ORAL CONTRACEPTIVE COMPLIANCE KAP BASELINE

Rural Bangladesh

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FOREWORD

Acceptance of oral contraceptive (OC) has considerably increased in Bangladesh as a result of intensive activities under family planning program during the last decade or so. The rate of OC users increased from 9.6% in 1989 (1989 BFS) to 20.8% in 1996-97 (BDHS). It is revealed from 1996-97 BDHS that half of the total modern method users are OC users and there has been a rapid shift in the method-mix. In fact, Bangladesh Family planning program is a pill-dominated program where OC has an important role to play in achieving replacement level fertility by the shortest possible time. Some of the major issues concerning the increase in the use of OC are associated with the users' knowledge of correct and safe method of pill-taking, problems concerning side-effect and contraindications as well as the level of field workers' knowledge in this regard. As the OC has emerged as the most dominant method in the family planning program, this study makes an attempt to provide necessary feed-back to policy makers and program managers for improving the program performance and thereby help attain the replacement level fertility by an early date.

The study has been executed by Population Development and Evaluation Unit (PDEU) of the Implementation Monitoring and Evaluation Division of the Ministry of Planning in close collaboration with the Associates for Community and Population Research (ACPR), Department of Statistics (Dr. Ataharul Islam), University of Dhaka and Family Health International (FHI) of the U.S.A. They all deserve appreciation.

I hope that the report will be useful to the planners, program managers and researchers working in the population discipline.

M. Saiful Islam
Secretary in Charge,
IMED, Ministry of Planning

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Dr. M. Bazlur Rahman of PDEU was mainly responsible for holding the meetings of the Technical Review Committee for guiding implementation of the study. Dr. M. Ataharul Islam of the Department of Statistics, University of Dhaka has contributed from planning to report writing stages and he was responsible for preparing the report with close collaboration from Dr. M. Bazlur Rahman of PDEU, Mr. A.P.M. Shafiur Rahman of ACPR and Ms. Dorace A. Trottier of FHI.

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CHAPTER 1

INTRODUCTION

Demographic Setting

Although Bangladesh is a small country in terms of land size, it is the world's ninth most populous country, with almost 120 million people. At the beginning of the century, the population of Bangladesh was only 29 million, so it has quadrupled in size. At its highest in the mid 1970s, the population growth has declined from around 2.5 percent to 1.8 percent in 1996. The decline in the growth rate is due in large part to a decline in the total fertility rate (TFR), which has decreased from 6.3 in the mid-1970s to 3.4 in 1993-94 (figures presented from Haider et al., 1995 and Mitra et al., 1994).

Although fertility has steadily declined, the current population level is such that it will continue to increase well into the future. Estimates of married women of reproductive age vary from 20 to almost 24 million, and by early next century this number could well exceed 30 million (Mitra et al., 1994; Haider et al., 1995). Given these figures, it is clear that the population has reached a critical mass and will continue to increase well into the future unless additional measures are taken.

Overview of Contraceptive History

The Bangladesh family planning program has changed profoundly since its inception in 1950. The contraceptive prevalence rate has more than doubled over the last 10 years, from 19 percent in 1983 to 45 percent in 1993-94. Modern method use has increased to 36 percent. Oral contraceptives (OCs) have become the most popular method, increasing from only 3 percent in 1983 to 17 percent in 1993-94. Their increased use has significantly contributed to the overall growth of contraceptive use in Bangladesh.

Although oral contraceptives in Bangladesh are channeled through three major sectors -- the Government of Bangladesh (GOB), non -governmental organizations (NGOs), and the commercial sector -- the network of fieldworkers has become the most prevalent source of OCs, nationally handling 67 percent of pill distribution, surpassing pharmacies (20 percent). This has increased substantially since 1989, when only 42 percent of users of resupply methods (both pills and condoms) got their method from a fieldworker. By 1992, the government employed approximately 23,000 fieldworkers. Another 7,000 private NGO fieldworkers distribute methods in rural villages. While this increase in the number of fieldworkers is undoubtedly responsible, at least in part, for the growing use of the pill, there are concerns that the rapid expansion of this distribution system will render it unable to meet the needs of ever-growing numbers of pill users, especially in the area of providing information about correct pill use.

Oral Contraceptive Compliance

Although oral contraceptives account for 45 percent of all modern methods used and 35 percent of total contraceptive use (BCPS, 1991), it is evident from research findings that women in Bangladesh do not follow correct procedures for taking the pill (Larson, Islam, and Mitra, 1991; BCPS, 1991). Larson, Islam, and Mitra's report states that "no group of women in Bangladesh receives adequate information about correct pill use, due largely to a dearth of accurate information". A study of 175 women in Matlab (Seaton, 1985) found incorrect pill use to be surprisingly high, with the average woman overtaking or undertaking at least 2 to 3 OCs per week. However, that study was not designed to investigate either the causes or consequences of poor compliance.

Studies elsewhere have documented erratic use or conscious irregular use stemming from a misunderstanding of correct pill use on the part of the both the user and the provider (Trottier et al., 1994; Hubacher and Potter, 1993; Loza et al., 1991; Havanõn et al., 1992; Potter et al., 1988). Poor compliance with oral contraceptive use can result in side-effects, discontinuation of the method, and unplanned pregnancy. Even if the user does not become pregnant, irregular use can result in greater incidence of minor side-effects, causing women to abandon the pill (Larson, Islam, and Mitra, 1991).

A worldwide shift towards lower dose OCs has occurred, due to the reduced side-effects associated with the lower dose (35 mcg of estrogen vs. the standard dose of 50 mcg of estrogen). Following that trend, national studies were conducted within Bangladesh that show Bangladeshi women are likely to prefer the lower dose regimen (Salway et al., 1994; Akhter et al., 1991; Larson, Islam and Mitra, 1991). In August, 1991, the National Technical Committee of the Bangladesh Directorate of Family Planning approved a phased national introduction of low dose oral contraceptives. With the introduction of low dose pills, correct use becomes even more crucial. Reduced hormonal levels increase the possibility of certain side-effects, breakthrough ovulation, and unplanned pregnancy. The failure to take a pill daily is more likely to bring on ovulation in lower dose pill users than in women using the standard dose (Population Information Program, 1988). In Bangladesh, low dose pills, once only available through the commercial sector, are now being provided by fieldworkers. This increase in distribution also increases the need for correct use, given the less forgiving nature of the lower dose pill and their increasing popularity within Bangladesh.

Studies conducted in Bangladesh have shown that women do not know the correct interval to wait between pill packs (Kamal, 1989; Larson, Islam and Mitra, 1991; BCPS, 1991). Women who miss a pill at either the beginning or end of a cycle may be at increased risk because they lengthen the hormone-free interval. This risk is even greater with the lower dose regimen. Clients and providers alike must understand this reduced margin of safety and why it is important.

Fieldworkers are obviously an important source of information regarding correct and consistent pill use. They may, however, be providing incomplete and/or inaccurate information, thereby worsening rather than improving knowledge about proper pill use. A recent study of fieldworkers has shown that among visits made to OC users, 80 percent of users did not receive information about family planning, and that the mean contact time of fieldworker to client was about 4 minutes (Janowitz et al., 1996). This finding indicates that pill users may be receiving information from sources other than fieldworkers, if indeed they are obtaining information at all.

Once more is known about where women in Bangladesh obtain their pills, what their knowledge and beliefs are about safe, effective pill-taking, and where they obtain that knowledge, policy makers can utilize this information to suggest improvements in the current system, or to design alternative educational programs to improve pill-taking behavior.

Study Rationale

Oral contraceptives are the most frequently used modern method in Bangladesh. Fieldworkers provide two-thirds (67 percent) of the pills to current users; pharmacies and the commercial sector provide another 20 percent. Fieldworkers are required to visit all couples in their catchment areas who are eligible for family planning use. Fieldworkers know which of their clients use the pill, regardless of whether or not the pills are provided by the fieldworker. In theory, fieldworkers are also required to provide information regarding pill use to all of the OC clients for whom they are responsible.

Accurate information is essential for correct and continued OC use. Assessing the user's knowledge of pill use in combination with where the pills are obtained, and determining where users receive information regarding pill-taking and other pill-related issues would be an important next step toward improving the quality of that information. This in turn could lead to increased acceptability of the method, along with an increase in prevalence and a decrease in side-effects, undesired pregnancy and discontinuation of pill use among users.

Study Purpose and Objectives

The purpose of this study was to determine the current levels of knowledge of correct oral contraceptive use among clients of rural fieldworkers who use OCs, and where those users obtain their information. In order to do this, this study had the following objectives:

1. To assess the client's knowledge of OCs and their correct use.
2. To assess the beliefs of rural OC users regarding safe, effective pill-taking.
3. To determine where rural users obtain their OCs and their information concerning pill use.
4. To determine whether fieldworkers provide correct and adequate information to their clients who use OCs.
5. To identify gaps in the provision of information regarding OCs to both OC users and fieldworkers.

CHAPTER 2

METHODOLOGY

A baseline survey of rural OC users visited by field workers is conducted to determine level of knowledge, attitudes and practices concerning specific issues of oral contraceptive compliance. Separate focus groups are conducted to provide qualitative data, and to assist in the development of questionnaires used for the in-depth interviews. Finally, a number of field workers are observed during home visits to OC users to gain information on their knowledge of OC use and the nature of interpersonal communication on OC related issues with their clientele. The guidelines for observation are derived from information gathered during the focus group discussions and in-depth interviews. This study has three components. Two components, focus groups and field observation, provide qualitative data. The third component, community based interview, provides quantitative data. The sampling procedure for each of the components of the study are discussed below.

Focus Group Study

Before the actual community-based data collection began, a series of twenty focus groups are conducted, ten for GOB and ten for NGO. Out of the ten focus groups conducted for each of GOB and NGO, five are conducted for field workers and five for OC users, one of each in each of the five divisions. Each group was expected to have 8 participants - four from high and four from low OC use areas. Based on MIS reports on OC use in different thana, one thana is selected for each of the four groups for five divisions. The participants of a focus group for workers consisted of eight FWAs from the selected thana- four from relatively high and four from relatively low OC use areas. Similarly, the focus groups for OC users comprised of participants from high and low performing areas in the selected thanas. The performance of workers in a thana, in terms of proportion of OC users, was obtained from the Thana Family Planning Officers. A list of field workers was prepared for each of the selected thanas and information was collected regarding OC use in the work areas in the selected thanas prior to conducting of focus groups. 4

The focus group study was conducted to have a cross-section of information from both field workers and client perspectives for three primary purposes:

a. to explore how and why women behave and feel as they do about family planning in general and oral contraceptives in particular, including their underlying motivations and feelings, beliefs and concepts concerning their bodies and the mode of action of OCs, and who they rely on for information and support with regard to family planning;

b. to explore field workers' attitudes toward the women they serve, family planning in general and the oral contraceptives they provide. This information can be used to target possible service gaps that result in incorrect OC use;

c. to explore content area, consumer language and preferences in learning materials and strategies in order to refine the questionnaires used in the subsequent survey component of the study.

Client Surveys

Using both information obtained from the focus groups and questionnaires developed for previous pill-use studies as a guide, interview instruments are developed which include the following topics: a brief sociodemographic and reproductive history, knowledge and practice of OC use, contraindications for OC use, potential side effects related to OC use and their management, and information about OC related counseling and other services provided by the field workers (i.e. home visit, knowledge of correct use and knowledge of back up methods and referrals for other OC-related problems, knowledge about side-effects and contraindications, etc.). Questionnaires are pretested, and refined based on those results prior to use in the proposed baseline interviews.

This study includes separate samples of OC users visited by GOB and NGO field workers. It is noteworthy that unlike GOB field workers, NGO workers in rural areas are subjected to more variations at the field level due to the existence of different types of NGOs involved with family planning programs in Bangladesh. This is why we considered the same sample size for GOB and NGO groups although NGO activities exist in about one third of the unions as compared to that of number of unions which are covered by GOB activities only.

Table 1 shows the distribution of unions by division where GOB and NGO field workers are operating in family planning related activities.

Table 1. Total Number Of Unions In Bangladesh By Division

Division	Unions		
	GOB	NGO	Total
Chittagong	964	250	1214
Dhaka	864	356	1220
Khulna	394	162	556
Rajshahi	747	341	1088
Barisal	304	23	327
Total	3273	1132	4405

A three stage sampling procedure is employed to select OC users for this study. In the first stage, proportional allocation of the stratified sampling is used to allocate number of unions for five divisions. In the second stage, one work area (unit) covered by an FWA is drawn randomly for each of the selected unions. The units covered by FWAs are well defined and updated list of eligible couples in their units are maintained through logbooks. The FWAs have the list of the current users

of various methods of contraception in their work area. The list of the OC users in selected units is used as a frame for drawing sample for this study. In this study, on an average, thirty current users of OC are selected from each of the selected units. A sample of size 1600 is needed for each of the GOB and NGO groups for a 95 percent confidence and 5 percent margin of error. Allowing for nonresponse and design effect, we can increase the sample size to 2000. The proportional allocation for each division for GOB and NGO groups are shown below. A relatively higher proportion of NGO units are allocated to Dhaka and Rajshahi divisions due to the observed tendency of concentration of NGO activities in those regions. A sharp contrast is observed for Barisal division. The ultimate sampling unit, current users of OC, are drawn randomly for selected units in each division. For this purpose, the list of current users of OC is obtained from the logbooks of the field workers of the selected units (work areas).

Table 2. Proportional Allocation Of OC Users By Division For GOB And NGO

Division	OC Users		Units	
	GOB	NGO	GOB	NGO
Chittagong	600	440	20	15
Dhaka	520	640	18	21
Khulna	240	280	8	10
Rajshahi	460	600	16	20
Barisal	180	40	6	2
Total	2000	2000	68	68

Although the number of work areas of FWAs considered for this study is 68 for each of GOB and NGO groups taking into account round figures for each division to cover the distribution of OC users shown in Table 2, we considered a larger number of units to make sure that there are adequate OC users. Hence, the number of OC users per unit was considered 31 and the total number of working units was prorated to 75 for each of the GOB and NGO areas. Out of 75 GOB areas, 6 units were found as NGO areas and could not be considered. Similarly, from the list of NGOs, 4 areas were found to be covered by both NGO and GOB workers so were excluded from the list. Table 3 shows the distribution of clients successfully interviewed.

Table 3. Percentage Of Clients Successfully Interviewed For GOB And NGO

Division	GOB	NGO
OC Users Sampled	2131	2137
Interviewed	1784	1846
Reasons for Nonresponse		
Not at Home	185	148
Refused/Deferred	3	-
Migrated	86	85
Could Not Be Located	64	52
Other Reasons	9	6
Total Nonresponse	347	291
Percent Successfully Interviewed	84	86
Non User of OC Listed as OC User in FW Register	728	537
Percent of False Reporting and Long Term Discontinuation	41	29

Field Observation

It is observed from the sampling frame, that the FWA registers are not updated in some cases. For that reason, a substantial proportion of respondents were listed in the register as current users of OC, although they were migrated, could not be located, some of them died long ago. But the more surprising and unexpected finding is about the quality of FWA register. It is observed that 41 percent in GOB and 29 percent in NGO of those who were listed in the register as OC users were found to be non-users (never users and long term discontinuers) of OCs at the time of interview.

The distribution of work areas or units determined for this study as shown in Table 2 is used for observation of field workers during actual home visits in order to assess first-hand their OC related knowledge, the nature of their interpersonal communication and the content of the home visit. Field observation is conducted for both GOB and NGO groups similar to the focus group study and the community based interviews. The same units are observed for client survey and field observation for ensuring a better comparability of the responses from clients regarding oral contraception and the actual performance of workers during home visits. Although it can be assumed that quality of home visits would be improved due to the presence an observer, field worker knowledge can still be measured and direct observation can still serve as a guideline for what an average home visit consists of for any given field worker.

Implementation of the Study

Initially this study was undertaken by the Population Development and Evaluation Unit (PDEU) of the Implementation Monitoring and Evaluation Division (IMED) of the Ministry of Planning, Bangladesh in 1995. After the completion of data collection, a preliminary report was prepared. Then an extended analysis was undertaken in addition to the findings from the preliminary analysis in collaboration with the Population Council, Dhaka. This report is a product of the collaborative effort of PDEU, Statistics Department of the University of Dhaka, the Associates for Community and Population Research (ACPR), the Family Health International (FHI) and the Population Council, Dhaka. The technical reviews were held at each phase of the study at PDEU. The data collection, data processing and data entry were conducted by ACPR. Dr. M. Ataharul Islam of the Department of Statistics was the In-Country Project Advisor and he was responsible for the study design, development of questionnaire, data analysis and report writing. The data analysis was conducted at the Department of Statistics, University of Dhaka. Ms. Dorace Trottier of FHI was the Project Coordinator. A Technical Committee was formed and the reviews were made at different phases of the study.

Data Collection Instruments

Three different data collection instruments, a Focus Group Discussion guideline, an individual semi-structured questionnaire and an observation guideline were used for collecting data for the study. The Focus Group Discussion (FGD) guidelines were employed for collecting information from the oral contraceptive users and field workers. Several pretests were conducted before conducting the actual focus groups, in two different divisions in the months of April and May 1995. The pretests were conducted by professional staffs of ACPR. On the basis of results from pretests, the instruments were modified and finalized for collection of data. Then a semi structured questionnaire was developed for conducting the survey on clients of OC. Observation guideline was administered for collecting information from field workers during home visits to OC users to observe their knowledge of OC use and also the nature of interpersonal communication on OC with their clients.

Data Collection

In this study twelve teams were deployed for data collection, each comprising of one Team Leader, one female Observer and two female Interviewers. The field staffs were recruited from amongst the trained staffs of ACPR who had participated in several other studies of similar nature. The field staffs were given a training for two weeks. After the completion of the basic training, the Observers and the Quality Control Officers (QCOs) were given additional training for six days on strategies for observation and quality control. Prior to the field work for the survey on OC users, the twelve Team Leaders worked as listers and completed listing of all the selected GOB and NGO unions. The listers were given training for a week.

To ensure adequate supervision of the field work at every phase of the work, five QCO teams were employed and the members of the research team also made visits to many selected areas.

The preparatory work for the study started in April, 1995. The field work for data collection was delayed due to political disturbances in the country and was conducted during the period from April, 1995 to June, 1996.

CHAPTER 3

BACKGROUND CHARACTERISTICS

The study aimed to determine the knowledge of correct OC use among clients of rural fieldworkers who use the method. Although selection of study participants was based only on these criteria, it is important to note the background characteristics of the women included in the study sample in order to assess their homogeneity. This chapter presents the background information of the study participants, including their reproductive history. The following variables are included: age; marital status; length of union; education; husband's occupation; and reproductive history. Data shown are broken down by the type of fieldworker the clients are served by (GOB vs. NGO). In most cases, characteristics for current vs. past users vary only slightly and are not mentioned separately, if not mentioned otherwise. In our analysis, some important features by users of various brands of OCs are also highlighted. Since September, 1995 a shift has been taking in the distribution of supplies of OC from high dose C-5 (50 mcg of estrogen) to low dose Sukhi (35 mcg of estrogen). Other than C-5 and Sukhi. Some other brands are also being used by the clients such as, Ovacon, Maya, Ovral, Lyndiol, Ovostat etc. Due to small number of users of these brands, we considered three broad categories of brands, C-5, Sukhi and other brands (all other brands excluding C-5 and Sukhi).

Age, Marital Status, Education, Socioeconomic Factors

Most of the women in the study ranged in age between 20 and 39 (83 percent among the GOB group and 81 percent among the NGO group). Table 3.1 demonstrates that among the current users, the age distributions are similar in both GOB and NGO areas. One-fourth of the OC users are observed in the age groups <25, 25-29 and 35 and over, compared to one fifth in the age groups 20-24 and 30-34. In both GOB and NGO catchment areas, another interesting similarity is observed. In comparison with the age composition of the current users of C-5, it is seen that users of Sukhi are relatively older and users of other methods are relatively younger. It is seen from Table 3.4 that fifty two (GOB) to fifty five percent (NGO) of the current users are less than 30 years old, compared to 46 percent (both GOB and NGO) of the Sukhi users and two-thirds of the users of other methods.

Almost all of the women were Muslim. The overwhelming majority (99 percent in both groups) were married, and most had been in union for between 5 to 24 years.

More than half of the respondents had no formal education; their spouses were slightly more educated (41 percent of GOB spouses and 44 percent of NGO spouses had no education). More than half of the current users (53-54 percent in GOB and NGO) did not have any formal education, compared to less than one-third with primary schooling and 15 percent with high school or higher level of education (Table 3.1). Although C-5 and Sukhi users had similarities, users of other brands are seemed to have higher level of education (one-third in GOB and one-

fifth in NGO areas had high school or higher level of education). This indicates that the users of other brands represent a selective group of relatively higher educated women compared to the users of C-5 and Sukhi (Table 3.4).

It is evident from Table 3.1 that about one third of husbands were employed in agriculture (39 percent GOB, 38 percent NGO). Another fourth worked in business/trade (24 percent GOB, 25 percent NGO), and around 20 percent were reported as working as day labourers (19 percent GOB, 21 percent NGO). Not surprisingly, a bit more than half of the respondents had cultivable land (57 percent GOB, 53 percent NGO).

Approximately one fourth of the women in the study belonged to a women's group (25 percent GOB, 26 percent NGO) . The specific women's group varied somewhat between GOB and NGO respondents. Well over half of the women stated that they listen to radio or television (62 percent GOB, 59 percent NGO).

Reproductive History

More than half of the respondents had between 2 and 4 children (57 percent GOB, 54 percent NGO). Women served by GOB fieldworkers appeared to have slightly more children than those in the NGO group (30 percent if GOB women had 5 or more children, as compared to 29 percent of NGO women). The differences by brands of OC of the current users match with the age compositions, for instance, compared to users of C-5, users of Sukhi and other brands have higher and lower number of children ever born, respectively (Table 3.4).

Table 3.2 shows that only a seventh of the women had gotten pregnant since the birth of their youngest child (16 percent in both groups). Of those who had conceived since their last birth, more than one third were currently pregnant (37 percent GOB, 45 percent NGO).

Last Pregnancy and Desire for More Children

In more than half of the cases, the woman's last pregnancy was not preplanned (62 percent GOB, 55 percent NGO), which may indicate that pill use was not correct or consistent (Table 3.2). This seems especially likely given that a pre-planned pregnancy was less likely to occur among current users than among past users (74 percent of current users among GOB had not planned their pregnancies vs. 56 percent of past users; 62 percent of NGO current users had not planned the pregnancy, vs. 51 percent of past users). This is consistent with the finding that more than two thirds of the respondents were likely to say that they did not want any additional children, regardless of current pill use (70 percent GOB, 66 percent NGO).

The last pregnancy was planned in case of only one out of eight to nine users of other brands, which is substantially higher for C-5 and Sukhi users (Table 3.4). This information contradicts with the finding that the users of other brands have relatively higher level of education. The women with higher schooling are expected to plan their pregnancy, at a higher rate than the

corresponding C-5 and Sukhi users. However, this may be attributed to: (i) users of other brands depend more on husband/relatives or FWs for procuring supplies of their choices of OC that might result in irregularity of use; (ii) relatively younger clients of other brands who had not attained their desired size of family, and (iii) small size of users of other brands. It is more likely that young age of other brand users explain this unexpected result which is also reflected from the response of clients on desire for additional children where it appears that other brand users expressed their desire for additional children at a higher proportion than the users of C-5 and Sukhi.

Respondents who said that they did not want more children were most likely to state that it was because they did not have the means to support them (31 percent GOB, 30 percent NGO), that it was difficult to educate the children (27 percent GOB, 29 percent NGO), or that they already had enough children (30 percent GOB, 27 percent NGO). Among women who did want more children, most wanted only one more child (84 percent GOB, 76 percent NGO). The most common reasons given for wanting more children were that they needed a son (39 percent GOB, 39 percent NGO), that they needed another child regardless of sex (32 percent GOB, 28 percent NGO), or that they needed a daughter (22 percent GOB, 22 percent NGO) (Table 3.3).

These findings are consistent with those of the focus groups, where the women stated that they wanted to have more children because they either did not have any, or because they or their husband wanted a child of the sex they did not have. Some women were also concerned that they might lose the children that they did have due to the high levels of infant and child mortality. The women who did not want more children stated that they could not afford any more, and that they had attained their desired family size. The advantages of smaller families, particularly those relating to health and economics, were mentioned frequently in the focus group discussions.

Characteristics of Users by Brands of OC

Table 3.4 shows the characteristics of current users of different brands of OC. Among the users of OC, 34 percent were using C-5, 55 percent Sukhi, and 11 percent other brands. Both the users of C-5 and other brands appeared to be younger than the users of Sukhi. Two-thirds of the other brand users and 52-55 percent of the C-5 users were 29 years or younger at the time of interview in both GOB and NGO areas as compared to 46 percent Sukhi users. This indicates that the majority of the Sukhi users are aged 30 years or older.

More than 50 percent of the C-5 and Sukhi users in both GOB and NGO areas do not have any formal schooling, compared to one-third in GOB and 46 percent in NGO among users of other brands. About 28-35 percent of the users of different brands of OC have primary level schooling, however, one-third of the users of other brands have high school or higher level of education in GOB areas which is much lower in NGO areas (19 percent).

Lower parity women of 3 or less use C-5 (57-60 percent) or other brands (nearly two-thirds) at a higher proportion than Sukhi (50 percent) in both GOB and NGO areas. It is interesting to note that the parity 1 women prefer other methods more as compared to C-5 or Sukhi.

There is a substantial variation in the use of different brands by age of youngest child. If the age of youngest child is less than two years then Sukhi (about 60 percent) or other brands (two-thirds) are used in greater proportion than C-5 (half of the C-5 users).

Only one-fourth of the GOB users and 39 percent of the NGO users who reported pregnancy after the birth of the youngest child had planned to give birth to an additional child (Table 3.2). This kind of planned pregnancy was the highest among C-5 users (only one-third of those cases though) in GOB areas and among Sukhi users (53 percent) in NGO areas. Most of these pregnancies among other brand users were reportedly unplanned.

More than two-thirds of the C-5 and Sukhi users as compared to 61 percent of the other brand users do not want additional children. A relatively higher proportion of the C-5 and Sukhi users expressed their willingness not to have any additional children as compared to that of other brand users of OC.

Majority (56 - 64 percent) of the C-5 and Sukhi users had been using these brands since the time of acceptance of OC in both the GOB and NGO areas, compared to 50 percent among the current users of other brands of OC.

About three-fourths of the OC users of C-5 and Sukhi named FWs as their source of knowledge of OC (Table 5.2a). Among the other brand users, 49 percent in GOB and 42 percent in NGO areas learnt about OC from the same source. Relatives or media are mentioned as the source by 32 percent and 38 percent of the other method users in GOB and NGO areas respectively, compared to less than 25 percent users of C-5 and Sukhi.

CHAPTER 4

ATTITUDE AND PRACTICE

This chapter presents the attitude and practice of oral pills among current or past users of OC for clients living in GOB and NGO areas. This chapter covers the following variables: (i) current or past use of oral pills, (ii) method being currently used by past users of OC; (iii) brand of OC currently used; (iv) number of times OC used uninterruptedly; (v) duration of use of OC; (vi) reason for discontinuing OC; (vii) duration of discontinuation; (viii) whether used any other method before using OC; (ix) method used before using OC; (x) reason for switching to OC; (xi) whether used any other method; and (xii) preferred brand of OC. The total number of respondents in the GOB and NGO samples are 1403 and 1600 respectively.

Current Users and Past Users

Among the respondents in GOB areas, 57 percent are current users and 43 percent are past users of OC (Table 4.1). Among the past users of OC, 24 percent are currently using another method of contraception. This indicates that three-fourths of the past users of OC are not currently using any method of contraception. Similar findings for NGO areas indicate that out of 1600 respondents from NGO areas, 64 percent are current users. Out of the past users, 24 percent are currently using a method.

Use of Methods among Past Users of OC

Among the past users of OC those who are currently using any method of contraception, most of the clients switched to injectables, 38 percent in GOB and 45 percent in NGO areas (Table 4.1). It is surprising that a substantial proportion of past users of OC (more than one-fourth in both GOB and NGO areas) switched to traditional methods. More than one-fifth of current users of a method among past users of OC are currently using condom in GOB areas, compared to 17 percent in NGO areas.

Brand of OC Used by Current Users

Most of the users are currently using Sukhi (55 percent in GOB and 45 percent in NGO areas) followed by C-5 (34 percent in GOB and 40 percent in NGO areas) as demonstrated in Table 4.2. There are 6 percent Ovacon users in GOB areas, compared to 5 percent in NGO areas. Other methods are being used only by a negligible proportion of current users.

Number of Spells of OC Use

The majority of the current and past users used OC only for one spell (55 percent in GOB areas and 59 percent in NGO areas among current users and three-fourths among past users). One-third of the GOB users and more than one-fourth of the NGO users have used OC in two spells. Three spells of OC use was reported by 9-12 percent of current or past users (Table 4.3).

Duration of Use of OC During Current/Last Spell

About one-fourth of the current users are continuing to use OC for less than one year. The largest proportion of current users are using the method for more than two years but less than four years (28-30 percent) in both GOB and NGO areas. It is noteworthy that one-fourth of the users continued the use of OC for more than four years (Table 4.3).

We do not obtain any rate of continuation or discontinuation from among the current users. However, the duration of use of OC by past users would provide us with such estimates. It is observed that about half of the past users in both GOB and NGO areas discontinued use of OC before completion of one year. Similarly two-thirds of the past users discontinued within two-years. Only 10 percent of the users continued use of OC for more than four years.

Reason for Discontinuation of OCs

The majority of the past users discontinued their use of OC due to side effects (53 percent in GOB and 47 percent in NGO areas). This is similar to findings reported in BDHS 93-94 (NIPORT, 1994). It is surprising that 21-24 percent of the past users mentioned desire for additional children as the reason for discontinuation of use of OC. Only 3-5 percent reported the objection by in-laws as the reason for discontinuation. About 18 percent discontinued use of OC due to other reasons (Table 4.4).

Out of all the clients who discontinued due to side-effects, two-thirds did not use any other method in both GOB and NGO areas, 6-7 percent switched to condom, 15 percent in GOB and 19 percent in NGO areas preferred to switch to injection and IUD, and 11 percent in GOB and 8 percent in NGO switched to traditional methods (Table 4.4a). Due to side-effects these transitions take place among 53 percent in GOB and 47 percent in NGO areas of the OC clients who discontinue the use of OC. This finding has an important policy implication. It indicates that instead of desire for additional children, side-effects of OC have emerged as the most crucial barrier to continuation of use of OC. Furthermore, most of the clients who discontinue due to side-effects, either do not use any other method or switch to traditional methods or condom. Only a negligible proportion prefer a longer acting methods such as injection and IUD.

The problem of side-effects is discussed by workers with only 4 percent of the new acceptors in GOB and 13 percent in NGO areas according to the workers' observation data.

Whether Used Any Method Before Use of OCs

Only 22-24 percent of the current users and 14-20 percent of the past users reported use of other methods of contraception before use of OC (Table 4.5). Among those respondents who had prior history of using other methods of contraception, 48-52 percent switched from injectables for current users. It is interesting to note that half of the past users who change method, switch from OC to injectables, and in contrast, half of the current users with history of use of other methods, switched from injectable to OC. Hence the switching between OC and injectable seems to be a popular choice. Among other methods, 18-25 percent of the current or past users (with history of prior use of contraception) reported condom as the last method, compared to 16-17 percent having prior use of IUD. Among the past users, 10-20 percent used traditional methods before they started to use OC.

Reason for Switching to OCs

The problem associated with side-effects of various methods appears to be the dominating reason for switching from or to OC. Half of the switching from or to OC are associated with injectables. Another substantial proportion of switch is made from IUD. According to the BDHS 93-94, the rates of first-year discontinuation attributable to side-effects are 57 percent for pills, 81 percent for IUD and 69 percent for injection. These three methods are popular, particularly pills followed by injectables, but the rates of discontinuation are also very high due to side-effects.

In this study we observed that majority of the clients who switched from other methods to OC reported side-effect of the previous method as the main reason for making such decision. Another reason related to side-effects is (ranging from one-fifth to one-third of the current or past OC users with a history of prior use of contraceptives) the less side-effects of OC. This is indicative of the fact that among the clients there is a desperate search for a method with lesser side-effects, and they consider OC as a method with that quality. On the other hand, only 11 percent of the current users and 5-7 percent of the past users think that OC is a method without any side-effects. It is noteworthy that OC is reported as a method with no side-effects by a lower proportion of past users than that of current users (Table 4.6).

One-fourth of the OC users in NGO and one-third in GOB areas consider OC as a method which is easy to use. This might be one of the important reasons for the widespread popularity of OC among women belonging to different socio-economic status.

It is observed from the discussion in focus groups that pills are utilized extensively for regularizing menstruation and in some cases for controlling menstruation. It is revealed from FGDs that there are multiple use of oral pills, for instance, to control menstruation during the month of Ramadan, white pills are taken from consecutive packets and iron tablets are thrown away by many women. This is mentioned by 15-17 percent of the current users and 9-16 percent of the past users (higher in NGOs) as the reason for switching to OC.

Whether Used Any Other Brand of OC

This question is asked only to the current users to obtain reliable answers. Two-thirds of the current users of OC responded that they used another brand of OC in the past. Most of these changes (two-thirds in both GOB and NGO areas) in brands of OC occurred due to change in the brand from C-5 to Sukhi just prior to the study was conducted. Other than C-5, Ovacon and Ovostat are reported as the previous brands of OC by 10 percent and 7-9 percent of the clients respectively (Table 4.7).

The reason for changing the brand reveals the following: (i) change in the brand by the government from C-5 to Sukhi is the major reason (64 percent in GOB and 51 percent in NGO areas); (ii) side-effect is mentioned by 17-20 percent of the current users of OC as the reason for change in the brand; and (iii) high price of the previous brand compelled to change the brand in case of 6-8 percent of those who changed a brand. Another observation needs attention here is that in NGO areas 11 percent reported that their new supplies of changed brand is supplied by the government workers. This fact reflects that there are some NGO areas where both GOB and NGO workers provide supplies at door-steps.

It is observed from FGDs that the most ever-used brand of oral pill among the OC users is C-5. This is obvious, because the major source of supplies of oral pills is the fieldworkers who supply C-5. The recent changes in the government system to introduce a lower dose oral pill, Sukhi, is also evident. A substantial number of oral pill users (31) have ever-used Sukhi. Four other brands (Maya, Ovacon, Ovostat, Norquest) are also used by negligible proportions of OC users. Among the currently used brands, C-5 and Sukhi are the two major brands. Only 3 OC users stated that they take Ovacon, and 1 OC user take Norquest. The major reasons for switching of brands are: (i) it was supplied by fieldworker and suggested that the new brand is better, (ii) the previous brand is not available, (iii) the current brand is free of cost, and (iv) side-effects with the previous brand. There is a specific comment by some OC users that husbands do not want to bring pills of their choice or it is hazardous to ask children to bring pills.

Preferred Brand of OC

A large proportion of past users (37-40 percent) and a modest proportion of current users (11-15 percent) responded that they do not have any idea of preferred brand of OC. The most preferred method among both current users (41-45 percent) and past users (31-37 percent) is the old method C-5. Sukhi is preferred by 23-27 percent of the current users and 7-8 percent of the past users. Among other methods, Ovacon and Ovostat are preferred by 11-15 percent of the users. Two-thirds of the current users mentioned less side-effect as the major reason for preferring their brand, while more than half of the past users mentioned other reasons for their preference (Table 4.8).

CHAPTER 5

KNOWLEDGE, AVAILABILITY AND SOURCE OF SUPPLY OF ORAL CONTRACEPTIVES

This section addresses the issues of client knowledge relating to oral contraceptives, where rural users obtain their OCs, and where they get their information concerning pill use. Specific variables that are included in this chapter are: OC related knowledge; source of knowledge; who motivated the client to use pills; preferences in contraceptive methods in general and the pill in particular, as well as the reasons for those preferences; source of OCs; alternative sources; source of last packet; average number of cycles received at a time; interruptions in supply and clients response to such interruptions; and questions regarding cost of oral contraceptives.

Knowledge Regarding Oral Contraceptives

Respondents were asked to mention some of the most important things that they knew concerning the pill. Almost 99 percent (in both GOB and NGO) mentioned that the pill prevents pregnancy irrespective of the brand they are currently using (Table 5.1). The second most common response was that the pill must be taken every day (53 percent GOB, 58 percent NGO). This response was also similar for users of different brands with an exception among users of other brands in NGO areas where 46 percent users of OC have the knowledge that pills should be taken every day. A quarter of the women said that the pill has no or few side-effects (21 percent GOB, 24 percent NGO), although current users were more likely to say this than past users. It is note worthy that more than one-third of the current users of OC of other brands know that the pill has no or few side-effects (Table 5.1a). Almost one-fourth said that taking the pill improves her health (23 percent GOB, 22 percent NGO), which is substantially lower in GOB areas (15 percent) among users of C-5. Other frequent responses were that pill use regulates menstrual periods (19 percent both GOB and NGO; current users were more likely to know this than past users and similarly C-5 and other brand users in NGO areas are more likely to know this than corresponding users in GOB areas); that the pill can be discontinued at any time (16 percent GOB, 20 percent NGO; slightly more so among past users than current users) and that it is easily available (14 percent GOB, 15 percent NGO; slightly more common among current than past users). These responses mirrored the discussions of participants in the focus groups held prior to collecting survey data for this study. Observation of fieldworkers showed that the most commonly mentioned information given was also consistent, with the most common things mentioned being that the pill must be taken every day, and that it prevents pregnancy.

Source of Knowledge and Motivation to Use Pills

Women were asked where they had received this information; the most common responses were from either a fieldworker (67 percent) or from a friend, relative or neighbor (17 percent GOB, 19 percent NGO). These are shown in Table 5.2. Three-fourths of the OC users of C-5 and Sukhi

named FWs as their source of knowledge of OC. Among the other brand users, 49 percent in GOB and 42 percent in NGO areas learnt about OC from the same source. Relatives or media are mentioned as the source by 32 percent and 38 percent of the other method users in GOB and NGO areas respectively, compared to less than 25 percent users of C-5 and Sukhi (Table 5.2a).

Clients of NGO fieldworkers also mentioned that they had received their information from a government fieldworker (17 percent), which once again shows the overlap among government and non-governmental fieldworkers. To examine the possible sources of knowledge about OC in GOB and NGO areas, another table is constructed for GOB and NGO by brand of OC used by the clients. It is revealing that while more than 70 percent of the C-5 and Sukhi users mentioned GOB fieldworkers as the source in GOB areas, 50-59 percent of the clients in NGOs reported NGO workers as their source of knowledge about OC (Table 5.2a). About 17-19 percent of the clients of C-5 and Sukhi in NGO areas mentioned GOB workers as their source compared to 1 percent of the users of Sukhi in GOB areas mentioned NGO workers as the source of such knowledge. This pattern is some what different among users of other brands. Among those clients, 49 percent in GOB areas and 8 percent in NGO areas mentioned GOB fieldworkers as their source of such knowledge, compared to 34 percent in NGO areas mentioned NGO fieldworkers as the source. A large proportion of other brand users in both GOB and NGO areas (44-45 percent) reported friends or relatives, husbands or mass media as their source of knowledge where friends and relatives play the most dominant role. However, in general, friends, relatives or neighbors were next to fieldworkers (20 percent GOB, 21 percent NGO).

When asked who had motivated them to take oral contraceptives, the responses were similar: fieldworkers were the most common response (48 percent GOB, 37 percent NGO); and once again clients of NGO fieldworkers also mentioned GOB fieldworkers (13 percent). However, husbands were also mentioned as an important source of motivation (19 percent GOB, 18 percent NGO), more likely so for other brand users (29 percent in GOB and 28 percent in NGO).

During the observation of fieldworkers, it was seen that education and motivation for family planning in general and oral contraceptives in specific was given most frequently to new users or to women who were not currently using a method. Current users were not given this type of information or motivation.

Reason for Preference for OCs

Women were asked why they preferred oral contraceptives, and were allowed to give more than one reason. Responses varied somewhat depending on whether or not the women were current or past pill users (Table 5.3). The two most common responses were fear of other methods (45 percent GOB, 44 percent NGO) and because the pill had no or fewer side-effects than other methods (43 percent GOB, 45 percent NGO). These patterns are similar among clients of all the available brands. Both of these responses were more common among current than past users. Respondents also frequently mentioned that the pill was easily available (31 percent GOB, 36 percent NGO); and that OCs could be discontinued at any time (24 percent GOB, 28 percent

NGO, mentioned more frequently by past users than by current ones). Pills were perceived as less hazardous than other methods by around a fourth of the women (21 percent GOB, 25 percent NGO). A closer look at this response reveals that a relatively higher proportion of other brand users, compared to C-5 and Sukhi users, mentioned less hazard as the reason for use of pills. This is again indicative of the fact that the brands supplied by the FWs are perceived as more hazardous than those sold in the shops (Table 5.3a). Some women said that they preferred pills because they improve their health (19 percent GOB,, 16 percent NGO). Both of these responses were mentioned more often by current users. Mention was also made of the temporary nature of the method (18 percent GOB, 15 percent NGO, mentioned more often by past users, and, among clients of government fieldworkers, of the fact that pills were available free of charge (15 percent GOB, 9 percent NGO) which is reported more often by users of C-5 than users of Sukhi in both GOB and NGO areas.

Table 5.4 shows that the majority of respondents preferred pills over any other method (85 percent GOB, 86 percent NGO), although this preference was understandably more marked among current users (96 percent GOB and 94 percent NGO current users vs. 70 percent GOB and 71 percent NGO past users). A further investigation by brands show that the preference of pills over any other method is similar among users of various brands in both GOB and NGO areas. Among the women who did prefer another method over the pill, the most commonly mentioned method was the IUD (35 percent GOB, 45 percent NGO, once again mentioned more often by past users than current users, as indeed were all methods mentioned). This finding was different than that of the focus group discussions, where most participants mentioned injectables if they preferred another method over the pill.

Women who preferred other methods did so primarily because of side-effects related to pill use (61 percent GOB, 57 percent NGO, more common among past users). Two other common reasons were that the women needed a long term method (32 percent GOB, 33 percent NGO) and because it was hazardous to take a pill every day (23 percent GOB, 29 percent NGO). Both responses were more common among current users.

Responses from the focus group discussions help to understand some of the survey information in more depth. In terms of availability, the focus group participants clarified that not only was the pill readily available, it was brought to their doorsteps, which helped to ensure privacy. This was one of the reasons that it was preferred over other methods such as injectables or IUDs, which must be procured at a clinic or hospital. Having to go to such a facility is not only less convenient, others are more likely to be aware that the women have gone to procure family planning methods than if they avail themselves of methods from a worker in their own homes. Focus group participants also said that their husbands preferred oral contraceptives, particularly over condoms.

Source of Pills

About three fourths of the women in the study usually get their pills from a fieldworker (Table 5.5). Most women in GOB catchment areas get their supplies from a government fieldworker (72 percent), although a few obtain their supplies from either an LIP volunteer (8 percent). The same is true in the areas served by NGO workers: approximately 73 percent got their pills from NGO fieldworkers and 13 percent from GOB fieldworkers. Some women obtained their pills from pharmacies (10 percent GOB, 6 percent NGO).

The fieldworkers/LIP volunteers supplied more than 90 percent of the supplies of OC to the C-5 and Sukhi clients in both GOB and NGO catchment areas, however, other brands are obtained mainly from pharmacies or markets/shops in GOB areas, 57 percent and 20 percent respectively (Table 5.5a). In NGO catchment areas, half of the clients of other brands get their supplies from these two sources. In GOB areas, 13 percent of the users of other brand depend on the fieldworkers/LIP volunteers for their supplies of pills, compared to 42 percent getting their supplies from NGO fieldworkers in NGO areas. This indicates that users of other brands of pills, depend on three major sources for their supplies irrespective of GOB or NGO catchment areas: (i) pharmacy, (ii) market/shop, and (iii) NGO fieldworkers.

Respondents were also asked where they obtained their last packet of pills; responses were virtually the same as those given for their usual source of supply. Almost all of the women obtain their supplies from the same source all year long (99 percent GOB, 98 percent NGO). However, two thirds or more of the women indicated that they do sometimes use sources other than their main source (68 percent GOB, 73 percent NGO). The most commonly mentioned alternative sources were hospitals or clinics (41 percent GOB, 37 percent NGO), pharmacies (35 percent GOB, 33 percent NGO), and markets or shops (34 percent both GOB and NGO), all of which were mentioned about one third of the time. Fieldworkers were also mentioned by about a fourth of the women (24 percent of government served women mentioned GOB workers, 23 percent of NGO served women mentioned NGO workers, and an additional 18 percent of NGO served women mentioned government workers.) This finding once again shows that there appears to be an overlap in service between GOB and NGO fieldworkers.

Number of Cycles of Pills Received

Respondents were asked how many packets of pills they received when they first started taking pills, how many they usually receive, and how many they received the last time. Almost three fourths (71 percent) of the women in GOB areas indicated that they first received 3 packets, and more than half (58 percent) of those in NGO areas also said that they received 3 packets when they began the most current spell of pill taking (Table 5.6). This is not similar with respect to brand (see Table 5.6a). In GOB areas about 80 percent of the C-5 and Sukhi users, compared to a little higher than 60 percent in NGO areas, received three packets, however, other brand users in both GOB (66 percent) and NGO (57 percent) areas received only one packet of pills at the time

of their starting of OC use. It was not uncommon among the C-5 and Sukhi brand users as well to have received 1 packet (5-10 percent GOB, 17-21 percent NGO) or 2 packets (10 percent GOB, 14-21 percent NGO).

When asked how many cycles they usually receive at a time, the proportion of recipient of three cycles have declined substantially as compared to the reported number of packets received at the time of first start of OC use for both C-5 and Sukhi. However, fewer women indicated that they usually receive 3 packets in NGO (29 percent Sukhi and 50 percent C-5) than in GOB areas (68 percent Sukhi and 61 percent C-5). Among other brand users, 83 percent in GOB and 90 percent in NGO areas receive usually one or two packets. It was, however, still the most common answer, given by around half of the respondents (54 percent GOB, 37 percent NGO). Most other women indicated that they usually receive either 2 packets (20 percent GOB, 31 percent NGO) or only 1 packet (16 percent GOB, 24 percent NGO). Three, two and one cycles for C-5 and Sukhi in GOB as well as for Sukhi in NGO areas, and two, three and one for C-5 in NGO areas were the most common number of packets that the women last received (Table 5.6a).

During the observation of fieldworkers, it could be seen that the numbers given by the users were consistent with the number of packets actually provided by the workers. Government workers most often provided 3 packets at a time, whereas NGO workers were more likely to provide 1 packet at a time.

Availability of Supply

An overwhelming majority of women did not experience any interruption in supply over the last three months (96-97 percent). It is interesting to note that there is no variation for different brands of pills as well (Table 5.7). For those few women who did mention that they had experienced an interruption in supply, the break was most often attributed to the fieldworker not coming (73 percent GOB, 76 percent NGO, for both government and non-government fieldworkers). If an interruption in supply was experienced, the women were asked how they responded. It is interesting to note that, although respondents mentioned other commercial sources as alternative supply options (see above), they did not say that they used these options when they had an interruption in supply. Many women simply borrowed from neighbours. Those women who did obtain replacement pills were most likely to borrow pills from a neighbor or relative (30 percent GOB, 35 percent NGO). A fifth to a fourth did purchase pills (20 percent GOB, 23 percent NGO). It is interesting to note that this response varied among current and past users; current users were more likely to have borrowed or purchased pills, whereas past users were more likely to have stopped taking the pills.

In addition to the sources of supply mentioned above, focus group participants also mentioned government clinics, hospitals and doctors. Although all of these alternative sources were mentioned, it was clear from the discussion that most women do not use them if they run out of pills. Rather, they borrow pills from relatives or neighbors, or they contact the fieldworkers themselves to request additional packets of pills.

Purchase of Oral Contraceptives

Respondents were also asked if they had ever purchased pills, if so who had purchased them, how much they had paid for the pills, and whether or not they would be willing to pay for pills (see Table 5.8). More women within the NGO group had purchased pills in the past than had those in the government group (63 percent NGO vs. only 36 percent GOB). Among women who had purchased pills, women in the NGO group were more likely to have purchased the pills themselves (56 percent NGO vs. 12 percent GOB), which is even more likely among the users of C-5 and Sukhi than that among other brand users in NGO areas. Husbands purchased the pills more often for the GOB group (82 percent) which is almost similar for users of different brands and were the second most likely to have purchased the pills in the NGO group (33 percent) and at a rate more than twice among other brand users than the C-5 and Sukhi users in NGO areas.

Although NGO women were more likely to have purchased pills, the price of those pills was less (more than half of the women paid only 1 Taka) than that paid by women who had purchased pills in the GOB group (approximately 35 percent paid 5 to 6 Taka). This has been observed irrespective of users of different brands. It is more likely that pills are supplied at a relatively lower price by the NGO FWs compared to their GOB counterparts.

The majority of respondents (86 percent in both GOB and NGO groups) would be willing to pay for pills if there was a charge for them in the future. This response is more positive among the current users and interestingly among more than 90 percent users of pills in GOB and NGO areas alike. More than half of the women (57 percent in both groups) would be willing to pay for the pill because they want to prevent births, which is considerably higher among the current users, but appears to be highest among users of other brands closely followed by users of C-5. Many respondents also said that it was difficult to educate many children, and that they did not have the means to feed or educate more children (41 percent both groups). Other common reasons mentioned were for the welfare and well being of the family (21 percent GOB, 16 percent NGO) and that the woman's health would deteriorate if she had more children (16 percent GOB, 15 percent NGO). Among the small number of women who said that they would be unwilling to pay for pills if the necessity arose, the most common reason was that they did not have the ability to do so (Table 5.9); this percentage, however, was also small (5 percent GOB, 6 percent NGO).

Once again, these findings were reminiscent of those discussed in the focus groups. The majority of participants agreed that, should the government introduce a token fee for oral contraceptives, women would pay it because they very much want to limit or space their births. It is worth noting, however, that participants also cautioned that poorer people would not purchase the pills.

CHAPTER 6

USE OF ORAL CONTRACEPTIVES

The respondents are asked about their knowledge and practice of taking oral pills in reality and the gaps between knowledge and practice of OC are identified through specific questions.

The principal objective of this study is to identify the following: (i) whether OC users take OC in correct order, (ii) start using OC from the correct day, (iii) knowledge and practice of starting second strip, (iv) knowledge and practice of use of OC after skipping one or more pills, (v) problems associated with continued use of OC; (vi) knowledge about brown pills, (vii) use of OC at the time of sickness, etc.

Starting Use of OC

The OC users appear to have started using OC from different days during or after menstruation. Most of the respondents (47-54 percent) irrespective of current or past use and GOB or NGO areas, started using OC since the end of menstruation (Table 6.1). However, substantial proportions of current or past users begun using OC since the first day of menstruation (15-18 percent) or between second to fourth day of menstruation (15-20 percent). Fifth day of menstruation is reported by 7-9 percent of the OC users.

Among the current users of different brands, about one-fifth of the Sukhi users in both GOB and NGO areas begun use of OC from the correct day, first day of menstruation, compared to one-tenth of the current users of C-5 (Table 6.1a). However, about fifty percent of the current users in GOB areas irrespective of their brands first started using OC after the end of menstruation, which is slightly higher in NGO areas.

The correct response by age does not show any association in either GOB or NGO areas. The correct response was lowest in the age group 20-24 in GOB areas (16 percent) and the age group 35 and over in NGO areas (13 percent). It is evident that variations by age are not substantial. Similar broad conclusions can be drawn from the association with parity, age of the youngest child, whether the client is a first time user or not and correct response (Table 6.1b). However, if we examine the variations by education, then a positive association between education and correct response on correct day of starting use of OC is observed. Twenty eight percent in GOB and 25 percent in NGO among respondents with high school or higher level of education could respond correctly, compared to thirteen-fifteen percent among respondents without any formal schooling in both the GOB and NGO catchment areas. The correct response is observed to be relatively higher among clients who get their usual supplies from relatives (19-21 percent) but it is lower if the source is FWs (15 -17 percent).

The source of this knowledge is mainly FWs. About 60-65 percent of the respondents referred FWs (NGO or GOB) as their source of such knowledge. Only 6-8 percent of the respondent learnt about the starting of use of OC from husband and 18-19 percent reported friend/relative as their source of information.

The selected OC users for FGDs have mentioned that they start taking pills from the arrow mark, then they take pills every night, take every pill of a strip, and continue brown pills even if menstruation is started. All the participants agreed that the pills should be taken every day.

The participants of different focus groups could not come to a consensus about the first start of taking oral pills. The views are quite different ranging from first day of menstruation to sixth day of menstruation and according to one group the starting point should be from the date of completion of menstruation. The pattern is similar for both GOB and NGO units.

From the workers' observation data, it appears that more than one-third (38 percent) of the new clients of OC are briefed by their workers in both GOB and NGO areas that the pill should be started since the first day of menstruation. Hence most of the new acceptors are not told about their starting of use of OC on the first day of getting their supplies. In addition, about 9 percent of the new acceptors of OC clients in GOB areas are instructed start taking oral pills either at the end of menstruation or between second to fourth day of menstruation.

Taking a Pill Every Day

Among the past and current users in GOB or NGO areas 6 percent of the users do not take pill every day. Two-thirds of the respondents learnt about taking pill every day from FWAs or LIP volunteers, FWAs in higher proportions among C-5 and Sukhi users in GOB areas and LIP volunteers in higher proportions in NGO areas, however, the help from workers or volunteers appeared to be substantially less among the users of other brands (Table 6.2). It is note worthy that 6-7 percent are taking pills without getting knowledge from anybody else, and a substantial proportion in both GOB and NGO areas (13-16 percent) taken help from friends/relatives, which is more likely to happen among other brand users, one-fourth in GOB and 28 percent in NGO areas (Table 6.2a). Husband is the source for this information only for 3-4 percent of the respondents, but considerably higher among other brand users in GOB areas (14 percent).

The workers are expected to instruct their clients to take one pill every day at the time of providing first supply to a client, but it is observed from workers' observation data that this message is provided to only 21 percent of the new acceptors in GOB and 13 percent in NGO areas.

Order of Taking Pills

Among the past users in the GOB areas three-fourths of the clients started from the beginning of arrow mark, compared to 87 percent of the current users in NGO and GOB areas. The pattern has been found similar among users of different brands. However, 6-10 percent of the users started

from opposite of the arrow mark. From the upper left position 5-10 percent of the clients started using OC (Table 6.2).

The order of taking pills has been examined by various characteristics of current users located in NGO and GOB areas. There is no remarkable differential pattern by age, education, parity, age of youngest child, desire for additional children, and source of supply of OC. However, a higher proportion of first time users of OC in both GOB and NGO areas are seemed to have knowledge about the correct order of taking pills.

There are variations in the opinion of focus groups of participants regarding the order of taking oral pills. Although most of the participants are in favour of starting from the beginning of arrow marks, one of the participants from GOB mentioned opposite to arrow as well.

Observation data show that the workers instruct 55 percent of the new acceptors in GOB and 48 percent in NGO areas that the pills should be started from the beginning of arrow mark.

It is also observed from the workers' observation data that workers checked the order of taking oral pills of the current users of OC in case of 8 percent of the clients of OC in GOB and 26 percent in NGO areas. Hence, the workers appear to ignore one of their important tasks at the time of their follow-up visits.

Time of Taking Pills

Almost all (more than 98 percent) of the clients take pills at night in GOB and NGO areas irrespective of current or past users and current users of various brands of OC.

Time of Starting a New Cycle

This is an important question regarding correct use of OC. The correct answer is reported by 79 percent of the current and 71 percent of the past users of GOB, compared to 83 percent of the current and 74 percent of the past users of NGO (Table 6.2). The time of starting is second to fourth day of menstruation among 9-11 percent of the GOB clients and 6 percent of the NGO clients. The extent of incorrect use is found to be relatively higher among all brand users in GOB areas, one fourth among C-5 and other brand users and one-fifth among Sukhi users. The other brand users in NGO areas have relatively higher proportion of incorrect starters in NGO areas which is comparable to clients of GOB areas. Fifth day of menstruation is reported by 4-5 percent of the clients in both GOB and NGO areas.

It is agreed by almost all the focus groups of participants from both GOB and NGO working units that after the completion of one strip of pills, the second strip should be started from the next night, only one group of participants from an NGO unit mentioned that the next strip should be started from fifth day of menstruation.

Workers' observation data show that starting a new cycle from the next day after finishing one cycle of pill is instructed to 17-19 percent of the new acceptors in GOB and NGO areas at the time of receiving their first supplies from workers.

Source of Consultation about Problems Taking Pills

Among the current users, the most likely person from whom a client would seek advice is a fieldworker. Seventy percent of the current GOB clients and 71-77 percent of the NGO clients would have discussed their problem regarding taking pills with fieldworkers. The past users would have done the same at a lower proportion in GOB areas (64 percent). In GOB areas, an additional 5-6 percent responded that they would talk to LIP volunteers. Again friends/relatives would be the choice for 11-16 percent of the clients regarding any consultation on the problems in taking pills (Table 6.2).

It is more likely that younger women would consult with relatives/friends at a higher proportion (29-30 percent), compared to women aged 20 years or higher (15-21 percent); in contrast, a client without formal schooling would consult with FWs at a slightly higher rate (more than three-fourths) than the clients with some formal schooling. Instructions regarding use of OC is given to higher parity women (4 or higher) at a higher rate than the lower parity women in both GOB and NGO areas. This indicates that the higher parity women would be willing to know about the correct procedures from FWs rather than other available sources. A relatively higher proportion of the lower parity women would prefer to take instructions from relatives/friends (more than one-fourth in NGO and more than one fifth in GOB areas). The clients who want to have additional children in the future consult with FWs at a lower proportion (70-72 percent) than those who do not have such desire (more than three-fourths) in both the catchment areas. The reverse is true for the first time users of OC. The first time users are more likely to consult with the FWs than those who are using the method second or higher times. This reflects that first time users, because of their inexperience about the method, want to know more about OC from the FWs. A cross-table on source of knowledge and person gives instruction reveals that, 88 percent of the clients having knowledge from FWs acknowledged that they receive instructions from the same source, compared to 57-58 percent from hospital/clinic and 45-56 percent from relatives/friends as the same source. Even if the source of knowledge about OC is different FWs, a large proportion of clients still get the necessary instructions from FWs.

One or More Pills Skipped

One Pill

One pill is skipped by 40-43 percent of the OC users, and those who skipped one pill mostly (56-58 percent) skipped one pill more than once during the last six months (Table 6.3). Among the current users of C-5 and Sukhi brands of OC in GOB areas, close to 45 percent skipped pills once or more. However, in NGO areas, C-5 and Sukhi clients skipped one pill at least once at a lower rate (less than 40 percent), compared to 50 percent for other brand users (Table 6.3a).

Majority of those who skipped one pill during the last six months did so for more than one times irrespective of brands being used by the clients of OC.

More than three-fourths of those who skipped one pill one or more times, forgot to take pill. Another 6-8 percent did not take pill because the respondent was away from home. Sickness was the reason for skipping one pill in case of 4 percent of those who missed one pill (Table 6.3).

More than two-thirds of those who skipped one pill had taken either one pill when remembered and one at night or two next night (Table 6.3). Five percent had taken two pills when they remembered next day. A substantial proportion (one-fourth) of the users had either taken only one pill as usual or thrown away the skipped pill.

The extent of correct response is observed to be the lowest among clients of C-5 (22 percent in GOB areas and 32 percent in NGO areas) and highest among Sukhi users (45 percent in GOB and 41 percent in NGO areas). We have considered taking one pill when remembers and another at night as usual as the correct response. If we consider taking two pills next day in case of missing one pill as the correct response then the extent of incorrect response remains the lowest for C-5 users (39 percent in GOB and 28 percent in NGO) and highest for users of other brands (18 percent in GOB and 22 percent in NGO) in both GOB and NGO areas.

It is however interesting to note that more than 90 percent of the current users of OC, which is almost similar among users of different brands of OC, reported that they should take two pills next day in response to the question regarding what should be done if some one skips one pill (Table 6.3a). This indicates that most of those who had taken pills incorrectly knew the correct use. This indicates that all those clients have some knowledge about taking pills if one pill is skipped. However, there is a gap between their knowledge and practice. Some of the clients ignore their knowledge at the time of application at the right time. This gap between knowledge and practice requires further investigation and it is most likely that such behaviour is associated to a large extent with the socio economic status of the clients of OC.

It is surprising that the younger women are less likely to do mistakes if they skip one pill. There is a positive relationship between age and incorrect response on what has been done in case of skipping a pill. An incorrect step is taken by less than one-fifth of the teenagers, compared to one-third in the age group 35 and over. The incorrect response is observed in large proportions among the women 30 years older. This finding has a direct policy implication in order to improve the training and monitoring of field level workers' performance. However, as expected, we observed an inverse relationship between level of education and incorrect response, the highest percentage of incorrect response of 28-30 percent among clients without having any formal education and the lowest (12 percent in NGO and 17 percent in GOB areas) among the clients having high school or higher level of education. Although not so strong, but it is observed that the higher parity users of OC are more likely to follow a wrong procedure in case of skipping a pill. The repeated users in GOB and the first time users in NGO are more likely to make mistakes after skipping one pill. If the source of knowledge is FW then the incorrect response appears to be the lowest. As we mentioned earlier,

there is a gap between the knowledge and the practice of correct procedures. It is evident from the association between age and incorrect response on what should be done if one pill is skipped, then the age specific rates of incorrect responses appear to be much smaller than what is really practiced. Much smaller percentages of incorrect responses are observed for variables, age of client, education, parity, desire for additional children and use of OC for the first time, etc. In some cases, the differential patterns observed in response to question on what was really practiced either disappeared or became negligible in response to what should be done, for instance, much smaller variation between younger (10-13 percent) and older women (10-14 percent), lower parity (10-13 percent for parity less than 3) and higher parity (11-18 percent for parity 4 or higher), desire for additional child (11-13 percent) and no desire for additional child (12 percent), first time user (11-13 percent) and repeated user (12 percent) of OC, etc. However, education of women stands out as an exception. Only three percent in NGO and 8 percent in GOB areas with high school or higher level of education do not know what should be done and the difference with the clients without having any formal education still remains substantial.

From FGDs two dominant opinions emerged from the discussion: (i) most of the participants are in favour of taking one when remembers and one at night; and (ii) a substantial number (24) opined that two pills should be taken at a time at night and 3 participants expressed that two pills should be taken when they remember. One participant from GOB unit would have rather taken one pill as usual.

The workers mentioned responded to questions related skipping of one pill to 21 percent of the new acceptors in GOB and 32 percent in NGOs.

Two Pills

Among past and current users, two pills are skipped by 16-17 percent of the clients and 37 percent reported skipping two pills more than once in GOB areas and 44 percent in NGO areas (Table 6.4). The main reason for skipping pills was that the respondents forgot to take pills (51 percent in GOB areas and 58 percent in NGO areas). Due to the reason that the respondent was away from home, one-fifth of the clients who missed two pills did so. Sickness caused skipping of two pills one or more times for 5-6 percent of those who missed two pills.

Two pills are skipped at a higher proportion in GOB than in NGO areas among the current users of OC. However, the pattern is similar among the users of different brands in both GOB and NGO areas, for instance, C-5 users skipped two pills at a higher rate (22 percent in GOB and 18 percent in NGO areas). Table 6.4a shows that this happened relatively at a lesser proportion among clients of Sukhi in both GOB and NGO catchment areas (13-14 percent). This is an important aspect in the regular and proper use of OC. This might be attributable to refreshers training of the workers on Sukhi which is introduced only in the recent past or to the suitability of the low dose pill like Sukhi to the ever increasing number of clients of pills in rural areas of Bangladesh. Another possible reason is the fewer or less severe side-effects of Sukhi experienced by the clients. In response to the question on number of times pills are skipped in consecutive days, most of the clients of C-5 and

other brands responded that they skipped two pills for more than once in NGO areas, compared to one-third among users of different brands in GOB as well as among Sukhi users in NGO areas.

Similar to the responses in case of skipping of one pill, reason for skipping two pills is dominantly attributed to forgetfulness of clients to take pills which is observed among users of all brands followed by the client was away from home or husband was away from home, no reason, sickness and side effects respectively.

The users had done a wild range of things in case of two missed pills. The correct use (taking two pills in consecutive days and/or husband used condom) was practiced by less than 1 percent of the clients. It is surprising that more than one-fourth (27-29 percent) had taken pills as usual after skipping two pills, and 5-7 percent had taken three pills at a time when remembered. Two pills were taken when remembered and one at night by 21-23 percent, and one pill when remembered and two at night by 4-5 percent of the clients who missed two pills in consecutive days.

If we compare the extent of correct/partially correct (taking two pills in consecutive days with or without condom) response for two major brands among current users, C-5 and Sukhi, then it is observed in GOB areas, clients of Sukhi responded correctly at a little higher proportions (7 percent of C-5 and 10 percent of Sukhi users who missed two pills once or more) (see Table 6.4a). However, in NGO areas, the response was similar for both the C-5 and Sukhi users (8 percent). It is surprising that the most frequent answer was taking pills as usual (25 percent for NGO Sukhi to 32 percent for NGO C-5) followed by two pills when remembered next day and one more at the same night (18 percent for GOB C-5 to 27 percent for GOB Sukhi) and threw away (15 percent to 22 percent; higher percentage for C-5 and lower for Sukhi). This is indicative of the fact that users of different brands of pill users have similarities in doing many things other than practicing the right approach if two pills are skipped for two consecutive days. More importantly, this incorrect practice is almost similar in both GOB and NGO areas.

Only a very few of the respondents could give correct answers on the question on what action was taken if skipped two pills consecutively. Hence instead of focusing on this response, a brief analysis is presented here on basis of a question on what should be done if two pills are skipped. An age specific analysis of incorrect responses reveal that 87-96 percent of the respondents do not know what steps should be taken if two pills are missed in consecutive days, and this happens irrespective of age and catchment areas. Furthermore, the extent of incorrect response is seemed to be equally prevalent irrespective of no schooling and some schooling, low parity or high parity, desire for an additional child or no desire for an additional child, first time user or repeated user, FW as the source of knowledge or supply and others as the source of knowledge or supply, etc. This is indicative of the fact that there exists serious lack of training of workers and dissemination of correct knowledge to clients on this issue.

From FGDs we observed similar pattern. On the issue of skipping two pills in a row by an OC user, the extent of variations in the knowledge is quite unexpected because two-thirds of the selected participants were using the method for more than a year. Only 12 out of 78 participants of the ten focus groups mentioned that two pills should be taken in the following two days but they have not

mentioned about use of condom. Out of these 12 participants, eight were from the NGO units. Among other major opinions about this problem, substantial number of participants expressed the following views: (i) take two when remember and one at night, (ii) take 3 when remember and take 3 next morning, (iii) use condom until the menstruation and then start a new cycle, and (iv) take one pill as usual.

In response to the question on what should be done if two pills are skipped, the knowledge and practice appear to be similar. For instance, the correct answer is obtained from only 1-2 percent of the clients. Another 7-8 percent of the clients mentioned about taking two pills at a time for following consecutive days. Taking pills as usual or throwing away the skipped pills is mentioned by one-fourth of the clients as the right thing to do. Three pills should be taken in one day was viewed by more than one-fourth of the clients in both GOB and NGO clients.

Three Pills

Table 6.5 shows that three pills were skipped by 6-7 percent of the clients, and similar to skipping one or two pills, C-5 users in NGO and GOB areas are more likely to skip three pills (8 percent) than the Sukhi users (4 percent in NGO and 7 percent in GOB areas).

Two-thirds of those who skipped pills in three consecutive days did so only one time during the last six months. However, among the current users of C-5 , almost half of them of GOB areas reported that skipping of three pills had taken place more than once, which is little higher than one-fourth in NGO areas (Table 6.5a). The most frequently mentioned reason among OC users (37-40 percent) for skipping three pills was that the either the respondent or her husband was away from home, which is observed among close to sixty percent of clients of C-5 in NGO areas, compared to only one-third of the same brand users in GOB areas. The second most common reason was that the client forgot to take her pills (28-30 percent) among past and current users, but lower among current users (22 percent). The reason of forgetfulness has been reported most frequently by the Sukhi users in GOB areas, 36 percent, compared to only 14 percent by the C-5 users. It is noteworthy that 9-10 percent of the clients reported side-effects as the reason for skipping three pills. Side-effect is found to be one of the major reason for skipping three pills among C-5 clients in GOB areas. The number of cases by brand is small so no attempt is made here to examine this issue further to avoid problems associated with small samples.

About 55-60 percent of the clients in NGO and GOB areas had either taken pills as usual or thrown away unused pills after skipping three pills. A relatively smaller proportion of clients reported menstruation started (12-16 percent), stopped taking pills and condom was used until menstruation (3 percent), or stopped having sex till the menstruation (3-4 percent).

The correct response to the question on what should be done if three pills are missed consecutively was given by only a small percentage of clients of OC. The extent of correct response was similar (86-97 percent) in all age groups of clients. There is no association between age and correct response. However, there is evidence of a positive association between level of education and correct response, for instance, the rates of correct response for clients with no schooling, primary

schooling and high or higher level of schooling are 6 percent, 10-12 percent and 24-27 percent respectively. In both GOB and NGO areas there appears to be no association between parity and correct response. Similar conclusion can be drawn for clients with or without any desire for additional children and first time or repeated user of OC. If FW is the source of knowledge about OC then the rate of incorrect response appears to be little higher (91 percent in both GOB and NGO) compared to other sources (85-87 percent). This indicates the necessity of extensive training on the issue of what should be done if one, two or more pills are missed in a row. The clients need to be informed about the correct procedures along with the possible consequences in order to improve the effective use of OC.

The FGDs revealed that if three white pills are skipped in a row then only 16 out of 78 participants mentioned that they would have stopped using oral pills and would use condom. Most of these 16 participants were from NGO units. A small number of participants opined that until the menstruation, they would not have sex and start from new strip when menstruation begins. Others have a wide range of speculations including their ignorance about this problem. Some of the speculations are: take 3 when remember and one at night (3), take two at a time in the following three days (8), take white pills as usual (7), take 3/6 at a time (2). All these points indicate that majority of the OC users do not have clear idea about the correct use of oral pills.

The variations in the opinion about the problem of skipping brown pills also match with that of the white pills.

In response to the question regarding what should be done if three pills are skipped, more than one-third of the clients in both GOB and NGO areas responded that they do not know about what to do. Only 12-13 percent of the clients would have either stopped sex or would wait till menstruation. Only 5 percent of the clients mentioned that they should stop using pills and instead they should use condoms, this response was observed to be the highest among other brand users (13 percent) and lowest among C-5 users (3 percent) . However, more than one-third of the clients know that another method should be used if two or more pills are skipped in a row.

Observation data indicate that at the time of receiving supplies from the workers , only 9 percent of OC acceptors in GOB and 16 percent in NGO areas receive general instructions about what should be done in case of skipping pills.

Brown Pills

Two-thirds of the clients responded that usually they take all the brown pills (Table 6.6). However, 45-47 percent of the clients know that brown pills are vitamin tablets, and only 8-9 percent consider them as iron tablets. More than one-third of the clients take brown pills to regularize menstruation, and 5-6 percent take brown pills for improving health. Two-thirds among the clients who do not take brown pills, do not take because these pills do not prevent pregnancy. No brown pills in the strip is reported by 7-11 percent of the clients. Nothing is done in case of skipping brown pills by almost half of the clients and most of the remaining clients follow the procedure to be followed similar to skipping white pills.

It is evident from the workers' observation data that workers tell (4 percent) new acceptors in GOB areas about improvement of health if someone takes OC.

Whether Stopped Taking White Pills

Some of the clients stop taking OC before finishing a strip. The extent of such stopping of taking white pills is observed among 9-11 percent of the users of pills (Table 6.7), however, this has been observed substantially lower among current users (5 percent). The most dominating reason for such decision is side effects in both GOB (48 percent) and NGO (36 percent). Most importantly, more than 50 percent of those who stopped taking pills among past users did so due to side-effects. Among the current users the main reason is the respondent or her husband was away from home, but in GOB areas current users of C-5 and Sukhi resembles to that of past users, that is, side-effects remain as a major cause for stopping use of white pills. Sickness (9-12 percent) and husband away from home (12-19 percent) are the two other compelling reasons.

After using OC for a long uninterrupted period 11-13 percent of the clients stop using pills for sometime, which is somewhat lower among the current users (11 percent in GOB and 8 percent in NGO), and which is relatively higher among users of C-5 and other brands, 13-14 percent in GOB and 8 percent for C-5 and 15 percent for other brands in NGO catchment areas (Table is not shown). In both the GOB and NGO areas, Sukhi users discontinue their use of OC less frequently than the high dose pills like C-5. And again side-effect appears to be the major reason (42-48 percent) followed by husband is away from home (18-27 percent). Health reason is reported by additional 16 percent of the clients, and fear of infection caused interruption in case of 3-4 percent of the users of OC.

Out of 78 participants in the focus group discussions, 13 have stopped taking pills before completion of a cycle. This has occurred mostly in the GOB units. The following reasons are discussed: (i) menstruation began so stopped taking pills, (ii) husband was away, (iii) jaundice, and (iv) no specific reason. Nine participants have discontinued use of oral pills after continuing it for a long time. No other methods were used during this period of discontinuation.

Several participants mentioned that they have experienced physical changes such as dizziness/headache, weakness, vomiting, irregular menstruation, and burning sensation. Some of the participants have better physique as a result of continued use of oral pills. Most of the participants seek advice from fieldworkers. Other than fieldworkers, husband, neighbor/relatives and doctors are consulted for these problems.

Whether User Took Pills When Sick, When Husband was Away, or Respondent was Away from Home

Among past and current users combined an overwhelming majority of the clients took pills (86 percent) even if they were sick (Table 6.7). This percentage is even higher for the current users in both GOB and NGO areas. In the absence of husband, a similar proportion of clients reported that they took pills. Similar responses were observed in cases when a respondent went to another place for a visit.

CHAPTER 7

SIDE-EFFECTS, CONTRAINDICATIONS AND OTHER OC-RELATED ISSUES

During the recent past, with an overwhelming increase in the use of OC, the problems associated with side-effects and contraindications have emerged as the barriers of longer continuation of OC for spacing or limiting births. It has already been discussed in the previous sections that the short term discontinuation or stopping of the use of OC takes place due to side-effects. Similarly, it is observed with surprise that majority of the OC users of any brand continue use of contraception at the time of their sickness. In this chapter the issues related to side-effects and contraindications and some other related problems have been examined. The findings are based on responses from combined past and current users, if not mentioned otherwise. However, the discussion on the findings by brands include only current users.

Knowledge and Source of Knowledge of Side Effects

Survey respondents were asked about both their knowledge and experience of side-effects related to pill use. Table 7.1 demonstrates that over 85 percent responded that they had heard of side-effects prior to using the pill (86 percent GOB, 85 percent NGO). Dizziness was the most commonly known, and was mentioned by almost all of the women (98 percent both groups). Vomiting and weakness/sickness were also mentioned by almost two thirds of the women (64 percent GOB, 68 percent NGO and 60 percent GOB, 62 percent NGO, respectively). Almost a fourth reported that a burning sensation in the body was a side-effect of oral contraceptive use (21 percent GOB, 20 percent NGO). Participants in the focus group discussions identified all of these side effects. In addition, loss of appetite and gastric/abdominal pain were also mentioned, as was irregular menstruation. Although abdominal pain and irregular menses were given by study respondents, they were much less frequently mentioned (4-5 percent and 4 percent, respectively). Loss of appetite was not given at all as a side effect by survey respondents. There is no substantial differences observed by past or current users as well as by brands of OC among current users.

Around half of the women heard about these side-effects from a fieldworker (46 percent GOB, 4 (46 percent GOB, 49 percent NGO). Friends or relatives were another common source of knowledge (44 percent GOB, 43 percent NGO). More than 80 percent of the women said that the side-effects would go away (82 percent GOB, 84 percent NGO), and more than 90 percent of the women said that they would disappear within 3 months of use.

Although many of the fieldworkers who were observed did not discuss either the advantages or disadvantages of the pill, it was more likely for them to discuss disadvantages. These were most often side effects, and the problems most likely to be mentioned were once again dizziness, vomiting and weakness or sickness.

Experience of Side Effects

Table 7.2 displays that more than half of the women reported that they had experienced some side-effect in the first 3 months of pill use (62 percent GOB, 60 percent NGO). Among the current users of different brands of OC, the highest percentages, 60 percent of Sukhi users in GOB and NGO areas, reported discomforts during the first three months of use of OC (Table 7.2a). Not unexpectedly, past users were more likely to report side-effects than current users (56-57 percent of current users vs. 67-68 percent of past users). The problems experienced by the women were similar to those reported as known: over 90 percent reported dizziness (93 percent GOB, 94 percent NGO); two fifths reported weakness/sickness (46 percent GOB, 59 percent NGO) and almost as many reported vomiting (38 percent GOB, 37 percent NGO). Some women also mentioned burning sensations (16 percent GOB, 12 percent NGO).

Current users of C-5 (46 percent) in NGO areas suffer from vomiting tendency at a higher proportion than Sukhi users (26 percent), however, there is no such variation in GOB areas for users of these brands (37 percent). Sukhi users of NGO areas mentioned about irregular menstruation at a higher proportion. Excessive menstruation and burning sensation are observed to be higher among C-5 users in GOB areas. The response of weakness/sickness appear to be higher for different brand users in GOB than in NGO catchment areas.

A much smaller percentage of users reported that their side-effects had lasted longer than 3 months (12 percent GOB, 11 percent NGO). Among the women who had longer periods of difficulties, the same side-effects were mentioned the most often, although in smaller percentages. About three fourths mentioned dizziness (78 percent GOB, 71 percent NGO), close to half felt weak or sick (46 percent in both groups), and approximately one fourth experienced either vomiting or a burning sensation (26 percent GOB, 17 percent NGO and 24 percent GOB, 19 percent NGO, respectively). In general, previous users complained of side-effects more often than current users. It is more likely that if the suffering from side-effects continued for more than three months then it resulted in discontinuation of OC. In other words, only satisfied users continued to use OC.

During the observation of fieldworkers, the side effects mentioned most often by clients were dizziness, weakness/sickness or vomiting.

When Side Effects Were Experienced and Duration of Side Effects

Table 7.3 summarizes the percentage distribution of clients on how long ago the women experienced the difficulties. About one third of the OC users mentioned that less than 12 months ago (30 percent GOB, 38 percent NGO), one fifth to one fourth said 13-24 months ago (24 percent GOB, 21 percent NGO), and close to another third said 25-60 months ago (31-32 percent).

In response to a question on the duration of discomforts about 10-11 percent of the current users mentioned that they suffered from discomforts for three months or less. Approximately two thirds of women (current and past users) who had these difficulties said that the problem had lasted for 6 months or longer (69 percent GOB, 63 percent NGO), and one third to one half (37 percent GOB, 53 percent NGO) said that they were still experiencing them. It is interesting to note that one fifth to one third of ex-users reported that they are still experiencing the side-effects, even though they are no longer using the pill (20 percent GOB, 32 percent NGO).

There is no marked variation by brands among current users on this issue. However, a comparison between C-5 and Sukhi users show that in both GOB and NGO areas relatively higher percentage of the clients of C-5 had suffered from discomforts for longer than 6 months. Three-fourths of the GOB and NGO users of C-5 and Sukhi users of NGO reported that they were suffering from discomforts at the time of interview.

Management of Side Effects

Tables 7.4 and 7.4a demonstrate the nature of side-effects management on the basis of responses from OC users. Most of the women who experienced side-effects did discuss the problem with someone (79 percent GOB, 84 percent NGO), usually a fieldworker (46 percent GOB, 56 percent NGO). A higher percentage of current users of Sukhi having side-effects in GOB areas consulted with fieldworkers or LIP volunteers (three-fourths), compared to only 55 percent of the C-5 users with similar problems. In NGO areas, there is no such variation (two-thirds for C-5 and Sukhi). Hospitals/clinics were also mentioned (20 percent GOB, 17 percent NGO), as were friends/relatives, to a lesser degree (13 percent in both groups). The utilization of hospital/clinic seems to be approximately same for C-5 and Sukhi users with side-effects in GOB and NGO areas, but substantially higher for users of other brands.

About one fourth of the women said that they were advised to eat something nutritious (26 percent GOB, 25 percent NGO). This response was reportedly higher among Sukhi users of both GOB (31 percent) and NGO (41 percent) areas. About a fifth of the women were told to do nothing, that the problem would disappear soon on its own (20 percent GOB, 24 percent NGO). Another fifth were advised to use another method (21 percent GOB, 18 percent NGO), which was suggested more often to the current users of C-5, compared to the current users of Sukhi, in both GOB and NGO areas. Other common advice was to drink something (14 percent GOB, 20 percent NGO) or to take medicine or vitamins that were supplied (17 percent GOB, 16 percent NGO). Government clients were also told to discontinue use (17 percent GOB vs. 9 percent NGO). Clients of NGO workers were also told to consult a physician (14 percent NGO vs. 9 percent GOB).

Among the fieldworkers observed, the most common advice given to women who were experiencing side effects was to drink something (water, lemon water, some cold drink). Second most common was to eat vegetables. A number of workers also counselled the women to do

nothing, that the problem would be cured after a few months. Another frequently mentioned advice to clients was to eat nutritious food.

Client Satisfaction with Management of Side Effects

Well over half of the women were satisfied with the response that they received (65 percent GOB, 59 percent NGO), primarily because the side-effects were reduced or went away (23 percent GOB, 19 percent NGO). The results are presented in Table 7.4b. Other women were satisfied with the outcome of the discussion because they felt better when they discontinued pill use (15 percent GOB, 7 percent NGO) or after they took the medication provided (12 percent GOB, 8 percent NGO).

Respondents who were not satisfied with the discussions reported that they were dissatisfied because they followed the advice given and the problems were not cured (20 percent both groups). One third of the women who had not discussed their problems with anyone said they did not because they did not feel the problems were important (33 percent both groups). Other common reasons were because they thought the side-effects would go away on their own (17 percent GOB, 22 percent NGO) or if they simply stopped taking the pill (22 percent GOB, 18 percent NGO).

It is interesting to note that although the so many women did experience side effects, the majority of them continued to take the pill. This was also reflected in the focus group discussions. Women mentioned that side effects of other methods (mostly IUD and injectables) were what led them to switch to using oral contraceptives. The focus group finding that women are likely to switch back to injectables but not to IUDs could mean that women felt that the side effects from IUDs are worse than those associated with the pill. It may also be that women are simply used to side effects from whatever method they choose, and are simply switching in the hopes of reducing those side effects.

Changes in Menstrual Cycle

Table 7.5 indicates that more than a third of the respondents reported a change in their menstrual cycles that they believed was due to pill use (41 percent GOB, 38 percent NGO). Of these women, almost half reported a reduced menstrual flow (41 percent GOB, 45 percent NGO). It is shown in Table 7.5a that the current users of C-5 in both GOB and NGO areas had experienced a reduced menstrual flow at a relatively higher proportion (53 percent in GOB and 64 percent in NGO), compared to users of Sukhi (45 percent in GOB and 43 percent in NGO). Another quarter of the women said that their menses had become more regular (27 percent GOB, 26 percent NGO), which was reported more frequently by current users of Sukhi and other brands (35-36 percent in GOB and 29-35 percent in NGO areas) as compared to that by C-5 users (23 percent in both GOB and NGO areas). Smaller percentages reported excessive (16 percent GOB, 18 percent NGO) or irregular (16 percent GOB, 13 percent NGO) menses. Some of the current users of different brands reported that their menstruation had stopped as a result of taking pills.

It was interesting to note that the menstrual changes most likely to be mentioned by clients during the observation of workers were slightly different than those mentioned in the surveys. Women mentioned irregular menses and excessive menses when discussing side effects with the worker. It is probable that women do not discuss menstrual changes that they perceive to be advantages with the workers, and only mention those changes they feel to be problems.

Advice Sought Prior to Pill Use

Table 7.6 shows that two thirds or more of the women sought their advice from a fieldworker (68 percent GOB, 70 percent NGO), and women who are in NGO catchment areas reported both NGO and GOB fieldworker contacts, although the majority of them were NGO workers (19 percent GOB and 51 percent NGO). However, three-fourths of the current users of C-5 and Sukhi in GOB areas obtained instructions from FWAs, and in NGO areas one-fifth of those who sought advice obtained instructions from GOB fieldworkers in addition to 51-58 percent who were served by the NGO workers (Table 7.6a). The next most likely person to be consulted was a friend or relative (15 percent GOB, 16 percent NGO).

More than 90 percent of the women were told from which side of the packet to start taking their pills (91 percent both groups). This response is similar by brand of OC as well. More than three fourths of the women had been told to take one pill each day, at the same time (76 percent GOB, 82 percent NGO). Although around one third of the women who had received instructions were told what to do if they missed one pill (31 percent GOB, 34 percent NGO), very few were told what to do if they missed 2 or 3 pills (5 percent GOB, 7 percent NGO and 3 percent GOB, 4 percent NGO, respectively). About a third mentioned that they were told what to do in case of side-effects (29 percent both groups), but less than one fifth were told to when to start their next cycle of pills (18 percent GOB, 19 percent NGO). Only a negligible proportion of current users (one-seventh) had mentioned that they were told to start taking pills from the first day of menstruation.

Advantages and Disadvantages Mentioned

It appears from Table 7.7 that eighty-five percent of the women (in both GOB and NGO groups) who were given advice prior to pill use were given information regarding advantages of the pill. The advantages most commonly mentioned were health improves (39 percent GOB, 38 percent NGO), that it can be discontinued at any time (37 percent both groups), that it has no or fewer side-effects as compared to other methods (35 percent GOB, 37 percent NGO), that it easy to obtain (28 percent GOB, 34 percent NGO), and that it is a temporary method (31 percent GOB, 27 percent NGO). It was interesting to note that the mention of fewer side-effects was much more marked among current than past users, indicating that fieldworkers are highlighting this aspect more than they did in the past. One of the advantages mentioned by about one-third to 40 percent of the current users of any brand of OC in GOB or NGO catchment areas was related to

improvement of health as a byproduct of using OC. This is indicative of the fact that some clients consider gaining weight through regular use of OC as an advantage.

Almost as many women (74 percent in both groups) were given information regarding the disadvantages associated with the pill, mostly about possible side-effects (Table 7.7). Almost all said that they were told that the pill causes dizziness (98 percent in both groups), and almost three fourths were told that it can cause vomiting (71 percent in both groups). Half of the women said that they had been told about the possibility of weakness/sickness caused by pill use (51 percent GOB, 49 percent NGO), and about 15 percent mentioned the possibility of experiencing a burning sensation in the body (14 percent GOB, 13 percent NGO). However, irregular or excessive menstruation were mentioned only by a very small proportion of current users of different brands. Similarly, gaining weight was identified by a negligible proportion of current users as a disadvantage.

The advantages and disadvantages mentioned by fieldworkers during the observation of their interactions with clients coincided with the information reported by the pill users in the surveys.

Contraindications of Oral Contraceptive Use

The widespread popularity of OC arises question whether contraindications are properly identified or not. This has emerged as an important issue due to the fact that a woman with some diseases such as anaemia or heart disease might have suffered from side-effects due to ignoring her health conditions regarding suitability of OC. This ignorance may lead to further complications resulting in not only discontinuation of the method but also setting a bad precedence to other users.

Knowledge

Respondents were asked regarding their knowledge of diseases, health conditions or habits under which a woman should not be given oral contraceptives. Interestingly, the variations are not very marked by GOB or NGO areas or by brands in these catchment areas as well . Table 7.8 shows that more than two thirds of the women did not know any of the contraindications (69.5 percent GOB, 66.1 percent NGO). Among the few women who had heard of some, gastric ulcers were mentioned most frequently (21 percent GOB, 24 percent NGO). Some other contraindications were mentioned, but only by seven percent or less of the respondents. About half of the few women who knew about the contraindications said that they had received their information from fieldworkers (48 percent GOB, 53 percent NGO, includes both NGO and GOB fieldworkers). Other sources were friends/relatives, mentioned by about a third of the women (28 percent GOB, 34 percent NGO), and hospitals/clinics to a lesser degree (13 percent GOB, 8 percent NGO).

Experience

It was somewhat disturbing to note that although so few women knew what the contraindications to pill use are, many of them reported that they were suffering from one or more contraindications at the time that they began using the pill (Table 7.9). More than 40 percent reported incidence of gastric ulcers (44 percent GOB, 43 percent NGO), again the response is similar among users of different brands; about a quarter reported that they had headaches/migraines (26-27 percent both groups), anaemia (24 percent GOB, 21 percent NGO), although these were little less for current users but there is no variation by brands; or were breastfeeding (26 percent GOB, 20 percent NGO). Ten percent or more of the respondents said that they had jaundice (12 percent GOB, 11 percent NGO), heart disease (10 percent GOB, 8 percent NGO), or abnormal vaginal bleeding (10 percent GOB, 9 percent NGO). All these percentages were remarkably similar among users of different brands indicating that the contraindications, as mentioned in their manuals or at the time of training, were not examined by the workers or were ignored by them. This is an important issue to be addressed very carefully by the policymakers in order to ensure proper health care, and suggestion for a proper method of contraception needs to be based on this aspect.

It is interesting to consider the findings regarding contraindications from the focus groups. Participants seemed to have difficulty distinguishing between side effects and contraindications, and frequently mentioned one as the other. This is consistent with the finding that focus group participants (both clients and fieldworkers) felt that the training of fieldworkers is inadequate in the area of counseling and treatment of side effects.

During the observation of fieldworker and client interaction, it was obvious that contraindications are not commonly discussed. Very few of the interactions observed included mention of contraindications (5 percent among GOB and 8 percent among NGO). From the observations, it would seem that the primary concern of the fieldworkers is to increase the prevalence of users, and contraindications for a specific method are for the most part ignored.

Client Experience with Fieldworkers

Last Visit

A series of questions was asked of oral contraceptive users regarding their recent experience with fieldworkers. It is observed from Table 7.10 that the women served by NGO fieldworkers were more likely than those served by GOB fieldworkers to have been visited by one in the past 6 months (66 percent GOB vs. 76 percent NGO). Not surprisingly, current users were more likely to have received a visit than past users (78 percent vs. 50 percent GOB, 86 percent vs. 58 percent NGO). More than two thirds of the women reported that they had received between 1 and 3 visits within the past 6 months (84 percent GOB, 64 percent NGO). Women who were seen by GOB workers were more likely to report that they had 2 visits (42 percent) or 3 visits (24 percent). The women who received visits from NGO workers were more likely to have seen the

worker four or more times (36 percent), 2 times (29 percent) or 3 times (23 percent) in the last 6 months. It is demonstrated in Table 7.10a that the least number of visits (2.3) in GOB area was observed for the users of other brands. The users of C-5 and Sukhi were visited more frequently, on an average 2.7 times, during the last six months prior the date of interview. However, in NGO areas, the clients of other brands were visited maximum number of times (3.9), compared to 3.2 times for C-5 and 3.8 times for Sukhi.. However, in response to a question regarding whether the fieldworker supplied OC to the client it appears to be less likely that a client of other brands received supplies, compared to clients of Sukhi and C-5.

Amount of Time Spent with Fieldworker

From Table 7.10 we observe that in two thirds of the visits, the amount of time that the fieldworker spent with the client was 5 minutes or less (61 percent GOB, 64 percent NGO). However, it should be mentioned that about one fifth of the women said that the worker had spent 6 to 10 minutes (17 percent GOB, 19 percent NGO), and another fifth reported 11 to 60 minutes (20 percent GOB, 17 percent NGO). In about one percent of the cases, the client was not home when the fieldworker came to visit (both groups).

The observations confirmed that very little time is actually spent with clients. Workers try to cover as many women as possible in one day so that they can cover their assigned areas. Most of the time spent with clients involves distribution of pills, and not much discussion takes place. Most of the discussion that does occur happens with new users. Problems and other issues are only discussed if they are raised by the client.

Number of Cycles of Pills Provided

Among current users, as shown in Table 7.10 that the workers had provided pills to over 80 percent of the women during their last visit (84 percent GOB, 82 percent NGO). Almost 100 percent of these women received 1 to 3 cycles of pills (98 percent GOB, 99 percent NGO). Government workers were more likely to provide 3 cycles of pills (65 percent), or 2 cycles of pills (24 percent), whereas NGO workers were almost equally likely to provide 1, 2 or 3 pill cycles (28 percent, 33 percent and 38 percent respectively).

These findings were corroborated by the fieldworker observations. The distribution of pills was the most common activity observed. The numbers of packets distributed was consistent with that reported by the women: government workers were more likely to give out 3 cycles; NGO workers were more likely to distribute only 1 packet at a time.

Discussion with Fieldworkers

Table 7.11 shows that In about one third of the visits, no discussion took place between the client and the fieldworker (34 percent GOB, 30 percent NGO) and this was observed for clients of any brand. When the worker did speak with the client, half of the inquiries concerned the use of the pill packet (42 percent GOB, 51 percent NGO), which is relatively higher for clients of Sukhi as

compared to that for clients of C-5 and other brands. Sukhi brand is a newly introduced brand, hence this response is quite expected. Side-effects were discussed only 10 to 16 percent of the time (non-government vs. government, respectively).

All respondents were asked if they had requested information other than that supplied by the worker; very few women said that they had (10 percent GOB, 7 percent NGO). Among those who asked for additional information, most asked regarding how to take the pills properly or about side-effects. Only one woman asked about contraindications.

Finally, all of the study respondents were asked if the had other questions or problems regarding the pill that they had not asked of the fieldworker. More than 80 percent of respondents said that they had no other questions(83 percent GOB, 85 percent NGO).

Overall Satisfaction with Fieldworker

Generally women seemed positive regarding their experience with the fieldworkers. Well over half of them said that the fieldworkers were enthusiastic and took special care concerning oral contraceptives (63 percent GOB, 70 percent NGO), and as expected, this response was more positive among the current users for clients of all the brands (Table 7.11). Almost a fourth said that the workers were willing to listen to the user's problems (25 percent GOB, 22 percent NGO), which appeared to be little higher in case of C-5 clients in both GOB and NGO catchment areas, compared to the clients of Sukhi and other brands. On the other hand, about a fifth of the clients said that workers merely supply them with their pills (22 percent GOB, 18 percent NGO), which is higher for the clients of Sukhi in both GOB and NGO areas. Fewer than 15 percent of the workers encouraged women to use other methods (12 percent GOB, 13 percent NGO). Only 2 percent or less of respondents reported that the fieldworkers did not listen to them or were very cautious in their dealings with their clients (< 1 percent GOB, 3 percent NGO).

During the observation of the fieldworkers, observers were asked to note the attitude of the workers regarding oral contraceptives. The most commonly mentioned response was that they were indeed enthusiastic, noted more often about NGO workers than GOB workers. Observers did note that some interactions were not so enthusiastic (more commonly mentioned of GOB workers than NGO workers). Workers were more likely to listen to problems that were mentioned than to not listen. Some workers did encourage the use of other methods.

Visits from Other Providers

Around 10 percent of the women in the survey said that someone other than the fieldworker who last visited had been to see them within the last six months (8 percent GOB, 10 percent NGO). This type of visits were reported by 9 percent of the C-5 clients in GOB, and 15 percent of the Sukhi and other brands clients in NGO areas (Table 7.12). Predictably, this was most likely to be another fieldworker. Government fieldworker clients reported another government worker had visited in 43 percent of the cases, and another 44 percent reported a visit by an LIP volunteer. Among women served by NGO workers, more than half reported a visit by a

government worker (56 percent), and almost two fifths reported a visit by another NGO fieldworker (38 percent). These responses indicate an overlap of services, both among government versus NGO workers, as well as within the NGO services themselves.

Pregnancy and Oral Contraceptive Use

Table 7.13 shows that less than two percent of respondents said that they had ever experienced pregnancy while using oral contraceptives (2 percent GOB, 1 percent NGO) which is even lower among the current users (less than 1 percent). Of this small number (only 26 women in the government group and 21 in the NGO group) , half to three fourths of the women did nothing when they discovered that they were pregnant (54 percent GOB, 76 percent NGO). Women attended by NGO fieldworkers were more likely to do nothing, whereas as women served by GOB fieldworkers were more likely to discuss the situation with the fieldworker or LIP volunteer (31 percent GOB, 14 percent NGO). The majority of the women who did get pregnant said that they could determine the reason (92 percent GOB, 81 percent NGO), and most of these pregnancies were attributed to a failure to take their pills. More than half stated that they simply forgot to take their pills (58 percent GOB, 59 percent NGO), but a few were able to pinpoint the failure to 1, 2 or 3 missed pills. There was also a small number of women who did not take their pills because they were sick (2 GOB women, 1 NGO woman) or away from home (3 NGO women).

Other Oral Contraceptive Related Issues

Other Problems and Attitude of Spouse

Study respondents were also asked regarding several other issues relating to their oral contraceptive use. Ninety percent of the women in both groups said that, other than side-effects, they faced no other problems in using oral contraceptives. Of those few who did mention other problems, 4 percent of the women in both groups mentioned that it was hazardous to take the pill daily, and another 4 percent of both groups said that they forget to take their pills (Table 7.14).

About two thirds of the women felt that their husband encourages their use of the method (60 percent GOB, 55 percent NGO), and another third said that their husbands were indifferent (31 percent GOB, 37 percent NGO). Although women in the focus group discussions had mentioned that some women take the pill only to improve their health, and study respondents also said that this was an advantage of OC use, only 1 percent of the women interviewed said that they had ever taken the pill only to improve their health. Only 4 percent said that they knew of anyone who had done so.

In addition to the issues mentioned above, the focus group findings also show that some women take pills secretly because they feel it is shameful to take them. The participants also mentioned that they experienced disapproval from either their husbands or their mothers-in-law. These problems were raised mostly from participants from GOB areas. They stated that these problems

were more marked during the initial stages of pill use, and it becomes easier for women to deal with them as they continue to use oral contraceptives.

Rumours Relating to Pill Use

As to rumours relating to the pill, two thirds said that they had heard of such rumours (63 percent GOB, 64 percent NGO), but fewer than 10 percent said that they believed in them (7 percent GOB, 9 percent NGO) (see Table 7.14). Over half of the women mentioned that pills accumulate in the body and form chains (55 percent GOB, 58 percent NGO). A third said that they cause snakes in the belly (33 percent in both), and almost a third mentioned the rumour that taking pills is a sin and that if a woman takes pills, the earth will not accept her body after death (27 percent GOB, 28 percent NGO). Around a fifth mentioned that the pills create stones in the belly (22 percent GOB, 19 percent NGO), and another fifth said that pills cause indigestion (20 percent GOB, 15 percent NGO). These rumours are consistent with those mentioned in the focus groups, and also with those found in other cultures around the world, particularly the notions that the pills accumulate in some way inside the stomach.

Client Suggestions for Improving OC Use

Finally, the respondents were asked for suggestions as to how the use of oral contraceptives could be improved. The results are shown in Table 7.15. About half of the women said that there should be more motivation (48 percent GOB, 52 percent NGO), and almost half said that it would be a good idea for satisfied pill clients to provide that motivation (43 percent GOB, 44 percent NGO). Almost a third of the respondents mentioned that there should be more efficient management of side-effects associated with pill use (31 percent in both groups). A fifth of the women suggested that vitamins be supplied along with the pills when they are distributed (19 percent in both groups). A more frequent follow up system of pill users was mentioned by a fifth of the respondents (20 percent GOB, 18 percent NGO), while others suggested a more regular follow up (15 percent GOB, 11 percent NGO).

CHAPTER 8

COMPARISON AMONG CLIENTS FROM GOB, NGO AND COMBINED GOB AND NGO CATCHMENT AREAS

About one-tenth of the respondents, both past and current users of OC, were reported to be covered by both GOB and NGO field workers. Most of these respondents were found in NGO areas. These show the existence of programme activities overlapped in a number of areas, although it is not expected to happen theoretically. To examine the characteristics of the clients representing overlapped groups, a comparison among clients from GOB, NGO and overlapped catchments areas are provided in this chapter.

The age composition of clients show that although there is a relatively higher percentage of current users of OC among the teenagers in the overlapped areas, the overall age distribution shows that the current users of overlapped areas are relatively older. The percentage of current users among teen agers is substantially low in GOB catchment areas. There is only a small variation by education particularly for primary or secondary or higher schooling, although the percentage of OC clients with no formal schooling appeared to be same in all the areas. There is no substantial variation observed by parity or age of youngest child in the catchment areas. However, compared to only one-fourth of the clients having planned the last pregnancy in GOB areas, 40 percent in NGO and overlapped areas, had planned for the child. This indicates a substantially higher proportion in GOB areas have unplanned pregnancy (Table 8.1).

The first time users of OC appears to be highest in the overlapped areas and lowest in GOB areas. More than two-thirds of the clients in the overlapped areas are clients of Sukhi, compared to 54 percent in GOB and 40 percent in NGO catchment areas (Table 8.2). The FWs are mentioned as the source of knowledge on OC by two-thirds of the clients in the overlapped areas which is lower as compared to that in the GOB areas (nearly three-fourths), but the source of the last spell of supplies is reported as FWs at a higher proportion in the overlapped areas (87 percent in the overlapped areas and 81 percent in the GOB and NGO areas). Similar response is found on the usual source of supplies. This is indicative of the fact that the supplies are provided by FWs to a substantially higher proportion of OC clients in the overlapped areas, although the reverse is true for source of knowledge.

The correct day of starting the use of OC was reported by a substantially higher proportion of clients in the overlapped areas (22 percent), compared to clients in GOB (18 percent) and in NGO (14 percent) areas (Table 8.3). There is no such variation in response to the question regarding correct side.

If one pill is missed then correct procedure was followed by three-fourths of the clients from GOB, NGO or overlapped areas, and the knowledge about correct procedure was reported by

nearly 90 percent of them. This gap between knowledge and practice does not seem to depend on catchment area.

About 9-10 percent of the clients who missed pills for two consecutive days in GOB and NGO areas had taken appropriate steps, but none followed the same (out of only 26 such cases) in the overlapped areas. However, the knowledge about the correct procedure was similar in GOB and overlapped areas (8-9 percent) which is little higher in NGO areas (13 percent).

No correct response procedure was followed by clients located in overlapped areas in case of missing three pills, compared to 4 percent in GOB and 2 percent in NGO catchment areas, but again surprisingly, 10-11 percent of the clients know the correct procedure. This kind of gap between knowledge and practice appears to be an interesting puzzle concerning behavioral pattern of some clients.

Knowledge about side-effects such as dizziness, irregular menstruation, excessive menstruation, menstruation stopped, gaining weight, abdominal pain, change in mood, etc. do not show substantial variations by GOB, NGO or overlapped areas. However, knowledge about weakness/sickness and burning sensation are reported higher in the overlapped areas. In response to the question on side-effects during the first three months, clients in overlapped areas have shown lower rate of suffering from vomiting tendency (38 percent in GOB and NGO areas compared to 26 percent in overlapped areas) and excessive menstruation (1 percent in overlapped areas compared to 3 percent in GOB areas). The percentage of clients suffered from other side-effects do not show any substantial variations in GOB, NGO or overlapped areas. The suffering from vomiting tendency, excessive menstruation, and abdominal pain continued for a duration of three months or more at a lower rate in overlapped areas compared to GOB areas. However, higher percentages of clients with suffering from side-effects such as irregular menstruation and weakness/sickness are observed in overlapped areas Table 8.4).

The contraindications such as gastric/ulcer, TB, anaemia are less known in overlapped areas compared to both GOB and NGO areas. The knowledge about gastric/ulcer as a contraindication to OC is known to 15 percent of the clients in overlapped areas, and TB and anaemia are known to only 1.7 and 3.4 percent of the clients respectively (Table 8.5). The contraindications were told by FWs to only one-fourth of the clients by GOB fieldworkers and less than one-fifth by NGO fieldworkers. A comparison between overlapped areas with exclusively GOB and NGO areas shows that the clients in overlapped areas have less exposure to knowledge about contraindications from fieldworkers. They mentioned hospital/clinics, friends/relatives and mass media as the source of such knowledge at higher percentages.

The above comparison between overlapped and GOB and NGO areas reveals some interesting features. It is observed that the FWs are mentioned as the source of knowledge about side-effects and contraindications less frequently by the clients in the overlapped areas, compared to the rest of the clients. However, it is surprising that the clients from the overlapped areas have mentioned FWs as the source of supplies of OC more frequently. This might be attributable to eagerness or competition among the GOB and NGO workers for supplies of OC in those areas rather than spending time for knowledge about side-effects or contraindications.

CHAPTER 9

DIFFERENTIALS OF DURATION OF OC USE

In this chapter the duration of use of OC is examined by various factors. The duration of OC use is computed here for the past users whose duration of last spell of OC use is uncensored. This has been done in order to exclude censored duration of OC use of current users. Other than some background characteristics, emphasis is given on the side-effects, contraindications, and related issues.

Age

The rate of discontinuation of OC use during the first year is the highest among the women less than 20 years old (44 percent in GOB and 55 percent in NGO areas) and the lowest in the age group 35 years and over (31 percent in GOB and 24 percent in NGO areas). It is evident that there is an inverse relationship between age and rate of discontinuation, in other words, higher the age a woman is likely to continue use of OC for longer time. The rate of continuation of OC use indicates that only 16-21 percent of the users of OC of age less than 20 years continue for longer than two years, compared to more than 50 percent in the age group 35 years or older. The rate of continuation after two years of OC use steadily increases with age of client (Table 9.1).

Education

There is no substantial variation in the continuation or discontinuation of OC use by education of clients. One third of the clients discontinued before completion of first year in all education categories, no formal schooling, primary schooling or high or higher level of schooling of clients. Two-year continuation rate ranges between 40 percent to 48 percent of the clients of OC.

Parity

About one-third of the OC users of parity 1 discontinued during the first year and it remained same for all other parities in the GOB areas, however, the rates of discontinuation are slightly lower (one-fourth) for the clients having parities four or higher in the NGO areas (Table 9.1). The continuation rate at two years of OC use shows that with an increase in the parity, the continuation increases in both GOB and NGO areas, however, the increment occurs at a higher rate among the clients in the NGO areas (thirty nine percent and one-third for parity one clients to 48 percent and 55 percent for clients having parity seven or higher, in GOB and NGO catchment areas respectively).

Desire for Additional Children

It is expected that the clients desiring for additional children would have higher rate of discontinuation which is reflected in our analysis as well. It is observed that one-third of those who desire for additional children continued use of OC after two years, compared to half of the clients who do not want to have another child (Table 9.1). The clients who do not desire for additional children could continue the use of OC for longer time at a much higher rate, but the discontinuation of the remaining fifty percent of them indicates that there might be other reasons such as side-effects, method failures, barriers of using OC, lack of regular supplies, etc.. The estimated continuation rates are observed to be similar for clients living in GOB and NGO areas.

OC Use First Time

A sharp difference in the continuation of OC use is observed by whether the client is a first time user or not. It is revealing that first time users of OC continues use for longer time. Two-thirds of the first time users are expected to continue the use of OC for two years or more, compared to one-third of the repeated users (Table 9.2). These results do not vary substantially by catchment areas. About one-third of the repeated users discontinue before completing even six months, compared to only 5-7 percent of the first time users. This might be attributable to some extent to the definition of a repeated user. If a client discontinued use of OC deliberately for more than 15 days then the use is considered to have interrupted use of OC and after that time period if she starts using OC once again then she becomes a repeated user of OC.

Source of Knowledge

The clients who mentioned FWs as the source of knowledge on OC have continued the use of OC for a substantially longer duration. About half of the clients who learned about OC from FWs continued the use for two years or longer in GOB areas, compared to nearly 40 percent of the clients who mentioned their sources hospital/clinic or relatives. One-fifth of the clients of FWs discontinued during first six months as compared to that of more than one-fourth of the clients who mentioned other sources of knowledge on OC (Table 9.2). In NGO areas, the rates of discontinuation appear to be substantially lower for the first year if the source of knowledge is hospital/clinic.

Correct Day of Starting

The correct day of starting use of OC is the first day of menstruation as documented in the Ministry of Health and Family Welfare ( ). However, most of the clients in both GOB and NGO areas do not practice the correct procedure of starting OC. It is interesting to note that the rates of continuation do not show any substantial variation by correct or incorrect procedure followed in

this regard. The continuation rate for both correct or incorrect procedures after two years of use of OC range between 44 percent to 47 percent irrespective catchment areas. In other words, more than 50 percent of the clients discontinue use of OC within two years (Table 9.3).

Correct Side of Starting

The duration of use of OC is observed to be higher for the clients who followed the correct side of starting OC in both the GOB and NGO areas. About half of those who followed correct procedure continued use for two years or longer, compared to about 40 percent of those who did not follow such procedures (Table 9.3).

Source of Instruction

If the source of instruction is FWs then about half of the clients continued for two years or longer but in case of other sources (hospital/clinic, relatives/friends, etc.) in GOB areas less than 40 percent of the clients continued use of OC for two years. This indicates that the follow-up visits of workers might have an influence on the use of OC such that initial mistakes are corrected at a subsequent phase. These evidences are surprisingly similar in both GOB and NGO areas.

Skipped One Pill

The correct knowledge about steps necessary to be taken if a client misses one pill increases the duration of use. About 47 percent of the clients who have correct knowledge continued use of OC for two years or longer, compared to 41 percent for clients who do not have correct knowledge (Table 9.4).

Skipped Two Pills in Consecutive Days

In NGOs, the duration of use seems to be higher among the clients of OC who could respond correctly in response to the question on what should be done if two pills are missed in consecutive days (Table 9.4). Fifty four percent of those who responded correctly continued use for two years or longer which is 46 percent for those who do not have the correct knowledge. This association is reverse for the clients from GOB areas. A possible reason is that the number of women responded correctly is relatively small in GOB areas, hence, it is likely that the women who take extra precaution is not reflected in the estimates for GOB.

Skipped Three Pills Consecutively

In GOB areas, 53 percent of the clients having knowledge about what to do if three pills are missed consecutively, continued to use the pills for two years or longer, compared to 44 percent without having the correct knowledge. No such evidence was found in NGO areas. Due to small number of clients who could respond correctly in both the catchment areas, we can not provide any estimate for the clients who had practiced it in reality. It may be recalled here that there is a large proportion of women in both the catchment areas who know the correct procedure but do not practice it.

Side-effects During First Three Months

It has been discussed earlier that most of the clients know that the side-effects might be gone after the first two or three months of use of pills. It is reflected in the duration of use by side-effects. It is interesting to note that some of the clients having suffered from side-effects such as vomiting tendency, dizziness, change in mood, etc. have either no variation or longer duration of use but those who suffered from other side-effects, more severe in nature, such as irregular menstruation, excessive menstruation, burning sensation, etc. have substantially lower duration of use of OC. Two-year continuation rates for those who suffered from irregular menstruation during the first three months of accepting the method is only 28-29 percent, compared to 40-43 percent for those who did not suffer from such side-effect (Table 9.5). Similarly, if suffered from excessive menstruation, then out of 5 clients only one in GOB, and out of 3 clients only one in NGO, continued use of OC for 24 months. In case of clients with burning sensation, about one-third of the clients continued use for two years in GOB areas, compared to 41 percent without burning sensation. The clients from NGOs do not show such differences for clients with or without burning sensation.

Contraindications

If a potential client accepts the method of OC ignoring the contraindications then the consequence might be difficult to handle at the grass-roots level. If the contraindications are present in the beginning then the resultant effect might be severe health problems at a later stage which could be misunderstood as side-effects although this could be avoided through routine checks by the field workers. Here duration of use of the last spell of OC by presence of disease prior to acceptance of OC has been examined. As we observed that many clients continue to use OC with side-effects, this may have relevance with contraindications as well. The demand for contraceptive methods, particularly OC , has increased to a large extent during the recent past. During this phase of a fast transition towards temporary modern methods, the workers could not be given adequate training on the contraindications of the disease, and the workers wanted to increase the number of clients without making much effort to identify clients on the basis of

contraindications. This endeavour produced a large number of clients who are currently suffering from various complications.

The duration of use of OC is computed by presence of absence of contraindications in the past. Here the comparisons are made only for two-year continuation rates. The users who have already completed their last spell of OC use are considered for this comparison.

The continuation rate for clients having history of heart disease is substantially lower in both GOB and NGO areas, one-fourth of the clients with history compared to one-third without any history of heart disease continued use of OC for two years. Similar differences are observed for diabetes, jaundice, vericose vein and vaginal bleeding in both the catchment areas. One-fourth of the clients having history of anaemia in GOB areas and one-third without anaemia continued use of OC for two years but no such difference is observed in NGO areas. The duration of use for clients with or without gastric/ulcer or headache/migraine are not substantially different in both GOB and NGO areas. These findings show that the duration of use of OC reduces greatly due to contraindications irrespective of the coverage by GOB or NGO.

CHAPTER 10

CONCLUSIONS

The use of OCs has increased dramatically during the recent past. A recent survey conducted by BBS (BBS, 1996) revealed that three-fourths of the users of modern reversible methods are OC users. This transformation has occurred with the old system when sterilization was the dominating method of contraception. But the recent increase in the contraceptive prevalence rate can be fully attributed to the increase in the acceptors of oral contraceptives. The training materials were developed for the fieldworkers in relation to the previous system and most of the workers received those before the transformation had taken place. The present study made efforts to identify the problems associated with the correct use of pills. The study also sought to explore what clients believe about the safe and effective use of pills and to investigate the gaps in the information regarding the use of oral contraceptives.

It is evident from the client surveys that among the past users of OCs, only one-fourth are currently using any method of contraception. Most of the clients who switched to other methods switched mainly to injectables. It is interesting that those who switched from other methods to oral contraceptives were mainly injectable and IUD users. For both types of transitions, from or to oral contraceptives, the major reason given was side effects. This is indicative of the fact that the continuation and effective use of oral contraceptives depends, to a large degree, on the adequate treatment of side effects due to OC use.

During the recent past the government started distributing supplies of the lower dose Sukhi brand of oral contraceptives instead of C-5. The change in brands was due to the change in the government supplies. However, some of the clients changed brands due to the fact that the current brand is provided free of charge, or because they experienced side effects with the previous brand. On the preference of brand, most of the current and past users responded in favour of C-5. Only one fourth of the current users actually preferred Sukhi, although half of the women who are currently using pills are using Sukhi. Ovacon and Ovostat are preferred by a substantial proportion of current users. The major reason given for preferring a specific brand was that users felt that the brand had fewer side effects.

Users of oral contraceptives clearly demonstrated their lack of knowledge regarding one of the first things that they should know: how to start the use of OCs. The correct day to start OC use was mentioned by less than one fifth of the clients. This may be attributed to several reasons, for instance: workers do not have adequate knowledge; workers do not provide adequate instructions to their clients; and clients do not follow the instructions provided by the workers. Similar findings were obtained for the time of starting a new cycle. The correct order in which to take the pills was known by most of the OC users. However, there are still some users (5-10 percent) who start on the side opposite to the arrow mark on the packet. This point needs to be reemphasized in order to ensure the effective use of the pill. Most women are likely to consult

the fieldworker regarding these issues (70-77 percent), however, friends and relatives are also a source of suggestions (11-16 percent) in both GOB and NGO areas.

One of the most important findings of this report is regarding skipping one or more pills. It was observed that most of the clients (more than 90 percent) know about what to do when they miss one pill. However, this knowledge does not seem to be practiced by all of the women who say that they do know what to do. There is a gap of about 15 percent in the knowledge and practice regarding what should be done if one pill is skipped.

The knowledge regarding what should be done if two or more pills are skipped seems to be severely deficient both among clients and workers. The correct procedures on missing two or more pills are practiced by only a negligible proportion (less than 10 percent) of the clients. This problem may lead to a large number of unplanned pregnancies due to incorrect pill use. The workers definitely need more training on this issue.

Some of the clients (11 percent-13 percent) stop taking pills after uninterrupted use for an extended period of time. Again, side effects appear to be the major cause for discontinuation of OC use. In addition, to side effects, about one fifth of those clients who stop using pills do so due to other health reasons or because of fear of infection.

One major issue of concern revealed by the study is that an overwhelming majority (more than 80 percent) take oral contraceptives even if they are sick. This may cause health problems for OC clients. The impact of such OC use needs to be examined more fully.

The majority of the women (64-68 percent) did not know about any contraindications to pill use, but many were likely to manifest some contraindication at the time they began using the method (for example, 43-44 percent had gastric ulcers, 27 percent reported headaches/migraines, and 21-24 percent reported anaemia). Although both clients and workers could name some of the contraindications, it is unclear that they understand their significance. This finding is of great concern, as certain preexisting conditions, when combined with the hormonal effects from OC use, can cause serious health problems, or in some cases, can lead to death. Another, lesser concern, is that it is difficult to differentiate between side effects caused by the pill vs. those due to pre-existing contraindications, many of which could be mistaken for side effects or aggravated by pill use. The problems that women attribute to the pill may be due to the pre-existing condition, or may exacerbated by pill use. In any case, the problems experienced by the user contribute to the number of women who discontinue use of the method.

In terms of client interaction with fieldworkers, clients did report that fieldworkers made regular visits. However, these visits are generally quite short (5 minutes or less), and very little discussion takes place. These visits could be utilized more efficiently to provide information to the clients and to manage side effects.

Interestingly, women know about alternative sources of pills but infrequently use them. They prefer instead to borrow pills from friends or relatives if their supply is delayed.

OC users suggested increased motivational efforts to improve pill use. They felt that satisfied clients would make good motivation. They also would like to see more efficient management of side effects.

Finally, the majority of women in the study (86 percent) indicated that they would be willing to pay a token price for pills if there was a charge for them in the future.

CHAPTER 11

POLICY IMPLICATIONS

This study has been conducted at a time when use of OC is playing the most important role in increasing the level of CPR in Bangladesh. According to a recent survey conducted by BBS, OC users constitute three-fourths of the total modern reversible method users. However, the increase in use of OC alone does not ensure quality use, hence to achieve the targets of replacement level fertility in coming years, the quality of use of OC needs proper attention. The problems associated with proper use of OC have been identified in the present study and a number of policy emerged from the findings of this which will have to be given top priority in order to achieve the short and long term goals of the FP programmes in Bangladesh. Some of the important policy implications are listed below.

I. Gaps in Knowledge about Use of Oral Pills:

There are several issues regarding gaps in knowledge of workers about correct use of OC. Although workers know about what to do in case of missing one pill, they do not have proper knowledge about what should be done if two or more pills are skipped. This may cause severe problem to the success of FP programme if this knowledge is not provided through local level trainings as soon as possible.

II. Gaps between Knowledge Provided by Workers and Practice by a Client:

It is evident that although clients know about what should be done in case of missing one pill, all of them do not practice it. This issue should be given importance and fieldworkers should be trained how to identify these clients and how to create awareness about correct use of OC to these women.

III. Starting Use of OC:

The workers and OC users need correct information regarding day of starting use of OC. Most of the users start use of OC either from second to fifth day of menstruation or from the day after the menstruation is over. The correct procedure should be disseminated to the workers at the grass-roots level through in-house and field level training at the local level.

IV. Order of Taking Pills:

Although most of the OC users know in what order the pills should be taken, a substantial proportion of clients do not have adequate knowledge. The workers or suppliers of OC to a new acceptor should spend more time with the new acceptors to explain them thoroughly the correct procedures. There should be frequent follow-up visits to new acceptors in order to know whether they are facing any problems regarding correct use of OC.

V. Involvement of Husbands:

The male participation in the discussion about correct use of pills can play a very important role. Most of the times, clients have to depend on workers, friends or relatives for any consultation regarding proper use of pills. The husbands are involved with this process in case of only a negligible proportion of users. Involvement of males can be tested on pilot basis in some selected areas to examine the improvement in the correct use of pills.

VI. Abuse of Pill Use:

In many cases pills are used to regulate (either to stop or to regularize) menstruation, for improving health, etc. The health hazards associated with such practice should be examined and necessary steps should be taken accordingly.

VII. Brown Pills:

The utility and necessity of brown pills are not clearly understood by the clients. Most of the OC users think that brown pills are vitamin tablets and a substantial proportion do not take brown pills at all. The long-term consequences of not taking brown pills should be disseminated to the workers so that they can motivate their clients to take brown pills with adequate information.

VIII. Side-effects:

Side-effects cause method discontinuation among half of those who drop using OC during their first year of acceptance of the method. Among the past users of OC who discontinued during the last year, only one-fourth use another method. Hence without ensuring proper care for side-effects, the continuation of OC use can not be improved. It is noteworthy that the users are desperately looking for a method with lesser side-effects. After having experienced side-effects of injectables and IUDs, clients switch to OC. If they experience side-effects from OC, then most of them do not use any other method at all (at least within a year). This shows without providing adequate and timely treatment for side-effects, the continuation of OC can not be increased. This point needs

immediate attention of the programme managers, and a service delivery system (for instance through satellite clinics) with adequate treatment facilities for clients having side-effects should be given top priority.

IX. Contraindications:

The preexistence of certain contraindications to oral contraceptive use can cause severe health problems. It was alarming to note that the majority of women in this study (64-68 percent) did not know the contraindications to pill use. Even more disturbing was the finding that a number of women who use the pill currently or who are past users presented some sort of contraindication prior to beginning OC use. Aside from the obvious and serious health risks related to this practice, the preexisting conditions make it difficult to differentiate between side effects that are caused by the pill versus those that may be due to the preexisting contraindication. Women who have certain conditions should not use oral contraceptives. Fieldworkers and OC clients alike appear to have inadequate knowledge regarding this aspect of OC use. Alternatively, it may be due to a desire to increase the acceptance of the method on the part of the worker. In any case, this point also needs immediate attention of the programme managers, perhaps in conjunction with the changes made in the training and service delivery system mentioned for the management of side effects.

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APPENDIX

SET OF TABLES

Table 3.1: Background Characteristics of OC Users in GOB and NGO Areas

Characteristics	GOB		NGO	
	Current User %	All %	Current User %	All %
Age				
<20	3.9	4.7	7.8	8.4
20-24	21.1	20.2	19.6	22.5
25-29	25.5	25.0	25.0	24.3
30-34	22.8	21.7	20.2	19.2
35-39	17.3	15.6	17.2	15.3
40+	10.0	12.8	10.2	10.3
Children everborn				
0	0.1	0.5	1.1	1.7
1	12.2	12.4	15.8	17.8
2	23.5	22.4	22.3	21.5
3	17.6	17.7	16.2	16.9
4	16.3	15.4	15.9	14.3
5+	30.3	31.6	28.7	28.1
Religion				
Muslim	82.8	84.6	90.2	91.4
Others	17.2	15.4	9.8	8.6
Marriage duration				
<5	4.1	4.6	8.7	10.0
5-14	47.9	47.0	43.0	44.6
15-24	36.9	34.3	36.5	33.6
25+	11.1	14.1	11.8	11.8

Table 3.1 Background Characteristics of OC Users in GOB and NGO Areas (contd.)

Characteristics	GOB		NGO	
	Current User %	All %	Current User %	All %
Respondent's education				
None	54.6	54.7	53.0	54.0
Primary	30.0	30.5	32.4	31.3
High school +	15.4	14.8	14.6	14.7
Husband's education				
None	41.3	41.4	43.6	44.2
Primary	22.7	23.9	22.4	22.8
High school +	36.0	34.7	34.0	33.0
Husband's occupation				
Agriculture	40.4	39.2	39.2	38.3
Day labourers	17.2	18.9	20.6	20.8
Business/trade	26.6	24.4	25.8	24.9
Others	15.8	17.5	14.4	16.0
Participation in women's group:	26.0	24.7	27.1	26.4
Listen Radio/TV	63.3	61.6	59.9	58.8
Land ownership				
No land	41.7	42.84	47.3	47.19
< 1 acre	23.0	23.82	22.6	23.37
≥1 acre	35.3	33.34	30.1	29.24
N	801	1403	1031	1600

Table 3.2: Distribution of OC Users Who Had Experienced Pregnancy After Last Living Child

Characteristics	GOB			NGO		
	Current users %	Past users %	Total %	Current users %	Past users %	Total %
Got pregnant after last living child:						
Yes	9.6	25.5	16.4	8.9	27.8	15.6
No	90.6	74.5	83.6	91.1	72.2	84.4
N	800	593	1393	1017	545	1562
Pregnancy pre-planned	26.0	44.4	38.2	38.5	49.3	45.3
Outcome of pregnancy						
Still pregnant	0.00	55.6	36.8	2.2	71.0	45.3
Live birth (died later)	26.0	12.6	17.1	26.4	11.8	17.3
Induced abortion	42.9	17.2	25.9	33.0	7.9	17.3
Still birth/ miscarriage	31.2	14.6	20.2	38.5	9.2	20.2
N	77	151	228	91	152	243

Table 3.3: Percentage Distribution of OC Users by Future Fertility Intentions and Reasons for Having or Not Having More Children.

	GOB			NGO		
	Current users %	Past users %	Total %	Current users %	Past users %	Total %
Want more children	29.5	30.6	29.9	1.9	37.8	34.0
Want no more children	70.5	69.4	70.1	68.1	62.2	66.0
N	801	602	1403	1031	569	1600
Number of children want						
One	89.8	77.2	84.3	83.0	65.1	75.9
Two or more	10.2	22.8	15.7	17.0	34.9	24.1
Reason for having more children in future						
Need a son	39.4	38.6	39.0	38.0	40.0	38.8
Need a daughter	23.7	19.0	21.7	25.2	16.7	21.9
Need a child of either sex	30.9	32.6	31.7	27.7	29.3	28.3
Other	6.0	9.8	7.6	9.1	14.0	11.0
N	236	184	420	329	215	544
Reason for not having more children in future						
Already have enough children	29.2	29.9	29.5	28.3	22.9	26.5
Don't have means to support	30.6	30.9	30.7	31.8	26.8	29.9
Difficult to educate	28.8	24.2	26.9	26.8	34.2	29.3
Other reasons	11.4	15.0	12.9	13.1	16.1	14.3
N	565	418	983	702	354	1056

Table 3.4: Characteristics of Current Users by Brand of OC

Characteristics	GOB			NGO		
	C-5 %	Sukhi %	Other %	C-5 %	Sukhi %	Other %
Age						
<29	51.7	46.4	65.9	55.2	45.8	63.1
30-40	37.3	44.6	25.3	36.4	41.2	29.4
40+	11.0	9.0	8.8	8.4	13.0	7.5
Education of respondent						
None	59.4	54.7	36.3	50.7	57.7	45.6
Primary	28.0	31.2	29.7	35.2	29.1	35.0
High school +	12.6	14.1	34.1	14.1	13.2	19.4
Children ever born						
0-1	12.2	11.8	14.3	17.5	13.0	26.3
2-3	44.7	37.7	47.2	41.9	35.1	38.7
4+	43.1	50.5	38.4	40.6	51.9	34.9
Using uninterruptedly since acceptance of OC	56.5	56.1	49.4	57.9	63.8	49.4
Desire for future children						
Yes	28.0	28.4	38.5	31.3	30.1	38.7
N	271	433	91	406	461	160
Whether last pregnancy after youngest child was preplanned						
Yes	33.3	26.3	13.3	36.8	52.8	11.8
N	24	38	15	38	36	17

Table 4.1: Percentage Distribution of Current Users of Different Methods among Past Users of OC

	GOB %	NGO %
Currently using any method		
Yes	24.0	23.6
No	76.0	76.4
N	608	573
Method using		
Condom	22.6	17.0
Injectable	37.7	45.2
IUD/Norplant	6.9	5.9
Traditional	26.0	27.4
Other	6.8	4.5
N	146	135

Table 4.2: Percentage Distribution of Current Users Using Different Brands of OC

Brand of OC	GOB %	NGO %
C-5	34.1	39.5
Sukhi	54.5	44.9
Ovacon	5.9	5.4
Maya	1.0	3.8
Other	4.5	6.4
N	795	1027

Table 4.3: Percentage Distribution of OC Users by Number of Spells of OC Use and Duration of Use During Current / Last Spell

	GOB		NGO	
	Current users %	Past users %	Current users %	Past users %
No. of spell				
1	55.6	74.1	59.3	72.8
2	33.2	17.4	28.7	18.1
3+	11.2	8.5	12.0	9.1
Duration of OC use (months)				
<12	25.1	49.0	22.0	49.6
12-23	21.1	18.6	24.1	18.4
24-47	28.2	22.1	30.0	22.0
48+	25.6	10.3	23.8	10.0
N	801	602	1031	569

Table 4.4: Percentage Distribution of Past Users of OC by Reason for Discontinuation

Reason for Discontinuation	GOB %	NGO %
Want children	21.3	24.1
Side-effects	52.8	46.6
Objection by in-laws	2.8	4.9
Method failure	2.7	2.6
Inadequate supply	2.5	3.9
Other reasons	17.9	17.9
N	602	569

Table 4.4a: Percentage Distribution of Users of Different Methods among Past Users of OC Who Discontinued OC due to Side-Effects

Method	GOB %	NGO %
No method	66.3	66.0
Condom	6.9	6.0
IUD/Injectable	14.8	19.2
Sterilization	0.9	0.4
Traditional/Other	11.0	8.3
N	318	265

Table 4.5: Percentage of OC Users by Method of FP Use Before Current/Last Spell of OC Use

	GOB		NGO	
	Current users %	Past users %	Current users %	Past users %
Used any method				
Yes	22.3	13.7	23.5	20.2
No	77.7	86.3	76.5	79.8
N	801	602	1031	569
Method used*				
Condom	19.0	24.7	18.2	15.6
Injectable	47.5	33.3	52.1	49.6
IUD	17.3	16.0	17.4	14.8
Traditional	13.4	19.7	9.9	16.5
Other	2.8	6.3	2.4	3.5
N	179	81	242	115

Notes:
* Multiple response possible

Table 4.6: Percentage of OC Users Mentioning Different Reasons for Switching to OC.

Reasons*	GOB		NGO	
	Current users %	Past users %	Current users %	Past users %
Side-effect of previous method	58.6	49.4	61.6	54.8
Less side-effect	29.0	25.9	33.9	20.9
No side-effect	11.2	4.9	11.2	7.0
Easy to use	29.0	33.3	24.0	23.5
Regular supply of OC	3.9	11.1	4.1	7.8
Can take secretly	2.8	3.7	2.1	2.6
Can be stopped any time	6.7	8.6	6.2	7.0
Regularize and control of menstruation	14.5	8.6	17.4	15.7
N	179	81	242	115

Notes:
* Multiple response possible

Table 4.7: Percentage of Current Users of OC by Brand of OC Used Previously and Reason for Switching to Current Brand

	GOB %	NGO %
Used any other brand of OC		
Yes	66.3	64.2
N	801	1031
Name of brand used		
C-5	68.9	64.2
Sukhi	5.8	3.9
Ovacon	10.4	10.3
Ovostat	6.8	8.8
Other	8.1	12.8
Reason for change of brand		
Supply by FWA	64.4	11.0
Supply by NGO worker	0.2	51.2
Side-effect of previous brand	16.6	19.9
High price of previous brand	6.4	8.5
Non-availability	6.2	5.7
Other reasons	6.2	3.7
N	531	662

Table 4.8: Percentage Distribution of OC User by Most Preferred Brand and Reason for Preferring that Brand of OC

	GOB		NGO	
	Current user %	Past user %	Current user %	Past user %
Preferred brand				
C-5	44.7	31.4	41.4	36.6
Sukhi	27.0	7.0	23.4	8.4
Ovacon / Ovostat	10.8	15.4	10.8	12.1
Others	7.1	6.3	9.3	5.8
No idea	11.4	39.9	15.1	37.1
Reason *				
Better quality	23.7	12.6	21.4	16.3
Less side-effect	70.5	37.4	68.0	38.1
Improve health	19.5	12.1	19.0	10.4
Other reason	22.3	54.8	23.0	51.7
N	801	602	1031	569

* Multiple answers possible

Table 5.1: Percentage of Current and Past Users by Knowledge about OC Use

Knowledge about OC*	GOB			NGO		
	Current user %	Past user %	All %	Current user %	Past user %	All %
Prevent pregnancy	98.5	98.8	98.6	98.8	98.6	98.7
Should be taken every day	52.7	54.3	53.4	58.6	57.1	58.1
Start 1st day of menstruation	5.0	3.8	4.5	4.1	3.3	3.8
Is a temporary method	7.1	9.8	8.3	6.7	8.3	7.2
Easily available	16.5	10.6	14.0	15.9	11.9	14.5
Can be discontinued any time	13.5	19.9	16.3	18.2	20.9	19.2
No/less side-effects	27.3	13.3	21.3	27.0	17.2	23.5
Improves health	24.0	21.3	22.8	23.8	18.8	22.0
Shouldn't be taken uninterruptedly for long time	2.5	1.5	2.1	1.6	2.1	1.8
Regularize menstruation period	21.2	16.8	19.3	20.4	16.0	18.8
N	801	602	1403	1031	569	1600

Notes:
* Multiple response possible

Table 5.1a: Percentage of Current Users by Knowledge about OC Use by Different Brands of OC

Knowledge about OC*	GOB			NGO		
	C-5 %	Sukhi %	Other %	C-5 %	Sukhi %	Other %
Prevent pregnancy	99.6	97.7	98.9	99.0	98.7	98.7
Should be taken every day	51.7	53.8	52.7	61.3	60.3	46.2
Start from first day of menstruation	4.8	4.6	7.7	3.2	4.3	15.0
Temporary method	6.6	7.2	8.8	5.9	6.9	8.1
Easily available	19.9	16.4	7.7	14.3	17.3	16.2
Can be discontinued any time	9.6	14.5	19.8	16.5	17.6	23.7
No/less side-effects	28.4	23.6	42.9	23.6	28.6	30.0
Improves health	15.1	28.9	28.5	25.4	21.3	26.9
Shouldn't be taken uninterruptedly for long time	2.9	2.5	1.1	0.7	0.9	6.2
Regularize menstruation	19.9	22.6	16.7	24.6	18.2	15.6
N	271	433	91	406	401	160

Notes: * Multiple response possible

Table 5.2: Percentage Distribution of OC Users by Source of Knowledge and Motivators for Using OC

	GOB %	NGO %
Source of knowledge		
FWA	66.7	17.0
NGO FW	0.5	50.1
LIP volunteer	2.4	0.2
Hospital/Clinic	3.8	3.7
Husband	4.3	4.3
Friends/Relatives	17.3	19.4
Mass media	3.6	4.2
Others	1.4	1.1
Motivators for using OC		
Self	6.5	5.9
FWA	48.1	13.4
NGO FW	0.4	37.4
LIP volunteer	1.3	0.1
Hospital/Clinic	2.8	2.2
Husband	19.4	17.7
Friends/Relatives	19.9	21.1
Mass media	1.1	1.3
Others	0.5	0.9
N	1403	1600

Table 5.2a: Percentage Distribution of Current Users by Brand of OC and by Source of Knowledge and Motivators for Using OC

	GOB			NGO		
	C-5 %	Sukhi %	Other %	C-5 %	Sukhi %	Other %
Source of knowledge						
FWA	70.0	72.3	49.4	19.0	16.7	7.5
NGO FW	-	0.9	-	50.0	59.2	34.4
LIP volunteer	5.2	1.1	-	0.5	-	-
Hospital/Clinic	1.8	2.8	8.8	1.2	4.6	6.2
Husband	3.7	2.8	5.5	3.0	2.6	12.5
Friends/Relatives	17.0	15.2	25.3	19.7	14.1	28.1
Mass media	2.2	3.5	6.6	4.9	2.6	9.4
Others	0.1	3.4	4.4	1.7	0.2	1.9
Motivators for using OC						
Self	5.2	6.2	6.6	5.4	5.2	8.1
FWA	49.5	52.4	29.7	15.5	14.1	5.6
NGO FW	-	0.5	1.1	36.9	43.1	24.4
LIP volunteer	2.2	0.9	-	0.5	-	-
Hospital/Clinic	0.7	2.1	8.8	1.5	2.6	3.1
Husband	21.4	15.9	28.6	13.5	15.8	26.9
Friends/Relatives	19.6	20.1	22.0	23.1	18	26.9
Mass media	0.7	1.4	2.2	2.5	0.4	3.1
Others	0.7	0.5	1.0	1.1	0.8	1.9
N	271	433	91	406	461	160

Table 5.3: Percentage of Current and Past Users by Reasons for Preferring OC Over Other Methods

	GOB			NGO		
	Current user %	Past user %	All %	Current user %	Past user %	All %
Reasons for choosing OC*						
Temporary method	15.9	20.8	18.0	13.0	18.8	15.1
Easily available	32.0	30.1	31.1	37.2	32.7	35.6
Can be discontinued any time	18.3	31.1	23.8	23.9	36.7	28.4
No/less side-effect	51.4	31.4	42.8	51.9	40.0	44.8
Confidentiality maintained	4.6	6.3	5.3	6.1	7.7	6.7
Available free of cost	16.5	12.1	14.6	8.6	10.4	9.2
Less health hazardous	23.1	18.3	21.0	29.2	18.4	25.4
Improves health	20.7	16.3	18.8	16.6	14.8	15.9
Fears of other methods	50.3	39.0	45.5	46.6	39.0	44.0
N	801	602	1403	1031	569	1600

Notes:
* Multiple response possible

Table 5.3a: Percentage of Current Users by Brand of OC by Reasons for Preferring OC over Other Methods

	GOB			NGO		
	C-5 %	Sukhi %	Other %	C-5 %	Sukhi %	Other %
Reasons for choosing OC*						
Temporary method	16.2	15.5	17.6	11.8	13.2	15.6
Easily available	32.8	33.7	20.9	39.9	38.4	28.1
Can be discontinued any time	16.6	18.9	22.0	20.0	25.4	28.7
No/less side-effect	49.1	51.0	60.4	52.5	49.5	56.9
Confidentiality maintained	3.3	4.8	7.7	6.2	7.6	1.9
Available free of cost	21.4	16.4	3.3	11.3	8.5	2.5
Less health hazardous	18.1	25.2	28.6	29.6	25.0	40.0
Improves health	18.1	23.1	18.7	17.7	14.3	19.4
Fears of other methods	49.5	48.3	60.4	45.1	46.4	52.5
N	271	433	91	406	461	160

Notes:
* Multiple response possible

Table 5.4: Percentage of Current and Past Users by Preference for Other Methods and Reasons for Preferring Other Methods

	GOB			NGO		
	Current users %	Past users %	All %	Current users %	Past users %	All %
Preferred other methods over OC						
Yes	4.4	29.7	15.2	5.5	29.2	13.9
N	801	602	1403	1031	569	1600
Method preferred						
IUD	16.4	45.5	35.0	27.6	59.8	45.4
Injectables	2.2	11.5	8.1	3.4	9.5	6.8
Norplant	2.2	8.5	6.2	3.4	8.4	6.2
Sterilization	3.0	5.5	4.6	4.1	7.8	6.2
Others	2.3	5.1	4.1	0.8	5.2	4.2
Not stated	73.9	23.8	42.0	60.7	7.3	31.2
N	134	235	369	145	179	324
Reason for preferring other methods*						
More side -effects of OC	37.1	65.4	60.7	33.3	64.5	56.5
Hazardous to take everyday	40.0	19.5	22.9	35.1	27.1	29.1
Need a more efficient method	14.3	10.1	10.7	17.5	9.6	11.7
Need a long term method	51.4	28.5	32.2	36.8	31.3	32.7
N	35	179	214	57	166	223

Notes:
* Multiple response possible

Table 5.5: Percentage of Current Users by Source of Supply of OC

	GOB %	NGO %
Usual Source of Supply of OC		
FWA	71.8	12.6
NGO FW	0.4	72.5
LIP Volunteer	8.3	0.1
Pharmacy	9.9	6.1
Hospital/Clinic	2.6	3.6
Market/Shop	2.8	2.7
Other	4.2	2.5
Source of Supply of Last Cycle		
FWA	69.1	11.7
NGO FW	-	70.6
LIP Volunteer	9.1	-
Pharmacy	10.0	6.2
Hospital/Clinic	2.6	3.8
Other	9.2	7.7
N	1403	1600
Knowledge about sources Other than Usual source	68.4	73.1
N	1403	1600
Other sources of supply*		
FWA	23.8	17.9
NGO FW	1.1	23.2
LIP Volunteer	6.8	0.8
Pharmacy	34.7	32.6
Hospital/clinic	41.0	36.9
Market/shop	33.6	33.8
N	960	1170

Notes:
* Multiple response possible

Table 5.5a: Percentage Distribution of Current Users by Brand of OC and by Usual Source of Supply of OC

	GOB			NGO		
	C-5 %	Sukhi %	Other %	C-5 %	Sukhi %	Other %
Usual source of supply of OC						
FWA	73.8	85.0	9.9	7.9	15.0	1.2
NGO FW	-	0.2	1.1	85.5	79.0	41.9
LIP Volunteer	19.9	7.2	2.2	0.2	-	-
Pharmacy	2.2	0.7	57.1	0.5	1.3	35.6
Hospital/Clinic	1.1	1.8	2.2	3.0	3.9	0.6
Market/Shop	-	0.5	19.8	1.0	-	16.2
Other	3.0	4.6	7.7	1.9	0.8	4.5
N	271	433	91	406	461	160

Table 5.6: Percentage Distribution of Users by Number of Cycle of Pills Supplied

	GOB %	NGO %
Numbers of cycles of pill received at the start of OC use		
1	17.2	25.2
2	9.5	15.7
3	71.3	58.1
4+	2.0	1.0
No of cycles usually receive		
1	16.3	23.6
2	20.2	31.1
3	54.0	37.1
4+ & Other	9.5	8.3
No of cycles received last time		
1	21.3	32.1
2	19.3	25.7
3	56.9	40.6
Other	2.3	1.6
N	1403	1600

Table 5.6a: Percentage of Current Users by Brand of OC by Number of Cycles of Pills Received

	GOB			NGO		
	C-5 %	Sukhi %	Other %	C-5 %	Sukhi %	Other %
Number of cycles of pill received at the start of OC use						
1	10.3	5.1	65.9	16.7	21.0	56.9
2	10.0	9.9	6.0	20.7	13.9	15.0
3	79.7	81.1	27.5	61.7	63.8	26.9
4+	0.0	4.8	0.0	0.9	1.3	1.2
No of cycles usually receive						
1	9.2	5.8	71.4	15.0	21.9	58.7
2	28.4	21.9	14.3	49.7	29.1	24.4
3	60.9	68.1	13.2	34.0	46.2	16.2
4+	1.5	5.1	1.1	1.3	2.8	0.7
No of cycles received last time						
1	12.2	6.9	76.9	22.7	28.0	68.1
2	28.0	20.1	13.2	38.4	22.8	18.7
3	57.9	68.8	9.9	37.2	46.4	12.5
Other	1.9	4.2	0.0	1.7	2.8	0.7
N	271	433	91	406	461	160

Table 5.7: Percentage of Users by whether Experienced Interruption in Supply of OC During 3 Months Prior to Interview

	GOB (%)	NGO (%)
Experienced interruption		
Yes	2.8	3.9
No	97.2	96.1
N	1403	1600
Reason for interruption		
FWA didn't come	72.5	11.3
NGO FW didn't come	-	64.5
LIP volunteer didn't come	5.0	-
Supply was not available	12.5	9.7
Other	10.0	14.5
Step taken during interruption		
Didn't take pill	37.5	16.1
Managed from neighbor	30.0	35.5
Purchased from shop	20.0	22.6
Other	12.5	25.8
N	40	62

Table 5.8: Percentage Distribution of Users of OC by Whether ever Purchased OC, Person Purchased OC and Price of OC

	GOB %	NGO %
Ever purchased OC		
Yes	36.2	63.2
N	1403	1600
Person purchased OC for respondent		
Husband	82.5	33.2
Self	11.6	56.4
Friends/relatives	4.5	2.0
Field Workers /Others	1.4	8.5
Price of OC per cycle (Taka)		
1	3.9	56.0
2	3.9	6.1
3-4	6.1	3.5
5-6	34.6	9.9
7-9	9.2	5.9
10+	42.3	18.6
N	508	1012

Table 5.8a: Percentage Distribution of Users by Brand and Whether ever Purchased OC, Person Purchased OC and Price of OC.

	GOB			NGO		
	C-5	Sukhi	Other	C-5	Sukhi	Other
Ever purchased OC						
Yes	30.3	28.2	97.8	70.0	57.5	93.7
No	69.7	71.8	2.2	30.0	42.5	6.3
N	271	433	91	406	461	160
Person buys OC for respondent						
Husband	82.9	85.2	86.5	21.8	21.9	68.0
Self	11.0	9.0	11.2	70.4	64.0	23.3
Friends/relatives	6.1	3.3	2.2	0.7	2.3	1.3
Field Workers /Others	0.0	2.5	0.1	7.1	11.8	7.4
Price of OC per cycle (Taka)						
1	1.2	5.7	0.0	71.1	66.8	16.0
2	4.9	6.6	4.5	6.3	6.8	7.3
3-4	12.2	4.1	4.5	2.8	2.6	4.7
5-6	39.0	36.9	25.8	8.8	12.4	18.0
7-9	6.1	4.9	24.7	2.5	2.6	24.7
10+	36.6	41.8	40.4	8.5	8.8	29.3
N	82	122	89	284	265	150

Table 5.9: Percentage of Respondents Who Never Bought OC but Willing to Pay If Necessary

	GOB %	NGO %
Willing to pay for OC		
Yes	85.8	85.5
No	14.2	14.5
Reason for willingness to buy*		
Pill prevents childbirth	57.3	57.0
To keep family small	7.9	5.4
Welfare and well-being of family	21.4	16.3
Difficult to educate many children	41.3	41.0
Health deteriorates if one has many children	15.6	15.1
For delaying birth	4.7	5.8
Reason for not willing to buy*		
Don't have ability to buy	5.5	5.9
Government should supply pill	1.7	1.2
will change method	1.8	2.5
Pill does not suit	3.5	3.9
Menstruation stopped	2.2	0.8
N	895	588

Notes:
* Multiple response possible

Table 6.1: Percentage Distribution of OC Users by Knowledge on When to Start Taking Pill and Source of Knowledge

	GOB			NGO		
	Current user	Past user	All	Current user	Past user	All
Knowledge: when to start using OC						
From 1st day of menstruation	17.8	17.1	17.5	15.2	14.8	15.1
From 2nd to 4th day of menstruation.	21.2	16.9	19.4	14.7	14.6	14.7
From 5th day of menstruation	7.5	8.6	8.0	7.3	6.7	7.1
Since end of menstruation	46.9	46.7	46.8	54.3	53.2	53.9
One/more days from menstruation	5.4	7.9	6.4	6.5	8.4	7.1
Other	1.2	2.8	1.9	2.0	2.3	2.1
Source of knowledge						
FWA	63.3	59.5	61.6	15.8	18.8	16.8
NGO FW	0.5	0.7	0.6	49.2	46.7	48.3
LIP volunteer	3.4	2.0	2.8	0.2	0.5	0.3
Husband	6.1	7.3	6.6	6.4	7.9	6.9
Friends/relatives	17.5	18.6	18.0	19.4	17.6	18.7
Mass media	9.0	11.8	10.2	9.0	8.4	8.8
Other (Depot etc.)	0.2	0.2	0.2	-	-	-
N	801	602	1403	1031	569	1600

Table 6.1a: Percentage Distribution of OC Users by Knowledge on When to Start Taking Pill by Brand of OC

	GOB			NGO		
	C-5	Sukhi	Other	C-5	Sukhi	Other
Knowledge: when to start using OC						
From 1st day of menstruation	11.1	20.8	25.3	10.3	19.1	15.6
From 2nd to 4th day of menstruation	27.7	17.8	19.8	14.8	14.3	16.2
From 5th day of menstruation	8.5	7.4	4.4	7.1	6.3	10.0
After end of menstruation	48.0	46.6	43.9	57.4	53.8	48.7
Other	4.7	7.4	7.5	10.4	6.5	9.5
N	271	433	91	406	461	160

Table 6.1b: Percentage of OC Users Having Correct Knowledge about When to Start OC by Selected Background Characteristics

Characteristics	GOB	NGO
Age		
<20	18.0	20.1
20-24	15.6	13.6
25-29	18.0	17.8
30-34	21.3	16.0
35+	16.7	12.5
Parity		
1	19.4	21.0
2-3	17.2	15.7
4-6	18.4	12.4
7+	16.4	13.3
Age of youngest child		
<1 year	16.4	20.0
2-3	13.3	17.4
2-5	17.9	15.4
Education		
No education	14.7	12.6
Primary	18.4	15.5
High+	28.4	25.3
Source of OC supply		
Field workers	17.4	14.8
Hospital/clinic etc.	15.2	16.9
Relatives	21.1	19.3
Using OC first time		
Yes	17.3	14.4
No	18.1	16.1
N	1403	1600

Table 6.2: Percentage Distribution of Respondents by Selected Characteristics

Characteristics	GOB			NGO		
	Current user	Past user	All	Current user	Past user	All
Takes pill every day	93.9	94.2	94.0	94.5	94.2	94.4
Person told to take pill every day						
Self	5.9	7.3	6.5	6.0	6.1	6.1
FWA	64.8	61.1	63.2	16.4	19.5	7.5
NGOFW	3.0	2.0	2.6	0.2	0.2	0.2
LIP	0.5	0.5	0.5	49.8	46.0	48.4
Husband	5.1	7.1	6.0	5.2	5.3	5.2
Friend/relatives	13.6	12.6	13.2	15.5	15.8	15.6
Other	7.1	11.4	8.0	6.9	7.1	7.0
Order of taking pills						
From beginning of arrow mark	87.1	75.2	82.0	86.7	82.9	85.4
From opposite to arrow mark	5.5	9.5	7.2	6.1	7.2	6.5
From the upper left	6.0	10.1	7.8	4.6	6.3	5.4
From the side marked by FW	0.9	2.0	1.3	1.2	1.9	1.4
Other	0.5	3.2	1.7	1.4	1.7	1.3
Time of taking pills						
At night	99.6	98.5	99.1	99.1	98.4	98.9
Other time	0.4	1.5	0.9	0.9	1.6	1.1
Time of starting new cycle						
Next day after last cycle is finished	79.1	71.1	75.7	83.2	74.0	79.9
1st day after menstruation	2.9	2.3	2.6	2.8	1.9	2.5
2nd-4th day after menstruation	11.2	8.5	10.0	5.8	5.4	5.7
Fifth day after menstruation	4.1	5.1	4.5	4.3	3.9	4.1
Other	2.7	13.0	7.2	3.9	14.9	8.8

Table 6.2 Percentage Distribution of Respondents by Selected Characteristics (Contd.)

Characteristics	GOB			NGO		
	Current user	Past user	All	Current user	Past user	All
Person the respondent consulted with about the rule of OC use						
FWA	70.7	63.8	67.7	7.7	12.6	9.4
NGO FW	0.6	0.8	0.7	69.9	58.2	65.7
LIP Volunteer	6.4	4.6	5.6	-	-	-
Hospital/Clinic	5.4	7.1	6.1	5.6	5.4	5.6
Husband	2.7	5.5	3.9	3.3	4.7	3.8
Friends/relatives	10.5	14.6	12.3	12.3	16.2	13.7
Other	3.7	3.6	3.7	1.2	2.9	1.8
N	801	602	1403	1031	569	1600

Table 6.2a: Percentage Distribution of Current Users by Selected Characteristics of OC Use and by Brand of OC

Characteristics	GOB			NGO		
	C-5	Sukhi	Other	C-5	Sukhi	Other
Takes pill every day	90.8	95.1	97.8	92.4	96.5	93.7
Person told to take pill every day						
Self	7.4	4.8	5.5	7.4	4.6	6.9
FWA	63.8	71.8	37.4	19.5	17.6	5.6
NGOFW	6.3	1.6	0.0	0.5	0.0	0.0
LIP	0.0	0.5	2.2	47.5	57.7	33.7
Husband	4.1	3.7	14.3	4.4	2.6	14.4
Friend/relatives	13.6	11.1	25.3	15.5	10.8	28.1
Other	4.8	6.5	15.3	5.2	6.7	11.3
N	271	433	91	406	461	160

Table 6.3: Percentage Distribution of Respondents Who Missed One Pill During Six Months Prior to Interview and Action Taken for that Missed Pill

	GOB	NGO
Missed One Pill		
Yes	43.4	39.6
N	987	1274
Number of times missed one pill		
Once	43.7	41.8
Twice or more	56.3	58.2
Reason for missing one pill		
Forgot to take	79.0	76.4
Respondent was away from home	5.8	8.1
Respondent was sick	3.5	3.6
Side-effects	2.6	3.0
No reason	6.1	4.7
Other	3.0	4.2
Action taken for the missed pill		
took one pill next day when remembered and one at night	37.6	35.2
took two at a time at night next day	32.0	33.1
took two pill when remembered	4.9	5.1
took one pill as usual	14.2	15.6
Threw away that missed pill	11.0	9.7
Other / DK	0.3	1.2
N	428	505
What should be done if missed one pill		
Take one pill next day when remembered and one at night	37.2 46.0	36.8 48.7
Take two next day when remembered or at next night	7.7	6.9
Take one pill as usual	3.6	3.7
Throw away that missed pill	5.5	3.9
Other / DK		
N	1403	1600

Table 6.3a: Percentage Distribution of Respondent Who Missed One Pill During Six Months Prior to Interview and Action Taken for The Missed Pill by Brand of OC

	GOB			NGO		
	C-5	Sukhi	Other	C-5	Sukhi	Other
Missed one pill						
Yes	44.6	44.6	37.4	38.2	39.3	49.4
N	271	433	91	406	461	160
Number of times missed one pill						
Once	46.3	40.4	44.1	43.2	39.2	43.0
Twice or more	53.7	59.6	55.9	56.8	60.8	57.0
Action taken for the missed pill						
took one pill next day when remembered and one at night	21.5	45.1	35.3	31.6	41.4	34.2
took two at a time at night next day	31.4	32.6	38.2	34.8	26.5	40.5
took two pill when remembered	8.3	2.1	8.8	3.9	7.2	3.8
took one pill as usual	25.6	10.9	5.9	14.2	17.7	11.4
Threw away that missed pill/Other	13.2	8.8	11.8	13.5	6.6	10.1
N	121	193	34	155	181	79
What should be done if missed one pill						
Take one pill next day when remembered and one at night	43.5	49.9	44.0	39.7	52.1	50.6
Take two next day when remembered or at next night	48.7	43.6	52.7	53.0	43.4	45.6
Throw away that missed pill	2.9	3.0	1.1	4.4	2.6	3.7
Other / DK	4.9	3.6	2.2	2.9	1.9	0.1
N	271	433	91	406	461	160

Table 6.4: Percentage Distribution of Respondent Who Missed Two Consecutive Pills During Six Months Prior to Interview and Action Taken for Missed Pills

	GOB	NGO
Missed two pills		
Yes	16.6	15.5
N	987	1274
Number of times missed two pills		
Once	63.4	56.3
Twice or more	36.6	43.7
Reasons for missing pills		
Forgot to take	51.2	57.9
Was away from home	21.9	20.3
Husband was away from home	3.7	3.0
Respondent was sick	5.5	5.1
Side-effects	5.5	4.1
No reason	8.5	5.1
Other	3.7	4.5
Action taken for missing pill		
took 2 pills when remembered and one at night	21.3	22.8
took 1 pill when remembered and two at night	4.3	5.1
took 2 pills at a time for following two days	9.1	7.6
took three pills at a time when remembered	6.7	5.1
took pills as usual	28.7	26.9
took two pills at a time for following two days and husband used condom	-	0.5
Threw away missed pills	19.5	19.3
Other / DK	10.4	12.7
N	164	197

Table 6.4 Percentage Distribution of Respondent Who Missed Two Consecutive Pills During Six Months Prior to Interview and Action Taken for Missed Pills (Contd.)

	GOB	NGO
What should be done if missed two pills		
Take 2 pills when remembered and one at night	15.0	14.6
Take 1 pill when remembered and two at night	3.3	3.9
Take 3 pills at a time when remembered	10.3	10.2
Take 2 pills at a time for following two days	6.5	8.2
Stop taking pills and husband should use condom	3.0	4.3
Take two at a time for next two days and husband should use condom	1.2	2.2
Take pills as usual	12.3	12.5
Threw away missed pills	13.2	10.6
Other	10.0	9.6
DK	25.2	23.9
N	1403	1600

Table 6.4a: Percentage Distribution of Respondent Who Missed Two Consecutive Pills During Six Months prior to interview and Action Taken for Missing Pills by Brand

	GOB			NGO		
	C-5	Sukhi	Other	C-5	Sukhi	Other
Missed two pills						
Yes	22.1	14.3	11.0	17.7	12.8	20.0
N	271	433	91	406	461	160
Number of times missed two pills						
Once	63.3	66.1	60.0	48.6	66.1	56.2
Twice or more	36.7	33.9	40.0	51.4	33.9	43.8
Reason for missing pills						
Forgot to take	46.7	56.4	40.0	56.9	47.5	62.5
Was away from home	25.0	17.7	40.0	16.7	30.5	25.0
Husband was away from home	1.7	6.4	0.0	5.6	1.7	0.0
Respondent was sick	3.3	8.1	10.0	2.8	8.5	3.1
Side-effects	5.0	4.8	0.0	4.2	6.8	0.0
No reason	13.3	4.8	0.0	3.3	1.7	6.2
Other	5.0	1.8	10.0	10.5	3.3	3.2
Action taken for missing pill						
took 2 pills when remembered and one at night	18.3	27.4	10.0	22.2	23.7	28.1
took 1 pill when remembered and two at night	8.3	1.6	0.0	4.2	5.1	6.2
took 2 pills at a time for following two days	6.7	9.6	20.0	6.9	8.7	5.4
took 3 pills at a time when remembered	10.0	1.6	20.0	5.6	5.8	3.1
took pills as usual	30.0	30.6	20.0	31.9	25.4	18.7
took 2 pills at a time for following two days and used condom	0.0	0.0	0.0	1.4	0.0	0.0
Threw away missed pills	21.6	14.5	20.0	19.4	15.2	15.6
Other / DK	5.1	14.7	10.0	8.4	16.1	22.9
N	60	62	10	72	59	32

Table 6.5: Percentage Distribution of Respondents Who Missed Three Consecutive Pills During Six Months prior to interview and Action Taken for Missing Pills

	GOB	NGO
Missed three pills		
Yes	6.9	6.0
N	987	1274
Number of times missed pills		
Once	64.7	66.2
Twice or more	35.3	33.8
Reasons for missing pills		
Forgot to take	27.9	29.9
Respondent was away from home	30.9	33.8
Husband was away from home	5.9	6.5
Respondent was sick	7.3	9.1
Side-effects	10.3	9.1
Other / DK	17.7	12.6
Action taken for missing pill		
took 3 pills when remembered and one at night	4.4	2.6
took 2 pills when remembered and two at night	2.9	3.9
took 2 at a time for next t 3 days	5.9	2.6
Stopped using pills and used condom till next menstruation	2.9	-
Menstruation started and started a new cycle	11.8	15.6
Stopped having sex till next menstruation	4.4	2.6
took pills as usual	36.8	31.2
Threw away missed pills	17.6	28.6
Other / DK	13.3	12.9
N	68	77

Table 6.5: Percentage Distribution of Respondents Who Missed Three Consecutive Pills During Six Months prior to interview and Action Taken for Missing Pills (Contd.)

	GOB	NGO
What should be done if missed three pills		
Stop using pill and use condom till next menstruation	4.6	4.8
Continue using pills and use condom till next menstruation	1.3	0.9
Stop having sex till next menstruation	3.1	3.1
Take 4 pills next day when remembers	11.1	10.1
Take pills as usual	10.3	11.6
Threw away missed pills	13.3	10.6
Other	17.2	22.7
DK	39.1	36.2
Whether use other methods if skipped three pills		
Yes	38.3	38.7
No	41.5	42.4
DK	20.1	18.9
N	1403	1600

Table 6.5a: Percentage Distribution of Respondent Who Missed Three Consecutive Pills During Six Months prior to interview and Action Taken for Missing Pills by Brands of OC

	GOB			NGO		
	C-5	Sukhi	Other	C-5	Sukhi	Other
Missed three pills						
Yes	8.1	6.5	5.5	7.9	4.3	4.4
N	271	433	91	406	461	160
Number of times missed pills						
Once	54.5	64.3	80.0	71.9	70.0	57.1
Twice or more	45.5	35.7	20.0	28.1	30.0	42.9
Reasons for missing pills						
Forgot to take	13.6	35.7	0.0	18.7	20.0	28.6
Respondent was away from home	27.3	39.3	60.0	46.9	40.0	14.3
Husband was away from home	9.1	3.6	0.0	12.5	0.0	0.0
Respondent was sick	13.6	3.6	0.0	6.2	15.0	14.3
Side-effects	18.2	3.6	0.0	3.1	20.0	14.3
Other / DK	18.2	14.2	40.0	12.6	5.0	28.5
N	22	28	5	32	20	7

Table 6.6: Percentage Distribution of Respondent Taking Brown Pills and by Reasons For Taking and Not Taking Brown Pills

Characteristics	GOB	NGO
Take all brown pills		
Yes	66.1	69.3
No	31.6	29.2
No brown pills in the strip	2.2	1.4
N	1403	1600
Reason for taking brown pills		
Brown pills are iron tablets	8.7	8.4
These are vitamin tablets	45.3	47.3
Improves health	5.6	5.4
Prevents pregnancy	2.8	1.9
Regulates menstruation	37.0	36.4
Other	0.6	0.5
N	928	1109
Reason for not taking brown pills		
Does not prevent pregnancy	68.2	69.9
Menstruation starts and then don't need them	4.4	3.5
Tastes bad	3.8	3.0
Causes excessive menstruation	4.4	6.5
No pills in the strip	10.7	7.1
Other	8.2	10.0
N	475	491
Things done if brown are skipped		
Nothing	48.4	46.4
Same as white pills	45.5	47.6
No brown pills in the strip/other	6.1	6.0
N	1403	1600

Table 6.7: Percentage Distribution of OC Users by Interruption During OC Use and Reasons for Interruption

Characteristics	GOB			NGO		
	Current user	Past user	All	Current user	Past user	All
Stopped taking pills before the cycle was finished	4.9	13.8	8.7	5.4	19.9	10.6
N	801	602	1403	1031	569	1600
Reason:						
Was sick	12.8	12.1	12.3	7.1	9.7	8.9
Was away from home	25.6	4.8	11.5	42.9	7.1	18.9
Husband was not at home	7.7	13.2	11.5	30.3	16.8	21.3
Side-effects	30.8	55.4	47.5	5.3	50.4	35.5
No reason/other	23.1	14.5	17.2	14.4	16.0	15.4
N	39	83	122	56	113	169
Stopped taking for some times after long uninterrupted use	11.0	15.4	12.9	8.3	16.7	11.3
N	801	602	1403	1031	569	1600
Reason						
Side-effects	42.1	53.8	48.1	36.1	47.4	42.0
Husband does not always stay at home	15.9	19.3	17.7	27.9	26.3	27.1
Health reasons	19.3	12.9	16.0	19.8	12.6	16.0
Fear of infection	5.6	3.2	4.4	1.2	4.2	2.8
Other	17.1	10.7	13.8	15.1	9.5	12.1
N	88	93	181	86	95	181
Whether took pill when.....						
Sick	89.9	80.1	86.4	89.9	80.1	86.4
Husband away	89.7	80.7	86.5	89.7	80.7	86.5
Respondent away	85.9	79.3	83.6	85.9	79.3	83.6
N	801	602	1403	1031	569	1600

Table 7.1: Percentage of OC Users (Current and Past) by Knowledge on Side-Effects, When Start Taking Pills and Sources of That Knowledge

	GOB	NGO
Knowledge about discomfort*		
Vomiting tendency	63.7	67.6
Dizziness	97.9	98.1
Weakness / sickness	60.3	61.7
Burning sensation	20.8	20.1
Irregular menstruation	4.2	4.3
Excessive menstruation	5.6	6.2
Gain in weight	2.5	3.0
Abdominal pain	4.6	4.4
N	1403	1600
Heard about side effect before using pill	86.2	85.2
N	1392	1590
Source of knowledge		
FWA	45.5	11.9
NGO FW	0.3	36.7
LIP volunteer	1.7	0.1
Hospital/clinic	2.7	2.3
Friends/relatives	44.3	43.4
Mass media	2.1	2.8
Other	3.4	2.8
N	1203	1355
Think that discomfort will go away soon	82.2	84.5
N	1392	1590
Think after how long discomfort will go away		
< 3 months	91.0	93.4
≥3 months	7.7	6.2
Other/DK	1.3	0.4
N	1144	1343

Notes:

* Multiple response possible

Table 7.2: Percentage of OC Users Experiencing Different Side-Effects and Nature of Discomforts

	GOB			NGO		
	Current user	Past user	All	Current user	Past user	All
Experienced any discomfort in first 3 months of pill use						
Yes	57.3	68.1	61.9	55.6	67.3	59.7
N	801	602	1403	1031	569	1600
Nature of discomfort*						
Vomiting tendency	37.7	37.8	37.7	36.1	37.6	36.7
Dizziness	93.9	91.9	92.6	94.1	94.0	94.0
Irregular menstruation	2.0	3.7	2.7	3.3	4.4	3.8
Excessive menstruation	3.3	6.8	4.9	2.1	6.8	4.0
Weakness / sickness	49.5	42.4	46.1	41.2	59.3	59.0
Burning sensation	16.3	16.1	16.2	11.3	13.3	12.1
Abdominal pain	3.5	4.4	3.9	3.0	3.7	3.2
N	459	410	869	573	383	956
Experienced discomfort which lasted more than 3 months						
Yes	8.4	16.9	12.0	8.9	13.9	10.7
N	801	602	1403	1031	569	1600
Nature of discomfort*						
Vomiting tendency	26.9	25.5	26.0	14.1	20.2	17.0
Dizziness	74.6	80.4	78.1	67.4	74.9	70.8
Irregular menstruation	4.5	5.9	5.3	16.5	6.3	6.4
Excessive menstruation	7.5	6.9	7.1	5.4	15.2	9.9
Weakness / sickness	41.8	49.0	46.1	42.4	49.4	45.6
Burning sensation	23.9	23.5	23.7	16.3	22.8	19.3
Abdominal pain	13.4	10.8	11.8	10.9	11.4	11.1
N	67	102	169	92	79	171

Notes:
* Multiple response possible

Table 7.2a: Percentage of Users Experiencing Different Side-Effects , and Nature of Discomforts by Brands of OC

	GOB			NGO		
	C-5	Sukhi	Other	C-5	Sukhi	Other
Experienced any discomfort in first 3 months of pill use						
Yes	52.4	60.0	58.2	53.2	60.0	60.0
N	271	433	91	406	461	160
Nature of discomfort*						
Vomiting tendency	37.0	36.5	45.3	45.8	25.6	41.7
Dizziness	95.1	93.1	96.2	94.8	93.0	96.9
Irregular menstruation	1.4	2.3	0.0	1.8	5.4	1.0
Excessive menstruation	3.5	3.5	1.9	0.9	2.7	3.1
Weakness / sickness	47.9	50.0	50.9	38.4	39.9	51.0
Burning sensation	17.6	15.8	5.1	13.4	11.2	6.2
Abdominal pain	3.5	3.1	5.7	2.8	3.1	3.1
N	142	260	53	216	258	96

Notes:
* Multiple response possible

Table 7.3: Percentage Distribution of OC Users by Timing and Duration of Side-Effects

	GOB			NGO		
	Current users	Past users	All	Current users	Past users	All
How long ago experienced side-effects (months)						
≤12	38.8	24.5	30.2	40.2	35.4	38.0
13-24	20.9	25.5	23.7	22.8	17.7	20.5
25-60	28.4	34.3	31.9	27.1	34.8	31.1
60+	11.9	15.7	14.2	9.8	11.4	10.5
Duration of side-effects						
3 months	13.4	7.8	10.1	10.9	10.1	10.5
4-5 months	23.9	16.7	19.5	19.6	31.6	25.1
6 months or more	61.2	74.5	69.2	69.6	55.7	63.2
Other/DK	1.5	1.0	1.2	-	2.5	1.2
Still suffering from side-effects:	62.7	19.6	36.7	71.7	31.6	53.2
N	67	102	169	92	79	171

Table 7.4: Percentage of Respondents by Discussion and Advice Related to Side-Effects Management

Characteristics	GOB	NGO
Discussed problems with someone:		
Yes	78.7	84.2
No	21.3	15.8
N	169	171
Person with whom discussed problem		
FWA / NGO FW / LIP	46.0	56.2
Hospital/clinic	19.5	17.4
Friends/relatives	12.8	12.5
Other	22.6	13.9
Advised provided*		
Problem will disappear soon	19.5	23.6
Drink more water/liquids	14.3	20.1
Take Nutritious food	26.3	25.0
Discontinue pill	16.5	9.0
Use other methods(IUD/Injectables)	21.0	18.1
Supplied vitamin/saline	16.5	16.0
To consult doctor/take medicine	9.0	13.9
Purchase better quality pill	4.5	2.1
N	133	144

Notes:
* Multiple response possible

Table 7.4a: Percentage of Respondents by Brand of OC and by Issues Related to Side-Effects Management

Characteristics	GOB			NGO		
	C-5	Sukhi	Other	C-5	Sukhi	Other
Discussed problems with someone:						
Yes	74	79	100	86	86	69
No	26	21	-	14	14	31
N	27	33	7	36	43	43
Person with whom discussed problem						
FWA / NGO FW / LIP	55	77	14	65	68	33
Hospital/clinic	15	15	29	13	14	33
Friends/relatives	25	8	28	22	9	22
Other	5	-	29	-	9	11
Advised provided*						
Problem will disappear soon	20	31	14	29	24	11
Drink more water/liquids	20	27	29	35	24	-
Take Nutritious food	15	29	29	26	41	11
Discontinue pill	5	12	14	3	3	11
Use other methods(IUD/Injectables)	25	8	14	16	11	44
Supplied vitamin/saline	20	15	29	13	16	-
To consult doctor/take medicine	20	8	-	10	16	22
N	20	26	7	31	37	9

Table 7.4b: Percentage of Respondents by Whether Satisfied with Side-Effect Management and by Reasons for Satisfaction and Dissatisfaction

Characteristics	GOB	NGO
Satisfied with advice		
Yes	64.7	58.3
No	35.3	41.7
N	133	144
Reason for satisfaction*		
Discomfort reduced	22.6	19.4
Became all right after discontinuation of pill	15.0	6.9
Became all right after taking medicine	12.0	8.3
Advised to another method	9.0	6.9
Listened to my problem	2.3	7.6
Reason for dissatisfaction*		
Did not have ability to by nutritious food	4.5	6.9
Problem was not solved after listening to advise	19.5	20.1
Did not supply medicine	3.0	6.2
Did not give importance to her problems	3.0	3.4
N	133	144
Reason for not discussing problem*		
Discomfort would be cured automatically	16.7	22.2
Became all right after discontinuing pill	22.2	18.5
Didn't think the problem is important	33.3	33.3
N	36	27

Notes:
* Multiple response possible

Table 7.5: Percentage of Respondents by Whether Menstrual Cycle Was Changed Due to Use of OC

	GOB	NGO
Menstrual cycle changed due to l use OC		
Yes	41.2	37.7
No	58.8	62.3
N	1403	1600
Nature of Change in Menstrual Cycle*		
Irregular menstruation	16.1	13.1
Regular menstruation	27.0	25.5
Excessive menstruation	15.9	17.5
Reduced menstruation	40.8	44.5
Menstruation stopped	2.2	3.1
N	578	604

Notes:
* Multiple response possible

Table 7.5a: Percentage of Respondent by Brand OC and by Nature of Change in Menstrual Cycle

	GOB			NGO		
	C-5	Sukhi	Other	C-5	Sukhi	Other
Menstrual cycle changed due to use of OC						
Yes	45	39	55	35	42	45
No	55	61	45	65	58	55
N	271	433	91	406	461	160
Nature of change in menstrual cycle*						
Irregular menstruation	12	14	16	8	12	11
Regular menstruation	23	35	36	23	29	35
Excessive menstruation	12	10	2	6	16	10
Reduced menstruation	53	45	44	64	43	47
Menstruation stopped	3	-	4	-	4	6
N	121	170	50	144	193	72

Notes: * Multiple response possible

Table 7.6: Percentage of Respondents by Person Provided Advice and Type of Advice Provided

Characteristics	GOB	NGO
Person provided advice		
FWA	67.8	18.6
NGO FW	0.7	51.1
LIP volunteer	2.5	0.4
Hospital/clinic	3.4	3.7
Friends/relatives/neighbor	14.5	16.2
Other (Husband, mass media etc.)	11.1	10.0
Advice provided*		
From which side should start 1st pill	90.5	90.8
Start using pill from 1st day of menstruation	15.5	12.4
Take 1 tablet each day	76.0	81.9
Start new cycle next day after last cycle finished	17.9	18.7
What to do if 1 pill is missed	31.2	33.9
What to do if 2 pill is missed	5.4	7.1
What to do if 3 pill is missed	2.8	3.7
What to do if side effects occurs	29.1	28.6
N	1403	1600

Notes:
* Multiple response possible

Table 7.6a: Percentage of Respondents by Brand of OC and by Person Provided Advice, and Type of Advice Provided

Characteristics	GOB			NGO		
	C-5	Sukhi	Other	C-5	Sukhi	Other
Person provided advice						
FWA	72	73	44	20	19	8
NGO FW	-	1	2	51	58	36
LIP volunteer	5	2	-	1	-	-
Hospital/clinic	2	2	9	2	4	5
Friends/relatives/neighbor	12	13	22	17	13	28
Other (Husband, mass media etc.)	9	9	23	9	6	28
Advice provided*						
From which side should start 1st pill	92	90	88	89	92	93
Start using pill from 1st day of menstruation	11	19	22	11	14	16
Take 1 pill each day	72	79	71	83	81	85
Start new cycle next day after last cycle finished	26	18	18	18	21	21
What to do if 1 pill is missed	32	33	32	34	38	36
What to do if 2 pills are missed	8	4	12	10	4	11
What to do if 3 pills are missed	3	2	7	5	2	4
What to do if side effects occur	34	31	23	27	31	30
N	271	433	91	406	461	160

Notes:

* Multiple response possible

Table 7.7: Percentage of Respondents by Whether Discussed Advantages and Disadvantages and The Contents of Such Discussion

	GOB	NGO
Whether discussed advantages		
Yes	85.1	84.7
No	14.9	15.3
N	1403	1600
Advantages discussed*		
Pill is temporary method	30.6	26.5
Easily available	28.2	34.0
Can be discontinued any time	36.6	37.2
No/less side effects	35.3	36.6
Available free of cost	18.7	13.6
Less hazardous	20.8	23.5
Health improves	39.4	37.5
N	1194	1356
Whether discussed disadvantages		
Yes	73.6	73.8
No	23.4	23.2
N	1403	1600
Disadvantages discussed*		
Vomiting tendency may occur	71.0	71.3
Dizziness	98.3	98.5
Irregular menstruation	2.7	3.6
Weakness/sickness	51.1	49.1
Burning sensation	14.4	12.7
Gain in weight	1.9	2.1
N	1032	1182

Notes:
* Multiple response possible

Table 7.8: Percentage of Respondents by Knowledge of Contraindications of OC and Source of That Knowledge

	GOB	NGO
Know contraindication of OC*		
Heart diseases	3.7	3.4
Diabetes	2.8	1.8
Jaundice	6.7	5.6
Breast tumor	1.1	1.2
Gastric	21.2	23.6
Asthma	4.5	4.1
TB	3.9	3.2
Anaemia	4.7	6.6
Headache/migraine	4.6	6.3
Abnormal vaginal bleeding	1.2	2.4
Know at least one of these contraindications	30.5	33.9
N	1403	1600
Source of knowledge*		
FWA	47.7	9.0
NGO FW	0.9	43.8
LIP volunteer	2.0	0.2
Hospital/clinic	12.7	8.3
Husband	4.4	2.6
Friends/relatives	28.1	33.6
Mass media	6.7	7.2
N	449	569

Notes:
* Multiple response possible

Table 7.9: Percentage of Respondents by Experience of Contraindications

Contraindication of OC*	GOB	NGO
Heart diseases	9.8	7.7
Diabetes	4.6	3.3
Jaundice	12.0	10.6
Breast tumor	2.1	2.3
Gastric	44.1	43.1
Asthma	4.3	2.9
TB	0.9	1.1
Anaemia	24.4	20.7
Headache/migraine	27.3	26.4
Abnormal vaginal bleeding	10.0	9.3
Breastfeeding	26.1	20.1
N	1403	1600

Notes:
* Multiple response possible

Table 7.10: Percentage Distribution of Respondents by Frequency of Visits of FP Workers During 6 Months Prior to Interview and Time Spent by FP Workers with Clients

Visit by FP workers and related issues	GOB			NGO		
	Current user	Past user	All	Current user	Past user	All
Visited by FW in last six months						
Yes	77.9	49.5	65.7	85.9	58.2	76.1
N	801	602	1403	1031	569	1600
Frequency of visit in last 6 months						
1	12.8	29.9	18.3	8.9	19.6	11.8
2	45.2	35.9	42.2	28.2	32.6	29.4
3	26.3	17.5	23.5	24.4	19.0	22.9
4+	15.7	16.4	15.9	38.5	28.8	35.9
Time spent with fieldworker (minutes)						
≤5	60.4	63.3	61.4	63.4	65.2	63.9
6-10	17.3	16.8	17.1	18.3	19.0	18.5
11-60	20.7	18.9	20.1	17.1	14.9	16.5
Client not at home	1.6	1.0	1.4	1.2	0.9	1.1
Supplied pills during last visit						
Yes	84.5	29.9	66.8	82.0	31.1	68.2
N	624	298	922	886	331	1217
Number of cycles Supplied during last visit						
1	8.5	9.0	8.6	28.1	26.2	27.8
2	24.3	24.7	24.3	33.6	27.2	32.8
3	65.3	64.0	65.1	37.1	46.6	38.3
4+	1.9	2.3	2.0	1.2	-	1.1
N	527	89	616	727	103	830

Table 7.11: Percentage of Respondents by Contents of Discussions with Fieldworkers and Outcome of Such Discussion

	GOB	NGO
Things discussed*		
Inquired about rule of OC use	41.6	51.4
Asked about side-effect	16.5	9.6
discussed long term method	9.3	8.6
No discussion	33.6	29.7
Requested further information about OC use	9.5	6.5
N	922	1217
Additional information asked about OC use*		
How to use pill	11.4	7.6
Whether problem will arise due to pill use	2.3	1.3
Additional information asked about side-effect*		
Dizziness		
Reason for irregular menstruation	36.4	25.3
What to do if side effects occur	12.5	21.5
	11.4	17.7
Additional information asked about contraindication		
Whether pill can be taken during sickness/weakness	1.1	1.3
N	88	79
Things still want to know		
Yes	17.1	14.5
No question	82.9	85.5
N	922	1217
Overall level of Satisfaction with FWs*		
Supply pill only	21.8	17.5
Very enthusiastic	63.2	70.4
Encourage to use other methods	12.3	13.2
Willing to listen to user's problem	24.8	21.8
Don't listen to clients problem	2.1	2.1
Very cautious	0.9	2.9
N	922	1217

Notes:
* Multiple response possible

Table 7.12: Percentage Distribution of Respondents by Whether They Were Visited by Providers Other than Field Workers

	GOB	NGO
Visited by other field workers during last 6 months		
Yes	8.1	10.3
No	91.9	89.7
N	922	1217
Type of field worker visited		
Another FW	42.6	56.3
NGO FW	5.3	38.1
LIP	44.8	1.6
Other	8.0	4.0
N	75	126

Table 7.13: Percentage of Respondents by Whether Became Pregnancy While Using OC, Whether Reason Was Determined and Reasons Mentioned

	GOB	NGO
Whether became pregnant while using OC		
Yes	1.8	1.3
No	98.2	98.7
N	1403	1600
Things done in such pregnancy		
Discussed with FW	53.8	76.2
MR	30.8	14.3
Other	7.7	-
Did nothing	7.7	9.5
N	26	21
Whether respondent could determine the reason		
Yes	92.3	80.9
No	7.7	9.1
N	26	21
Reasons*		
Forgot to take pill correctly	58.3	58.8
Forgot to take pill 1 day	8.3	5.9
Forgot to take pill 2/3 days	21.0	5.8
Away from home didn't take pill	8.3	17.6
N	24	17

Notes:
* Multiple response possible

Table 7.14: Percentage of Respondents Faced Problems Other Than Side-Effects During OC Use, Attitudes of Spouse, and Rumors Heard about OC

	GOB	NGO
Problems faced other than side-effects*		
Hazardous to take pill everyday	3.7	3.8
Sometimes forget to take pills	4.3	3.6
No problem	89.7	89.7
Spouse's attitude towards OC use*		
Encouraging	59.7	55.4
Talk about side-effects	2.8	2.6
Indifferent	31.1	36.7
Disfavor	8.2	8.7
Ever taken pill to improve health:		
Yes	1.3	1.0
Know anybody who took pill for improving health:		
Yes	3.8	3.5
N	1403	1600
Ever heard rumors:		
Yes	63.4	63.7
N	1403	1403
Different rumors heard*		
Taking OC is a sin/ earth won't accept body	26.8	28.5
Snakes grow in stomach	32.7	33.0
Pill accumulates in belly and form chain	54.7	57.8
Pill crates indigestion	19.7	15.2
Create stone in the belly	22.5	19.1
Intestine becomes heavy/get rotten	5.2	7.7
No conception if one use pill for long time	9.4	7.9
Babies die/stillbirths if use OC	5.6	6.5
Believes in these rumors:		
Yes	7.1	9.2
N	890	1019

Notes:
* Multiple response possible

Table 7.15: Percentage of Respondents Mentioning Different Suggestions on Improve in OC Use

Suggestions*	GOB	NGO
Regular follow-up	14.8	10.9
More frequent follow-up	20.0	17.8
More motivation	47.7	52.4
Motivation by satisfied clients	43.3	43.9
Efficient management of side-effects	30.6	30.8
Supply of vitamin tablets	19.2	18.9
Regular supervision by higher authority	7.6	6.7
Provide MCH services with FP	3.0	3.7
improve in female literacy	3.0	3.0
Motivation by mass media	7.4	7.5
N	1403	1600

Notes:
* Multiple response possible

Table 8.1: Percentage Distribution of Respondents by Selected Background Characteristics for GOB, NGO and Combined Area

Characteristics	GOB	NGO	Combined Area
Age			
<20	3.9	7.6	8.6
20-29	46.5	46.1	37.1
30+	49.6	46.2	54.3
Education			
No schooling	54.1	52.5	54.9
Primary	29.9	33.6	26.9
High school+	16.0	13.9	18.3
Parity			
0-1	12.4	17.1	15.4
2-3	41.0	38.4	39.4
4+	46.6	44.5	45.1
Wasted pregnancy			
Planned	26.0	38.2	40.0
Not planned	74.0	61.8	60.0
N	800	857	175

Table 8.2: Percentage Distribution of Respondents by Brands of OC, Sources of Knowledge and Source of Supply

	GOB	NGO	GOB+NGO
First time OC user:	55.6	58.8	61.1
Brand of OC use			
C-5	34.1	43.5	19.8
Sukhi	54.4	40.3	68.0
Other	11.5	16.2	12.2
Source of knowledge on OC			
FWs	71.7	68.6	64.0
Hospital / clinic	3.2	3.0	6.3
Relatives / media	25.0	28.3	29.7
Source of Supply (last spell)			
FWs	81.4	81.3	86.9
Hospital / clinic	3.6	4.1	2.9
Relatives/ friends etc.	15.0	14.6	10.3
Usual source of OC			
FWs	83.1	84.9	89.7
Hospital / clinic	3.5	3.4	2.3
Relatives/ friends etc.	13.4	11.7	8.0
N	800	857	175

Table 8.3: Percentage Distribution of Current Users by Level of Knowledge on Correct Use of OC

Types of Knowledge	GOB	NGO	GOB+NGO
Correct knowledge on day start OC	18.1	14.2	21.8
Know correct side	88.0	88.2	86.3
N	800	857	175
Correct action taken when missed 1 pill	73.3	74.4	72.6
N	349	355	62
Know correct action that should be taken when missed 1 pill	88.2	90.3	88.3
N	773	843	171
Correct action taken when missed 2 pills	9.2	10.2	0.0
N	130	137	26
Know correct action that should be taken when missed 2 pills	8.0	13.0	8.6
N	611	698	128
Correct action taken when missed 3 pill s	3.6	2.1	0.0
N	551	48	11
Know correct action that should be taken when missed 3 pills	10.2	10.8	10.1
N	490	595	99

Table 8.4 : Percentage of Current Users by Knowledge of Side-Effects and Experience of Side-Effects

	GOB	NGO	GOB+NGO
Knowledge on side-effects*			
Dizziness	97.6	98.8	99.4
Irregular menstruation	4.4	4.4	2.3
Excessive menstruation	4.5	4.9	4.0
Weakness	63.6	63.0	68.6
Burning sensation	21.7	19.4	26.9
Abdominal pain	4.6	4.5	4.0
N	800	857	175
Experience of side-effects during 1st 3 months of OC use*			
Vomiting tendency	37.6	38.5	26.1
Irregular menstruation	2.0	3.4	2.8
Excessive menstruation	3.3	2.4	0.9
Weakness	49.3	39.2	50.5
Burning sensation	16.4	10.5	14.9
Abdominal pain	3.4	2.8	3.7
N	458	467	107
Side effects continued more than 3 months*			
Vomiting tendency	26.9	13.3	17.6
Dizziness	74.6	65.3	76.4
Irregular menstruation	4.5	5.3	11.8
Excessive menstruation	7.5	6.7	0.0
Weakness	41.8	34.7	76.8
Burning sensation	23.8	14.7	23.5
Abdominal pain	13.4	12.0	5.9
N	67	75	17

Notes:
* Multiple response possible

Table 8.5: Percentage of Current Users by Knowledge about Contraindications and Source of Knowledge On Contraindications

	GOB	NGO	GOB+NGO
Know Contraindications*			
Heart Disease	3.6	4.1	2.3
Diabetes	2.9	2.2	1.7
Jaundice	6.5	6.5	5.7
Gastric ulcer	20.1	26.8	14.9
Asthma	4.1	5.7	4.0
TB	3.2	4.0	1.7
Anemia	5.0	7.7	3.4
Headache/migraine	5.6	6.8	6.0
N	800	857	175
Source of Knowledge on Contraindication*			
FW	52.8	5.1	27.9
NGO FW	1.2	52.5	18.6
LIP Volunteer	2.0	0.0	0.0
Hospital / clinic	8.4	6.0	11.6
Relatives/friends	25.8	36.0	37.2
Mass media	7.3	6.0	13.9
N	248	333	43

Notes:
* Multiple response possible

Table 9.1: Percentage of OC Users by Duration of Use in Months by Selected Background Characteristics

Characteristics	Duration of OC use (months)							
	GOB				NGO			
	N	<12	12-23	24+	N	<12	12-23	24+
Age								
<20	66	44.0	34.8	21.2	134	55.2	29.1	15.7
20-24	283	39.2	24.4	36.4	360	34.2	31.4	34.4
25-29	351	35.6	22.5	41.9	389	32.4	22.6	45.0
30-34	304	35.5	14.8	49.7	307	28.0	18.9	63.1
35+	399	30.9	16.3	52.9	410	24.4	13.7	61.9
Education								
No schooling	768	36.3	21.2	42.4	864	30.8	20.0	49.2
Primary	428	33.2	18.7	48.1	501	33.3	23.3	43.3
High school +	207	36.2	18.4	45.4	235	32.3	27.2	40.4
Parity								
0-1	181	37.6	23.2	39.2	313	39.6	28.1	32.3
2-3	563	34.6	21.0	44.4	614	34.2	22.6	43.2
4-6	491	35.6	18.7	45.6	471	25.1	20.0	55.0
7+	108	34.5	17.3	48.2	202	28.2	16.3	55.4
Desire for more children								
Yes	420	41.4	24.3	34.3	544	39.9	26.6	33.5
No	983	32.6	18.2	49.0	1056	27.6	19.8	52.6

Table 9.2: Duration of OC Use in Months by Whether Respondent is First Time User and Source of Knowledge On OC

Characteristics	Duration of OC use (months)									
	GOB					NGO				
	N	<6	6-12	12-23	24+	N	6<	6-12	12-23	24+
OC use first time										
Yes	445	6.7	7.6	19.3	66.3	611	4.9	7.4	24.2	63.5
No	958	32.4	12.7	20.3	34.5	989	31.5	12.3	20.8	35.3
Source of knowledge										
FWs	977	22.4	11.5	19.0	47.1	1079	20.7	10.4	22.0	47.0
Hospital/clinic	55	27.3	9.1	25.4	38.2	60	16.7	8.3	23.3	51.7
Relatives	371	28.6	10.5	21.8	39.1	461	23.6	10.8	22.3	43.2

Table 9.3: Duration OC Use in Months by Knowledge about Correct Rule of OC Use

Characteristics	Duration of OC use (months)							
	GOB				NGO			
	N	<12	12-23	24+	N	<12	12-23	24+
Knowledge on day start OC								
Correct	246	34.5	18.3	47.1	241	35.3	19.9	44.8
Incorrect	1157	35.5	20.4	44.1	1359	31.2	22.5	46.3
Side of Strip								
Correct	1170	33.8	20.3	45.9	1389	30.4	20.0	46.9
Incorrect	233	43.3	18.4	38.2	211	37.0	22.7	40.3
Source of information on OC								
FW	1039	34.7	19.0	46.3	1204	30.7	21.2	48.1
Hospital/clinic	95	34.7	24.2	41.0	90	33.3	17.8	48.9
Relatives/media	269	37.9	22.7	39.4	306	35.6	27.1	37.2

Table 9.4: Duration of OC Use in Months by Knowledge about Missing Pills

Characteristics	Duration of OC use (months)							
	GOB				NGO			
	N	<12	12-23	24+	N	<12	12-23	24+
Action should take if skipped one pill								
Correct	1168	33.7	19.8	46.5	1369	30.1	22.6	46.3
Incorrect	164	35.4	23.8	40.8	180	35.6	23.3	41.1
Action should take if skipped two pills								
Correct	93	36.5	22.6	40.9	178	23.9	21.7	54.3
Incorrect	955	32.4	20.9	46.7	1079	30.4	23.2	46.4
Action should take if skipped three pills								
Correct	94	28.7	18.1	53.2	105	30.5	23.8	45.7
Incorrect	760	34.3	21.3	44.3	916	28.2	23.6	48.2

Table 9.5: Duration of OC Use (Months) by Experience of Side-Effects

Side-effects	Duration of OC use (months)							
	GOB				NGO			
	N	<12	12-23	24+	N	<12	12-23	24+
Vomiting tendency								
Yes	328	36.9	17.7	45.4	351	35.6	20.5	43.9
No	541	41.7	21.4	36.8	605	37.0	20.8	42.1
Dizziness								
Yes	805	38.8	20.5	40.6	899	36.5	20.6	42.9
No	64	53.1	14.0	32.8	57	36.8	22.8	40.3
Irregular menses								
Yes	24	58.3	12.5	29.2	36	41.7	30.6	27.8
No	845	39.4	20.2	40.4	920	36.3	20.3	43.4
Excess bleeding								
Yes	43	60.5	18.6	20.9	38	55.3	10.5	34.2
No	826	38.9	20.1	41.0	918	35.7	21.1	43.1
Weakness/sick								
Yes	401	38.4	19.2	42.4	392	38.5	20.7	40.8
No	468	41.2	20.7	38.0	564	35.1	20.7	44.1
Burning sensation								
Yes	141	43.3	22.0	34.7	116	37.1	18.1	44.8
No	728	39.3	19.6	41.1	840	36.4	21.1	42.5
Change of mood								
Yes	16	37.5	6.2	56.2	13	69.1	7.7	23.1
No	853	40.0	20.3	39.7	943	36.1	20.9	43.0

Table 9.6: Two-Year Continuation Rate of OC Use by Contraindications for those Who Have Already Completed their Last Spell

Contraindication	GOB		NGO	
	N	%	N	%
Heart Disease				
Yes	68	25.0	53	26.4
No	521	33.2	505	32.3
Diabetes				
Yes	27	25.9	27	25.9
No	563	32.1	522	31.8
Jaundice				
Yes	89	29.2	65	29.2
No	511	32.9	502	32.5
Bericose vein				
Yes	14	21.4	11	27.3
No	585	32.6	556	32.2
Gastric ulcer				
Yes	30	33.3	261	33.3
No	769	31.6	306	31.0
Anaemia				
Yes	170	26.5	135	32.6
No	428	35.0	432	31.9
Headache/migraine				
Yes	159	30.2	163	31.3
No	443	33.2	406	32.3
Abnormal vaginal bleeding				
Yes	72	23.6	68	44.4
No	530	33.6	500	54.6