Assess the Constraints to Promote Long-Acting and Permanent Contraceptive Methods (LAPMs)

National Institute of Population Research and Training (NIPORT)
Azimpur, Dhaka

Conducted by
Human Development Research Centre (HDRC)

Dhaka: August 2013

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Director General

National Institute of Population
Research and Training (NIPORT)
Ministry of Health and Family Welfare

FOREWORD

The National Institute of Population Research and Training (NIPORT) under the Health, Population and Nutrition Sector Development Program (HNPSDP) of the Ministry of Health and Family Welfare (MOHFW) have been assigned to conduct the study entitled “Assess the Constraints to Promote Long-Acting and Permanent Methods (LAPMs)” in 2013. Human Development Research Centre (HDRC) under the overall guidance of NIPORT has carried out the study with an aim to address the causes of not accepting the LAPMs in order to provide appropriate recommendations for its promotion.

The study identified that the problems lying with low acceptance of LAPMs are both from the demand and supply side. The programme has failed to create demand that much due to socio-cultural problems and lack of proper BCC approach through use of media communication, lack of counseling of couples and involvement of community and religious leaders. Husbands in most of the cases are not counseled about its advantages and some probable side effects of LAPMs. In supply side, lack of a quality approach and subsequent sufferings from complications of LAPMs has a negative impact that discourages others to accept it. Problems with leadership, shortage of manpower and supply of IUD and implants, and shortage of MSR for LAPMs also are great obstacles towards quality service provision.

I believe that the study findings will help in formulating appropriate strategies to resolve the problems lying with low acceptance of LAPMs.

I am grateful to the researchers of HDRC, who have generously helped us to bring out this research report within stipulated time frame.

I express my gratitude to the professionals of NIPORT for their sincerest efforts in publishing this report.

Shelina Afroza, *Ph.D*

Director Research

National Institute of Population
Research and Training (NIPORT)
Ministry of Health and Family Welfare

PREFACE

The study entitled “Assess the Constraints to Promote Long-Acting and Permanent Methods (LAPMs)” conducted during the year 2013 is a collaborative effort of National Institute of Population Research and Training (NIPORT) and Human Development Research Centre (HDRC) conducted with an aim to address the causes of not accepting the LAPMs in order to provide appropriate recommendations for its promotion.

The study is basically a sample survey conducted in all 7 divisions and has identified the problems lying with low acceptance of LAPMs both from the demand and supply side. In spite of increasing acceptance of family planning, in one side the programme has failed to create demand on LAPMs that much due to socio-cultural problems and lack of proper BCC approach through use of media communication, lack of counseling of couples and involvement of community and religious leaders. On the other hand, in supply side, due to lack of quality approach and subsequent sufferings from complications of LAPMs has created a negative impact that has discouraged couples to accept it. The study has also identified that, problems with leadership, shortage of manpower and supply of IUD and implants, and shortage of MSR for LAPMs are great obstacles towards quality service provision to attract couples to accept it.

I would like to acknowledge the contributors with great appreciation for their sincere contributions in finalization of this report.

I also express my thanks to HDRC for completion of this research report.

I am deeply indebted to the professionals of the Research unit of NIPORT for their sincerest efforts for completion of this report.

Md. Rafiqul Islam Sarker

ACKNOWLEDGEMENTS

In Bangladesh, currently only 8 percent of the married couples use a long-acting and permanent method (LAPM), that account for 13 percent of contraceptive use. The plateauing of LAPM is of concern, and in this backdrop, Human Development Research Centre (HDRC) has been assigned by National Institute of Population Research and Training (NIPORT) to conduct the research to assess the constraints to promote long-acting and permanent contraceptive methods (LAPMs). This report has been prepared by HDRC after completion of the study with due attention to quality in all activities from data collection to preparation of report.

We are grateful to M.M. Neaz Uddin, Secretary, Niru Shamsun Nahar, Joint Chief (Planning), Shaila Sharmin Zaman, Senior Assistant Chief, Ministry of Health and Family Welfare, Government of Bangladesh for their valuable support provided for the study.

It is an outcome of team effort of the Consultants of Human Development Research Centre (HDRC) and relevant officials of NIPORT. We would like to express our sense of deep gratitude to Dr. Shelina Afroza, Director General, NIPORT for entrusting us to conduct this nationally important study, and their sincere cooperation extended throughout the study.

We are immensely grateful to Md. Rafiqul Islam Sarker, Director (Research) and Mohammed. Ahsanul Alam, Evaluation Specialist, and Mr. Subrata Kumar Bhadra, Senior Research Associate from NIPORT for their contribution in finalizing study methodology and data collection instruments.

We are sincerely indebted to A. K. M. Amir Hossain, Director General, Directorate General of Family Planning (DGFP), Dr. Abul Kalam Azad, Additional Director General, Directorate General of Health Services (DGHS), Dr. Deen Mohammad, Director and Line Director, ESD, DGHS, Dr. Mohammed Sharif, Director, MCH Services and Line Director, MCRAH, DGFP, Dr. A.K.M. Mahbubur Rahman, Line Director, Clinical Contraception Services Delivery Program, DGFP, Government of Bangladesh. We are highly grateful to Dr. A. J. Faisal, Country Representative, Engender Health, Bangladesh, Prof. Latifa Shamsuddin, President, Obstetrical and Gynaecological Society of Bangladesh (OGSB), Prof. Parvin Fatema, General Secretary, Obstetrical and Gynaecological Society of Bangladesh (OGSB) for their valuable information provided in the study. We are thankful to Deputy Directors of Family Planning of survey districts for their support provided throughout the field data collection process, and Upazila Family Planning Officers (UFPOs), Medical Officer-MCHs (MO-MCHs), FWVs, FPIs, and FWAs who cooperated with us during key informant interviews. Our special thanks go to all respondent women, who participated in household survey.

We are indeed grateful to the technical and support staff of HDRC, and all the field staffs worked in data collection process for this study.

All our efforts with this study would really be fruitful on the day when LAPM will be well practiced and Bangladesh will achieve the replacement level fertility at the earliest.

Abul Barkat, *Ph.D*
Chief Advisor (Hon.)
Human Development Research Centre (HDRC)
&
Team Leader of the Study

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
BCC	Behavior Change Communication
BDHS	Bangladesh Demographic and Health Survey
BMMS	Bangladesh Maternal Health Services & Mortality Survey
CPR	Contraceptive Prevalence Rate
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
EA	Enumeration Area
EOC	Emergency Obstetric Care
FPI	Family Planning Inspector
FS	Field Supervisor
FWA	Family Welfare Assistant
FWC	Family Welfare Center
FWV	Family Welfare Visitor
HDRC	Human Development Research Centre
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IEM	Information Education Motivation
IUD	Intrauterine Device
KII	Key Informant Interview
LAPM	Long-Acting and Permanent Methods
MCWC	Maternal and Child Welfare Centre
MIS	Management Information System
MOHFW	Ministry of Health and Family Welfare
MO-MCH	Medical Officer-Maternal and Child Health
MSR	Medical and Surgical Requisite
NGO	Non-Government Organization
NIPORT	National Institute of Population Research and Training
OGSB	Gynecological Society of Bangladesh
QCO	Quality Control Officer
SACMO	Sub-assistant Community Medical Officer
STD	Sexually Transmitted Diseases
UFPO	Upazila Family Planning Officer
UHC	Upazila Health Complex
UPHCP	Urban Primary Health Care Program

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EXECUTIVE SUMMARY

Background

In Bangladesh, population program had a tremendous progress in eighties and nineties and still it is in progress. Use of different family planning methods have increased with rise of contraceptive prevalence rate (CPR) from 7.7 in 1975 to 61.2 in 2011. However, the method mix has changed over the past two decades, and currently 8 percent of the married couples use a long-acting and permanent method (LAPM), namely IUD, implants, and male and female sterilization. Overall, the plateauing of LAPMs is of concern, as fertility is now so low that most child-bearing is completed by the mid-to-late twenties, and the women face two subsequent decades of reproductive life depending on the hormonal methods, during which they could easily protect themselves from unwanted pregnancies and unsafe abortion through use of different LAPMs.

In this backdrop, National Institute of Population Research and Training (NIPORT) has assigned Human Development Research Centre (HDRC) to conduct the research study entitled “Assess the constraints to promote long-acting and permanent contraceptive methods (LAPMs)”. This report has been prepared by HDRC under overall guidance of NIPORT with due attention to quality in all activities from data collection to preparation of report.

Objectives of the Study

The **broad objective** of the study is to assess reasons for not accepting long acting and permanent methods in order to provide appropriate recommendations to promote long acting and permanent contraceptive methods.

The **specific objectives** of the study are:

1. To know the knowledge of long term permanent method (availability, advantages, disadvantages, duration, accessibility of methods)
2. To determine their choice (why using and not using, cultural restriction, and misbelieve) related to long term and permanent methods (IUD, Norplant, sterilization-male and female).
3. To get opinion of the program managers and service providers about the problem in service provision (supply of IUD and Norplant, manpower, MSR and compensation, BCC).
4. To get opinion of the program managers and service providers about the problem in service provision (demand: choice, advantage and disadvantages, socio-cultural proposition, availability)
5. To recommend culturally appropriate and acceptable ways/ means to promote long acting and permanent methods)

Methodology

The study has been conducted using both quantitative and qualitative techniques. Quantitative study has been conducted with interview of sample of eligible women or men aged 15-49 with at least one child. The sample women and men have been selected from BDHS 2011 Enumeration area (EA). Out of 600 EAs of BDHS 2011, 140 EAs has been randomly selected proportionately from seven divisions covering both the urban and rural areas. From each of the EAs, a statistically valid sample of 30 respondents has been interviewed.

Information has also been collected from program managers and service providers through personal interview. In each division 6 MO-MCH, 6 UFPOs, 6 FWVs, 6FPIs and 6FWAs has been selected randomly for interview. Special Key Informant Interviews has also been conducted with concerned Directors in charge at Directorate General of Family Planning (DGFP), Director in charge of Essential Service Delivery (ESD) at Directorate General of Health Services (DGHS), one national NGOs promoting LAPMs (Engender Health), and Obstetrical and Gynaecological Society of Bangladesh (OGSB).

The analysis has been done using SPSS/PC+ Data Entry II module as required for the assessment. Finally, a triangulation of findings of quantitative and qualitative data has been done for further analysis.

Findings

Background characteristics of the respondents: It has been found that the mean age of all surveyed women is 30.3 years and over one-fourth (24.6%) belongs to the age group of 25-29 years. More than two-thirds (70.7%) of surveyed women attended school, and more than one-fourth (26.8%) women have incomplete secondary level education. A large share of women (92.1%) is engaged in household activities (housewife), and around 90 percent of the surveyed women are Muslim. The average household size for all surveyed divisions is 4.9 persons. The average number of living children in all surveyed divisions is 2.4, ranging between 2.0 and 2.9 percent. Less than half (43.3%) of the women would like to have at least 1 more children.

Knowledge of long acting and permanent methods (LAPMs): Overall, 85.4 percent respondents' have heard about LAPMs. Around 63 percent of the respondents have knowledge on IUD, and 68.2 percent have knowledge on implants, 66.4 percent tubectomy, and 45.6 percent on vasectomy. Half of the respondents have heard of LAPMs from relatives and friends, followed by Upazila Health Complex (34.5%), government hospitals (34.5%) and others.

Knowledge of Advantages of LAPMs: Regarding advantages of IUD they reported that, one can remain free from hazard of everyday use of condom or pill (60%), and can protect pregnancy up to 10 years by using it (59%). Regarding advantages of implants, they reported that is very much effective method (85.2%), action starts immediately (43.5%), and pregnancy capacity starts immediately after quitting the method (32.6%). Regarding tubectomy they reported that it is effective immediately after operation (66%); and regarding vasectomy they reported that it is permanent, safe and effective method (81.3%).

Knowledge of Disadvantages of LAPMs: Regarding disadvantages of IUD they reported that, it causes 'feeling of pain in the lower abdomen' (50.2%) and 'increased bleeding between two menstruation periods' (51.2%), and 'white discharge' (40%). Regarding disadvantages of implants they reported that, it causes 'stopped menstruation' (60.5%), and 'headache and vomiting tendency' (53.6%). Regarding disadvantages of tubectomy they reported that, 'need to think as it is a permanent method' (68.3%), 'there is some health risks in spite of being small operation' (55.2%).

Knowledge about sources of getting LAPM service: More than 60 percent of the respondents mentioned government hospital and Upazila Health Complex for IUD, implants, tubectomy and vasectomy. However, over 20 percent reported MCWCs for these services.

Effectiveness period of LAPMs: Majority of the respondents reported correctly about the effectiveness period of IUD, implants, tubectomy and vasectomy which shows that they are aware of it.

Choice related to use of LAPMs: The household survey reports that 11.7 percent of respondents (women having at least 1 child) are LAPMs users, with implant 3.4 percent, and tubectomy 5.1 percent. On average they are using LAPMs for 3 years, and in 65.6 percent cases prime decision maker is husband, and in 28.7 percent cases herself.

Causes of not choosing LAPMS: The non-users of IUD mentioned reasons of non-use as, white discharge during menstruation (45.5%), increased bleeding during menstruation (41.5%), and feeling pain in lower abdomen (37%). The non-users of implants mentioned reasons of non-use as, stops menstruation (52.0%), health problems (51.5%), and continuation of small amount of bleeding for long time (31.3%).The non-users of tubectomy mentioned reasons of non-use as, one need to think before taking decision as it's a permanent method (60.4%), there is a some risk (54.2%). pain remains for a few days after operation (21.5%), and one needs to go to service center for operation (21.1%).The non-users of vasectomy mentioned reasons of non-use as, it is not possible to take child again as it is a permanent method (64.6%), it is not possible to take child again as it is a permanent method (64.6%), although it is a minor operation still there are some risk elements (49.7%).

Socio-cultural reasons for not using LAPMs: According to respondents, key socio-cultural reasons for non-use of LAPMs are, 'husbands not liking it' (55.6%),'herself do not like it' (47.1%), 'community not liking it' (33.7%), etc. Misconceptions about LAPMs reported by them are, 'using LAPM is a sin' (79.2%), 'children are gift of Allah' (49.9%), and 'child dies of person who use LAPM' (35.3%).

Future intention to use LAPMs: Around 14 percent non-users expressed their future intention to use LAPMs. Among those intended, use of IUD (15.8%), implants (49.5%), tubectomy (31.4%), and vasectomy (3.3%) was reported by them.

Opinion of the program managers and service providers regarding supply issues: On an average there are 71,071 eligible couples in each survey upazilas, and 1150 eligible couples under each FWAs. As to UFPOs, 68.6 percent were using modern contraceptive methods during 2012, where 12.4 percent were user of LAPMs. As to FWAs, on average 19 women accepted IUD, and 15 implants, and 7 women on average either discontinued or switched from IUD to other methods, and 4 abstained from using implants, in one catchment area during the last one year. Around 80 percent IUDs are provided by FWVs, and 80 percent implants provided by doctors. Per UHCs/ MCWCs, lowest numbers of IUDs were inserted in Sylhet division, and lowest number of implants, tubectomy and vasectomies done in Barisal division during 2012. However, as to FWAs, Chittagong division performed the least for most of the LAPMs. As to FWVs, no camp has been arranged for long acting methods in Chittagong division during three months before the study period. The program managers and service providers reported shortage of doctors, FWVs, and FWAs right now. About 25 percent MO-MCHs reported shortage of IUD and implant right now. The service providers also reported shortage of MSR for IUD, implants and tubectomy. One-third of sterilizers are not in workable condition.

Opinion of program managers and service providers on demand issues: According to service providers, major disadvantages that work as reasons for not accepting and discontinuing IUDs are, feeling of pain in lower abdomen and menorrhagia, and for implants, these are irregular bleeding or spotting between two menstrual cycles, amenorrhea, menstrual bleeding for more than a week, headache/nausea and weight gain. For tubectomy major reasons are, taking decision of a permanent method is difficult, pain remains for a few days after operation, and botheration of operation, and for vasectomy the reasons reported are, taking decision of a permanent method is difficult, does not work immediately after operation, and

have to wait for 3 months to be effective. Major socio-cultural reasons of non-acceptance and non-use of LAPMs on regular basis mentioned are, 'lack of awareness', 'side effects very common', religious superstition, husband does not allow, social barrier, etc.

According to service providers, clients are provided medicine for most of the complications and problems of IUD. However, in one-third cases of complications, IUD is withdrawn. For LAPMs service provision the service providers reported facing problems as, 'low payment to LAPM clients', 'lack of supply of MSR', and 'no separate OT and post-operative room for family planning procedures'.

The program managers of government, EngenderHealth and OGSB reported that there are lacking in quality service provision, maintenance of proper sterility during IUD insertion and tubectomy and vasectomy operation, and other infection prevention measures after insertion and operation. There is lack of empathy to clients, counseling not done properly in presence of their husbands, and client selection and screening is not done properly. Program managers from DGFP informed that government has taken initiatives to fill-in the vacant posts of doctors, FWVs, FPIs and FWAs. Currently, government, NGOs (EngenderHealth, and SHOPs), and OGSB are providing orientation to service providers. Government and NGOs are using satisfied clients approach for motivational activities on LAPMs.

Suggestions

Suggestions for increasing acceptance and quality of service of LAPMs: The service providers and managers were enquired for their suggestions for increasing acceptance and quality of service of LAPMs.

For increasing acceptance of LAPMs, peripheral level mangers and providers suggested to increase compensation to clients, arrange refreshers training for FWAs, increase referral fees, increase frequency of counseling and *Uthan Baithak,* deploy additional FWAs, increase media communications, increase awareness of community leaders and religious leaders, increase financial support for managing *Uthan Baithak,* increase social awareness, and arrange video shows.

They suggested arrange separate OT and post-operative bed for family planning, improve quality of care, arrange more training of FWVs, regular supply of MSR for LAPM services, increase providers' fees, supply of medicine for treatment of complications for solving problems of LAPMs service provision.

Suggestions of national level managers: The national level managers from DGFP, DGHS, EngenderHealth, and OGSB suggested improving quality of care of LAPM service provision at all levels through training of main service providers including team. They suggested solving the leadership problem in DGFP with special attention to new recruitment and scope of promotion of all service providers; Ensure privacy of the clients during and after operation; Ensure that medicine is provided free of cost to the clients after the procedure; Ensure that the clients get compensation after the procedure; Train doctors on side-effect management; Popularize IUD at private level; Arrange free treatment of complications, and free management of side-effects of LAPMs; Pay special attention to areas with high religiosity, and areas with high CPR with low LAPMs rates; Address LAPMs issue in Community Clinic Co-ordination Committee meetings; Strengthen monitoring, supervision and in co-ordination with DGHS both in clinics and at field level; Disseminate information and provide training on LAPMs to doctors providing EOC service, and private doctors; Train and involve doctors in screening of IUD clients; Involve OGSB to

provide technical guidance during orientation/training to doctors on screening of clients and management of complications; and Motivate clients in such a way so that they understand that it is for their own benefit, not the government.

Conclusions

The problem lying with increasing acceptance of LAPMs is both from the demand and supply side. The programme has failed to create demand due to socio-cultural problems and lack of proper BCC approach through use of media communication, counseling, and involvement of community and religious leaders. Although most of the LAPMs are for women, their husbands in most of the cases are not counseled properly, especially about its advantages and some probable side effects. The husbands are also not informed of the advantages of vasectomy, which is the safest among all the LAPMs. The complications due to lack of a quality approach has also increased. Complications have negative impact on their families causing discontinuation, and discourage others to use that method. The complications thus prevent their friends, relatives and neighbours to accept it. Shortage of manpower and supply of IUD and implants, and shortage of MSR for LAPMs also are great obstructions towards quality service provision.

Recommendations for increasing acceptance of LAPMs

The study findings warrant a set of practical, implementable and time-bound recommendations broadly as follows:

1. Establish quality LAPM services provided with more empathy, ensuring privacy of the clients during and after operation with scope of follow-up care to counter fears of side-effects and misconceptions. Provide treatment free of cost for the LAPM complications by trained doctors.
2. Resolve the leadership problem with special attention to the recruitment and scope of promotion of all level of service providers in DGFP. Increase number of service-providers (doctors and FWVs) and field-level staff (FWAs).
3. Launch an effective information-education-motivation (IEM) campaign with greater focus on LAPMs low-performing areas. Also counsel women on LAPMs during household visit, hospital/clinic visit, post-natal care, MR and post-abortion care. Popularize IUD at all levels through provision of proper information, uninterrupted supply, quality service provision, and proper management of complication.
4. Involve Community Clinic Co-ordination Committee, and local government institutions and NGOs for information dissemination, and OGSB, Engender health and others for technical support and training.
5. Strengthen monitoring, supervision and reporting of LAPMs using modern technologies in innovative ways, and keeping close liaison between DGHS and DGFP officials.

CHAPTER I
INTRODUCTION

1.1 Background

Population program has been inducted in Bangladesh in mid-seventies, and tremendous progress has been made in eighties and nineties. Although both fertility and mortality have declined, fertility decline lagged behind compared to that of the mortality. This imbalance resulted in high population growth rate during that period. Use of different family planning methods have increased with rise of contraceptive prevalence rate (CPR) from 7.7 in 1975[1] to 61.2 in 2011[2] .

However, the method mix has changed over the past two decades, and currently 8 percent of the married couples use a long-acting and permanent method (LAPM), namely IUD, implants, and male and female sterilization account for 13 percent of contraceptive use. Use of IUD was at its peak during 1993-94 at 2.2 percent that started to decline in early 1990s and currently it is at 0.7 percent. Use of implants has increased slowly from 0.1 percent in 1996 to level of 1.1 in 2011. Among the permanent methods, female sterilization was in its peak in at 9.1 percent during 1991 that slowly decreased like the IUD and currently 5 percent women uses it. Similarly male sterilization was at its peak in 1985 that decreased to the level of 0.5 percent and then has increased to the level of 1.2 percent currently. Basically, female sterilization on decrease and male sterilization is on increase slowly during the recent years[2]. However, regarding the long acting methods, decreasing of use of IUD, a non-hormonal method is of concern, although use of implants, a hormonal method is increasing slowly.

Overall, the plateauing of LAPM is of concern, as fertility is now so low that most child-bearing is completed by the mid-to-late twenties, and the women face two subsequent decades of reproductive life during which they can easily protect themselves from unwanted pregnancies and life-threatening consequences of unsafe abortion through use of different LAPMs.

In this backdrop, Human Development Research Centre (HDRC) has been assigned by National Institute of Population Research and Training (NIPORT) to conduct the research study entitled “Assess the constraints to promote long-acting and permanent contraceptive methods (LAPMs)” under package: 2-PFORS. This report has been prepared by HDRC after completion of the study with due attention to quality in all activities from data collection to preparation of report.

1.2 Literature Review

A 30 year projection done in 1996 done for MOHFW shows that, if a quality approach would have been followed, a better-balanced method mix with increase of share of long-term methods might increase with time, and CPR projected in that approach for the year 2011 was 70.8. The quality strategy emphasized on adoption on un-met need approach, and focused upon clients satisfaction, with steep improvements in program services, modification of worker targets, reformation of IEC, among other changes. Quality-strategy in fact emphasized on continuation rates, effectiveness rate, acceptance rates, and method-mix[3].

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1 *Bangladesh Fertility Survey, 1975-76,* Ministry of Health and Population Control, Population Control and Family Planning Division, Govt. of the People's Republic of Bangladesh, 1978

2 National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. 2013. *Bangladesh Demographic and Health Survey 2011*. Dhaka, Bangladesh and Calverton, Maryland, USA: NIPORT, Mitra and Associates, and ICF International.

3 Barkat A,M. Ataharul Islam, A.K.M. Rafiquz-Zaman, M. Bazlur Rahman, Ahmed Al Sabir, 1996, *Strategic Directions for the Bangladesh National Family Planning Program, 1995-2005*, Prepared for Ministry of Health and family Welfare, Government of People’s Republic of Bangladesh.

Use of LAPM was 12 percent in 1991, accounting for 30 percent of contraceptive use. Use of LAPM started to decline in the early 1990s, stabilized in 2007, and hints a slight increase in 2011. Since 2004 there has been a slow increase in the use of male sterilization and implants, although usage rate of these methods remains low. Currently 0.7 percent women are using IUD, 1.1 percent Implants, 5.0 percent Female sterilization, and 1.2 percent Male sterilization. Differentials in current use of family planning shows that currently the women with no education s more likely to use female sterilization than educated women. Women with no education are more likely to use female sterilization than educated women. Women in lowest two educational quintiles are mostly like to use sterilization[2]. Median age of Female sterilization is 28 years, which is higher than reported in 2007 BDHS (NIPORT et al, 2009).

Further analysis of BDHS 2011 data reveals that, about one in three users of contraceptive methods in Bangladesh stop using the method within 12 months of starting. Discontinuation rates are much higher for more temporary methods like condoms (47 percent) and the pill (39 percent) than for longer-term methods like the IUD and implants[2].

In Bangladesh, 67 percent of the married women are mothers of 2 living children by the age of 29 years (BMMS, 2010)[4]. Among the women having 2 living children, 45.7 percent are, Pill and Injectables, and use of LAPMs is very low at only 8.1 percent. Female sterilization is highest (4.1 percent) among the LAPM use at this period of their life[2]. All these women not adopting LAPM after birth of 2 children within the age of 29 years are using hormonal methods like, Pill and Injectables for a large part of their reproductive period up to 49 years of age, and are at risk of unwanted pregnancies due to discontinuation at some part its use.

Considering all these points mentioned above is very much important at this moment to know the causes of not accepting LAPMs, even after completion of their family size with two or more living children.

1.3 Objectives of the Study

The **broad objective** of the study is to assess reasons for not accepting long acting and permanent methods in order to provide appropriate recommendations to promote long-acting and permanent contraceptive methods.

The **specific objectives** of the study are:

6. To know the knowledge of long term permanent method (availability, advantages, disadvantages, duration, accessibility of methods)
7. To determine their choice (why using and not using, cultural restriction, and misbelieve) related to long term and permanent methods (IUD, Norplant, sterilization-male and female).
8. To get opinion of the program managers and service providers about the problem in service provision (supply of IUD and Norplant, manpower, MSR and compensation, BCC).
9. To get opinion of the program managers and service providers about the problem in service provision (demand: choice, advantage and disadvantages, socio-cultural proposition, availability)
10. To recommend culturally appropriate and acceptable ways/means to promote long acting and permanent methods)

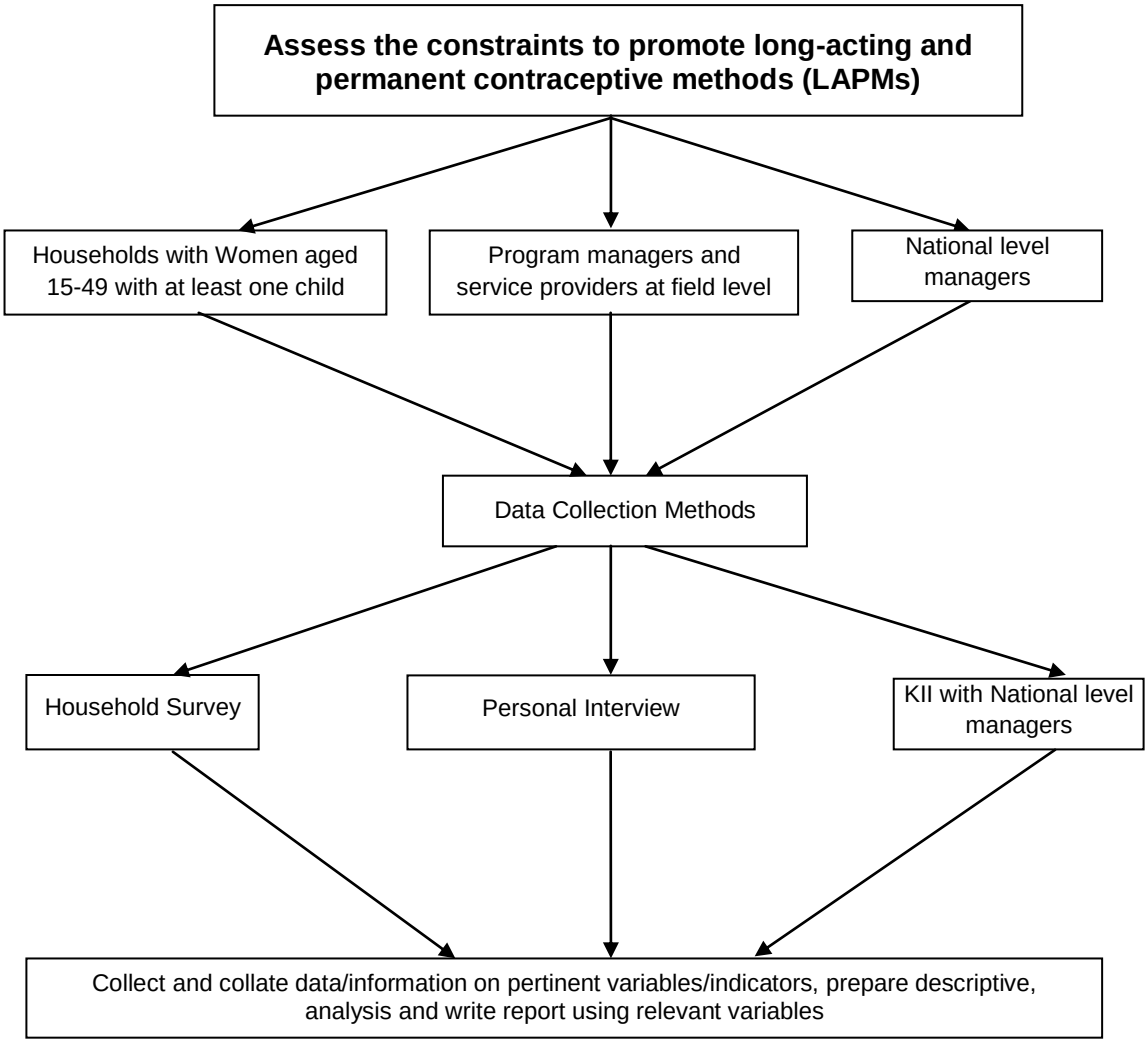
[4] National Institute of Population Orientation and Training (NIPORT), MEASURE Evaluation, and icddr'b, 2012, Bangladesh Maternal Mortality and Health Care Survey, 2010, Dhaka, Bangladesh

1.4 Methodology

A quantitative study has been conducted with interview of sample of eligible women or men aged 15-49 with at least one child. Information has also been collected from program managers and service providers.

The following figure provides schematic view of the study design (Figure 1.1).

Figure 1.1: Schematic view of the study design



Sample Design

The respondents of the study comprised of three categories:

(i) Women and men aged 15-49 with at least one child
(ii) Program managers and service providers at field level
(iii) Program managers at divisional and national level

The study is a mixed one (using both quantitative and qualitative methods), and following exercises has been performed for the data generation.

Methods of data generation	Number
Household survey with women or men aged 15-49 with at least one child	4200 (Division wise number detailed below)
Personal interview with Program managers and Service providers at field level	210 (6 MO-MCH, 6 UFPOs, 6 FWVs, 6 FPIs and 6 FWAs in each division)
Key Informant Interview (KII) with divisional and national level managers	12 (Divisional Directors and Program managers from DGHS, DGFP, UPHCP, NSDP, Engender Health, OGSB)

The sample women and men have been selected from BDHS 2011 Enumeration area (EA). Out of 600 EAs of BDHS 2011, 140 EAs has been randomly selected proportionately from seven divisions covering both the urban and rural areas. From each of the EAs, a statistically valid sample of 30 respondents has been taken for interview. Out of these 140 EAs, 49 were in urban and 91 in rural areas (Table 1.1). The urban areas were over-sampled because of the low proportion of urban population. However, adjustments were made in order to remedy such over-sampling while preparing the estimates.

Table 1.1: Sample allocation of EAs by division and type of residence

Division	Urban			Rural	Urban + Rural
	City Corporation	Other urban areas	Total Urban		
Barisal	2	3	5	12	17
Chittagong	4	4	8	14	22
Dhaka	5	6	11	14	25
Khulna	2	5	7	13	20
Rajshahi	2	5	7	13	20
Rangpur	2	4	6	14	20
Sylhet	2	3	5	11	16
Total	**19**	**30**	**49**	**91**	**140**

Sample Size

Sample size of households: At the second stage of selection, a fixed number of 30 households from each cluster have been selected with an equal probability systematic selection from previously created household listing of 120 households for each stratum. Sample allocation of respondents by division and type of residence has been shown in Table 1.2 as follows.

Table 1.2: Sample allocation of respondents by division and type of residence

Division	Urban			Rural	Urban + Rural
	City Corporation	Other urban areas	Total Urban		
Barisal	60	90	150	360	510
Chittagong	120	120	240	420	660
Dhaka	150	180	330	420	750
Khulna	60	150	210	390	600

Division	Urban			Rural	Urban + Rural
	City Corporation	Other urban areas	Total Urban		
Rajshahi	60	150	210	390	600
Rangpur	60	120	180	420	600
Sylhet	60	90	150	330	480
Total	570	900	1,470	2,730	4,200

Sample size of Program managers and Service providers: Information has also been collected from program managers and service providers through personal interview. In each division 6 MO-MCH, 6 UFPOs, 6 FWVs, 6FPIs and 6FWAs has been selected randomly for interview. List of such personnel has been collected from districts offices of Directorate of Family Planning before interview.

Key Informant Interviews: Special Key Informant Interviews has also been conducted with concerned Director in charge at Directorate General of Family Planning (DGFP), Director in charge of Essential Service Delivery, and Maternal Health Programme at Directorate General of Health Services (DGHS), Divisional Directors of DGFP and DGHS, one national NGOs promoting LAPMs (Engender Health), and Obstetrical and Gynaecological Society of Bangladesh (OGSB). At least 12 such interviews have been conducted.

1.5 Study Instruments

After submission of Inception report, eight types of study instruments have been devised for administration in the field to generate data:

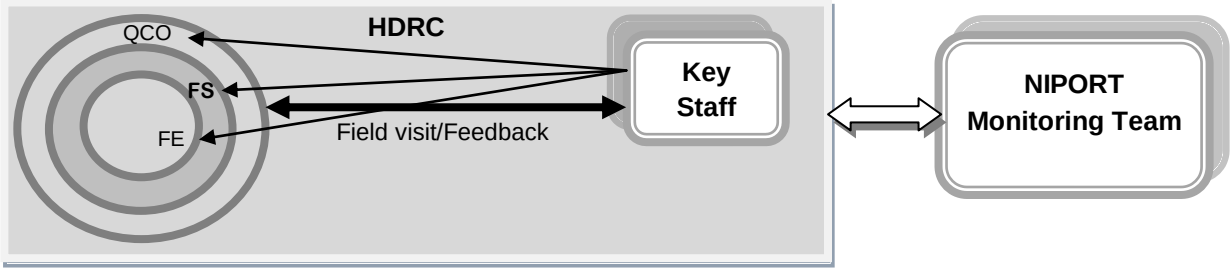
(i) Questionnaire for female
(ii) Questionnaire for male
(iii) Questionnaire for MO-MCH
(iv) Questionnaire for UFPOs
(v) Questionnaire for FWVs
(vi) Questionnaire for FPIs
(vii) Questionnaire for FWAs
(viii) Key Informant Interview Check-list

1.6 Field Data Collection

Before onset of field data collection, listing of households has been done to identify eligible women (aged 15-49 years) and men who has at least one child. Lister has been recruited for this purpose. For this purpose 14 persons (lister) had been recruited.

In total, 30 field enumerators (24 female and 6 male) had been recruited to complete interview of 4200 persons. Six Field Supervisors (FS) and 3 Quality Control Officers (QCOs) had also been recruited for field supervision and quality control. Layers of field supervision and quality control have been shown in Figure 1.2 below.

Figure 1.2: Layers of quality control mechanism for field data and information collection



Seven Interviewers had been recruited and specially trained for interview of program managers and service providers.

Key Informant Interview of relevant Directors at DGHS and DGFP, Divisional Directors of DGHS and DGFP, Engender Health and OGSB has been conducted by the Consultants.

1.7 Data Management

Data collection and data management has been done side by side. Data management comprised of the following activities: (a) registration of questionnaires received from the field; (b) data processing, and (c) computerization of data.

After editing and coding, data has been entered using ICR and SPSS/PC+ Data Entry II module which is a fully integrated data entry, cleaning and editing tool with user defined skip logic rules, and input screens. Before giving output tables, proper range checks and checks of internal consistencies has been done.

1.8 Data Analysis

All members of the core survey team had been involved in data analysis and writing of the draft report. The analysis has been undergone after coding and editing of data, and preparation of dummy tables. The analysis has been done using SPSS/PC+ Data Entry II module as required for the assessment.

Quantitative Analysis: A lucid analysis of data has been made using sound statistical tools. Tests on differences among groups, and confidence intervals with respect to crucial indicators have also been estimated. Relative importance of issues identified and analyzed. Principally two types of analysis techniques namely, descriptive and inferential analysis have been adopted.

Qualitative Analysis: Since qualitative analysis plays an important role to validate and supplement the quantitative data, information processing has been directed toward 'deductive transcription' of quantitatively organized information into qualitative listing. Both thematic and inferential analysis of qualitative information (KII outputs) has been made using appropriate techniques.

Triangulation: Triangulation of quantitative and qualitative data/information, the most crucial in any combined research has been applied in an input–outcome framework. The analysis has been conducted on indicators related to LAPM service utilization, quality of care, knowledge on LAPM, birth spacing and decision making process. Inferential analysis (i.e., hypothesis-testing, cause-effect relation analysis) has been conducted to explore the inter-relationship between different indicators/ variables as and where found suitable using appropriate information compilation and analysis formats.

CHAPTER 2
BACKGROUND CHARACTERISTICS OF THE RESPONDENTS

Key Findings

- Highest proportion (24.6%) of respondents from all division belongs to the age group of 25-29 years. About one-fourth (24.8%) of urban respondents are in the age group of 18 to 24 and more than one-fourth (27%) of rural respondents are in the age group of 25 to 29 years.
- The mean age of all surveyed women is 30.3 years
- Overall, more than two-third (70.7%) of surveyed women attended school
- More than one-fourth (26.8%) women have found incomplete secondary level education
- A large share of women (92.1%) are engaged in household activities (housewife)
- Almost all the surveyed women (90.3%) are Muslim
- The average household size for all surveyed divisions is 4.9 person, which is 0.2 person higher than the national level household size (4.7 person)
- The average number of living children in all surveyed divisions is 2.4
- About one-fourth (23.9%) of the women would like to have at least 1 more children
- Only 17.5 % women have own house
- The main dwelling of house are made of tin, earth and bricks
- Table/chair, mobile phone, television, almirah, motorcycle, bicycle, etc. have found as major assets of the surveyed women
- More than two-third (68.1%) of households have electricity connection
- Tube well is the main source of drinking water to most of the women (92.7%)
- Pit latrine with slab is the main toilet facility mentioned around 60.6% women.

This chapter presents the background characteristics of the respondents including demographic and socio-economic characteristics of the survey households. Socio-demographic characteristics of the survey respondents include: age structure, education, religion and occupational status, and socio-economic status of survey households include the condition of main house, assets ownership, electricity connection, and sanitation condition of the survey households.

2.1 Survey Respondents: Socio-Demographic Characteristics

2.1.1 Age Structure

Analysis of age structure of the survey respondents shows that overall, about one-fourth (24.6%) of them belong to the age group of 25-29 years. More than one-fifth (23.1%) are from the age group of 18-24 years, while exactly 19.3 percent are from the age group of 30 to 34 years. Only 5.5 percent are in the age group of above 45 years. The mean age of the respondents is 30.3 years. Moreover, age distribution by rural and urban category show that highest proportion of rural women (27%) belongs to the age group of 25 to 29 years while highest proportion of urban women (24.8%) belong to age group of 18 to 24 years. The mean age for rural women is 30.4 years while the mean age for rural women is 30.1 years. Age distribution of the respondents by surveyed divisions shows that the mean age is: 28.7 years in Dhaka, 29.5 years in Khulna, 31.2 years in Rajshahi, 30.6 years in Chittagong, 30.5 years in Sylhet and 31.1 years both in Barisal and Rangpur.

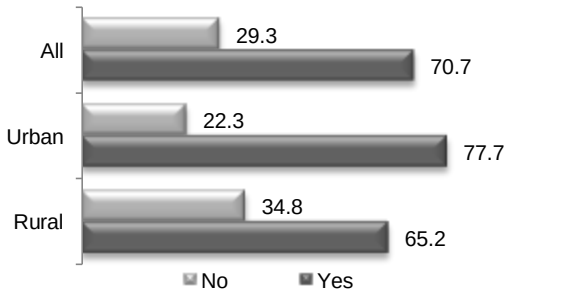
Table 2.1: Percentage distribution of women by age by division

Age group	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
<18	0.5	1.3	1.0		0.8		0.7	0.4	1.1	0.7
18-24	28.5	28.9	15.6	25.2	21.2	19.2	19.0	21.8	24.8	23.1
25-29	24.5	23.8	26.7	23.3	27.3	25.0	26.0	27.0	21.6	24.6
30-34	22.9	18.1	18.1	20.3	17.3	19.2	16.3	18.1	20.9	19.3
35-39	13.9	12.7	23.2	12.4	18.1	16.2	18.0	16.5	15.7	16.1
40-44	7.2	8.9	10.8	9.4	10.4	14.2	14.7	10.4	11.0	10.7
45+	2.4	6.3	4.8	9.4	5.0	6.2	5.3	6.0	4.8	5.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Mean	28.7	29.5	31.2	30.6	30.5	31.1	31.1	30.4	30.1	30.3
Median	28.0	28.0	30.0	30.0	30.0	30.0	30.0	30.0	30.0	30.0
N	701	589	589	617	486	486	561	2637	1393	4030

2.1.2 Educational Status

With respect to educational attainments, overall, a notable proportion (29.3%) of the respondents in surveyed households has no formal education or had never attended school (Figure 2.1). It has also been found that more than one-fifth (22.3%) of the urban respondents and over one-third (34.8%) of the rural respondents do not have any formal education or never attended in the school (Figure 2.1) The highest proportion of respondents with no institutional education have been found in Rangpur division (41%), followed by 33.1 per cent in Sylhet division and 31.8 per cent in Chittagong division. See Annex Table 2.2 for details.

Figure 2.1: Distribution of women by attaining education (%)



2.1.3 Type of Educational Institute Attended

Overall, almost all the women respondents (97.5%) reported that they had attended general education school. Only 2.2% of them mentioned *Alia Madrasah* and only 0.3% reported *Kaomi Madrasah* as their educational institute. Around 97.8 per cent urban and 97.3 per cent rural women reported that they attended general line school. In Chittagong division about 1.0% of the respondents reported that they have attended *Kaomi Madrasah*. In other divisions majority of the women has mentioned that they attended general level school for their education. See Annex Table 2.3 for details (Table 2.2).

Table 2.2: Percentage distribution of women by type of educational institution and by division

Type of educational institutions	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
General School	98.2	99.1	99.5	89.3	99.4	97.5	100.0	97.3	97.8	97.5
Alia Madrasha	1.5	0.4	0.5	9.8	0.6	2.0	0.0	2.3	2.1	2.2
Vocational school	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Kaomi Madrasha	0.4	0.4	0.0	0.9	0.0	0.5	0.0	0.4	0.2	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100	100	100
N	509	432	413	421	325	370	331	1719	1083	2801

2.1.4 Attainment of Highest Class Education

Overall, more than one-fourth (26.8%) of the women reported that they could not complete secondary education. Around 18.4 percent of them reported that they have completed primary level education. Another 13.8 percent have completed secondary education. The rate of never attending school among the respondents is 29.3 percent. However, highest proportion of rural (24.9%) and urban (29.1%) women has found not completing secondary level education. Division wise data shows that, in Rangpur division a good majority of the women (41%) have been found with no education followed by Sylhet 33.1% and Chittagong 31.8%. Majority of the respondents in all division have been found with secondary incomplete education level (Table 2.3). See Annex Table 2.4 for details.

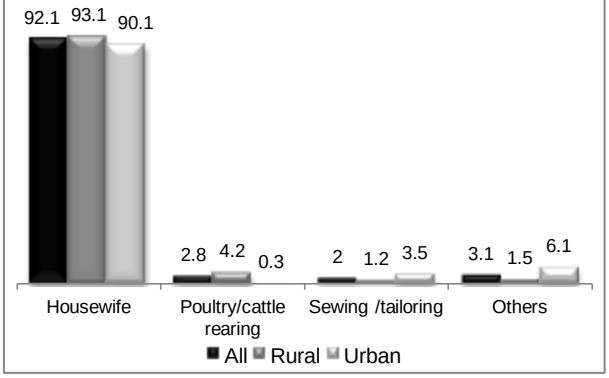
Table 2.3: Percentage distribution of women by their attainment of highest class education by division

Class	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
No education	27.5	26.7	29.8	31.8	33.1	23.8	41.0	34.8	22.3	29.3
Primary incomplete	11.7	13.7	12.1	7.3	17.3	9.6	10.0	11.9	10.9	11.5
Primary complete	23.7	19.0	14.3	17.6	16.2	19.6	17.7	18.4	18.5	18.4
Secondary incomplete	24.8	29.8	30.8	26.4	24.2	25.4	22.7	24.9	29.1	26.8
Secondary complete of higher	12.0	10.5	13.0	16.4	9.2	21.2	8.7	9.6	19.1	13.8
Koumi madrasha	0.3	0.3	0.0	0.6	0.0	0.4	0.0	0.3	0.1	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	701	589	589	617	486	486	561	2637	1393	4030

2.1.5 Occupational Status

The study has been undertaken both in the rural and urban areas in seven divisions of Bangladesh. All the respondents were currently married women with at least one child whose mean age was estimated at 30.3 years. Home-making (housewife) have been found as the sole major occupation of the respondents. As data reveal, overall, 92.1 percent of the respondents are home-makers, followed by 2.8 percent poultry/cattle raiser, 2 percent involved in sewing/tailoring, and 3.1 percent involved in other occupations, like agricultural worker, home based manufacturing, domestic servant, factory workers, small business, etc. (Figure 2.2). Although as many as 15 types of occupations were found among the respondents, most of them are not remarkable in terms of number under each of them. By rural – urban distribution it has been found that around 93.1 per cent rural and 90.1 per cent urban women engaged themselves at home based activities. Division wise distribution of occupation shows that in Rajshahi division a good number of respondents (19.4%) are involved in poultry/cattle rearing. Most of them are involved in home based activities (housewife) in other divisions. See Annex Table 2.5 for details.

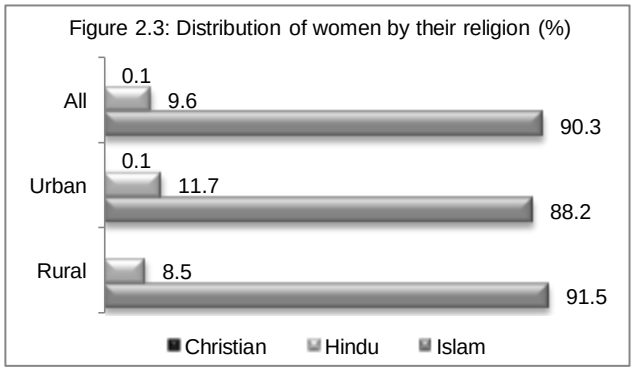
Figure 2.2: Distribution of women by main occupation (%)



2.1.6 Religion

In the surveyed districts, two religions have been found among the surveyed respondents. Majority of the households are believer of Islam or Muslim (90.3%) and rest are Hindu (9.6%) (Figure 2.3). In urban area 88.2 per cent of them are Muslim and in rural area 91.5 per cent of them are Muslim. Thus, Hindu respondents were found in urban area which proportion is 11.7 per cent. Division wise data shows that a good proportion of the respondents are believer of Hinduism in Sylhet, Chittagong and Rangpur division. The share of Hindu respondents is 16.5 percent in Sylhet, 13.3 percent in Rangpur, and 13 percent in Chittagong. See Annex Table 2.6 for details.

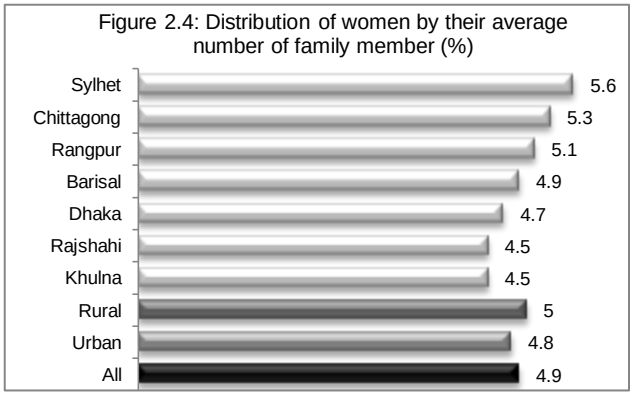
Figure 2.3: Distribution of women by their religion (%)



2.1.7 Household Size

The estimated average household size of the surveyed households in all divisions is 4.9 persons. It is 0.3 persons higher than the nationally reported average household size of 4.6 persons according to BDHS 2011. However, the average household size in urban area is 4.8 while it is 5 in rural area (Figure 2.4). The highest household sizes (5.6 persons) have been reported in Sylhet division. Generally, 65.8 percent of the surveyed households in Sylhet division have more than 5 persons and followed by 63.3 percent in Chittagong, 57.7 percent in Rangpur, 53.8 percent in Barisal, 48 percent in Dhaka,41 percent in Rajshahi and 40.3 percent in Khulna have 5 or more than 5 persons (Table 2.7 in Annex for details).

Figure 2.4: Distribution of women by their average number of family member (%)



2.1.8 Number of Living Children

The estimated average number of children per household in surveyed areas is found 2.4. In rural area it is 2.5 and in urban area it is 2.2. In Chittagong it is 2.9 and about the same in Sylhet division (2.8). The average numbers of living children in Barisal and Rangpur divisions are 2.6 and 2.5 each respectively (Table 2.4).

Table 2.4: Percentage distribution of women by their total number of living children by division

Total living children	Division					Total				
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
1	32.0	32.7	29.2	21.2	23.1	26.2	20.7	24.7	30.5	27.3
2	35.7	39.7	40.6	27.3	25.8	31.2	37.7	32.7	37.2	34.7
3	19.5	21.0	21.3	21.5	22.7	19.6	26.7	22.8	19.5	21.3
4	6.9	4.1	5.7	14.5	14.2	13.5	7.3	9.8	8.2	9.1
5 +	5.9	2.5	3.2	15.5	14.2	9.6	7.7	10.0	4.7	7.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Mean	2.2	2.0	2.1	2.9	2.8	2.6	2.5	2.5	2.2	2.4
Median	2.0	2.0	2.0	3.0	3.0	2.0	2.0	2.0	2.0	2.0
N	701	589	589	617	486	486	561	2637	1393	4030

2.1.9 Desired Number of Children

The respondents were also enquired about their intention of having more children beside their present one. The overall study finding reveals that more than half (57.6%) of them did not desire to take any more child. More than one-fifth (23.9%) want to take 1 (one) more children in future. However, no major variation has been observed by urban and rural segmentation. Division-wise findings show that a major proportion of the respondents desired no more children further. In Sylhet and Rangpur division this proportion is high (70.8%) and (70%) respectively (Table 2.5).

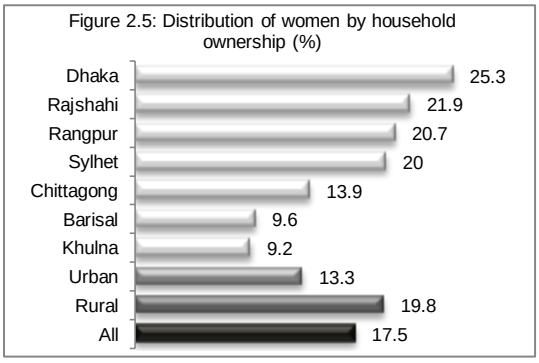
Table 2.5: Percentage distribution of women by their desired number of children by division

Total desired no. of children	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
0	39.2	35.6	69.5	61.8	70.8	56.2	70.0	58.4	53.4	57.6
1	29.3	14.6	26.7	20.9	25.0	23.8	23.7	24.3	22.0	23.9
2	8.8	27.3	1.6	2.1	1.9	6.5	1.7	6.4	9.1	6.8
3	0.8	1.9	0.3	1.5	0.0	0.0	0.0	0.8	0.5	0.8
4+	0.0	1.3	0.3	.6	1.2	0.8	0.3	0.7	0.4	0.7
Don't know	21.9	19.4	1.6	13.0	1.2	12.7	4.3	9.4	14.5	10.2
Mean	0.63	0.99	0.33	0.37	0.34	0.46	0.30	0.47	0.51	0.47
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	701	589	589	617	486	486	561	2637	1393	4030

2.2 Poverty Status

2.2.1 Ownership of House

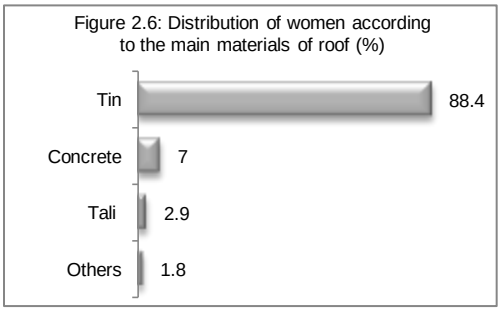
Regarding ownership of house it has been found that a small proportion of women (17.5%) possess own household. Most of the women do not have their own houses (Figure 2.5). About one-fifth (19.8%) of rural women possess own house while in urban area only 13.3 per cent women possess own house. Across division a highest proportion of women from Dhaka division possess own house and lowest proportion of women (9.2%) from Khulna division possess own house (Table 2.9 in Annex for details).



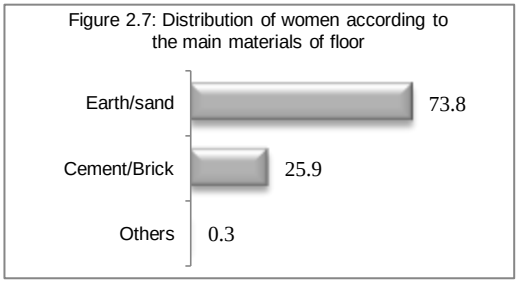
2.2.2 Housing Condition

In the present research, housing condition of the surveyed women have also been assessed. Construction materials of main dwelling of house (roof, floor and wall) have been taken into consideration.

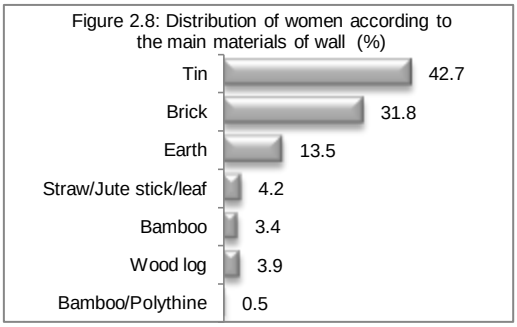
Main materials of roof: Overall, a large majority of the respondents (88.4%) have mentioned that the roof of their main dwelling of house is made of tin. Only 7 percent women mentioned concrete as roof materials. The other materials mentioned by them are: tali (2.9%), thatch/ jute stick/palm leaf (1.5%), etc. (Figure 2.6). A large proportion of rural women (90.9%) and around 83.5 per cent of urban women has mentioned that the main material of roof of their house is 'Tin'. A highest



proportion (94.9%) of women from Dhaka and lowest (67.9%) from Khulna division have mentioned 'Tin' as the main materials of roof of their main house (Table 2.10 in Annex for details).



Main materials of floor: Overall, around 73.8 percent of surveyed women from all divisions have mentioned that floor of their main dwelling of house is made with earth/sands. Over one-fourth (25.9%) have mentioned cement/bricks as main materials of floor of their main dwelling of house (Figure 2.7). A large proportion of rural mentioned earth/ sand as the main materials of floor while over half of the urban respondents (51.6%) mentioned that floor of their main house are made with cement/ bricks. Among division a substantial proportion of women (91%) from Rangpur mentioned earth/sand as main materials of floor while more than two-fifth (42.7%) of respondents from Sylhet mentioned cement/bricks as main materials of floor of their main house (Table 2.11 in Annex).



Main materials of wall: Overall, more than two-fifths (42.7%) of women from all surveyed division have mentioned 'tin' as the main material of wall of their main dwelling of house. About one -third (31.8%) mentioned bricks and 13.5 percent mentioned 'earth/mud' as the main material of wall (Figure 2.8). The highest proportion of rural (47.6%) and urban (51.4%) women mentioned 'Tin' as main materials of wall. Across division no significant variation has been observed (Table 2.12 in Annex).

2.2.3 Possession of Household Assets

The respondent women were also requested to provide information about their household assets. Overall, a very large proportion of women (97.5%) have mentioned 'bed' as household asset. A large majority of them (87.2%) reported that they have table/chair in their household. Over one-third (34.1%) have mobile phone and more than two-thirds (68.1%) have electricity connection in their household. Around two-fifths (40.6) possess television. The other major household assets that they mentioned are: bicycle (18.7%), almirah (10%), motorcycle (5%), etc. By urban rural category and by division no major variation has been observed regarding possession of household assets (Table 2.6).

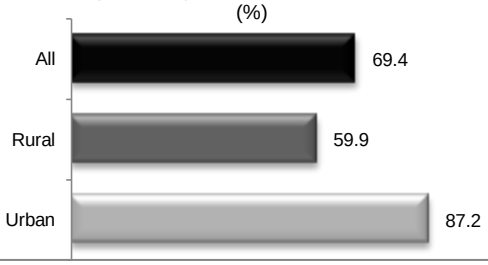
Table 2.6: Percentage distribution of women according to their possession of household assets by division (Multiple answers possible)

Household assets	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Electricity	79.2	72.4	74.6	76.4	73.5	68.5	29.0	58.6	86.2	68.1
Radio	2.9	1.6	4.4	1.2	1.5	1.5	0.7	1.0	4.0	2.0
Television	50.4	45.4	43.2	40.9	44.6	39.6	17.7	27.3	65.8	40.6
Mobile Phone	48.5	21.3	24.4	58.5	18.8	34.6	25.3	25.6	50.1	34.1
Land Phone	1.1	0.0	1.0	4.5	0.8	0.4	1.0	0.7	2.4	1.3
Refrigerator	1.9	0.6	1.3	1.5	1.5	2.3	2.7	0.6	3.6	1.7
Computer	0.0	0.0	0.6	0.0	0.0	0.4	0.7	0.3	0.1	0.2
Washing Machine	0.5	0.0	0.0	0.0	0.4	0.0	0.3	0.1	0.4	0.2
Almirah	11.5	2.2	11.4	19.4	12.7	7.7	4.3	5.2	19.1	10.0
Sofa	0.3	0.0	0.6	0.3	0.4	0.4	0.7	0.4	0.3	0.4
Table/chair	89.1	81.6	87.6	87.9	84.6	94.6	85.3	85.5	90.3	87.2
Bed	97.6	96.5	92.4	99.4	98.5	99.6	99.0	97.9	96.6	97.5
Motor cycle	2.7	7.0	7.6	3.0	3.8	6.2	5.0	3.6	7.5	5.0
Bicycle	13.3	34.6	11.4	6.7	4.6	10.4	48.7	19.9	16.4	18.7
N	701	589	589	617	486	486	561	2637	1393	4030

2.2.4 Status of Electricity Connection

Regarding electricity connection more than two-thirds (69.4%) of women reported that they have electricity in their households (Figure 2.9). About three-fifth (59.9%) rural and 87.2 per cent urban respondents reported that they have electricity connection in their household (Figure 2.9). Highest proportion of women (79.5%) from Dhaka division and lowest proportion (31.7%) of women from Rangpur division reported having elecetricity connection in their household (Table 2.14 for detail).

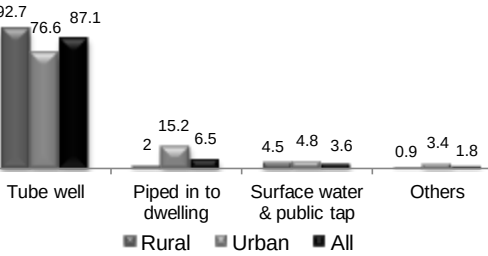
Figure 2.9: Distribution of women according to having electricity connection in their household (%)



2.2.5 Sources of Drinking Water

A very large proportion of the respondents (87.1%) from all division drink water from tube well. Around 92.7 per cent rural and 76.6 per cent urban respondents mentioned tube well as their main source of drinking water (Figure 2.10). The other sources of drinking water are: piped water (6.5%), surface water (2.9%), etc. More than one-fifth (22.7%) of women from Barisal division have mentioned surface water as main source of drinking water (Table 2.16 in Annex).

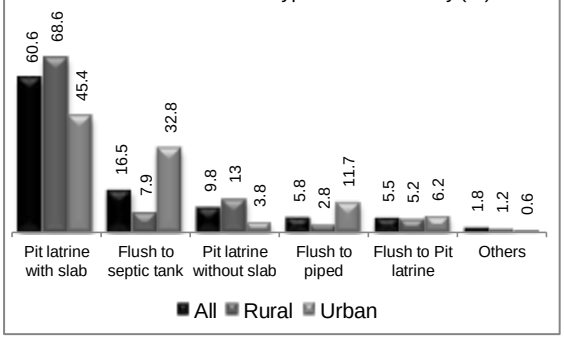
Figure 2.10: Distribution of women according to their household's main source of drinking water (%)



2.2.6 Toilet Facilities

Regarding toilet facilities, overall, a good proportion of women (60.6%) from all surveyed division have mentioned that they use pit latrine with slab. More than two-third (68.6%) urban and 45.4 per cent rural women have mentioned 'Pit latrine with slab' as main toilet facilities of their household. The other facilities mentioned by the women from all divisions are: 'flush to septic tank' (16.5%), 'Pit latrine without slab' (9.8%), etc (Figure 2.11). Across division highest proportion of women (81.3%) from Rangpur and lowest (38.7%) from Khulna mentioned "Pit latrine with slab' as main toilet facility (Table 2.16 in Annex).

Figure 2.11: Distribution of women according to their household's types of toilet facility (%)



CHAPTER 3
KNOWLEDGE OF LONG ACTING AND PERMANENT METHODS

Key Findings

Knowledge about LAPMs and Sources -

- 85.4% respondents' have knowledge about LAPM
- On an average over two-thirds of respondents have knowledge about specific LAPMs
- 52.3% respondents have heard of LAPMs from relatives and friends
- 63% respondents have knowledge on IUD
- 68.2% respondents know about implants
- 66.4% respondents are informed about tubectomy
- 45.6% respondents know about vasectomy

Advantages of LAPM –

- By using IUD one can remain free from hazard of everyday use of condom or pill
- Implant is a very much effective method
- Action starts immediately after tubectomy operation
- Vasectomy is a permanent method and has no long term side affect

Disadvantages of LAPMs -

- IUD causes 'increased bleeding between two menstrual periods'
- Implants causes 'stopped menstruation' and 'may suffer from headache and vomiting tendency'
- Need to think before decision of tubectomy, 'as it is a permanent method' and 'there are some health risks in spite of being small operation'
- It is not possible to give birth to child again, as it is a permanent method

Knowledge about sources of LAPM –

- Government hospital, Upazila Health Complex (UHC), Family Welfare Center (FWC), private hospital/clinic and NGO clinic have been mentioned by the respondents as the main sources of getting LAPM services

Effectiveness period of LAPMs –

Majority of the respondents from all surveyed divisions know about the effectiveness period of specific LAPMs, like- IUD, implants, tubectomy and vasectomy.

3.1 Knowledge of the Respondents about Long Acting and Permanent Methods (LAPMs)

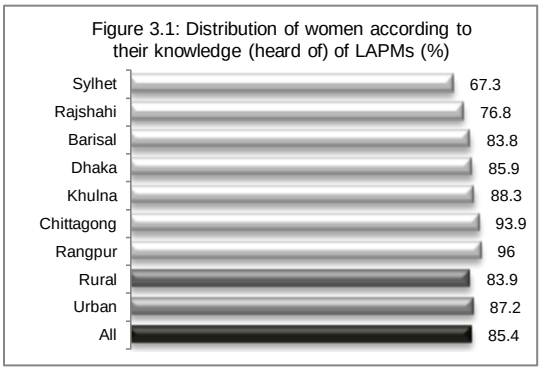
The general awareness of the respondents about the long acting and permanent methods (LAPMs) has been revealed in this chapter. Advantages, disadvantages, sources and effectiveness period of specific LAPMs have also been assessed. To mention here, in this report, the knowledge about LAPM refers to knowledge of IUD, implants, tubectomy and vasectomy. It is also to note that, regarding long acting methods (IUD and implants) emphasis has been given to gather information from those respondents who has at least one living children. Regarding permanent methods (tubectomy and vasectomy) information has been gathered from the respondents having at least two or more living children. In the first section of this report a general question was asked to all women respondents whether they have heard of LAPMs or not. Secondly, respondents' knowledge on specific LAPMs has been assessed, and thirdly, knowledge about their sources. In the second section, knowledge about specific LAPM, its advantage, disadvantages, sources and effectiveness period have been analyzed.

3.1.1 General Awareness/Knowledge about LAPMs

Knowledge is a familiarity with someone or something, which can include facts, information, descriptions, or skills acquired through experience or education. It can refer to the theoretical or practical understanding of a subject. However, in this section knowledge of women

respondents about different LAPM, their advantages, disadvantages, sources and effectiveness period have been analyzed based on the field data.

The overall survey finding shows that a large majority of the respondents in all divisions (85.4%) are aware of long acting and permanent contraceptive methods. Urban respondents are more aware than the rural women. Around 87.2 per cent urban and 83.9 per cent rural women mentioned that they heard of LAPMs. The greatest proportion of the respondents in Rangpur division (96%) is aware of LAPMs, followed by Chittagong (93.9%) and Khulna (88.3%) (Figure 3.1). The above findings indicate that awareness about LAPMs in all division among the people is on rise (Annex Table 3.1 for details)



3.1.2 Sources of Knowledge about LAPMs

Sources of knowledge of LAPMs in the surveyed households in all seven divisions have been assessed. Overall, the major sources of information of the LAPMs reported are relatives and friends (52.3%), followed by Upazila Health Complex (34.5%), government hospital (34.3%), Family Welfare Assistant (FWA), television, Family Welfare Center (FWC), NGO workers/Clinics (16.5%), Health assistant, and Maternal and Child Health Center. The sources of information by urban and rural are almost similar. However, a little bit variation has been observed. For instance, government hospital has been mentioned as source by over two-fifth (41.5%) of urban women while more than one-fourth (28.6%) mentioned it as source of information about LAPMs. Around 38.5 per cent rural and 29.5 per cent urban respondents mentioned upazila health complex as a source of information. Similarly, FWA is the source of information to 23.7 per cent rural women while only 19.5 per cent urban women consider FWA as a source of information.

The sources of information LAPMs in sample division are broadly similar. However, a notable variation is observed across the divisions as regards their major sources of information. For instance, government hospital is a source of information to more than two-thirds of the respondents (68%) in Khulna. However, this is around one-sixth (16.5%) to the respondents in Barisal. Upazila Health Complex is the source of information to 61.9 percent of the respondents in Khulna, which is source to 19.4 percent only in Chittagong. Similarly, FWA and television have been mentioned as sources of information by 41.3 percent and 24.8 percent respectively by the respondents in Dhaka (Table 3.1).

Table 3.1: Percentage distribution of women according to their source of knowledge about LAPMs by division (Multiple answers possible)

Source of knowledge about LAPMs (from whom/ where)	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Government hospital	29.2	68.0	25.2	43.2	18.9	16.5	21.2	28.6	41.5	34.3
Family Welfare Centre/FWV	21.7	6.8	14.0	28.1	11.4	4.1	18.8	15.3	17.2	16.1
Upazila Health Complex	21.1	61.9	37.2	19.4	26.3	36.2	45.8	38.5	29.5	34.5
Satellite Clinic	10.6	11.2	2.1	3.2	0.0	1.8	30.9	9.4	9.5	9.4
Maternal and Child Welfare Centre	13.4	37.8	13.6	5.8	8.6	15.1	10.4	11.8	21.1	15.9
Community Clinic	3.4	5.8	4.1	4.2	0.0	0.0	0.3	2.8	2.8	2.8
Private hospital/clinic	12.4	16.2	1.7	3.2	37.7	2.8	1.0	7.6	12.9	9.9

Source of knowledge about LAPMs (from whom/ where)	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
FWA	41.3	2.5	31.4	22.9	33.7	1.4	20.1	23.7	19.5	21.8
HA	14.9	23.7	31.8	8.1	18.3	16.5	3.8	17.0	14.5	15.9
NGO worker/clinic	15.2	7.9	7.4	16.8	12.0	49.5	11.1	17.7	14.3	16.2
Relatives/Friends	61.5	24.8	43.8	48.1	33.7	88.1	65.3	53.1	51.2	52.3
Religious leaders	3.4	0.0	0.0	0.3	0.0	0.9	0.0	1.1	0.2	0.7
Community leaders	3.4	0.0	0.0	9.4	0.0	0.0	0.3	0.8	4.8	2.6
Printed media	9.6	0.4	0.0	1.0	0.6	0.9	1.4	0.2	6.2	2.9
Radio	3.7	0.0	0.8	0.6	0.0	0.5	0.3	0.3	2.2	1.1
TV	24.8	20.9	4.5	16.1	5.1	38.5	7.3	11.4	27.4	18.5
Cinema	0.3	0.0	0.0	0.0	0.0	0.0	0.0		0.2	0.1
Street corner drama/Folk song	0.3	0.7	0.0	0.3	0.0	0.0	0.0	0.3	0.2	0.3
N	**603**	**521**	**453**	**580**	**328**	**408**	**539**	**2213**	**1215**	**3442**

3.2 Knowledge of Specific LAPM, its Advantages, Disadvantages, Sources and Effectiveness Period

Knowledge about Specific LAPMs

Regarding married women's knowledge about specific LAMP, it has been found that overall, a very good proportion of them (63%) heard of IUD, more than two-third (68.2 %) of them heard of Implant / Norplant, over two-third (66.4% heard of tubectomy and around 45.6 per cent heard of vasectomy. Naturally, urban respondents are more aware than rural women. In the present study it has also been found that urban respondents are little bit aware than rural respondents. Across division it has been found that highest proportion of respondents from Rangpur division heard of LAPMs (IUD, Implant, tubectomy and Vasectomy) than other divisions. However, in Sylhet division overall knowledge of the respondents about IUD, implants, tubectomy and vasectomy has found very low. (Table 3.2)

Table 3.2: Percentage distribution of women according to their knowledge (Heard of) of specific LAPMs by division (Multiple answers)

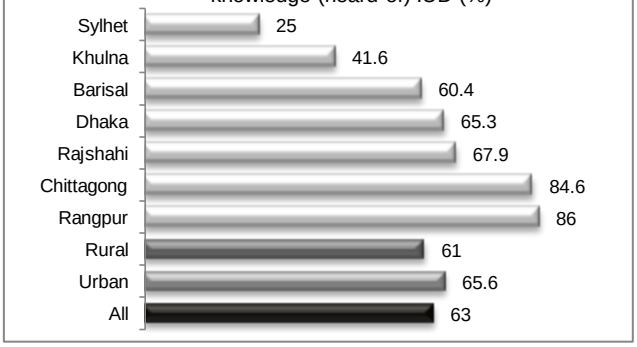
Heard of specific LAPMs	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
IUD	65.3	41.6	67.9	84.5	25.0	60.4	86.0	61.0	65.6	63.0
Implant/ Norplant	78.1	58.4	71.1	62.7	33.1	71.2	94.3	66.6	70.2	68.2
Tubectomy	64.5	72.7	70.5	61.8	46.9	58.5	82.7	63.8	69.7	66.4
Vasectomy	42.7	61.6	55.2	38.8	5.4	32.3	71.3	42.6	49.3	45.6
Heard of none	0.5	0.3	0.0	0.3	7.3	0.0	0.0	1.3	0.7	1.0
N	701	589	589	617	486	486	561	2637	1393	4030

A. IUD

3.2.1 Knowledge about IUD

The respondents were asked whether they have heard about IUD or not. It has been found that overall, around 63 percent of them had heard about IUD. However, about two-third (65.6%) urban and 61 per cent rural women had heard of IUD. Thus, the knowledge about IUD of urban women is little bit higher than the rural women. The highest proportion of respondents (86%) in Rangpur division had knowledge about IUD followed by 84.5 percent in Chittagong and 65.3 percent in Dhaka, with Sylhet division the lowest (25%) (Figure 3.2).

Figure 3.2: Distribution of women according to their knowledge (heard of) IUD (%)



3.2.2 Knowledge about Advantages of IUD

Regarding advantages of IUD, overall 59.1 percent of the respondents mentioned that 'IUD could protect pregnancy up to 10 years', and 59.9 per cent of them mentioned that 'one can remain free from everyday hazard of using condom or pill'. More than one-third (37.8%) of them reported that IUD is very much effective. More than one-fourth (26.9%) stated that pregnancy capacity returns immediately after quitting the method. About 18.7 percent of the respondents mentioned that action of IUD starts immediately after inserting it. About 16.1 percent opined that insertion of IUD is easy. Regarding advantages of IUD some small variation has been observed between urban and rural respondents. For instance, around 38.2 per cent urban respondents and 37.4 per cent rural respondents stated that IUD is very much effective. Similarly, 65.2 per cent rural respondents and 51.5 per cent urban respondents mentioned that IUD can protect pregnancy up to 10 years. A large proportion of respondents both from rural (63.3%) and urban (55.6%) opined that it is possible to remain free from hazards of everyday use of condom or pill (Table 3.3).

However, regarding the advantage of IUD much variation has been observed across the divisions. In Rangpur division around 63.2 percent respondents mentioned about effectiveness of IUD, while in Chittagong division only 7.5 percent mentioned the same. In Sylhet division more than half (56.9%) of the respondents mentioned that action starts immediately after insertion of IUD. However, in Rajshahi (14.2%) and Chittagong division a low proportion of the respondents (9%) agreed to this statement. Difference was also observed regarding the advantage 'remain free from everyday use of condom or pill'. In both Rajshahi and Barisal division about 80 percent stated the same, which is 17.6 percent in Khulna and 10.8 percent in Sylhet. However, the respondents from all divisions have mentioned some other advantages of IUD, like-it does not create any hormonal problem, does not create barrier to sexual intercourse, no difference appears in breast milk, etc (Table 3.3).

Table 3.3: Percentage distribution of women according to their opinion on advantages of IUD by division (Multiple answers possible)

Advantages of IUD	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Very much effective	38.4	47.3	44.4	7.5	53.8	24.8	63.2	37.4	38.2	37.8
Can protect pregnancy up to10 years	49.0	55.7	78.0	36.9	52.3	83.4	71.7	65.2	51.5	59.1
Easy to use/take	25.7	33.6	7.5	6.5	20.0	26.8	7.4	15.3	17.0	16.1
Action starts immediately after use/taking	18.8	41.2	10.7	9.0	56.9	20.4	14.7	19.5	17.8	18.7
No difference appears in the breast milk after taking IUD	18.0	16.8	2.3	1.8	1.5	2.5	3.9	7.4	5.5	6.6
Pregnancy capacity return immediately after quitting the method	19.2	18.3	26.6	37.3	30.8	8.9	39.9	29.2	24.1	26.9
Does not create barriers to sexual intercourse	15.9	13.7	0.5	21.5	6.2	19.7	6.6	9.5	18.0	13.3
No hormonal problem	2.0	5.3	5.6	4.3	0.0	1.3	17.4	5.7	7.0	6.3
Remain free from everyday hazard of using condom or pill	66.5	17.6	79.9	58.8	10.8	79.6	63.2	63.3	55.6	59.9
Others		4.6	0.5	1.4	0.0	0.0	0.0	0.8	0.8	0.8
N	458	245	400	522	122	294	482	1608	914	2523

3.2.3 Knowledge about Disadvantages of IUD

Regarding disadvantages of IUD, overall more than half of the respondents (51.2%) from all divisions have mentioned that, 'IUD causes increased bleeding during menstruation', followed by 'feeling pain in lower abdomen after using IUD' (50.2%), 'white discharge during menstruation' (42.6%), and 'sometimes IUD comes outside of vagina' (35.6%). The other disadvantages of IUD that respondents reported are: vaginal wall is damaged (17.9%), need to examine the string after each menstruation (15.6%), become pregnant in-spite of taking IUD (9.7%), needs experienced worker to take and remove IUD (6%), it does not protect STD/HIV/AIDS (4.2%), increased risk of infection of reproductive organs (10.6%) and so on. It is to note that by urban rural category a little variation has been observed among respondents. For instance, around 54.2 per cent rural and 47.4 per cent urban respondents stated the problem of IUD as ''IUD causes increased bleeding during menstruation'. Similarly, 46.5 per cent rural respondents and 37.6 per cent urban respondents mentioned that while using IUD it causes 'white discharge during menstruation'. Around 39.3 per cent urban women and 32.7 per cent rural women mentioned the problem of IUD as 'sometimes IUD comes outside of vagina'. Thus the disadvantages of IUD vary from urban to rural respondents. However, regarding the disadvantage of IUD no major variation has been found across the division. From all the divisions surveyed, the respondents mentioned the disadvantages of IUD in more or less same proportion (Table 3.4).

Table 3.4: Percentage distribution of women according to their opinion on disadvantages of IUD by division (Multiple answers)

Disadvantages of IUD	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Feeling of pain in lower abdomen	50.6	59.5	41.6	49.8	64.6	56.1	45.3	50.2	50.1	50.2
Increased bleeding during menstruation	48.2	62.6	43.9	55.2	63.1	72.6	36.8	54.2	47.4	51.2
White discharge during menstruation	45.7	39.7	50.9	22.9	58.5	83.4	30.2	46.5	37.6	42.6
Sometimes IUD comes outside of vagina	31.0	27.5	73.4	28.0	12.3	26.1	29.8	32.7	39.3	35.6
Become pregnant instead of taking IUD	13.5	16.0	5.6	11.8	6.2	11.5	2.7	8.6	11.0	9.7
Sometimes vagina becomes damaged	9.4	16.8	5.6	9.0	0.0	6.4	58.1	19.9	14.5	17.5
Needs experienced worker to take and remove of IUD	6.1	1.5	18.7	1.4	0.0	1.9	7.4	6.6	5.3	6.0
Need to examine the string after each menstruation	16.7	10.7	11.7	10.0	3.1	11.5	31.8	14.0	18.4	16.0
It does not protect STD/HIV/AIDS	13.9	3.8	2.3	1.4	1.5	0.0	1.9	3.3	5.3	4.2
Reproductive organs transition risks increase	4.9	6.1	2.8	9.0	7.7	2.5	32.6	11.0	10.0	10.6
Others	1.2	6.1	1.4	1.4	0.0	0.0	0.0	1.4	1.2	1.3
N	458	245	400	522	122	294	482	1608	914	2523

3.2.4 Knowledge about Sources of IUD

Regarding sources of getting IUD respondents from all surveyed divisions have mentioned numbers of sources from where they can get IUD services. Overall, the major sources of getting IUD are government hospitals (68.1%). Upazila Health Complex (64.3%), Family Welfare Center/FWV (20.8%), maternal and child health center (20.5%), NGO workers/ Clinics (16.5%), etc. are the main sources of getting the IUD mentioned by the respondents. A small variation

has also been observed between rural and urban respondents regarding the sources of information about IUD. For example, government hospital has been mentioned by a high proportion of urban respondents (79.1%) while 59.3 per cent rural respondents mentioned it as source of getting information. On the other hand, 'Upazila Health Complex' has been mentioned as source of getting information by more rural respondents (73.4%) than urban respondents (52.8%). About 23 per cent urban respondents have mentioned that they received information about IUD from NGO clinics/ workers where as only 11.4 per cent rural women mentioned it as sources of information.

The sources of IUD by divisions are broadly similar. However, some variation is observed across the divisions as regard to getting IUD. For instance, government hospital is a source of getting IUD to majority of the respondents in Chittagong (79.9%), Barisal (73.9%), Khulna (91.6%) and Dhaka (62.9%). However, it is less than one-third among the respondents of Sylhet (30.8%). A good proportion of the respondents have mentioned NGO workers/ Clinics as source of IUD in Barisal and Sylhet division, whereas in Khulna, Rajshahi and Rangpur divisions very few of them mentioned so (Table 3.5).

Table 3.5: Percentage distribution of women according to their knowledge about sources of IUD by division (Multiple answers)

Knowledge about sources of getting IUD	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Government hospital	62.9	91.6	56.1	79.9	30.8	73.9	55.8	59.3	79.1	68.1
Family Welfare Centre/FWV	24.5	13.7	24.3	31.5	23.1	15.3	9.7	21.4	20.0	20.8
Upazila Health Complex	49.4	80.2	65.4	53.0	50.8	88.5	78.7	73.4	52.8	64.3
Satellite Clinic	3.7	3.8	0.5	1.4		1.3	3.1	1.3	3.7	2.4
Maternal and Child Welfare Centre	23.7	23.7	16.4	3.2	23.1	40.1	20.2	15.1	27.2	20.5
Community Clinic	9.4	0.8	4.2	3.9	0.0	0.6	0.0	3.0	3.9	3.4
FWV	9.4	2.3	0.9	10.0	46.2	3.2	7.4	8.4	7.8	8.1
HA	2.9	3.1	2.3	1.1	0.0	6.4	0.0	2.3	1.8	2.1
Private hospital/clinic	10.2	14.5	0.5	6.5	0.0	19.1	0.8	4.4	11.7	7.6
NGO worker/clinic	20.8	7.6	1.9	14.0	38.5	44.6	4.3	11.4	22.9	16.5
Pharmacy	0.4	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.4	0.2
Shop	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Others	0.0	3.8	0.0	0.0	0.0	0.0	0.0	0.6	0.0	0.3
N	458	245	400	522	122	294	482	1608	914	2523

3.2.5 Knowledge about Effectiveness Period of IUD

The respondents were also asked about the period up to which IUD remains effective. The study reveals that a very large proportion (74%) of women mentioned that once inserted IUD remains effective up to 10 years. On the other hand, over one-fourth of them (26.2%) do not have any idea about the effectiveness period of IUD. However, no significant variation has been observed regarding effectiveness period of IUD by urban rural segmentation and by division (Table 3.6).

Table 3.6: Percentage distribution of women according to their opinion about duration of effectiveness of IUD once inserted by division

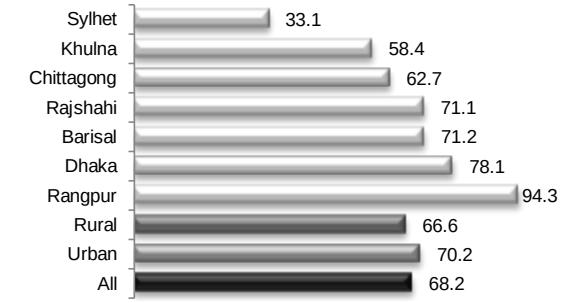
Effectiveness period of IUD	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
up to 5	30.2	7.6	13.1	27.2	20.0	12.1	3.9	13.1	23.9	17.9
up to 10	71.0	92.4	78.5	49.5	38.5	98.1	83.7	73.1	75.1	74.0
10 +	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Don't Know	29.0	7.6	21.5	50.5	61.5	1.9	16.3	26.9	24.9	26.0
Mean	4.9	8.5	7.0	3.4	2.7	8.9	8.0	6.45	5.85	6.2
Median	3.0	10.0	10.0	0.0	0.0	10.0	10.0	10.0	6.0	8.2
N	458	245	400	522	122	294	482	1608	914	2523

B. Implants

3.2.6 Knowledge about Implants

It has been found that overall, more than two-thirds of respondents (68.2%) from all surveyed divisions know about implants. However, around 70.2 per cent urban and 66.6 per cent rural women are informed about implants. In Rangpur, highest proportion of respondents (94.3%) has the knowledge about implants. In Sylhet division only one-third (33.1%) respondents reported knowing about implants, and it is the lowest among all the divisions (Figure 3.3).

Figure 3.3: Distribution of women according to their knowledge (heard of) Implant (%)



3.2.7 Knowledge about Advantages of Implants

Regarding advantages of implants, a large majority of the respondents (85.2%) from all surveyed divisions reported that implant is very much effective as long term method which can protect pregnancy from 3 to 5 years. However, 88.7 per cent rural and 80.9 per cent urban respondents have expressed the same opinion. Over two-fifths (43.5%) of them mentioned that user of implants can remain free from hazards of everyday use of condom or pill. Around 47.4 per cent rural and 38.6 per cent urban women have opined the same. About one-third (32.6%) of them reported that capacity to become pregnant returns immediately after quitting implant. Over one-third of rural women (33.3%) and 31.7 per cent urban women have found in the same opinion. More than one-fourth (26.4%) stated that action of implants start within 24 hours of insertion. However, 29.5 per cent rural women and 22.6 per cent urban women have expressed the same opinion. Whereas, over one-fifths (22%) of them opined that, implants can be removed at any time. However, regarding the advantage of implants no significant variation has been found across the divisions (Table 3.7).

Table 3.7: Percentage distribution of women according to their opinion on advantages of Implant/Norplant by division (Multiple answers)

Advantages of Implant	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Very much effective as temporary long term method which could protect pregnancy till 3-5 years	81.6	93.5	96.4	59.4	82.6	92.4	93.3	88.7	80.9	85.2
Effectiveness starts within 24 hours after setting	16.7	33.2	53.6	1.9	7.0	31.4	34.3	29.5	22.6	26.4
Pregnancy capacity returns immediately after quitting the method	39.2	20.7	19.2	35.3	52.3	43.8	29.7	33.3	31.7	32.6
Remains free from everyday hazard of using condom or pill	54.3	27.2	43.8	60.4	23.3	48.6	37.1	47.4	38.6	43.5
Does not create barriers to sexual intercourse	13.3	9.8	3.6	28.5	7.0	20.0	30.0	14.9	21.4	17.8
Does not require to visit clinic again and again except some certain follow up visit	12.3	3.3	2.7	2.9	0.0	3.2	8.1	6.4	4.4	5.5
Makes no difference in breast milk; so implant could be use after 6 weeks of child birth	7.2	4.3		1.9	0.0	0.5	1.4	2.1	3.4	2.7
No side affect due to Estrogen hormone	0.3	40.2	3.1	0.0	0.0	0.0	2.1	4.6	8.6	6.4
Cures iron deficiency	0.7	12.0	0.0	9.2	0.0	0.0	3.2	3.1	4.4	3.7
Could be removed at any time	22.5	13.0	14.3	11.1	18.6	29.7	38.9	23.4	20.3	22.0
Others	0.3	4.3	0.4	0.0	0.0	0.0	0.0	0.9	0.4	0.7
N	**548**	**344**	**419**	**387**	**161**	**346**	**529**	**1756**	**978**	**2734**

3.2.8 Knowledge about Disadvantages of Implants

Regarding disadvantages of implants, overall 60.5 percent respondents mentioned that, menstruation has stopped after using implants. A substantial proportion of rural (64%) and urban (56.2%) women have stated the same disadvantage. More than half (53.5%) of them also reported that they have suffered from headache, vomiting tendency and weight gain after using implants. A good proportion of rural (54.8%) have mentioned it while the urban women proportion is 51.8 per cent. More than one-third (37.8%) of respondents mentioned the problem of small amount of menstrual bleeding for a long time. Around 40.1 per cent rural and 35 per cent urban respondents have stated the same problem. Less than one-third (30.8%) mentioned of spotting between two menstrual periods. While about same proportion from rural and urban (31.9% and 29.4% respectively) have stated this shortcoming of implants. The other disadvantages of implants that they reported are: hazards to insert and open implant (26.5%), feeling of tiredness (12%), pain in breast (12.9%), etc. However, regarding the disadvantages of implants, no major variation has been found across the divisions (Table 3.8).

Table 3.8: Percentage distribution of women according to their opinion on disadvantages of Implant/ Norplant by division (Multiple answers)

Disadvantages of Implant/ Norplant	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Drop hemorrhage between two menstrual period	31.7	40.2	15.2	28.5	5.8	35.1	43.8	31.9	29.4	30.8
Little bleeding for a long time	51.5	38.6	17.4	47.3	44.2	55.1	21.6	40.1	35.0	37.8
Stopped menstruation	61.8	51.6	62.1	47.8	80.2	84.3	55.1	64.0	56.2	60.5
Headache, vomiting tendency and weight gain	44.4	55.4	74.1	44.4	64.0	65.4	42.4	54.8	51.8	53.5
Feeling of tiredness	2.7	12.0	22.8	1.0	19.8	7.6	21.9	12.5	11.3	12.0
Weighty /Pain in breast	9.6	14.7	31.7	4.8	0.0	15.7	8.5	13.0	12.8	12.9
Hazard to open and use self	36.5	3.8	40.6	19.3	0.0	13.0	41.7	27.9	23.9	26.1
Need small operation to take and open	16.0	6.5	12.1	8.7	0.0	8.1	13.1	12.1	8.0	10.3
Transition, bleeding problem	10.2	3.8	2.2	8.2	9.3	8.1	29.7	10.2	13.4	11.6
Does not protect STD/HIV/AIDS	2.0	1.6	0.0	0.5	0.0	0.5	0.0	0.5	1.1	0.8
Others	0.3	2.7	1.3	0.0	0.0	1.1	0.4	0.7	1.0	0.8
N	**548**	**344**	**419**	**387**	**161**	**346**	**529**	**1756**	**978**	**2734**

3.2.9 Knowledge about Sources of Implants

Respondents have mentioned a number of sources from where they can insert implants. Overall, the major sources of implants mentioned by them are Upazila Health Complex (68.8%) and government hospitals (66%), followed by Family Welfare Center/ FWV (16%), MCWC (24.2%), NGO workers/Clinics (15.3%) and so on. However, a small variation has been observed by rural urban segmentation. For instance, a highest proportion of urban women (77.1%) have mentioned government hospital as main source of information about implants while 57.1 per cent rural women mentioned it as the same. On the other hand, a very large proportion of rural women (76.8%) mentioned Upazila Health Complex as source of information about implants while only 58.7 per cent urban women mentioned it as source of information.

The sources of implants among the divisions are broadly similar. However, some variations are observed across the divisions as regards getting implants. For instance, government hospital is a source of getting implants to a vast majority of respondents of Khulna (92.4%), Chittagong (81.2%), Dhaka (63.5%), Barisal (65.4%), Rangpur (57.6%) and Rajshahi division (50.9%). (Table 3.9).

Table 3.9: Percentage distribution of women according to their knowledge about sources of getting Implant/ Norplant by division (Multiple answers)

Knowledge about sources of getting Implant/ Norplant	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Government hospital	63.5	92.4	50.9	81.2	19.8	65.4	57.6	57.1	77.1	66.0
Family Welfare Centre/FWV	22.2	7.1	25.4	30.9	5.8	10.3	4.9	16.8	15.1	16.0
Upazila Health Complex	56.7	86.4	63.8	61.8	61.6	85.4	78.1	76.8	58.7	68.8
Satellite Clinic	0.0	0.0	0.0	0.0	0.0	1.1	0.0	0.2	0.0	0.1
Maternal and Child Welfare Centre	23.2	32.1	17.0	4.8	24.4	38.9	22.6	16.5	33.8	24.2
Community Clinic	8.5	2.2	4.0	5.3	0.0	0.5	0.0	3.3	3.6	3.4
FWV	8.9		1.3	9.7	40.7	5.9	3.5	7.1	7.3	7.2
HA	3.1	2.7	1.8	0.5	3.5	7.0	0.0	2.6	2.1	2.4
Private hospital/clinic	9.9	12.5		1.9		19.5	0.0	4.0	10.3	6.8
NGO worker/clinic	14.7	9.8	2.7	10.6	38.4	47.0	2.8	13.1	18.0	15.3
Pharmacy	0.0	0.0	0.0	0.5	0.0	0.5	0.0	0.2	0.0	0.1
Shop	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.0	0.2	0.1
Others	0.0	2.2	04	0.0	0.0	0.0	0.0	0.3	0.4	0.3
N	**548**	**344**	**419**	**387**	**161**	**346**	**529**	**1756**	**978**	**2734**

3.2.10 Knowledge about Period of Effectiveness of Implants

The respondents' knowledge about effectiveness period of implants was also assessed in the present study. It has been found that a large proportion of respondents (87%) have mentioned that once inserted implants can protect pregnancy up to 5 years. More than two-fifth (43.8%) of them have mentioned that implants could protect pregnancy up to 3 years. About 12 percent do not have any idea about the effectiveness period of implants. However, no significant variation has been observed by urban rural segmentation and by division (Table 3.10).

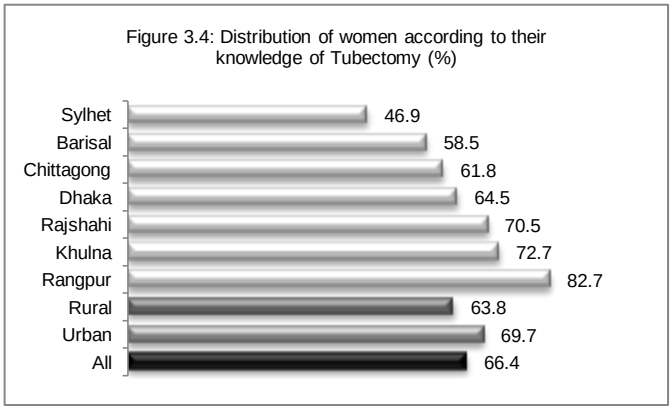
Table 3.10: Percentage distribution of women according to their opinion about duration of effectiveness of Implant/ Norplant once inserted by division

Years	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
up to 3	34.5	62.0	51.8	22.2	27.9	75.7	34.3	42.8	45.1	43.8
up to 5	86.0	90.2	91.1	69.6	74.4	98.9	92.6	88.1	85.7	87.0
5 +	2.0	1.6	2.2	0.5			0.4	1.2	1.0	1.1
Don't Know	11.9	8.2	6.7	30.0	25.6	1.1	7.1	10.8	13.4	12.0
Mean	3.7	3.4	3.7	3.0	3.1	3.4	4.0	3.6	3.3	3.5
Median	4.0	3.0	3.0	3.0	3.0	3.0	5.0	3.0	3.0	3.0
N	**548**	**344**	**419**	**387**	**161**	**346**	**529**	**1756**	**978**	**2734**

C. Tubectomy

3.2.11 Knowledge about Tubectomy

The respondents were also asked whether they know about tubectomy in specific or not**.** It has been found that, overall about two-thirds (66.4%) of them know about tubectomy. However, higher proportion of urban women (69.7%) than rural women (63.8%) knows about tubectomy. Division wise data indicates that in Rangpur division, highest proportion of respondents (82.7%) has knowledge of it, followed by 72.7 percent in Khulna, 70.5 percent in Rajshahi and 64.5 percent in Dhaka



division. In Sylhet division only 46.9 percent respondents know about tubectomy, and it is the lowest among all the divisions (Figure 3.4).

3.2.12 Knowledge about Advantages of Tubectomy

Regarding advantages of tubectomy, more than two-thirds of the respondents (67.4%) from all surveyed divisions reported that by doing tubectomy one can remain free from the hazards of everyday use of condom or pill. Overall, around 73 per cent rural and 60.3 per cent urban women have mentioned the same. Around two-thirds (66.1%) of them mentioned that, once tubectomy is done it's action starts immediately. High proportion of rural women (69.6%) has expressed the same. About one-third (32.7%) of them mentioned that tubectomy do not have any long term side affect. More than one-third (35.2%) of rural women have stated the same. Other advantages of tubectomy respondents mentioned are: need not to go to clinic or worker again and again except some follow up visits (12.1%), can return home after operation (13.8%), does not reduce power of sexual intercourse or physical strength (7.8%), easy and safe operation using local anesthesia (11.9%), and so on. However, regarding the advantage of tubectomy no significant variation has been found across the divisions (Table 3.11).

Table 3.11: Percentage distribution of women according to their opinion on advantages of Tubectomy by division (Multiple answers)

Advantages of Tubectomy	Division					Total				
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Effective immediately after operation and very much safe method	55.8	76.4	78.4	28.4	68.0	59.9	93.1	69.6	61.8	66.1
Remain free from everyday hazard of using condom or pill or other methods	62.0	56.8	73.4	70.1	88.5	63.8	72.2	73.0	60.3	67.4
Need not to go to clinic or worker again and again except some follow up visits	11.2	18.3	9.0	9.3	2.5	23.0	10.1	11.7	12.7	12.1
Does not reduce power of sexual intercourse or physical strength	12.4	8.7	3.2	9.8	2.5	5.3	6.0	4.6	11.9	7.8
No long term side affect or health risk	28.9	36.7	43.7	17.6	12.3	49.3	37.5	35.2	29.5	32.7
Increase sexual intercourse will, power and satisfaction as there are no fear of being pregnant	11.6	7.0		25.5	9.0	6.6	7.3	9.6	9.4	9.5
No effect on breast milk so it could be done after delivery	22.7	5.7	0.5	5.4	0.0	2.6	2.4	6.1	6.7	6.4
Good method for those who may have health risk if they become pregnant	3.3	5.7	1.4	3.4	0.0	2.0	6.5	3.2	4.0	3.6
Easy and safe operation, don't using local anesthesia	19.0	10.9	2.7	16.2	20.5	17.8	2.0	11.0	13.1	11.9
Can return home after operation	27.7	4.8	1.4	16.7	4.1	30.3	10.9	12.8	15.0	13.8
Others	0.0	4.4	0.0	0.0	0.0	0.0	0.0	1.0	0.2	0.6
N	**453**	**428**	**415**	**381**	**228**	**284**	**464**	**1683**	**971**	**2654**

3.2.13 Knowledge about Disadvantages of Tubectomy

Overall, regarding disadvantages of tubectomy a large proportion (68.3%) of respondents from all divisions reported that it need to think before doing tubectomy as it is a permanent method. Around 69.3 percent rural women and 67.1 per cent urban women have stated the same opinion. More than half (55.%) of them reported that it is risky to do tubectomy although it is a small operation. A High proportion of rural women (58.7%) have expressed the same opinion while proportion of urban women is 50.7 per cent. More than one-fourth (28.5%) also reported that pain remains for a few days after operation. More or less same proportion of urban and rural women has expressed the same. Over one-fourth (25.7%) also mentioned that coming to service center for operation is a problem. The other disadvantages of tubectomy that

respondents reported are: needs trained doctor and assistant (9.9%), possibilities of ectopic pregnancy and so on. However, regarding the disadvantage of tubectomy no major variation has been found across the divisions (Table 3.12).

Table 3.12: Percentage distribution of women according to their opinion on disadvantages of Tubectomy by division (Multiple answers possible)

Disadvantages of Tubectomy	Division					Total				
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Need to think as it's a permanent method	67.8	77.7	77.9	53.4	74.6	57.9	68.1	69.3	67.1	68.3
Have risk in spite of being a small operation	46.7	55.0	42.3	60.3	78.7	55.9	62.1	58.7	50.7	55.2
Pain remains for a few days after operation	43.0	34.1	24.3	18.1	23.0	47.4	11.7	27.6	29.7	28.5
Possibility of Ectopic pregnancy	2.1	9.2	3.2	11.3	17.2	14.5	5.6	7.1	9.4	8.1
Need to come to service center for operation	36.8	7.4	34.2	15.2	0.8	36.2	39.5	26.4	24.9	25.7
Need trained doctor and assistant	16.5	10.9	2.7	8.8	0.0	14.5	12.1	9.8	10.2	10.0
Does not protect STD/ AIDS	3.3	0.9	0.5	2.0		0.7	2.8	1.3	2.1	1.7
Others	0.4	7.0	1.4	0.5	1.6	0.0	0.4	1.3	2.3	1.7
N	**453**	**428**	**415**	**381**	**228**	**284**	**464**	**1683**	**971**	**2654**

3.2.14 Knowledge about Sources of Tubectomy

Respondents mentioned numbers of sources from where they can do tubectomy. Overall, the major source for doing tubectomy is government hospital (79.1%). UHC (66%), MCWC (23.6%), private hospital/clinic (11.5%), and NGO workers/ clinics (17.3%) are also the main sources for doing tubectomy mentioned by the respondents. However, government hospital is the main source of getting information mentioned by high proportion of urban respondents (88.2%) while Upazila Health Complex is a main source of getting information about tubectomy to most of the rural women (73.9%). Similarly, MCWC is mentioned as source of information by around one-third (33.1%) of urban women.

Some variation is also observed across the divisions as regard to source of doing tubectomy. As for example, Family Welfare Visitor (FWV) is a source from where tubectomy can be done has been mentioned by about half of the respondents (49.2%) in Sylhet division. However, in other divisions a very small proportion of the respondents mentioned so. Similarly, about one-third (32.9%) respondents in Barisal division have reported private clinic/ hospital as a source of doing tubectomy, which in other divisions is much lower (Annex Table 3.13).

Table 3.13: Percentage distribution of women according to their knowledge about sources of doing Tubectomy by division (Multiple answers)

Knowledge about sources of doing Tubectomy	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Government hospital	84.3	96.1	59.5	93.1	31.1	94.1	71.8	71.9	88.2	79.1
Family Welfare Centre/FWV	8.3	5.7	16.2	11.3	5.7	11.2	4.4	8.3	10.0	9.1
Upazila Health Complex	53.7	72.9	62.6	64.7	55.7	89.5	74.2	73.9	56.1	66.0
Satellite Clinic	0.0		0.9	0.5	0.0		1.2	0.2	0.8	0.5
Maternal and Child Welfare Centre	27.3	28.4	14.4	9.3	23.0	26.3	27.0	16.1	33.1	23.6
Community Clinic	4.1	2.6	3.2	0.0	0.0	0.0	0.4	1.9	1.3	1.6
FWV	3.7	0.9	1.4	1.0	49.2	0.7	3.2	6.4	5.2	5.9
HA	1.2	1.7	0.5	0.0	1.6	1.3	0.0	1.1	0.4	0.8
Private hospital/clinic	14.5	19.2	0.5	12.3	0.0	32.9	0.0	8.2	15.6	11.5
NGO worker/clinic	19.4	13.1	3.6	21.1	45.9	27.6	4.4	13.8	21.8	17.3
Pharmacy	0.0	0.0	0.5	1.0	0.0	0.0	0.0	0.2	0.2	0.2
Shop	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Others	0.0	0.9	0.0	0.0	0.8	0.0	0.0	0.1	0.4	0.2
N	**453**	**428**	**415**	**381**	**228**	**284**	**464**	**1683**	**971**	**2654**

3.2.15 Knowledge about Effectiveness Period of Tubectomy

The respondents' knowledge about effectiveness period of tubectomy was also assessed in the present study. It has been found that a large proportion of the respondents (63.8%) have mentioned that once done, tubectomy could protect pregnancy for lifelong. On the other hand, more than one-third (36.2%) of them do not have any idea about the effectiveness period of tubectomy. However, urban women's knowledge about effectiveness period of tubectomy is little bit higher than rural women. More than two-third (67.6%) urban women and 60.7 per cent rural women have stated that once tubectomy is done it can protect pregnancy forever.

A significant variation has been observed regarding the knowledge of effectiveness period of tubectomy across the divisions. A very large proportion of the respondents (93.4%) in Sylhet division do not know the effectiveness period of tubectomy. On the other hand, a good proportion of the respondents (83.1%) in Rangpur division mentioned that once done it can protect pregnancy for lifelong (Table 3.14).

Table 3.14: Percentage distribution of women according to their opinion about duration of effectiveness of Tubectomy once done by division

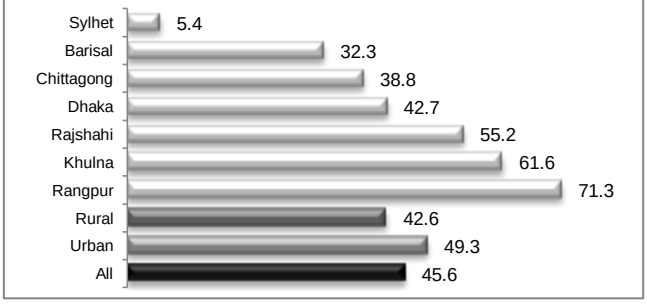
Years	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
1-5	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.1
6-10	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
For life long	63.2	69.9	77.5	55.9	6.6	55.3	83.1	60.7	67.6	63.8
Don't Know	36.8	30.1	22.5	44.1	93.4	44.7	16.9	39.3	32.4	36.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**453**	**428**	**415**	**381**	**228**	**284**	**464**	**1683**	**971**	**2654**

D. Vasectomy

3.2.16 Knowledge about Vasectomy

The respondents were also asked whether they have heard of vasectomy or not**.** It has been revealed that overall, more than two-fifths (45.6%) of them knows about vasectomy. Overall, urban women is more aware than rural women. About half (49.3%) of urban women knew about vasectomy. Some variation has also been observed across the divisions. Highest proportion of women (71.3%) in Rangpur division and lowest proportion of women (5.4%) in Sylhet division ever heard of vasectomy (Figure 3.5).

Figure 3.5: Distribution of women according to their Knowledge of Vasectomy (%)



3.2.17 Knowledge about Advantages of Vasectomy

Regarding advantages of vasectomy a very large proportion of respondents (81.3%) from all surveyed divisions mentioned that vasectomy is a permanent, and very much safe and effective method. However, around 83.2 per cent rural and 79 per cent urban women have expressed the same opinion. Over one-third (35%) of them mentioned that vasectomy has no long term side effect or health risk. Around 37.1 per cent urban and 33.4 per cent rural women stated the same opinion. A good proportion of them (29.6%) have also reported that it does not reduce sexual intercourse power. Over one-third (34.1%) rural and less than one-fourth (24%) urban women

have mentioned it as advantages of vasectomy. However, a small proportion (12%) has also mentioned that, it increases the will of sexual intercourse and brings more satisfaction. The other advantages of vasectomy are: it takes shorter time to do vasectomy (16%), easy and safe operation (12%), and no need to take rest after operation (8.8%).

However, regarding the advantage of vasectomy some variation has found across the divisions. For example, in Rangpur division almost all the respondents (97.7%) mentioned that vasectomy is a permanent, safe and effective method, whereas, 50.8 percent of those in Chittagong division reported the same. In Barisal division around 61.9 percent reported that vasectomy has no long term side effect, while in Chittagong division only 17.2 percent of them mentioned the same (Table 3.15).

Table 3.15: Percentage distribution of women according to their opinion on advantages of Vasectomy by division (Multiple answers)

Advantages of Vasectomy	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Permanent method, very much safe and effective	80.0	86.1	90.2	50.8	71.4	64.3	97.7	83.2	79.0	81.3
Do not reduce sexual intercourse power or physical strength	18.1	35.1	34.5	17.2	14.3	11.9	47.7	34.1	24.0	29.6
Increase sexual intercourse will, power and satisfaction as there are no fear of being pregnant	11.9	21.1	4.6	23.4	21.4	6.0	5.1	12.6	11.2	12.0
No long term side affect or health risk	29.4	43.8	32.8	17.2	50.0	61.9	31.3	33.4	37.1	35.0
Easy and safe operation, no need to do senseless	22.5	13.4	2.3	20.3	21.4	9.5	5.6	11.1	13.1	12.0
Take shorter time (5-7 minutes)	33.8	3.1	2.3	21.1	21.4	45.2	12.1	17.3	14.7	16.1
No need to take rest after operation	8.1	7.2	1.7	17.2	14.3	14.3	8.4	8.2	9.5	8.8
Others	0.0	2.1	0.0	0.8	0.0	0.0	0.0	0.8		0.4
N	**299**	**363**	**325**	**239**	**26**	**157**	**400**	**1124**	**686**	**1810**

3.2.18 Knowledge about Disadvantages of Vasectomy

Regarding disadvantages of vasectomy, overall, a large proportion (77.4%) of the respondents mentioned that it is not possible to take child again as it is a permanent method. However, no major variation has been observed regarding rural urban variation. Around 78.5 per cent urban women and 76.5 per cent rural women stated the same opinion. More than two-fifth (46.6%) of them mentioned that vasectomy has some risks in spite of being a small operation. More than half (52.1%) of rural women and 39.8 per cent urban women have reported the same shortcoming of vasectomy. More than one-fifth (22.7%) of respondents also reported that it does not work immediately after operation. Around 24.3 per cent rural women have agreed to this statement. About the same proportion of them (22.5%) also mentioned that it needs to come to service center for operation. The other disadvantages of vasectomy that respondents reported are: needs trained doctor and assistant (9.5%), needs to use condom during physical intercourse until the vasectomy becomes effective, and it does not protect STD/HIV and AIDS and so on.

However, regarding the disadvantage of vasectomy no major variation has been found across the division and by major disadvantages category mentioned by the respondents (Table 3.16).

Table 3.16: Percentage distribution of women according to their opinion on disadvantages of Vasectomy by division (Multiple answers)

Disadvantages of Vasectomy	Division							Total		
	Dhaka	Khulna	Rajshahi	Chitta-gong	Sylhet	Barisal	Rangpur	Rural	Urban	All
It is not possible to take child again as it is a permanent method	68.8	90.7	86.8	85.9	42.9	59.5	67.8	76.5	78.5	77.4
There have some risk in spite of being a small operation	36.3	48.5	38.5	49.2	64.3	36.9	64.0	52.1	39.8	46.6
It does not work immediately after operation	35.6	18.6	6.9	4.7	35.7	64.3	24.3	24.3	20.7	22.7
Have to wait for 3 months to be effective	12.5	8.2	4.6	7.8	14.3	31.0	9.8	11.5	9.3	10.5
Need to use condom for intercourse before it become effective	10.0	2.6	1.7	6.3	21.4	1.2	9.3	6.3	4.9	5.7
Need to come to service center for operation	29.4	7.7	31.0	5.5	7.1	29.8	30.4	19.8	25.9	22.5
Need trained doctor and assistant	11.9	9.3	1.1	5.5	7.1	13.1	15.0	8.7	10.4	9.5
Does not protect STD/HIV/AIDS	9.4	2.6		3.9	7.1		0.9	2.2	4.1	3.0
Others	0.0	5.2	3.4	0.8	0.0	0.0	0.0	1.2	2.7	1.9
N	**299**	**363**	**325**	**239**	**26**	**157**	**400**	**1124**	**686**	**1810**

3.2.19 Knowledge about Sources of Vasectomy

Regarding sources of doing vasectomy, respondents from all surveyed divisions have mentioned numbers of sources from where their husband or male can do vasectomy. Overall, the major sources of doing vasectomy mentioned are government hospital (85.4 %) and Upazila Health Complex (UHC). However, government hospital is the source of getting information to almost all the urban respondents (94.8%). On the other hand to rural respondents (75.4%) UHC is the main source of getting information about vasectomy. MCWC (20.8%), private hospital/ clinic (10.8%), NGO workers/ clinics (12.8%), etc. are also the main sources of doing vasectomy mentioned by the respondents. However, no significant variation has been observed across the divisions as regard to knowledge of sources of vasectomy (Table 3.17).

Table 3.17: Percentage distribution of women according to their knowledge about sources of doing Vasectomy by division (Multiple answers)

Knowledge about sources of doing Tubectomy	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Government hospital	85.6	95.4	70.7	92.2	21.4	97.6	79.0	78.0	94.8	85.4
Family Welfare Centre/FWV	5.0	4.6	12.1	11.7	14.3	6.0	3.7	7.8	5.7	6.9
Upazila Health Complex	46.9	75.3	60.9	71.1	71.4	95.2	68.7	75.4	55.0	66.4
Satellite Clinic	1.3	1.5	0.6	1.6	0.0	0.0	0.9	1.2	0.8	1.0
Maternal and Child Welfare Centre	27.5	25.3	12.6	8.6	14.3	20.2	21.5	13.3	30.2	20.8
Community Clinic	5.0	1.5		0.0	7.1	1.2	0.0	0.8	2.2	1.4
FWV	2.5	0.5	0.6	1.6	21.4	1.2	1.4	1.3	1.9	1.6
HA	0.6	1.0	0.6	0.8	7.1	0.0	0.0	0.7	0.5	0.6
Private hospital/clinic	21.9	18.6	0.0	7.0	0.0	25.0	0.0	8.5	13.6	10.8
NGO worker/clinic	26.9	7.7	1.7	13.3	14.3	35.7	3.7	8.3	18.5	12.8
Pharmacy		0.0	0.0	1.6	0.0	0.0	0.0	0.3	0.0	0.2
Shop	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Others	0.0	1.5	0.6	0.0	0.0	0.0	0.0	0.3	0.5	0.4
N	**299**	**363**	**325**	**239**	**26**	**157**	**400**	**1124**	**686**	**1810**

3.2.20 Knowledge about Effectiveness Period of Vasectomy

The respondents' knowledge about effectiveness period of vasectomy was also assessed in the study. Almost all the respondents (97.9%) have mentioned that once done vasectomy could protect pregnancy lifelong. Only a few (2.1%) of them do not have any idea about the effectiveness period of vasectomy. However, no significant variation has been observed regarding the knowledge of effectiveness period of vasectomy across the divisions and rural urban segmentation (Table 3.18).

Table 3.18: Percentage distribution of women according to their opinion about duration of effectiveness of Vasectomy once done by division

Years	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
1-5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
6-10	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
For life long	93.8	100.0	98.9	94.5	92.9	100.0	100.0	97.8	98.1	97.9
Don't Know	6.3	0.0	1.1	5.5	7.1	0.0	0.0	2.2	1.9	2.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**299**	**363**	**325**	**239**	**26**	**157**	**400**	**1124**	**686**	**1810**

To summarize, it can be commented that a very large proportion of the respondents (85.4%) from all surveyed divisions are aware of long acting and permanent methods (LAPM). On an average over two-thirds of respondents have heard of IUD, implants, tubectomy and vasectomy. According to their opinion relatives and friends (52.3%) are the prime source of knowing about LAPM. Upazila Health Complex (UHC) and government hospital are also main sources of getting LAPM services. About two-thirds (63%) of them from all surveyed divisions are informed about IUD, and more than two-thirds (68.2%) of them have knowledge about implants. Over two-thirds (66.4%) of respondents from all surveyed divisions reported that they are informed about tubectomy, and over two-fifths (45.6%) are informed about vasectomy. The frequently reported advantage of IUD has been found as 'by using IUD it could be remained free from hazard of everyday use of condom or pill'. A large share of the respondents (85.2%) reported the advantage of implants as 'it is a very much effective method'. Regarding the advantages of tubectomy they reported that 'action starts immediately after operation' and 'remain free from hazard of using condom or pill forever'. A good proportion of the respondents (81.3%) mentioned the advantage of vasectomy as 'it is a permanent method and no long term side affect or health risk'. More than half of the respondents (51.2%) mentioned the following disadvantage of IUD, as 'increased bleeding between two menstruation periods'. The mostly reported disadvantages of implants are: 'it stops menstruation' and 'may suffer from headache and vomiting tendency'. Disadvantages of tubectomy are reported as 'it needs to think before doing tubectomy as it is a permanent method' and 'there are health risk in spite of being a small operation'. A large proportion of the respondents (77.4%) reported that 'it is not possible to give birth to child again as it is a permanent method' as a major disadvantages of vasectomy. Government hospital, Upazila Health Complex (UHC), Family Welfare Center (FWC), private hospital/clinic and NGO clinic have been mentioned by the respondents as the main sources of getting LAPM services. It has also been found that majority of the respondents from all surveyed divisions know about the effectiveness period of specific LAPM like-IUD, implants, tubectomy and vasectomy.

CHAPTER 4
CHOICE RELATED TO LONG ACTING AND PERMANENT METHODS

Key Findings

The key findings related to choice of LAPMs, reasons for non-use, socio-cultural barrier and future intention of currently LAPM non-users are:

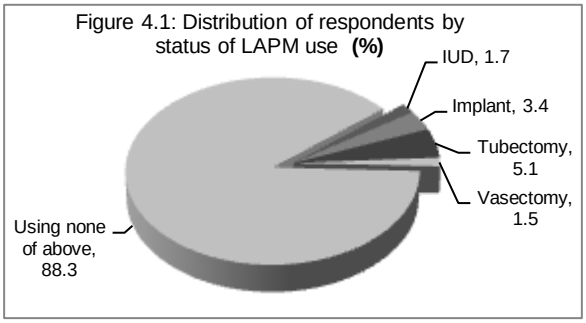
- Proportion of LAPM users: 11.7% (implant 3.4%, Tubectomy 5.1%)
- Average duration of LAPM use: 3 years
- Prime decision maker: 28.7% herself, 65.6% both
- Key reasons (reported) for LAPM use:
  - Effective for long term-80.7%
  - Free from everyday use of contraceptive-41.7%
- Key socio-cultural reasons of LAPM non-use:
  - Husband's dislike-55.6%
  - Herself dislike-47.1%
  - Fear of side effect-33.7%
  - Community dislike-33.7%
- Misconceptions about LAPM:
  - Using LAPM is a sin-79.2%
  - Children are gift of Allah-44.9%
  - Child dies of person who use LAPM-35.3%
- Opinion by locality people about non-use of LAPMs
  - Have many side effects-50.8%
  - Husband opposes-46.6%
  - Against religion-41.8%
- Future intention to use LAPM expressed by 14.2% non users
  - IUD-2.2%
  - Implant-7.0%
  - Tubectomy-4.5%
  - Vasectomy-0.5%

The accompanying chapter delineated pertinent issues related to use and non-use of long acting and permanent methods (LAPM). Use rate of LAPMs, distribution by methods, places where the services were received are presented in Section 4.1. Causes of choosing LAPMs and method specific reasons for non-using are presented in Section 2. Cultural and social reasons for non-use of LAPMs and misbelieves about the same are narrated in Section 4.3. Section 4.4 describes future intentions of currently non-users of LAPMs including reasons for using in future, and non-use of the same.

4.1 Use of LAPM

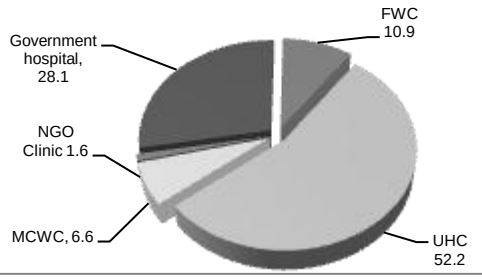
The study revealed that, 11.7 percent women having at least one child use LAPMs. About 5.1 percent mentioned of using tubectomy, 3.4 percent using implant, about 1.5 percent vasectomy, and 1.7 using IUD currently (Figure 4.1). See Annex Table 4.1 for details by division.

Figure 4.1: Distribution of respondents by status of LAPM use **(%)**



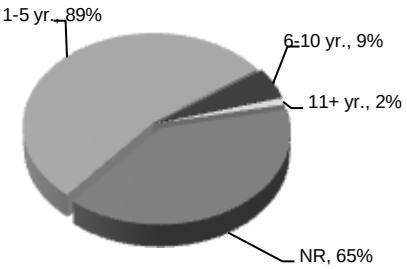
The users were asked to share about the facilities where they received long acting and permanent method. About 52.2 percent users reported that they had received the method in Upazila Health Complex, while 28.1 percent received in Government hospitals. It is to note that about 6.6 percent received the same in Maternal and Child Welfare Centres (MCWC), and 10.9 percent in Family Welfare Centers (FWC) (Figure 4.2). See Annex Table 4.2 for details by division.

Figure 4.2: Distribution of users by facilities of receiving LAPMs



Enquiry on duration of use revealed that average duration of long acting and permanent method use is 3.1 years. About 30.3 percent of LAPM users accepted respective method between 1 to 5 years, 3.4 percent between 6 to 10 years, and 1.3 percent were using LAPMs for 11 years or above. However, 65 percent users not responded to the above question (Figure 4.3). See Annex Table 4.3 for details by division.

Figure 4.3 Duration of LAPM use (%).



4.2 Prime Decision Maker for Choosing LAPMs

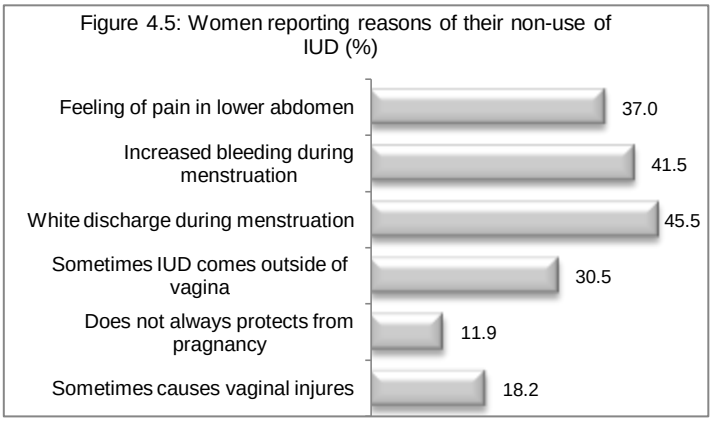
As a part of the study, the women were asked to share about the prime decision maker of LAPM use. In 65.6 percent instances she took decision jointly with her husband, and 28.7 percent mentioned that the women herself was the prime decision maker (Figure 4.4). See Annex Table 4.4 for details by division.

Figure 4.4: Women reporting prime decision maker regarding use of LAPMs **(%)**

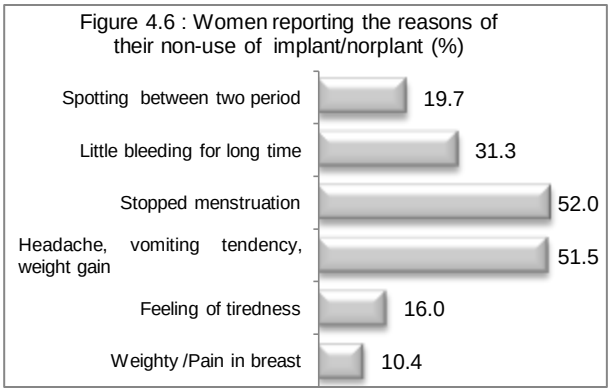
4.3 Causes of Not Choosing LAPMs

Causes of not choosing IUD: The study enquired about the reasons of non-use of IUD among the women who are not using the same. Multiple responses (if any) were recorded. About 45.5 percent of the respondents related their non-use with white discharge during menstruation, a 41.5 percent mentioned increased bleeding during menstruation as reason for non-use, 37 percent stated of feeling pain in lower abdomen, and 30 percent pointed that sometimes IUD comes outside vagina. About 18.2 percent apprehend that, sometimes it causes vaginal injuries (Figure 4.5). See Annex Table 4.7 for details.

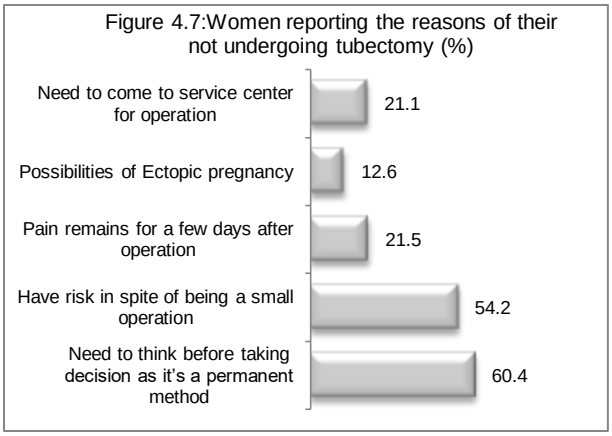
Figure 4.5: Women reporting reasons of their non-use of IUD (%)



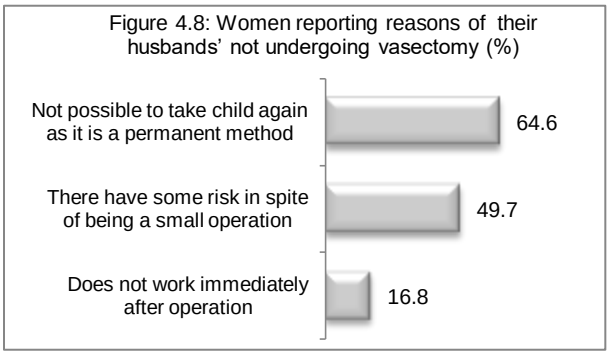
Causes of not choosing Implants: Women who are non-users of implants shared reasons behind non-use. A 52.0 percent referred that, it stops menstruation, and 51.5 percent reported of health problems, e.g., headache, vomiting and weight gain as to reasons for non-use of this. About 31.3 percent related reason of non-use with continuation of small amount of bleeding for a long time, while 19.7 percent related the same with spotting between two successive menstrual periods (Figure 4.6). See Annex Table 4.9 for details.



Causes of not choosing Tubectomy: The respondents who do not have tubectomy were asked to explain the reason(s) of the reasons behind this. Multiple responses (if any) were also accepted. As to reasons about 60.4 percent of respondents mentioned that one need to think before taking decision as it's a permanent method, while about 54.2 percent stated that in spite of being a small operation there is a risk. A 21.5 percent specified that pain remains for a few days after operation, a similar proportion pointed that one needs to go to service center for operation (21.1%) and about 12.6 percent stated that, possibilities of ectopic pregnancy still remains after tubectomy (Figure 4.7). See Annex Table 4.11 for details.

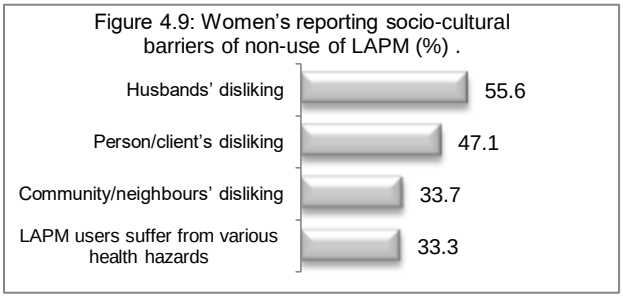


Causes of not choosing Vasectomy: In reply to questions about vasectomy by the husbands, only 2 percent of the respondents shared that, her husband has undergone vasectomy. The study explored reasons of not undergoing vasectomy among those who reported in negative to the earlier question. About 64.6 percent of the respondents stated that, it is not possible to take child again as it is a permanent method. About 49.7 percent mentioned that although it is a minor operation, still there are some risk elements (Figure 4.8). See Annex Table 4.13 for details.



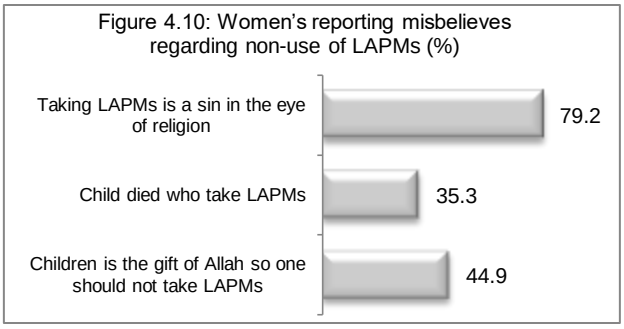
4.4 Cultural Reasons and Misbelieves Regarding not Using LAPMs

The community perceptions on reasons of non-use of LAPMs were asked to the respondents. Multiple responses were also considered. About 55.6 percent stated 'husbands' disliking' as the most prominent socio-cultural barrier of using LAPMs. It is followed by 'respective persons' disliking'

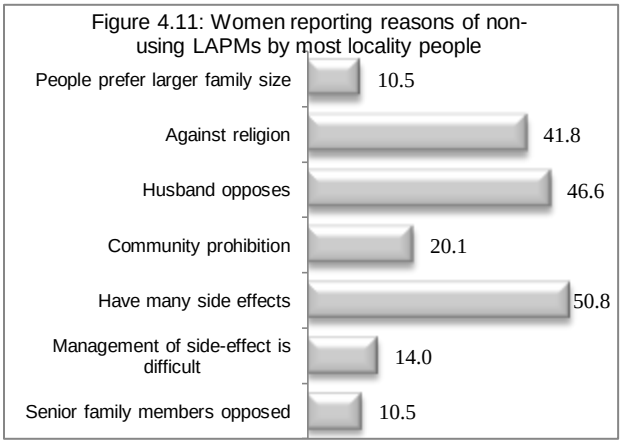


towards LAPMs (47.1%). A 33.7 percent reported that community/ neighbours' disliking is one of the major socio-cultural barriers towards use of LAPMs. A 33.3 percent mentioned that there is a belief that LAPM users suffer from various health hazards (stomache, pain in the waist, loss of sexual power, etc.) (Figure 4.9). See Annex Table 4.14 for details.

The study investigated the misbelieves prevailing in the society related to non-use of long acting and permanent methods. Multiple answers from the respondents were accepted. Analysis shows that, as many as 79.2 percent of the respondents mentioned that it is commonly believed by the non-users that using LAPM is a sin in the eyes of religion. In addition, about 44.9 percent stated that non-users believe that children are gift of Allah, so we should not go for LAPM. More than one-third believes that children of LAPM users die (35.3%) (Figure 4.10). See Annex Table 4.15 for details.

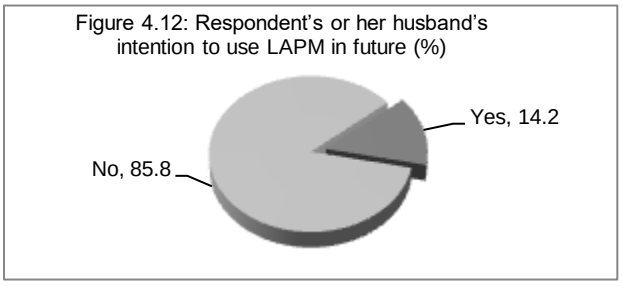


The study explored what according to respondents' opinion are the reasons for not using LAPMs currently prevailing in the community. Multiple responses were recorded in case the respondents mentioned. It is revealed that apprehension of having side effect (50.8%) is the most prominent reason of non-use, and is followed by husband opposes (46.6%), and against religion (41.8%). A 20.1 percent shared about community prohibition/ senior household members' opposition as one of the reasons for non-use (Figure 4.11). See Annex Table 4.16 for details.

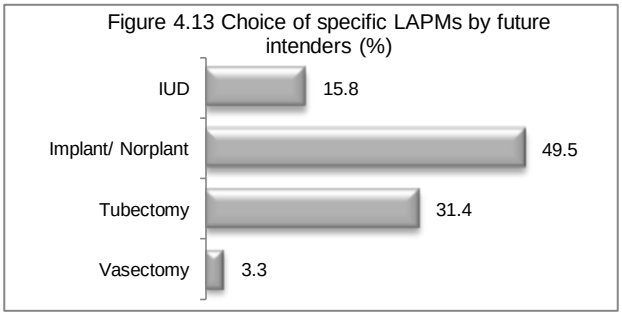


4.5 Future Intention to Use LAPMs

In reply to query about future use, about 14.2 percent of those who currently are not using LAPM expressed their future intention to use any of the long acting methods. It is noteworthy that the proportion of future intenders of LAPM is little higher than the current users (Figure 4.12). See Annex Table 4.17 for details.

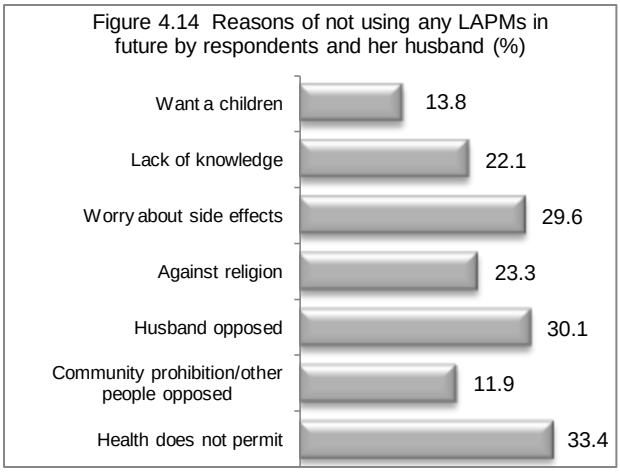


Among those reported of future intention to use LAPM regarding specific method of choice for 49.5 percent of those who shared intention of using one of the LAPM in future is implants, followed by tubectomy 31.4 percent. About 15.8 percent intends to use IUD in future, while only 3.3 percent shared intention to go for vasectomy (Figure 4.13). See Annex Table 4.18 for details.



Reasons for not Having Future Intention to Use LAPMs: The respondents who do not have intention to use any one of long acting and permanent methods were asked to share the reasons for such intention. A 33.4 percent explained their intention related to health ground (health does not permit), a very close proportion 30.1 percent each either linked it with opposition from husband's, and 29.6 percent for fear of side effects . It is worth noting that, about 23.3 percent mentioned that they do not intend to use LAPM in future because it is against religion, about 11.9 percent shared that reason behind non-use of LAPM due to community prohibition, and 22.1 percent expressed the same due to lack of knowledge. Only 13.8 percent reported want a children as one of the causes behind non-use of LAMPs (Figure 4.14). See Annex Table 4.19 for details.

Figure 4.14 Reasons of not using any LAPMs in future by respondents and her husband (%)



CHAPTER 5
OPINION OF THE PROGRAM MANAGERS AND SERVICE PROVIDERS ON SUPPLY ISSUES

Key Findings

- On average there are 71,071 eligible couples in survey upazilas, and 1150 eligible couples under each FWAs.
- As to UFPOs, 68.6 % eligible couples were using modern contraceptive method during 2012, with 2% IUD, 2.3% implants, 5.9% tubectomy and 2.2% vasectomy.
- As to FWAs, on average 19 IUD, 15 implants, 16 tubectomy, and 14 vasectomy have been done in their catchment areas each during the last one year.
- As to FWAs, 7 women on average either discontinued or switched from IUD to other methods, and 4 abstained from using implants in their catchment areas during last 2012.
- According to concerned Directors of DGFP, situation of LAPMs is on improvement now with uninterrupted supply of long acting methods and increased use of implants.
- Around 80% IUDs are provided by FWVs, and 80% implants provided by doctors.
- Per UHCs/MCWCs lowest number of IUDs inserted in Sylhet division, and lowest number of implants, tubectomy and vasectomies done in Barisal division during 2012.
- Regarding providing LAPMs through arranging camps almost 85% of MO-MCHs reported in positive.
- As to FWVs no camp has been arranged for long acting methods in Chittagong division during three months before the study period.
- Around three-fourths of MO-MCHs reported shortage of manpower for provision of LAPMs.
- According to UFPOs, there are shortage of 17% FWAs and 9% FWVs.
- About 25% MO-MCHs reported shortage of IUD and implant right now, that according to UFPOs is more (30%).
- Shortage of MSR for IUD was reported most for 'spot light/ torch light' 'kerosene stove', 'IUD table', 'IUD sterilizer', 'sponge holding forceps', and 'scissors'.
- Shortage of MSR for implants was reported most for 'arm rest' and 'BP blade'.
- Shortage of MSR for tubectomy was reported most for 'silk thread', 'surgical blade (sterile)', 'surgical gauze', and 'cutting curved needle'.
- Shortage of MSR for vasectomy was reported most for 'silk thread', 'surgical bandage', and 'Uristic GP-2 (for Glucose & Albumin test)'.
- According to FWVs, one-third of sterilizers are not in workable condition.
- MO-MCHs, UFPOs, FWVs and UFPOs opined that the compensation provided to the clients for LAPMs is not adequate.

This chapter covers the opinion of the program managers and service providers regarding supply issues, that include population served and service provision, manpower issues, training, supply of IUD and implants, supply of MSR for all types of LAPMs, and related BCC activities. Upazila Family Planning Officer as program manager, Medical Officer-MCH (MO-MCH) and Family Welfare Visitor (FWV) as clinical service provider, and Family Planning Inspector (FPI) and Family Welfare Assistant (FWA) have been interviewed as field level workers for this purpose.

5.1 Population Served and Service Provision

5.1.1 Population Served

The UFPOs reported that on average there were 71,071 eligible couples in survey upazilas during the year 2012. The highest average number of eligible couples was reported in Dhaka and the lowest in Barisal division (Table 5.1).

Table 5.1: Average number of eligible couples reported by UFPOs by division

Eligible couples	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Number	99706	89544	81406	60578	63988	38840	67747	71071
N	4	5	5	5	4	5	5	33

The FWVs reported that, on average there are 17,446 eligible couples in each of their catchment areas. The number of eligible couples among the population they were serving ranged from 4,366 in Rajshahi division to 65,681 in Dhaka division. However, it is to note that population and eligible couples are higher in the urban areas where NGOs and other service providers are there (Table 5.2).

Table 5.2: Distribution of FWVs by average number of eligible couples in the catchment area reported by them by division

Eligible couples	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Number	65681	5969	4366	5626	10726	4900	23509	17446
N	5	5	5	5	4	5	5	34

FWAs reports that, on average there are 1150 eligible couples in their catchment areas. The number of eligible couples per FWA is highest in Khulna and lowest in Chittagong division.

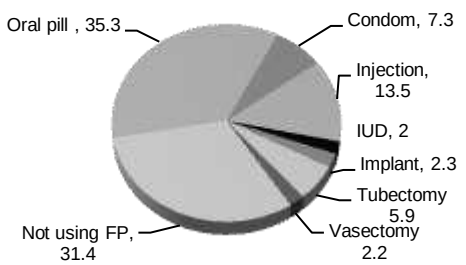
Table 5.3: Average number of eligible couples served by FWAs reported by them by division

Eligible couples	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Number	1325.0	1387.2	1158.7	676.8	1046.3	1063.2	1371.0	1150.1
N	**5**	**5**	**6**	**5**	**4**	**5**	**5**	**35**

5.1.2 Service Provision

The UFPOs reports that 68.6 percent eligible couples were using some modern contraceptive method during 2012, where 35.3 percent eligible couples used oral pill, 7.3 percent condom, 13.5 percent injection, 2 percent IUD, 2.3 percent implants, 5.9 percent tubectomy and 2.2 percent vasectomy. The rest 31.4 percent eligible couples did not use any modern contraceptives for family planning. On analysis of report of UFPOs, it has been found that 12.4 percent were users of LAPMs, which is 18 percent of the total users of modern family planning method (Figure 5.1). For details see Annex Table 5.1.

Figure 5.1: Distribution of eligible couples by use of FP methods reported by UFPOs (%)



According to MO-MCHs, on average each of the UHCs and MCWCs provided 658 IUDs during the year 2012, that was highest in Rajshahi division (1524) and lowest in Sylhet division (342). Around 80 percent of these IUDs were provided by FWVs. As to them, on average each of the UHCs and MCWCs provided 671 implants during the year 2012, which was highest in Rajshahi division (1162), and lowest in Barisal division (197). About 80 percent of these implants have been inserted by doctors. The MO-MCHs also reported that, on average 527.6 women were done tubectomy by each of the doctors during the year 2012, with highest in Rajshahi division (1572.6), and lowest in Barisal division (95). During the same period on average 415 men were done vasectomy in the UHCs by doctors, that was highest in Rajshahi division (1064), and lowest in Barisal division (99). See Annex Table 5.2 for details.

The FPIs reported that situation of provision of IUD was better in Rajshahi and very poor in Sylhet division during the year 2012. As to them, situation of provision of implants was also better in Rajshahi and very poor in Chittagong and Sylhet division during that time.

The FWAs were inquired as to how many eligible couples use different types of FP methods in their catchment areas. As reported, the oral pill was by far the most popular method. See Annex Table 5.3 for details.

As to them, on average 64 eligible couples received LAPMs in their catchment areas during the last one year, and 19 IUD, 15 implants, 16 tubectomy, and 14 vasectomy. For most of the LAPMs, Chittagong division performed the least (Table 5.4).

Table 5.4: Average number of eligible couples accepted LAPMs during last year reported by FWAs by division

Type of LAPMs	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
IUD	9.2	3.2	15.7	9.6	66.0	26.2	12.0	18.8
Implants	9.0	25.4	21.0	12.2	14.5	11.0	13.4	15.4
Tubectomy	7.2	33.2	11.7	4.0	12.3	34.4	6.0	15.5
Vasectomy	6.6	6.8	27.7	2.4	27.3	15.2	11.4	13.9
N	**5**	**5**	**6**	**5**	**4**	**5**	**5**	**35**

The FWAs also reported that, 7 eligible couples on average either discontinued or switched from IUD to other methods during last one year. As good as 4 eligible couples on average either abstained from using implants or leaning to other devices (Table 5.5).

Table 5.5: Average number of eligible couples discontinued LAPMs or switched to other FP methods reported by FWAs by division

Type of LAPMs	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
IUD	2.8	0.2	12.3	10.2	13.5	4.8	2.0	6.5
Implants	4.4	2.0	7.0	7.2	1.5	2.2	2.2	3.9
Tubectomy	2.4	2.4	10.3	0.0	0.3	0.6	0.0	2.6
Vasectomy	0.4	0.0	6.3	0.0	0.0	0.0	0.0	1.1
N	**5**	**5**	**6**	**5**	**4**	**5**	**5**	**35**

Opinion of National level Program Managers: Regarding current situation of LAPMs most of the National level Program Managers opined that, the situation of LAPM service provision is not up to their level of satisfaction. However, it is now improving slowly with improvement in uninterrupted supply of long acting methods, specially increased use of implants. The Directors from DGFP deferred with BDHS 2011 data and opined that the situation of LAPMs was not that much worse during that period. They referred to the MIS data of DGFP, which shows a better picture in terms of acceptance and provision of LAPMs. According to them, 3,25,000 new clients have accepted implants during the year 2012.

5.2 Arrangement of Camps for LAPMs

Regarding whether providing LAPMs through arranging camps almost 85 percent of MO-MCHs reported in positive. They reported arranging on an average 33.2 camps for IUD, 38.3 camps for implants, 51.8 camps for tubectomy, and 52.7 camps for vasectomy during the year 2012 (Table 5.6). Also see Annex Table 5.4.

Table 5.6: Average number of camps organized for LAPMs as reported by MO-MCHs by division

Name of Camp	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
IUD	87.0	21.6	14.0	10.0	10.0	24.6	33.6	33.2
Implant	87.8	21.6	30.8	30.0	30.0	26.4	29.8	38.3
Tubectomy	138.2	21.6	31.3	31.0	31.0	31.2	49.2	51.8
Vasectomy	143.2	21.6	31.5	31.0	31.0	31.2	49.2	52.7
N	5	5	4	2	2	5	5	28

UFPOs also reported arrangement of almost same numbers of camps in their working areas. See Annex Table 5.5 and 5.6 for details.

Around 18 percent FWVs reported that camps were not arranged in their working areas for IUD and implants. Overall, 79.4 percent FWVs reported that they have provided IUDs through camps. See Annex Tables 5.7 for details.

Regarding arrangement of camps for long acting methods during last three months, FWVs reported that, on average 7.4 camps have been arranged where they have attended. As to them, no camp has been arranged for long acting methods in Chittagong division during last three months.

5.3 Manpower Issues

5.3.1 Manpower Shortage

Around three-fourths of MO-MCHs reported that, they have shortage of manpower for provision of LAPMs, and one-fourth reported ‘no shortage’. Regarding type of manpower they have shortage of for provision of LAPMs, around one-fourth and half of them respectively reported that, ‘they have shortage of trained doctor and FWV for outdoor’. Shortage of ‘trained FWV for provision of IUD and OT assistance’, ‘aya’ and ‘male OT nurse’ was reported by nearly one-third of each of them (Table 5.7 and 5.8). See Annex Table 5.8 and 5.9 for details.

Table 5.7: Percentage distribution of MO-MCHs by reported manpower shortage for LAPMs by division

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Yes	100.0	100.0	40.0	75.0	75.0	80.0	60.0	75.8
No			60.0	25.0	25.0	20.0	40.0	24.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	5	5	5	4	4	5	5	33

Table: 5.8: Percentage distribution of MO-MCHs by reported manpower shortage by types for provision of LAPMs by division

Type of manpower shortage	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Trained doctor for outdoor	60.0			25.0	25.0	40.0	20.0	24.2
Trained FWV for outdoor	40.0	100.0	20.0	25.0	25.0	40.0	60.0	45.5
Trained doctor for provision of Implants/ Tubectomy and Vasectomy							20.0	3.0
Trained FWV for provision of IUD and OT assistance		100.0	20.0	25.0	25.0	20.0	20.0	30.3
Trained manpower for handling sterilizer	60.0					40.0	20.0	18.2
Aya	20.0	100.0		25.0	25.0	40.0		30.3
Male OT Nurse	80.0		20.0	25.0	25.0	40.0	20.0	30.3
Sweeper	20.0		20.0	25.0	25.0	40.0		18.2
No shortage			60.0	25.0	25.0	20.0	40.0	24.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	5	5	5	4	4	5	5	33

However, the UFPOs in the study areas reported that of the approved manpower, 83 percent FWAs and 91 percent FWVs were currently available in the working areas. According to them, there were shortage of 17 percent FWAs and 9 percent FWVs in their working areas (Table 5.9 and 5.10).

Table 5.9: Distribution of total approved and current manpower (FWVs) for informing people about LAPMs reported by UFPOs by division

FWVs	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Approved number	18	16	11	16	13	12	11	14
Available number	17	15	10	14	13	11	10	13
Available manpower (%)	88.5	93.8	92.9	88.5	96.2	91.4	84.2	91.2
N	4	5	5	5	4	5	5	33

Table 5.10: Distribution of total approved and current manpower (FWAs) for informing people about LAPMs reported by UFPOs by division

FWAs	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Approved number	75	72	57	75	60	55	51	63
Available number	61	60	52	53	52	49	41	52
Available manpower (%)	81.1	83.8	91.5	71.6	85.9	89.4	80.0	82.8
N	4	5	5	5	4	5	5	33

5.3.2 Training of Manpower

All of the MO-MCHs reported that they have training on providing LAPMs. Almost all of them also opined that they provide LAPMs in their own hand (Table 5.11).

Table 5.11: Percentage distribution of MO-MCHs by training received on providing LAPMs, and by providing LAPMs in own hand by division

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Training received on providing LAPMs								
Yes	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Providing LAPMs in own hand								
Yes	80.0	100.0	100.0	100.0	100.0	100.0	100.0	97.0
No	20.0							3.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	5	5	5	4	4	5	5	33

Around two-thirds of the FWVs (61.8%) reported that they have received refresher's training on providing LAPMs (Table 5.12). Overall 57.1 percent FWVs reported that they have received refresher's training on providing IUD, followed by 28.6 percent on implants. See Annex Tables 5.10 for details.

Table 5.12: Percentage distribution of FWVs by receiving refresher training on LAPMs reported by them by division (Q104)

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Yes	80.0	80.0	60.0	60.0		100.0	40.0	61.8
No	20.0	20.0	40.0	40.0	100.0		60.0	38.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	5	5	5	5	4	5	5	34

5.4 Supply of IUD and Norplant

Among MO-MCHs, around one-fourth each reported that they have shortage of IUD and implant right now. Regarding whether they received adequate supply of long acting methods as per demand on regular basis, one-fourth of them reported in negative (Tables 5.13, 5.14 & 5.15). Reporting of FWVs was almost the same as those of MO-MCHs on these issues. See Annex Tables 5.11, 5.12, and 5.13 for details of FWVs.

Table 5.13: Percentage distribution of MO-MCHs by reported shortage of IUD by division

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Yes	60.0					100.0		24.2
No	40.0	100.0	100.0	100.0	100.0		100.0	75.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	5	5	5	4	4	5	5	33

Table 5.14: Percentage distribution of MO-MCHs by reported shortage of implants by division

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Yes	60.0					100.0		24.2
No	40.0	100.0	100.0	100.0	100.0		100.0	75.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	5	5	5	4	4	5	5	33

Table 5.15: Percentage distribution of MO-MCHs by getting adequate supply of long acting methods as per demand by division

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Yes	80.0	100.0	100.0	75.0	75.0	20.0	80.0	75.8
No	20.0			25.0	25.0	80.0	20.0	24.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	5	5	5	4	4	5	5	33

About one-third UFPOs reported shortage of IUD and near about one-third (28%) UFPO reported shortage of implant method right now. The concerned UFPOs reported of no shortage of IUD in Khulna and Rajshahi and of Implant in Khulna, Rajshahi and Sylhet (Table 5.16 and 5.17).

Table 5.16: Percentage distribution of UFPOs reported shortage of IUDs by division

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Yes	50.0	-	-	20.0	25.0	100.0	20.0	30.3
No	50.0	100.0	100.0	80.0	75.0	-	80.0	69.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	4	5	5	5	4	5	5	33

Table 5.17: Percentage distribution of UFPOs reported shortage of implants by division

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Yes	50.0	-	-	20.0	-	100.0	25.0	28.1
No	50.0	100.0	100.0	80.0	100.0	-	75.0	71.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	4	5	5	5	4	5	5	33

When asked whether getting adequate supply of long acting methods on regular basis, about 60.6 percent UFPOs responded positively. All UFPOs in Rajshahi mentioned that they have adequate supply of long acting methods (Table 5.18).

Table 5.18: Percentage distribution of UFPOs reported whether they are getting adequate supply of long acting methods by division

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Yes	50.0	20.0	100.0	80.0	50.0	40.0	80.0	60.6
No	50.0	80.0	-	20.0	50.0	60.0	20.0	39.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	4	5	5	5	4	5	5	33

5.5 Supply of MSR

Regarding shortage of MSR for LAPMs more than half of the MO-MCHs (57.6%) and around the same proportion of FWVs (55.6%) reported that they have shortage of it. However, shortage was reported by all of them in Barisal, and none of them in Khulna division (Table 5.19 and 5.20).

Table 5.19: Percentage distribution of MO-MCHs by reported shortage of MSR for LAPMs by division

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Yes	80.0		20.0	75.0	75.0	100.0	60.0	57.6
No	20.0	100.0	80.0	25.0	25.0		40.0	42.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	5	5	5	4	4	5	5	33

Table 5.20: Percentage distribution of FWVs by reported shortage of MSR for IUD and implant by division

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Yes	80.0		20.0	80.0	75.0	100.0	40.0	55.9
No	20.0	100.0	80.0	20.0	25.0		60.0	44.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	5	5	5	5	4	5	5	34

MSR for IUD: Shortage of MSR for IUD was reported most for 'spot light/ torch light' by more than one-third of MO-MCHs. However, one-fifth reported shortage of 'kerosene stove', and around one-sixth each reported of shortage of 'IUD table', 'IUD sterilizer', 'sponge holding forceps', and 'scissors'. However, reporting of FWVs varied to some extent. See Annex Table 5.14 and 5.15 for details.

MSR for implants: Shortage of MSR for implants was reported most for 'arm rest' and 'BP blade' by around 40 percent MO-MCHs. Shortage of 'electric shock for emergency' was reported by one-fourth of them. Reporting of FWVs was more or less the same. See Annex Table 5.16 and 5.17 for details.

MSR for tubectomy: Shortage of MSR for tubectomy was reported mostly for 'silk thread' by 46 percent of MO-MCHs. One-fourth of them reported shortage of 'surgical blade (sterile)' and nearly the same proportion reported shortage of 'surgical gauze', and 'cutting curved needle' each. However, regarding medicine one-fourth of them reported of shortage of 'broad spectrum antibiotics', and one-fifth 'Injection Atropine'. Shortage was reported most in Barisal division, followed by Dhaka division. However, reporting of FWVs varied to some extent. See Annex Table 5.18 and 5.19 for details.

MSR for vasectomy: As to MSR for vasectomy 45.6 percent MO-MCHs reported shortage of 'silk thread (1/20)'. Around one-fifth each of them reported shortage of 'surgical bandage', and 'Uristic GP-2 (for Glucose & Albumin test)'. However, reporting of FWVs varied to some extent. See Annex Table 5.20 and 5.21 for details.

MSR for Management of Emergency: Shortage of MSR for management of emergency situation was reported mostly for 'Filled-up oxygen cylinder' and 'Epinephrine (Adrenaline 1: 1000, 1 mg/ml injection)' by more than 40 percent MO-MCHs each. Around one-third each of them reported of shortage of 'Face musk with tube', 'Naloxone injection', 'Hydrocortisone injection' and 'Calcium Gluconate injection'. Shortage was also reported for other items like,

'Butterfly infusion set, 'Aminophylline injection' 'Sodium bi-carbonate injection, 'Diazepam injection', 'Normal saline', 'Automatic catgut', 'Ryle's tube', 'Foleys catheter', 'Rubber catheter' , and others. However, Barisal division reported shortage of most of the items most frequently, and Rangpur and Dhaka division were the next. However, reporting of FWVs varied to some extent. See Annex Table 5.22 and 5.23 for details.

Sterilizer: All of them have sterilizer. Almost 91 percent MO-MCHs and 66 percent FWVs reported that the sterilizer is working properly (Table 5.21 and 5.22).

Table 5.21: Percentage distribution of MO-MCHs by reported condition of sterilizer of clinic by division

Condition of sterilizer	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Functioning	80.0	100.0	80.0	100.0	100.0	100.0	80.0	90.9
Not functioning	20.0		20.0				20.0	9.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	5	5	5	4	4	5	5	33

Table 5.22: Percentage distribution of sterilizer of clinic working properly reported by FWVs by division

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Yes	100.0	40.0	80.0	100.0	25.0	20.0	100.0	65.6
No		60.0	20.0		25.0	80.0		28.1
No response					50.0			6.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	5	5	5	5	4	5	3	32

5.6 Compensation

Compensation provided to clients is an important issue in LAPMs service delivery system. It is paid in terms of money to all LAPM clients. However, in addition, *saree* is given only for tubectomy, and *lungi* for vasectomy. The service providers were asked about compensation provided for LAPMs to clients, and their opinion on it. They also asked about provider's fee and referral fee for the same.

Money: The MO-MCHs reported paying Tk. 167 to each IUD client and Tk. 166 to each implant client on average, ranging between Tk. 150 and Tk. 270 as compensation money. They also reported paying Tk. 2000 each to tubectomy and vasectomy clients. See Annex Table 5.24 for details.

Saree: As per current programme on family planning, the tubectomy clients are supposed to receive one *saree* each. The MO-MCHs also reported the same. See Annex Table 5.25 for details.

Lungi: The Vasectomy clients are supposed to receive one *lungi* each. The MO-MCHs also reported the same. See Annex Table 5.25 for details.

Opinion on compensation: Around 85 percent of the MO-MCHs opined that the compensation provided to the clients is inadequate. Except in Rangpur division, this opinion is prevalent in other divisions. Those opined in favor of provision of more compensation to the clients reported that, IUD clients should be paid Tk. 377, implant clients Tk. 387, tubectomy clients Tk. 4446, and vasectomy clients Tk. 3992 each on average. In Sylhet and Khulna division the MO-MCHs opined that, Tubectomy clients should be given 2 Saree each. See Annex Table 5.26 and 5.27 for details.

The UFPOs proposed average monetary compensation amounting Tk.419 for IUD, Tk. 413 for Implants, Tk.4,034 for tubectomy and Tk.3,928 for vasectomy. See Annex Table 5.28 for details.

Provider's fee: The MO-MCHs reported that providers are paid on average Tk. 57 for IUDs, Tk. 50 for implants, and Tk. 300 each for tubectomy and vasectomy. The UFPOs also reported mostly the same amount. See Annex Table 5.29 and 5.30 for details.

Referral fee: The respondent MO-MCHs reported that an amount of Tk. 73 has been paid for IUD, Tk. 88 for implant, and Tk. 388 each for tubectomy and vasectomy on average to the referrers for each of their referrals. The UFPOs also reported mostly the same amount. See Annex Table 5.31 and 5.32 for details.

5.7 BCC Activities for LAPMs

Regarding BCC activities, about 94 percent UFPOs reported that they have taken initiatives for BCC activities in their working areas to make the clients aware of LAPMs. About 90 percent took initiative for 'counseling' to make the clients aware of LAPMs in the working areas. Around 94 percent mentioned that they have asked their field staff to arrange meeting in groups/*Uthan Baithak*, 55 percent took initiative for postering, 13 percent advised to watch TV programmes, and 10 percent mentioned arranging mobile video shows (Table 5.23).

Table 5.23: Percentage distribution of UFPOs reported BCC activities by methods/types for making clients aware of LAPMs by division

BCC activities by methods	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Interpersonal/ Counseling	100.0	40.0	100.0	100.0	100.0	100.0	100.0	90.3
Meeting in groups/ Uthan Baithak	100.0	100.0	100.0	50.0	100.0	100.0	100.0	93.5
Radio	25.0	0.0	0.0	0.0	25.0	0.0	0.0	6.5
TV	0.0	0.0	20.0	0.0	75.0	0.0	0.0	12.9
Poster	75.0	20.0	80.0	50.0	50.0	100.0	0.0	54.8
Workshop with other government and NGOs	0.0	0.0	20.0	0.0	0.0	0.0	0.0	3.2
Arrange mobile Video shows	25.0	0.0	40.0	0.0	0.0	0.0	0.0	9.7
N	4	5	5	4	4	5	4	31

The FWAs regarding undertaking BCC activities in their working areas to make the clients aware of LAPMs reported that, about 90 percent have done 'interpersonal counseling' to make the clients aware of LAPMs in the working areas. Around 79 percent FWAs mentioned that they have arranged meeting in groups/*Uthan Baithak* for the same (Table 5.24).

Table 5.24: Percentage distribution of FWAs reported BCC activities by methods/types for making clients aware of LAPMs by division

BCC methods	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Interpersonal/ Counseling	100.0	100.0	80.0	100.0	66.7	75.0	80.0	86.2
Meeting in groups/Uthan Baithak	80.0	75.0	100.0	66.7	66.7	100.0	60.0	79.3
Others	20.0							3.4
N	5	4	5	3	3	4	5	29

Around 60 percent FWAs have training on counseling, *Uthan Baithak* and other BCC methods to motivate clients for LAPMs (Table 5.25).

Table 5.25: Percentage distribution of FWAs by whether they have training on counseling, *Uthan Baithak* and other BCC methods to motivate clients for LAPMs by division

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Yes	80.0	100.0	33.3	60.0	25.0	60.0	60.0	60.0
No	20.0		66.7	40.0	75.0	40.0	40.0	40.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	5	5	6	5	4	5	5	35

While asked about the most effective method for promoting LAPMs, about 88 percent UFPOs reported 'interpersonal communication/ counseling' and the rest 12 percent mentioned 'group meeting/*Uthan Baithak'* for the same (Table 5.26).

Table 5.26: Percentage distribution of UFPOs by reporting on effective BCC methods for promoting LAPMs by division

BCC methods	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Interpersonal/Counseling	100	60	100	80	100	100	80	87.9
Meeting in groups/ Uthan Baithak		40		20			20	12.1
N	4	5	5	5	4	5	5	33

The UFPOs, regarding innovative ideas of effective BCC activities for promoting LAPMs reported that more than fifty percent (55%) have so. About fifty percent of them asked 'to train religious leaders and arrangement of meeting with people by involving them' as one the most effective innovative idea for promoting LAPMs. One-third placed their demand for 'arrangement of cultural programmes (drama/*Jari* and *Pala* songs)', 17 percent each mentioned 'arrange meetings involving satisfied LAPMs clients as guest' and 'arrange awareness meetings with community peoples', 'arrange meeting with local people involving high officials and local leaders', 'arrange *Uthan Baithak* frequently', 'more training to FPIs and FWAs', 'more communication activities in hard to reach areas', 'show down with posters in hand', and 'provide books on LAPMs in mosque based libraries'. For details see Annex Table 5.33 and 5.34.

CHAPTER 6
OPINION OF PROGRAM MANAGERS AND SERVICE PROVIDERS ON DEMAND ISSUES

Key Findings

- Disadvantages that work as reasons for not accepting and discontinuing IUDs are feeling of pain in lower abdomen and menorrhagia.
- For implants the reasons are: irregular bleeding or spotting between two menstrual cycles, amenorrhea, menstrual bleeding for more than a week, headache/nausea and weight gain.
- For tubectomy the reasons are: taking decision of a permanent method, pain remains for a few days after operation, and botheration of operation.
- For vasectomy the reasons are: taking decision of a permanent method, does not work immediately after operation, and have to wait for 3 months to be effective.
- Socio-cultural reasons of non-acceptance and non-use of LAPMs on regular basis were 'lack of awareness', 'side effects very common', religious superstition, husband does not allow, and 'social barrier'.
- Clients are provided medicine for most of the complications and problems of IUD, and in one-third complications IUD is withdrawn.
- For complications of implants, the clients are provided medicine, and provided advice and counseling.
- Problems faced in LAPMs service provision are: 'low payment to LAPM clients', 'lack of supply of MSR', no separate OT and post-operative room for family planning.

Opinion of Government and NGO Program Managers and OGSB

- There is lack in quality service provision, maintenance of proper sterility during IUD, tubectomy and vasectomy, and maintenance of infection prevention measures after operation. There is lack of empathy to clients, counseling not done properly in presence of their husbands, and client selection and screening is not done properly.
- Government has taken initiatives to fill-in the vacant posts of doctors, FWVs, FPIs and FWAs.
- Government, NGOs (EngenderHealth, and SHOPs), and professional organization, OGSB are providing orientation to service providers.
- Government and NGOs are using satisfied clients approach for motivational activities on LAPMs.

This chapter covers the opinion of the program managers and service providers regarding demand issues, that include: disadvantages, socio-cultural proposition or reasons for not accepting or discontinuing LAPMs, complications and problems of LAPMs and its management, problems faced in LAPMs service provision, problems behind low rate of LAPMs as to national level program managers, and initiatives taken by government and non-government organizations.

Upazila Family Planning Officer as program manager, Medical Officer-MCH (MO-MCH) and Family Welfare Visitor (FWV) as clinical service provider, and Family Planning Inspector (FPI) and Family Welfare Assistant (FWA) have been interviewed as field level workers for this purpose.

6.1 Disadvantages of LAPMs that Work as Reasons of Non-acceptance or Discontinuation of LAPMs

IUD: Regarding disadvantages that work as reasons for not accepting or discontinuation of IUDs, the MO-MCHs reported a lot. These include, feeling of pain in lower abdomen (75.8%), menorrhagia (66.7%), examination of string after each menstruation (42.4%), becoming pregnant in-spite of taking IUD (30.3%), etc. The FWVs and FWAs while interviewed also reported almost the same. See Annex Tables 6.1, 6.2, and 6.3 for details.

Implants: Similarly, regarding disadvantages that work as reasons for not accepting implants, the MO-MCHs reported, irregular bleeding or spotting between two menstrual cycles (90.9%), amenorrhea (70.4%), menstrual bleeding for more than a week (60.6%), headache/nausea and weight gain (64%), etc. The FWVs and FWAs also reported almost the same. See Annex Table 6.4, 6.5 and 6.6 for details.

Tubectomy: Regarding disadvantages that act as reasons for not accepting tubectomy in women having at least two children, the MO-MCHs reported that, they think before taking decision as it is a permanent method (87.9%), pain remains for a few days after operation (63.6%), need to come to service center for operation (54.5%), have risk in spite of being a small operation (48.5%), etc. The FWVs and FWAs while enquired also reported almost the same. See Annex Table 6.7, 6.8, and 6.9 for details.

Vasectomy: Similarly, regarding disadvantages that act as reasons for not accepting vasectomy in women having at least two children, the MO-MCHs reported that, they think before taking decision as it is a permanent method (81.8%), it does not work immediately after operation (63.6%), have to wait for 3 months to be effective (48.5%), have risk in spite of being a small operation (54.5%), etc. The FWVs and FWAs while enquired also reported almost the same. See Annex Tables 6.10, 6.11, and 6.12 for details.

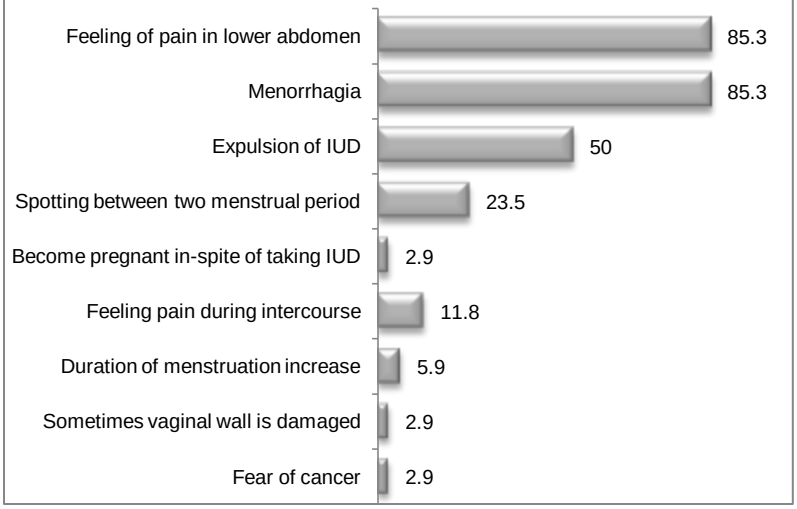
6.2 Socio-cultural Proposition, Reasons for Not Accepting, Discontinuation of LAPMs

Regarding the socio-cultural proposition of non-acceptance and non-use of LAPMs on regular basis was discussed with FWVs. As to prime reasons of not using long acting methods on regular basis around 60 percent FWVs reported 'lack of awareness', followed by 'side effects very common' (47%), religious superstition (41%), husband does not allow (24%), and 'social barrier' (21%). All of them in Sylhet division reported 'religious superstition' as the prime cause behind this non-use. Higher proportion of FWVs reported 'lack of awareness' (80%), and 'husband does not allow' (100%) as to reasons. See Annex Table 6.13 for details.

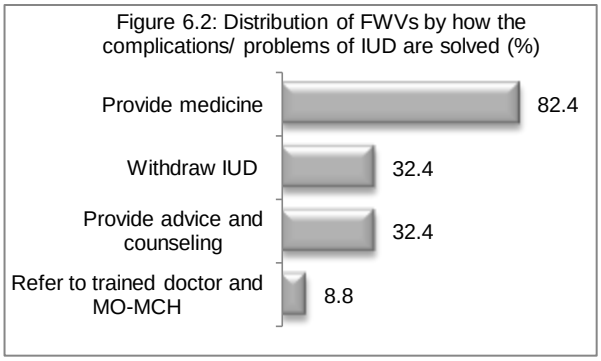
6.3 Complications and Problems of LAPMs and its Management

FWVs are the prime persons dealing with the complications of LAPMs as the clients are mostly women and they report to FWVs first for their problems. Primarily they try to solve the problems in their own, and then refer some of the cases to doctors whenever it is not manageable by them. Regarding IUD the most commonly reported complications are: feeling of pain in lower abdomen (85.3%), menorrhagia (85.3%), and expulsion of IUD (50%) (Figure 6.1). See Annex Table 6.14 for details.

Figure 6.1: Percentage distribution of FWVs by complications/ problems the clients generally face after accepting IUD by division

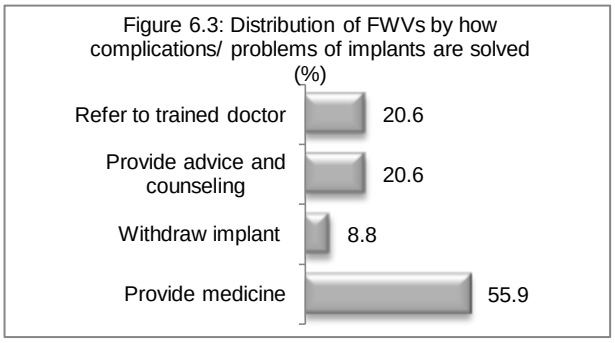


The complications that the implant clients face most commonly reported by FWVs are: headache, vomiting tendency and weight gain (50%), menorrhagia (47.1%), and amenorrhea (47.1%). See Annex Table 6.15 for details.



Regarding how the complications and problems of IUD are addressed, the FWVs reported that, the clients are provided medicine (82.4%), IUD withdrawn (32.4%), and provided advice and counseling (32.4%). Only 8.8 percent of the clients reporting of complications/ problems of IUD are referred to trained doctor and MO-MCH (Figure 6.2). See Annex Table 6.16 for details.

Regarding how the complications of implants are addressed the FWVs reported that, the clients are provided medicine (55.9%), provided advice and counseling (20.6%), and referred to trained doctor (20.6%) (Figure 6.3). See Annex Table 6.17 for details.



Regarding whether the complications arising in clients after insertion of LAPMs have been resolved or not after following advice/ treatment of their clinics, the FWVs reported that, in 94 percent cases the problems are resolved (Table 6.1).

Table 6.1: Percentage distribution of FWVs by their opinion on whether clients' problems have been solved following advice/ treatment of their clinics by division

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Solved	100.0	100.0	100.0	100.0	75.0	100.0	80.0	94.1
Not solved					25.0		20.0	5.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	5	5	5	5	4	5	5	34

6.4 Problems Faced in LAPMs Service Provision

Regarding problems faced in LAPMs service provision, about 30 percent of the MO-MCHs reported 'low payment to LAPM clients', and around 20 percent reported 'lack of supply of MSR'. They also reported of other problems, e.g., no separate OT and post-operative room for family planning, lack of training of field workers, lack of trained doctor, etc. See Annex Table 6.18 for details.

Regarding problems faced in LAPMs service provision, irrespective of divisions, all the FWAs reported that they faced one or more problem. About 68.6 percent FWAs corroborated that they face problem tainted by religious superstition, 42.9 percent mentioned lack of awareness, 20 percent stated negative impression about LAPMs, 14.3 percent each lack of cooperation from community leaders and Imams, low payment to LAPMs clients and side effects of IUD. See Annex Table 6.19 for details.

6.5 Problems Behind Low Rate of LAPMs as per National Level Program Managers

As to reasons behind low acceptance of LAPMs, most of the National level program managers were of opinion that the eligible couples are not properly aware of it. They also informed of non-availability of service providers, pain and bleeding after IUD, increased and irregular menstrual cycle after IUD and implants, fear of operation, fear of complication, and fear of impotence after vasectomy. Country Representative, EngenderHealth and President, OGSB informed that implants migrate in 8 to 10 percent cases. There is lack in quality service provision, maintenance of proper sterility during IUD, tubectomy and vasectomy, and maintenance of infection prevention measures after operation. They termed it as lack of empathy to the clients who are coming to get LAPM service. The clients are not counseled properly in presence of their husbands, client selection and screening is not done properly before providing the method, the service is not provided meticulously addressing all quality measures with due respect to the clients, and finally, the complications are not properly addressed by the service provision authority, that include- cost of treatment of complication including further surgery, medicine, cost of hospitalization, and further counseling. Cost of treatment of infertility and recanalization (in case of child mortality) is not also borne by them. Due to the last one cause, OGSB is not in favour of popularizing post-partum/ post-caesarean tubectomy among mass people having two children who are not able to bear the expenses of recanalization that may be needed in case of child death.

6.6 Initiatives Taken by Government and Non-government Organizations

Regarding initiatives taken to improve the situation, the Program Managers informed that DGFP with assistance from Engender Heath and SHOPs has started orientation programmes for the doctors, district and divisional level program managers, and other service providers. They have trained doctors on LAPMs and have requested SMC to supply long acting methods to private doctors and gynaecologists. OGSB provides technical support in the orientation and training programmes arranged by DGFP, Engender Health and SHOPs. In addition, DGFP Program Managers informed that, 750 posts of doctors, 600 posts of FWVs, and 200 posts of FPI and FWA are lying vacant. Initiatives have been taken to recruit doctors (MO-MCH), FWV, FPI and FWA to fill in the vacant posts. Both DGFP and Engender Health informed that, ‘motivational activities using satisfied clients approach’ is working well for increasing awareness among clients on LAPMs, and now it is being implemented in a number of places. Engender Health informed of a helpline approach being piloted in Comilla. In this approach, the clients of LAPMs have been provided a card with serial number and a mobile phone number, where they can contact the LAPMs helper (a female) after mentioning their card serial number. They informed that, the initiative is working well in-spite of many problems, e.g. the client women are not having mobile phone of their own, so they hesitate to phone in an unknown number. Engender Health also mentioned of another successful initiative of sending monthly MIS report of IUD by FWV through SMS. It has increased their performance with increasing accountability. It has also eased monitoring and supervision. They also informed of providing implants to nulliparous married adolescent and young women who want to delay child-birth for education or other reasons.

CHAPTER 7
SUGGESTIONS FOR INCREASING ACCEPTANCE AND QUALITY OF LAPM SERVICE

During the study the service providers and managers were enquired for their suggestions for increasing acceptance and quality of service of LAPMs. For this purpose the program managers at national level, MO-MCHs and FWVs as service providers, UFPOs and FPIs as managers, and FWAs as field level workers were interviewed. They had the following suggestions.

7.1 Suggestions of Service Providers and Managers at Peripheral Level

A. Suggestions of UFPO

For solving the problems of LAPMs service provision the UFPOs suggested as follows.

- Increase compensation to LAPMs clients
- Improve quality of care
- Arrange refreshers training of FWAs
- Increase referral fees and providers' fees
- Increase frequency of counseling and *Uthan Baithak*
- Deploy additional FWAs
- Increase media communications , and
- Separate OT and post-operative bed for LAPMs.

A smaller proportion of UFPOs suggested:

- Supply MSR for operation
- Arrange treatment for complications
- Increase awareness among community leaders and Imams
- Arrange refreshers training for FWVs, doctors, SACMOs, and
- Utilize community leaders and Imams to increase awareness of LAPMs.

See Annex Table 7.1 for details.

B. Suggestions of MO-MCHs

For solving the problems of LAPMs service provision the MO-MCHs suggested as follows:

- Separate OT and post-operative bed for family planning
- Regular supply of MSR for LAPM services, and
- Increase quality of care.

For increasing acceptance of LAPMs,

- Increase media communications
- Arrange meeting involving community leaders, and
- Increase compensation to LAPMs clients'.
- Arranging training of field workers, and
- Increase *Uthan Baithak* and counseling.

See Annex Table 7.2 for details.

C. Suggestions of FWVs

For increasing acceptance of LAPMs the FWVs suggested as follows:

- Increase media communication,
- Increase awareness of community leaders and religious leaders
- Increase compensation to LAPMs clients
- Arranging training of field workers
- Increase financial support for managing *Uthan Baithak*
- Increase referral fees.

See Annex Table 7.3 for details.

D. Suggestions of FPIs

For solving the problems of LAPMs service provision the FPIs suggested as follows:

- Arrange meeting involving community leaders
- Increase compensation to LAPMs clients
- Increase awareness of local leaders and Imams
- Increase quality of care, and
- Increase media communication.

A lower proportion of FPIs suggested-

- Arrangement of more training of FWVs
- Increase allowance for LAPMs referrals
- Separate OT and post-operative bed for LAPMs
- Supply of medicine for treatment of complications
- Increase number of field workers
- Upgrade education level of couples
- Deploy male FWAs for vasectomy
- Increase financial support to arrange meetings and *Uthan Baithak*.

For details see Annex Table 7.4.

E. Suggestions of FWAs

Regarding solution of the problems in LAPMs service provision FWAs proposed as follows.

- Increase allowance for LAPMs clients
- Arrange meeting involving community leaders and Imams
- Arrange training for community leaders and Imams
- Increase social awareness, and
- Increase media communication.

A lower proportion of FWAs suggested to-

- Increase allowance for LAPMs referral and doctors
- Increase quality of service and care
- Arrange of video show, increase in the number of field workers
- Arrange of more training of FWAs
- Separate OT and post-operative bed for LAPMs, and
- Increase counseling and guidance.

For details see Annex Table 7.5.

7.2 Suggestions of National Level Managers

The national level managers from DGFP, DGHS, Engender Health, and OGSB were much worried of the situation, and had the suggestions as follows for improvement of the situation:

1. Leadership problem with special attention to the recruitment and scope of promotion of all service providers in DGFP to be solved.
2. Improve quality of care of LAPMs service provision at all levels through training of service providers including the team.
3. Ensure privacy of the clients during and after operation.
4. Ensure that medicine is provided free of cost to the clients after the procedure.
5. Ensure that the clients get compensation after the procedure.
6. Train doctors on side-effect management.
7. Counseling to women on LAPMs during household visit, hospital/clinic visit, post-natal care, MR and post-abortion care.
8. IUD should be popularized at private level through SMC.
9. Arrange free treatment of complications, and free management of side-effects of LAPMs.
10. Use satisfied vasectomy clients to motivate others in group approach.
11. Special attention to be given to areas with high religiosity, and areas with high CPR with low LAPM rates.
12. Address LAPMs in meetings/seminars on MCH and other issues at various levels.
13. Address LAPMs issue in Community Clinic Co-ordination Committee meetings.
14. Strengthen monitoring, supervision and in co-ordination with DGHS both in clinics and at field level.
15. Disseminate information and provide training on LAPMs to doctors providing EOC service, and doctors in private practice.
16. Post-caesarean tubectomy done by doctors under DGHS to be reported and fees to be distributed through respective Civil Surgeon.
17. Doctors should be trained and involved in screening of IUD clients.
18. OGSB should be involved to provide technical guidance during orientation/training to doctors on screening of clients and management of complications using video and booklets through its divisional branches.
19. Although Directors of DGFP were in favour of increasing compensation to LAPM clients, others did not support it that much. According to them, it inhibits the non-poor in using government facilities for LAPMs with an understanding that it is only for the poor. Providing medicine to them after the procedure is more important as to them.
20. According to most of the national level program managers, clients should be motivated in such a way so that they understand that it is for their own benefit, not the government.

HAPTER 8
DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

8.1 Discussion

Based on the findings of survey in seven divisions and interviewed with Key Informants the following points can be discussed beforehand to reach conclusions and recommendations.

Knowledge of long acting and permanent methods

Although LAPMs is not that popular, around two-thirds of the respondents have knowledge of specific LAPMs except vasectomy, which is known to less than half of them. Among those having knowledge of the specific LAPMs, more than half knows of at least two major advantages of the method. A good proportion of them also know of their period of effectiveness, and two-thirds of them are aware of its sources where it is available. However, they know more about the disadvantages of different LAPMs. Regarding long acting methods the most commonly reported disadvantage is menstrual problem, and regarding permanent methods it is 'not possible to give birth to child again as it is a permanent method'. According to their opinion, relatives and friends are the prime sources of knowledge of LAPMs, and Upazila Health Complexes (UHC) and government hospitals are the main sources of getting LAPM services. However, variations are there, and respondents from Sylhet and Chittagong divisions do not have that much knowledge of LAPMs.

Choice of long acting and permanent methods and reasons behind non-use

In-spite of the fact that a high proportion of women have knowledge of different LAPMs, only 12.2 percent reports of using it, where proportion of users of tubectomy is the highest (5.3%), followed by implants, vasectomy and IUD. Perhaps, fear of side effects and socio-cultural barriers has overwhelming influence on the clientele, as evident from their responses. Socio-cultural barriers are more prominent in Sylhet and Chittagong.

Husband disliking (56%), herself disliking (47%), fear of side effect (51%), and community disliking (34%) are the main socio-cultural barriers behind non-use of LAPMs. In this context, it seems that the interplay of fear of side-effect, and socio-cultural factors are largely responsible for creating situations determining the characteristics of individual and group behaviour.

Opinion of the program managers and service providers

On average there are 71,071 eligible couples in each survey upazilas, and 1150 eligible couples under each FWAs. Although improved, around one-fourth of the program managers and service providers were of opinion that there are shortage of long-acting methods, and MSR related to LAPMs. They also reported shortage of trained doctors and FWVs for clinical service provision, and FWAs for field level services. Around 85 percent MO-MCHs reported arranging camps where average number of camps arranged for tubectomy and vasectomy was around 50 each with camps for IUD and implants ranging between 30 to 40 during last one year. FWVs reported that they have attended in camps arranged for long acting methods during last three months except in Chittagong division. However, the national level program managers of DGFP informed that the situation of LAPMs service is not that much worse and rate of insertion of implants is on increase. They informed that government has taken steps to fill in the vacant posts of both clinical service providers and field staff step by step. Supply of long acting methods and MSR is

also more regular. EngenderHealth and OGSB program managers stressed on the quality of care issues and lack of treatment facilities from the public service facilities for complications of LAPMs. Some of the program managers, service providers and field level staff from FP programme of government although asked for increased compensation to the LAPM clients and referrers, others did not agree with it, and they rather asked to concentrate more on quality issues including uninterrupted supply of methods and prevent shortage of MSR. They were of opinion that people are not coming for money, *saree* or *lungi* like the earlier days of FP programme. They are coming for quality service for their own benefit.

8.2 Conclusions

The problem lying with increasing acceptance of LAPMs is both from the demand and supply side. While the programme has failed to create demand that much due to socio-cultural problems and lack of proper BCC approach through use of media communication, counseling, and involvement of community and religious leaders. Although most of the LAPMs are for women, their husbands in most of the cases are not counseled properly, especially about its advantages and some probable side effects. The husbands are also not informed of the advantages of vasectomy, which is the safest among all the LAPMs. The complications due to lack of a quality approach has also increased, and while one women suffers from complication of LAPM, it not only have negative impact on her family but also discourages others who were motivated earlier and was ready to accept it. The complications thus prevent friends, relatives and neighbours of the sufferer to accept it. Shortage of manpower and supply of IUD and implants, and shortage of MSR for LAPMs also are great obstructions towards quality service provision.

8.3 Recommendations for Increasing Acceptance of LAPMs

The study findings warrant a set of practical, implementable and time-bound recommendations broadly as follows:

1. Establish quality LAPM services provided with more empathy, ensuring privacy of the clients during and after operation with scope of follow-up care to counter fears of side-effects and misconceptions. Provide treatment free of cost for the LAPM complications by trained doctors.
2. Resolve the leadership problem with special attention to the recruitment and scope of promotion of all level of service providers in DGFP. Increase number of service-providers (doctors and FWVs) and field-level staff (FWAs).
3. Launch an effective information-education-motivation (IEM) campaign with greater focus on LAPMs low-performing areas. Also counsel women on LAPMs during household visit, hospital/clinic visit, post-natal care, MR and post-abortion care. Popularize IUD at all levels through provision of proper information, uninterrupted supply, quality service provision, and proper management of complication.
4. Involve Community Clinic Co-ordination Committee, and local government institutions and NGOs for information dissemination, and OGSB, Engender health and others for technical support and training.
5. Strengthen monitoring, supervision and reporting of LAPMs using modern technologies in innovative ways, and keeping close liaison between DGHS and DGFP officials.

8.4 Proposed Strategies for Implementation

The study team proposes the following strategies to implement the recommendations in the current situation.

1. Establish quality LAPM services provided with more empathy, ensuring privacy of the clients during and after operation with scope of follow-up care to counter fears of side-effects and misconceptions. Provide treatment free of cost for the LAPM complications by trained doctors. Improve quality of care of LAPM service provision at all levels through training of whole team of service providers.

Specific actions: Activities to be accomplished in continuous process

1. Provide training to service providers (doctors and FWVs) so that clients while coming for service can be dealt with due attention without any harassment and injury leading to complication (Responsibility: Director, CC at DGFP; NIPORT)
2. Arrange separate OT and post-operative room for LAPM services (Responsibility: DGFP office, MOHFW)
3. Ensure pre and post counseling of LAPM acceptors. It is important that client-friendly atmosphere prevails/maintained at any time (Responsibility: FWV, MO-MCH and concerned service-providers)
4. Ensure that periodic visits DGFP and DDFP office (Clinical Contraception supervising staff) at all LAPM service delivery points (UHC, MCWC, and other service delivery points where applicable) and Follow-up care at FWC for quality assurance (Responsibility: DGFP office, DDFP office, ADCC).
5. Hold brain-storming discussions with service-providers and LAPM acceptors/clients to devise best practice to provide best care within the available resources and capacity (Responsibility: UFPO and MO-MCH).
6. Equip LAPM facilities with required outfit/equipment, etc. to deliver and maintain quality service in a planned way (Responsibility: DDFP and officials of DGFP).
7. Train doctors on providing of services for complications of LAPM (Responsibility: DGFP,NIPORT, EngenderHealth, SHOPS, OGSB)
8. Supply of medicine for treatment of complications (Responsibility: DGFP)
9. Provide fund for treatment (Responsibility: DGFP)
10. Impart job-related training/retraining both short course and long course, to raise skill and commitment to perform assigned tasks. This should be carried on the basis of a implementable Training Calendar giving more emphasis on the training needs of LAPM service providers (Responsibility: NIPORT in collaboration with DGFP).
11. Doctors should be trained on screening of IUD clients
12. Disseminate information and provide training on LAPMs to doctors providing EOC service, and private doctors.
13. Training is to be imparted to doctors, FWV, Nurse/ Aya, Male nurse, Ward boy and OT assistant (Responsibility: DGFP, NIPORT, involving OGSB, EngenderHealth, SHOPS and other related NGOs)
14. Provision of refresher's training at a regular interval
15. Service providers to be more client-friendly and warm.

2. Resolve the leadership problem with special attention to the recruitment and scope of promotion of all level of service providers in DGFP. Increase number of service-providers (doctors and FWVs) and field-level staff (FWAs)

It is well-acknowledged that leadership problem and scope of promotion of service providers and mangers is a serious impediment to LAPM service-delivery to the clients. If it this does not go well, frustration among the service providers and mangers, and failure of the programme loom large on the country as a whole. As a consequence, the national FP program suffers due to chronic shortage of staff that also adds to the burning issues of failure.

Specific actions: Activities to be accomplished.

1. Fill up the vacant posts with recruitment of qualified persons (Responsibility: MoHFW & DGFP)
2. Create ladder for scope of promotion of the service providers for reaching the top most position to provide proper leadership
3. Provide leadership to the peoples having experience in the field and able to solve the ongoing problems.
4. Fill up the vacant posts of doctors, FWVs and FWAs.
5. New posts of FWAs are to be created to cover growing population.

3. Launch an effective information-education-motivation (IEM) campaign with greater focus on areas with low-performing LAPMs. Counsel women on LAPMs during household visit, hospital/clinic visit, post-natal care, MR and post-abortion care. Popularize IUD at all levels through uninterrupted supply, quality service provision, and proper management of complication.

Specific actions: To be carried out on a continuous process (non-stop)

1. Hold courtyard meeting regularly, with community / family members, both male and female separately (responsibility: FPI and FWAs concerned);
2. Hold local level meetings, group-meetings with community leaders, religious leaders, opinion leaders and stakeholders to create positive attitude about LAPM (responsibility: UFPO, UHFPO, MO-MCH).
3. Encourage FP service recipients and eligible couples to visit service centers, namely, community clinic, family welfare center, upazila health complex, and NGO clinics to get LAPM service (responsibility: FPI, FWA)
4. Hold local level workshop to devise suitable motivational strategy and campaign addressing the needs of the community lagging behind in FP acceptance (responsibility: UFPO, MO-MCH)
5. Provide information to the people using media communication (Responsibility: IEM cell of DGFP, Ministry of Communication).

6. Recruit village-level volunteers (male/female) as supporting hand to FWA and deploy them after proper training within a period of 6 months (Responsibility: DDFP with DGFP's approval).
7. Use satisfied clients to motivate others in group approach (Responsibility: DDFP with DGFP's approval).
8. Counsel women during home visit on LAPM (Responsibility: FWA)
9. Counsel women during hospital / clinic visit. (Responsibility: FWVs/ doctors)
10. Counsel women on post natal care (Responsibility: FWVs, doctors)
11. Ensure uninterrupted supply of quality LAPMs product of choice (Responsibility: DDFP and officials of DGFP).
12. Streamline the distribution system (Responsibility: DDFP and officials of DGFP).
13. Safe- guard against stock-out of long-acting methods (Responsibility: UFPO, MO-MCH, DDFP and officials of DGFP).
14. LAPM should be available at District hospitals, UHCs and MCWCs and these facilities be kept open timely (Responsibility: UFPO, MO-MCH, CS, DDFP and officials of DGHS and DGFP).
15. More involvement of private sector in the supply chain of long-acting methods (Responsibility: DGFP, DGHS, SMC)

While designing an effective information-education-motivation (IEM) campaign the following key points/issues should be kept in view.

1. Focus motivation of male members in the community to ensure the cooperation and support for LAPM by husband and elders in the family.
2. Special attention to be given to areas with high religiosity, and areas with high CPR with low LAPM rates.
3. Better inter-spousal (husband-wife) communication;
4. Special program for removing religious preconception and superstition.
5. Tailor information-motivation program based on community characteristics and their needs.
6. Fear of side-effects of LAPM methods;

4. Involve Community Clinic Co-ordination Committee, and local government institutions and NGOs for information dissemination, and OGSB, Engender health and others for technical support and training.

Specific actions: Activities to be accomplished in continuous process

1. Hold meeting with local govt. bodies at union and upazila level, and Community Clinic Co-ordination Committee to seek their cooperation. At all these levels there exist Health-FP committee with members from relevant department/organizations, and activating their role may be fruitful (Responsibility: DDFP, UHFPO and UFPO).
2. Establish and activate relationship with OGSB, Engender health, SHOPS and other NGOs for technical support and training in LAPM program to get their hands of cooperation (Responsibility: DGFP, DDFP).
3. Strengthen monitoring, supervision and in co-ordination with DGFP and DGHS both at clinic and at field level (Responsibility: DGHS, DGFP, Civil Surgeon, DDFP).

5. *Strengthen monitoring, supervision and reporting of LAPMs using modern technologies in innovative ways*

Specific actions: Activities to be accomplished in continuous process

1. Regular visit at UHCs, MCWCs, and FWCs to enquire shortage of LAPM and proper number of services provided, satisfaction level of clients, complications, medicine provided and to enquire health and related well being of LAPM acceptors (Responsibility: DDFP, ADCC)
2. Periodic visit of doctors in UHCs, MCWCs, and FWCs (Responsibility: DDFP, ADCC)
3. Reporting using modern technology such as e-mail, SMS (Responsibility: UFPO to DDFP, and FWAs to UFPO).
4. Periodic field visit by managers at FWC and clients to check list of LAPM clients (Responsibility: DDFP, UFPO, FPI)
5. Close liaison between DGHS and DGFP officials (Responsibility: Civil Surgeon and DDFP)

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Annex-1
Data Tables

Annex Tables Chapter: 2

Table 2.1: Percentage distribution of women by age by division

Age Group	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
<18	0.5	1.3	1.0	-	0.8	-	0.7	0.4	1.1	0.7
18-24	28.5	28.9	15.6	25.2	21.2	19.2	19.0	21.8	24.8	23.1
25-29	24.5	23.8	26.7	23.3	27.3	25.0	26.0	27.0	21.6	24.6
30-34	22.9	18.1	18.1	20.3	17.3	19.2	16.3	18.1	20.9	19.3
35-39	13.9	12.7	23.2	12.4	18.1	16.2	18.0	16.5	15.7	16.1
40-44	7.2	8.9	10.8	9.4	10.4	14.2	14.7	10.4	11.0	10.7
45+	2.4	6.3	4.8	9.4	5.0	6.2	5.3	6.0	4.8	5.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Mean	28.7	29.5	31.2	30.6	30.5	31.1	31.1	30.4	30.1	30.3
Median	28.0	28.0	30.0	30.0	30.0	30.0	30.0	30.0	30.0	30.0
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 2.2: Percentage distribution of women by attaining education by division

Attaining education	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Yes	72.5	73.3	70.2	68.2	66.9	76.2	59.0	65.2	77.7	70.7
No	27.5	26.7	29.8	31.8	33.1	23.8	41.0	34.8	22.3	29.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 2.3: Percentage distribution of women by type of educational institution and by division

Type of educational institutions	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
General School	98.2	99.1	99.5	89.3	99.4	97.5	100.0	97.3	97.8	97.5
Alia Madrasha	1.5	0.4	0.5	9.8	0.6	2.0	-	2.3	2.1	2.2
Kaomi Madrasha	0.4	0.4	-	0.9		0.5	-	0.4	0.2	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100	100	100
N	**509**	**432**	**413**	**421**	**325**	**370**	**331**	**1719**	**1083**	**2801**

Table 2.4: Percentage distribution of women by their attainment of highest class education by division

Class	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
No education	27.5	26.7	29.8	31.8	33.1	23.8	41.0	34.8	22.3	29.3
Primary incomplete	11.7	13.7	12.1	7.3	17.3	9.6	10.0	11.9	10.9	11.5
Primary complete	23.7	19.0	14.3	17.6	16.2	19.6	17.7	18.4	18.5	18.4
Secondary incomplete	24.8	29.8	30.8	26.4	24.2	25.4	22.7	24.9	29.1	26.8
Secondary complete of higher	12.0	10.5	13.0	16.4	9.2	21.2	8.7	9.6	19.1	13.8
Koumi madrasha	0.3	0.3	-	0.6	-	0.4	-	0.3	0.1	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 2.5: Percentage distribution of women by their main occupation by division

Occupation	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Land owner	-	-	-	-	-	-	-	-	-	-
Farmer	-	-	-	-	-	-	-	-	-	-
Agricultural worker	-	-	-	-	-	-	0.7	0.1	-	0.1
Fisherman	0.3	-	-	0.3	-	-	-	0.1	0.1	0.1
Poultry/cattle raising	-	-	19.4	-	-	-	-	4.2	0.3	2.8
Home-based manufacturing	-	0.3	1.6	-	-	-	-	0.3	0.3	0.3
Brick breaking/road bridge	-	0.3	-	0.3	-	-	-	0.1	0.1	0.1
Domestic servant	0.5	1.3	0.3	1.2	0.4	1.2	0.7	0.6	1.1	0.8
Factory worker/blue collar service	0.3	0.3	-	-	-	-	-		0.3	0.1
Sewing/tailor	0.3	3.2	6.7	1.2	1.2	-	1.3	1.2	3.5	2.0
Doctor/engineer/lawyer/teacher/ FWV/Govt./private services	2.9	0.6	0.3	1.2	1.9	1.5	1.3	0.1	3.9	1.4
Large business	-	-	-	-	-	-	0.3	0.1		0.0
Small business	-	-	0.3	-	-	-	-	-	0.1	0.0
Unemployed/student	-	-	-	-	-	-	-	-	-	-
Housewife	95.7	93.0	71.4	95.8	96.5	97.3	95.7	93.1	90.1	92.1

Occupation	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Others	-	1.0	-	-	-	-	-	0.1	0.3	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 2.6: Percentage distribution of women by their religion by division

Religion	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Islam	93.1	93.3	95.6	87.0	83.5	91.9	86.7	91.5	88.2	90.3
Hindu	6.7	6.7	4.4	13.0	16.5	8.1	13.3	8.5	11.7	9.6
Christian	0.3	-	-	-	-	-	-	-	0.1	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 2.7: Percentage distribution of women by their total number of household member by division

Total HH member	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
1	-	-	0.3	0.6	1.2	-	-	0.4	0.1	0.3
2	0.8	1.6	0.6	1.2	0.8	1.5	0.3	0.9	1.2	1.0
3	21.6	25.4	20.0	12.1	13.8	18.1	14.0	17.3	19.5	18.3
4	29.6	32.7	38.1	22.7	18.5	26.5	28.0	26.5	31.8	28.8
5 +	48.0	40.3	41.0	63.3	65.8	53.8	57.7	55.0	47.4	51.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Mean	4.7	4.5	4.5	5.3	5.6	4.9	5.1	5.0	4.8	4.9
Median	4.0	4.0	4.0	5.0	5.0	5.0	5.0	5.0	4.0	5.0
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 2.8: Percentage distribution of women by their total number of living children by division

Total living children	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
1	32.0	32.7	29.2	21.2	23.1	26.2	20.7	24.7	30.5	27.3
2	35.7	39.7	40.6	27.3	25.8	31.2	37.7	32.7	37.2	34.7
3	19.5	21.0	21.3	21.5	22.7	19.6	26.7	22.8	19.5	21.3
4	6.9	4.1	5.7	14.5	14.2	13.5	7.3	9.8	8.2	9.1
5 +	5.9	2.5	3.2	15.5	14.2	9.6	7.7	10.0	4.7	7.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Mean	2.2	2.0	2.1	2.9	2.8	2.6	2.5	2.5	2.2	2.4
Median	2.0	2.0	2.0	3.0	3.0	2.0	2.0	2.0	2.0	2.0
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 2.9: Percentage distribution of women by their desired number of children by division

Total desired no. of children	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
0	39.2	35.6	69.5	61.8	70.8	56.2	70.0	58.4	53.4	57.6
1	29.3	14.6	26.7	20.9	25.0	23.8	23.7	24.3	22.0	23.9
2	8.8	27.3	1.6	2.1	1.9	6.5	1.7	6.4	9.1	6.8
3	0.8	1.9	0.3	1.5	-	-	-	0.8	0.5	0.8
4+	-	1.3	0.3	.6	1.2	0.8	0.3	0.7	0.4	0.7
Don't know	21.9	19.4	1.6	13.0	1.2	12.7	4.3	9.4	14.5	10.2
Mean	0.63	0.99	0.33	0.37	0.34	0.46	0.30	0.47	0.51	0.47
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Section 2: Household Assets

Table 2.10: Percentage distribution of women by their household ownership by division

Household ownership	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Yes	25.3	9.2	21.9	13.9	20.0	9.6	20.7	19.8	13.3	17.5
No	74.7	90.8	78.1	86.1	80.0	90.4	79.3	80.2	86.7	82.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 2.11: Percentage distribution of women according to the main materials of roof of their living house by division

Main materials of roof	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Concrete	4.5	8.9	8.6	9.4	8.5	8.1	1.3	3.8	12.9	7.0
Tin	94.9	67.9	91.4	86.7	91.2	88.8	97.3	90.9	83.5	88.4
Tali	-	19.4	-	-	-	0.8	-	2.8	3.1	2.9
Thatch/jute stick/palm leaf	0.5	3.8	-	2.7	0.4	1.5	1.3	2.1	0.4	1.5
Bamboo/Polythine	-	-	-	1.2	-	0.8	-	0.4	0.1	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 2.12: Percentage distribution of women according to the main materials of floor of their living house by division

Main materials of floor	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Earth/sand	66.7	78.4	67.6	73.9	56.9	82.7	91.0	87.3	48.19	73.8
Palm log/Bamboo	-	-	-	-	0.4	0.4	-	0.1		0.1
Ceramic tiles/Mosaic	-	0.6	-	-	-	0.8	-	0.1	0.27	0.2
Cement/Brick	33.3	21.0	32.4	26.1	42.7	16.2	9.0	12.4	51.54	25.9
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 2.13: Percentage distribution of women according to the main materials of wall of their living house by division

Main materials of wall	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Brick	27.2	44.1	39.7	26.7	49.2	18.1	18.7	21.4	51.4	31.8
Tin	68.3	6.7	52.1	44.2	20.4	46.9	53.0	47.6	33.6	42.7
Earth	1.6	36.5	7.0	17.6	21.5	-	11.3	17.6	5.8	13.5
Bamboo	0.8	7.0	0.6	9.7	1.5	-	3.3	2.7	4.7	3.4
Straw/Jute stick/leaf	1.9	4.4	0.6	0.6	6.5	5.4	11.7	5.0	2.7	4.2
Bamboo/Polythine	0.3	-	-	1.2	-	-	2.0	0.5	0.5	0.5
Wood log	-	1.3	-	-	0.8	29.6	-	5.2	1.3	3.9
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 2.14: Percentage distribution of women according to their possession of household assets by division (Multiple answers possible)

Household assets	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Electricity	79.2	72.4	74.6	76.4	73.5	68.5	29.0	58.6	86.2	68.1
Radio	2.9	1.6	4.4	1.2	1.5	1.5	0.7	1.0	4.0	2.0
Television	50.4	45.4	43.2	40.9	44.6	39.6	17.7	27.3	65.8	40.6
Mobile Phone	48.5	21.3	24.4	58.5	18.8	34.6	25.3	25.6	50.1	34.1
Land Phone	1.1	-	1.0	4.5	0.8	0.4	1.0	0.7	2.4	1.3
Refrigerator	1.9	0.6	1.3	1.5	1.5	2.3	2.7	0.6	3.6	1.7
Computer	-	-	0.6	-	-	0.4	0.7	0.3	0.1	0.2
Washing Machine	0.5	-	-	-	0.4	-	0.3	0.1	0.4	0.2
Almirah	11.5	2.2	11.4	19.4	12.7	7.7	4.3	5.2	19.1	10.0
Sofa	0.3	-	0.6	0.3	0.4	0.4	0.7	0.4	0.3	0.4
Table/chair	89.1	81.6	87.6	87.9	84.6	94.6	85.3	85.5	90.3	87.2
Bed	97.6	96.5	92.4	99.4	98.5	99.6	99.0	97.9	96.6	97.5
Motor cycle	2.7	7.0	7.6	3.0	3.8	6.2	5.0	3.6	7.5	5.0
Bicycle	13.3	34.6	11.4	6.7	4.6	10.4	48.7	19.9	16.4	18.7
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 2.15: Percentage distribution of women according to having electricity connection in their household by division

Status of electricity connection	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Yes	79.5	76.8	74.0	75.2	76.9	68.8	31.7	59.9	87.2	69.4
No	20.5	23.2	26.0	24.8	23.1	31.2	68.3	40.1	12.8	30.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	100.0	100.0	100.0
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 2.16: Percentage distribution of women according to their household's main source of drinking water by division

Main source of drinking water	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Piped into dwelling	21.3	12.1	1.6	3.3	1.2	0.4	1.0	2.0	15.2	6.5
Piped to yard/plot	2.4	1.3	1.6	0.6	-	1.2	0.3	0.1	3.1	1.1
Public tap	-	1.0	1.0	5.2	5.0	-	-	0.2	4.4	1.7
Tube well	76.3	85.1	95.9	88.5	93.1	73.8	98.7	92.7	76.6	87.1
Water from protected spring	-	-	-	2.4	-	-	-	0.4	0.3	0.4
Rain water	-	-	-	-	-	1.9	-	0.4		0.2
Surface water	-	0.6	-	-	0.8	22.7	-	4.3	0.4	2.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 2.17: Percentage distribution of women according to their household's types of toilet facility by division

Main source of drinking water	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Flush to piped sewer system	8.0	16.8	5.1	3.6	1.5	0.8	3.0	2.8	11.7	5.8
Flush to septic tank	24.5	1.6	11.1	26.4	28.8	15.4	7.0	7.9	32.8	16.5
Flush to pit latrine	1.9	27.6	-	3.3	2.3	3.1	-	5.2	6.2	5.5
No facility/Bush/Field	1.9	-	-	3.0	1.2	-	5.3	2.4	0.3	1.7
Pit latrine with slab	58.9	38.7	55.6	62.7	55.0	74.2	81.3	68.6	45.4	60.6
Pit latrine without slab/open pit	4.8	15.2	27.9	0.9	11.2	6.5	3.0	13.0	3.8	9.8
Hanging toilet	-	-	0.3	-	-	-	0.3	0.1	-	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

.

Annex Tables Chapter: 3

Table 3.1: Percentage distribution of women according to their knowledge (Heard of) of LAPMs by division

Heard of LAPMs	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Yes	85.9	88.3	76.8	93.9	67.3	83.8	96.0	83.9	87.2	85.4
No	14.1	11.7	23.2	6.1	32.7	16.2	4.0	16.1	12.8	14.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 3.2: Percentage distribution of women according to their knowledge (Heard of) of specific LAPMs by division (Multiple answers possible)

Heard of specific LAPMs	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
IUD	65.3	41.6	67.9	84.5	25.0	60.4	86.0	61.0	65.6	63.0
Implant/ Norplant	78.1	58.4	71.1	62.7	33.1	71.2	94.3	66.6	70.2	68.2
Tubectomy	64.5	72.7	70.5	61.8	46.9	58.5	82.7	63.8	69.7	66.4
Vasectomy	42.7	61.6	55.2	38.8	5.4	32.3	71.3	42.6	49.3	45.6
Heard of none	0.5	0.3	-	0.3	7.3	-	-	1.3	0.7	1.0
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 3.3: Percentage distribution of women according to their source of knowledge about LAPMs by division (Multiple answers possible)

Source of knowledge about LAPMs (from whom/ where)	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Government hospital	29.2	68.0	25.2	43.2	18.9	16.5	21.2	28.6	41.5	34.3
Family Welfare Centre/FWV	21.7	6.8	14.0	28.1	11.4	4.1	18.8	15.3	17.2	16.1
Upazila Health Complex	21.1	61.9	37.2	19.4	26.3	36.2	45.8	38.5	29.5	34.5
Satellite Clinic	10.6	11.2	2.1	3.2	-	1.8	30.9	9.4	9.5	9.4
Maternal and Child Welfare Centre	13.4	37.8	13.6	5.8	8.6	15.1	10.4	11.8	21.1	15.9
Community Clinic	3.4	5.8	4.1	4.2	-	-	0.3	2.8	2.8	2.8
Private hospital/clinic	12.4	16.2	1.7	3.2	37.7	2.8	1.0	7.6	12.9	9.9
FWA	41.3	2.5	31.4	22.9	33.7	1.4	20.1	23.7	19.5	21.8
HA	14.9	23.7	31.8	8.1	18.3	16.5	3.8	17.0	14.5	15.9
NGO worker/clinic	15.2	7.9	7.4	16.8	12.0	49.5	11.1	17.7	14.3	16.2
Relatives/Friends	61.5	24.8	43.8	48.1	33.7	88.1	65.3	53.1	51.2	52.3
Religious leaders	3.4	-	-	0.3	-	0.9	-	1.1	0.2	0.7
Community leaders	3.4	-	-	9.4	-	-	0.3	0.8	4.8	2.6
Printed media	9.6	0.4	-	1.0	0.6	0.9	1.4	0.2	6.2	2.9
Radio	3.7	-	0.8	0.6	-	0.5	0.3	0.3	2.2	1.1
TV	24.8	20.9	4.5	16.1	5.1	38.5	7.3	11.4	27.4	18.5
Cinema	0.3	-	-	-	-	-	-	-	0.2	0.1
Street corner drama/Folk song	0.3	0.7	-	0.3	-	-	-	0.3	0.2	0.3
N	**603**	**521**	**453**	**580**	**328**	**408**	**539**	**2213**	**1215**	**3442**

Section 3 B: Knowledge of Advantages and Disadvantages, Sources and Duration of LAPMs

Table 3.4: Percentage distribution of women according to their knowledge (Heard of) of IUD (Copper T) by division

Heard of IUD (Copper T)	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Yes	65.3	41.6	67.9	84.5	25.0	60.4	86.0	61.0	65.6	63.0
No	34.7	58.4	32.1	15.5	75.0	39.6	14.0	39.0	34.4	37.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 3.5: Percentage distribution of women according to their opinion on advantages of IUD by division (Multiple answers possible)

Advantages of IUD	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Very much effective	38.4	47.3	44.4	7.5	53.8	24.8	63.2	37.4	38.2	37.8
Can protect pregnancy up to10 years	49.0	55.7	78.0	36.9	52.3	83.4	71.7	65.2	51.5	59.1
Easy to use/take	25.7	33.6	7.5	6.5	20.0	26.8	7.4	15.3	17.0	16.1
Action starts immediately after use/taking	18.8	41.2	10.7	9.0	56.9	20.4	14.7	19.5	17.8	18.7
No difference appears in the breast milk after taking IUD	18.0	16.8	2.3	1.8	1.5	2.5	3.9	7.4	5.5	6.6
Pregnancy capacity return immediately after quitting the method	19.2	18.3	26.6	37.3	30.8	8.9	39.9	29.2	24.1	26.9
Does not create barriers to sexual intercourse	15.9	13.7	0.5	21.5	6.2	19.7	6.6	9.5	18.0	13.3
No hormonal problem	2.0	5.3	5.6	4.3		1.3	17.4	5.7	7.0	6.3
Remain free from everyday hazard of using condom or pill	66.5	17.6	79.9	58.8	10.8	79.6	63.2	63.3	55.6	59.9
Others	-	4.6	0.5	1.4	-	-	-	0.8	0.8	0.8
N	**458**	**245**	**400**	**522**	**122**	**294**	**482**	**1608**	**914**	**2523**

Table 3.6: Percentage distribution of women according to their opinion on disadvantages of IUD by division (Multiple answers possible)

Disadvantages of IUD	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Feeling of pain in lower abdomen	50.6	59.5	41.6	49.8	64.6	56.1	45.3	50.2	50.1	50.2
Increased bleeding during menstruation	48.2	62.6	43.9	55.2	63.1	72.6	36.8	54.2	47.4	51.2
White srab during menstruation	45.7	39.7	50.9	22.9	58.5	83.4	30.2	46.5	37.6	42.6
Sometimes IUD comes outside of vagina	31.0	27.5	73.4	28.0	12.3	26.1	29.8	32.7	39.3	35.6
Become pregnant instead of taking IUD	13.5	16.0	5.6	11.8	6.2	11.5	2.7	8.6	11.0	9.7
Sometimes vagina becomes damaged	9.4	16.8	5.6	9.0	-	6.4	58.1	19.9	14.5	17.5
Needs experienced worker to take and remove of IUD	6.1	1.5	18.7	1.4	-	1.9	7.4	6.6	5.3	6.0
Need to examine the string after each menstruation	16.7	10.7	11.7	10.0	3.1	11.5	31.8	14.0	18.4	16.0
It does not protect STD/HIV/AIDS	13.9	3.8	2.3	1.4	1.5		1.9	3.3	5.3	4.2
Reproductive organs transition risks increase	4.9	6.1	2.8	9.0	7.7	2.5	32.6	11.0	10.0	10.6
Others	1.2	6.1	1.4	1.4	-	-	-	1.4	1.2	1.3
N	**458**	**245**	**400**	**522**	**122**	**294**	**482**	**1608**	**914**	**2523**

Table 3.7: Percentage distribution of women according to their knowledge about sources of IUD by division (Multiple answers possible)

Knowledge about sources of getting IUD	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Government hospital	62.9	91.6	56.1	79.9	30.8	73.9	55.8	59.3	79.1	68.1
Family Welfare Centre/FWV	24.5	13.7	24.3	31.5	23.1	15.3	9.7	21.4	20.0	20.8
Upazila Health Complex	49.4	80.2	65.4	53.0	50.8	88.5	78.7	73.4	52.8	64.3
Satellite Clinic	3.7	3.8	0.5	1.4	-	1.3	3.1	1.3	3.7	2.4
Maternal and Child Welfare Centre	23.7	23.7	16.4	3.2	23.1	40.1	20.2	15.1	27.2	20.5
Community Clinic	9.4	0.8	4.2	3.9	-	0.6	-	3.0	3.9	3.4
FWV	9.4	2.3	0.9	10.0	46.2	3.2	7.4	8.4	7.8	8.1
HA	2.9	3.1	2.3	1.1	-	6.4	-	2.3	1.8	2.1
Private hospital/clinic	10.2	14.5	0.5	6.5	-	19.1	0.8	4.4	11.7	7.6
NGO worker/clinic	20.8	7.6	1.9	14.0	38.5	44.6	4.3	11.4	22.9	16.5
Pharmacy	0.4	-	0.5	-	-	-	-	-	0.4	0.2
Others	-	3.8	-	-	-	-	-	0.6	-	0.3
N	**458**	**245**	**400**	**522**	**122**	**294**	**482**	**1608**	**914**	**2523**

Table 3.8: Percentage distribution of women according to their opinion about duration of effectiveness of IUD once inserted by division

Years	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
up to 5	30.2	7.6	13.1	27.2	20.0	12.1	3.9	13.1	23.9	17.9
up to 10	71.0	92.4	78.5	49.5	38.5	98.1	83.7	73.1	75.1	74.0
Don't Know	29.0	7.6	21.5	50.5	61.5	1.9	16.3	26.9	24.9	26.0
Mean	4.9	8.5	7.0	3.4	2.7	8.9	8.0	6.45	5.85	6.2
Median	3.0	10.0	10.0	0.0	0.0	10.0	10.0	10.0	6.0	8.2
N	**458**	**245**	**400**	**522**	**122**	**294**	**482**	**1608**	**914**	**2523**

Table 3.9: Percentage distribution of women according to their knowledge (Heard of) of Implant/ Norplant by division

Heard about Implant/ Norplant	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Yes	78.1	58.4	71.1	62.7	33.1	71.2	94.3	66.6	70.2	68.2
No	21.9	41.6	28.9	37.3	66.9	28.8	5.7	33.4	29.8	31.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 3.10: Percentage distribution of women according to their opinion on advantages of Implant/Norplant by division (Multiple answers possible)

Advantages of Implant	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Very much effective as temporary long term method which could protect pregnancy till 3-5 years	81.6	93.5	96.4	59.4	82.6	92.4	93.3	88.7	80.9	85.2
Effectiveness starts within 24 hours after setting	16.7	33.2	53.6	1.9	7.0	31.4	34.3	29.5	22.6	26.4
Pregnancy capacity returns immediately after quitting the method	39.2	20.7	19.2	35.3	52.3	43.8	29.7	33.3	31.7	32.6
Remains free from everyday hazard of using condom or pill	54.3	27.2	43.8	60.4	23.3	48.6	37.1	47.4	38.6	43.5
Does not create barriers to sexual intercourse	13.3	9.8	3.6	28.5	7.0	20.0	30.0	14.9	21.4	17.8
Does not require to visit clinic again and again except some certain follow up visit	12.3	3.3	2.7	2.9		3.2	8.1	6.4	4.4	5.5
Makes no difference in breast milk; so implant could be use after 6 weeks of child birth	7.2	4.3		1.9		0.5	1.4	2.1	3.4	2.7
No side affect due to Estrogen hormone	0.3	40.2	3.1	-	-	-	2.1	4.6	8.6	6.4
Cures iron deficiency	0.7	12.0	-	9.2	-	-	3.2	3.1	4.4	3.7
Could be removed at any time	22.5	13.0	14.3	11.1	18.6	29.7	38.9	23.4	20.3	22.0
Others	0.3	4.3	0.4	-	-	-	-	0.9	0.4	0.7
N	**548**	**344**	**419**	**387**	**161**	**346**	**529**	**1756**	**978**	**2734**

Table 3.11: Percentage distribution of women according to their opinion on disadvantages of Implant/ Norplant by division (Multiple answers possible)

Disadvantages of Implant/ Norplant	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Drop hemorrhage between two menstrual period	31.7	40.2	15.2	28.5	5.8	35.1	43.8	31.9	29.4	30.8
Little bleeding for a long time	51.5	38.6	17.4	47.3	44.2	55.1	21.6	40.1	35.0	37.8
Stopped menstruation	61.8	51.6	62.1	47.8	80.2	84.3	55.1	64.0	56.2	60.5
Headache, vomiting tendency and weight gain	44.4	55.4	74.1	44.4	64.0	65.4	42.4	54.8	51.8	53.5
Feeling of tiredness	2.7	12.0	22.8	1.0	19.8	7.6	21.9	12.5	11.3	12.0
Weighty /Pain in breast	9.6	14.7	31.7	4.8	-	15.7	8.5	13.0	12.8	12.9
Hazard to open and use self	36.5	3.8	40.6	19.3	-	13.0	41.7	27.9	23.9	26.1
Need small operation to take and open	16.0	6.5	12.1	8.7	-	8.1	13.1	12.1	8.0	10.3
Transition, bleeding problem	10.2	3.8	2.2	8.2	9.3	8.1	29.7	10.2	13.4	11.6
Does not protect STD/HIV/AIDS	2.0	1.6		0.5	-	0.5	-	0.5	1.1	0.8
Others	0.3	2.7	1.3	-	-	1.1	0.4	0.7	1.0	0.8
N	**548**	**344**	**419**	**387**	**161**	**346**	**529**	**1756**	**978**	**2734**

Table 3.12: Percentage distribution of women according to their knowledge about sources of getting Implant/ Norplant by division (Multiple answers possible)

Knowledge about sources of getting Implant/ Norplant	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Government hospital	63.5	92.4	50.9	81.2	19.8	65.4	57.6	57.1	77.1	66.0
Family Welfare Centre/FWV	22.2	7.1	25.4	30.9	5.8	10.3	4.9	16.8	15.1	16.0
Upazila Health Complex	56.7	86.4	63.8	61.8	61.6	85.4	78.1	76.8	58.7	68.8
Satellite Clinic	-	-	-	-	-	1.1	-	0.2	-	0.1
Maternal and Child Welfare Centre	23.2	32.1	17.0	4.8	24.4	38.9	22.6	16.5	33.8	24.2
Community Clinic	8.5	2.2	4.0	5.3	-	0.5	-	3.3	3.6	3.4
FWV	8.9	-	1.3	9.7	40.7	5.9	3.5	7.1	7.3	7.2
HA	3.1	2.7	1.8	0.5	3.5	7.0		2.6	2.1	2.4
Private hospital/clinic	9.9	12.5		1.9		19.5		4.0	10.3	6.8
NGO worker/clinic	14.7	9.8	2.7	10.6	38.4	47.0	2.8	13.1	18.0	15.3
Pharmacy	-	-	-	0.5	-	0.5	-	0.2	-	0.1
Shop	-	-	-	-	-	0.5	-	-	0.2	0.1
Others	-	2.2	0.4	-	-	-	-	0.3	0.4	0.3
N	**548**	**344**	**419**	**387**	**161**	**346**	**529**	**1756**	**978**	**2734**

Table 3.13: Percentage distribution of women according to their opinion about duration of effectiveness of Implant/ Norplant once inserted by division

Years	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
up to 3	34.5	62.0	51.8	22.2	27.9	75.7	34.3	42.8	45.1	43.8
up to 5	86.0	90.2	91.1	69.6	74.4	98.9	92.6	88.1	85.7	87.0
5 +	2.0	1.6	2.2	0.5			0.4	1.2	1.0	1.1
Don't Know	11.9	8.2	6.7	30.0	25.6	1.1	7.1	10.8	13.4	12.0
Mean	3.7	3.4	3.7	3.0	3.1	3.4	4.0	3.6	3.3	3.5
Median	4.0	3.0	3.0	3.0	3.0	3.0	5.0	3.0	3.0	3.0
N	**548**	**344**	**419**	**387**	**161**	**346**	**529**	**1756**	**978**	**2734**

Table 3.14: Percentage distribution of women according to their knowledge (Heard of) of Tubectomy by division

Heard of Tubectomy	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Yes	64.5	72.7	70.5	61.8	46.9	58.5	82.7	63.8	69.7	66.4
No	35.5	27.3	29.5	38.2	53.1	41.5	17.3	36.2	30.3	33.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 3.15: Percentage distribution of women according to their opinion on advantages of Tubectomy by division (Multiple answers possible)

Advantages of Tubectomy	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Effective immediately after operation and very much safe method	55.8	76.4	78.4	28.4	68.0	59.9	93.1	69.6	61.8	66.1
Remain free from everyday hazard of using condom or pill or other methods	62.0	56.8	73.4	70.1	88.5	63.8	72.2	73.0	60.3	67.4
Need not to go to clinic or worker again and again except some follow up visits	11.2	18.3	9.0	9.3	2.5	23.0	10.1	11.7	12.7	12.1
Does not reduce power of sexual intercourse or physical strength	12.4	8.7	3.2	9.8	2.5	5.3	6.0	4.6	11.9	7.8
No long term side affect or health risk	28.9	36.7	43.7	17.6	12.3	49.3	37.5	35.2	29.5	32.7
Increase sexual intercourse will, power and satisfaction as there are no fear of being pregnant	11.6	7.0		25.5	9.0	6.6	7.3	9.6	9.4	9.5
No effect on breast milk so it could be done after delivery	22.7	5.7	0.5	5.4		2.6	2.4	6.1	6.7	6.4
Good method for those who may have health risk if they become pregnant	3.3	5.7	1.4	3.4		2.0	6.5	3.2	4.0	3.6
Easy and safe operation, don't using local anesthesia	19.0	10.9	2.7	16.2	20.5	17.8	2.0	11.0	13.1	11.9
Can return home after operation	27.7	4.8	1.4	16.7	4.1	30.3	10.9	12.8	15.0	13.8
Others		4.4						1.0	0.2	0.6
N	**453**	**428**	**415**	**381**	**228**	**284**	**464**	**1683**	**971**	**2654**

Table 3.16: Percentage distribution of women according to their opinion on disadvantages of Tubectomy by division (Multiple answers possible)

Disadvantages of Tubectomy	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Need to think before taking decision as it's a permanent method	67.8	77.7	77.9	53.4	74.6	57.9	68.1	69.3	67.1	68.3
Have risk in spite of being a small operation	46.7	55.0	42.3	60.3	78.7	55.9	62.1	58.7	50.7	55.2
Pain remains for a few days after operation	43.0	34.1	24.3	18.1	23.0	47.4	11.7	27.6	29.7	28.5
Possibilities of Ectopic pregnancy	2.1	9.2	3.2	11.3	17.2	14.5	5.6	7.1	9.4	8.1
Need to come to service center for operation	36.8	7.4	34.2	15.2	0.8	36.2	39.5	26.4	24.9	25.7
Need trained doctor and assistant	16.5	10.9	2.7	8.8		14.5	12.1	9.8	10.2	10.0
Does not protect STD/HIV/AIDS	3.3	0.9	0.5	2.0		0.7	2.8	1.3	2.1	1.7
Others	0.4	7.0	1.4	0.5	1.6		0.4	1.3	2.3	1.7
N	**453**	**428**	**415**	**381**	**228**	**284**	**464**	**1683**	**971**	**2654**

Table 3.17: Percentage distribution of women according to their knowledge about sources of doing Tubectomy by division (Multiple answers possible)

Knowledge about sources of doing Tubectomy	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Government hospital	84.3	96.1	59.5	93.1	31.1	94.1	71.8	71.9	88.2	79.1
Family Welfare Centre/FWV	8.3	5.7	16.2	11.3	5.7	11.2	4.4	8.3	10.0	9.1
Upazila Health Complex	53.7	72.9	62.6	64.7	55.7	89.5	74.2	73.9	56.1	66.0
Satellite Clinic			0.9	0.5			1.2	0.2	0.8	0.5
Maternal and Child Welfare Centre	27.3	28.4	14.4	9.3	23.0	26.3	27.0	16.1	33.1	23.6
Community Clinic	4.1	2.6	3.2				0.4	1.9	1.3	1.6
FWV	3.7	0.9	1.4	1.0	49.2	0.7	3.2	6.4	5.2	5.9
HA	1.2	1.7	0.5		1.6	1.3		1.1	0.4	0.8
Private hospital/clinic	14.5	19.2	0.5	12.3		32.9		8.2	15.6	11.5
NGO worker/clinic	19.4	13.1	3.6	21.1	45.9	27.6	4.4	13.8	21.8	17.3
Pharmacy			0.5	1.0				0.2	0.2	0.2
Others		0.9			0.8			0.1	0.4	0.2
N	**453**	**428**	**415**	**381**	**228**	**284**	**464**	**1683**	**971**	**2654**

Table 3.18: Percentage distribution of women according to their opinion about duration of effectiveness of Tubectomy once done by division

Years	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
1-5	0.4							0.1		0.1
For life long	63.2	69.9	77.5	55.9	6.6	55.3	83.1	60.7	67.6	63.8
Don't Know	36.8	30.1	22.5	44.1	93.4	44.7	16.9	39.3	32.4	36.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**453**	**428**	**415**	**381**	**228**	**284**	**464**	**1683**	**971**	**2654**

Table 3.19: Percentage distribution of women according to their knowledge (Heard of) of Vasectomy by division

Heard of Vasectomy	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Yes	42.7	61.6	55.2	38.8	5.4	32.3	71.3	42.6	49.3	45.6
No	57.3	38.4	44.8	61.2	94.6	67.7	28.7	57.4	50.7	54.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 3.20: Percentage distribution of women according to their opinion on advantages of Vasectomy by division (Multiple answers possible)

Advantages of Vasectomy	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Permanent method, very much safe and effective	80.0	86.1	90.2	50.8	71.4	64.3	97.7	83.2	79.0	81.3
Do not reduce sexual intercourse power or physical strength	18.1	35.1	34.5	17.2	14.3	11.9	47.7	34.1	24.0	29.6
Increase sexual intercourse will, power and satisfaction as there are no fear of being pregnant	11.9	21.1	4.6	23.4	21.4	6.0	5.1	12.6	11.2	12.0
No long term side affect or health risk	29.4	43.8	32.8	17.2	50.0	61.9	31.3	33.4	37.1	35.0
Easy and safe operation, no need to do senseless	22.5	13.4	2.3	20.3	21.4	9.5	5.6	11.1	13.1	12.0
Take shorter time (5-7 minutes)	33.8	3.1	2.3	21.1	21.4	45.2	12.1	17.3	14.7	16.1
No need to take rest after operation	8.1	7.2	1.7	17.2	14.3	14.3	8.4	8.2	9.5	8.8
Others		2.1		0.8				0.8		0.4
N	**299**	**363**	**325**	**239**	**26**	**157**	**400**	**1124**	**686**	**1810**

Table 3.21: Percentage distribution of women according to their opinion on disadvantages of Vasectomy by division (Multiple answers possible)

Disadvantages of Vasectomy	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
It is not possible to take child again as it is a permanent method	68.8	90.7	86.8	85.9	42.9	59.5	67.8	76.5	78.5	77.4
There have some risk in spite of being a small operation	36.3	48.5	38.5	49.2	64.3	36.9	64.0	52.1	39.8	46.6
It does not work immediately after operation	35.6	18.6	6.9	4.7	35.7	64.3	24.3	24.3	20.7	22.7
Have to wait for 3 months to be effective	12.5	8.2	4.6	7.8	14.3	31.0	9.8	11.5	9.3	10.5
Need to use condom for intercourse before it become effective	10.0	2.6	1.7	6.3	21.4	1.2	9.3	6.3	4.9	5.7
Need to come to service center for operation	29.4	7.7	31.0	5.5	7.1	29.8	30.4	19.8	25.9	22.5
Need trained doctor and assistant	11.9	9.3	1.1	5.5	7.1	13.1	15.0	8.7	10.4	9.5
Does not protect STD/HIV/AIDS	9.4	2.6		3.9	7.1		0.9	2.2	4.1	3.0
Others		5.2	3.4	0.8				1.2	2.7	1.9
N	**299**	**363**	**325**	**239**	**26**	**157**	**400**	**1124**	**686**	**1810**

Table 3.22: Percentage distribution of women according to their knowledge about sources of doing Vasectomy by division (Multiple answers possible)

Knowledge about sources of doing Tubectomy	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Government hospital	85.6	95.4	70.7	92.2	21.4	97.6	79.0	78.0	94.8	85.4
Family Welfare Centre/FWV	5.0	4.6	12.1	11.7	14.3	6.0	3.7	7.8	5.7	6.9
Upazila Health Complex	46.9	75.3	60.9	71.1	71.4	95.2	68.7	75.4	55.0	66.4
Satellite Clinic	1.3	1.5	0.6	1.6			0.9	1.2	0.8	1.0
Maternal and Child Welfare Centre	27.5	25.3	12.6	8.6	14.3	20.2	21.5	13.3	30.2	20.8
Community Clinic	5.0	1.5			7.1	1.2		0.8	2.2	1.4
FWV	2.5	0.5	0.6	1.6	21.4	1.2	1.4	1.3	1.9	1.6
HA	0.6	1.0	0.6	0.8	7.1			0.7	0.5	0.6
Private hospital/clinic	21.9	18.6		7.0		25.0		8.5	13.6	10.8
NGO worker/clinic	26.9	7.7	1.7	13.3	14.3	35.7	3.7	8.3	18.5	12.8
Pharmacy				1.6				0.3		0.2
Others		1.5	0.6					0.3	0.5	0.4
N	**299**	**363**	**325**	**239**	**26**	**157**	**400**	**1124**	**686**	**1810**

Table 3.23: Percentage distribution of women according to their opinion about duration of effectiveness of Vasectomy once done by division

Years	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
For life long	93.8	100.0	98.9	94.5	92.9	100.0	100.0	97.8	98.1	97.9
Don't Know	6.3		1.1	5.5	7.1			2.2	1.9	2.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**299**	**363**	**325**	**239**	**26**	**157**	**400**	**1124**	**686**	**1810**

Annex Tables Chapter: 4

Table 4.1: Percentage distribution of women according to their (or husband) status of using LAPMs (Tubectomy and Vasectomy)

Status of use of LAPMs	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
IUD	3.2	0.3	1.9	0.9	1.5	3.1	0.7	1.6	1.9	1.7
Implant/ Norplant	3.2	2.2	5.7	1.2	3.1	7.7	2.0	3.9	2.7	3.4
Tubectomy	3.5	4.4	8.9	1.2	6.9	3.8	9.0	5.7	4.4	5.1
Vasectomy	1.3	0.3	0.0	1.5	1.5	1.2	6.7	2.6	0.1	1.5
Using none of above	88.8	92.7	83.5	95.2	86.9	84.2	81.7	86.2	90.9	88.3
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 4.2: Percentage distribution of women according to the sources of getting LAPMs by division

Sources of getting LAPMs	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Government hospital	38.1	34.8	23.1	6.3	23.5	36.6	25.5	28.2	27.9	28.1
Family Welfare Centre/FWV	4.8		1.9	43.8	8.8	24.4	1.8	6.7	16.2	10.9
Upazila Health Complex	45.2	65.2	71.2	12.5	67.6	26.8	65.5	57.4	45.6	52.2
Maternal and Child Welfare Centre	7.1		1.9	31.3		12.2	7.3	7.2	5.9	6.6
FWV				6.3					1.5	0.7
NGO worker/clinic	4.8		1.9					0.5	2.9	1.6
Shop										0.0
N	**79**	**43**	**97**	**30**	**64**	**77**	**103**	**365**	**127**	**492**

Table 4.3: Percentage distribution of women according to the duration of use of LAPMs by division

Duration (Years)	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
1-5	47.6	17.4	26.9	43.8	23.5	48.8	9.1	28.7	32.4	30.3
6-10		8.7	1.9		5.9	4.9	1.8	2.6	4.4	3.4
11+						4.9			2.9	1.3
NR	52.4	73.9	71.2	56.3	70.6	41.5	89.1	68.7	60.3	65.0
Mean	2.4	5.1	2.2	2.1	3.3	3.5	2.3	2.7	3.6	3.1
N	**79**	**43**	**97**	**30**	**64**	**77**	**103**	**365**	**127**	**492**

Table 4.4: Percentage distribution of women according to their opinion of taking decision to take LAPMs by division

Who takes decision regarding use of LAPMs	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Self	32.4	36.8	25.5	20.0	6.3	51.4	25.0	27.9	29.8	28.7
Husband		10.5		13.3	6.3	2.7	21.2	8.4	5.3	7.0
Both	67.6	57.9	76.6	73.3	87.5	45.9	53.8	64.8	66.7	65.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**64**	**36**	**88**	**28**	**60**	**69**	**97**	**335**	**107**	**441**

Table 4.5: Percentage distribution of women according to the reasons of using specific LAPMs by division

Reasons of using specific LAPMs	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Long term and very much effective	82.4	94.7	95.7	53.3	84.4	51.4	90.4	82.1	78.9	80.7
Easy to take	26.5	73.7	25.5	33.3	46.9	24.3	9.6	30.2	26.3	28.5
Action starts immediately after use/taking	26.5	52.6	29.8	6.7	31.3	10.8	17.3	24.0	24.6	24.3
No difference appears in the breast milk after taking the method	20.6		2.1			2.7	5.8	5.0	5.3	5.1
Pregnancy capacity returns immediately after quitting the method	29.4	5.3	17.0	20.0	9.4	8.1	1.9	12.8	10.5	11.8
Does not create barriers to sexual intercourse	20.6	5.3	14.9	20.0	21.9	32.4	38.5	21.2	33.3	26.6
No hormonal problem	2.9		8.5		3.1		1.9	1.7	7.0	4.0
Free from everyday hazard of using condom or pill	50.0	36.8	31.9	20.0	25.0	62.2	48.1	41.3	42.1	41.7
No side effect	20.6	52.6	53.2	20.0	21.9	21.6	19.2	26.3	40.4	32.5
Could be removed at any time	17.6	15.8	25.5		3.1	40.5	5.8	16.8	17.5	17.1
Need not go to clinic or worker again and again except some follow up visit	2.9		8.5				3.8	2.8	3.5	3.1
Do not reduce sexual intercourse power or physical strength	5.9				3.1		3.8	2.2	1.8	2.0
Can return home after operation	26.5	15.8	2.1	13.3	6.3	18.9	5.8	11.2	12.3	11.7
Availability of the methods										0.0
Can get suggestion/help/services at any time from service center/ worker	8.8		4.3			21.6	1.9	6.1	5.3	5.7
N	**64**	**36**	**88**	**28**	**60**	**69**	**97**	**335**	**107**	**441**

Table 4.6: Percentage distribution of women according to their current using status of IUD by division

Whether respondents is a current user of IUD	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Yes	3.8	.4	2.5	1.0	2.6	3.7	.7	1.9	2.2	2.0
No	96.3	99.6	97.5	99.0	97.4	96.3	99.3	98.1	97.8	98.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**598**	**518**	**453**	**578**	**292**	**408**	**539**	**2177**	**1208**	**3385**

Table 4.7: Percentage distribution of women according to the reasons of not using IUD by division (Multiple answers possible)

Disadvantages of IUD	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Feeling of pain in lower abdomen	48.4	15.2	24.2	21.9	67.1	49.0	50.0	38.6	35.1	37.0
Increased bleeding during menstruation	58.1	10.5	35.2	31.7	62.5	72.4	38.8	44.1	38.3	41.5
White srab during menstruation	51.3	39.9	48.3	28.1	53.9	82.4	32.2	47.8	42.6	45.5
Sometimes IUD comes outside of vagina	30.2	1.1	74.6	33.7	15.8	27.1	26.6	28.4	32.9	30.4
Become pregnant instead of taking IUD	24.4	0.7	9.3	21.9	5.9	12.9	2.1	10.9	13.1	11.9
Sometimes vagina becomes damaged	24.4	1.1	16.1	18.3	1.3	12.4	44.4	19.3	16.9	18.2
Needs experienced worker to take and remove of IUD	6.8	1.1	9.7	9.5		5.7	5.9	6.1	5.5	5.8
Need to examine the string after each menstruation	9.4		2.5	6.2	5.3	11.0	28.0	9.1	9.7	9.4
It does not protect STD/HIV/AIDS	1.0	0.7	0.4	4.9	0.7	1.0	1.4	1.6	1.6	1.6
Reproductive organs transition risks increase	2.3	0.7		4.9	2.0	0.5	23.8	5.7	4.9	5.3
Others	1.9	35.1	6.8					7.3	5.7	6.6
N	**576**	**516**	**441**	**572**	**284**	**393**	**535**	**2136**	**1182**	**3317**

Table 4.8: Percentage distribution of women according to their current using status of Implant/ Norplant by division

Whether respondents is a current user of Implant/ Norplant	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Yes	3.8	2.5	7.4	1.3	5.1	9.2	2.1	4.7	3.1	4.0
No	96.3	97.5	92.6	98.7	94.9	90.8	97.9	95.3	96.9	96.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**598**	**518**	**453**	**578**	**292**	**408**	**539**	**2177**	**1208**	**3385**

Table 4.9: Percentage distribution of women according to the reasons of not using Implant/ Norplant by division (Multiple answers possible)

Reasons of not using Implant/ Norplant	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Drop hemorrhage between two menstrual period	24.0	15.9	8.5	6.9	4.7	36.4	40.1	21.9	16.9	19.7
Little bleeding for a long time	43.5	15.6	12.5	18.0	58.1	68.7	25.2	33.9	28.1	31.3
Stopped menstruation	56.2	28.1	54.5	32.1	79.7	83.8	57.4	55.8	47.3	52.0
Headache, vomiting tendency and weight gain	49.7	31.5	79.5	53.4	63.5	60.6	38.7	54.1	48.2	51.5
Feeling of tiredness	11.4	3.0	30.4	11.8	16.2	19.2	22.0	14.1	18.4	16.0
Weighty /Pain in breast	10.7	10.0	20.5	8.9	4.1	9.6	8.9	11.0	9.7	10.4
Hazard to open and use self	18.8	2.2	9.8	12.8		5.6	20.2	9.8	13.4	11.4
Need small operation to take and open	18.2	4.4	10.3	13.4	2.0	2.5	15.6	10.1	11.5	10.7
Transition, bleeding problem	8.4	2.6	1.3	13.8	4.1	3.0	29.1	9.6	10.5	10.0
Others	2.6	46.3	7.1	5.2			0.4	9.4	9.9	9.6
N	**576**	**505**	**419**	**570**	**277**	**370**	**527**	**2074**	**1171**	**3244**

Table 4.10: Percentage distribution of women according to their current using status of Tubectomy by division

Whether respondent has done Tubectomy or not	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Yes	4.1	5.1	11.6	1.3	11.5	4.6	9.4	7.0	5.1	6.2
No	95.9	94.9	88.4	98.7	88.5	95.4	90.6	93.0	94.9	93.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**598**	**518**	**453**	**578**	**292**	**408**	**539**	**2177**	**1208**	**3385**

Table 4.11: Percentage distribution of women according to the reasons of not using Tubectomy by division (Multiple answers possible)

Reasons of not doing Tubectomy	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Need to think before taking decision as it's a permanent method	60.9	48.7	79.0	44.6	66.7	60.6	75.1	63.6	56.3	60.4
Have risk in spite of being a small operation	51.5	30.4	41.1	55.1	84.8	70.7	67.8	59.3	47.8	54.2
Pain remains for a few days after operation	34.9	9.9	9.8	16.4	25.4	45.7	10.3	20.1	23.3	21.5
Possibilities of Ectopic pregnancy	11.7	9.1	4.7	17.4	21.7	23.6	3.8	11.9	13.5	12.6
Need to come to service center for operation	42.0	3.4	21.0	13.8	1.4	15.9	35.6	19.7	22.8	21.1
Need trained doctor and assistant	14.0	5.3	.5	5.9	-	6.7	7.7	5.6	8.0	6.7
Does not protect STD/HIV/AIDS	2.0	1.1	-	1.0	-	-	1.1	0.7	1.1	0.9
Others	1.6	43.0	9.8	3.6	.7	-	-	7.8	10.8	9.1
N	**574**	**492**	**400**	**570**	**258**	**389**	**488**	**2025**	**1146**	**3172**

Table 4.12: Percentage distribution of women according to their husband's current using status of Vasectomy by division

Whether respondent's husband has done Vasectomy or not	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Yes	1.6	0.4	-	1.6	2.6	1.4	6.9	3.2	0.2	1.9
No	98.4	99.6	100.0	98.4	97.4	98.6	93.1	96.8	99.8	98..1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**598**	**518**	**453**	**578**	**292**	**408**	**539**	**2177**	**1208**	**3385**

Table 4.13: Percentage distribution of women according to the reasons of not doing Vasectomy by their husband by division (Multiple answers possible)

Reasons of not doing Vasectomy	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
It is not possible to take child again as it is a permanent method	60.3	44.9	71.1	76.0	70.4	66.5	67.5	65.4	63.7	64.6
There have some risk in spite of being a small operation	44.4	35.1	49.6	40.8	72.4	55.3	66.4	52.4	46.2	49.7
It does not work immediately after operation	26.0	6.2	9.1	5.6	25.0	30.7	22.4	18.5	14.6	16.8
Have to wait for 3 months to be effective	22.2	10.5	3.7	6.3	10.5	18.6	6.7	9.8	14.1	11.7
Need to use condom for intercourse before it become effective	13.3	3.3	7.4	2.6	6.6	8.8	11.2	7.0	8.8	7.8
Need to come to service center for operation	0.6				1.3	7.9		1.7	0.3	1.1
Need trained doctor and assistant	12.4	5.4	1.2	10.2	1.3	13.5	7.5	6.4	10.4	8.2
Does not protect STD/HIV/AIDS	3.2	2.2		2.3		0.9	1.1	1.6	1.6	1.6
Others	3.5	45.3	14.9	3.0	0.7			10.8	9.3	10.1
N	**589**	**516**	**453**	**568**	**284**	**402**	**501**	**2107**	**1206**	**3314**

Table 4.14: Percentage distribution of women according to the socio-cultural barriers regarding not use of LAPMs by division (Multiple answers possible)

Socio-cultural reasons	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Husband does not like it	51.7	48.3	62.9	64.5	55.0	58.1	50.7	56.5	54.5	55.6
I myself do not like it	44.8	50.2	42.5	37.0	45.4	59.2	52.3	46.3	48.1	47.1
Father-in-law/mother-in-law does not like it	0.3		0.6	0.9	0.8	0.4		0.4	0.5	0.4
Community people/Neighbouring people do not like it	39.2	38.7	23.5	18.2	15.8	40.4	61.7	35.4	31.5	33.7
Those who take LAPMs suffer from various health hazards like, stomache, pain in the waist, loss of sexual power, etc	33.3	51.4	21.6	31.8	15.4	46.5	32.3	33.5	33.0	33.3
Others	2.4	25.4	1.6	1.5	0.4			5.2	3.6	4.5
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 4.15: Percentage distribution of women according to the misbelieves regarding not use of LAPMs by division (Multiple answers possible)

Misbelieves regarding not use of LAPMs	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Taking LAPMs is a sin in the eye of religion	90.4	78.1	69.5	80.3	63.5	90.4	79.0	78.9	79.6	79.2
Child died who take LAPMs	72.8	42.5	27.3	31.8	2.3	39.6	13.7	32.7	38.5	35.3
Children is the gift of Allah so one should not take LAPMs	49.9	19.0	25.7	30.3	90.8	46.2	65.3	47.5	41.6	44.9
Others	1.3	40.6	2.5	2.1	.4		.3	7.7	5.6	6.8
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 4.16: Percentage distribution of women according to their opinion on reasons of not using LAPMs by most of the locality people by division (Multiple answers possible)

Reasons of not using LAPMs by most locality people	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
People prefer larger family size	22.1	2.5	1.9	22.7	6.2	5.4	6.7	9.7	11.4	10.5
LAPM methods are not easily available	8.0	2.9	7.6	15.8	1.9	21.5	2.7	8.2	9.1	8.6
Against religion	63.7	16.8	28.9	35.2	55.8	44.6	51.3	44.5	38.4	41.8
Husband opposes	58.9	27.9	50.5	40.0	64.6	46.2	41.7	48.5	44.2	46.6
Community prohibition	23.7	28.6	22.2	7.3	7.7	18.5	33.7	21.9	17.9	20.1
Have many side effects	43.5	71.4	51.4	43.9	61.9	54.2	32.0	50.4	51.3	50.8
Management of side-effect is difficult	9.3	28.9	26.0	7.3	2.7	17.7	3.7	13.0	15.2	14.0
Service Center is not easy to reach	9.1	1.9	2.5	5.8	1.9	15.8	1.0	4.6	6.8	5.6
Front line workers are not proactive	5.6	1.9	4.8	13.6		2.3	15.7	6.6	6.3	6.5
Lack of awarness about small family	17.1	2.2	1.9	17.3	3.5	4.2	8.0	7.6	9.5	8.4
Senior family members opposed	16.3	14.3	9.5	9.1	3.5	11.9	7.3	10.7	10.3	10.5
Don't know	7.5	10.8	18.4	7.3	22.7	26.9	8.3	14.1	13.3	13.7
Others	0.3	27.9	1.0	0.3				4.8	3.5	4.2
N	**701**	**589**	**589**	**617**	**486**	**486**	**561**	**2637**	**1393**	**4030**

Table 4.17: Percentage distribution of women according to their opinion regarding future use of LAPMs by her or by her husband by division

Whether respondents or her husband will use LAPMs in future	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Yes	20.4	11.0	11.0	15.3	9.7	27.9	4.9	15.4	12.6	14.2
No	79.6	89.0	89.0	84.7	90.3	72.1	95.1	84.6	87.4	85.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**623**	**546**	**492**	**587**	**423**	**410**	**458**	**2272**	**1266**	**3538**

Table 4.18: Percentage distribution of women according to their choice of specific LAPMs that they will use in future by division

Choice of specific LAPMs	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
IUD	16.2	9.4	13.8	12.5	9.1	24.6	8.3	14.4	17.6	15.8
Implant/ Norplant	72.1	31.3	55.2	37.5	13.6	45.9	75.0	47.6	51.8	49.5
Tubectomy	8.8	53.1	31.0	45.8	72.7	27.9	16.7	35.8	25.9	31.4
Vasectomy	2.9	6.3		4.2	4.5	1.6		2.1	4.7	3.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	**127**	**60**	**54**	**90**	**41**	**114**	**22**	**350**	**159**	**509**

Table 4.19: Percentage distribution of women according to their opinion on reasons of not using any LAPMs in future by division (Multiple answers possible)

Reasons of not using any LAPMs in future by respondents and her husband	Division							Total		
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	Rural	Urban	All
Want a children	34.7	20.8	6.0	5.6	13.7	10.1	0.9	12.7	15.2	13.8
Want a son	6.0	1.9	0.4	3.8	4.9	4.4		3.2	2.7	3.0
Want a daughter	4.9	0.4	0.9	4.5	2.0	4.4	0.4	2.1	3.0	2.5
Lack of knowledge	39.2	12.3	39.3	17.7	11.3	30.4	5.6	22.5	21.6	22.1
Cost too much	3.8	0.8			1.0	8.2		1.8	1.4	1.6
Worry about side effects	45.7	22.3	52.6	32.0	17.2	18.4	12.4	29.6	29.7	29.6
Hard to get methods	7.9		0.4	1.9	0.5	9.5	1.7	3.0	2.7	2.9
Against religion	31.7	5.8	9.8	9.0	31.4	38.0	46.8	23.7	22.8	23.3
Husband opposed	24.2	11.2	28.2	8.3	52.0	39.9	60.5	31.1	28.9	30.1
Other people opposed	16.6	4.2	11.1	0.8	0.5	7.6	16.3	8.4	8.1	8.3
Community prohibition	18.9	6.2	19.7	1.1	2.0	11.4	26.6	13.8	9.6	11.9
Health does not permit	17.4	48.1	30.8	13.2	65.7	47.5	22.3	32.9	34.0	33.4
Don't like existing method	7.2	27.3	5.1	8.6	1.5	35.4	30.0	18.1	11.5	15.2
Others	0.8	31.2	1.3	0.8		0.6		5.4	5.7	5.5
N	**496**	**486**	**438**	**497**	**381**	**295**	**436**	**1922**	**1107**	**3029**

Annex Tables Chapter: 5

Table 5.1: Percentage distribution of eligible couples using FP methods reported by UFPOs by division

FP method	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Oral pill	28.2	37.0	38.3	42.6	19.5	38.6	41.5	35.3
Condom	11.7	9.4	6.8	10.9	0.6	5.5	2.6	7.3
Injection	6.7	13.6	19.4	19.7	0.3	13.2	18.9	13.5
IUD	0.9	1.6	3.3	3.5	0.2	3.3	1.8	2.0
Implant	2.0	4.1	2.9	1.6	0.1	2.2	2.0	2.3
Tubectomy	3.6	9.5	5.7	8.9	0.1	6.6	5.5	5.9
Vasectomy	0.8	1.5	3.6	0.8	0.0	2.4	5.8	2.2
Not using FP	46.1	23.3	20.0	11.9	79.3	28.3	21.7	31.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	4	5	5	5	4	5	5	33

Table 5.2: Average number of LAPMs provided by doctors, FWVs and nurses as reported by MO-MCHs by division

LAPMs	Providers	Division							All
		Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
IUD	Doctor			1318.0 (1)				235.0 (1)	776.5 (2)
	FWV	554.3 (4)	316.2 (5)	997.0 (5)	342.3 (4)	342.3 (4)	617.8 (5)	858.0 (2)	563.0 (29)
	Nurse	1207.0 (1)		1318.0 (1)					1262.0 (1)
	Total	684.8	316.2	1524.2	342.3	342.3	617.8	650.3	658.2
Implant	Doctor	588.0 (2)	1137.6 (5)	1162.4 (5)	378.8 (4)	378.8 (4)	196.8 (5)	572.3 (3)	657.4 (28)
	FWV	198.5 (2)							198.5 (2)
	Nurse	506.0 (1)							506.0 (1)
	Total	415.8	1137.6	1162.4	378.8	378.8	196.8	572.3	622.9
Tubectomy	Doctor	356.4	576.8	1572.6	350.3	350.3	95.6	175.7	527.6
Vasectomy	Doctor	192.4	258.8	1063.6	155.0	155.0	99.0	544.0	352.9
	N	5	5	5	4	4	5	3	31

Table 5.3: Average number of eligible couples using FP method by types reported by FWAs by division

Type of FP method	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Oral pill	621.8	491.0	518.0	266.0	140.5	363.2	617.0	441.9
Condom	119.4	71.4	113.2	91.8	49.5	74.6	21.4	79.1
Injection	88.2	525.6	221.8	155.6	35.0	141.0	265.6	210.0
IUD	15.8	13.4	81.8	26.4	4.8	38.2	20.8	30.9
Implants	23.2	140.0	29.3	16.8	11.5	25.8	28.4	39.8
Tubectomy	76.8	184.0	61.0	52.2	1.5	68.2	89.4	77.9
Vasectomy	34.0	13.0	57.2	8.2	4.5	26.2	60.2	30.5
Others	1.4	0.0	0.0	0.0	0.0	0.0	0.0	0.2
N	**5**	**5**	**6**	**5**	**4**	**5**	**5**	**35**

Table 5.4: Distribution MO-MCHs by camps organized for providing LAPMs reported by division

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Yes	100.0	100.0	80.0	50.0	50.0	100.0	100.0	84.8
No			20.0	25.0	25.0			9.1
NR				25.0	25.0			6.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	5	5	5	4	4	5	5	33

Table 5.5: Percentage distribution of UFPOs by reporting of arranging camps for providing LAPMs by division

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Yes	100.0	100.0	80.0	80.0	75.0	100.0	100.0	90.9
No	0.0	0.0	20.0	20.0	25.0	0.0	0.0	9.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	4	5	5	5	4	5	5	33

Table 5.6: Average number of camps arranged for providing LAPMs reported by UFPOs by division

Name of Camp	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
IUD	99	2	28	.	23	24	37	36
Implant	81	2	31	68	71	26	34	40
Tubectomy	87	2	41	68	73	31	65	49
Vasectomy	117	2	31	58	73	31	65	50
N	4	5	5	5	4	5	5	33

Table 5.7: Percentage distribution of FWVs by reporting providing IUD and implants in clinic through camps by division

Methods of LA	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
IUD	80.0	100.0	80.0	40.0	75.0	100.0	80.0	79.4
Implants					25.0			2.9
Camps not done	20.0		20.0	60.0			20.0	17.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	5	5	5	5		5	5	34

Table 5.8: Average number of camps reported by FPIs for providing LAPMs by division (Q109)

Name of Camp	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
IUD	6.5	2.0	-	36.0	6.0	5.7	6.8	6.7
Implant	6.5	2.0	52.0	36.0	-	5.7	7.0	9.3
Tubectomy	1.3	2.0	52.0	36.0	-	6.3	3.8	7.5
Vasectomy	1.3	2.0	52.0	36.0	-	6.3	4.5	7.7
N	**4**	**4**	**1**	**1**	**1**	**3**	**4**	**18**

Table 5.9: Percentage distribution of FPIs reported not organizing camps for providing LAPMs by reason by division (Q110)

Reason for not organizing camp	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Shortage of trained manpower			25.0	50.0	33.3		100.0	31.3
Shortage of vehicle				25.0	66.7		100.0	25.0
Shortage of MSR			50.0	25.0				18.8
Shortage of long acting method		100.0		25.0				12.5
Lack of initiative from MO-MCH		100.0		50.0				18.8
Low/ No incentive for these type of works			25.0		33.3		100.0	18.8
People of these area s are very conservative		100.0	75.0		66.7		100.0	43.8
Arranged no camps in surrounding union of Upazila Health Complex	100.0		50.0	25.0	33.3	100.0		43.8
N	**1**	**1**	**4**	**4**	**3**	**2**	**1**	**16**

Table 5.10: Percentage distribution of FWVs by receiving types of refresher training on LAPMs reported by them by division

Type of refreshers course	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
IUD	75.0	25.0	33.3			100.0	100.0	57.1
Implant	25.0	25.0	66.7			20.0	50.0	28.6
MR	25.0			33.3				9.5
LAPMs				33.3				4.8
OT training				33.3				4.8
TBA				33.3				4.8
Injection			33.3					4.8
Demographic Health service						20.0		4.8
STI						20.0		4.8
NR		75.0	33.3	33.3	100.0			23.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	5	5	5	5	4	5	5	34

Table 5.11: Percentage distribution of FWVs by reported shortage of IUD by division

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Yes	20.0		20.0		25.0	100.0	20.0	26.5
No	80.0	100.0	80.0	100.0	75.0		80.0	73.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	5	5	5	5	4	5	5	34

Table 5.12: Percentage distribution of FWV by reported shortage of implants by division

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Yes	20.0	20.0		20.0	50.0	100.0		29.4
No	80.0	80.0	100.0	80.0	50.0		100.0	70.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	5	5	5	5	4	5	5	34

Table 5.13: Percentage distribution of FWVs by getting adequate supply of long acting methods as per demand by division

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Yes	100.0	100.0	100.0	60.0	100.0	20.0	80.0	79.4
No				40.0		80.0	20.0	20.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	5	5	5	5	4	5	5	34

Table 5.14: Percentage distribution of MO-MCHs by reported shortage of MSR for IUD by division

MSR for IUD	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
IUD table	20.0					40.0	40.0	15.2
Spot light/torch light	40.0		20.0	25.0	25.0	80.0	60.0	36.4
Sponge holding forceps				25.0	25.0	40.0	20.0	15.2
Small/medium/large size bulb/Cuscos speculum	20.0					20.0	20.0	9.1
Tenaculam/Volcellum						20.0	20.0	6.1
Uterine sound						40.0	20.0	9.1
Scissors				25.0	25.0	60.0		15.2
Straight artery forceps	20.0					40.0		9.1
Gloves	20.0					20.0		6.1
Surgical tray with cover	20.0		20.0			60.0	20.0	18.2
Galley pot for keeping cotton ball	20.0					40.0	20.0	12.1
Cotton ball	20.0					20.0	20.0	9.1
Povidine iodine							20.0	3.0
IUD sterilizer (with 3 racks)	20.0					40.0	40.0	15.2
Kerosene stove	40.0			25.0	25.0	40.0		18.2
No shortage	20.0	100.0	80.0	25.0	25.0		40.0	42.4
N	5	5	5	4	4	5	5	33

Table 5.15: Percentage distribution of FWVs by reported shortage of MSR for IUD by division

MSR for IUD	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
IUD Table	40.0			20.0	50.0	40.0	20.0	23.5
Spot light/ Touch light			20.0	60.0	75.0	80.0	40.0	38.2
Sponge holding forceps					25.0	20.0		5.9
Small, middle & big size bi-valve/Cuscus speculum							20.0	2.9
Tenaculam/Volsellum					25.0			2.9
Uterine sound						20.0		2.9
Scissors						20.0	20.0	5.9
Straight artery forceps						20.0		2.9
Gloves	20.0			20.0		40.0		11.8
Surgical trey with cover for preserve equipment	20.0			20.0		60.0		14.7
Gully pot for preserve cotton ball	20.0					40.0		8.8
Cotton ball					25.0	20.0		5.9
IUD sterilizer (with 3 rack)	40.0		20.0	40.0	25.0	40.0	20.0	26.5
Kerosene Stove	20.0			20.0		40.0	40.0	17.6
No shortage	20.0	100.0	80.0	20.0	25.0		60.0	44.1
N	5	5	5	5	4	5	5	34

Table 5.16: Percentage distribution of MO-MCHs by reported shortage of MSR for implant by division

MSR for Implant	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
OT table						60.0	40.0	15.2
Arm rest	80.0			25.0	25.0	80.0	60.0	39.4
Germ free rubber gloves	20.0							3.0
Soap	20.0			25.0	25.0	40.0		15.2
Antiseptic solution				25.0	25.0	40.0		12.1
Local anesthetic- 1% Lidocaine	20.0			25.0	25.0			9.1
Disposible syringe 5cc	40.0			25.0	25.0			12.1
Trucker #10 and Canula with plunger				25.0	25.0	20.0	20.0	12.1
Template				25.0	25.0	40.0		12.1
BP blade	60.0		20.0	75.0	75.0	80.0		42.4
Sponge holding forceps				25.0	25.0	40.0		12.1
Elastomeric dressing metric	20.0			50.0	50.0	80.0		27.3
Electric shock for emergency				50.0	50.0	60.0	20.0	24.2
Inj. Promethazine hydrochloride 25mg-2 ample						60.0		9.1
Inj. Hydrocortisone 100mg 2 vial/ample			20.0			80.0	20.0	18.2
Inj. Adrenaline			20.0	25.0	25.0	80.0	20.0	24.2
No shortage	20.0	100.0	80.0	25.0	25.0		40.0	42.4
N	5	5	5	4	4	5	5	33

Table 5.17: Percentage distribution of FWVs by reported shortage of MSR for implant by division

MSR for Implant	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
O.T. Table					25.0	40.0		8.8
Arms rest table	60.0			40.0	25.0	80.0	20.0	32.4
Germs free Gloves					25.0	20.0		5.9
Soap				20.0	25.0	40.0		11.8
Antiseptic Solution (Providine iodine/ Chlorohexidine)					25.0	40.0		8.8
1% Lidoceine with local anesthetic adrenaline					25.0			2.9
5 cc. Disposable syringe (2.5-4 cm long)	20.0				25.0			5.9
10 no. Trocker with Plunzer and Cannula					25.0			2.9
Template (Only applicable for Norplants)					25.0	20.0		5.9
B.P. blade	40.0				25.0	60.0		17.6
Sponge holding forceps						20.0		2.9

MSR for Implant	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Elastomeric dressing matrix (Size 10 cm × 5 cm) or band-aid or germs-free bandage with surgical tape				20.0		40.0		8.8
For managing emergency situation (Anaphylactic shock)				20.0		60.0		11.8
Inj. Promethazine hydrochloride (25 mg- 2 ample)				20.0		60.0	20.0	14.7
Inj. Hydrocortisone (100 mg)- 2 Vial/ ample				40.0		80.0	20.0	20.6
Inj. Adrenaline (1: 1000)- 2 Vial/ ample				40.0		60.0	20.0	17.6
No shortage	20.0	100.0	80.0	20.0	25.0		60.0	44.1
N	5	5	5	5	4	5	5	34

Table 5.18: Percentage distribution of MO-MCHs by reported shortage of MSR for tubectomy by division

MSR for Tubectomy	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Medicine								
Injection Atropine Sulphate (0.6mg/ml)	60.0			25.0	25.0		20.0	18.2
Injection Promethazine (12.5mg/ml)						40.0		6.1
Injection Pathedine or Pentazosin (30mg/ml)	20.0					40.0		9.1
Capsule Amoxicillin or any broad spectrum antibiotic (dose for 7 days)	40.0			25.0	25.0	40.0	40.0	24.2
Tablet Diazepam (5ml)	20.0							3.0
Tablet Paracetamol (500mg)	20.0							3.0
Tablet Iron & Folic acid				25.0	25.0			6.1
Surgical Equipment								
Absorbing cotton (100g)						100.0		15.2
Surgical gauge (20 yards/role)				25.0	25.0	100.0		21.2
Subsequent catgut (sterile 1-0 152cm)			20.0			40.0		9.1
Surgical gloves (s6.5)						20.0	20.0	6.1
Surgical gloves (s7)	20.0					60.0		12.1
Disposable sterile syringe (5cc)	20.0							3.0
Surgical blade (sterile/s10)	40.0			50.0	50.0	40.0		24.2
Heuristic GP-2 (glucose/albumin test)				25.0	25.0	60.0		15.2
Sterile disposable lancet	20.0			50.0	50.0	40.0		21.2
Elastomeric dressing metrics				25.0	25.0	40.0		12.1
Telquist book	20.0					20.0		6.1
Cutting curved needle	40.0			25.0	25.0	60.0		21.2
Cutting straight needle	20.0			25.0	25.0	40.0		15.2
Curved round body needle	20.0					40.0		9.1
Silk thread	40.0		20.0	75.0	75.0	100.0	20.0	45.5
No shortage	20.0	100.0	80.0	25.0	25.0		40.0	42.4
N	5	5	5	4	4	5	5	33

Table 5.19: Percentage distribution of FWVs by reported shortage of MSR for tubectomy by division

MSR for Tubectomy	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Medicine								
Injection Atropine sulphate (0.6 mg/ ml)	20.0				25.0			5.9
Injection Promethazine (12.5 mg/ ml)					25.0	60.0		11.8
(a) Injection Pathedine (25 mg/ ml) or (b) Injection Pentazocin (30 mg/ml)					25.0	40.0		8.8
Injection Xylocain (1%/50 ml)					25.0			2.9
Capsule Amoxicillin or any others Broad-spectrum	20.0			20.0	25.0	60.0	20.0	20.6
Tablet Diazepam (5 mg/ tablet)	20.0				25.0			5.9
Tablet Paracetamol (500 mg/ tablet)				20.0	25.0		20.0	8.8
Tablet Iron + Folic acid					25.0			2.9
Surgical Equipment								
Cotton (100 gm)					25.0	80.0		14.7
Surgical bandage (20 yards/ edge)					25.0	100.0		17.6
Chromic catgut (sterile/1-0/152 cm)						20.0		2.9

MSR for Tubectomy	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Surgical gloves (Size 6.5)						20.0		2.9
Surgical gloves (Size 7)	20.0			20.0		40.0		11.8
Disposable sterile syringe (5 cc)	20.0					20.0		5.9
Surgical blade (Sterile/ Size-10)	20.0					40.0		8.8
Uristic GP-2 (for glucose & albumin test)				20.0		40.0		8.8
Sterile disposable lancet						40.0		5.9
Elastomeric dressing matrix (duo-durm/ Size 10 cm × 10 cm)						20.0		2.9
Talquist book	20.0							2.9
Cutting curved needle	40.0					40.0		11.8
Cutting straight needle	20.0			20.0		20.0		8.8
Curved round body needle	20.0							2.9
Silk thread (1-0)	40.0			20.0		80.0		20.6
No shortage	20.0	100.0	80.0	20.0	25.0		60.0	44.1
N	5	5	5	5	4	5	5	34

Table 5.20: Percentage distribution of MO-MCHs by reported shortage of MSR for Vasectomy by division

MSR for Vasectomy	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Medicine								
Injection Xylocaine (% 50 ml)		0.0					20.0	3.0
Capsule Amoxicillin or any other Broad-spectrum (Doze for 7 days)		0.0		25.0	25.0	40.0	20.0	15.2
Tablet Paracetamol (500 mg/tablet)		0.0				20.0		3.0
Tablet Vitamin B-complex	40.0	0.0				40.0	20.0	15.2
Surgical Equipment								
Cotton (100 gm)		0.0				80.0		12.1
Surgical bandage (20 yards/edge)		0.0		25.0	25.0	80.0		18.2
Surgical gloves (size 6.5)		0.0				20.0	20.0	6.1
Surgical gloves (size 7)		0.0				40.0	40.0	12.1
Disposable sterile syringe (5 CC)	20.0	0.0						3.0
Uristic GP-2 (for glucose & albumin test)	20.0	0.0		25.0	25.0	60.0		18.2
Elastomeric dressing matrix (duo-durm size 10 cm × 05 cm)	40.0	0.0				60.0		15.2
Sterile disposable lancet		0.0				20.0		3.0
Talquist book		0.0				20.0		3.0
Lungee		0.0				20.0		3.0
Silk thread (1/20)	40.0	0.0		75.0	75.0	100.0	40.0	45.5
No shortage	20.0	100.0	80.0	25.0	25.0		40.0	42.4
N	5	5	5	4	4	5	5	33

Table 5.21: Percentage distribution of FWVs by reported shortage of MSR for vasectomy by division

MSR for Vasectomy	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Medicine								
Injection Xylocain (1%/50 ml)					25.0			2.9
Capsule Amoxicillin or any other Broad-spectrum (Doze for 7 days)				40.0	25.0	60.0	20.0	20.6
Tablet Paracetamol (500 mg/ tablet)					25.0	20.0	20.0	8.8
Tablet Vitamin B-Complex	20.0			40.0	25.0	40.0	20.0	20.6
Surgical Equipments								
Cotton (100 gm)						80.0		11.8
Surgical bandage (20 yards/edge)					25.0	80.0		14.7
Povidine iodine solution (100 ml)					25.0			2.9
Surgical gloves (size 6.5)						40.0		5.9
Surgical gloves (size 7)				20.0	25.0	60.0		14.7
Disposable sterile syringe (5 CC)	20.0				25.0	20.0		8.8
Uristic GP-2 (for glucose & albumin test)				20.0	25.0	40.0		11.8
Elastomeric dressing matrix (duo-durm/size 10 cm × 05 cm)	20.0				25.0	40.0		11.8
Sterile disposable lancet	20.0					40.0		8.8
Talquist book	20.0							2.9

MSR for Vasectomy	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Lungi						20.0		2.9
Silk thread (1/20)	20.0		20.0	20.0		80.0		20.6
No shortage	20.0	100.0	80.0	20.0	25.0		60.0	44.1
N	5	5	5	5	4	5	5	34

Table 5.22: Percentage distribution of MO-MCHs by reported shortage of MSR for managing emergency situation by division

MSR for managing emergency situation	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
(a). Emergency equipment (which are use in long time)								
Oxygen therapy unit								
(a) Filled up Oxygen cylinder	80.0		20.0	25.0	25.0	100.0	40.0	42.4
(b) Cylinder stand or trolley	40.0			25.0	25.0	80.0	40.0	30.3
(c). Therapy set:								
Presser meter	40.0					80.0	20.0	21.2
Flow meter and control bulb	40.0					100.0	20.0	24.2
Cylinder key (it may be attached with cylinder)						100.0	20.0	18.2
Face musk with tube	40.0		20.0			100.0	20.0	27.3
Water bottle with ring						60.0	40.0	15.2
Airway tube			20.0			80.0	20.0	18.2
Suction machine			20.0	25.0	25.0	80.0	20.0	24.2
Manual resuscitator or Ambu bag						60.0		9.1
Emergency light (3 battery torch lighter or rechargeable electric torch lighter)	20.0			50.0	50.0	60.0	40.0	30.3
Metallic catheter (for women)	20.0			50.0	50.0	60.0	40.0	30.3
Laparotomy set (with veinesection kit vein- flow)	20.0			25.0	25.0	80.0	40.0	27.3
(b). Emergency MSR which will be re-disposable placement if used once times								
Automatic catgut (‘0’)	40.0		20.0	50.0	50.0	60.0	40.0	36.4
Ryle’s tube	20.0			75.0	75.0	40.0	20.0	30.3
Foleys catheter	40.0			75.0	75.0	60.0	20.0	36.4
Rubber catheter	20.0			50.0	50.0	60.0	40.0	30.3
(c). List of Emergency medicine								
Naloxone injection (0.4 Mg/ ml)	40.0		20.0	50.0	50.0	80.0	40.0	39.4
Epinephrine (Adrenaline 1:1000) 1 mg/ ml injection	60.0		20.0	50.0	50.0	100.0	40.0	45.5
Hydrocortisone injection (100 mg)	40.0		20.0			80.0	60.0	30.3
Promethazine injection (25 mg/ml)	20.0		20.0			40.0	40.0	18.2
5% Dextrose in normal saline (500 ml bag)	40.0		20.0			80.0	40.0	27.3
Normal saline (500 ml bag)	20.0		20.0			80.0	40.0	24.2
Diazepam injection (10 mg/ml)	20.0		20.0			80.0	40.0	24.2
10% Calcium goconate injection (10 ml/ ampule)	40.0		20.0			80.0	40.0	27.3
7.5% Sodium-bi carbonate injection (25 ml/ ampule)	20.0		20.0			60.0	60.0	24.2
Aminophylline injection (250 mg/10 ml)	40.0		20.0			40.0	40.0	21.2
Atropine injection (0.6 mg/ ml)	20.0			25.0	25.0		20.0	12.1
Fisostigomine injection (1 mg/ml)	20.0					20.0	40.0	12.1
Butterfly infusion Set	60.0		20.0			20.0	60.0	24.2
Sterile disposable syringe/ 2/5/10/50 ml size	60.0					20.0	20.0	15.2
No shortage	20.0	100.0	80.0	25.0	25.0		40.0	42.4
N	5	5	5	4	4	5	5	33

Table 5.23: Percentage distribution of FWVs by reported shortage of MSR for managing emergency situation by division

MSR for managing emergency situation	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
(a). Emergency equipment (which are use in long time)								
Oxygen therapy unit								
(a) Filled up Oxygen cylinder	20.0				25.0	60.0		14.7
(b) Cylinder stand or trolley	40.0			20.0	25.0	80.0		23.5
(c). Therapy set:								
Pressure meter	20.0				25.0	80.0	20.0	20.6
Flow meter and control valve	40.0				25.0	100.0	20.0	26.5
Cylinder key (it may be attached with cylinder)	40.0			20.0	25.0	100.0	20.0	29.4
Face musk with tube	20.0		20.0	20.0	25.0	80.0	20.0	26.5
Water bottle with ring	20.0			20.0		40.0	20.0	14.7
Airway tube	20.0		20.0		25.0	60.0		17.6
Suction machine (electric/manual)	60.0		20.0		25.0	80.0		26.5
Manual resuscitator or Ambubag	20.0				25.0	60.0		14.7
Emergency light (3 battery touch lighter or rechargeable electric touch lighter)	40.0				25.0	60.0	20.0	20.6
Metallic catheter (for women)	60.0			20.0		60.0	20.0	23.5
Laparatomy set (with vein section kit for vein- flow)	60.0		20.0			60.0		20.6
(b). Emergency MSR which will be re-disposable placement if used once times								
Atromatic catgut ('0')	40.0		20.0			40.0	20.0	17.6
Ryles cube	40.0			20.0		60.0		17.6
Folleys catheter	20.0			20.0		80.0	20.0	20.6
Elastic catheter	20.0			20.0		20.0	20.0	11.8
(c). List of Emergency medicine								
Naloxone injection (0.4 Mg/ ml)	20.0		20.0	40.0		60.0	20.0	23.5
Epinephrine (Adrenaline 1:1000) 1 mg/ml injection	40.0		20.0	40.0		60.0	20.0	26.5
Hydrocortisone injection (100 mg)	20.0		20.0	40.0		60.0	20.0	23.5
Promethazine injection (25 mg/ml)	40.0		20.0	20.0		40.0		17.6
5% Dextrose in normal saline (500 ml bag)	20.0		20.0	20.0		20.0	20.0	14.7
Normal saline (500 ml bag)	20.0		20.0	20.0		40.0		14.7
Diazepam injection (10 mg/ml)	20.0		20.0	20.0		20.0		11.8
10% Calcium gluconate injection (10 ml/ ampule)			20.0	40.0		20.0		11.8
7.5% Sodium-bi carbonate injection (25 ml/ ampule)			20.0	40.0		20.0	20.0	14.7
Aminophylline injection (250 mg/10 ml)			20.0	20.0		20.0		8.8
Atropine injection (0.6 mg/ ml)				20.0				2.9
Fisostigomine injection (1 mg/ml)				40.0		20.0		8.8
Butterfly infusion Set	40.0			40.0				11.8
Sterile disposable syringe/2/5/10/50 ml size	40.0			20.0				8.8
No shortage	20.0	100.0	80.0	20.0	25.0		60.0	44.1
N	5	5	5	5	4	5	5	34

Table 5.24: Distribution of MO-MCH by amount of monetary compensation for accepting LAPM reported by methods by division

Methods		Division							All
		Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
IUD	Mean	150.0	150.0	168.0	210.0	210.0	150.0	150.0	167.3
	Minimum	150	150	150	150	150	150	150	150
	Maximum	150	150	240	390	390	150	150	390
Implants	Mean	150.0	150.0	162.0	210.0	210.0	150.0	150.0	166.4
	Minimum	150	150	150	150	150	150	150	150
	Maximum	150	150	210	390	390	150	150	390
Tubectomy	Mean	2000	2000	2000	2000	2000	2000	2000	2000
	Minimum	2000	2000	2000	2000	2000	2000	2000	2000
	Maximum	2000	2000	2000	2000	2000	2000	2000	2000
Vasectomy	Mean	2000	2000	2000	2000	2000	2000	2000	2000
	Minimum	2000	2000	2000	2000	2000	2000	2000	2000
	Maximum	2000	2000	2000	2000	2000	2000	2000	2000
N		5	5	5	4	4	5	5	33

Table 5.25: Distribution of MO-MCHs by compensation provided in terms of materials for accepting LAPM reported by methods by division

Methods		Division							All
		Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Tubectomy	Saree	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
	Lungi	-	-	-	-	-	-	-	-
	None	-	-	-	-	-	-	-	-
Vasectomy	Saree	-	-	-	-	-	-	-	-
	Lungi	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
	None	-	-	-	-	-	-	-	-
N		5	5	5	4	4	5	5	33

Table 5.26: Percentage distribution of MO-MCHs by reporting on adequacy of compensation to women and men for LAPMs as adequate by division

Adequate	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Yes		20.0					60.0	12.1
No	80.0	80.0	100.0	100.0	100.0	100.0	40.0	84.8
NR	20.0							3.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	5	5	5	4	4	5	5	33

Table 5.27: Distribution of MO-MCHs by proposed compensation for LAPMs by specific methods by division

Methods	Compensation	Division							All
		Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
IUD	Money	312.5	325.0	460.0	437.5	437.5	380.0	150.0	376.8
	Sharee	0.0	1.0	0.0	0.5	0.5	0.0	0.0	0.3
	Lungi								
	Others								
Implants	Money	312.5	325.0	460.0	475.0	475.0	380.0	150.0	387.5
	Sharee	0.0	1.0	0.0	0.5	0.5	0.0	0.0	0.3
	Lungi								
	Others								
Tubectomy	Money	3375	7000	6000	3375	3375	4000	3000	4446.4
	Saree	1.0	2.0	0.0	2.0	2.0	0.0	0.5	1.0
	Lungi								
	Others	0.0	0.0	0.0	0.5	0.5	0.0	0.0	0.1
Vasectomy	Money	3200	4000	6000	3375	3375	4000	3000	3992.9
	Saree								
	Lungi	1.3	2.0	0.0	2.0	2.0	0.0	1.0	1.1
	Others	0.0	0.0	0.0	0.5	0.5	0.0	0.0	0.1
N		4	4	5	4	4	5	2	28

Table 5.28: Distribution of UFPOs by their proposed compensation for LAPM clients by division

Methods	Compensation	Division							All
		Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
IUD	Money	433	500	330	460	463	420	367	419
	Sharee				1			1	1
	Lungi								
Implants	Money	388	500	370	440	438	420	367	413
	Sharee				1			1	1
	Lungi								
	Others								
Tubectomy	Money	4000	4500	4600	4000	3500	3600	4250	4034
	Sharee	1	1	1	1	1	1	1	1
	Lungi								
Vasectomy	Money	3100	4500	4600	4000	3625	3600	4250	3928
	Sharee								
	Lungi	2	2	2	2	2	2	2	2
N		3	2	5	5	4	5	3	27

Table 5.29: Distribution of MO-MCHs by money the providers getting for LAPM service by division

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
IUD	60.0	60.0	48.0	55.0	55.0	60.0	60.0	57.0
Implants	60.0	50.0	60.0	60.0	60.0	60.0	60.0	58.5
Tubectomy	300.0	300.0	343.0	300.0	300.0	300.0	270.0	302.0
Vasectomy	300.0	304.0	342.0	300.0	300.0	300.0	270.0	302.4
N	5	5	5	4	4	5	5	33

Table 5.30: Distribution of UFPOs by money the providers getting for LAPM service by division

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
IUD	60	60	60	60	60	60	60	60
Implants	208	60	74	60	60	60	178	98
Tubectomy	300	300	383	300	350	300	276	315
Vasectomy	300	300	381	300	300	300	276	309
N	4	5	5	5	4	5	5	33

Table 5.31: Distribution of MO-MCH by referral fee for referring for LAPMs reported by division

LAPMs	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
IUD	146.0	48.0	50.0	87.5	87.5	50.0	50.0	73.3
Implants	148.0	52.0	60.0	125.0	125.0	60.0	60.0	87.9
Tubectomy	440.0	300.0	300.0	575.0	575.0	300.0	300.0	387.9
Vasectomy	440.0	300.0	300.0	575.0	575.0	300.0	300.0	387.9
N	5	5	5	4	4	5	5	33

Table 5.32: Distribution of UFPOs by referral fee paid for LAPMs by division

LAPMs	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
IUD	53	50	50	54	88	50	50	55
Implants	60	60	60	58	165	60	54	72
Tubectomy	300	300	300	300	775	300	300	358
Vasectomy	300	300	300	300	825	300	300	364
N	4	5	5	5	4	5	5	33

Table 5.33: Percentage distribution of UFPOs reported innovative BCC activities for promoting LAPMs by division

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Yes	25.0	60.0	60.0	40.0	-	100.0	80.0	54.5
No	75.0	40.0	40.0	60.0	100.0		20.0	45.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	4	5	5	5	4	5	5	33

Table 5.34: Percentage distribution of UFPOs reported explanation for innovative BCC activities by division

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Arrange meetings involving satisfied LAPMs clients as guest	100.0	-	-	-	-	20.0	25.0	16.7
Arrange video show	-	-	-	-	-	20.0	-	5.6
Arrange cultural programmes (drama/ Jari and Pala songs)	-	-	-	-	-	20.0	125.0	33.3
Arrange awareness meetings with community peoples	-	-	-	50.0	-	20.0	25.0	16.7
Train for religious leaders and arrange meeting with people involving them	100.0	33.3	100.0	50.0	-	60.0	-	50.0
Arrange meeting with local people involving high officials and local leaders	-	33.3	-	-	-	-	-	5.6
Arrange Uthan Baithok frequently	-	-	-	-	-	-	25.0	5.6
More training to FPIs and FWAs	-	-	-	-	-	-	25.0	5.6
More communication activities in hard to	-	-	33.3	-	-	-	-	5.6

Indicators	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
reach areas								
Postering	-	33.3	33.3	-	-	-	-	11.1
Show down with posters in hand	-	33.3	-	-	-	-	-	5.6
Provide books on LAPMs in mosque based libraries	-	33.3	-	-	-	-	-	5.6
N	1	3	3	2	-	5	4	18

Table 5.35: Average number of years back FWAs received training reported by themselves by division

Years	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Average	1.8	1.6	2.5	2.0	9.0	3.0	4.3	2.7
Maximum	4	3	4	3	9	3	7	9
Minimum	1	1	1	1	9	3	1	1
N	4	5	2	3	1	3	3	21

Annex Tables Chapter: 6

Table 6.1: Percentage distribution of MO-MCHs by reasons of not accepting or discontinuation of IUD by division

Types of reasons	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Feeling of pain in lower abdomen	100.0	100.0	60.0	50.0	50.0	100.0	60.0	75.8
Menorrhagia	100.0		60.0	100.0	100.0	80.0	40.0	66.7
Expulsion of IUD	40.0	20.0	60.0			40.0		24.2
Become pregnant in-spite of taking IUD	40.0	100.0	20.0				40.0	30.3
Abrasion of vaginal wall	20.0		60.0	25.0	25.0		20.0	21.2
Needs experienced worker to take and remove of IUD	100.0		40.0			60.0		30.3
Need to examine the string after each menstruation	60.0	100.0	20.0			80.0	20.0	42.4
It does not protect STD/HIV/AIDS	20.0		20.0			100.0		21.2
Increased risk of infection of reproductive organs			80.0	50.0	50.0	40.0	20.0	33.3
Others							20.0	3.0
NR				25.0	25.0		20.0	9.1
N	5	5	5	4	4	5	5	33

Table 6.2: Percentage distribution of FWVs by reasons by reasons of not accepting or discontinuation of IUD by couples having one child by division

Types of reasons	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Feeling of pain in lower abdomen	80.0	100.0	60.0	80.0	25.0	80.0	60.0	70.6
Menorrhagia	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Expulsion of IUD	80.0	80.0	80.0	60.0	100.0	80.0	80.0	79.4
Become pregnant in spite of taking IUD	60.0	20.0	80.0	60.0			40.0	38.2
Abrasion of vaginal wall	80.0	40.0	80.0	40.0	25.0	20.0	60.0	50.0
Needs experienced worker to take and remove of IUD	20.0				75.0		20.0	14.7
Need to examine the string after each menstruation	40.0	20.0	20.0	20.0	25.0	20.0		20.6
It does not protect STD/HIV/AIDS	20.0	60.0		40.0		60.0	20.0	29.4
Increased risk of infection of reproductive organs						40.0		5.9
Others					75.0			8.8
N	5	5	5	5	4	5	5	34

Table 6.3: Percentage distribution of FWAs by reasons by reasons of not accepting or discontinuation of IUD by couples having one child by division

Types of reasons	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Feeling of pain in lower abdomen	80.0	80.0	83.3	100.0	100.0	80.0	100.0	88.6
Increased bleeding during menstruation	100.0	100.0	100.0	100.0	75.0	100.0	20.0	85.7
Increased white discharge	80.0	60.0	100.0	80.0	50.0	100.0	80.0	80.0
Sometimes IUD comes outside of vagina	40.0	20.0	66.7	40.0	50.0		20.0	34.3
Become pregnant instead of taking IUD	40.0		66.7	20.0				20.0
Sometimes vagina becomes damaged	40.0		33.3	40.0	25.0	20.0	60.0	31.4
Needs experienced worker to take and remove of IUD	60.0		83.3	20.0	25.0	20.0		31.4
Need to examine the string after each menstruation	80.0	20.0	16.7	40.0		80.0		34.3
It does not protect STD/HIV/AIDS	40.0					20.0		8.6
Reproductive organs transition risks increase	20.0	20.0			25.0			8.6
Feeling shyness							20.0	2.9
Total								
N	**5**	**5**	**6**	**5**	**4**	**5**	**5**	**35**

Table 6.4: Percentage distribution of MO-MCHs by disadvantages that work as reasons for not accepting implants by division

Types of reasons	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Spotting between two menstrual period	100.0	100.0	80.0	100.0	100.0	100.0	60.0	90.9
Period continues for more than 7 days	80.0		100.0	50.0	50.0	100.0	40.0	60.6
Amenorrhea	60.0	100.0	60.0	100.0	100.0	100.0	20.0	75.8
Headache, nausea and weight gain	100.0	100.0	20.0	75.0	75.0	60.0	20.0	63.6
Feeling of tiredness	40.0	100.0	40.0			20.0	60.0	39.4
Heaviness /Pain in breast	20.0	100.0						18.2
Hazards to open	60.0		80.0			80.0		33.3
Needs small operation to take it	40.0		60.0	25.0	25.0			21.2
Periodic bleeding problems							40.0	6.1
Does not protect STD/HIV/AIDS						20.0		3.0
Others							20.0	3.0
N	5	5	5	4	4	5	5	33

Table 6.5: Percentage distribution of FWVs by disadvantages that work as reasons for not accepting implants in couples having one child by division

Types of reasons	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Spotting between two menstrual period	100.0	100.0	100.0	100.0	75.0	100.0	100.0	97.1
Period continues for more than 7 days	100.0	40.0	100.0	40.0	75.0	80.0	40.0	67.6
Amenorrhea	80.0	60.0	80.0	40.0	50.0	60.0	60.0	61.8
Headache/vomiting tendency and weight gain	80.0	40.0	80.0	40.0	25.0	60.0	40.0	52.9
Feeling of tiredness	60.0	40.0	40.0	20.0		80.0	40.0	41.2
Weighty /Pain in breast	40.0	80.0	20.0	20.0		40.0		29.4
Hazard to open and use self	20.0		20.0		75.0	40.0		20.6
Need small operation to take and open	20.0				100.0			14.7
Risk of infection /bleeding		40.0			50.0			11.8
Does not protect STD/HIV/AIDS				20.0				2.9
N	5	5	5	5	4	5	5	34

Table 6.6: Percentage distribution of FWAs by disadvantages that work as reasons for not accepting implants in couples having one child by division

Types of reasons	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Spotted between two menstrual period	100.0		66.7	80.0	75.0	100.0	60.0	68.6
Menstruation bleeding for a long time	100.0	20.0	66.7	80.0	50.0	100.0	40.0	65.7
Stopped menstruation	60.0	100.0	83.3	100.0	100.0	40.0	80.0	80.0
Headache, vomiting tendency and weight gain	100.0	60.0	66.7	60.0	50.0	40.0	40.0	60.0
Feeling of tiredness	60.0	20.0	33.3	20.0		40.0	60.0	34.3
Weighty /Pain in breast	80.0	80.0	50.0	20.0		40.0		40.0
Hazard to open and use self	100.0	20.0	66.7	40.0	25.0	60.0	20.0	48.6
Need small operation to take and open	60.0		50.0	40.0	25.0	40.0	40.0	37.1
Transition, bleeding problem	40.0	20.0	16.7	20.0	25.0	20.0		20.0
N	**5**	**5**	**6**	**5**	**4**	**5**	**5**	**35**

Table 6.7: Percentage distribution of MO-MCHs by reasons of not accepting tubectomy in couples having at least two children by division

Types of reasons	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Need to think before taking decision as it is a permanent method	100.0	100.0	80.0	75.0	75.0	100.0	80.0	87.9
Think it risky in spite of being a small operation	80.0		80.0	75.0	75.0	40.0		48.5
Pain remains for a few days after operation	100.0	100.0	80.0	50.0	50.0	40.0	20.0	63.6
Possibilities of Ectopic pregnancy	60.0		20.0					12.1
Need to come to service center for operation	80.0		80.0	25.0	25.0	80.0	80.0	54.5
Need trained doctor and assistant	40.0		80.0			100.0		33.3
Does not protect STD/HIV/AIDS						80.0		12.1
NR				25.0	25.0		20.0	9.1
N	5	5	5	4	4	5	5	33

Table 6.8: Percentage distribution of FWVs by reasons of not accepting tubectomy in couples having at least two children by division

Types of reasons	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Need to think before taking decision as it is a permanent method	100.0	20.0	80.0	100.0	50.0	80.0	100.0	76.5
Risky in spite of being a small operation	100.0	80.0	60.0	40.0	100.0	40.0	20.0	61.8
Pain remains for a few days after operation	80.0	60.0	60.0	40.0	25.0	40.0	40.0	50.0
Possibilities of ectopic pregnancy	60.0	40.0	20.0	20.0	25.0	20.0		26.5
Need to come to service center for operation	100.0	40.0	80.0	20.0	75.0	80.0		55.9
Need trained doctor and assistant	20.0		60.0			100.0	20.0	29.4
Does not protect STD/HIV/AIDS						60.0		8.8
N	5	5	5	5	4	5	5	34

Table 6.9: Percentage distribution of FWA by reasons of not accepting tubectomy in couples having at least two children by division

Types of reasons	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Need to think before taking decision as it's a	100.0	80.0	100.0	80.0	100.0	80.0	80.0	88.6
Have risk in spite of being a small operation	100.0	100.0	66.7	100.0		60.0	40.0	68.6
Pain remains for a few days after operation	80.0	80.0	66.7	80.0	50.0	60.0	80.0	71.4
Possibilities of Ectopic pregnancy			33.3		25.0			8.6
Need to come to service center for operation	60.0	60.0	83.3	60.0	25.0	40.0	80.0	60.0
Need trained doctor and assistant	80.0	20.0	66.7	60.0	25.0	80.0	20.0	51.4
Does not protect STD/HIV/AIDS	40.0							5.7
Expectation of two sons					25.0		20.0	5.7
N	**5**	**5**	**6**	**5**	**4**	**5**	**5**	**35**

Table 6.10: Percentage distribution of MO-MCHs by reasons of non- acceptance of vasectomy by couples having at least two children by division

Types of reasons	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
It is not possible to take child again as it is a permanent method	100.0	100.0	40.0	75.0	75.0	100.0	80.0	81.8
There have some risk in spite of being a small operation	80.0		80.0	100.0	100.0	40.0		54.5
It does not work immediately after operation	80.0	100.0	40.0	75.0	75.0	40.0	40.0	63.6
Have to wait for 3 months to be effective	100.0		60.0	25.0	25.0	80.0	40.0	48.5
Need to use condom for intercourse before it become effective	80.0		40.0			100.0	20.0	36.4
Need to come to service center for operation			80.0	25.0	25.0	20.0	60.0	30.3
Need trained doctor and assistant			20.0			80.0		15.2
Does not protect STD/HIV/AIDS	20.0					20.0		6.1
Others			20.0					3.0
N	5	5	5	4	4	5	5	33

Table 6.11: Percentage distribution of MO-MCHs by reasons of non- acceptance of vasectomy by couples having at least two children by division

Types of reasons	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
It is not possible to take child again as it is a permanent method	100.0	60.0	60.0	100.0	50.0	100.0	100.0	82.4
There have some risk in spite of being a small operation	100.0	20.0	60.0	20.0	50.0	40.0		41.2
It does not work immediately after operation	80.0	100.0	60.0	40.0	25.0	40.0	60.0	58.8
Have to wait for 3 months to be effective	100.0	20.0	60.0	20.0	50.0	40.0	20.0	44.1
Need to use condom for intercourse before it become effective	60.0	20.0	60.0	40.0		40.0	40.0	38.2
Need to come to service center for operation		80.0	40.0			40.0	20.0	26.5
Need trained doctor and assistant			20.0			20.0		5.9
Does not protect STD/HIV/AIDS	20.0							2.9
N	5	5	5	5	4	5	5	34

Table 6.12: Percentage distribution of FWA by reasons of non- acceptance of vasectomy by couples having at least two children by division

Types of reasons	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
It is not possible to take child again as it is a permanent method	80.0	100.0	66.7	80.0	50.0	80.0	100.0	80.0
There have some risk in spite of being a small operation	80.0	80.0	66.7	40.0	75.0	40.0	20.0	57.1
It does not work immediately after operation	80.0	20.0	83.3	80.0	25.0	20.0	60.0	54.3
Have to wait for 3 months to be effective	60.0		66.7	40.0	50.0	80.0	60.0	51.4
Need to use condom for intercourse before it become effective	60.0	80.0	100.0	40.0	25.0	60.0	20.0	57.1
Need to come to service center for operation		20.0	100.0	60.0	25.0	40.0	40.0	42.9
Need trained doctor and assistant	20.0		50.0	60.0		100.0		34.3
Does not protect STD/HIV/AIDS	20.0			20.0		20.0	20.0	11.4
Failure of method					25.0			2.9
May create impotent in vasectomy	20.0							2.9
N	**5**	**5**	**6**	**5**	**4**	**5**	**5**	**35**

Table 6.13: Percentage distribution of by FWVs by their opinion on socio-cultural propositions behind non-use of long acting methods by division

Prime causes	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Religious superstition	20.0	60.0	20.0	20.0	100.0	20.0	60.0	41.2
Lack of awareness	60.0	80.0	40.0	40.0	75.0	60.0	60.0	58.8
Side effect is very common	80.0		40.0	40.0	25.0	60.0	80.0	47.1
Uncomfortable for irregular menstruation				20.0		20.0	20.0	8.8
Menstruation stops			20.0	20.0				5.9
Husband does not allow	20.0	100.0		20.0			20.0	23.5
Social barrier		80.0	20.0	20.0			20.0	20.6
May create impotency in vasectomy						20.0		2.9
Negative impression on LAPMs in society					25.0		20.0	5.9
Complication of LAPMs is common							20.0	2.9
Problem with uterus							20.0	2.9
Heavy work is not possible	20.0							2.9
Poverty			20.0					2.9
N	5	5	5	5	4	5	5	34

Table 6.14: Percentage distribution of FWVs by complications/ problems the clients generally face after accepting IUD by division

Complications/ problems	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Feeling of pain in lower abdomen	100.0	100.0	80.0	100.0	100.0	80.0	40.0	85.3
Menorrhagia	80.0	100.0	100.0	80.0	75.0	80.0	80.0	85.3
Expulsion of IUD	60.0		40.0	40.0	50.0	100.0	60.0	50.0
Become pregnant in-spite of taking IUD							20.0	2.9
Spotting between two menstrual period	60.0			40.0	25.0	20.0	20.0	23.5
Sometimes vaginal wall is damaged			20.0					2.9
Feeling of pain during sexual intercourse	20.0		20.0				40.0	11.8
Fear of attract cancer							20.0	2.9
Duration of menstruation increase						20.0	20.0	5.9
N	5	5	5	5	4	5	5	34

Table 6.15: Percentage distribution of FWVs by complications/ problems the clients generally face after accepting implants reported by division

Complications/ problems	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Spotting between two menstrual period					50.0	40.0		11.8
Menorrhagia	40.0	100.0	60.0	40.0	25.0	20.0	40.0	47.1
Amenorrhea	60.0		100.0	40.0	50.0	60.0	20.0	47.1
Headache, vomiting tendency and weight gain	80.0	80.0	60.0	40.0	25.0	40.0	20.0	50.0
Need small operation to take and open						20.0		2.9
Weighty /Pain in breast					25.0			2.9
Side effect is very common	40.0				25.0			8.8
Transitional bleeding problem			20.0					2.9
Negative impression in society							20.0	2.9
Feeling of tiredness	40.0							5.9
No response				40.0		40.0	60.0	20.6
N	5	5	5	5	4	5	5	34

Table 6.16: Percentage distribution of FWVs by how the complications/ problems of IUD are solved by division

Process	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Provide medicine	60.0	100.0	60.0	100.0	125.0	100.0	40.0	82.4
Withdraw IUD	40.0	80.0			50.0	20.0	40.0	32.4
Provide advice and counseling	40.0		60.0	20.0		60.0	40.0	32.4
Refer to trained doctor and MO-MCH	40.0		20.0					8.8
N	5	5	5	5	4	5	5	34

Table 6.17: Percentage distribution of FWVs by how the complications/ problems of implants are solved by division

Process	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Provide medicine	60.0	100.0	80.0	40.0	25.0	80.0		55.9
Withdraw implant	40.0						20.0	8.8
Provide advice and counseling	40.0		60.0	20.0			20.0	20.6
Refer to trained doctor	60.0		20.0			20.0	40.0	20.6
No response			20.0	60.0	75.0		60.0	29.4
N	5	5	5	5	4	5	5	34

Table 6.18: Percentage distribution of MO-MCHs by problems faced in LAPMs service provision by division

Problems faced	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Lack of supply of MSR	40.0		40.0	25.0	25.0			18.2
In-sufficient light in OT			20.0					3.0
No separate OT room for family planning			20.0				40.0	9.1
No post-operative room for family planning							40.0	6.1
Low payment to LAPM clients		100.0		50.0	50.0	20.0		30.3
Failure of methods creates social problem				25.0	25.0			6.1
People fear of operative LAPMs						20.0		3.0
Lack of training of field workers	20.0			25.0	25.0		20.0	12.1

Problems faced	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Lack of trained nurse							20.0	3.0
Negative impression on LAPMs in society							20.0	3.0
No trained doctor at present	20.0						20.0	6.1
Fear of being impotent after vasectomy							20.0	3.0
Lack of manpower	20.0							3.0
Problem with privacy during procedure							20.0	3.0
Community people creates problem in provision of LAPM service							20.0	3.0
Lack of administrative accountability						20.0		3.0
NR	20.0		40.0	25.0	25.0			15.2
N	5	5	5	4	4	5	5	33

Table 6.19: Percentage distribution of FWAs by problems faced in LAPMs service provision by division

Problems	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Religious superstition	80.0	100.0	50.0	80.0	50.0	80.0	40.0	68.6
Lack of awareness		100.0	33.3	40.0		80.0	40.0	42.9
Lack of cooperation from community leaders and Imams	20.0	20.0	16.7				40.0	14.3
Cannot take another child if any child dies			16.7	20.0				5.7
Lack of supply of MSR			16.7		25.0			5.7
Low payment to LAPMs clients	20.0		16.7		25.0	40.0		14.3
Low payment for communication in working area					50.0			5.7
May create impotency in vasectomy			16.7	20.0				5.7
Side effect of IUD is very common			16.7		25.0	40.0	20.0	14.3
Husband does not allow		20.0		20.0				5.7
Lack of proper motivation and counseling					25.0		20.0	5.7
Negative impression on LAPMs in society	40.0		16.7	20.0	25.0		40.0	20.0
Low payment to their bringing LAPMs clients						20.0		2.9
People fear of operative LAPMs	20.0		16.7	20.0				8.6
Heavy work is not possible			16.7	20.0				5.7
N	**5**	**5**	**6**	**5**	**4**	**5**	**5**	**35**

Annex Tables Chapter: 7

Table 7.1: Percentage distribution of UFPOs by their suggestions for solving the problems in LAPMs service provision to increase its acceptance by divisions

Suggested initiatives for solving the problems	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Religious leaders/ Imams to be made aware	-	-	-	-	33.3		-	4.8
Arrange refreshers training of FWAs	-	50.0	-	33.3	66.7		60.0	33.3
Supply MSR for operation up to union level	-	-	-	-	66.7		-	9.5
Media communication o be increased	-	-	33.3	-	-		80.0	23.8
FWA should not work at CCs	-	-	-	-	-	40.0	-	9.5
LAPM clients allowance should be increased	-	50.0	-	-	-	100.0	80.0	47.6
Separate OT an post-operative bed for family planning	-	-	33.3	-	-	40.0	20.0	19.0
Arrange treatment of complications	-	-	33.3	33.3	-	-	-	9.5
Increase fee of motivators and providers	-	-	100.0	-	-	60.0	-	28.6
Increase quality of care of UH& FWC	-	-	133.3	-	-	60.0	40.0	42.9
More counseling and Uthan Baithak to increase awareness of people	-	50.0	66.7	33.3	-	20.0	20.0	28.6
Recruit additional FWAs	-	-	-	33.3	-	-	100.0	28.6
Fill up the vacant posts of deputy directors in all districts	-	-	33.3	-	-	-	20.0	9.5
Arrange refreshes course for workers at all level	-	-	-	-	-	-	40.0	9.5
Arrange refreshers training of FWVs, doctors, SACMOs	-	-	-	33.3	-	-	-	4.8
Utilize elected leaders to come forward	-	-	-	-	-	20.0	-	4.8
N	0	2	3	3	3	5	5	21

Table 7.2: Percentage distribution of MO-MCH by their suggestions for solving the problems of LAPMs service provision and increasing its acceptance by divisions

Suggested initiatives for solving the problems	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Increase awareness		20.0	20.0				20.0	9.1
Arrange training of field workers			20.0	25.0	25.0		40.0	15.2
Supply MSR for LAPMs	20.0		40.0	75.0	75.0	20.0	20.0	33.3
Media communication should be increased	60.0	60.0		25.0	25.0		20.0	27.3
Increase quality of service and care						20.0	100.0	18.2
LAPM clients' allowance should be increased			20.0	50.0	50.0	20.0		18.2
Increase allowance for LAPMs referral				50.0	50.0	20.0		15.2
Increase fee of motivators and Providers						20.0		3.0
Separate OT and post operative bed for family planning			40.0	50.0	50.0	160.0	80.0	54.5
Increase manpower			20.0			20.0		6.1
Arrange meeting involving community leaders	20.0	100.0					40.0	24.2
Arrange meeting involving clients							20.0	3.0
Increase *Uthan Baithak* and Counseling		100.0						15.2
Increase inter-personal communication		80.0						12.1
Fund should be increased	20.0							3.0
Increase accountability of field workers							20.0	3.0
Increase accountability of administrative officers						40.0		6.1
FWAs should not work in community clinic 2 days a week						40.0		6.1
Sufficient light in OT should be ensured			20.0					3.0
NR	40.0			25.0	25.0			12.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	5	5	5	4	4	5	5	33

Table 7.3: Percentage distribution of FWVs by their suggestions for solving the problems of LAPMs service provision for increasing its acceptance by divisions

Suggested initiatives for solving the problems	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Religious leaders/ Imams to be made aware	20.0	80.0	40.0		50.0			26.5
Arrange training of FWA	20.0		20.0		75.0		60.0	23.5
Arrange training of community leaders/Imams		40.0			25.0			8.8
Supply of quality MSR to be increased							20.0	2.9
LAPMs clients allowance should be increased	40.0	40.0				80.0	20.0	26.5
Increase fee of motivators, referee and providers	20.0		20.0			60.0		14.7
Separate OT and post operative bed for family planning						40.0		5.9
Increase quality of service and care						20.0		2.9
Increase media communication	60.0	40.0		80.0	50.0	20.0	60.0	44.1
Arrange meeting/*Uthan Baithak* involving community leaders/Imams/teacher				40.0			20.0	8.8
Increase supervision			20.0	20.0		20.0		8.8
Arrange drama, film show	20.0				25.0			5.9
Increase financial helps for managing meeting/Uthan Baithak		60.0			25.0		20.0	14.7
Number of field workers to be increased	20.0			20.0	25.0			8.8
Utilize elected leaders to come forwards					25.0			2.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	5	5	5	5	4	5	5	34

Table 7.4: Percentage distribution of FPIs their suggestions for solving the problems of LAPMs service provision for increasing its acceptance by division

Suggested initiatives for solving the problems	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Religious leaders/ Imams should be made aware first	20.0	80.0	20.0	20.0	75.0	20.0		32.4
More training of FWVs					75.0			8.8
Increase allowance for LAPM clients	40.0	20.0	20.0	40.0	50.0	40.0	40.0	35.3
Arrange meeting involving community leaders	40.0	40.0	120.0	80.0	50.0	40.0	160.0	76.5
Increase financial help for arranging meeting/ Uthan Baithak					25.0			2.9
Media communication should be increased		80.0	20.0	40.0		20.0		23.5
Increase allowance for LAPMs referrals						40.0		5.9
Separate OT and Post operative bed						20.0		2.9
Medicine to be supplied during complications			20.0				20.0	5.9
Quality of care to be increased	20.0		120.0	20.0			20.0	26.5
Increase quality of service at FWC							20.0	2.9
Increase rate of education			20.0	20.0				5.9
Number of field workers to be increased	20.0						20.0	5.9
Deploy male FWAs for vasectomy	40.0							5.9
N	**5**	**5**	**5**	**5**	**4**	**5**	**5**	**34**

Table 7.5: Percentage distribution of FWAs by suggestions for solving the problems of LAPMs service provision for increasing its acceptance by divisions

Suggested initiatives for solving the problems	Division							All
	Dhaka	Khulna	Rajshahi	Chittagong	Sylhet	Barisal	Rangpur	
Religious leaders/ Imams should be made aware first	20.0	40.0			25.0	20.0	40.0	20.0
More training of FWAs						20.0		2.9
Increase allowance for LAPMs clients	40.0	20.0		20.0	75.0	80.0	60.0	40.0
Arrange meeting involving community leaders/ Imams	20.0	20.0	33.3	40.0	50.0	20.0	40.0	31.4
Arrange training for community leaders/ Imams			16.7	60.0	75.0		40.0	25.7
Media communication should be increased	40.0	20.0	33.3		25.0	20.0		20.0
Increase allowance for LAPM referral, doctors			16.7			20.0	20.0	8.6
Separate OT and post operative bed						20.0		2.9
Number of Uthan Baithak and counseling should be increased	20.0				50.0	20.0	20.0	14.3
Increase social awareness		60.0	33.3	60.0				22.9
Quality of service and care to be increased			16.7				40.0	8.6
Number of field workers to be increased			16.7				20.0	5.7
Education rate to be increased			16.7					2.9
Arrange film show		60.0						8.6
N	**5**	**5**	**6**	**5**	**4**	**5**	**5**	**35**

Annex-2
Data Collection Instruments (DCIs)

DCI-1

Cluster No. | | | | ID No. | | | |

ASSESS THE CONSTRAINTS TO PROMOTE LONG-ACTING AND PERMANENT CONTRACEPTIVE METHODS (LAPMs)

HOUSEHOLD QUESTIONNAIRE

(For User and Non-user Eligible Women with at least one child)

Interviewer: Introduce yourself to the respondent. Then tell the main purpose of your visit to her/him. Take her/his permission before start of interview or to ask question. In case of refusal, move to next respondent. Thank the respondent both at the start and the end of interview.

LOCATION INFORMATION

DIVISION _____

DISTRICT _____

UPAZILA _____

UNION/WARD _____

VILLAGE/MOHALLA/PARA _____

NAME OF HOUSEHOLD HEAD _____

MOBILE NO (if any) _____

NAME OF INTERVIEWEE _____

INTERVIEWER VISITS

ENUMERATOR	SUPERVISOR	QUALITY CONTROL OFFICER
NAME _____	NAME _____	NAME _____
DATE _____/ _____/ _____	DATE _____	DATE _____/ _____/ _____

Starting time of Interview:

Study undertaken for

National Institute for Population Research and Training (NIPORT)

Study conducted by

Human Development Research Centre

Road # 8, House #5, Mohammadia Housing Society,
Mohammadpur, Dhaka –1207, Bangladesh
Phone: (880 2) 8116972, 8157621, Fax: (880 2) 8157620
E-mail: hdrc.bd@gmail.com, info@hdrc-bd.com
Website: www.hdrc-bd.com

Dhaka: June 2013

SECTION I: BACKGROUND OF THE RESPONDENTS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	How old are you?	Age in completed years..... ☐☐	
102	Have you ever attended general school or Madrasha?	1. Yes ☐ 2. No ☐	→105
103	What type of school did you attend at the highest level?	1. General School ..... ☐ 2. Aliya Madrasha ..... ☐ 3. Vocational School ..... ☐ 4. Quomi Madrasha ..... ☐	
104	What is the highest class you completed at that level?	Class..... ☐☐ 88. Quomi Madrasha ..... ☐	
105	What is your main occupation? [*Large business means capital is above Tk. 20,000; ** Small business means capital is Tk. 20,000 or below]	1. Land owner ……..…… ☐ 2. Farmer…… ☐ 3. Agricultural worker……..……. ☐ 4. Fisherman…… ☐ 5. Poultry/cattle raising…….....…. ☐ 6. Home-based manufacturing…….....…. ☐ 7. Brick breaking/road bridge……..... ☐ 8. Domestic servant……..…. ☐ 9. Factoryworker/blue collar service…… ☐ 10. Sewing/tailor…… ☐ 11. Doctor/engineer/lawyer/teacher/ FWV/Govt./private services……. ☐ 12. Large business*…… ☐ 13. Small business**…… ☐ 14. Unemployed/student……..... ☐ 15. Housewife…… ☐ . ☐ 77.Others _____ (specify)	
106	What is your religion?	1. Islam ..... ☐ 2. Hindu ..... ☐ 3. Christian ..... ☐ 4. Buddhist ..... ☐	
107	How many members are there in your household?	Total member..... ☐	
108	How many living children do you have?	Boys..... ☐☐ Girls..... ☐☐ Total…..... ☐☐	
109	How many children do you desire more?	Number..... ☐ 77. Don't know/God knows..... ☐	

SECTION 2: HOUSEHOLD ASSETS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
201	Do you live at your own/husband's household?	1. Yes ..... ☐ 2. No ..... ☐	
202	**Housing Condition:** (a) Main material of the roof	1. Concrete ..... ☐ 2. Tin ..... ☐ 3. Tali ..... ☐ 4. Wood ..... ☐ 5. Bamboo..... ☐ 6. Thatch/jute stick/palm leaf ..... ☐ 7. Bamboo/Polythine ..... ☐	
	(b) Main material of the floor	1. Earth/sand..... ☐ 2. Wood planks ..... ☐ 3. Palm log/Bamboo..... ☐ 4. Polished wood..... ☐ 5. Ceramic tiles/Mosaic ..... ☐ 6. Cement/Brick..... ☐	
	(c) Main material of the wall	1. Brick ..... ☐ 2. Tin ..... ☐ 3. Earth ..... ☐ 4. Bamboo ..... ☐ 5. Straw/Jute stick/leaf..... ☐ 6. Bamboo/Polythine ..... ☐ 7. Wood log..... ☐	
203	Do your households have the following assets? *[Prompt] [Multiple answers possible]*	1. Radio ..... ☐ 2. Television..... ☐ 3. Mobile Phone ..... ☐ 4. Land Phone ..... ☐ 5. Refrigerator ..... ☐ 6. Computer ..... ☐ 7. Washing Machine..... ☐ 8. Air Conditioner/Cooler ..... ☐ 9. Almirah..... ☐ 10. Sofa ..... ☐ 11. Table/chair ..... ☐ 12. Bed ..... ☐ 13. Motor cycle..... ☐ 14. Bicycle ..... ☐ 15. Car ..... ☐	
204	Does your house have electricity?	1. Yes ..... ☐ 2. No ..... ☐	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
205	What is the main source of drinking water of your household?	1. Piped into dwelling ☐ 2. Piped to yard/plot ☐ 3. Public tap ☐ 4. Tube well ☐ 5. Dug well ☐ 6. Water from protected spring ☐ 7. Water from unprotected spring ☐ 8. Rain water ☐ 9. Tanker truck ☐ 10. Surface water ☐ 11. Bottled water ☐	
206	What kind of toilet facility do members of your household usually use?	1. Flush to piped sewer system ☐ 2. Flush to septic tank ☐ 3. Flush to pit latrine ☐ 4. No facility/Bush/Field ☐ 5. Pit latrine with slab ☐ 6. Pit latrine without slab/open pit ☐ 7. Bucket toilet ☐ 8. Hanging toile ☐	
Section 3 A: Knowledge of LAPMs			
301	Have you ever heard of long term and permanent methods (LAPMs) (IUD (Copper T), Implant/Norplant, Tubectomy, and Vasectomy)?	1. Yes ☐ 2. No ☐	***701***
302	Which LAPM have you heard of? (Multiple answer possible)	1. IUD ☐ 2. Implant/ Norplant ☐ 3. Tubectomy ☐ 4. Vasectomy ☐ 5. Heard of none ☐	***701***
303	From whom/where have you heard of it? *[Multiple answers possible]*	1. Government hospital ☐ 2. Family Welfare Centre/FWV ☐ 3. Upazila Health Complex ☐ 4. Satellite Clinic ☐ 5. Maternal and Child Welfare Centre ☐ 6. Community Clinic ☐ 7. Private hospital/clinic ☐ 8. FWA ☐ 9. HA ☐ 10. NGO worker/clinic ☐ 11. Relatives/Friends ☐ 12. Religious leaders ☐ 13. Community leaders ☐ 14. Printed media ☐ 15. Radio ☐ 16. TV ☐ 17. Cinema ☐ 18. Street corner drama/Folk song ☐	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
Section 3.B: Knowledge of Advantages and Disadvantages, Sources and Duration of LAPMs			
304 A	**Interviewer:** Check question no.302 whether the respondents have heard about IUD (Copper T)?	3. Yes ..... ☐ 4. No ..... ☐ →	**308A**
304B	In your opinion what are the advantages of IUD to limit child birth? *[Multiple answers possible]*	1. Very much effective ..... ☐ 2. Can protect pregnancy up to10 years..... ☐ 3. Easy to use/take ..... ☐ 4. Action starts immediately after use/taking .. ☐ 5. No difference appears in the breast milk after taking IUD..... ☐ 6. Pregnancy capacity return immediately after quitting the method ..... ☐ 7. Does not create barriers to sexual intercourse ..... ☐ 8. No hormonal problem ..... ☐ 9. Remain free from everyday hazard of using condom or pill..... ☐ 10. Others (specify)	
305	In your opinion what are the disadvantages of IUD? *[Multiple answers possible]*	1. Feeling of pain in lower abdomen ..... ☐ 2. Increased bleeding during menstruation..... ☐ 3. Sometimes IUD comes outside of vagina... ☐ 4. Become pregnant instead of taking IUD ..... ☐ 5. Sometimes vagina becomes damaged..... ☐ 6. Needs experienced worker to take and remove of IUD ..... ☐ 7. Need to examine the string after each menstruation ..... ☐ 8. It does not protect STD/HIV/AIDS ..... ☐ 9. Reproductive organs transition risks ..... ☐ 10. Others(specify) ..... ☐	
306	Do you know where/whom should a person go for getting IUD? *[Multiple answers possible]*	1. Government hospital..... ☐ 2. Family Welfare Centre ..... ☐ 3. Upazila Health Complex..... ☐ 4. Satellite Clinic..... ☐ 5. Maternal and Child Welfare Centre ..... ☐ 6. Community Clinic..... ☐ 7. FWA..... ☐ 8. HA..... ☐ 9. Private Hospital ..... ☐ 10. NGO Clinic ..... ☐ 11. Pharmacy..... ☐ 12. Shops..... ☐ 13. Others (Specify).....	
307	Once inserted, for how many years an IUD can give protection to child birth?	Years…….... ☐☐ 88. Don't Know……..…… ☐	
308 A	**Interviewer:** Check question no.302 whether the respondents have heard about Implant/ Norplant?	1.Yes ..... ☐ 2.No ..... ☐ →	**312A**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
308B	In your opinion what are the advantages of Implant/Norplant? *[Multiple answers possible]*	1. Very much effective as temporary long term method which could protect pregnancy till 3-5 years ☐ 2. Effectiveness starts within 24 hours after setting ☐ 3. Pregnancy capacity returns immediately after quitting the method ☐ 4. Remains free from everyday hazard of using condom or pill ☐ 5. Does not create barriers to sexual intercourse ☐ 6. Does not require to visit clinic again and again except some certain follow up visit ☐ 7. Makes no difference in breast milk; so implant could be use after 6 weeks of child birth ☐ 8. No side affect due to Estrogen hormone ☐ 9. Cures iron deficiency ☐ 10. Could be removed at any time ☐ 11. Others (Specify) ☐	
309	In your opinion what are the disadvantages of Implant/Norplant? *[Multiple answers possible]*	1. Drop hemorrhage between two menstrual period ☐ 2. Little bleeding for a long time ☐ 3. Stopped menstruation ☐ 4. Headache, vomiting tendency and weight gain ☐ 5. Feeling of tiredness ☐ 6. Weighty /Pain in breast ☐ 7. Hazard to open and use self ☐ 8. Need small operation to take and open ☐ 9. Transition, bleeding problem ☐ 10. Does not protect STD/HIV/AIDS ☐ 11. Others (specify)	
310	Do you know where/whom should a person go for getting Implant/ Norplant? *[Multiple answers possible]*	1. Government hospital ☐ 2. Family Welfare Centre ☐ 3. Upazila Health Complex ☐ 4. Satellite Clinic ☐ 5. Maternal and Child Welfare Centre ☐ 6. Community Clinic ☐ 7. FWA ☐ 8. HA ☐ 9. Private Hospital ☐ 10. NGO Clinic ☐ 11. Pharmacy ☐ 12. Shops ☐ 13. Others (Specify) ☐	
311	Once inserted, for how many years an Implant/ Norplant can give protection to child birth?	Years ☐☐ 88. Don't Know ☐	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
312 A	**Interviewer:** Check question no.302 whether the respondents have heard about Tubectomy?	1.Yes ..... ☐ 2.No ..... ☐ → **316A**	
312 B	In your opinion what are the advantages of Tubectomy? *[Multiple answers possible]*	1. Effective immediately after operation and very much safe method ..... ☐ 2. Remain free from everyday hazard of using condom or pill or other methods..... ☐ 3. Need not to go to clinic or worker again and again except some follow up visits..... ☐ 4. Does not reduce power of sexual intercourse or physical strength..... ☐ 5. No long term side affect or health risk ..... ☐ 6. Increase sexual intercourse will, power and satisfaction as there are no fear of being pregnant ..... ☐ 7. No effect on breast milk so it could be done after delivery ..... ☐ 8. Good method for those who may have health risk if they become pregnant..... ☐ 9. Free of side-effect of hormonal method .... ☐ 10. Easy and safe operation, don't using local anesthesia..... ☐ 11. Can return home after operation ..... ☐ 12. Others (Specify)..... ☐	
313	In your opinion what are the disadvantages of Tubectomy**?** *[Multiple answers possible]*	1. Need to think before taking decision as it's a permanent method ..... ☐ 2. Have risk in spite of being a small operation ..... ☐ 3. Pain remains for a few days after operation ..... ☐ 4. Possibilities of Ectopic pregnancy ..... ☐ 5. Need to come to service center for operation ..... ☐ 6. Need trained doctor and assistant..... ☐ 7. Does not protect STD/HIV/AIDS ..... ☐ 8. Others (specify) ..... ☐	
314	Do you know where/whom should a person go for getting Tubectomy? *[Multiple answers possible]*	1. Government hospital..... ☐ 2. Family Welfare Centre ..... ☐ 3. Upazila Health Complex..... ☐ 4. Satellite Clinic..... ☐ 5. Maternal and Child Welfare Centre ..... ☐ 6. Community Clinic..... ☐ 7. FWA..... ☐ 8. HA..... ☐ 9. Private Hospital ..... ☐ 10. NGO Clinic ..... ☐ 11. Pharmacy..... ☐ 12. Shops..... ☐ 13. Others (Specify)..... ☐	
315	Once done, for how many years Tubectomy can give protection to child birth?	Years..... ☐☐ 88. Don't Know ..... ☐	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
316 A	**Interviewer:** Check question no.302 whether the respondents have heard about Vasectomy?	1.Yes ..... ☐ 2.No ..... ☐ → **401**	
316 B	In your opinion what are the advantages of Vasectomy? *[Multiple answers possible]*	1. Permanent method, very much safe and effective..... ☐ 2. Do not reduce sexual intercourse power or physical strength ..... ☐ 3. Increase sexual intercourse will, power and satisfaction as there are no fear of being pregnant ..... ☐ 4. No long term side affect or health risk..... ☐ 5. Easy and safe operation, no need to do senseless..... ☐ 6. Take shorter time (5-7 minutes)..... ☐ 7. No need to take rest after operation..... ☐ 8. Others (specify) ..... ☐	
317	In your opinion what are the disadvantages of Vasectomy? *[Multiple answers possible]*	1. It is not possible to take child again as it is a permanent method..... ☐ 2. There have some risk in spite of being a small operation..... ☐ 3. It does not work immediately after operation..... ☐ 4. Have to wait for 3 months to be effective.... ☐ 5. Need to use condom for intercourse before it become effective..... ☐ 6. Need to come to service center for operation ..... ☐ 7. Need trained doctor and assistant ..... ☐ 8. Does not protect STD/HIV/AIDS ..... ☐ 9. Others (specify) ..... ☐	
318	Do you know where/whom should a person go for getting Vasectomy? *[Multiple answers possible]*	1. Government hospital..... ☐ 2. Family Welfare Centre ..... ☐ 3. Upazila Health Complex..... ☐ 4. Satellite Clinic..... ☐ 5. Maternal and Child Welfare Centre ..... ☐ 6. Community Clinic..... ☐ 7. FWA..... ☐ 8. HA..... ☐ 9. Private Hospital ..... ☐ 10. NGO Clinic ..... ☐ 11. Pharmacy..... ☐ 12. Shops..... ☐ 13. Others (Specify)..... ☐	
319	Once done, for how many years Vasectomy can give protection to child birth?	Years ..... ☐☐ 88. Don't Know..... ☐	
Section 4.A: Use of LAPMs			
401	**Check Question No.108:** Whether the woman has only one living child at present?	1. Yes ..... ☐ 2. No ..... ☐ → 403	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
402	If yes, are you currently using the following long-acting contraceptives (IUD/.Implant) to limit child birth?	**Yes** 1. IUD ..... ☐ 2. Implant/ Norplant..... ☐ → 405 3. None of these ..... ☐ → 501A	
403	**Check Question No.108:** Whether the woman has two or more living children at present?	1. Yes = ☐ 2. No = ☐ → 407	
404	If yes, are you currently using the following long-acting and permanent methods to limit child birth?	**Yes** 1. IUD ..... ☐ 2. Implant/ Norplant..... ☐ 3. Tubectomy ..... ☐ → **501A** 4. Vasectomy ..... ☐ 5. Using none of those ..... ☐ → 501A	
405	From where/whom did you go for getting the method? *[Multiple answers possible]*	1. Government hospital ..... ☐ 2. Family Welfare Centre..... ☐ 3. Upazila Health Complex ..... ☐ 4. Satellite Clinic..... ☐ 5. Maternal and Child Welfare Centre ..... ☐ 6. Community Clinic..... ☐ 7. FWA ..... ☐ 8. HA ..... ☐ 9. Private Hospital ..... ☐ 10. NGO Clinic..... ☐ 11. Pharmacy ..... ☐ 12. Shops..... ☐	
Section 4.B: Duration of use of LAPMs			
406	Since how many years are you using the specific LAPMs (IUD, Implant/ Norplant, Tubectomy, Vasectomy)?	Years ..... ☐☐	
407	Have you ever switched off or stopped any specific LAPM ?	1. Yes ..... ☐ 2. No..... ☐ → 01A	
408	Which method did you switch off and which method did you take during last time?		
	Immediate past method(*use code) ☐	Current method* (use code) ☐	
	=1, Condom=2, Injection=3, IUD=4, Implant = 5, Tubectomy = 6, Vasectomy=7, Withdrawal =8, Safe period=9, None=10		
409	Why have you stopped or switched of to another method ? *[Multiple answers possible]*	1. Desire for children..... ☐ 2. Health cause ..... ☐ 3. LAPMs are not available ..... ☐ 4. Husband opposed..... ☐ 5. Family prohibition..... ☐ 6. Method failed..... ☐ 7. Lack of sexual satisfaction ..... ☐ 8. Myself did not like the method..... ☐ 9. Fear of side effect..... ☐ 10. To get rid of side effect ..... ☐ 11. Others (specify) ..... ☐	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
Section 5: Accessibility to LAPMs			
501 A	Did you contact anyone to get any LAPMs?	1. Yes ☐ 2. No ☐	→ 506
501B	With whom did you contact last?	1. FWA ☐ 2. HA ☐ 3. NGO worker ☐ 4. Others (Specify) ☐	
502	Where did you contact with him/her?	1. District hospital ☐ 2. Upazila Health Complex ☐ 3. Family Welfare Center ☐ 4. Community Clinic ☐ 5. NGO clinic ☐ 6. At home ☐ 7. Others (Specify) ☐	
503	When did you contact with him/her?	Months back…….. ☐☐☐	
504	Did they discuss about any LAPMs?	1. Yes ☐ 2. No ☐	→ 506
505	What was the content of the discussion?	1. About method ☐ 2. Advantages of LAPMs ☐ 3. Disadvantages of LAPMs ☐ 4. Sources of LAPMs ☐ 5. Duration of specific LAPMs ☐ 6. Complications of LAPMs ☐ 7. Management of complications of LAPMs ☐ 8. Others (Specify) ☐	
506	Did you visit FWC/CC/UHC/ District hospital/NGO clinic recently?	1. Yes ☐ 2. No ☐	→ 511
507	Which clinic did you visit last time?	1. FWC ☐ 2. CC ☐ 3. UHC ☐ 4. District hospital ☐ 5. NGO clinic ☐	
508	When did you visit to FWC/UHC/District hospital/NGO clinic/CC last time?	Months back…….. ☐	
509	What was the travelling time to that clinic/ hospitals?	Minutes ☐☐☐	
510	What was the purpose of visit to that clinic/ hospitals? *[Multiple answers possible]*	1. Receive LAPM services/advice ☐ 2. Other purpose ☐	} 512
511	What is the cause behind not visiting Clinic/ hospitals? *[Multiple answers possible]*	1. Far away ☐ 2. Community people dislike visiting there ☐ 3. Physical cause ☐ 4. Transport cost ☐ 5. Did not need to visit ☐ 6. Did not get desired methods ☐ 7. Behavior of service provider is not good ☐ 8. Sitting arrangement of FWC/NGO clinic/ CC is not good ☐ 9. FWC/NGO clinic/CC remains closed most of the time ☐ 10. Others (specify)	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
512	Did anyone discuss about LAPMs during last 3 months with you at home?	1. Yes ☐ 2. No ☐ →	601
513	Who discussed?	1. Family Welfare Assistant (FWA) ☐ 2. Health Assistant (HA) ☐ 3. NGO worker ☐ 4. Others ☐	
514	What was the content of the discussion	1. About method ☐ 2. Advantages and disadvantages of LAPMs ☐ 3. Sources of LAPMs ☐ 4. Duration of specific LAPMs ☐ 5. Complications of LAPMs ☐ 6. Management of complications ☐ 7. Others (Specify) ☐	
515	Did you visit FWC/UHC/ District hospital/NGO clinic to take any LAPMs services?	1. Yes ☐ → 2. No ☐	601
516	Why do you not visit UHC/Government Hospital/NGO clinic to get LAPMs? *[Multiple answers possible]*	1. Far away ☐ 2. Community people dislike visiting them ☐ 3. Physical cause ☐ 4. Transport cost ☐ 5. Did not need to visit ☐ 6. Not get desired LAPMs ☐ 7. Behavior of service provider is not good ☐ 8. Sitting arrangement is not good ☐ 9. Remains closed most of the time ☐ 10. Others (specify) ☐	
Section 6: Causes of choosing and not choosing LAPMs			
601	Did you and your spouse discussed about LAPMs during last 3 months?	1. Yes ☐ 2. No ☐ →	603
602	What was the content of the discussion?	1. Regarding use of specific LAPMs ☐ 2. Advantages of specific LAPMs ☐ 3. Disadvantages of specific LAPMs ☐ 4. Financial benefit of specific LAPMs ☐ 5. Others (Specify) ☐	
603	(**Interviewer:** Please checked question no. 404 whether the woman is a user or not)	1. Yes ☐ 2. No ☐ →	606
604	Who has taken decision to use the specific LAPMs? (IUD/Implant/Tubectomy/Vasectomy)	1. Self ☐ 2. Husband ☐ 3. Both ☐	
605	Why are you using the specific LAPMs? (IUD/Implant/Tubectomy/Vasectomy) *[Multiple answers possible]*	1. Long term and very much effective ☐ 2. Easy to take ☐ 3. Action starts immediately after use/taking ☐ 4. No difference appears in the breast milk after taking the method ☐ 5. Pregnancy capacity returns immediately after quitting the method ☐ 6. Does not create barriers to sexual intercourse ☐ 7. No hormonal problem ☐ 8. Free from everyday hazard of using condom or pill ☐	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
		9. No side effect.....☐ 10. Could be removed at any time.....☐ 11. Need not go to clinic or worker again and again except some follow up visit .....☐ 12. Do not reduce sexual intercourse power or ☐ physical strength.....☐ 13. Can return home after operation .....☐ 14. Availability of the methods ..... 15. Can get suggestion/help/services at any ☐ time from service center/ worker .....☐ 16. Others(specify)	
606	**Interviewer: Check Q. 402/404:** Whether the woman is using IUD at present?	1. Yes .....☐ 2. No .....☐	→ **608**
607	Why are you not using the IUD ? *[Multiple answers possible]*	1. Feeling of pain in lower abdomen/ stomachache .....☐ 2. Bleeding during menstruation.....☐ 3. Become pregnant instead of taking ☐ method ..... 4. It needs experienced worker to introduce ☐ and remove of method ..... 5. It needs to examine the string after each ☐ menstruation.....☐ 6. It does not protect from STD/HIV/ AIDS ..... 7. Increase risk of infection of reproductive ☐ organs .....☐ 8. Others (specify) .....☐	
608	**Interviewer:** Check **question no. 402 and 404**: whether woman is using Implant/Norplant at present?	1. Yes .....☐ 2. No .....☐	→ 610
609	Why are you not using the Implant/ Norplant? *[Multiple answers possible]*	1. Drop haemrrhage between two menstruation period.....☐ 2. Minor bleeding continues for a long time .....☐ 3. Stops menstruation.....☐ 4. Headache, vomiting tendency and weight gain .....☐ 5. Feeling of tiredness .....☐ 6. Heaviness /Pain in breast .....☐ 7. Hazard to go to health center to open and use of IUD .....☐ 8. Need small operation to take the Implant and to open it.....☐ 9. Transition, bleeding problem.....☐ 10.Others (specify) .....☐	
610	**Interviewer: Check Q. 404:** Whether the woman has done tubectomy or not?	3. Yes .....☐ 4. No .....☐	→ **612**
611	Why did you not do Tubectomy? *[Multiple answers possible]*	1. It needs to think before taking decision as it's a permanent method .....☐ 2. There have risk in spite of being a small operation.....☐ 3. Pain remains for a few days after operation.....☐	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
		4. Possibilities of Ectopic pregnancy ..... ☐ 5. Its need to come service center for operation ..... ☐ 6. Its need trained doctor and assistant..... ☐ 7. It does not protect STD/HIV/AIDS ..... 8. Others (specify)	
612	**Interviewer: Check Q. 404:** Whether the husband of woman has done vasectomy or not?	1. Yes ..... ☐ 2. No ..... ☐	→ 701
613	Why did you not do Vasectomy? *[Multiple answers possible]*	1. It is not possible to take child again as it is a permanent method..... ☐ 2. There have risk in spite of being a small operation ..... ☐ 3. It does not work immediately after operation, have to wait 3 months to be effective of the method and need to use condom for physical intercourse during this time ☐ 4. Its need to come service center for operation ..... ☐ 5. Its need trained doctor and assistant ..... ☐ 6. It does not protect STD/HIV/AIDS ..... 7. Others (specify)	
Section 7: Cultural Reasons and Misbelieves Regarding not using LAPMs			
701	What are the socio-cultural reasons that create barrier to take LAPMs? *[Multiple answers possible]*	1. Husband does not like it ..... ☐ 2. I myself do not like it ..... ☐ 3. Father-in-law/mother-in-law does not like it ..... ☐ 4. Community people/Neighbouring people do not like it ..... ☐ 5. Those who take LAPMs suffer from various health hazards like, stomache, pain in the waist, loss of sexual power, etc. ..... ☐ 6. Others (specify)	
702	Are their any misbelieves that create barriers taking LAPMs? *[Multiple answers possible]*	1. Taking LAPMs is a sin in the eye of religion ..... ☐ 2. Child died who take LAPMs ..... 3. Children is the gift of Allah so one should not take LAPMs ..... ☐ 4. Others (specify)	
703	What according to you are the reasons for non-use of LAPMs in your locality? *[Multiple answers possible]*	1. People prefer larger family size..... ☐ 2. LAPM methods are not easily available..... ☐ 3. Against religion ..... ☐ 4. Husband opposes ☐ 5. Community prohibition ..... ☐ 6. Have many side effects ☐ 7. Management of side-effect is difficult ..... ☐ 8. Service Center is not easy to reach..... ☐ 9. Front line workers are not proactive ..... ☐ 10. Lack of awarness about small family..... ☐ 11. Senior family members opposed..... ☐ 12. Don't know ..... ☐ 13. Others (specify) ..... ☐	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
Section 8: Future Intention to use LAPMs			
801 A	**Interviewer: Check Q. 402 and 404:** Whether the respondents and her husband is a LAPMs user or not?	1. Yes ☐ → 901 2. No ☐	
801 B	Do you and your husband intend to use any LAPMs in future?	1. Yes ☐ 2. No ☐ → 803	
802	Which LAPMs do you intend to use?	1. IUD ☐ 2. Implant ☐ 3. Tubectomy ☐ 4. Vasectomy ☐	→ 901
803	Why do you not intend to use LAPMs? *[Multiple answers possible]*	1. Want a children ☐ 2. Want a son ☐ 3. Want a daughter ☐ 4. Lack of knowledge ☐ 5. Cost too much ☐ 6. Worry about side effects ☐ 7. Hard to get methods ☐ 8. Against religion ☐ 9. Husband opposed ☐ 10. Other people opposed ☐ 11. Community prohibition ☐ 12. Health does not permit ☐ 13. Don't like existing method ☐ 14. Others (specify) ☐	
Section 9: Suggestions			
901.	What are your suggestions regarding increasing knowledge of people on LAPMs? *[Multiple answers possible]*	1. Publicity through print and electronics media ☐ 2. To organize campaign on LAPMs ☐ 3. Include in the school and college text book ☐ 4. Inform through government and NGO health and family workers ☐ 5. Increase awarness on LAPMs among community leaders ☐ 6. Others (Specify) ☐	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
902.	What are your suggestions for increasing use of LAPMs in your locality? *[Multiple answers possible]*	1. LAPMs service center should be set up near by ..... ☐ 2. Some programme should be started to create awareness among mass people ..... ☐ 3. Inform people that LAPMs is not harmful for female & male..... ☐ 4. FWC/Community Clinic should be open timely ..... ☐ 5. LAPMs should be available in FWCs and CCs ..... ☐ 6. FWA/HA should visit home more frequently ..... ☐ 7. Motivate males to use LAPMs..... ☐ 8. Late pregnancy after first child should be encouraged ..... ☐ 9. To create awarness in community that repeated pregnancy is harmfulfor health..... ☐ 10. Arrange courtyard meetings with females on LAPMs ..... ☐ 11. FP worker should make regular door- to-door visit.to collect information about the situation of LAPMs,..... ☐ 12. Provide services on a wide range of LAPMs through mobile outreach/camps ..... ☐ 13. Awareness raising campaign to be undertaken involving community influentials & religious leaders..... ☐ 14. Others (Specify)..... ☐	

End of Interview (Time): Hour……Min…….

THANK YOU

DCI- 2

ID No.	

Study on Access the Constraints to Promote Long-Acting and Permanent Contraceptive Methods (LAPMs)

Questionnaire for Interview of MO-MCH

INSTRUCTION TO THE INTERVIEWER
Check whether: 1. The permission of respondent has been sought; 2. The respondent has been informed that his/her identity will be kept confidential; 3. The objectives of the study have been explained.

Name of the Respondent: ……

Place of posting: Upazila:……District:……Division:……

Type of Clinic: MCWC=1, Upazilla Health Complex=2,

Name of Interviewer: ……..

Signature of Interviewer: ……..... Date: ……..

Study undertaken for

National Institute of Population Research and Training (NIPORT)

Study conducted by

Human Development Research Centre (HDRC)

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Dhaka, June 2013

I. Population Served, Service Provision and Manpower

<table>
<tr><th>Sl. no.</th><th>Question and Response</th><th>Skip</th></tr>
<tr><td>101</td><td>How many eligible couples are using LAPMs in your upazila during the last year (2012) and who have provided?
Code: Doctor= 1, FWV= 2, Nurse= 3, Others= 4.
<table><tr><th>Name of LAPMs</th><th>Who have Provided? (Use code)</th><th>Number (in 2012)</th></tr><tr><td>1 IUD</td><td></td><td></td></tr><tr><td>2 Implants</td><td></td><td></td></tr><tr><td>3 Tubectomy</td><td></td><td></td></tr><tr><td>4 Vasectomy</td><td></td><td></td></tr></table></td><td></td></tr>
<tr><td>102</td><td>Do you have any shortage in manpower in your clinic for provision of LAPMs?
Yes =1
No =2</td><td>

→104</td></tr>
<tr><td>103</td><td>Which manpower do you have shortage in your clinic for provision of LAPMs?
Trained doctor for outdoor=1
Trained FWV for outdoor=2
Trained doctor for provision of Implants, Tubectomy and Vasectomy=3
Trained FWV for provision of IUD and OT assistance=4
Trained manpower for handling sterilizer=5
Aya=6
Male OT Nurse=7
Sweeper=8</td><td></td></tr>
<tr><td>104.</td><td>Do you have training on providing LAPMs?
Yes=1
No=2</td><td></td></tr>
<tr><td>105.</td><td>Do you provide LAPMs in clinic in your own hand?
Yes=1
No=2</td><td></td></tr>
<tr><td>106.</td><td>Was there any camp organized for providing LAPMs?
Yes=1
No=2</td><td>

→ 215</td></tr>
<tr><td>107.</td><td>If yes, How many Camps have you organized during last year (2012)?
<table><tr><th>Name of LAPM</th><th>Number of Camps (2012)</th></tr><tr><td>a. IUD</td><td></td></tr><tr><td>b. Implant</td><td></td></tr><tr><td>c. Tubectomy</td><td></td></tr><tr><td>d. Vasectomy</td><td></td></tr></table></td><td></td></tr>
<tr><td>108.</td><td>What are the causes behind not doing any camp on LAPMs?
Shortage of trained manpower=1
Shortage of vehicle=2
Shortage of MSR=3
Shortage of long acting method=4
Lack of initiative from UFPO/field force=5
Low/ No incentive for these type of works=6
Peoples of these area is very conservative=7
Others (specify)……=8</td><td></td></tr>
</table>

II. Supply of LA Methods and MSR for LAPM

201.	Do you have any shortage of IUD methods right now? Yes=1 No=2	
202.	Do you have any shortage of Implant methods right now? Yes=1 No=2	
203	Do you get adequate supply of long acting methods as per demand on regular basis? Yes=1 No=2	
204	Do you have any shortage of MSR for LAPM right now? Yes=1 No=2 → 206	
205	Which MSR for LAPM do you have shortage now? (If any shortage, please make circle)	

A. MSR for IUD methods:

IUD Table	1
Spot light/ Touch light	2
Sponge holding forsep	3
Small, middle & big size bi bulb, cuscose speculum	4
Tenaculum/ Volselam	5
Uterine sound	6
Scissors	7
straight artery forsep	8
Gloves	9
Surgical trey with cover for preserve equipment	10
Gully pot for preserve cotton ball	11
Cotton ball	12
Povidine iodine	13
IUD sterilizer (with 3 rack)	14
kerosene Stove	15

B. MSR for Implant methods:

O.T. Table	1
Harms rest table	2
Germs free Gloves	3
Soap	4
Antiseptic Solution (Povidine iodine, Clorohexadine)	5
1% Lidoceine with local anesthetic adrenaline	6
5 CC Disposable syringe (2.5-4c.m long)	7
10 No. Tracer with planser and Canola	8
Template (Only applicable for Norplant's)	9
B.P. Blade	10
Sponge holding forsep	11
astomeric dressing matrix (Size 10 cm × 5 cm) or band -Aid or germs free bandage with surgical tape	12
For managing emergency situation (Anfilecotic shock)	13
Injection Promethazine hydrochloride (25 mg- 2 ampule)	14
Injection Hydrocortisone (100 mg)- 2 Veale/ ampule	15
Injection Adrenaline (1: 1000)- 2 Veale/ ampule	16

C. MSR for Tubectomy methods:

Medicine	
Injection Atropine sulfate (0.6 mg/ ml)	1
Injection Promethazine (12.5 mg/ ml)	2
(a) Injection Pathidine (25 mg/ ml) or (b) Injection Pentagocin (30 mg/ ml)	3

Injection Xyilocaion (1%, 50 ml)	4	
Capsule Amoxicillin or any others Broad-spectrum	5	
Tablet Diazepam (5 mg/ tablet)	6	
Tablet Paracetamol (500 mg/ tablet)	7	
Tablet Iron + Folic aside	8	
Surgical Equipments		
Cotton (100 gm)	9	
Surgical bandage (20 yards/ edge)	10	
Chromic catgut (sterile, 1-0, 152 cm)	11	
Povidine iodine solution (100 ml)	12	
Surgical gloves (size 6.5)	13	
Surgical gloves (size 7)	14	
Disposable sterile syringe (10 CC)	15	
Disposable sterile syringe (5 CC)	16	
Surgical blade (sterile, size-10)	17	
Uristic GP-2 (for glucose & albumin test)	18	
Sterile disposable lancet	19	
Elastomeric dressing matrix (duo-durm, Size 10 cm × 10 cm)	20	
Talquist book	21	
Cutting curved needle	22	
Cutting straight needle	23	
Curved round body needle	24	
Silk thread (1-0)	25	

D. MSR for Vasectomy methods:

Medicine	
Injection Xylocaion (1%, 50 ml)	1
Capsule Amoxicillin or any others Broad-spectrum (Doze for 7 days)	2
Tablet Paracetamol (500 mg/ tablet)	3
Tablet Vitamin B-complex	4
Surgical Equipments	
Cotton (100 gm)	5
Surgical bandage (20 yards/ edge)	6
Povidine iodine solution (100 ml)	7
Surgical gloves (size 6.5)	8
Surgical gloves (size 7)	9
Disposable sterile syringe (5 CC)	10
Uristic GP-2 (for glucose & albumin test)	11
Elastomeric dressing matrix (duo-durm, size 10 cm × 05 cm)	12
Sterile disposable lancet	13
Talquist book	14
Lungee	15
Condom	16
Silk thread (1/20)	17

E. MSR for managing emergency situation:

(a). Emergency equipment (which are use in long time)	
Oxygen therapy unit	
(c) Filled up Oxygen cylinder	1
(d) Cylinder stand or trolley	2
(c). Therapy set:	
Presser meter	3
Flow meter and control bulb	4
Cylinder key (it may be attached with cylinder)	5
Face musk with tube	6
Water bottle with ring	7
Airway tube	8

		Suction machine (electric/ manual) (If suction machine are available then one MR syringe and catheter is necessary)	9		
		Manual resuscitator or Ambubag	10		
		Emergency light (3 battery touch lighter or rechargeable electric touch lighter)	11		
		Metallic catheter (for women)			
		Laperetomy set (with venisection kit vain- flow)	13		
		(b). Emergency MSR which will be re-disposable placement if used once times			
		Atromatic catgut (‘0’)	2		
		Ryles cube	3		
		Folleys catheter	4		
		Elastic catheter	5		
		(c). List of Emergency medicine			
		Naloxone injection (0.4 Mg/ ml)	6		
		Epinephrine (Adrenaline 1:1000) 1 mg/ ml injection	7		
		Hydrocortisone injection (100 mg)	8		
		Promethazine injection (25 mg/ml)	9		
		5% Dextrose in normal saline (500 ml bag)	10		
		Normal saline (500 ml bag)	11		
		Diazepam injection (10 mg/ml)	12		
		10% Calcium goconate injection (10 ml/ ampule)	13		
		7.5% Sodium-bi carbonate injection (25 ml/ ampule)	14		
		Aminophyline injection (250 mg/10 ml)	15		
		Atropine injection (0.6 mg/ ml)	16		
		Fisostigomine injection (1 mg/ml)	17		
		Butterfly infusion Set	18		
		Sterile disposable syringe, 2/5/10/50 ml size	19		
206	Is the sterilizer of your clinic working properly? Yes=1 No=2				

III. Compensation for LAPMs

301 What compensation in terms of money and materials are the women and men getting for accepting LAPM?

LAPMs	Money (amount in Tk.)	Materials*
a. IUD		
b. Implants		
c. Tubectomy		
d. Vasectomy		

*(Sharee=1, Lungi=2, None=3)

302 Do you think the compensation provided to women and men for LAPMs is adequate?
Yes=1
No=2 → 304

303 What should the amount of compensation?

LAPMs	Money (Tk.)	Materials		
		Sharee	Lungi	Others (specify)
a. IUD				
b. Implants				
c. Tubectomy				
d. Vasectomy				

304	What amount of money are the providers getting for providing LAPM? LAPMs / Money (amount in Tk.) a. IUD b. Implants c. Tubectomy d. Vasectomy	
305	What amount of referral fee are the referees getting for providing LAPM? LAPMs / Money (amount in Tk.) a. IUD b. Implants c. Tubectomy d. Vasectomy	

IV. Disadvantage, Misunderstanding and Reasons for not accepting LAPMs

401.	What are the reasons for not accepting IUD and Implants in couples having one child in your area? (If yes, please make circle)		Skip
	Reasons		
	IUD		
	Feeling of pain in lower abdomen	1	
	Increased bleeding during menstruation	2	
	Sometimes IUD comes outside of vagina	3	
	Become pregnant instead of taking IUD	4	
	Sometimes vagina becomes damaged	5	
	Needs experienced worker to take and remove of IUD	6	
	Need to examine the string after each menstruation	7	
	It does not protect STD/HIV/AIDS	8	
	Reproductive organs transition risks increase	9	
	Others(specify)……..	10	
	Implants		
	Drop hemorrhage between two menstrual period	1	
	Little bleeding for a long time	2	
	Stopped menstruation	3	
	Headache, vomiting tendency and weight gain	4	
	Feeling of tiredness	5	
	Weighty /Pain in breast	6	
	Hazard to open and use self	7	
	Need small operation to take and open	8	
	Transition, bleeding problem	9	
	Does not protect STD/HIV/AIDS	10	
	Others (specify) ……	11	
402	at are the reasons for not accepting tubectomy / vasectomy in couples having two children in your area? (If yes, please make circle)		
	Reasons		
	Tubectomy		
	Need to think before taking decision as it's a permanent method	1	
	Have risk in spite of being a small operation	2	
	Pain remains for a few days after operation	3	
	Possibilities of Ectopic pregnancy	4	
	Need to come to service center for operation	5	

	Need trained doctor and assistant	6	
	Does not protect STD/HIV/AIDS	7	
	Others (specify)	8	
	Vasectomy		
	It is not possible to take child again as it is a permanent method	1	
	There have some risk in spite of being a small operation	2	
	It does not work immediately after operation	3	
	Have to wait for 3 months to be effective	4	
	Need to use condom for intercourse before it become effective	5	
	Need to come to service center for operation	6	
	Need trained doctor and assistant	7	
	Does not protect STD/HIV/AIDS	8	
	Others (specify)	9	
403	What problems do you face in provision of LAPM service?		
	1.		
	2.		
	3.		
	4.		
	5.		
404	What steps should be taken for solving the problems in LAPMs service provision and increase its acceptance?		
	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
	7.		

Thanks for your cordial cooperation

DCI- 3

ID No.	

Study on Access the Constraints to Promote Long-Acting and Permanent Contraceptive Methods (LAPMs)

Questionnaire for Interview of UFPO

INSTRUCTION TO THE INTERVIEWER

Check whether:

4. The permission of respondent has been sought;
5. The respondent has been informed that his/her identity will be kept confidential;
6. The objectives of the study have been explained.

Name of the Respondent: ……

Place of posting:

Upazila:……District:……Division:……

Name of Interviewer: ……..

Signature of Interviewer: ……..... Date: ……..

Study undertaken for:

National Institute of Population Research and Training (NIPORT)

Study conducted by:

Human Development Research Centre (HDRC)
Road # 8, House #5, Mohammadia Housing Society,
Mohammadpur, Dhaka –1207, Bangladesh
Phone: (880 2) 8116972, 8157621, Fax: (880 2) 8157620
E-mail: info@hdrc-bd.com
Website: www.hdrc-bd.com

Dhaka, June 2013

I. Population Served, Service Provision and Manpower

<table>
<tr><th>Sl. no.</th><th>Question</th><th>Skip</th></tr>
<tr><td>101.</td><td>What is the population of your catchment area?
a. Male: …….
b. Female: ……..</td><td></td></tr>
<tr><td>102.</td><td>How many eligible couples are there in your working area?
# …….
DK= 9</td><td></td></tr>
<tr><td>103.</td><td>How many eligible couples are using any FP method in your working area at present? (Collect information from monthly MIS report)
<table>
<tr><th>Name of FP methods</th><th>Quantity</th></tr>
<tr><td>1. Oral pill</td><td></td></tr>
<tr><td>2. Condom</td><td></td></tr>
<tr><td>3. Injection</td><td></td></tr>
<tr><td>4. IUD</td><td></td></tr>
<tr><td>5. Implant</td><td></td></tr>
<tr><td>6. Tubectomy</td><td></td></tr>
<tr><td>7. Vasectomy</td><td></td></tr>
<tr><td>8. Others (Specify)……</td><td></td></tr>
</table></td><td></td></tr>
<tr><td>104</td><td>What is the total approved manpower (FWAs) in your upazila for informing people about LAPMs? #……</td><td></td></tr>
<tr><td>105</td><td>What is the current manpower (FWAs) in your upazila for informing people about LAPMs? #……</td><td></td></tr>
<tr><td>106</td><td>What is the total approved manpower (FWVs) in your upazila for informing people about LAPMs? #……</td><td></td></tr>
<tr><td>107</td><td>What is the current manpower (FWVs) in your upazila for informing people about LAPMs? #……</td><td></td></tr>
<tr><td>108</td><td>Was there any Camp arranged in your upazila for providing LAPMs?
Yes=1
No=2</td><td>→110</td></tr>
<tr><td>109</td><td>If yes, how many Camps have been arranged during last one year (2012) for providing LAPMs?
<table>
<tr><th>Name of LAPM provided in Camp</th><th>Number of Camps</th></tr>
<tr><td>a. IUD</td><td></td></tr>
<tr><td>b. Implant</td><td></td></tr>
<tr><td>c. Tubectomy</td><td></td></tr>
<tr><td>d. Vasectomy</td><td></td></tr>
</table></td><td></td></tr>
<tr><td>110</td><td>If no, what are the causes behind not arranging any camp on LAPMs?
Shortage of trained manpower=1
Shortage of vehicle=2
Shortage of MSR=3
Shortage of long acting method=4
Lack of initiative from MO-MCH=5
Lack of initiative from field workers=6
Low/ No incentive for these type of works=7
Peoples of these area is very conservative=8
Others (specify)……=9</td><td></td></tr>
</table>

III. Supply of LA methods and MSR for LAPM

201.	Do you have any shortage of IUD methods right now? Yes=1 No=2	
202	Do you have any shortage of Implant methods right now? Yes=1 No=2	
203	Do you get adequate supply of long acting methods as per demand on regular basis? Yes=1 No=2	
204	Do you have any shortage of MSR for LAPM right now? Yes=1 No=2 →	206
205	Which MSR for LAPM do you have shortage now? (if any shortage, please make circle)	

F. MSR for IUD methods:

IUD Table	16
Spot light/ Touch light	17
Sponge holding forsep	18
Small, middle & big size bi bulb, cuscose speculum	19
Tenaculum/ Volselam	20
Uterine sound	21
Scissors	22
straight artery forsep	23
Gloves	24
Surgical trey with cover for preserve equipment	25
Gully pot for preserve cotton ball	26
Cotton ball	27
Povidine iodine	28
IUD sterilizer (with 3 rack)	29
kerosene Stove	30

G. MSR for Implant methods:

O.T. Table	17
Harms rest table	18
Germs free Gloves	19
Soap	20
Antiseptic Solution (Povidine iodine, Clorohexadine)	21
1% Lidoceine with local anesthetic adrenaline	22
5 CC Disposable syringe (2.5-4c.m long)	23
10 No. Tracer with planser and Canola	24
Template (Only applicable for Norplant's)	25
B.P. Blade	26
Sponge holding forsep	27
lastomeric dressing matrix (Size 10 cm × 5 cm) or band –Aid or germs free bandage with surgical tape	28
For managing emergency situation (Anfilecotic shock)	29
Injection Promethazine hydrochloride (25 mg- 2 ampule)	30
Injection Hydrocortisone (100 mg)- 2 Veale/ ampule	31
Injection Adrenaline (1: 1000)- 2 Veale/ ampule	32

H. MSR for Tubectomy methods:

Medicine	
Injection Atropine sulfate (0.6 mg/ ml)	26
Injection Promethazine (12.5 mg/ ml)	27
(a) Injection Pathidine (25 mg/ ml) or (b) Injection Pentagocin (30 mg/ ml)	28
Injection Xyilocaion (1%, 50 ml)	29

Capsule Amoxicillin or any others Broad-spectrum	30	
Tablet Diazepam (5 mg/ tablet)	31	
Tablet Paracetamol (500 mg/ tablet)	32	
Tablet Iron + Folic aside	33	
Surgical Equipments		
Cotton (100 gm)	34	
Surgical bandage (20 yards/ edge)	35	
Chromic catgut (sterile, 1-0, 152 cm)	36	
Povidine iodine solution (100 ml)	37	
Surgical gloves (size 6.5)	38	
Surgical gloves (size 7)	39	
Disposable sterile syringe (10 CC)	40	
Disposable sterile syringe (5 CC)	41	
Surgical blade (sterile, size-10)	42	
Uristic GP-2 (for glucose & albumin test)	43	
Sterile disposable lancet	44	
Elastomeric dressing matrix (duo-durm, Size 10 cm × 10 cm)	45	
Talquist book	46	
Cutting curved needle	47	
Cutting straight needle	48	
Curved round body needle	49	
Silk thread (1-0)	50	

I. MSR for Vasectomy methods:

Medicine	
Injection Xylocaion (1%, 50 ml)	5
Capsule Amoxicillin or any others Broad-spectrum (Doze for 7 days)	6
Tablet Paracetamol (500 mg/ tablet)	7
Tablet Vitamin B-complex	8
Surgical Equipments	
Cotton (100 gm)	5
Surgical bandage (20 yards/ edge)	6
Povidine iodine solution (100 ml)	7
Surgical gloves (size 6.5)	8
Surgical gloves (size 7)	9
Disposable sterile syringe (5 CC)	10
Uristic GP-2 (for glucose & albumin test)	11
Elastomeric dressing matrix (duo-durm, size 10 cm × 05 cm)	12
Sterile disposable lancet	13
Talquist book	14
Lungee	15
Condom	16
Silk thread (1/20)	17

J. MSR for managing emergency situation:

(a). Emergency equipment (which are use in long time)	
Oxygen therapy unit	
(e) Filled up Oxygen cylinder	20
(f) Cylinder stand or trolley	21
. Therapy set:	
Presser meter	22
Flow meter and control bulb	23
Cylinder key (it may be attached with cylinder)	24
Face musk with tube	25

		Water bottle with ring	26	
		Airway tube	27	
		Suction machine (electric/ manual) (If suction machine are available then one MR syringe and catheter is necessary)	28	
		Manual resuscitator or Ambubag	29	
		Emergency light (3 battery touch lighter or rechargeable electric touch lighter)	30	
		Metallic catheter (for women)	31	
		Laperetomy set (with venisection kit vain- flow)	32	
		(b). Emergency MSR which will be re-disposable placement if used once times		
		Atromatic catgut ('0')	33	
		Ryles cube	34	
		Folleys catheter	35	
		Elastic catheter	36	
		List of Emergency medicine		
		Naloxone injection (0.4 Mg/ ml)	37	
		Epinephrine (Adrenaline 1:1000) 1 mg/ ml injection	38	
		Hydrocortisone injection (100 mg)	39	
		Promethazine injection (25 mg/ml)	40	
		5% Dextrose in normal saline (500 ml bag)	41	
		Normal saline (500 ml bag)	42	
		Diazepam injection (10 mg/ml)	43	
		10% Calcium goconate injection (10 ml/ ampule)	44	
		7.5% Sodium-bi carbonate injection (25 ml/ ampule)	45	
		Aminophyline injection (250 mg/10 ml)	46	
		Atropine injection (0.6 mg/ ml)	47	
		Fisostigomine injection (1 mg/ml)	48	
		Butterfly infusion Set	49	
		Sterile disposable syringe, 2/5/10/50 ml size	50	
206.	Is the sterilizer of your clinic working properly? Yes=1 No=2			

IV. Compensation and BCC

301 What compensation in terms of money and materials are the women and men getting for accepting LAPMs?

LAPMs	Money (amount in Tk.)	Materials*
a. IUD		
b. Implants		
c. Tubectomy		
d. Vasectomy		

*(Sharee=1, Lungi=2, None=3)

302 Do you think the compensation provided to women and men for LAPMs is adequate?
Yes=1
No=2 → 304

303 What should be amount of compensation?

LAPMs	Money (Tk.)	Materials		
		Sharee	Lungi	Others (specify)
a. IUD				
b. Implants				
c. Tubectomy				
d. Vasectomy				

304	What amount of money is the main provider getting for providing LAPM? LAPMs / Money (Amount in Tk.) a. IUD b. Implants c. Tubectomy d. Vasectomy	
305.	What amount of referral fee are the referees getting for providing LAPM? LAPMs / Money (amount in Tk.) e. IUD f. Implants g. Tubectomy h. Vasectomy	
306	Is there any initiative or BCC activity in your working area to make the clients aware of LAPMs? Yes=1 No=2	→ 308
307	If yes, how the clients are made aware of the methods and motivated to accept the LAPMs? Interpersonal/Counseling=1 Meeting in groups/ Uthan Baithak=2 Radio=3 TV=4 Poster=5 Others (specify)……. =6	
308	Which one is the most effective method in your opinion for promoting LAPMs? Interpersonal/Counseling=1 Meeting in groups/ Uthan Baithak=2 Radio=3 TV=4 Poster=5 Others (specify)……. =6	
309	Do you have any innovative BCC activities in your mind for promoting LAPMs? Yes=1 No=2	→ 401
310	If yes, please explain the innovative BCC activities? 1. ---------- 2. ---------- 3. ---------- 4. ----------	

IV. Disadvantage, Misunderstanding and Reasons for not accepting LAPMs

401.	What are the reasons for not accepting IUD and Implants in couples having one child in your area? (If yes, please make circle)		Skip
	Reasons		
	IUD		
	Feeling of pain in lower abdomen	1	
	Increased bleeding during menstruation	2	
	Sometimes IUD comes outside of vagina	3	
	Become pregnant instead of taking IUD	4	
	Sometimes vagina becomes damaged	5	
	Needs experienced worker to take and remove of IUD	6	

	Need to examine the string after each menstruation	7	
	It does not protect STD/HIV/AIDS	8	
	Reproductive organs transition risks increase	9	
	Others (specify)……..	10	
	Implants		
	Drop hemorrhage between two menstrual period	1	
	Little bleeding for a long time	2	
	Stopped menstruation	3	
	Headache, vomiting tendency and weight gain	4	
	Feeling of tiredness	5	
	Weighty /Pain in breast	6	
	Hazard to open and use self	7	
	Need small operation to take and open	8	
	Transition, bleeding problem	9	
	Does not protect STD/HIV/AIDS	10	
	Others (specify) ……	11	
402	What are the reasons for not accepting tubectomy / vasectomy in couples having two children in your area? (If yes, please make circle)		
	Reasons		
	Tubectomy		
	Need to think before taking decision as it's a permanent method	1	
	Have risk in spite of being a small operation	2	
	Pain remains for a few days after operation	3	
	Possibilities of Ectopic pregnancy	4	
	Need to come to service center for operation	5	
	Need trained doctor and assistant	6	
	Does not protect STD/HIV/AIDS	7	
	Others (specify)	8	
	Vasectomy		
	It is not possible to take child again as it is a permanent method	1	
	There have some risk in spite of being a small operation	2	
	It does not work immediately after operation	3	
	Have to wait for 3 months to be effective	4	
	Need to use condom for intercourse before it become effective	5	
	Need to come to service center for operation	6	
	Need trained doctor and assistant	7	
	Does not protect STD/HIV/AIDS	8	
	Others (specify)	9	
403	What problems do you face in provision of LAPM service?		
	6.		
	7.		
	8.		
	9.		
	10.		
404	What steps should be taken for solving the problems in LAPMs service provision and increase its acceptance?		
	8.		
	9.		
	10.		
	11.		
	12.		
	13.		
	14.		

Thanks for your cordial cooperation

DCI- 4

ID No.	

Study on Access the Constraints to Promote Long-Acting and Permanent Contraceptive Methods (LAPMs)

Questionnaire for Interview of FWV

INSTRUCTION TO THE INTERVIEWER

Check whether:

7. The permission of respondent has been sought;
8. The respondent has been informed that his/her identity will be kept confidential;
9. The objectives of the study have been explained.

Name of the Respondent: ……

Place of posting:

Union……..Upazila:……District:……Division:……

Type of Clinic: FWC=1, CC=2, MCWC=3, Upazilla Health Complex=4

Name of Interviewer: ……..

Signature of Interviewer: ……..... Date: ……..

Study undertaken for:

National Institute of Population Research and Training (NIPORT)

Study conducted by:

Human Development Research Centre (HDRC)

Road # 8, House #5, Mohammadia Housing Society,
Mohammadpur, Dhaka –1207, Bangladesh
Phone: (880 2) 8116972, 8157621, Fax: (880 2) 8157620
E-mail: info@hdrc-bd.com; *Website:* www.hdrc-bd.com

Dhaka, June 2013

I. Population Served, Service Provision and Manpower

Sl. no.	Question and Response	Skip
101.	What is the population of your catchment area? a. Total: …… b. Male: …… c. Female: ..……..	
102.	How many eligible couples are there in your catchment area? ……couples.	
103.	What are the prime causes behind discontinuation of the long acting methods? 1. …… 2. …… 3. …… 4. ……	
104.	Have you got refresher training on LAPMs? Yes=1 No=2	→ 106
105.	If yes, on which subject and for how many days? Subjects — Days 1…….. …… 2. …….. …… 3. …….. …… 4. …… ……..	
106.	Do you provide IUD and Implant in clinic? IUD=1 Implant=2 None=3	
107.	Do you provide IUD and Implant through Camps? IUD=1 Implant=2 Camps not done=9	→ 109
108.	How many Camps did you attend during last three months? #……. Camps not done=9	
109.	What are causes behind not arranging camps during last three months? 1. …… 2. …… 3. …… 4. ……	

II. Supply of LA methods and MSR for LAPM

201.	Do you have any shortage of IUD right now? Yes=1 No=2	
202.	Do you have any shortage of Implant right now? Yes=1 No=2	
203	Do you get adequate supply of long acting methods as per demand on regular basis? Yes=1 No=2	
204.	Do you have any shortage of MSR for IUD and Implant right now? Yes=1 No=2	→ 206

205. Which MSR for LAPM do you have shortage now? (If any shortage, please make circle)

K. MSR for IUD methods:

IUD Table	31
Spot light/ Touch light	32
Sponge holding forsep	33
Small, middle & big size bi bulb, cuscose speculum	34
Tenaculum/ Volselam	35
Uterine sound	36
Scissors	37
straight artery forsep	38
Gloves	39
Surgical trey with cover for preserve equipment	40
Gully pot for preserve cotton ball	41
Cotton ball	42
Povidine iodine	43
IUD sterilizer (with 3 rack)	44
kerosene Stove	45

L. MSR for Implant methods:

O.T. Table	33
Harms rest table	34
Germs free Gloves	35
Soap	36
Antiseptic Solution (Povidine iodine, Clorohexadine)	37
1% Lidoceine with local anesthetic adrenaline	38
5 CC Disposable syringe (2.5-4c.m long)	39
10 No. Tracer with planser and Canola	40
Template (Only applicable for Norplant's)	41
B.P. Blade	42
Sponge holding forsep	43
astomeric dressing matrix (Size 10 cm × 5 cm) or band -Aid or germs free bandage with surgical tape	44
For managing emergency situation (Anfilecotic shock)	45
Injection Promethazine hydrochloride (25 mg- 2 ampule)	46
Injection Hydrocortisone (100 mg)- 2 Veale/ ampule	47
Injection Adrenaline (1: 1000)- 2 Veale/ ampule	48

M. MSR for Tubectomy methods:

Medicine	
Injection Atropine sulfate (0.6 mg/ ml)	51
Injection Promethazine (12.5 mg/ ml)	52
(a) Injection Pathidine (25 mg/ ml) or (b) Injection Pentagocin (30 mg/ ml)	53
Injection Xyilocaion (1%, 50 ml)	54
Capsule Amoxicillin or any others Broad-spectrum	55
Tablet Diazepam (5 mg/ tablet)	56
Tablet Paracetamol (500 mg/ tablet)	57
Tablet Iron + Folic aside	58
Surgical Equipments	
Cotton (100 gm)	59
Surgical bandage (20 yards/ edge)	60
Chromic catgut (sterile, 1-0, 152 cm)	61
Povidine iodine solution (100 ml)	62
Surgical gloves (size 6.5)	63
Surgical gloves (size 7)	64
Disposable sterile syringe (10 CC)	65
Disposable sterile syringe (5 CC)	66
Surgical blade (sterile, size-10)	67

		Uristic GP-2 (for glucose & albumin test)	68	
		Sterile disposable lancet	69	
		Elastomeric dressing matrix (duo-durm, Size 10 cm × 10 cm)	70	
		Talquist book	71	
		Cutting curved needle	72	
		Cutting straight needle	73	
		Curved round body needle	74	
		Silk thread (1-0)	75	

N. MSR for Vasectomy methods:

Medicine	
Injection Xylocaion (1%, 50 ml)	9
Capsule Amoxicillin or any others Broad-spectrum (Doze for 7 days)	10
Tablet Paracetamol (500 mg/ tablet)	11
Tablet Vitamin B-complex	12
Surgical Equipments	
Cotton (100 gm)	5
Surgical bandage (20 yards/ edge)	6
Povidine iodine solution (100 ml)	7
Surgical gloves (size 6.5)	8
Surgical gloves (size 7)	9
Disposable sterile syringe (5 CC)	10
Uristic GP-2 (for glucose & albumin test)	11
Elastomeric dressing matrix (duo-durm, size 10 cm × 05 cm)	12
Sterile disposable lancet	13
Talquist book	14
Lungee	15
Condom	16
Silk thread (1/20)	17

O. MSR for managing emergency situation:

(a). Emergency equipment (which are use in long time)	
Oxygen therapy unit	
(g) Filled up Oxygen cylinder	51
(h) Cylinder stand or trolley	52
(c). Therapy set:	
Presser meter	53
Flow meter and control bulb	54
Cylinder key (it may be attached with cylinder)	55
Face musk with tube	56
Water bottle with ring	57
Airway tube	58
Suction machine (electric/ manual) (If suction machine are available then one MR syringe and catheter is necessary)	59
Manual resuscitator or Ambubag	60
Emergency light (3 battery touch lighter or rechargeable electric touch lighter)	61
Metallic catheter (for women)	62
Laperetomy set (with venisection kit vain- flow)	63
(b). Emergency MSR which will be re-disposable placement if used once times	
Atromatic catgut (‘0’)	64
Ryles cube	65
Folleys catheter	66
Elastic catheter	67
(c). List of Emergency medicine	
Naloxone injection (0.4 Mg/ ml)	68
Epinephrine (Adrenaline 1:1000) 1 mg/ ml injection	69
Hydrocortisone injection (100 mg)	70
Promethazine injection (25 mg/ml)	71

		5% Dextrose in normal saline (500 ml bag)	72	
		Normal saline (500 ml bag)	73	
		Diazepam injection (10 mg/ml)	74	
		10% Calcium goconate injection (10 ml/ ampule)	75	
		7.5% Sodium-bi carbonate injection (25 ml/ ampule)	76	
		Aminophyline injection (250 mg/10 ml)	77	
		Atropine injection (0.6 mg/ ml)	78	
		Fisostigomine injection (1 mg/ml)	79	
		Butterfly infusion Set	80	
		Sterile disposable syringe, 2/5/10/50 ml size	81	
206.	Is there any sterilizer in your clinic for sterilization of the instruments for LAPMs? Yes=1 No=2			
207.	Is the sterilizer of your clinic working properly? Yes=1 No=2			

III. Complications in providing LAPMs and its management

301.	What are the complications/ problems the clients generally face after accepting IUD and implants?	Skip
	Complications/ problems	
	IUD	
	1.	
	2.	
	3.	
	4.	
	Implants	
	1	
	2	
	3	
	4	
302.	How do you solve those problems?	
	Ways how the complications/ problems of IUD/Implants are solved	
	IUD	
	1.	
	2.	
	3.	
	4.	
	Implants	
	1.	
	2.	
	3.	
	4.	
303	Do you think their problems are solved through following your advice? Yes=1 No=2	→ 401
304	If no, what can be done to solve their problems after receipt of IUD/Implants effectively? 1. ..... 2. ..... 3. ..... 4.	

IV. Reasons for not accepting LAPMs and Suggestions

401.	What are the reasons for not accepting IUD and Implants in couples having one child in your area? (If yes, please make circle)	Skip
	Reasons	
	IUD	
	Feeling of pain in lower abdomen	1
	Increased bleeding during menstruation	2
	Sometimes IUD comes outside of vagina	3
	Become pregnant instead of taking IUD	4
	Sometimes vagina becomes damaged	5
	Needs experienced worker to take and remove of IUD	6

	Need to examine the string after each menstruation	7	
	It does not protect STD/HIV/AIDS	8	
	Reproductive organs transition risks increase	9	
	Others(specify)……..	10	
	Implants		
	Drop hemorrhage between two menstrual period	1	
	Little bleeding for a long time	2	
	Stopped menstruation	3	
	Headache, vomiting tendency and weight gain	4	
	Feeling of tiredness	5	
	Weighty /Pain in breast	6	
	Hazard to open and use self	7	
	Need small operation to take and open	8	
	Transition, bleeding problem	9	
	Does not protect STD/HIV/AIDS	10	
	Others (specify) ……	11	
402	at are the reasons for not accepting tubectomy / vasectomy in couples having two children in your area? (If yes, please make circle)		
	Reasons		
	Tubectomy		
	Need to think before taking decision as it's a permanent method	1	
	Have risk in spite of being a small operation	2	
	Pain remains for a few days after operation	3	
	Possibilities of Ectopic pregnancy	4	
	Need to come to service center for operation	5	
	Need trained doctor and assistant	6	
	Does not protect STD/HIV/AIDS	7	
	Others (specify)	8	
	Vasectomy		
	It is not possible to take child again as it is a permanent method	1	
	There have some risk in spite of being a small operation	2	
	It does not work immediately after operation	3	
	Have to wait for 3 months to be effective	4	
	Need to use condom for intercourse before it become effective	5	
	Need to come to service center for operation	6	
	Need trained doctor and assistant	7	
	Does not protect STD/HIV/AIDS	8	
	Others (specify)	9	
403	What problems do you face in provision of LAPM service?		
	1.		
	2.		
	3.		
	4.		
	5.		
404	What steps should be taken for solving the problems in LAPMs service provision and increase its acceptance?		
	1.		
	2.		
	3.		
	4.		
	5.		

Thanks for your cordial cooperation

DCI- 5

ID No.	

Study on Access the Constraints to Promote Long-Acting and Permanent Contraceptive Methods (LAPMs)

Questionnaire for Interview of FPI

INSTRUCTION TO THE INTERVIEWER

Check whether:

10. The permission of respondent has been sought;
11. The respondent has been informed that his/her identity will be kept confidential;
12. The objectives of the study have been explained.

Name of the Respondent: ……

Place of posting:

Union……Upazila:……..……District:……

Name of Interviewer: ……..

Signature of Interviewer: ……..... Date: ……..

Study undertaken for:

National Institute of Population Research and Training (NIPORT)

Study conducted by:

Human Development Research Centre (HDRC)

Road # 8, House #5, Mohammadia Housing Society,
Mohammadpur, Dhaka –1207, Bangladesh
Phone: (880 2) 8116972, 8157621, Fax: (880 2) 8157620
E-mail: info@hdrc-bd.com
Website: www.hdrc-bd.com

Dhaka, June 2013

I. Population Served, Service Provision and Manpower

<table>
<tr><th>Sl. no.</th><th>Questions and Response</th><th>Skip</th></tr>
<tr><td>101.</td><td>What is the population of your catchment area?
a. Total: …….
b. Male: …….
c. Female: ..……...</td><td></td></tr>
<tr><td>102.</td><td>How many eligible couples are there in your catchment area?
#. ……..</td><td></td></tr>
<tr><td>103.</td><td>How many couples are using any FP method in your working area at present? (please collect information from monthly MIS report)
<table><tr><th>Name of FP method</th><th>Number</th></tr><tr><td>1. Oral pill</td><td></td></tr><tr><td>2. Condom</td><td></td></tr><tr><td>3. Injection</td><td></td></tr><tr><td>4. IUD</td><td></td></tr><tr><td>5. Implants</td><td></td></tr><tr><td>6. Tubectomy</td><td></td></tr><tr><td>7. Vasectomy</td><td></td></tr><tr><td>8. Others (specify)……..</td><td></td></tr></table></td><td></td></tr>
<tr><td>104</td><td>How many LAPMs have been provided in your catchment area during the last one year (2012)?
<table><tr><th>Name of LAPMs</th><th>Who have Provided?</th><th>Numbers</th></tr><tr><td>a. IUD</td><td></td><td></td></tr><tr><td>b. Implants</td><td></td><td></td></tr><tr><td>c. Tubectomy</td><td></td><td></td></tr><tr><td>d. Vasectomy</td><td></td><td></td></tr></table></td><td></td></tr>
<tr><td>105</td><td>What is the current manpower (FWAs) in your catchment area for informing people about LAPMs?
#..... ……</td><td></td></tr>
<tr><td>106</td><td>Do you think the current field manpower (FWAs) should be increased for informing people about LAPMs?
Yes=1
No=2 → 108</td><td></td></tr>
<tr><td>107</td><td>If yes, what should be the number of field manpower (FWAs) in your opinion to inform and motivate people for use of LAPMs and other FP methods?
……..</td><td></td></tr>
<tr><td>108</td><td>Was there any camp arranged in your catchment area during last one year (2012) for providing LAPMs?
Yes=1
No=2 → 110</td><td></td></tr>
<tr><td>109</td><td>If yes, how many Camps have been arranged in your catchment area during last one year (2012) for providing LAPMs?
<table><tr><th>Name of LAPM</th><th>Number of Camps</th></tr><tr><td>a. IUD</td><td></td></tr><tr><td>b. Implant</td><td></td></tr><tr><td>c. Tubectomy</td><td></td></tr><tr><td>d. Vasectomy</td><td></td></tr></table></td><td></td></tr>
</table>

110	What are the causes behind not doing any camp on LAPMs? Shortage of trained manpower=1 Shortage of vehicle=2 Shortage of MSR=3 Shortage of long acting method=4 Lack of initiative from MO-MCH=5 Lack of initiative from UFPO=5 Lack of cooperation from FWA=5 Low/ No incentive for these type of works=6 Peoples of these area is very conservative=7 Others (specify)…….=8	

II. Compensation and BCC

201.	Do you think the compensation provided to clients for accepting LAPMs is adequate? Yes=1 No=2 →	203
202	If no, what should be amount of compensation as to you?	

LAPMs	Money (Tk.)	Materials		
		Sharee	Lungi	Others (specify)
a. IUD				
b. Implants				
c. Tubectomy				
d. Vasectomy				

203	Is there any initiative or BCC activity in your working area to make the clients aware of LAPMs? Yes=1 No=2 →	205
204	If yes, how the clients are made aware of the methods and motivated to accept the LAPMs? Interpersonal/Counseling=1 Meeting in groups/ Uthan Baithak=2 Others (specify)……. =7	
205	Do the FWAs working under your supervision have adequate training on counseling and Uthan baithak to motivate clients for LAPMs? Yes=1 No=2	

III. Reasons for not accepting LAPMs and Suggestions

301.	What are the reasons for not accepting IUD and Implants in couples having one child in your area? (If yes, please make circle)		Skip
	Reasons		
	IUD		
	Feeling of pain in lower abdomen	1	
	Increased bleeding during menstruation	2	
	Sometimes IUD comes outside of vagina	3	
	Become pregnant instead of taking IUD	4	
	Sometimes vagina becomes damaged	5	
	Needs experienced worker to take and remove of IUD	6	
	Need to examine the string after each menstruation	7	
	It does not protect STD/HIV/AIDS	8	
	Reproductive organs transition risks increase	9	
	Others(specify)……..	10	
	Implants		
	Drop hemorrhage between two menstrual period	1	
	Little bleeding for a long time	2	
	Stopped menstruation	3	

	Headache, vomiting tendency and weight gain	4	
	Feeling of tiredness	5	
	Weighty /Pain in breast	6	
	Hazard to open and use self	7	
	Need small operation to take and open	8	
	Transition, bleeding problem	9	
	Does not protect STD/HIV/AIDS	10	
	Others (specify) ……	11	
302	What are the reasons for not accepting tubectomy / vasectomy in couples having two children in your area? (If yes, please make circle)		
	Reasons		
	Tubectomy		
	Need to think before taking decision as it's a permanent method	1	
	Have risk in spite of being a small operation	2	
	Pain remains for a few days after operation	3	
	Possibilities of Ectopic pregnancy	4	
	Need to come to service center for operation	5	
	Need trained doctor and assistant	6	
	Does not protect STD/HIV/AIDS	7	
	Others (specify)	8	
	Vasectomy		
	It is not possible to take child again as it is a permanent method	1	
	There have some risk in spite of being a small operation	2	
	It does not work immediately after operation	3	
	Have to wait for 3 months to be effective	4	
	Need to use condom for intercourse before it become effective	5	
	Need to come to service center for operation	6	
	Need trained doctor and assistant	7	
	Does not protect STD/HIV/AIDS	8	
	Others (specify)	9	
303	What problems do you face in provision of LAPM service?		
	1.		
	2.		
	3.		
	4.		
	5.		
304	What steps should be taken for solving the problems in LAPMs service provision and increase its acceptance?		
	1.		
	6.		
	7.		
	8.		
	9.		

Thanks for your cordial cooperation

	DCI- 6
ID No.	

Study on Access the Constraints to Promote Long-Acting and Permanent Contraceptive Methods (LAPMs)

Questionnaire for Interview of FWA

INSTRUCTION TO THE INTERVIEWER
Check whether: 1. The permission of respondent has been sought; 2. The respondent has been informed that his/her identity will be kept confidential; 3. The objectives of the study have been explained.

Name of the Respondent: ……

Place of posting:

Union……Upazila:……..……District:……

Name of Interviewer: ……..

Signature of Interviewer: ……..... Date: ……..

Study undertaken for:

National Institute of Population Research and Training (NIPORT)

Study conducted by:

Human Development Research Centre (HDRC)

Road # 8, House #5, Mohammadia Housing Society,
Mohammadpur, Dhaka –1207, Bangladesh
Phone: (880 2) 8116972, 8157621, Fax: (880 2) 8157620
E-mail: info@hdrc-bd.com
Website: www.hdrc-bd.com

Dhaka, June 2013

I. Population Served, Service Provision and Manpower

<table>
<tr><th>Sl. no.</th><th>Question</th><th>Skip</th></tr>
<tr><td>101.</td><td>For how many years you are working here in this position? …….years</td><td></td></tr>
<tr><td>102.</td><td>What is the population of your catchment area?
a. Total: ……..
b. Male: ..……...
c. Female: ……..……</td><td></td></tr>
<tr><td>103.</td><td>How many eligible couples are there in your catchment area?
…….</td><td></td></tr>
<tr><td>104.</td><td>How many eligible couples are using any FP method in your working area at present? (Please collect information from monthly MIS report)
<table>
<tr><th>Name of FP method</th><th>Number</th></tr>
<tr><td>1. Oral pill</td><td></td></tr>
<tr><td>2. Condom</td><td></td></tr>
<tr><td>3. Injection</td><td></td></tr>
<tr><td>4. IUD</td><td></td></tr>
<tr><td>5. Implants</td><td></td></tr>
<tr><td>6. Tubectomy</td><td></td></tr>
<tr><td>7. Vasectomy</td><td></td></tr>
<tr><td>8. Others (specify)……..</td><td></td></tr>
</table></td><td></td></tr>
<tr><td>105</td><td>How many eligible couples in your catchment area have accepted LAPMs during the last one year (2012)?
<table>
<tr><th>Name of LAPMs</th><th>Number (in 2012)</th></tr>
<tr><td>1. IUD</td><td></td></tr>
<tr><td>2. Implants</td><td></td></tr>
<tr><td>3. Tubectomy</td><td></td></tr>
<tr><td>4. Vasectomy</td><td></td></tr>
</table></td><td></td></tr>
<tr><td>106</td><td>How many eligible couples in your catchment area have discontinued LAPMs or switched to other method during the last one year (2012)?
<table>
<tr><th>Name of LAPMs</th><th>Number (in 2012)</th></tr>
<tr><td>1. IUD</td><td></td></tr>
<tr><td>2. Implants</td><td></td></tr>
<tr><td>3. Tubectomy</td><td></td></tr>
<tr><td>4. Vasectomy</td><td></td></tr>
</table></td><td></td></tr>
<tr><td>107</td><td>Do you think that you alone are sufficient in your catchment area to inform people about LAPMs and provide other FP methods?
Yes=1
No=2 →</td><td>109</td></tr>
<tr><td>108</td><td>If No, what in your opinion should be the number of FWAs in your catchment area to inform and motivate people to use of LAPMs and other FP methods?
……persons</td><td></td></tr>
<tr><td>109</td><td>Was there any camp arranged in your catchment area during last one year (2012) for providing LAPMs?
Yes=1
No=2 →</td><td>111</td></tr>
<tr><td>110</td><td>If yes, How many Camps have been arranged in your catchment area during last one year (2012) for providing LAPMs?
<table>
<tr><th>Name of LAPM</th><th>Number of Camps</th></tr>
<tr><td>a. IUD</td><td></td></tr>
<tr><td>b. Implant</td><td></td></tr>
<tr><td>c. Tubectomy</td><td></td></tr>
<tr><td>d. Vasectomy</td><td></td></tr>
</table></td><td></td></tr>
</table>

111	What are the causes behind not arranging any camp on LAPMs? Shortage of trained manpower=1 Shortage of vehicle=2 Shortage of MSR=3 Shortage of long acting method=4 Lack of initiative from MO-MCH=5 Lack of initiative from UFPO=5 Lack of cooperation from community people=5 Low/ No incentive for these type of works=6 Peoples of these area is very conservative=7 Others (specify)……=8	

II. Compensation and BCC

201.	Do you think the compensation provided to clients for accepting LAPMs is adequate? Yes=1 No=2 → 203	
202.	If not, what should be amount of compensation as to you?	

LAPMs	Money (Tk.)	Materials		
		Sharee	Lungi	Others (specify)
IUD				
Implants				
Tubectomy				
Vasectomy				

203.	What amount of remuneration money do you get for referring a LAPM client?	

LAPMs	Money (Tk.)
1. IUD	
2. Implants	
3. Tubectomy	
4. Vasectomy	

204	Is there any initiative or BCC activity in your working area to make the clients aware of LAPMs? Yes=1 No=2 → 206	
205.	If yes, how the clients are made aware of the methods and motivated to accept the LAPMs? Interpersonal/Counseling=1 Meeting in groups/ Uthan Baithak=2 Others (specify)…… =7	
206.	Do you have training on counseling, Uthan Baithak and other BCC methods to motivate clients for LAPMs? Yes=1 No=2 → 301	
207.	If yes, how many years back have you received the training? ……years	

III. Reasons for not accepting LAPMs and Suggestions

301.	What are the reasons for not accepting IUD and Implants in couples having one child in your area? (If yes, please make circle)		Skip
	Reasons		
	IUD		
	Feeling of pain in lower abdomen	1	
	Increased bleeding during menstruation	2	
	Sometimes IUD comes outside of vagina	3	
	Become pregnant instead of taking IUD	4	
	Sometimes vagina becomes damaged	5	

	Needs experienced worker to take and remove of IUD	6	
	Need to examine the string after each menstruation	7	
	It does not protect STD/HIV/AIDS	8	
	Reproductive organs transition risks increase	9	
	Others(specify)……..	10	
	Implants		
	)p hemorrhage between two menstrual period	1	
	Little bleeding for a long time	2	
	Stopped menstruation	3	
	Headache, vomiting tendency and weight gain	4	
	Feeling of tiredness	5	
	Weighty /Pain in breast	6	
	Hazard to open and use self	7	
	Need small operation to take and open	8	
	Transition, bleeding problem	9	
	Does not protect STD/HIV/AIDS	10	
	Others (specify) ……	11	
302	What are the reasons for not accepting tubectomy / vasectomy in couples having two children in your area? (If yes, please make circle)		
	Reasons		
	Tubectomy		
	Need to think before taking decision as it's a permanent method	1	
	Have risk in spite of being a small operation	2	
	Pain remains for a few days after operation	3	
	Possibilities of Ectopic pregnancy	4	
	Need to come to service center for operation	5	
	Need trained doctor and assistant	6	
	Does not protect STD/HIV/AIDS	7	
	Others (specify)	8	
	Vasectomy		
	It is not possible to take child again as it is a permanent method	1	
	There have some risk in spite of being a small operation	2	
	It does not work immediately after operation	3	
	Have to wait for 3 months to be effective	4	
	Need to use condom for intercourse before it become effective	5	
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	Need trained doctor and assistant	7	
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	Others (specify)	9	
303	What problems do you face in provision of LAPM service?		
	1.		
	2.		
	3.		
	4.		
	5.		
304	What steps should be taken for solving the problems in LAPMs service provision and increase its acceptance?		
	1.		
	2.		
	3.		
	4.		
	5.		

Thanks for your cordial cooperation

DCI-7

Study on Access the Constraints to Promote Long-Acting and Permanent Contraceptive Methods (LAPMs)

Key Informant Interview Guideline

(Program Manager DGFP, DGHS, Engender Health, OGSB)

Introduction: Population program has being duly inducted in Bangladesh in seventies and currently the CPR is 61.2. However, the concern is currently only 8 percent of the married couples are using long-acting and permanent methods (LAPMs), IUD-0.7%, implants-1.1%, tubectomy-5%, vasectomy-1.2%. Thus, LAPMs account for 13 percent of total contraceptive use. The plateauing of LAPM is of concern, as fertility is now so low that most child-bearing is completed by the mid-to-late twenties and most women pass two decades using hormonal FP methods to protect themselves from unwanted pregnancies avoiding LAPMs.

In this backdrop, National Institute of Population Research and Training (NIPORT) has undertaken an initiative to conduct the research studies to "Assess the constraints to promote long-acting and permanent contraceptive methods (LAPMs)" where Human Development Research Centre (HDRC) has been selected to conduct the study.

Now if you permit, I would like to discuss something on it with you and take your suggestion regarding how to increase the use of LAPMs.

INSTRUCTION TO THE INTERVIEWER

Check whether:

1. The permission of respondent has been sought;
2. The respondent has been informed that his/her identity will be kept confidential;
3. The objectives of the study have been explained.

Name of the Respondent: ……

Designation: ……

Name of Interviewer: ……..

Signature of Interviewer: ……..... Date: ……..

Study undertaken for:

National Institute of Population Research and Training (NIPORT)

Study conducted by:

Human Development Research Centre (HDRC)

Road # 8, House #5, Mohammadia Housing Society,
Mohammadpur, Dhaka –1207, Bangladesh
Phone: (880 2) 8116972, 8157621, Fax: (880 2) 8157620
E-mail: info@hdrc-bd.com; Website: www.hdrc-bd.com

KII Issues

1. Since how many years you are working on health/reproductive health/family planning?

IUDs

2. What are the problems you think behind the low rate of acceptance of IUD/Copper T in women having at least one child in comparison to other FP methods in our country?
3. Do you think IUDs are being inserted by appropriately trained people maintaining proper quality?
4. What initiatives have you taken from your organization for increasing acceptance of IUDs?
5. Do you know of any new initiative taken by other directorates/organizations in this respect regarding increasing acceptance of IUDs? If yes, what are those?
6. What are your suggestions to increase acceptance of IUDs as FP method for those who have at least one child or have completed the expected family size?

Implant

7. What are the problems you think behind the low rate of acceptance of Implants in women having at least one child in comparison to other FP methods in our country?
8. Do you think Implants are being inserted by appropriately trained people maintaining proper quality?
9. What initiatives have you taken from your organization for increasing acceptance of Implants?
10. Do you know of any new initiative taken by other directorates/organizations in this respect regarding increasing acceptance of Implants? If yes, what are those?
11. What are your suggestions to increase acceptance of Implants as FP method for those who have at least one child or have completed the expected family size?

Tubectomy

12. What are the problems you think behind the low rate of acceptance of Tubectomy in women having at least two child in comparison to other FP methods in our country?
13. Do you think Tubectomy are being done by appropriately trained providers maintaining proper quality?
14. What initiatives have you taken from your organization for increasing acceptance of Tubectomy?
15. Has any initiative been undertaken by your Directorate/Organization to increase Post-partum/Post-caesarean Tubectomy through involvement of doctors? If yes, how is it working now?
16. Has any initiative taken by your Directorate/Organization to involve Gynaecologists in Post-caesarean Tubectomy?
17. Do you know of any new initiative taken by other directorates/organizations in this respect regarding increasing acceptance of Tubectomy? If yes, what are those?
18. What are your suggestions to increase acceptance of Tubectomy as FP method for those who have at least one child or have completed the expected family size?

Vasectomy

19. What are the problems you think behind the low rate of acceptance of Vasectomy in women having at least two child in comparison to other FP methods in our country?
20. Do you think Vasectomy are being done by appropriately trained providers maintaining proper quality?
21. What initiatives have you taken from your organization for increasing acceptance of Vasectomy?
22. Do you know of any new initiative taken by other directorates/organizations in this respect regarding increasing acceptance of Vasectomy? If yes, what are those?
23. What are your suggestions to increase acceptance of Vasectomy as FP method for those who have at least one child or have completed the expected family size?

Overall

24. Has any initiative been taken by your Directorate/Organization to train private doctors for provision of IUD/Implant/Tubectomy/Vasectomy? If yes, how it is working now?
25. Has any initiative been undertaken by your Directorate/Organization to increase quality of service for provision of IUD/Implant/Tubectomy/Vasectomy?
26. Has any initiative been undertaken by your Directorate/Organization for management of complications of IUD/Implant/Tubectomy/Vasectomy?
27. What your suggestions for providing IUD/Implant/Tubectomy/Vasectomy to more people and increasing quality of service.

Annex-3

List of Enumeration Areas

Cluster list

Sl	Cluster number	Division	Division name	Zila	Zila name	Upza	Upza name	Union	Union name	Mauza	Mauza name	Village	Rmo	Village name
1	20	10	Barisal	06	Barisal	51	Barisal sadar (kotwali)	13	Ward no-13	580	Khan sarak		9	Khan sarak
2	23	10	Barisal	06	Barisal	51	Barisal sadar (kotwali)	28	Ward no-28	515	Kashipur chahutpur		9	Kashipur chahutpur
3	31	10	Barisal	09	Bhola	18	Bhola sadar	01	Ward no-01	186	Bapta (part)		2	Bapta (part)
4	32	10	Barisal	09	Bhola	18	Bhola sadar	14	Bapta	373	Char noabad (part)		3	Char noabad (part)
5	43	10	Barisal	09	Bhola	54	Lalmohan	57	Lalmohan	336	Char lalmohan		3	Char lalmohan
6	9	10	Barisal	06	Barisal	02	Agailjhara	47	Gaila	896	Talta	01	1	Talta
7	10	10	Barisal	06	Barisal	03	Babuganj	54	Kedarpur	140	Bhutardia	01	1	Bhutardia
8	11	10	Barisal	06	Barisal	07	Bakerganj	27	Darial	982	Uttar kajlakati	01	1	Uttar kajlakati
9	33	10	Barisal	09	Bhola	18	Bhola sadar	36	Dhania	497	Dhania	01	1	Dhania
10	34	10	Barisal	09	Bhola	18	Bhola sadar	65	Uttar dighaldi	994	Uttar dighaldi	01	1	Uttar dighaldi
11	42	10	Barisal	09	Bhola	54	Lalmohan	47	Kalma	321	Char lakshmi	01	1	Char lakshmi
12	41	10	Barisal	09	Bhola	54	Lalmohan	16	Badarpur	107	Badarpur	01	1	Badarpur
13	64	10	Barisal	79	Pirojpur	14	Bhandaria	59	Ikri	053	Betagi singhakhali	01	1	Betagi singhakhali
14	65	10	Barisal	79	Pirojpur	58	Mathbaria	15	Amragachhia	030	Amragachhia hogalpati	03	1	Kalikabari
15	66	10	Barisal	79	Pirojpur	58	Mathbaria	69	Mirukhali	256	Chhota harji	01	1	Chhota harji
16	67	10	Barisal	79	Pirojpur	76	Nazirpur upazila	21	Purba deulbaridobra	697	Mugarjhor	01	1	Mugarjhor
17	72	10	Barisal	79	Pirojpur	87	Nesarabad (swarupkati)	95	Nesarabad (swarupkati)	946	Sultanpur alankarkati	01	1	Sultanpur
18	90	20	Chittagong	15	Chittagong	06	Bayejid bostami	02	Ward no-02	326	Jalalabad		9	Jalalabad
19	107	20	Chittagong	15	Chittagong	43	Khulshi	09	Ward no-09 (part)	940	Foy's lake		9	Foy's lake
20	108	20	Chittagong	15	Chittagong	43	Khulshi	14	Ward no-14 (part)	828	Tiger pass		9	Tiger pass
21	111	20	Chittagong	15	Chittagong	55	Pahartali	12	Ward no-12	515	Paschim nasirabad		9	Paschim nasirabad
22	122	20	Chittagang	19	Comilla	27	Chandina	03	Ward no-03	379	Dakshin harang mahallah (part)		2	Dakshin harang mahallah (part)
23	127	20	Chittagang	19	Comilla	40	Debidwar	07	Ward no-07	232	Champanagar		2	Champanagar
24	130	20	Chittagang	19	Comilla	67	Comilla adarsha sadar	16	Ward no-16	870	Sangraish		2	Sangraish
25	134	20	Chittagang	19	Comilla	87	Nangalkot	02	Ward no-02	643	Naogoda		2	Naogoda
26	136	20	Chittagang	22	Cox's bazar	16	Chakaria	16	Baraitali	091	Baraitali	01	1	Hindu para
27	137	20	Chittagang	22	Cox's bazar	24	Cox's bazar sadar	35	Idgaon	104	Bhomariaghona	05	1	Bhomaria ghona(e.daillajari)
28	139	20	Chittagang	22	Cox's bazar	49	Maheshkhali	59	Kalarmarchhara	545	Kalarmarchhara	04	1	Kahar para
29	140	20	Chittagang	22	Cox's bazar	66	Ramu	57	Khuniapalong	612	Khunia palong	01	1	Khunia palong
30	141	20	Chittagang	22	Cox's bazar	94	Ukhia upazila	79	Palong khali	459	Palong khali	01	1	Palong khali
31	154	20	Chittagang	75	Noakhali	07	Begumganj	12	Amanullapur	612	Mohammadpur	01	1	Mohammadpur
32	155	20	Chittagang	75	Noakhali	10	Chatkhil	17	Badalkut	883	Satbaria	01	1	Satbaria
33	158	20	Chittagang	75	Noakhali	36	Hatiya	69	Nijumdip	430	Char osman (nijum island)	01	1	Char osman (nijum island)
34	159	20	Chittagang	75	Noakhali	80	Senbagh	47	Kabilpur	452	Kabilpur	01	1	Kabilpur
35	160	20	Chittagang	75	Noakhali	83	Sonaimuri	77	Nateshwar	376	Ghoshkamta	01	1	Ghoshkamta
36	161	20	Chittagang	75	Noakhali	87	Noakhali sadar	21	Anderchar	460	Kazir char (taluk)	01	1	Kazir char (taluk)
37	143	20	Chittagang	30	Feni	25	Daganbhuiyan	90	Sindurpur	964	Uttar raghunathpur	01	1	Uttar raghunathpur
38	144	20	Chittagang	30	Feni	41	Fulgazi	13	Amjadhat	086	Basantapur	01	1	Basantapur
39	146	20	Chittagang	30	Feni	94	Sonagazi	57	Mangalkandi	901	Sampur	01	1	Sampur
40	182	30	Dhaka	26	Dhaka	42	Lalbagh	92	Ward no-92 (part)	165	Asrafabad		9	Islamnagar
41	183	30	Dhaka	26	Dhaka	48	Mirpur	12	Ward no-12(part)	877	Tolar bagh		9	Tolar bagh
42	187	30	Dhaka	26	Dhaka	64	Pallabi	02	Ward no-02(part)	451	Mirpur sec-12 (block-d)		9	Mirpur sec-12 (block-d)
43	184	30	Dhaka	26	Dhaka	50	Mohammadpur	44	Ward no-44	695	Nurjahan road		9	Nurjahan road
44	190	30	Dhaka	26	Dhaka	67	Rampura	22	Ward no-22 (part)	625	Uttar banasree		9	Uttar banasree
45	231	30	Dhaka	61	Mymensingh	13	Bhaluka	69	Mallikbari	137	Bhandabo		3	Bhandabo
46	237	30	Dhaka	61	Mymensingh	52	Mymensingh sadar	21	Ward no-21	204	Bara bhaluka		2	Bara bhaluka
47	244	30	Dhaka	67	Narayanganj	06	Bandar	05	Ward no-05	993	Willson road (uttar)		2	Willson road (uttar)
48	272	30	Dhaka	93	Tangail	76	Nagarpur	73	Nagarpur	069	Babna para		3	Babna para
49	205	30	Dhaka	33	Gazipur	32	Kaliakair	05	Ward no-05	475	Haritakitala		2	Haritakitala
50	211	30	Dhaka	39	Jamalpur	15	Dewanganj	05	Ward no-05	180	Banianirchar paschim para(par		2	Banianirchar paschim para(par
51	233	30	Dhaka	61	Mymensingh	20	Fulbaria	59	Kushmail	353	Dhamar	01	1	Dhamar
52	236	30	Dhaka	61	Mymensingh	31	Ishwarganj	67	Rajibpur	849	Sahebnagar	01	1	Sahebnagar
53	238	30	Dhaka	61	Mymensingh	52	Mymensingh sadar	88	Paranganj union	897	Sanadia	01	1	Sanadia
54	240	30	Dhaka	61	Mymensingh	81	Phulpur	27	Baola	480	Hatibanda	01	1	Hatibanda
55	241	30	Dhaka	61	Mymensingh	94	Trishal	15	Bailar	122	Bailar	09	1	Bashkuri
56	266	30	Dhaka	93	Tangail	19	Bhuapur	54	Gabsara	675	Meghar patal	01	1	Meghar patal

Sl	Cluster number	Division	Division name	Zila	Zila name	Upza	Upza name	Union	Union name	Mauza	Mauza name	Village	Rmo	Village name
57	270	30	Dhaka	93	Tangail	66	Mirzapur	23	Bahuria	201	Betrasin	01	1	Betrasin
58	271	30	Dhaka	93	Tangail	76	Nagarpur	65	Mokhna	504	Jaktala	01	1	Jaktala
59	273	30	Dhaka	93	Tangail	95	Tangail sadar	47	Gharinda	966	Suranchа	01	1	Suranchа
60	213	30	Dhaka	39	Jamalpur	36	Jamalpur sadar	23	Itail	480	Itail	01	1	Itail
61	214	30	Dhaka	39	Jamalpur	58	Madarganj	11	Adarbhita	855	Patadaha	01	1	Patadaha
62	215	30	Dhaka	39	Jamalpur	61	Melandaha	76	Mahmudpur	746	Paila	01	1	Panch paila
63	206	30	Dhaka	33	Gazipur	32	Kaliakair	85	Sutrapur	685	Nayanagar	01	1	Nayanagar
64	207	30	Dhaka	33	Gazipur	36	Kapasia	69	Sanmania	868	Sanmania	01	1	Sanmania
65	318	40	Khulna	47	Khulna	45	Khalishpur	15	Ward no-15(part)	510	Palpara		9	Palpara
66	319	40	Khulna	47	Khulna	51	Ward no-07	23	Ward no-23	497	Mirzapur road		9	Mirzapur road
67	297	40	Khulna	41	Jessore	61	Manirampur	04	Ward no-04	742	Sawrupdha		2	Sawrupdha
68	292	40	Khulna	41	Jessore	38	Keshabpur	07	Ward no-07	385	Habaspol		2	Habaspol
69	354	40	Khulna	87	Satkhira	82	Satkhira sadar	06	Ward no-06	328	Kukhrali		2	Kukhrali
70	330	40	Khulna	50	Kushtia	39	Daulatpur	61	Mathurapur	645	Mathurapur		3	Mathurapur
71	334	40	Khulna	50	Kushtia	79	Kushtia sadar	09	Ward no-09	450	Kali shankarpur d.mill para		2	Kali shankarpur d.mill para
72	350	40	Khulna	87	Satkhira	04	Assasuni	43	Durgapur	308	Chhota durgapur	01	1	Chhota durgapur
73	352	40	Khulna	87	Satkhira	43	Kalaroa	71	Keralkata	518	Kismat ilishpur	01	1	Kismat ilishpur
74	355	40	Khulna	87	Satkhira	82	Satkhira sadar	40	Bhomra	757	Panitar chak	01	1	Panitar chak
75	357	40	Khulna	87	Satkhira	86	Shyamnagar	79	Padma pukur	797	Patakhali	01	1	Purba patakhali
76	328	40	Khulna	50	Kushtia	15	Bheramara	13	Bahadurpur	710	Madhabpur	01	1	Madhabpur
77	331	40	Khulna	50	Kushtia	39	Daulatpur	67	Pearpur	416	Hariballabhpur	01	1	Pura salua
78	335	40	Khulna	50	Kushtia	79	Kushtia sadar	18	Alampur	943	Shimulia	03	1	Shwargapur
79	337	40	Khulna	50	Kushtia	94	Mirpur	43	Chithulia	318	Dhubail	01	1	Dhubali
80	322	40	Khulna	47	Khulna	53	Koyra	72	Maharajpur	940	Sreerampur	01	1	Sreerampur
81	323	40	Khulna	47	Khulna	64	Paikgachha	67	Lata	416	Guachhoba	03	1	Rekhamari
82	296	40	Khulna	41	Jessore	47	Kotwali	47	Haibatpur	982	Tirerhat	01	1	Tirerhat
83	299	40	Khulna	41	Jessore	61	Manirampur	55	Kheda para	572	Krishnabati	01	1	Krishnabati
84	300	40	Khulna	41	Jessore	90	Sharsha	25	Benapole	626	Narayanpur	01	1	Narayanpur
85	421	50	Rajshahi	81	Rajshahi	22	Boalia	22	Ward no-22	506	Kumar para		9	Kumar para
86	429	50	Rajshahi	81	Rajshahi	85	Rajpara	02	Ward no-02	641	Harogram nutan para		9	Harogram nutan para
87	440	50	Rajshahi	88	Sirajganj	78	Sirajganj sadar	01	Ward no-01	633	Masimpur		2	Masimpur
88	441	50	Rajshahi	88	Sirajganj	78	Sirajganj sadar	15	Ward no-15	850	Railway colony		2	Railway colony
89	411	50	Rajshahi	76	Pabna	55	Pabna sadar	02	Ward no-02	331	Gopalpur		2	Gopalpur
90	360	50	Rajshahi	10	Bogra	20	Bogra sadar	02	Ward no-02	109	Brindaban para		2	Brindaban para
91	362	50	Rajshahi	10	Bogra	20	Bogra sadar	20	Ward no-20	174	Buzrag baria		2	Buzrag baria
92	442	50	Rajshahi	88	Sirajganj	78	Sirajganj sadar	25	Kalia haripur	703	Narayanbari	01	1	Rajabnagar
93	444	50	Rajshahi	88	Sirajganj	94	Ullah para	21	Bara pangashi	870	Saidpur	01	1	Saidpur
94	445	50	Rajshahi	88	Sirajganj	94	Ullah para	65	Ramkrishnapur	533	Khurda shimulia	01	1	Khurda shimulia
95	438	50	Rajshahi	88	Sirajganj	67	Shahjadpur	14	Gala	411	Gala	04	1	Gala
96	439	50	Rajshahi	88	Sirajganj	67	Shahjadpur	65	Porjana	778	Porjana	01	1	Porjana
97	407	50	Rajshahi	76	Pabna	16	Bera	21	Dhalar char	370	Dharai	01	1	Dharai
98	410	50	Rajshahi	76	Pabna	39	Ishwardi	52	Pakshi	433	Diar baghail	01	1	Diar baghail
99	412	50	Rajshahi	76	Pabna	55	Pabna sadar	34	Dapunia	376	Ganti	01	1	Ganti
100	415	50	Rajshahi	76	Pabna	72	Santhia	69	Khatu para	146	Bishnubaria	02	1	Nishi para
101	363	50	Rajshahi	10	Bogra	27	Dhunat	15	Bhandarbari	820	Ramkrishnapur	02	1	Marichtala
102	364	50	Rajshahi	10	Bogra	27	Dhunat	95	Nimgachhi	371	Dhamachama	01	1	Dhamachama
103	373	50	Rajshahi	10	Bogra	94	Shibganj	23	Buriganj	190	Bilhamla	02	1	Sonapura
104	374	50	Rajshahi	10	Bogra	94	Shibganj	87	Saidpur	304	Daha para	02	1	Dakshin daha para
105	513	55	Rangpur	85	Rangpur	49	Rangpur sadar	02	Ward no-02	945	Satgara		2	Satgara
106	515	55	Rangpur	85	Rangpur	49	Rangpur sadar	13	Ward no-13	160	Ashratpur		2	Ashratpur
107	525	55	Rangpur	94	Thakurgaon	08	Baliadangi	73	Duosuo	433	Duosuo		3	Duosuo
108	485	55	Rangpur	49	Kurigram	94	Ulipur	05	Ward no-05	735	Purba shibbari		2	Purba shibbari
109	481	55	Rangpur	49	Kurigram	61	Nageshwari	06	Ward no-06	050	Badizamapur		2	Badizamapur
110	456	55	Rangpur	27	Dinajpur	64	Dinajpur sadar	07	Ward no-07	865	Uttar balubari		2	Uttar balubari
111	524	55	Rangpur	94	Thakurgaon	08	Baliadangi	63	Dhantala	408	Dhukurjhari	01	1	Dhukurjhari
112	529	55	Rangpur	94	Thakurgaon	94	Thakurgaon sadar	21	Balia	642	Kumarpur	01	1	Kumarpur
113	530	55	Rangpur	94	Thakurgaon	94	Thakurgaon sadar	73	Roypur	868	Roypur	01	1	Roypur
114	486	55	Rangpur	49	Kurigram	94	Ulipur	44	Dharanibari	555	Madhupur	01	1	Madhupur
115	483	55	Rangpur	49	Kurigram	77	Rajarhat	31	Chhinai	186	Chhinaihat	03	1	Chhinaihat
116	482	55	Rangpur	49	Kurigram	61	Nageshwari	50	Kedar	075	Baher kedar	01	1	Taria
117	478	55	Rangpur	49	Kurigram	18	Phulbari	54	Kashipur	019	Anantapur	06	1	Pachimanantapur
118	450	55	Rangpur	27	Dinajpur	30	Chirirbandar	13	Abdulpur	027	Andharmuha	01	1	Andharmuha
119	451	55	Rangpur	27	Dinajpur	30	Chirirbandar	79	Saintara	288	Dakshin palashbari	01	1	Dakshin palashbari
120	460	55	Rangpur	27	Dinajpur	69	Nawabganj	86	Putimara	259	Dakshin jaydebpur	01	1	Dakshin jaydebpur
121	461	55	Rangpur	27	Dinajpur	77	Parbatipur	60	Mominpur	320	Duania	01	1	Duania

Sl	Cluster number	Division	Division name	Zila	Zila name	Upza	Upza name	Union	Union name	Mauza	Mauza name	Village	Rmo	Village name
122	447	55	Rangpur	27	Dinajpur	10	Birampur	71	Khanpur	686	Mangalpur	01	1	Mangalpur
123	508	55	Rangpur	85	Rangpur	03	Badarganj	18	Bishnupur	344	Ghrilai	01	1	Ghrilai
124	509	55	Rangpur	85	Rangpur	03	Badarganj	88	Ramnathpur	995	Uttar ramnanthpur	01	1	Uttar ramnanthpur
125	589	60	Syshet	91	Sylhet	62	Sylhet sadar	08	Ward no-08	701	Coloni-2		9	Coloni-2
126	593	60	Syshet	91	Sylhet	62	Sylhet sadar	17	Ward no-17	443	Kazi tala		9	Kazi tala
127	547	60	Syshet	58	Maulvibazar	56	Kamalganj	05	Ward no-05	405	Khosal pur		2	Khosal pur
128	540	60	Syshet	36	Habiganj	71	Madhabpur	06	Ward no-06	400	Katiara		2	Katiara
129	574	60	Syshet	91	Sylhet	17	Beani bazar	05	Ward no-05	734	Noagram		2	Noagram
130	549	60	Syshet	58	Maulvibazar	65	Kulaura	10	Bhukshimail	523	Korbanpur	02	1	Madangauri
131	550	60	Syshet	58	Maulvibazar	65	Kulaura	59	Karmadha	465	Kaliti t.e.	01	1	Kaliti t.e.
132	555	60	Syshet	58	Maulvibazar	83	Sreemangal	15	Ashidron	768	Ramnagar	01	1	Ramnagar
133	556	60	Syshet	58	Maulvibazar	83	Sreemangal	57	Rajghat	750	Rajghat t.g.	01	1	Rajghat t.g.
134	541	60	Syshet	36	Habiganj	71	Madhabpur	17	Bagasura	865	Uttar manikpur	01	1	Uttar manikpur
135	542	60	Syshet	36	Habiganj	71	Madhabpur	69	Jagadishpur	874	Santoshpur	01	1	Santoshpur
136	543	60	Syshet	36	Habiganj	77	Nabiganj	29	Dighalbak	284	Daudpur	02	1	Darbeshpur
137	544	60	Syshet	36	Habiganj	77	Nabiganj	87	Paniunda	729	Paniumda	02	1	Barakandi
138	572	60	Syshet	91	Sylhet	08	Balaganj	11	Balaganj	075	Babrakpur	01	1	Babrakpur
139	573	60	Syshet	91	Sylhet	08	Balaganj	55	Osmanpur	547	Latibpur	01	1	Latibpur
140	575	60	Syshet	91	Sylhet	17	Beani bazar	25	Charkhai	185	Chak rabbani	01	1	Chak rabbani

Annex-4

HDRC Support & Field Staff Involved in the Study

HDRC Support & Field Staff Involved in the Study

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