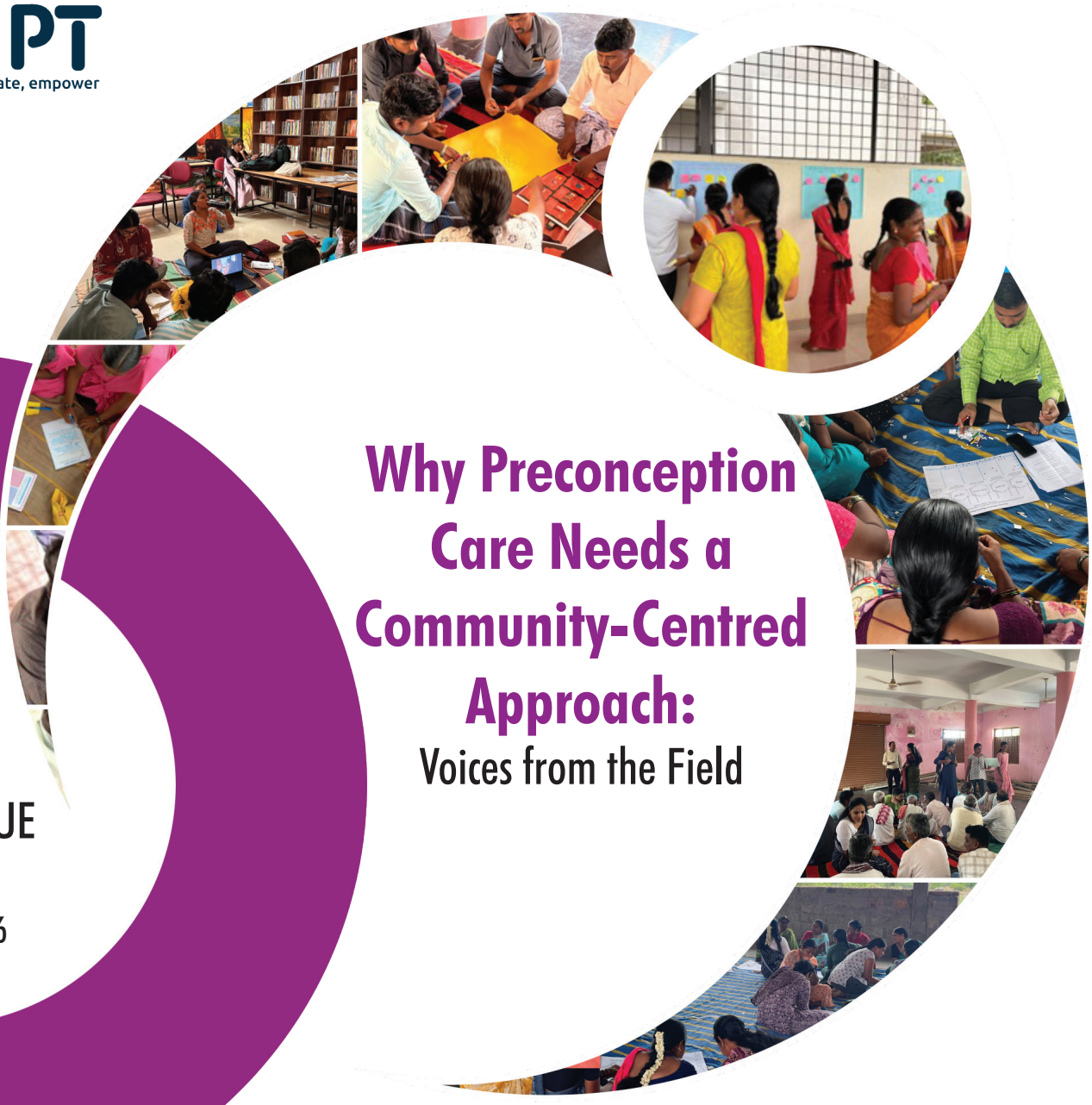
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Why Preconception Care Needs a Community-Centred Approach:

Voices from the Field

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Introduction

Preconception Care (PCC) is defined by the WHO as the "provision of biomedical, behavioural and social health interventions to women and couples before conception occurs" (WHO 2014). It includes nutrition, health check-ups, family planning, and emotional wellbeing - all before pregnancy even begins.

PCC matters especially in the Indian context, where the median age of marriage for women is 19.2 years, and first birth, 21.2 years (IIPS 2021). This means most women conceive within two years of marriage, often before they are physically and mentally ready, still adjusting to their marital home and family expectations. Often poor nutrition, heavy household work, and intimate partner violence (IPV) compound these experiences, leaving little time or space to prepare for a healthy pregnancy.[3] Other literature shows under and over nutrition, intimate partner violence, tobacco and alcohol consumption to be risk factors for women in the preconception stage.[4]

Currently, public health responses to PCC are fragmented. Programmes like Anaemia Mukt Bharat (AMB) and Anaemia Muktha Poushtika Karnataka (AMPK) focus on anaemia and nutrition; Rashtriya Kishor Swasthya Karyakram (RKSK) works with adolescents; the Indian Newborn Action Plan (INAP) works to reduce neonatal mortality. No single programme, however, encapsulates the full PCC model, and aspects like mental health, interpersonal communication between spouses, and family decision-making dynamics are rarely addressed at all.

There is a need to work with families, communities and couples in designing care. A recent comprehensive scoping review across various low- and middle-income countries (LMICs), identifies individual level

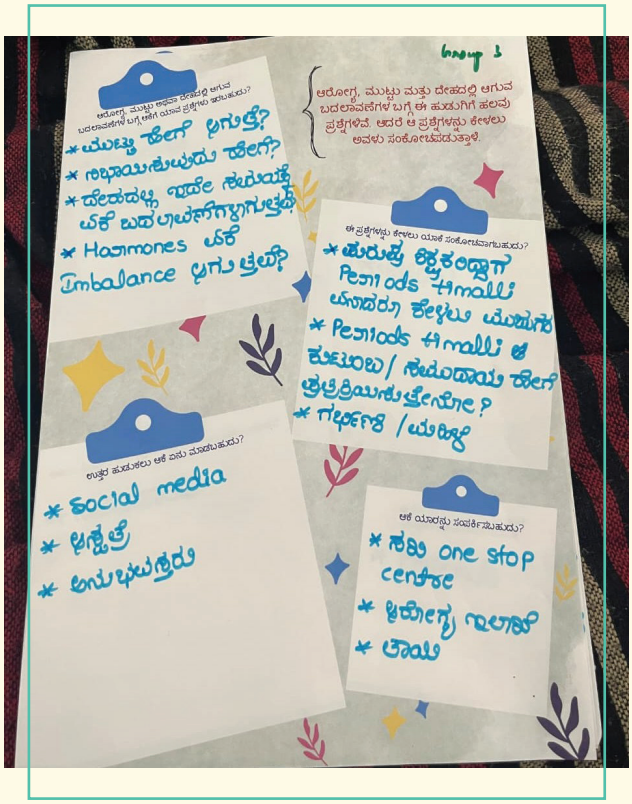
factors such as knowledge and awareness and women's empowerment, family level factors such as partner support and influence of friends and family, and community level factors such as healthcare services cost and delivery challenges, as barriers to be addressed through PCC programs.[5] However, they note that further research is required to overcome the barriers and harness the facilitators for effective PCC programs.[5] This brief builds on existing literature and offers community's perspectives on PCC and offers insights for developing holistic PCC interventions. While these directions for PCC are general in nature, we acknowledge the need for more in-depth field-based engagements within specific contexts and communities for developing contextualized interventions.

Methodology

Our team carried out six participatory workshops across Vijayanagara, Koppal, and Kunigal in Karnataka, engaging women across different age groups, adolescent girls, men, eligible couple and frontline workers. The aim was twofold: to understand community needs and perspectives on women's sexual and reproductive health (SRH), marriage, conception, and family planning, and to think through - together with communities - on designing a PCC intervention.

Group	Location	Methods
30 women (20-60 years) 36 men (20-60 years) 15 Adolescent girls (17-22 yrs) 10 FLWs 11 Eligible couples	Tumkur, Vijayanagara, Koppal	Daily timeline mapping Influence mapping Story cards FGDs Vignettes Story-based, film-based discussions

Key insights for developing a holistic, community-centred PCC intervention are given below, drawn from a narrative analysis of the information shared by key informants.



Marriage and Conception Through a Community Lens:

Field-based Insights

Preparing for marriage

Across field sites, girls had mostly completed 12th Std or graduation, and women's education levels were higher than their partners, but most did not hold paid jobs. Girls also recounted the inevitability of marriage, which mostly arrived early, even when it was not their priority. Data shows that one in five girls are married by the age of 18 years.[2] Against this context they emphasized the importance of 'skills' for jobs, as a protection against future possibilities of unsupportive marriages, separation and widowhood. Adolescent girls from Koppal reported having received negative impressions of life after marriage from older women in the family, but no information related to SRH or nutrition. However, they expressed confidence in navigating marriage with skills, suggesting a valuable and meaningful entry point for PCC through a holistic adolescent development and life-course approach.[1]

> Girls recount the inevitability of marriage and the importance of 'skills' to navigate precarious post-marriage futures.

- "Maduve namage bekadaru bedadaru aaguthe" (Whether we want or don't want it, we will get married)

Choosing a partner

Marriage across the sites largely continued to be arranged by families, who weigh considerations of government jobs, wealth, and social standing in groom selection, with negligible say for couples; though love marriages are becoming more common, in peri-urban areas like Kunigal. Young men and women also have minimal opportunity to speak to one another before marriage, through occasional phone calls and during the engagement ceremony.

[1]The adolescent girls engaged through the workshops were part of the Sphoorthi Girls Empowerment program conducted by KHPT to improve adolescent health, nutrition and prevent child marriages

Advice before marriage

Field insights showed that advice before marriage is gendered and incomplete. Girls are told mainly about **"ಹೊಂದಾಣಿಕೆ"** or adjusting to their new household: waking up early, doing pooja, respecting elders, and keeping the peace. Boys get advice from friends on courtship and affectionate communication with fiancé, and contradictory advice from mothers to retain control over their partners, to avoid pampering them before marriage so that they learn early to adjust and fit into the family. Neither group receives much information about SRH or family planning before marriage – a gap raised in every single workshop, from adolescent girls', women, men, to eligible couples and frontline workers.

> While girls and boys are prepared with messages around women's adjustment to marital homes, no information is available to them on intimate partner relationships, SRH or family planning



Settling in after marriage

Across the workshops, respondents described the period immediately after marriage as difficult and fragile for the woman, who has to learn about household routines, her partners' preferences, and so on from in-laws, i.e., mothers, sisters or brothers of the partner. In India, anywhere between 32-77 per cent women face domestic violence as per national estimates, resulting in fatal or non-fatal impacts on women and children's health.[6] A recurring finding across workshops was that couples only found time to speak privately to each other at night, after work and household chores were over, Couples emphasised that speaking privately to each other in front of family was considered inappropriate. One participant humorously described these conversations as a nightly "crime report," on how the day had gone. Discussions on planned or shared futures and understanding each other's aspirations were however rare.



Pressure to conceive, and who decides when

The workshops also showed that "Good news" is asked about, often jokingly, from the very first meeting with relatives that happens after marriage; pressure builds sharply after the first year of marriage. Nearly all respondents also stated that conception was understood as something that does not require planning and should not be planned as a child is considered a gift from God, arriving in its own time. In cases where couples did delay pregnancy, it was mostly always because of practical circumstances such as health or finances, rather than a deliberate, discussed decision. Importantly, decisions around conception, delaying pregnancy, spacing and sterilization, are considered family decisions, rather than couple's or women's decisions. Even men reported difficulties in negotiating such decisions if not in line with the family's wishes.

> Childbirth is seen as 'God's gift', arriving in its own time, with no planning or intervention required

Two children is a widely accepted norm, and after which even families advise the couple to go for sterilization. Communities widely believed that one must have as many children as one can afford ("aasthi thakkantha makkalu irabeku"). It was usually women who were expected to adopt permanent family planning methods, while men's use of family planning was dismissed even by women themselves.





What influences and information matter during the preconception period

As seen above, little information is available to girls and women on preconception care prior to marriage. Post marriage, ASHAs and Anganwadi workers are trusted for nutrition guidance, antenatal care, and referrals, but not for sensitive topics like sex, sexual health, fertility, or family planning. While medical interventions are considered the last resort for difficulties with conception, preference is awarded to temples, local faith healers and prayers. Medical doctors are seen as the appropriate sources to provide information on technical concerns such as how sex of child is determined, to reduce gendered violence. The influence of medical doctors was also described as much higher after first conception, when couples are much more receptive to pregnancy- and post-delivery related advice, including temporary and permanent methods of sterilization

Messaging on PCC immediately after marriage, however, was considered as mis-timed by men and FLWs, when couples were reportedly not mentally prepared for a child.

> There is a need to reconsider the timing, messaging and messenger for PCC, based on couples' preparedness, and community perceptions around child birth and planning

For example, for women, informal networks of influence by mothers, older sisters, and friends prior to marriage, and mothers-in-law and marital families post marriage, suggest the need to engage these networks in PCC care. Further, older women (i.e., a few years into marriage) in the household and community, who were reportedly able to negotiate decisions around conception, spacing, childbirth, rest, and household matters better than newly married women, also emerged as potential community-level mentors for newly married women.

For men, friends are by far the most influential voice on positive relationships, communication and emotional support within marriage, though not for health- or family planning-related decisions. However, men's peer groups provide an important avenue through which health-related messages on PCC can be provided. Men also emphasized the need for one-to-one counselling for PCC rather than group strategies, reiterating that such discussions are personal, and not to be externally influenced or disclosed. Novel strategies to engage these stakeholders was considered important as pregnancy is considered a "women's issue", with low male engagement; however, women's management of health prior to pregnancy is strongly influenced by family members such as mothers-in-law and husbands.

> Pregnancy is considered a 'women's issue', with low male engagement. Thus novel strategies to engage family and men is required



Pregnancy and after

Once conception happens, support becomes highly visible and well organised, largely through mothers, mothers-in-law, and ASHA workers, with husbands playing a supportive role and taking on financial responsibilities. However, this support was described as almost entirely practical and biomedical: rest, nutritious food, hospital visits, vaccination follow-up. The emotional and relational sides of pregnancy, particularly during subsequent pregnancies (as women worry about the consequences of having a second girl child) and early parenting, the importance of intimate relationship between spouses were rarely discussed on their own, unless specifically prompted.

> Support for pregnant women was described almost entirely in biomedical terms, rather than in emotional or relational terms

What This Means for Designing Community-Based PCC Strategies

01 Reconsidering the unit for PCC delivery

Reproductive decisions are mainly family decisions, and not independently undertaken by the couple. Hence family-centric approaches, involving mothers-in-law, husbands and other influential members of the family is important. Scientific literature on PCC also reiterates this observation. Partner support, family's cultural beliefs and practices, and role models within the family are seen to play an important role in influencing PCC decisions and planning in countries such as India, Pakistan, Kenya, South Africa and New Zealand.[5] Yet, most PCC interventions are designed around the couple as the target unit. Reconceptualising how PCC interventions can engage different members of the family individually and collectively is important for better PCC outcomes.

02 Harnessing social networks and influencers within the community

FLWs and medical doctors are trusted for biomedical guidance, but not for sensitive topics like sex, fertility, or family conflict. Peers, older women and media have better reach here, especially with influential decision makers like mothers-in-law. Existing research also demonstrates the importance of harnessing social networks for PCC messaging, as friends and family can act as significant barriers in accessing information from the health system, and are relied upon more for PCC information.[5] PCC interventions must consider how mentorship models for newly married women, social networks and peer groups for men, can be used to deliver biomedical, socio-emotional messages, and address gender and social norms related to PCC.

03 Identifying entry points for PCC discussions, harnessing women's recreational interests

Media, films, serials, street play and social media reels offer novel opportunities to bring mothers-in-law, younger and older women in community to discuss gendered aspects of pregnancy and preconception care.

04 Timing PCC interventions

Identifying the ideal timing for PCC interventions can play an important part in influencing the uptake and impact of messages. While newly married men are less willing to attend or engage with PCC interventions, and newly married women have far little bargaining power than women married for three years or more, girls and women in late adolescence and early adulthood (17.5 to 22 years) and young men prior to and during the engagement period (20+ years) show willingness to engage with PCC messaging.

05 Holistic approach and addressing gendered barriers to PCC

PCC delivery today is almost entirely biomedical: nutrition, health screening, folic acid supplementation. It is not just the absence of adequate health information or knowledge that are currently barriers to uptake of PCC; but also unequal power relations within the household, and lack of autonomy in relation to reproductive health choices. PCC interventions must address the gendered, social and socio-emotional aspects such as sensitization of significant members of the family, addressing masculinities, empowerment of women, and healthy couple's communication, to be effective.

06 PCC requires a health-systems and community-centric approach

While health screening, nutritional counselling, availability of contraceptives, counselling for family planning can be made available through FLWs, health officers and sub-centres, it is also important to identify influential and trusted members within the community, such as community or religious leaders, Self-Help Groups, Kavala Samiti (or Women and Child Protection Committee) members who can address the gendered and normative barriers for PCC.



What Potential Models Should Emphasise

The field explorations offer directions for a mutli-stakeholder PCC intervention. Four key stakeholders around whom interventions should be designed include: eligible couples, mothers-in-law, men, and families. The model must adopt a multi-layered approach to address barriers to PCC at the individual, family and community level. Working across these levels can therefore help address not only **individual knowledge and behaviours,** but also the **interpersonal** and social **environments** that influence them. Beyond nutrition, literature emphasizes the need for interventions that address women's confidence and agency, interpersonal communication, spousal participation and support, psychosocial well-being and reduction in domestic violence.[4,6]

PCC interventions can be delivered through existing community level platforms and frontline staff: for example, through one-to-one counselling on PCC and interpersonal communication, for couples during home visits by ASHAs or Anganwadi workers. Other stakeholders within the family can similarly be engaged during such visits through innovative methods such as games or films, to build a supportive home environment for women within the family through nutrition, rest and care.

At the community level, intergenerational groups of women (comprising of women in the reproductive age, but also older women or mothers-in-laws) can be addressed through platforms such as Thayindra Sabhes or VHNDs within Anganwadis, or as part of SHG groups to further sensitize them on the gender and social norms that are barriers to PCC. Similarly, men's interest groups or peer groups can be explored at the GP level, as part of NREGA groups or by harnessing the space of the library, where a trained facilitator from the community can address masculinity norms and encourage male participation in PCC. Across these different platforms gender sensitisation, health knowledge-sharing, and promoting health-seeking behaviours, through participatory, community-rooted activities such as dialogues, role plays, films/ theatre, peer engagement, counselling, screening and preparedness activities must be planned and implemented through a convergence approach.

Conclusion

Community-based insights show that PCC interventions cannot be delivered as a standardised, fragmentary programmes addressing only the bio-medical aspects of preconception care. Families, not individuals, make the decisions that affect PCC uptake and gendered barriers prevent women from receiving timely PCC. What is trusted, delayed, or avoided in relation to PCC also depends on who is asking, and when. More research is also needed to contextualise interventions and design PCC models for specific vulnerable groups (e.g., urban versus rural communities; tribal, minority and migrant communities, etc). As we move forward, continued investment in participatory, community-based field learning strategies to engage communities in PCC, along with biomedical service delivery, will be essential to close the gap between what PCC promises and what community life actually requires.





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