

# **JourneyMaa 2018 Report**

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## **INTRODUCTION**

The JourneyMaa 2018 report will explore  
maternal health in rural Bangladesh. The

Maternal Aid Association (MAA) is committed to improving the state of maternal healthcare in Bangladesh, and one way of achieving this has been through the development of education seminars for rural populations. These have been developed following research that suggests maternal education improves the maternal mortality ratio (MMR), child health outcomes, and health-seeking behaviour of women (Cleland, 1988; Bicego, 1993; Guldan, 1993). To find out more about the current state of maternal healthcare in Bangladesh, please refer to the *JourneyMaa Report 2017*. This report explores the baseline knowledge, attitudes and behaviours towards maternal health within rural populations of pregnant women and assesses the impact of MAA's maternal health education (MHE) seminars in influencing this baseline. To do this, the different lifestyle choices indicated by women before and after the seminar will be explored.

## METHODOLOGY

This study was carried out in August 2018 as part of the MAA's flagship project, JourneyMaa. MAA set up a two-day mobile maternal health screening camp in the rural villages of Balagonj and Ramsiri in Bangladesh.

A total of 400 pregnant women attended the health camps across the two villages in the four days. At the camps, participants received free basic healthcare checks, which included blood pressure, urinalysis and blood glucose checks. These were carried out by the MAA Bangladesh team and UK JourneyMaa volunteers. The MAA Bangladesh team consisted of final year medical students and qualified doctors, whilst the UK volunteers consisted of healthcare students and professionals.

Once the basic check-ups were complete, each participant was invited to a maternal health education (MHE) seminar.

This addressed a variety of topics around pregnancy and delivery, tackling key misconceptions and highlighting red flag symptoms for women to be aware of during their

pregnancy. At the end of the seminar, participants received a questionnaire that explored each woman's individual pregnancy experiences, their engagement with healthcare facilities in Bangladesh, and the impact of MAA's MHE seminar. See *Appendix 1* for the screening and evaluation form used.

The questions were asked by JourneyMaa volunteers from the UK to the participants in Bangla and volunteers recorded their responses on the questionnaire in English. 60 women were randomly selected to complete the survey. 5 women refused to consent to their data being shared, hence a total of 55 women were included in the analysis of each response.

Further details as to the exact methodology, as well as the contents of the health camp, seminar and questionnaire, can be found in the *JourneyMaa 2017 report*, as the same method was repeated in 2018.

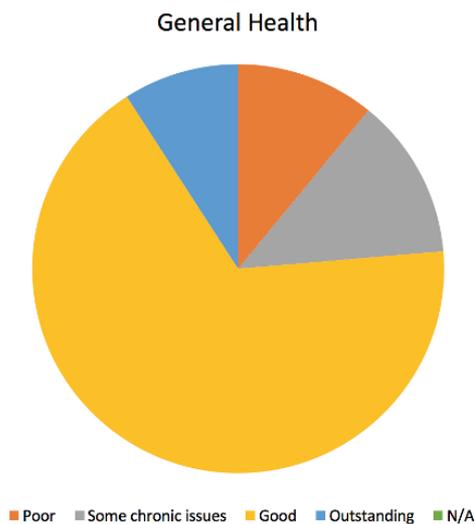
All the participants who completed the questionnaire were pregnant at the time. The questionnaire responses of 55 women are included in the following analysis in this report.

Verbal consent to take part in the questionnaire was obtained from participants. Ethical approval was obtained from Sylhet Women's Medical College. Data from the maternal health education seminar questionnaire was analysed and interpreted by MAA UK's Academics Team for this report.

## RESULTS AND DISCUSSION

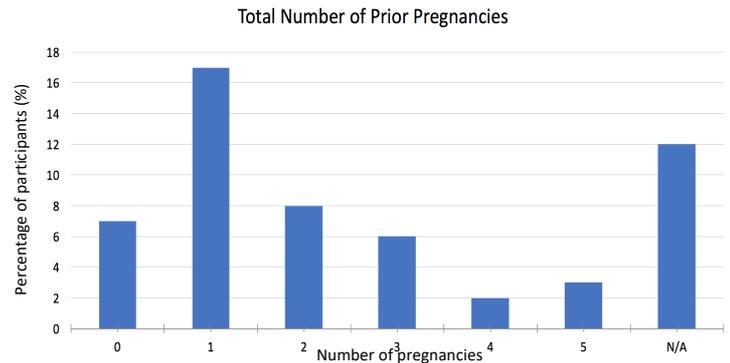
### A. GENERAL HEALTH

Overall, the general health of the participants was good. Out of 55 women, 37 women (67%) claimed to have good health and 5 women (9%) had outstanding health. 6 women (11%) stated to have poor health, with 7 women (13%) suffering from chronic issues. Significant findings for the general health section of the questionnaire included 4 women who claimed to have hypertension during the general health screening and 2 women had diabetes. Back problems were the most claimed chronic issue (29 out of 55 women had back problems). However, it must be noted that this is likely to have been as a consequence of pregnancy rather than a chronic condition (CDC, 2019).

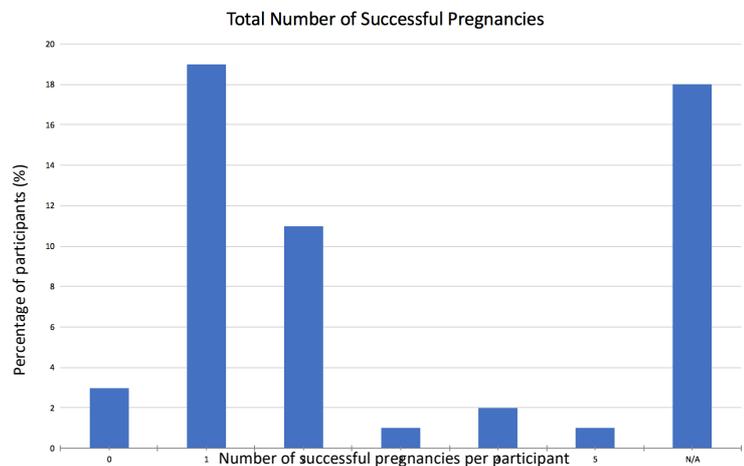


**Figure 1.** Percentage of participants (n=55) with: Some chronic issues = 13%, Poor health = 11%, Good health = 67%, Outstanding health = 9%.

### B. PREGNANCY

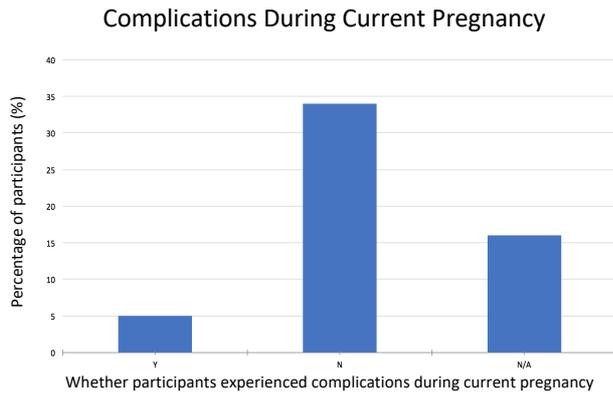


**Figure 2.** Total number of prior pregnancies (n=55): zero prior pregnancies = 7, one prior pregnancy = 17, two prior pregnancies = 8, three prior pregnancies = 6, four prior pregnancies = 2, five prior pregnancies = 3, N/A = 12.



**Figure 3.** Total number of successful pregnancies (n=55): zero successful pregnancies = 3, one successful pregnancy = 19, two successful pregnancies = 11, three successful pregnancies = 1, four successful pregnancies = 2, five successful pregnancies = 1, N/A = 18.

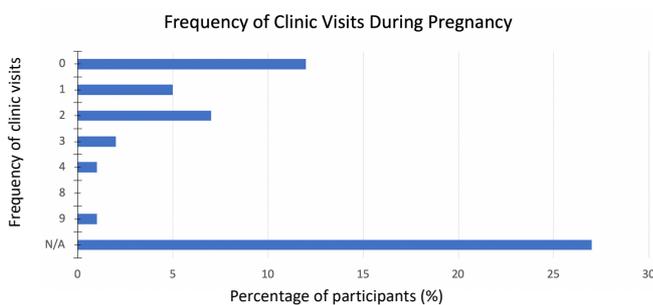
Out of 55 women, 65% had a previous pregnancy with only 13% of women describing this pregnancy as their first. However, the number of successful pregnancies did not reflect the number of prior pregnancies women reported to have had. 62% had a prior successful pregnancy and 5% claimed to have had no successful pregnancy. The reason for this discrepancy may be as a result of their current pregnancy being their first, or due to previous miscarriages.



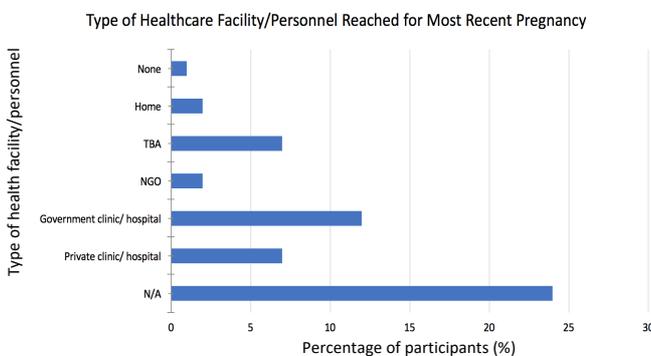
**Figure 4.** Whether participants experienced complications during their current pregnancy (n=55): Y (yes) = 5, N (no) = 34, N/A = 16.

According to figure 4, 62% of women had suffered no complications during their current pregnancy thus far. However, 9% had experienced complications. Complications of note included one woman who reported having a breech baby and another woman with premature rupture of membranes.

### C. HEALTHCARE FACILITIES

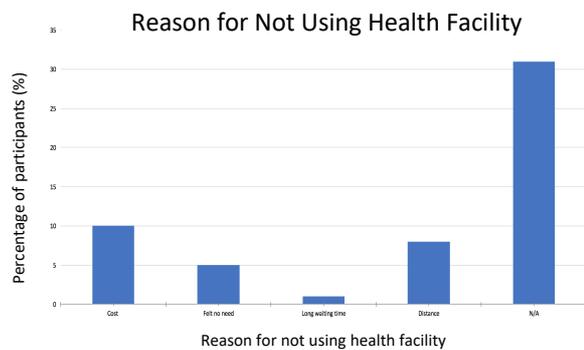


**Figure 5.** Frequency of clinic visits during pregnancy (n=55): zero = 12, one time = 5, two times = 7, three times = 2, four times = 1, eight times = 0, nine times = 1, N/A = 27.

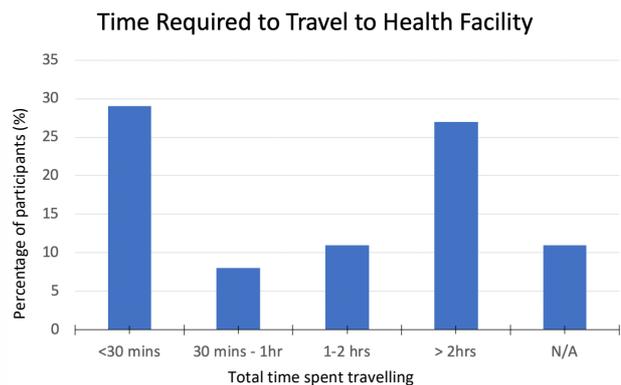


**Figure 6.** Type of healthcare facility/personnel reached for most recent pregnancy (n=55): Home = 2, Traditional birth attendant = 7, NGO = 2, Government clinic/hospital = 12, Private clinic/hospital = 7, None = 1, N/A = 24.

Figure 5 shows 22% of participants had not attended a healthcare facility during their current pregnancy, whilst 29% had attended a facility between 1 to 9 times during their current pregnancy. From figure 6, of the women who visited a health facility, 22% visited a government clinic/ hospital. Only 13% were attended by a traditional birth attendant (TBA).



**Figure 7.** Reasons for not using a health facility (n=55): Cost = 10, Distance = 8, Felt no need = 5, Long waiting time = 1, N/A = 31.



**Figure 8.** Time required to travel to a health facility (n=55) where: <30 mins = 12 women, 30mins-1hr = 11 women, 1-2 hrs = 15 women, >2hrs = 6 women, N/A = 11.

The main reasons given for not using a health facility (figure 7) were financial and travel constraints. Whilst 5 out of 55 women felt there was no need to attend a health facility, 10 women claimed cost to be the main reason for not attending and 8 women reported distance to be a problem. Distance to a health facility was further explored (figure 8), and it was found that 27% of women travelled between 1 to 2 hours to access a health facility, whilst 11% of women travelled more than 2 hours to reach one.

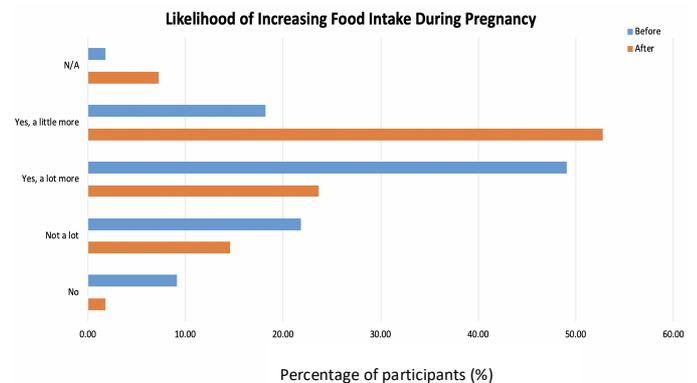
## SUMMARY

These figures highlight some of the key barriers women face in obtaining adequate healthcare. Firstly, not recognising the importance of antenatal check-ups and early detection during pregnancy leads to a delay in women’s decision to seek care. This, coupled with other deterrents such as financial constraints and long distances to appropriate medical facilities further contribute to the insufficient healthcare these pregnant women receive, which as a result, may lead to preventable maternal deaths. The obstacles noted for women’s access to healthcare is supported by the three-delay model to maternal health (Calvello et al., 2015). The model depicts how pregnancy-related mortality is due to delays in 1) deciding to seek care; 2) identifying and reaching a health facility, and 3) receiving adequate and appropriate treatment once a facility is reached (Calvello et al., 2015). Thus, the three-delay model describes and categorises the different barriers discussed by the women visiting MAA’s health camps.

## SEMINAR EVALUTION

MAA’s MHE seminar programme was introduced in JourneyMaa 2017 and positively impacted health practices and health-seeking behaviours of women during pregnancy. Therefore, the MHE programme was repeated in 2018 to continue this progress. After the MHE seminars were delivered, women were asked to complete a questionnaire which explored their current health-seeking behaviours and assessed the impact of the seminar on challenging negative health behaviours and encouraging positive ones. The overall satisfaction of the Maa MHE programme for 2018 was significantly positive with 55% of women declaring an ‘outstanding’ level of satisfaction, and 42% a ‘good’ level. Of the 55 women who consented for the questionnaire, 97% praised the programme. Most of the women (63%) expressed that their understanding of pregnancy improved following the seminar, which signifies that the general consensus is consistent with the previous feedback in 2017.

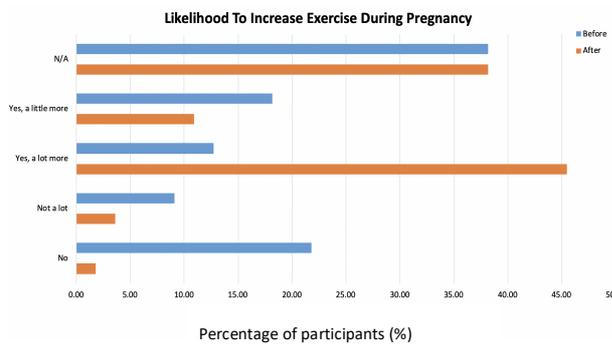
### i. NUTRITION



**Figure 9.** Number of participants (n=55) pre-seminar to respond with: no = 5, not a lot = 12, yes, a little more = 27, yes, a lot more = 10, n/a = 1. Number of participants (n=55) post-seminar to respond with: no = 1, not a lot = 8, yes, a little more = 13, yes, a lot more = 29, n/a = 4.

Nutrition is an important part of a healthy pregnancy, however, there are currently many misconceptions surrounding it in Bangladesh. Many women believe a restrictive diet means the baby will be smaller, leading to an easier delivery (Choudhury & Ahmed, 2011). In fact, this increases the risk of low birth neonates and gestational diabetes mellitus for the mother (WHO, 2015). To evaluate the knowledge of the participants on this topic, women were asked to provide their views both before and after the seminar (figure 9). It is encouraging to observe that the probability of women increasing their food intake during pregnancy was high both before and after the MHE seminars. The data suggests that women were fairly aware of the importance of nutrition prior to the seminar with nearly half (49%) stating they would increase food intake “a little” during pregnancy. Despite this, there was an encouraging 34% increase in the number of women likely to eat “a lot more” food during pregnancy after the seminar. In keeping with 2017 results of a 31% increase, this trend has so far shown a positive skew in changing health behaviours.

## ii. EXERCISE

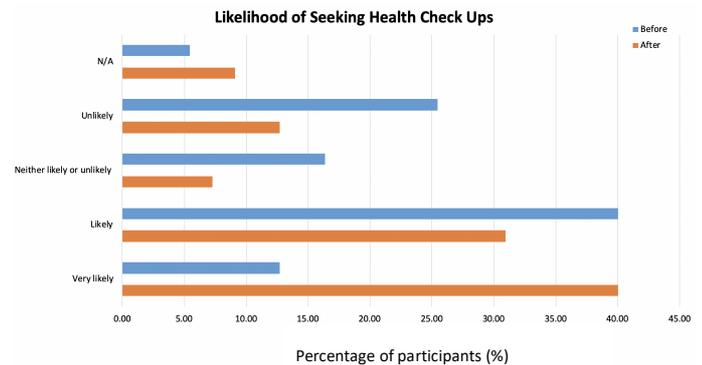


**Figure 10.** Percentage of participants (n=55) pre-seminar to respond with: yes, a little more = 18%, yes, a lot more = 13%, not a lot = 9%, no = 22%, n/a = 38%. Percentage of participant (n=55) post-seminar to respond with: yes, a little more = 11%, yes, a lot more = 45%, not a lot = 4%, no = 2%, n/a = 38%.

Many people in Bangladesh have cultural and spiritual beliefs which may limit the amount and type of activity a woman can engage in, such as restricting women from going outdoors in the evening to guard their safety (Choudhury & Ahmed, 2011). Other women may simply not recognise the importance of remaining mobile and active during pregnancy. This is reflected in the results (figure 10) as 22% of women selected “no” to the likelihood to exercise during pregnancy before the seminar. This number was substantially reduced to 2%, whilst there was a 32% increase in women stating they were “a lot more” likely to exercise during pregnancy post-seminar, highlighting the influence of the programme in shifting attitudes towards exercising during pregnancy. Although there are significant differences in responses before and after the intervention, almost 40% of participants did not to answer this question. Thus, the responses of only 33 women were recorded, making this figure less generalisable.

The importance of good hygiene practices was also included in the seminar. This was seen to be highly appreciated by participants in 2017 with 98% likely to follow recommendations around hygiene practices. This year, the majority of women (60%) were already “likely” to be more hygienic during pregnancy before attending the seminar; however, post-seminar, 60% reported being “very likely” (a 29% increase) to improve hygiene standards during pregnancy.

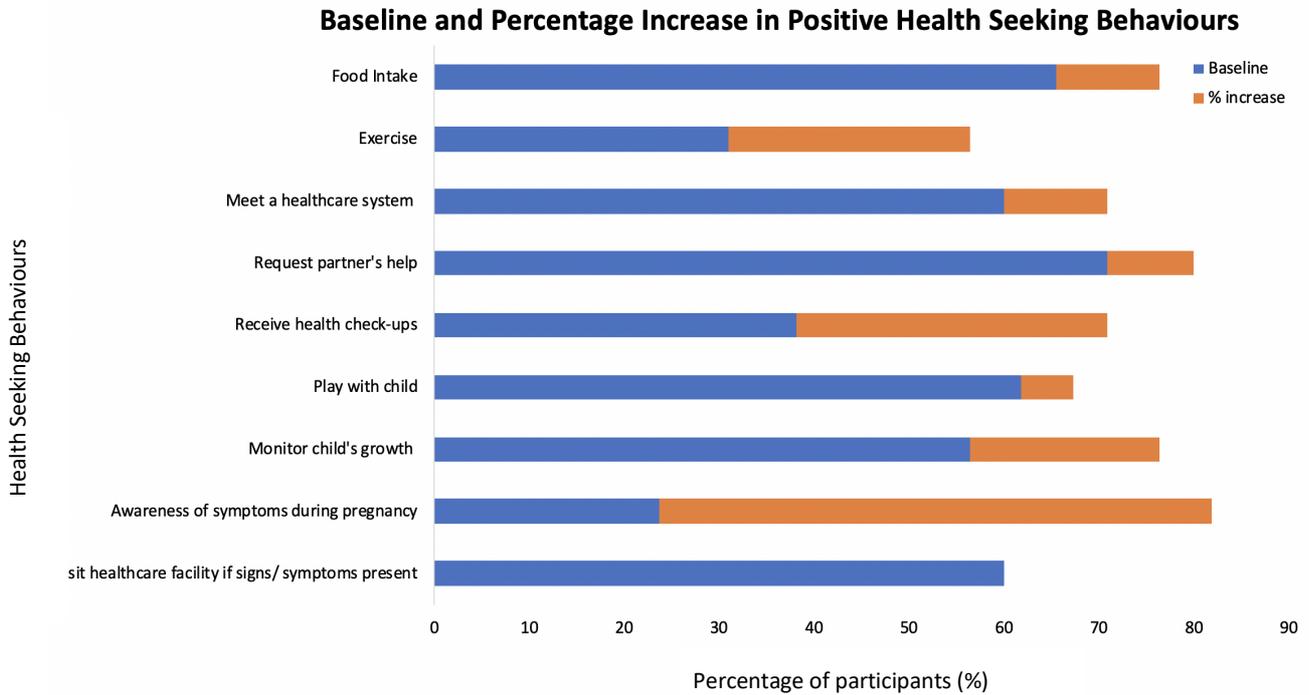
## iii. ANTENATAL CARE



**Figure 11.** Percentage of participants (n=55) pre-seminar to respond with: unlikely 25%, neither likely or unlikely 16%, likely 40%, very likely 13%, N/A = 6%. Percentage of participants (n=55) post-seminar to respond with: unlikely 13%, neither likely or unlikely 7%, likely 31%, very likely 40%, N/A = 9%..

The probability of a successful pregnancy is significantly improved by receiving health check-ups for antenatal care (UN, 2016; Bhutta et al., 2014). Last year, following the MHE seminar, the number of women more likely to seek health check-ups increased by 19%. This year, a similar increase of 18% was observed for the proportion of women more likely to seek health check-ups during pregnancy (figure 11). This illustrates how the seminar has again been consistent between the two years in positively influencing the health behaviours of women with regards to ANC. It would be interesting to explore whether women considered barriers to accessing maternal healthcare such as distance and cost when answering this question, as it may explain why the remaining 29% of women who chose to answer with “neither likely or unlikely”, “unlikely” or “n/a”.

iv. HEALTH-SEEKING



**Figure 12.** Percentage of participants (n=55); Baseline knowledge (blue); increase food intake = 65%, increase exercise = 31%, more hygienic = 91%, meet a healthcare system = 60%, request partner's help = 71%, seek health check-ups = 38%, play with child = 62%, monitor child's growth = 56.36%, awareness of symptoms during pregnancy = 24%, and visit healthcare facility if signs/symptoms present = 60%. Percentage increase (orange) of positive health seeking behaviours after educational seminar: increase food intake = 11%, increase exercise = 25%, more hygienic = -2%, meet a healthcare system = 11%, request partner's help = 9%, seek health check-ups = 33%, play with child = 5%, monitor child's growth = 20%, awareness of symptoms during pregnancy = 58%, and visit healthcare facility if signs/symptoms present = 0%.

Figure 12 explores the baseline and percentage increase in certain health seeking behaviours before and after the MHE seminar. The main positive changes were seen in physical activity, seeking health check-ups, monitoring their child's growth and the awareness of red-flag symptoms during pregnancy. These factors may have been influenced by the material in the seminar as the baseline data shows they were behaviours that less than 50% of the women had been inclined towards at baseline.

The baseline for awareness of nutrition, hygiene, and visiting a healthcare facility if signs/symptoms are present seems to be apparent in more than 50% of the women in this cohort, suggesting there is already a strong understanding and acceptance towards these behaviours.

It is interesting to note that after discussing the red-flag symptoms of pregnancy and labour, and educating women on conditions such as pre-eclampsia, post-partum haemorrhage (PPH) and urinary tract infections (UTIs), there was a 34% increase in women reporting to be more aware of, and able to recognise relevant signs and symptoms (figure 12). MAA included this in the seminars as knowledge of these symptoms and how to deal with them are critical during pregnancy and is imperative for a preventative medicine approach (Saxena et al, 2018).

However, this education did not seem to translate into anything actionable, as the proportion of women (60%) that would visit a health facility should these symptoms arise remained the same both before and after the

seminar. This is the only behaviour from figure 12 that did not show a percentage increase. This is surprising as figure 11 demonstrated an increase in the number of women who would seek regular antenatal check-ups even without experiencing any symptoms, so it is unusual that both being aware of, and experiencing symptoms would not prompt women to seek healthcare. This suggests that either the importance of seeking healthcare if these symptoms were to present was not conveyed strongly during the seminar, or that women may have been responding realistically, taking into account the different barriers to accessing healthcare that they experience. This raises a crucial point about the effectiveness of education and promoting good health-seeking behaviours without actually facilitating access to an adequate healthcare facility and allowing that education to be actioned.

## LIMITATIONS

There were many limitations to this study. Firstly, the sample size was small and corresponds to the view of only 55 women, therefore the impact of the maternal health camps cannot be accurately obtained, and the results are not generalisable to the wider population. Moreover, for logistical reasons, participants were asked about their baseline knowledge after the MHE seminar had been conducted. To reduce bias, MAA needs to ensure that participants' baseline knowledge is assessed prior to the delivery of the seminar. In this way, the true efficacy of the MHE sessions can be measured. There were also a significant number of non-applicable responses. This lack of information diminishes the overall clarity of the results as it causes discrepancies in figures. A reason for such a gap in information may have been due to the language barrier between interviewers and participants. This is because the JourneyMaa volunteers from the UK had varying levels of Bangla speaking abilities and this caused issues when translating the questionnaire to the women in Bangla and recording their responses in English. Where questions were not adequately communicated, many of the women would have found it difficult to respond, resulting in no

responses. There were also inconsistencies in the questioning styles of each interviewer, thus adequate training prior to the health camps would have been beneficial for standardization of the questionnaires. Moreover, there may have been a lack of clarity in defining certain terms, such as what qualifies as a 'chronic condition' or a 'successful pregnancy'. It would have also been useful and insightful to have included the number of abortions, miscarriages, stillbirths and neonatal deaths to the questionnaire. Finally, it is difficult to truly gauge whether the participants will actually implement the knowledge gained through attending our camps in their daily lives through the questionnaires. Therefore, in the future, it would be beneficial to follow up participants at regular intervals during their pregnancy to gauge the long-term impact of the camps in influencing women's health-seeking behaviours during pregnancy and post-partum.

## CONCLUSION

This study provides a small insight into the current state of maternal healthcare in rural Bangladesh. The pregnancy screening results demonstrated some of the key barriers that women face in accessing adequate healthcare, with cost and distance being the largest constraints. The Maa MHE seminar evaluations depict the positive impact of the sessions in improving the practices and health seeking behaviours of the participants during pregnancy and post-partum. In particular, improvements were seen in women's acknowledgement of red-flag symptoms during pregnancy. Although there were limitations to the study, these have been highlighted and steps will be taken to overcome them in future JourneyMaa projects. In the future, MAA hopes to tackle some of these barriers to maternal healthcare through strengthening the primary healthcare services and health education delivered to pregnant women. In doing so, MAA will be targeting the different delays women experience in accessing adequate maternal healthcare and will thus be one step closer to revolutionising maternal healthcare in Bangladesh.

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## Appendix 1 – Maternal Health Screening and Evaluation

PERSONAL INFORMATION			
Mr/Mrs/Ms/Miss	Last name:	First name:	Marital status:
Address:		Birth date:	Age:
			Sex: <input type="radio"/> M <input type="radio"/> F
GENERAL HEALTH INFORMATION			
In general, what is the quality of your health:	<input type="checkbox"/> Outstanding Other comments:	<input type="checkbox"/> Good	<input type="checkbox"/> Some chronic issues <input type="checkbox"/> Poor
How often have you visited a healthcare facility in the past year:	<input type="checkbox"/> First visit Other comments:	<input type="checkbox"/> 2-5 visits	<input type="checkbox"/> 6-10 visits <input type="checkbox"/> > 10
General Health Screen:	<input type="checkbox"/> Allergies <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension Neurological <input type="checkbox"/> Psychiatric conditions Seizures Other comments:	<input type="checkbox"/> Back problems <input type="checkbox"/> Epil:psy <input type="checkbox"/> Joint problems <input type="checkbox"/> Recent surgery	<input type="checkbox"/> Balance problems <input type="checkbox"/> Heart problems <input type="checkbox"/> Liver disease <input type="checkbox"/> Cancer <input type="checkbox"/> Hernia <input type="checkbox"/> <input type="checkbox"/> Respiratory <input type="checkbox"/>
PREGNANCY SCREENING			
Are you currently pregnant?	<input type="radio"/> Yes <input type="radio"/> No	Have you been pregnant before?	<input type="radio"/> Yes <input type="radio"/> No
How many times have you previously been pregnant?		How many pregnancies were successful?	
Did you receive medical care during your pregnancy at the health clinic?	<input type="radio"/> Yes <input type="radio"/> No	How many times did you visit the clinic during your pregnancy?	
Any complications with the pregnancies? Explain	<input type="radio"/> Yes <input type="radio"/> No		
What type of health facility did you visit for your most recent pregnancy?	<input type="checkbox"/> Government clinic/hospital attendant Other:	<input type="checkbox"/> Private clinic/hospital <input type="checkbox"/> NGO	<input type="checkbox"/> Traditional birth
If you did not use a health facility, what was the main reason?	<input type="checkbox"/> Long waiting time not available Other:	<input type="checkbox"/> Distance <input type="checkbox"/> Cost	<input type="checkbox"/> Doctors/Medicines
How long did it take you to travel to the health facility?	<input type="checkbox"/> < 30 mins hrs Other:	<input type="checkbox"/> 30 mins – 1 hr <input type="checkbox"/> > 2 hrs	<input type="checkbox"/> 1 – 2
What health services did you receive when you visited the clinic?	<input type="checkbox"/> Physical examination examination	<input type="checkbox"/> Gynaecological <input type="checkbox"/> Ultrasound	<input type="checkbox"/> Blood test

	<input type="checkbox"/> HIV/STD tests vaccinations Other:	<input type="checkbox"/> Nutritional supplements	<input type="checkbox"/> Any	
During delivery, what healthcare staff were you attended by?	<input type="checkbox"/> Doctor Midwife Other:	<input type="checkbox"/> Nurse <input type="checkbox"/> SBA	<input type="checkbox"/>	
How happy were you with the care you received from the healthcare staff?	<input type="checkbox"/> Very satisfied or dissatisfied Other:	<input type="checkbox"/> Satisfied <input type="checkbox"/> Dissatisfied	<input type="checkbox"/> Neither satisfied	
EVALUATION SUMMARY				
	BEFORE		AFTER	
How likely are you to increase your food intake for pregnancies?	<input type="checkbox"/> Yes, a lot more little more <input type="checkbox"/> Not a lot	<input type="checkbox"/> Yes, a <input type="checkbox"/> No	<input type="checkbox"/> Yes, a lot more <input type="checkbox"/> Not a lot	<input type="checkbox"/> Yes, a little more <input type="checkbox"/> No
How likely are you to give up smoking?	<input type="checkbox"/> Yes, a lot more little more <input type="checkbox"/> Not a lot	<input type="checkbox"/> Yes, a <input type="checkbox"/> No	<input type="checkbox"/> Yes, a lot more <input type="checkbox"/> Not a lot	<input type="checkbox"/> Yes, a little more <input type="checkbox"/> No
How likely are you to exercise during pregnancy?	<input type="checkbox"/> Yes, a lot more little more <input type="checkbox"/> Not a lot	<input type="checkbox"/> Yes, a <input type="checkbox"/> No	<input type="checkbox"/> Yes, a lot more <input type="checkbox"/> Not a lot	<input type="checkbox"/> Yes, a little more <input type="checkbox"/> No
How likely are you to be more hygienic (wash hands, clean food) now?	<input type="checkbox"/> Very likely <input type="checkbox"/> Neither likely or unlikely	<input type="checkbox"/> Likely <input type="checkbox"/> Unlikely	<input type="checkbox"/> Very likely <input type="checkbox"/> Neither likely or unlikely	<input type="checkbox"/> Likely <input type="checkbox"/> Unlikely
How likely are you to meet the healthcare system for a pregnancy?	<input type="checkbox"/> Very likely <input type="checkbox"/> Neither likely or unlikely	<input type="checkbox"/> Likely <input type="checkbox"/> Unlikely	<input type="checkbox"/> Very likely <input type="checkbox"/> Neither likely or unlikely	<input type="checkbox"/> Likely <input type="checkbox"/> Unlikely
How likely are you to request your partners help?	<input type="checkbox"/> Very likely <input type="checkbox"/> Neither likely or unlikely	<input type="checkbox"/> Likely <input type="checkbox"/> Unlikely	<input type="checkbox"/> Very likely <input type="checkbox"/> Neither likely or unlikely	<input type="checkbox"/> Likely <input type="checkbox"/> Unlikely
How likely are you to receive health check-ups?	<input type="checkbox"/> Very likely <input type="checkbox"/> Neither likely or unlikely	<input type="checkbox"/> Likely <input type="checkbox"/> Unlikely	<input type="checkbox"/> Very likely <input type="checkbox"/> Neither likely or unlikely	<input type="checkbox"/> Likely <input type="checkbox"/> Unlikely
How willing are you to spend time each day playing with your child?	<input type="checkbox"/> Very likely <input type="checkbox"/> Neither likely or unlikely	<input type="checkbox"/> Likely <input type="checkbox"/> Unlikely	<input type="checkbox"/> Very likely <input type="checkbox"/> Neither likely or unlikely	<input type="checkbox"/> Likely <input type="checkbox"/> Unlikely
How likely are you to monitor your child's growth (height/weight)?	<input type="checkbox"/> Very likely <input type="checkbox"/> Neither likely or unlikely	<input type="checkbox"/> Likely <input type="checkbox"/> Unlikely	<input type="checkbox"/> Very likely <input type="checkbox"/> Neither likely or unlikely	<input type="checkbox"/> Likely <input type="checkbox"/> Unlikely
How aware are of the signs/symptoms of any diseases during pregnancy?	<input type="checkbox"/> Very likely <input type="checkbox"/> Neither likely or unlikely	<input type="checkbox"/> Likely <input type="checkbox"/> Unlikely	<input type="checkbox"/> Very likely <input type="checkbox"/> Neither likely or unlikely	<input type="checkbox"/> Likely <input type="checkbox"/> Unlikely
How likely are you to contact/visit healthcare staff if you become aware of these signs/symptoms?	<input type="checkbox"/> Very likely <input type="checkbox"/> Neither likely or unlikely	<input type="checkbox"/> Likely <input type="checkbox"/> Unlikely	<input type="checkbox"/> Very likely <input type="checkbox"/> Neither likely or unlikely	<input type="checkbox"/> Likely <input type="checkbox"/> Unlikely
CONSENT				
The above information is true to the best of my knowledge. By agreeing to complete this form I authorize MAA to release any information required for further research.				
Signed:				