved in this process? Please describe the types of foods given.

4.2 what inspired you to be involved? probe: motivate you or compel you to be involved.

4.3. If no, please list the reasons you are not involved.

5. Normally, when do you wash your hands with soap and water? please describe.

5.1. Do you think, rather above mentioned, need to wash hand with soap other time? Please mentioned specific times. 5.2 After having knowledge, why not being possible to follow hand washing practice with soap? what would enable you to be involved? probe: motivate you or compel you to be involved.

6. What are the **barriers** and **challenges** for getting accurate and appropriate information related to FP, nutrition, maternal health, child health and hygiene practice?

7. According to your view, What measures are needed to remove the barriers?

B) Mother-in-laws' roles in pregnancy and child health

8. When you were a young bride, who did you turn to for advice about pregnancy and caring for your child?

8.1 Is it important to you that your daughter-in-law have a good outcome (healthy baby) of her pregnancy? Why or why not?8.2 What are some things a young woman should do during her pregnancy to have a healthy baby? (list all those things mentioned even if they are not accurate)

8.3 Where could she get good advice about doing these things? (Probe: specifically, about the responses to the previous question.)

9. Who in your household decides whether the young daughter-in-law attends antenatal care?

9.1 Probe: If the husband is away (migrant worker), who decides?

9.2 If the MIL says the decision is made by people other than herself or the daughter-in-law, ask: Is there anything you can do to influence the decision-maker?

9.3 What are some reasons why a household may decide she should not attend antenatal care? Please describe.

10. When your baby grandchild gets sick (diarrhea) who decides where and when to seek health care?

10.1 What are factors that lead the decision-maker to decide against seeking care?

10.2 If the decision-maker is not the MIL, ask: Can you do anything to influence the decision?

11. If your son and daughter-in-law want to delay pregnancy, who will make the decision to seek family planning services?

C) Media Exposure and Sources of Information

12. How do you spend your leisure time? (Prob if required: watching TV, reading new paper, social media use-Facebook, Youtube, TikTok, gossiping with neighbors etc.)

12.1 Is there any seasonal differences regarding leisure period and time? What are the changes in different seasons?

13. What content do you prefer to watch in social media through mobile? How often do you use social media in a day? What is your preferred time to watch social media?

14. What do you know (What kinds of information do you have?) about maternal and child health and nutrition? please describe? From where you learnt this or from where you received these messages?

15. For you, what is the best way/channels to receive messages (probe to identify preference the visual, non-visual, written and verbal ways)? Why do you prefer those channels? Please provide some examples.

Guideline 3: Group Consultations for Mothers-in-Law of Pregnant and Lactating Women and/or Children under two (living in same household)

Consultation Setting

- Identify a quiet, private place with enough space for all participants to gather comfortably, preferably in a circle
- Thank participants for coming and read the consent script
- Ask women to introduce themselves and the age of their child
- Ask all questions listed in the guide
- Take notes [Use annex 1 format]
- End the consultation by giving clear indication that it is coming to a close.

Informed consent: Important to not record any personally identifiable information of participants

[Read the informed consent statement below aloud in front of a witness who will sign their acknowledgement that the informed consent was given and accepted by participants.]

Hello! My name is _____ and I will be facilitating today's group discussion. Thank you for joining us. I am working with a group of organizations working to improve health and nutrition outcomes. You are being asked to participate in this study to to understand how you get information to make decisions about nutrition and health for your family. You are free to say no now or leave at any point without negative consequences to you or anyone else. I expect the discussion to last for about one hour. The discussion will be audio-taped and *[notetaker's name]* is taking written notes; these will be used internally and confidentially for analysis only. You do not have to answer any questions that make you feel uncomfortable. While we require that all participants in this room keep the conversation confidential, it is possible that fellow participants here could violate this agreement by telling others in the community what you said. This is a risk you must consider. However, we will not record your surnames and your responses will be anonymous. The audio recordings and any notes will always be stored either in locked boxes or on a computer protected by passwords.

Do you have any questions?
Do you agree to participate in the study?

Witness of Oral Consent

I confirm that the elements of informed consent, the purpose of the research, the study procedures, and the possible risks and benefits have been explained to the participants. All questions have been answered. The participants have agreed to participate in the study, and to be audio-taped.

_____ Witness signature
_____ Date

Ground rules

Thank you very much for agreeing to talk with us. Now I will explain some ground rules to protect the privacy of everyone and to ensure we all have equal opportunity to share our thoughts in a respectful environment.

1. During this discussion today, please turn off your mobile phones to help us ensure confidentiality. We will do so too.

2. We are interested in all your ideas and experiences, so please feel free to speak openly. We would like to have many different points of view. However, please respect each other and do not criticise opinions that conflict with your own.
3. We want this to be a group discussion between yourselves, so you need not wait for me to call on you. But please speak one at a time. And please make sure to give others a chance to speak up so we can hear from everyone.
4. Again, it is critical that you do not discuss anything from today's discussion with anyone once you leave here. This means that you should not tell anyone outside of this group who was here or what was said. This will protect everyone's right to confidentiality.

Would anyone like to add or clarify anything?

Objectives: To understand support for key practices for PLW and children under 2, media access and habits, participation in key platforms

A) Health and Nutrition Care and Support

1. In your community, how many times does a woman take meals during her pregnancy? How do you know this?, probe: what are the source of information.
    1.1 What are the reasons families support women to have adequate nutrition during pregnancy?
    1.2 What do you think are the reasons families don't support children introduced to have solid foods two-three times a day at seven months of age? Probe: social stigma, cultural norms etc.
2. In your community, are children introduced to solid foods at six months of age? probe: What types of foods? and what are the feeding frequencies in a day etc.? *Probe: how do you know this, what are the source of information.*
    2.1 What do you think are the reasons families support children introduced to have solid foods at seven months of age? 2.2 What do you think are the reasons families don't support children introduced to have solid foods at six months of age? Probe: social stigma, cultural norms etc.

3. In your community, during illness are children under the age of two fed just a little at a time and as much as possible?. *Probe: how do you know this, what are the source of information.*
    3.1 What do you think are the reasons families support children feeding several times a day at six months of age?
    3.2. What do you think are the reasons families don't support children feeding several times a day at six months of age? Probe: social stigma, cultural norms etc.
4. What is the common practices of handwashing with soap and water in your community? What would make it easier to handwash with soap and water? What makes it difficult to handwash with soap and water?

B) Mother-in-laws' roles in pregnancy and child health

5. When you were a young bride, who did you turn to for advice about pregnancy and caring for your child?
    5.1 Is it important to you that your daughter-in-law have a good outcome (healthy baby) of her pregnancy? Why or why not?

5.2 What are some things a young woman should do during her pregnancy to have a healthy baby? (list all those things mentioned even if they are not accurate)
5.3 Where could she get good advice about doing these things? (Probe specifically about the responses to the previous question.)

6. Who in your household decides whether the young daughter-in-law attends antenatal care?
6.1 What are some reasons why a household may decide she should not attend antenatal care?
6.2 Probe: If the husband is away (migrant worker), who decides?
6.3 If the MIL says the decision is made by people other than herself or the daughter-in-law, ask: Is there anything you can do to influence the decision-maker?

7. When your baby grandchild gets sick (diarrhea) who decides where and when to seek health care?
7.1 What are factors that lead the decision-maker to decide against seeking care?
7.2 If the decision-maker is not the MIL, ask: Can you do anything to influence the decision?

8. If your son and daughter-in-law want to delay pregnancy, who will make the decision to seek family planning services?

C) Media Exposure and Sources of Information

9. How do you spend your leisure time? (Prob if required: watching TV, reading new paper, social media use-Facebook, Youtube, TikTok, gossiping with neighbors etc.)
9.1 Is there any seasonal differences regarding leisure period and time? What are the changes in different seasons?

10. What content do you prefer to watch in social media through mobile? How often do you use social media in a day? What is your preferred time to watch social media?

11. What do you know (What kinds of information do you have?) about maternal and child health and nutrition? please describe? From where you learnt this or from where you received these messages?

12. For you, what is the best way/channels to receive messages (probe to identify preference the visual, non-visual, written and verbal ways)? Why do you prefer those channels? Please provide some example.

Guideline 4: In-Depth Interviews for Husbands of Pregnant and Lactating Women and/or Children under two (living in same household)

Respondent Selection Guideline Part: Selection: *must respond yes to ONE of the questions below and must live in the CNHA target unions*

- *Do you live with your spouse between the ages of 15-49 years who is currently pregnant or lactating?*
- *Do you live with your spouse between the ages of 15-49 years who has a child under the age of two years?*

Consultation Setting

- Identify a quiet, private place
- Thank respondent for coming and read the consent script
- Ask all questions listed in the guide
- Take notes
- End the consultation by giving clear indication that it is coming to a close.

Informed consent: Important to not record any personally identifiable information of participants
[Read the informed consent statement below aloud in front of a witness who will sign their acknowledgement that the informed consent was given and accepted by participants.]

Hello! My name is _____ and I will be facilitating today's individual interview. I am working with a group of organizations working to improve health and nutrition outcomes. You are being asked to participate in this study to understand health and nutrition practices in this community. You are free to say no now or leave at any point without negative consequences to you or anyone else. I expect the discussion to last for about one hour. The discussion will be audio-taped and *[notetaker's name]* is taking written notes; these will be used internally and confidentially for analysis only. You do not have to answer any questions that make you feel uncomfortable. The audio recordings and any notes will always be stored either in locked boxes or on a computer protected by passwords.

Do you have any questions?
Do you agree to participate in the study?

Witness of Oral Consent
I confirm that the elements of informed consent, the purpose of the research, the study procedures, and the possible risks and benefits have been explained to the participants. All questions have been answered. The participants have agreed to participate in the study, and to be audio-taped.

_____ Witness signature

_____ Date

Objectives: to understand support for key practices for PLW and children under 2, media access and habits, participation in key platforms

A) Health and Nutrition Care and Support

1. How is it important for husbands that their wife deliver a healthy baby? What husbands can do to ensure she does?

1.1 Is there someone else in the house who makes decisions or gives advice? Can the husbands intercede in this?

2. Are you involved or were you involved in your wife seeking antenatal care from a health facility at least four times during pregnancy?
- 2.1 If yes, how were you involved in this process? Please describe.
- 2.2 what influenced you to be involved. probe: motivate you or compel you to be involved.
- 2.3 If no, please list the reasons why you are not involved and
- 2.4 Who makes the decision in the household about seeking antenatal care? If you are away from home, who decides?

3. Are you involved or were you involved in ensuring your wife had adequate nutrition during pregnancy?
- 3.1 If yes, how were you involved in this process? Please describe.
- 3.2 what influenced you to be involved. probe: motivate you or compel you to be involved.
- 3.3 If no, please list the reasons you are not involved.
- 3.4 Who makes the decision in the household about food consumption, especially for pregnant women?

[Note: If age of the children is less than 6 months, Skip Q 4 and Q5 section]

4. Are you involved or were you involved in complementary feeding of your child under two years of age?
- 4.1 If yes, how were you involved in this process? Please describe the types of foods given and frequency of food given by age 6-8 months, 9-11 months, and 12-24 months.
- 4.2 what influenced you to be involved? probe: motivate you or compel you to be involved.
- 4.3 If not, please list the reasons you are not involved.
- 4.4 Who makes the decision in the household about complementary feeding? If you are away from home, who decides?

5. Are you involved or were you involved in child feeding during illness for your child under two years of age? (e.g. during diarrhea)
- 5.1 If yes, how were you involved in this process? Please describe the types of foods given.
- 5.2 what influenced you to be involved?
- 5.3 If no, please list the reasons you are not involved and

6. Normally, when do you wash your hands with soap and water? please describe.
- 6.1 P Do you think, rather above mentioned, need to wash hand with soap other time? Please mentioned specific times.
- 6.2 After having knowledge, why not being possible to follow hand washing practice with soap? what would enable you to be involved? probe: motivate you or compel you to be involved.

7. Who took decision about the timing of childbirth in the household?
8. In your household, who will make the decision to seek family planning services? In that case, what is the role of a husband?
9. What are the barriers and challenges for getting accurate and appropriate information related to FP, nutrition, maternal health, child health and hygiene practice? What measures are needed to remove the barriers?

B) Media Exposure and Sources of Information

10. How do you spend your leisure time? (Prob if required: watching TV, reading new paper, social media use-Facebook, Youtube, TikTok, gossiping with neighbors etc.

10.1 Is there any seasonal differences regarding leisure period and time? What are the changes in different seasons?

11. What content do you prefer to watch in social media through mobile? How often do you use social media in a day? What is your preferred time to watch social media?
12. What do you know (What kinds of information do you have?) about maternal and child health and nutrition? please describe? From where you learnt this or from where you received these messages?
13. 13. For you, what is the best way/channels to receive messages (probe to identify preference the visual, non-visual, written and verbal ways)? Why do you prefer those channels? Please provide some examples.

Thank You

Guideline 5: For Unmarried Adolescent Girls 15-19 years of age

Instruction for Participant Recruitment Guideline
Selection: must respond yes to all of the questions below and must live in the CNHA target unions

- Are you female and between the ages of 15-19?
- Are you currently unmarried?

Consultation Setting

- Identify a quiet, private place with enough space for all participants to gather comfortably, preferably in a circle
- Thank participants for coming and read the consent script
- Ask women to introduce themselves and the age of their child
- Ask all questions listed in the guide
- Take notes
- End the consultation by giving clear indication that it is coming to a close.

Informed consent: Important to not record any personally identifiable information of participants
[Read the informed consent statement below aloud in front of a witness who will sign their acknowledgement that the informed consent was given and accepted by participants.]

Hello! My name is _____ and I will be facilitating today's group discussion. Thank you for joining us. I am working with a group of organizations working to improve health and nutrition outcomes. You are being asked to participate in this study to understand health and nutrition practices in this community. You are free to say no now or leave at any point without negative consequences to you or anyone else. I expect the discussion to last for about one hour. The discussion will be audio-taped and *[notetaker's name]* is taking written notes; these will be used internally and confidentially for analysis only. You do not have to answer any questions that make you feel uncomfortable. While we require that all participants in this room keep the conversation confidential, it is possible that fellow participants here could violate this agreement by telling others in the community what you said. This is a risk you must consider. However, we will not record your surnames and your responses will be anonymous. The audio recordings and any notes will always be stored either in locked boxes or on a computer protected by passwords.

Do you have any questions?
Do you agree to participate in the study?

Witness of Oral Consent
I confirm that the elements of informed consent, the purpose of the research, the study procedures, and the possible risks and benefits have been explained to the participants. All questions have been answered. The participants have agreed to participate in the study, and to be audio-taped.

_____ Witness signature

_____ Date

Ground rules

Thank you very much for agreeing to talk with us. Now I will explain some ground rules to protect the privacy of everyone and to ensure we all have equal opportunity to share our thoughts in a respectful environment.

1. During this discussion today, please turn off your mobile phones to help us ensure confidentiality. We will do so too.
2. We are interested in all your ideas and experiences, so please feel free to speak openly. We would like to have many different points of view. However, please respect each other and do not criticise opinions that conflict with your own.
3. We want this to be a group discussion between yourselves, so you need not wait for me to call on you. But please speak one at a time. And please make sure to give others a chance to speak up so we can hear from everyone.
4. Again, it is critical that you do not discuss anything from today's discussion with anyone once you leave here. This means that you should not tell anyone outside of this group who was here or what was said. This will protect everyone's right to confidentiality.

Would anyone like to add or clarify anything?

Objectives: to understand care seeking, media access and habits of CNHA primary target groups, participation in key platforms

A. Dreams and Aspirations

What are your dreams and aspirations for your future? What do you want to be? [Focused your discussion based on their dreams/ Allow respondents to describe and note the categories of responses]

2. Are you able to choose the timing of your marriage?
   2.1 If yes, who supports you in this choice?
   2.2 2.3. If no, what prevents you from making this choice?
3. What would make it easier for you to achieve your dreams and aspirations?
4. In this community is it easy for girls to use sanitary pads and hygiene during menstruation?
   4.1 If yes, what factors make it easy for them to use?
   4.2 If not, what barriers do they face?

B. Media Exposure and Sources of Information

5. How do you spend your leisure time? (Prob if required: watching TV, reading new paper, social media use-facebook, Youtube, Tiktok, gossiping with neighbors, playing, extra cubiculum activities etc.)

5.1 Is there any seasonal differences regarding leisure period and time? What are the changes in different seasons ?

6. What content do you prefer to watch in social media through mobile? How often do you use social media in a day? What is your preferred time to watch social media?
7. Would you like to learn more about your health and healthy eating? What would be the easiest way for you to learn about this? Please provide some examples.
8. If you are in school, do you get any useful health information through school? Do they want more information there?
9. For you, what is the best way/channels to receive messages (probe to identify preference the visual, non-visual, written and verbal ways)? Why do you prefer those channels? Please provide some examples.
10. Do you know of adolescent clubs in your area? Have you participated in these adolescent clubs? If yes, what activities did you conduct in these clubs? If no, why did you not participate?

Guideline 6: **KII for Community Health Care Provider (CHCP)**

Experience:

1. Are you able to counsel on nutrition, FP, and health through your work at Community Clinics?

1.1 What message and materials do you use for FP, Child nutrition?
1.2 Are there particular materials or methods you use that are most useful? Could you show us?

2. Have you had **CHCP foundation training before posting your work station**? How long was the training period? [A CHCP should get 3 months Foundation training. Ask detailed about the training, place, year of participation etc.
3. IN the training you have received lots of information regarding maternal and child health and nutrition. Have you used the key messages covered during that training?

If yes, which messages or material do you find the most useful?

4. What are some of the **barriers** you face in providing nutrition counseling? What would help you in overcoming these barriers?
5. As CHCP, You are providing counseling service related to mother and child nutrition. What are some of the successes you have had in providing nutrition counseling?
   5.1 Which types of materials are most useful for your counseling? Which materials do your clients find most useful? Probe to identify specific types of materials- for example- visual aids like food chart, recipes and meal plan, food diagram; written materials like- leaflet, brochure; interactive materials like apps, social media etc.
6. Have you used any media messages (TV, radio) in health and nutrition counseling? How? Please share any example.
7. Are you involved with counseling of pregnant, lactating mother or adolescent in your CC? If Yes,
   7.1 what kind of materials are you using?
   7.2 The materials you used for counselling, which one are easier to deliver the message appropriately or found most effective?
8. In your area, are you aware of any NGOs in your area working on health, nutrition, and FP?

8.1 If Yes, What are the names of the NGOs and their program? Which programs do you find useful?

Recommendations

9. What are your recommendations for improving outreach accessibility for nutrition, FP, and hygiene services?
10. What are your recommendations for promoting nutrition, family planning, and hygiene knowledge among lactating mothers, girls, and their families?
11. Could you please share your experiences with any CSGs or CGs? (e.g. have they supported community mobilization, vulnerable household mapping, referral of cases from the community, and raising awareness, etc.)?

Thank You

Guideline 7: KII for Health Care Professionals (HI/FPI/FWA/FWV)

Experience:

1. Are you able to counsel on nutrition, FP, and health through your work? Are there **particular materials or methods** you use that are most useful? Could you show us?
2. What are some of the **barriers** you face in providing nutrition counseling? What would help you in overcoming these barriers? Probe to identify barriers at individual/client level, service provider level and institutional/facility level
3. What are some of the **successes** you have had in providing nutrition counseling? Which **types of materials** are most useful for your counseling? Which materials do your clients find most useful? Probe to identify specific types of materials- for example- visual aids like food chart, recipes and meal plan, food diagram; written materials like- leaflet**,** brochure**;** interactive materials like apps, social media etc.
4. Have you used any media messages in health/ nutrition/ FP counseling? How? Please share any example.
5. Are you able to use **counseling materials** for pregnant and lactating women, adolescents? Which materials do your clients find most useful?
6. What is the best way/channels for you to provide counselling or messages on FP, nutrition, health? Which channels are more appropriate to reach pregnant and lactating mothers? Why? Please provide some examples.
7. In your area, what NGO programs are you aware of for health, nutrition, and FP? Which programs do you find useful?

Recommendations

8. What are your recommendations for improving outreach accessibility for nutrition, FP, and hygiene services?
9. What are your recommendations for promoting nutrition, family planning, and hygiene knowledge among lactating mothers, girls, and their families?
10. Could you please share your experiences with any CSGs or CGs? (e.g. have they supported community mobilization, vulnerable household mapping, referral of cases from the community, and raising awareness, etc.)?

Thank You

Annex 2: Supplement Tables

Table: Distribution of sample by union and Upazila

Cluster	District	Upazila	Union name	Tools exercise by groups								Union Total			
				FGD-P&L (15-24)	FGD-P&L (25-49)	FGD-Motherin-law	IDI-Mother in Law	IDI Husband	FGD-Adolescent girls	KII-CHCP	KII- HI/ FPI/HWA/HA	ToTal FGDs	Total IDI	Total KII	ALL
Padma Basin (ZOI)	Shariatpur	Bhedarganj	South Tarabunia	1	1	-	2	2	-	1	2	2	4	3	**9**
			Char Census	1	1	-	2	2	1	1	2	3	4	3	**10**
	Madaripur	Shibchar	Kanthalbari	1	1	-	2	2	-	1	2	2	4	3	**9**
			Char Janajat	1	1	1	-	2	--	1	2	3	2	3	**8**
	Faridpur	Nagarkanda	Charjoshordi	2	2	1	-	2	-	1	2	5	2	3	**10**
			Ramnagar	2	2	-	2	2	1	1	2	5	4	3	**12**
Char	Kurigram	Nageshwari	Narayanpur	2	2	1	-	2	-	1	2	5	2	3	**10**
			Nunkhawa	1	1	-	2	2		1	2	2	4	3	**9**
	Joypurhat	Akkelpur	Rukindipur	2	2	-	2	2	1	1	2	5	4	3	**12**
			Sonamukhi	1	1	-	2	2	-	1	2	2	4	3	**9**
	Gaibandha	Sundarganj	Dhabondo	2	2	1	-	2	-	1	2	5	2	3	**10**
			Belka	2	2	-	2	2	-	1	2	4	4	3	**11**
	Rangpur	Kawnia	Haragach	1	1	-	2	2		1	2	2	4	3	**9**
			Balapara	2	2	-	2	2	1	1	2	5	4	3	**12**
Haor	Kishoreganj	Mithamain	Khatkhal	1	1	-	2	2	-	1	2	2	4	3	**9**
			Bairati	1	1	-	2	2	1	1	2	3	4	3	**10**
	Sunamganj	Derai	Charnarchar	1	1	1	-	2	-	1	2	3	2	3	**8**
			Karimpur	2	2	-	2	2	-	1	2	4	4	3	**11**
	Netrokona	Durgapur	Gaonkandia	1	1	-	2	2	-	1	2	2	4	3	**9**
			Durgapur	1	1	1	-	2	-	1	2	3	2	3	**8**
	Habiganj	Ajmiriganj	Shibpasha	2	2		2	2	1	1	2	5	4	3	**12**
			Jolshukha	1	1	--	2	2	-	1	2	2	4	3	**9**
Coastal	Patuakhali	Dashmina	Chorborhan	1	1	-	2	2	-	1	2	2	4	3	**9**
			Alipura	1	1	1	-	2	-	1	2	3	2	3	**8**
	Barguna	Amtali	Atharogachia	1	1	-	2	2	1	1	2	3	4	3	**10**
			Chawra	1	1	1	-	2	-	1	2	3	2	3	**8**
	Bhola	Manpura	Manpura	1	1	-	2	2	-	1	2	2	4	3	**9**
			Sakuchia South	1	1	-	2	2	1	1	2	3	4	3	**10**
				37	**37**	**8**	**40**	**56**	**8**	**28**	**56**	**90**	**96**	**84**	**270**

Table 2: Facebook using status by gender and zones

Zone/Cluster	Gender	n	Do you use Facebook regularly?	
			Yes	No
Padma Basin	Male	8	87.5%	12.5%
	Female	42	92.9%	7.1%
	Total	**50**	**92.0%**	**8.0%**
Char	Male	8	87.5%	12.5%
	Female	45	71.1%	28.9%
	Total	**53**	**73.6%**	**26.4%**
Haor	Male	8	62.5%	37.5%
	Female	31	64.5%	35.5%
	Total	**39**	**64.1%**	**35.9%**
Coastal	Male	7	85.7%	14.3%
	Female	22	90.9%	9.1%
	Total	**29**	**89.7%**	**10.3%**
Total	Male	31	80.6%	19.4%
	Female	140	79.3%	20.7%
	Total	**171**	**79.5%**	**20.5%**

Annex 3: Photo of different consultative Groups

Photo: FGD-PL-15-24Y-2-Gaibandha-20 Feb-2024

Photo: FGD-ML-Gaibandha-22 Feb-2024

Photo: FGD-PL-25-49Y-Netrokona-12 Feb 2024

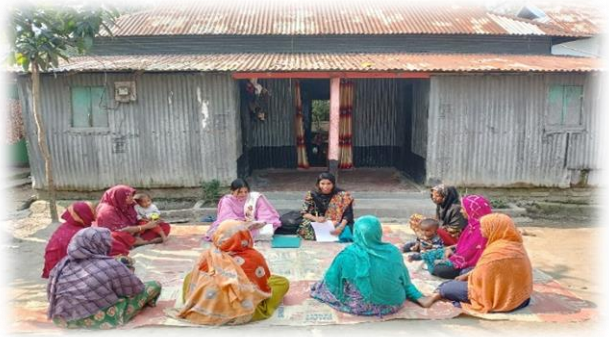

Photo: FGD-PL-25-49Y-Habiganj -17 Feb-2024

Photo: FGD-PL-15-24Y-2-Rangpur-19Feb-2024

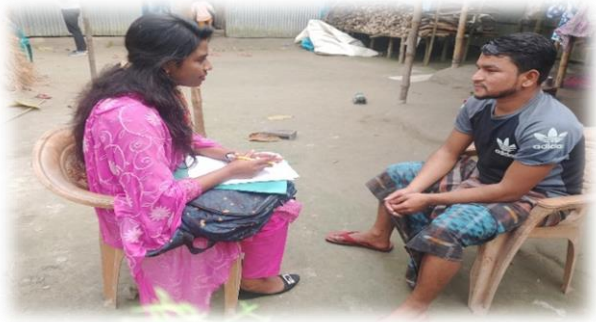

Photo: IDI-HUS-Gaibandha--20 Feb-2024

Photo: FGD-PL-25-49Y-Gaibandha-24 Feb-2024

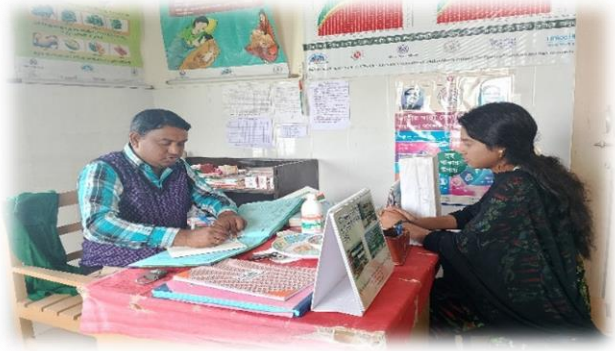

Photo: KII-CHCP-Habiganj

Photo: IDI-ML-Rangpur-18Feb2024

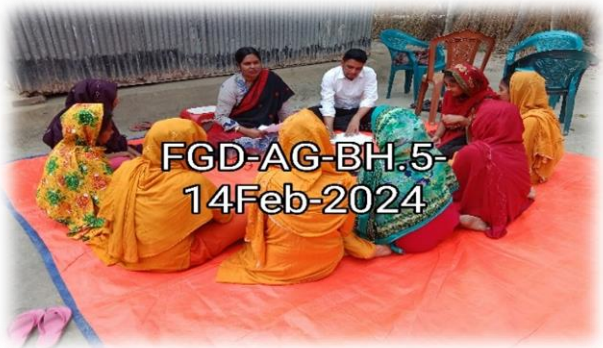

Photo: FGD-AG-Bholar-14Feb2024

Photo: Consultative Meeting Facilitators Training

Photo: KII-HA-Barguna 13 Feb 2024

Photo: KII-FWA-Madaripur 23 Feb 2024

Photo: KII-FWA-Faridpur 28 Feb 2024

Photo: KII-CHCP-Shariatpur 23Feb 2024

Photo: FGD-PL-25-49Y-Madaripur-25 Feb-2024

Photo: IDI-ML-Barguna-16 Feb2024