

**Formative Research on Healthy Fertility Practices
and Postpartum Care in Sylhet District, Bangladesh**

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Executive Summary

It is estimated that half a million mothers and four million neonates die annually around the globe, the vast majority of these deaths occurring in the developing world. Fertility practices such as early initiation of childbearing, short birth-to-pregnancy intervals and low contraceptive use prevalence contribute to the increased maternal and neonatal mortality in developing nations. Despite this relationship, there is a paucity of programmatic research on how to promote healthy fertility practices, particularly for newlywed couples and women in the postpartum period.

In order to inform the development of a planned pilot study looking at ways to integrate the promotion of healthy fertility practices into an ongoing maternal and newborn health project, formative research was conducted on current fertility-related practices in Sylhet District in northeastern Bangladesh. Sylhet Division, in which Sylhet District is located, has the highest fertility rates (TFR=4.2) and the highest proportion of births spaced less than 36 months (55.5%) in Bangladesh. This formative research examined user perceptions of contraception use; identified perceptions of risks and benefits associated with family planning, breastfeeding and birth spacing; and identified programmatic strategies for supporting the use of healthy fertility practices at the community level. In addition, this research served to examine the quality of existing health services with regard to fertility practices and identify appropriate communication channels in the community in anticipation of future intervention development.

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There were six components to this formative research:

1. Semi-structured in-depth interviews on birth spacing, timing of first birth, contraceptive practices and other issues of healthy fertility
2. Semi-structured interviews and free-listing exercises on benefits and risks of birth spacing
3. Semi-structured interviews with health care providers on birth spacing, delayed first birth and contraceptive practices
4. Focus group discussions with various community groups and leaders
5. A household survey with recently delivered women and newly married women
6. Facility audits, structured observations of health facilities and exit interviews with users of the facilities

Findings from both the qualitative interviews and the quantitative results of the household survey indicate a discrepancy between the self-reported knowledge and reproductive intentions of recently married or delivered women and their spouses and the actions taken with regard to fertility practices and contraceptive use. Since behavior results from a complex combination of individual knowledge, community and social norms and environmental cues and barriers, this formative research served to identify the obstacles to promoting healthy fertility practices, such as modern contraceptives and exclusive breastfeeding.

Although the legal age of marriage in Bangladesh is 18 years, many couples are married prior to reaching this age and begin having children almost immediately. While newly married couples may be able to identify risks associated with early initiation of childbearing and often express a desire to delay pregnancy, primarily for the sake of the wife's health, pressure from family and community members to reproduce often takes precedence. Family members such as mother-in-laws and extended family on the husband's side expect a child to be born soon after marriage in order to strengthen family bonds and ensure the family lineage. In addition, in order to be accepted into her husband's family, a woman may need to first produce a child to prove that she is fertile. Families may begin to search for a new wife if the gap between marriage and pregnancy is too long, and rumors of infertility may begin to spread throughout the community.

Contraceptive use among newly married couples is extremely low, though knowledge of a wide variety of contraceptive methods, both traditional and modern, is relatively high among newly married women. Reasons given for not using contraceptives despite having intentions of delaying pregnancy include disagreement with the husband, who holds most of the decision-making power in the relationship, lack of access to contraceptives once living in the husband's family's house, and concerns about side effects of modern methods such as hormonal methods. Traditional methods were mentioned as the most often used when attempting to delay pregnancy, especially because of misconceptions about potential infertility or difficulty conceiving after using modern methods. Once a couple gave birth to one or more children they were more likely to accept the idea of using contraception.

In Sylhet Division the majority of births occur with spacing less than 36 months. While most women seem aware of the risks associated with shorter birth intervals, particularly with respect to maternal and newborn health outcomes, and express that at least 3 years is an ideal space between births, this knowledge and desire does not translate into action with regards to fertility practices. Reasons given by recently delivered women for using contraceptives have more to do with limiting the number of births, not for spacing the intervals between the births.

Women, husbands and mother-in-laws all have expressed the idea that a woman cannot get pregnant until her 40-day "postpartum pollution" ends. Aside from government workers, none of the respondents connected fertility decline during the postpartum period to exclusive breastfeeding and the Lactational Amenorrhea method (LAM). Women did not seem to know about the connection between breastfeeding and the resumption of their menstrual cycles.

Government health providers primarily target couples that have already reached their desired family size or have several children. Newly married couples and young, recently delivered women with fewer children are not viewed as primary targets for health interventions regarding family planning. Likewise, the methods promoted are usually long-term, such as IUDs, implants, or sterilization, and thus health workers are often not equipped to provide information about short-term family planning methods for the intent of increasing birth intervals.

Family planning and birth spacing practices are viewed as inconsistent with Islamic teaching by some religious leaders in the community, and many husbands, mother-in-laws and wives view birth spacing practices and family planning as interfering with Allah's plan. Reframing programmatic messages about family planning as behaviors vital to improving family welfare, particularly newborn and maternal survival, is essential for gaining acceptance and promotion by religious leaders. This finding lends support to plan to pilot test an intervention in Sylhet District that integrates promotion of healthy timing and spacing of pregnancy into community-based provision of antenatal and postpartum/newborn care services.

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Acronyms

BDHS	Bangladesh Demographic and Health Survey 2004
BMMS	Bangladesh Maternal Health Services and Maternal Mortality Survey 2001
CBR	Crude Birth Rate
CC	Clinic Care intervention arm, Projahnmo 1 project
CHW	Community Health Worker
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
HC	Home Care intervention arm, Projahnmo 1 project
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
IUD	Intra-uterine device
LAM	Lactational Amenorrhea Method
MIL	Mother-in-law
Minicon	Progestin-only pill marketed in Bangladesh
MIS	Management Information System
MMR	Maternal Mortality Ratio
NGO	Non-governmental organization
NMH	Newly-Married Husband
NMR	Neonatal Mortality Rate
NMW	Newly Married Woman
OBS	Optimal Birth Spacing
Projahnmo	Project for Advancing the Health of Newborns and Mothers
RDW	Recently Delivered Woman
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate

I. Background

I.1. Overview

This report presents the results of a formative research project to examine the programmatic potential to promote healthy fertility practices in Sylhet District, a rural area of northeast Bangladesh with one of the highest rates of fertility and closely spaced births in the country. This research was conducted from January to June 2006. The operational definition of “healthy fertility practices” for this report includes the use of family planning method by newly married women to delay pregnancy until at least age 18 and by postpartum women to achieve a birth-to-pregnancy interval of at least 24 months. The program components to promote these practices may include postpartum family planning counseling; provision of information on benefits of breastfeeding and risks of short birth-to-pregnancy intervals; and provision of a balanced contraceptive method mix, including side effect management, as well as behavior change communication involving clients, non-clients, extended families and influential social networks. This formative research will enable the development of an intervention study to integrate the promotion of health fertility practices into our ongoing project of community-based maternal and newborn care.

The specific aims of this research project were to:

Understand the context of current fertility-related practices: Investigate local perceptions of risks associated with high risk fertility behavior, and perceptions of benefits associated with family planning, breastfeeding/LAM, and birth spacing (including health and economic benefits associated with longer birth-to-pregnancy intervals); identify strategies that could be used in support of healthy fertility practices such as increasing birth intervals and delaying first birth, as well as those used to promote newborns’ health, and identify practices that could mitigate the harmful effects of short birth intervals when these occur; collect information appropriate for designing more effective interventions to promote healthy fertility behaviors with particular emphasis on young women and newly-married couples.

Identify opportunities for improving health services in support of the intervention: Understand the delivery of health services, counseling, and availability of contraceptive methods and contraceptive side-effect management services; make recommendations for improving health services, particularly advising families about high-risk fertility behaviors; increase availability of mix of contraceptive methods and provide education on side-effect management and the relationship between exclusive breastfeeding and fertility.

Determine appropriate communication approaches to support adoption of healthy fertility practices: Document channels of communication and flow of information within social networks relevant to the promotion of healthy fertility practices and make recommendations for strategies to support adoption of health fertility practices.

I.2. The global burden of neonatal mortality

An estimated 4 million neonates die each year globally, accounting for approximately two-thirds of infant deaths, or 40% of the deaths among children less than five years of age [1]. Over the past two decades, there has been little reduction in rates of low birth weight (LBW), preterm birth, and small for gestational age (SGA), conditions which are linked to neonatal mortality. Conclusions from the 2004 USAID birth spacing programmatic review, 2006 USAID-sponsored perinatal birth spacing meta-analysis, and the Institute of Medicine’s Improving Birth Outcomes study all point to a lack of practical, programmatic interventions to address these three conditions [2] [3] [4]. Increasing birth intervals would be one strategy to reduce rates of LBW, preterm birth and SGA. Another strategy would be to reduce the proportion of births that occur among adolescent mothers. However, traditional family planning programs have sometimes given more emphasis to limiting total fertility by providing contraceptives to families that have already achieved their desired family size.

1.3. Research on the importance of healthy fertility practices

Early initiation of childbearing is associated with increased neonatal and maternal risks. Research from 19 countries in Latin America and the Caribbean region shows a clear trend towards increasing rates of maternal morbidity as maternal age decreases [5]. Compared to mothers aged 20-24 years, mothers aged 15-19 years have 4 times increased risk of maternal death, 4.5 times increased risk for eclampsia and 3.7 times increased risk for puerperal endometritis. In addition, infants of the youngest mothers have an increased risk for low birth weight, preterm delivery, small for gestational age and fetal death [6, 7]. Delaying first pregnancy until women are at least 18 years old could reduce the risk of death for first-born children by 20 percent on average, with reductions of up to 30 percent in some countries [8]. This research is of particular programmatic importance for countries such as Bangladesh where a high proportion of women marry before the age of 18 and subsequently report low rates of contraceptive use.

Women with too short and too long intervals between births also face increased risk of mortality and complications such as puerperal endometritis, anemia, third trimester bleeding, premature rupture of membranes [9]. Key findings are as follows:

- **Perinatal Health:** A recent perinatal meta-analysis has shown that birth-to-pregnancy intervals of less than 18 months (corresponding to a 27 month birth-to-birth interval) and longer than 59 months are related to an increased risk of preterm births, small for gestational age and low birth weight babies [2]. For each month that birth- to- birth intervals are shortened from 27 months, the risk increase for preterm birth, low birth weight, and small for gestational age is 1.9%, 3.3% and 1.5%, respectively
- **Neonatal Health:** Two studies have shown that birth-to-birth intervals of less than 36 months are associated with significantly increased risk of neonatal mortality [10, 11].
- **Maternal Health:** A 2006 systematic review of the literature found that birth-to-pregnancy intervals longer than 59 months are associated with significant increased risk of preeclampsia.

Thus, while observational data suggest that shorter birth intervals are associated with increased risk of pregnancy and obstetric complications, maternal deaths, and adverse pregnancy outcomes (including prematurity, low birth weight, stillbirth and neonatal death [5, 12] there is, to date, no programmatic evidence that increasing the birth interval improves birth outcomes or results in significant improvements in any indicators of maternal or newborn health [3]. Furthermore, research is lacking in the socio-cultural and contextual factors that influence the potential for birth spacing interventions [2].

Among the general population in developing countries, the relationship between short birth intervals and birth outcomes and the risks associated with early initiation of childbearing are little understood, and health care providers rarely discuss the benefits and risks of longer and shorter birth intervals due to lack of standard guidelines and protocols [13]. In Bangladesh, a gap has been observed between women's contraceptive practices and fertility aspirations. Many women say that they prefer to prevent altogether or delay pregnancy two years before having another child, but they do not report on contraceptive practices to achieve these objectives. [14]. As such, some programs incorporate recommendations on the healthy timing and spacing of pregnancy into existing health and non-health interventions at the community level, targeting women, husbands, families, health care providers and influential social networks. Programs that may be possibilities for integration include antenatal and postnatal visits, educational campaigns, microcredit ventures, literacy programs, voluntary counseling and testing (VCT) programs and primary health care visits [15].

1.4. Fertility levels and contraceptive use in Bangladesh

Over the past three decades, the total fertility rate in Bangladesh has declined precipitously, from 6.3 in the early 1970s to 3.0 in 2000 [16]. Part of the reason for this trend is the increase in use of contraceptive methods. Currently, 80% of women surveyed report having used family planning methods at some point in their lives, up from 14% in 1975, a fivefold increase over the past 30 years.

In Sylhet District, the study area for this project, there is a higher reported fertility rate and shorter birth interval than in the general population of Bangladesh. The national TFR for Bangladesh is 3.3, whereas it is 4.2 in Sylhet Division [14]. About 76% of 15-19 year old Bangladeshi mothers had a birth interval of less than 36 months and 45.3% of the 20-29 year old mothers had a birth interval of less than 36 months. During the past four decades, Bangladesh has seen a dramatic increase in contraceptive acceptance, from less than 7.5% in the mid-1970's to 58% in 2004, although this increase has been much slower in Sylhet Division [16]. These trends have impacted fertility rates as well as birth spacing [17].

Previous analyses have shown that demand for birth spacing in Bangladesh was substantial and that much of this demand remained unsatisfied. In the BDHS 2004, the Bangladesh national unmet need for birth spacing was calculated at 5.1%, while the unmet need for birth limiting was 6.3% [16]. In Sylhet Division, the proportion of total unmet need was 20.6% in 2004 [16]. Moreover, women in Sylhet reported an ideal fertility rate of 2.9, much lower than the actual fertility rate of 4.2 [16]. Similarly, 73.7% of Sylheti women with three living children said that they did not want any more children [16].

Table 1. Total Fertility Rate and Birth Intervals¹ in Bangladesh Divisions

Source: Bangladesh DHS 2004 [16]

Division	Total Fertility Rate	Interval between births				
		7-17 Months	18-23 Months	24-35 Months	<36 Months	Mean (Months)
Bangladesh	3.3	6.5%	9.9%	25.5	41.9%	39.3
Barisal	2.9	4.6%	7.2%	26.3%	38.1%	41.6
Chittagong	3.7	6.8%	10.4	30.1%	47.3%	36.8
Dhaka	2.9	6.1%	9.7%	26.4%	42.2%	39.7
Khulna	2.8	6.8%	7.8%	14.8%	29.4%	49.2
Rajshahi	2.6	5.2%	9.9%	21.7%	36.8%	43.5
Sylhet	4.2	10.7%	13.9%	30.9%	55.5%	33.7

Contraceptive use in Sylhet is lower than both the national average and each of the other Divisions within Bangladesh. Use of modern contraceptive methods among married women was 47.3% at the national level and 22.0% in Sylhet Division [16]. In addition, the method mix was also somewhat different in Sylhet Division than in other Divisions, or in Bangladesh as a whole (Table 2). About 11% of married women nationally and 10% in Sylhet reported using traditional methods, usually periodic abstinence [16]. Only 10% of currently married women in Sylhet used oral contraceptives (pill) as compared to 26% at the national level, and only 4% used an injectable method of contraception as compared to the national average of 10% [16]. In Sylhet Division, long-term/permanent methods (IUD, Norplant, sterilization) make up 27% of the method mix, as compared to 15% at the national level [16].

¹ Birth-to-birth intervals are used in the Bangladesh Demographic Health Survey, 2004.

Table 2. Percent distribution of currently married women by contraceptive method currently used in Bangladeshi Divisions

Source: Bangladesh DHS 2004 [16]

Division	Any Method	Modern Method	Pill	Injectables
Bangladesh	58.1	47.3	26.2	9.7
Barisal	54.2	42.7	22.5	12.8
Chittagong	47.1	37.4	19.4	8.3
Dhaka	59.3	48.5	27.3	8.0
Khulna	63.8	50.7	28.6	11.5
Rajshahi	68.3	57.8	33.1	12.2
Sylhet	31.8	22.0	9.6	4.1

Table 3. Modern contraceptive method mix in Sylhet Division compared with method mix for the entire country

Source: Bangladesh DHS 2004 [16]

Division	Pill	IUD	Injectables	Norplant	Condom	Female Sterilization	Male Sterilization
Bangladesh	55.4%	1.3%	20.5%	1.7%	8.9%	11.0%	1.3%
Sylhet	43.6%	4.1%	18.6%	5.5%	11.4%	16.8%	0.5%

1.5. Timing of marriage and pregnancy

The declining total fertility rate in Bangladesh has corresponded with an increasing age of first marriage at the national level, though most women still marry before the age of 18 [16]. The median age at first marriage was 13.9 in the cohort of women ages 45-49 and 16.0 in the cohort of women ages 20-24 [16]. In addition, there has been a gradual downward trend in the percentage of women married before the age 18, from 79% in 1989 to 65% in 1999. However, this trend has recently reversed, as it has increased from 65% in the 1999-2000 Bangladesh Demographic Health Survey (BDHS) to 68% in the 2004 BHDS [16]. Women residing in Sylhet Division had a higher median age of first marriage as compared to the national average, when comparing women ages 20-49 (15.9 as opposed to 14.8) [16]. Although parents of adolescent girls can identify some arguments against adolescent marriage and cite twenty as the ideal age for marriage, social circumstances convince most parents to marry their daughters off at a younger age [18].

Adolescent marriage remains common, and this practice generally leads to adolescent childbearing, which bears increased risks for both mother and child. Newly married couples (those who are married within the last 12 months) are rarely visited by field workers that promote health and family planning, and they have may limited access to reproductive health services [19]. Contraceptive use among the 15-19-year-old newly married women has been estimated at 30% [14]. In addition, research has shown that in several developing countries, including Bangladesh, a high proportion of the demand for family planning in women under the age of 29 is for birth spacing. The largest portion of the demand for birth spacing came from zero-parity females ages 15-19, indicating that newly married adolescents are a significant percentage of the population intending or wishing to use family planning methods for the purposes of delaying first birth or increasing birth-to-pregnancy intervals [20]. Therefore, newly married adolescent girls are particularly in need of information about birth spacing.

Postpartum Contraceptive Use

For those women wanting to postpone the birth of their next child, one of the critical strategies to increase birth intervals is to ensure that women resume contraceptive use as soon as possible after giving birth. Women should begin using some form of contraception one month after birth if they want to delay having another pregnancy and prevent any further pregnancies. In Bangladesh, health policies promote the use of contraception at 40-45 days following the birth, regardless of menstrual status or breastfeeding [13, 21]. However, in practice, most women in Bangladesh wait until the return of menstruation following a birth before they begin to use contraception again. Some women interviewed did not resume their menstrual cycle until after a reported 18 months after giving birth, during which it is highly likely that they could have (or did) become pregnant. Combination birth control pills that contain estrogen are not recommended during breastfeeding, because they decrease lactation. Progestin-only pills are currently socially marketed in Bangladesh, but not always available in rural areas.

IUDs may be suitable, depending on the length of birth spacing preferred, although this requires clinical settings for insertion and therefore may not be suitable for rural Bangladesh. As a result, in this study area, the most appropriate methods would be injectables, condoms, and the Lactational Amenorrhea Method (LAM). LAM refers to the use of exclusive breastfeeding to reduce pregnancy risk by delaying the resumption of menstruation. The risk of pregnancy has proven to be less than 2% if women are breastfeeding exclusively and not menstruating in the first 6 months postpartum [22]. Each additional month of breastfeeding is thought to add approximately 0.4 months to the birth interval [23].

Breastfeeding Practices

It has been previously reported that nearly 100 percent of Bangladeshi women breastfeed during the immediate postpartum period dipping to below 90 percent after 15 months and down to 60 percent at 30 months [24]. The mean duration of breastfeeding is 32.4 months [16]. While there are high rates of immediate breastfeeding and a long average duration of breastfeeding practice throughout Bangladesh, the rates of exclusive breastfeeding are low. Only 54.8% of children under the age of 2 months are exclusively breastfed [16]. That number drops to 38.1% for children age 2-3 months, and 21.3% for children age 4-5 months [16]. Studies in Bangladesh indicate that there is an awareness of a lower risk of pregnancy during the postpartum amenorrhea period [13, 21]. However, few studies have described programmatic interventions to increase breastfeeding for contraceptive reasons.

1.6. Ethnographic research on the postpartum period

Birth spacing is the outcome of a complex set of behaviors, perceptions, and motivations at the individual, family, community, and socio-cultural levels. Prior research has examined these influences on family planning, focusing on the health services provider, the socio-cultural and economic environment, as well as on the female client.

Prior research in Bangladesh has suggested that current family planning programs to encourage contraception shortly following childbirth may have limited acceptability and may run counter to women's understanding of the risk of conception and of contraceptive methods [21]. In general, the postpartum period is regarded as a time of heightened risk for mothers and newborns, and families seek to reduce this risk by sequestering the mother and baby within the home, reducing their movement outside the home and their contact with outsiders [25]. Studies have suggested that women may perceive very little chance of pregnancy occurring in the period of postpartum amenorrhea, although there is no widespread understanding that breastfeeding patterns affect this risk of conception [13]. Research has also suggested that the majority of health system staff and female clients are unaware that natural protection begins to wane over the course of breastfeeding and postpartum amenorrhea so that supplementation of contraception may be warranted. Women also perceive modern contraceptive methods to be too strong for the health of the recent mother, already weakened by pregnancy and childbirth. Some methods are known to negatively affect the quantity of breast milk produced, as described previously. While many women believe modern contraception is appropriate only after menses have returned, research suggests that a lack of standardized and locally appropriate policy among providers does little to improve the situation [21].

1.7. History of family planning service in Bangladesh

Family planning services being delivered to the households was first introduced in 1978 and has been considered the most important reason behind the rapid decline in TFR [26]. The Government of Bangladesh employed several thousands of Family Welfare Assistants for the service delivery in collaboration with NGOs, where the major part was played by the government [27]. Rising costs of this model of FP service delivery and the issue of financial sustainability prompted the government, with increasing pressure from the donor community, to bring about a major change in the delivery system. Thus the Health and Population Sector Programme 1998-2003 (HPSP) was introduced. In this program, an extended Essential Service Package was introduced, which would be delivered through static Community Clinics [28].

There was much apprehension regarding this shift in service delivery strategy, considering the Bangladeshi context where women's mobility outside the home is deemed restricted [29]. However, research showed that the perceived apprehension was not founded on reality and that women were willing and able to go out of their homes to obtain family planning services [30].

Despite the research results, the community clinic-based FP service delivery system never really got off the ground and it was stopped, without a formal evaluation, in 2003. Ministry of Health and Family Welfare (MOHFW) reintroduced the domiciliary services and the satellite clinics under the Health, Nutrition and Population Sector Programme 2003-2007 (HNPSPP) [31].

1.8. Health services and behavior change interventions

Quality of care is a complex, multi-faceted issue which has a direct impact on not only on health outcomes, but also on perceptions that prospective clients have, thereby influencing care seeking related to family planning. At the individual level, improved quality of care in family planning programs ensures that women and men receive respectful treatment by technically competent providers; it is intended to empower them to make choices consistent with their own reproductive intentions. At the aggregate level, greater satisfaction with services should translate into greater contraceptive adoption and continuation rates, thus increasing contraceptive prevalence. Improved quality of care also may prompt women to act on their intentions to seek services in areas where there is fragile demand for contraception. Therefore, efforts to increase demand for postpartum contraceptive use must be paired with efforts to improve the quality of counseling and service provision.

1.9. Channels of communication and social networks for promoting healthy fertility practices

Some pilot studies in Bangladesh have pursued innovative ways of expanding contraceptive acceptance. For example, Kincaid found that social networks could be more effective than outreach workers in increasing contraceptive acceptance and, very importantly, in improving family planning continuation rates [32]. The social networks approach leverages central community figures, who are respected and known to many to facilitate widespread knowledge and potential for adoption of behaviors and products. Kincaid found that a social networks approach increased contraceptive acceptance (family planning use was 2.5 times greater in the intervention group, controlling for confounding factors) and 1 year continuation rates by 43%. The study demonstrates that innovative approaches tailored to local contexts can yield significant gains even among individuals with weak network ties [32]. Kincaid's findings are particularly important because very few, if any, family planning interventions, including significant improvements in clinical service quality, have been found to improve family planning continuation rates. Improving family planning continuation rates will be critical for helping women achieve longer birth intervals.

In 1997, national policy shifted away from doorstep delivery of contraceptives toward clinic-based services (the policy has recently reverted to emphasizing home-based provision of contraceptives.) This formative research examined the use of social networks for promoting healthy fertility behaviors and increasing birth spacing intervals. A major concern with the Kincaid study is that of the different sites in Bangladesh involved in the study, there

apparently was little or very limited impact in the Zakiganj site. (Zakiganj is a sub-district (upazila) located in the proposed site for the current study.) It is possible that social or cultural characteristics of Zakiganj and surrounding areas limit the effectiveness of the approach used by Kincaid. This research identified ways in which the social network approach could be adapted to make it more effective in this setting.

II. Methods

Eighty in-depth interviews were conducted using an unstructured format aimed at eliciting information on birth spacing, timing of first birth, contraceptive practices and other issues of healthy fertility. These interviews were conducted in the homes of both newly married women (women who had been married less than a year with no children and not currently pregnant) and recently delivered women (mothers of a child between the ages of 6 and 23 months) with birth spacing either greater than 35 months or less than 19 months. In addition, the husbands and mothers-in-law of these women were also interviewed. The women were further stratified by socio-economic status (SES), with participants from four different classes, defined as high SES, middle SES, low SES, and very low SES.

Semi-structured interviews and free-listing exercises were conducted with mothers who practice birth spacing, mothers who do not practice birth spacing, and the mother-in-laws of these mothers. These were carried out to determine current understandings of both the benefits of birth spacing and the risks associated with short birth intervals, along with a list of health care providers associated with family planning (See Appendix B for complete free-listing results).

Semi-structured interviews were also conducted with various health care providers regarding their views on birth spacing, delayed first birth and contraceptive practices. The providers interviewed were from both the private and governmental sectors, including drug sellers/local pharmacists, government health workers, homeopaths, traditional healers, village doctors (*gram daktar*), and traditional birth attendants (TBAs).

Focus group discussions were held with various community groups, including religious leaders, village governments (*gram parishad*), local health officials and traditional healers. Focus groups and mapping exercises were also conducted with groups of newly married women and recently delivered women. Focus groups for both groups were structured to elicit information regarding healthy fertility practices.

Household surveys were also conducted with newly married women and recently delivered women throughout the research area, focusing on gathering quantitative data regarding all aspects of the women's personal, social, economic and relational experiences.

In addition, facility audits, observations and client exit interviews were conducted for both government and private health facilities.

(See Appendix A for complete list of methods used and Appendix C for sample household survey instruments)

III. Results: Timing of initiation of childbearing

“My wish is to have a child after two years [of marriage]. My husband’s desire is to have a child now. He married me at a later age, so if he doesn’t have a baby now, he won’t be able to raise him to self-sufficiency (*manush kora*). I’m younger, so if I have a child now, it will be harmful to my health. I watch on the TV that if a woman has a child before she is 18, the mother could die, and the baby could also die. But all my in-laws want me to have a baby soon. My mother-in law is bed-ridden, she can die at any time, so she wants to see her grandchildren from her son before she dies.” (NMW)

One of the objectives of this study was to understand the factors that affect the timing of initiation of childbearing, specifically childbearing during adolescence. Since a majority of women in this setting marry before age 18 and initiate childbearing soon afterwards, newly married couples were selected for both qualitative and quantitative interviews to examine their attitudes toward early initiation of childbearing and contraception use prior to initiation of childbearing. Couples that had been married for less than one year were interviewed separately regarding the timing of their marriage, their knowledge of and experience in using family planning methods, their attitudes toward the timing of the first birth and the spacing of birth within a marriage. Recently delivered women and their husbands were also interviewed separately about the course of their marriage and reproductive lives, which included the timing of their marriage and the birth of their first child. Community leaders and health care providers (in both the government and private sector) were asked to describe how they present information about family planning to newly married couples and what the social norms are with regard to these issues. Ultimately, these findings were analyzed with consideration of their implications for program planning.

III.1. Timing of marriage

Reducing the rate of adolescent marriage has been on the Bangladeshi government and NGO policy agenda for some time. As such, the minimum age for a woman to be married in Bangladesh has been set at the age of 18. Because of this focus on the reduction of adolescent marriage, there has been an increase in the average age of marriage over the past two decades. However, the majority of females are still married prior to the age of 18, and in some cases there are reports of girls getting married as young as 12 and 13 years old. As shown in Table 4 below, results from our household survey of newly married women shown that over half (53%) of women surveyed had been married under the age of 18. This number may, in fact, be even greater, as there is a tendency to overstate the age of the woman in order to comply with the legal age of marriage. This is also evident in a discrepancy between the perceived and actual age of newly married women. In focus group discussions, union council members said that there has been an increase in the average age of marriage since the 1990s and that between 80% and 90% of women are eighteen years of age or older at the time of their first marriage. In contrast to that, a contradictory estimation was given by the sub-district (upazila) health official who stated that approximately 40% of newly-married women are under the age of eighteen.

Table 4. Age at marriage of newly married women in Sylhet District

Data collection method: Household survey

Population (n): Newly married women (n=740) defined as women married between January 2005 and June 2006 who have not yet had a live birth

Timing of data collection: March-June 2006

Age at Marriage	Frequency	Percent	Cumulative
12	1	0.14%	0.14%
13	3	0.41%	0.55%
14	14	1.89%	2.43%

Age at Marriage	Frequency	Percent	Cumulative
15	32	4.32%	6.76%
16	85	11.49%	18.24%
17	258	34.86%	53.11%
18 and older	347	46.89%	100.00%
Total	740	100.00%	100.00%

Despite social policies and programs to promote delayed marriage, other social forces encourage younger marriage among women, as was discussed. Social norms, the desire to secure a husband early, and economic issues are often stated as a reason for early marriage. For example, families of younger women may be required to pay smaller dowries than families of older women. Thus, delaying marriage can create a financial burden. In this setting, most marriages are arranged by the parents, and so the young couple's preferences hold little influence. Many of the newlywed women informants said that they thought it would be better to get married around age 20, but they had no control over the situation. Therefore, our findings are consistent with previous studies suggesting that significant barriers remain to increasing the age of marriage among women.

III.2. Timing of first birth

“I’ll have a baby right now, and then I’ll stop having babies after that. Moreover, I have the ability to rear a baby. I don’t have any *bimar* (sickness) in my body. If I delay, then *bimar* could come to my body. If you delay having first baby, you may not have any in the future.” (NMW)

Most women in this setting become pregnant soon after marriage. As shown in Table 5, nearly 40% of the newly married women identified in the household census were already pregnant at the time the survey was conducted. This does not include the newly married women who were excluded from the survey due to their status as having recently delivered a child. In addition, the high rate of pregnancy occurs throughout the age spectrum, as nearly 38% of adolescent women who got married prior to the age of 18 are currently pregnant.

Table 5. Pregnancy rates among newly married women

Data collection method: Household survey

Population (n): Newly married women (n=740) defined as women married between January 2005 and June 2006 who have not yet had a live birth

Timing of data collection: March-June 2006

Age at Marriage	Frequency	Pregnant	Percent	Cumulative
12	1	0	0.00%	0.00%
13	3	3	100.00%	75.00%
14	14	6	42.86%	50.00%
15	32	9	28.13%	36.00%
16	85	31	36.47%	36.30%
17	258	99	38.37%	37.66%
18 and older	347	141	40.63%	39.05%
Total	740	289	39.05%	39.05%

While early marriage in and of itself cannot be construed as inherently unhealthy, it is the accompanying early childbearing that makes the behavior a significant health risk. Nearly 90% of newly married women surveyed who were currently pregnant became pregnant within the first six months of marriage, 70% becoming pregnant within the first three months of marriage. Due to the prevalence of adolescent marriage, this creates a high number of pregnancies in women under the age of 18. All told, 83 of the 289 women who became pregnant (29%) were definitely below the age of 18, and that number could be as high as 156 out of 289 (54%).

Table 6. Time between marriage and first pregnancy among newly married women

Data collection method: Household survey

Population (n): Newly married women (n=740) defined as women married between January 2005 and June 2006 who have not yet had a live birth

Timing of data collection: March-June 2006

Age at Marriage	Total Newly Married Women Currently Pregnant	Time (in months) between marriage and first pregnancy			
		0 Months (Immediate)	1-3 Months	4-6 Months	% of Pregnancies within 6 Months
13	3	1	1	1	100.00%
14	6	0	3	1	66.67%
15	9	4	2	3	100.00%
16	31	6	8	10	77.42%
17	99	34	41	14	89.90%
18 and older	141	55	47	22	87.94%
Total	289	100	102	51	87.54%

A fear of infertility was often cited as a primary reason for having a child soon after marriage, by married women and their husbands, mothers-in-law and community members. This fear of infertility was also given as a reason for not using contraceptive methods after marriage. For both women and men, apparent infertility, as evidenced by a delay in childbearing can lead to social stigma, teasing and gossip.

“If you have a baby in the year of your marriage, then the villagers will not say anything bad about you. But if two or three years pass without a baby, then they will call you *banja* (adjective for an infertile woman) or *atkura* (adjective for an infertile man). So, you could avoid all of this gossip if you have a child soon after marriage.” (NMW)

This stigma can spread to the couple’s family, leading the parents to pressure the couple to have children. If the marriage continues for a few years without pregnancy, the wife may fear that her husband will want to take another wife, or the husband may be pressured to do so. One man described the pressure that continued during the two-year period between his marriage and his wife’s first pregnancy:

“During this time, many people were asking me, ‘Why do you keep this [woman]? She is not yet able to produce a child, so why do you keep her?’ Then, my wife got pregnant, but had a stillbirth. Again people said, ‘Why are you still keeping this wife? Leave her and get another wife. What will you do with this? Change it.’ But then, by the grace of Allah I got a child.” (NMH)

Some male informants had taken second wives as a result of their inability to have children.

Having a child soon after marriage also serves to strength family bonds, to ensure the family lineage and to establish newly married women’s role in the family. Prior to having a child, the newly married woman is often not considered a complete member of the family. She has yet to prove her value to the family. From this perspective, having a child soon after marriage is attractive to wives, husbands, in-laws and even the natal family.

“When I got married, I was very young, I didn’t understand things very well. After I got married, I felt shame talking with my husband (about family planning issues), so I didn’t talk to him. After three months, I became pregnant. This is because my husband wanted to take a child right after marriage, since my husband is the eldest son, and my mother-in-law and father-in-law want to see grandchildren before they die.” (RDW)

In Sylhet, a significant proportion of the adult male population migrates to the Middle East, Europe or the United States. In these families, the husband and wife frequently live apart for years; usually the wife lives with her husband’s parents or extended family. When this occurs, having a child is seen as a way to cement the bonds between the husband and wife, and between the wife and the in-laws. The husband may spend a few weeks or months in Sylhet after his wedding, then migrate out of the country for a year or more. Therefore, if pregnancy does not occur during this honeymoon period, the couple may wait years for another opportunity. Even when the husband resides in Sylhet, men often said that they wanted to have a child soon after marriage.

Although women typically marry young, men frequently wait until they are economically established or feel ready to have a child. Therefore, having a child is the impetus for marriage. For example, one recently married male informant said that he was 36 years old and that he feared he might become infertile soon and so he wanted to have a child as soon as possible. In addition, having a child is critical to establishing a new bride’s role in the family.

III.3. Perceived risks of adolescent childbearing

“If you consider the health of the mother, it’s good to have a delayed first childbirth. If there is large gap, then mother’s health will remain okay. But if there is frequent childbirth, the mother’s body will become weak.” (NMH)

Most of the newly married women, their husbands and mother-in-laws stated that the ideal age for both marriage and the first child is about 18-20. Moreover, during the interviews it was clear that many newly married couples, including husbands, were aware of some general risks to the mother associated with early childbearing. However, these risks to the mother tend to be more focused on morbidity, as few of the informants stated that adolescent childbearing could actually result in the death of the mother. It may be that this lower perceived severity of risk helps to prevent action being taken in the form of contraceptive use and delayed first birth. In terms of morbidity risks, some of the women interviewed mentioned that they were not physically mature enough for a child. They said that their body was not prepared; their bones and muscles are not prepared. One newly married woman was only 16 years old, and her husband believed that her body would stay healthy longer if the first birth was delayed. Another husband wanted to wait because he was not sure that his wife’s body could take the stress of pregnancy and childbirth. However, this concern over the risks of early childbirth was uncommon.

Many community-based health providers that were interviewed, such as village doctors and traditional birth attendants (*dai*), were able to list physical risks associated with early childbearing. For example, they reported that the mother would be more likely to have an obstetric emergency and need to give birth in a facility. However, most said that delaying the first child has no impact on the health of the child.

III.4. Perceived benefits of delaying first birth

In addition to the perceived risks of adolescent childbirth, there were other benefits mentioned during the interviews that acted as factors to delay the onset of pregnancy and first birth. A few couples said that economic factors influenced their desire regarding the timing of the first birth, as they would like to improve their economic situation before having children. Some husbands sought to save money before a child, or wanted to emigrate to another country to work before having children. For example, one couple had been married for one year and had no children. The wife’s wish was to have child after one year, and her husband’s wish was to have a child after 4 years. He listed both economic and physical reasons for his preference to wait. Firstly, he said that if they didn’t have children, they can save some money. Furthermore, the husband’s fear was that if they had a baby soon and the baby got sick, they wouldn’t have any money to get care. A few said they would prefer to have the chance to enjoy married life for a few years without the pressure of childbearing. In addition, the media has played a large role in recognition of the value of delayed first birth; women have been exposed to public health messages suggesting that they delay childbirth. One woman said she saw this information on a billboard. Another woman said she received this information from a health worker that came to the house during her sister-in-law’s pregnancy. In addition, some husbands echoed similar concerns.

However, despite the recognition of various benefits to delaying the newlywed couple’s first pregnancy, this knowledge has not translated into action, particularly in the case of adolescent marriages. Results from the household survey show that most newly married women under the age of 18 wish to become pregnant right away. Among these newly married women who were not already pregnant, 52% wanted a child immediately (see Table 7).

Table 7. Fertility intentions among newly married women under the age of 18 and not currently pregnant: How many months or years from now would they like to conceive?

Data collection method: Household survey

Population (n): Newly married women (defined as women married between January 2005 and June 2006 who have not yet had a live birth) under the age of 18 and who are not currently pregnant and would like to have a child in the future (n=241)

Timing of data collection: March-June 2006

Response	Frequency	Percentage	Cumulative
Soon/Now	125	51.87%	51.87%
1 Year	25	10.37%	62.24%
2 Years	39	16.18%	78.42%
3 or More Years	34	14.11%	92.53%
Don't Know/Other	18	7.47%	100.00%
Total	241	100.00%	100.00%

III.5. Contraceptive use before first pregnancy

Because of the desires of newly married women to express their fertility and establish their place within the family, few couples take consistent actions to prevent pregnancy. Of the 740 newly married women surveyed, there were only 108 reported instances of any current or previous method use, with condoms, pills and withdrawal being the most common methods mentioned. The situation is even more disconcerting for women under the age of 18, as there are only 55 reported instances of method use, with over a third of them being non-modern methods. In addition, only 5% of newly married women surveyed (who were not already pregnant) reported current use of a contraceptive method.

As evident from the data in Tables 8 and 9, there is a great disparity between knowledge of contraceptive methods and use. This is due to reasons such as fear of infertility, family and social pressures, and desire to establish place in the family. From the quantitative data, it is evident that while there is a failure to translate knowledge into action among most newly married women, it is even more evident among newly married women under the age of 18. Both the decreased knowledge and use of various methods further increase the risk of adolescent pregnancy.

Table 8. Knowledge and use of contraceptive methods among all newly married women

Data collection method: Household survey

Population (n): Newly married women (n=740)

Timing of data collection: March-June 2006

Method	# NMW that have heard of method	% of NMW that have heard of method	# NMW that have used method	% of NMW that have used method
Female Sterilization	314	42.43%	0	0.00%
Male Sterilization	128	17.30%	0	0.00%
Pill	607	82.03%	30	4.05%
IUD	254	34.32%	0	0.00%
Injectables	556	75.14%	3	0.41%
Implants	218	29.46%	1	0.14%
Condoms	403	54.46%	41	5.54%
Lactational Amenorrhea Method (LAM)	110	14.86%	0	0.00%
Rhythm Method/Periodic Abstinence	125	16.89%	10	1.35%
Withdrawal	135	18.24%	22	2.97%
Emergency Contraception	43	5.81%	1	0.14%
Other	31	4.19%	0	0.00%

Table 9. Knowledge and use of contraceptive methods among newly married women married prior to the age of 18

Data collection method: Household survey

Population (n): Newly married women married prior to the age of 18 (n=393)

Timing of data collection: March-June 2006

Method	# NMW<18 that have heard of method	% of NMW<18 that have heard of method	# NMW<18 that have used method	% of NMW<18 that have used method
Female Sterilization	136	34.61%	0	0.00%
Male Sterilization	45	11.45%	0	0.00%
Pill	305	77.61%	16	4.07%
IUD	102	25.95%	0	0.00%
Injectables	274	69.72%	2	0.51
Implants	105	26.72%	0	0.00%
Condoms	191	48.60%	17	4.33%
Lactational Amenorrhea Method (LAM)	42	10.69%	0	0.00%
Rhythm Method/Periodic Abstinence	53	13.49%	6	1.53%
Withdrawal	65	16.54%	13	3.31%
Emergency Contraception	17	4.33%	1	0.25%
Other	16	4.07%	0	0.00%

Besides the reasons previously mentioned for lack of method use, such as fear of infertility, family and social pressures, and desire to establish place in the family, the interviews and focus group discussions also suggested some reasons that couples may forgo contraceptive use before the birth of the first child. One factor that may distinguish those who used contraceptive methods before the first birth from those who do not is the discordance between the beliefs of the husband and wife about appropriate timing of the first birth. Another possible factor affecting early contraceptive use is the opposition of the mother-in-law to family planning measures. The husband's family may also play a role in contraceptive use if the couple is under pressure for an immediate birth. In addition, the husband's exposure to family planning information may play a role in timing of first birth, as well as limited access to contraceptive information and supplies, as will be discussed further.

Women: Knowledge, Sources of Information and roles of social networks

Most newly married women interviewed, even the adolescent wives, knew of at least a couple of family planning methods. However, knowledge of specific methods is far from universal, as is evident from Tables 8 and 9. Specifically among adolescent women, knowledge of methods beyond pills and injections is very low. In spite of this, however, many women were still able to list a variety of methods. In addition, newly married women interviewed were very aware of the side effects attributed to various methods, especially pills and injection.

“The pill makes your head spin, gives you nausea and blurry vision. Injection stops menstruation for some women, and for others it causes spotting. It also makes you gain weight.” (NMW)

Some women reported that they are afraid to use pills, injections and copper T, (IUD) because of side effects and problems with pregnancy. As mentioned previously, most said that they had never used any method, and fear of infertility was one of the primary reasons for avoiding the use of modern methods. Wives and some health care providers stated that hormonal methods could cause infertility and were therefore dangerous for newly married couples particularly before the birth of the first child.

With regard to information about various contraceptive methods, most women interviewed said that they received information from outside the health care sector, especially through social networks. Women obtained their information regarding contraceptive methods primarily through friends, neighbors and the wives of brothers and brother-in-laws. Secondary sources of information include radio, television, their natal kin and government health worker, although these sources were not as available to adolescent wives. Some of them got information about contraception before they were married, by overhearing conversations in their household. After getting married and living with their husband’s family, however, they seemed to have less access to information, especially in the case of newly married women under the age of 18. They were not comfortable discussing these matters with their husband’s family, and they rarely had the chance to leave the house.

“My brother’s wife and my husband’s brother’s wife informed me that if I have babies with a large gap, my health will remain well. The health of the children will also remain well. I also heard this information from the health workers when they came to talk to my brother’s wife when she delivered. Moreover, I watched this on TV at my father’s house. But after my marriage I cannot watch TV. My parents-in-law own a TV, but my mother-in-law doesn’t allow me to watch it.” (NMW)

The seclusion and isolation of a newly married woman is another critical factor in her ability to obtain information regarding health and family planning issues. Most women are not permitted to make independent decisions. For example, one newly married informant said, “I have to take instructions from my mother-in-law before doing anything.” She has a daily routine, which includes certain tasks, and there is very little chance for deviation. She must ask either her husband or her husband’s parents before going outside the house. To go to the marketplace, or her relatives’ house, she has to put forth this idea a few days in advance. If she desires visiting her natal family, it’s a serious decision, requiring the involvement of both the mother and father-in-law. Someone from her natal family must come and propose the visit. Then, she will need someone trustworthy to accompany her on her visit. Often, after she asks her husband, the husband and wife then go together and ask the mother-in-law for permission. Also, in order to buy things outside of the normal budget, like treats, jewelry, or ornaments from vendors, she has to ask the husband for money and permission. Anything that involves money, she must ask her husband first. Anything related to her daily activities, she has to receive consent from either her mother-in-law or elder sister-in-law.

Few women said they discussed family planning matters with their mother-in-law, because they had a difference in status within the family and may not have established a close relationship. Usually, newly married wives cannot go outside of their own rooms; they may spend the whole day in kitchen and back of the house. If health care providers come to the home, family members often discourage them from discussing matters with newly married women. Therefore, misinformation and fear are critical barriers that prevent newly married women from using contraceptives. However, even if they want to use methods, they may face resistance from their husbands and usually have limited ability to access information and services outside the home.

Survey findings also suggest that government family planning services are rarely provided to newly married women. Only about 10% of newly married women said that a health care worker had come to their house to visit them since their marriage, and another 9% had gone to a health facility. Only 6% said a health worker had spoken with them

about family planning. Moreover, providers discourage contraceptive use by newly married couples before their first child, saying that it's a risk to the mother's future fertility. However, among the small group of women who had contact with a health worker, roughly half of them reported that the health worker discussed delaying the first pregnancy, and again half report having received information on the importance of birth spacing.

Men: Knowledge and Sources of Information

“Before my marriage, I used to sit and chat in a pharmacy. I had discussion with many “doctors” (*gram daktar*, medicine sellers, health workers). I know many of them, and I heard many things from them. Because I mix with them, I know many things. The person in Siddiq Pharmacy, I used to chat with him.” (NMH)

Men generally have much more access to information regarding contraceptive methods than their wives do, particularly information from health care providers. They obtain information from friends, neighbors, family members, village doctors, and pharmacists. For example, one husband who was using condoms had a friend living in Dhaka, and this person had suggested he do something to delay the birth of their first child. Men who migrate outside of Sylhet for work also may have better access to information about contraception, although this information is not necessarily accurate. One of the newly married husbands interviewed had worked in Japan and said that he had learned about the withdrawal method there. However, like women, some of men's knowledge was at odds with current biomedical knowledge. One common misperception encountered in the research was the idea of that the most likely time to conceive was the first few days after the menstrual cycle ends. Therefore, couples might abstain or use condoms only during this period. According to one newly married husband, “The rule is, husband shouldn't go to wife during menstruation and for one week after menstruation. There is some security if you follow this code.” Despite having greater access to information than that available to women, men sometimes lack the information from which to make informed decisions. One husband interviewed said that he wants to delay the birth of his first child, but he doesn't have any information, so he could not really decide.

III.6. Communication between couples about family planning and timing of the first pregnancy

“(W)hat is her opinion about? If I decide, it will be. We can discuss, but if I decide I will use, and if I do not I will not. So, basically, there is not too much point in discussing.” (NMH)

Many couples discuss how many children they will have and when will they start having children. However, most of them don't discuss family planning methods. In fact, nearly 40% of newly married women surveyed reported not having discussed family planning with their husband at all, and another 40% only discussed once or twice in the past year. This is not simply because the couple is uncomfortable discussing the topic, although this may be a factor.

One important issue is that the husband's opinion takes priority, so it is not necessary to discuss. A husband may feel that it's his choice and that it's not necessary to discuss the subject with the wife. He will impose his decision on the couple. In addition, the husband's family may impose their preference on the couple, further limiting the role of communication between the husband and wife. The family's preference becomes the husband's preference. In six out of the ten newly married couples interviewed, the husband was the key decision maker. If they were using a method, the husband initiated the method use and the methods used were dependent on his cooperation (condoms, withdrawal). We found no cases of clandestine use by newly married women interviewed, though it is thought to be occurring. Similarly, communication between newly married women and mother's-in-law about family planning is very rare, only occurring in about 5% of the families surveyed.

III.7. Conclusions

Despite apparent knowledge of the potential risks and consequences of early childbearing for young women, there is a strong desire among most newly married women, including those under the age of 18, to have a child soon, if not immediately, after marriage. Because of the large number of newly married women that are under the age of 18, this desire results in a high number of pregnancies during adolescence, leading to a variety of increased health risks, including fatalities, to both the mother and the child. Because of this discrepancy between knowledge and action, a variety of reasons have been identified as barriers to delaying the first pregnancy, including familial and social pressures, economic factors, fear of infertility, incorrect information about contraceptives and male decision-making power.

First, there are strong familial pressures for couples to have a child shortly after marriage. It is believed that this will strengthen the family bonds, ensure the continuing lineage of the husband's family, establish the newly married woman's place in the family, and prove her fertility. As such, issues regarding timing of the first birth are not solely up to the woman or to her husband, but are more of a family decision.

Social factors can also contribute to early childbearing. Rumors and innuendo regarding fertility status are the result of failure to produce a child soon after marriage. In addition, delaying first birth can bring shame on the family, and may cause the husband's family to find another wife for their son.

Incorrect information obtained through social networks also contributes to early childbearing. Information regarding use of contraceptive methods prior to the birth of the first child has led to fear of infertility from these methods. Likewise, social networks, especially among newly married husbands, have contributed to the widespread practice of the "standard days" method of contraception that is inconsistent with the biomedical model of fertility.

The fact that the society is dominated by the males is also a factor. Husbands are responsible for most of the decisions of the household, including contraceptive and family planning issues. If the husband wants a child immediately after marriage, most likely it will be so. Most women are not yet empowered enough to make decisions regarding the timing of the first birth or the use of contraceptive methods.

III.8. Implications for intervention design

With newly married couples, there is an awareness of the risks of early childbearing, along with an understanding of the benefits of delaying the birth of the first child until the woman is at least 18 years old. This has not, however, translated into action resulting in behaviors designed to improve healthy fertility. Because of the multi-faceted pressures faced by newly married couples to have a child immediately after marriage, not to mention the various social and cultural norms regarding the timing of marriage, it is difficult to target an intervention directly focusing on delaying the first birth without causing a possible social backlash in regards to other intervention components. Any intervention strategy must be handled with delicacy and tact, focusing on improving communication between the husband and the wife, and informing them of various strategies to maintain the health of the mother and child, including contraception methods and delaying first birth. With this in mind, the following recommendations are made.

Target audience: An intervention should be planned to target newly married women under the age of 18, as well as the husbands and the husband's family, since the decision to delay childbirth is not only an individual-level or couple-level decision, but often involves the entire family. In addition, women under the age of 18 who are engaged to be married should also be targeted, along with the future husband and in-laws.

Community health workers should include newly married adolescent women identified during bi-monthly home visits and invite them to a meeting/information session at a local health clinic or office. During this meeting, general discussions about the future health of the mother, the newborn and the family would be the focus. This

would be followed by couple sessions every two months or, in the alternative, individual sessions with a focus on continued communication regarding healthy fertility between husband and wife in the home.

Another facet of the intervention would be the incorporation of the husband's family, particularly the mother-in-law, in a separate counseling session or meeting. In addition, soon-be-married men could also be targeted separately, using male health informants (MHIs). Since the husband is the primary decision-maker, it is essential that he receive information about contraceptive methods and risks of early childbirth.

Information and Public Health Messages: Though some of newlywed couples are aware of risks of early childbearing, none of them recognized the risks for the newborn. Risks for both the mother and newborn should be emphasized and public health messages should stress the benefits of waiting at least one year before pregnancy. In addition, there are misconceptions about the side effects of hormonal methods and IUDs. Information should be disseminated about the unreliability of the most common, traditional methods such as withdrawal and the rhythm method, and should address concerns about infertility. Concern about infertility due to method use is a critical concern in the community. This concern is common to both women in the community and the community health workers and local health practitioners.

Access: There is limited access to both information about family planning and the actual contraceptive methods for this population that need to be addressed in the intervention. Health workers should visit newly married couples immediately after identification, since once a woman moves into her husband's family's house, she has much less contact with people outside and information from outside sources.

Linkage to Newborn Care Interventions: Meeting with newly married couples early in their marriage will likely increase communication and agreement with regards to healthy fertility practices, such as family size, birth spacing, contraceptive use and timing of first birth. When the newly married couple decides to have their first child, this increase in harmony regarding fertility practices will carry over into increased compliance with newborn care strategies and interventions, increasing the likelihood of a healthier birth. As such, interventions aimed at increasing the healthy fertility practices of newly married couples provide early support for, and are a critical component of, newborn care interventions.

IV. Results: Birth Spacing

IV.1. Overview of the results

As described in the introduction, women in Sylhet are more likely to have closely spaced births than women in Bangladesh as a whole. The qualitative components of the research sought to illuminate the mechanisms through which close birth intervals occur. The household survey sought to describe to women’s knowledge, attitudes and practices regarding contraceptive use and their access to reproductive health services. Table 10 illustrates both factors in support of a community-based healthy fertility/birth spacing intervention and barriers against it, by level (type of individual, community). Opportunities for intervention are also identified.

Table 10. Overview of favorable factors, constraints and opportunities for intervention related to promotion of birth spacing in Sylhet District

Recently Delivered Women (RDW)		
Favorable Factors	Constraints and Barriers	Opportunities for Intervention
<ul style="list-style-type: none"> • High level of recognition that “ideal” space between births is 3 years • High level of knowledge of both benefits of birth spacing and risks of short birth intervals • High level of knowledge of various contraceptive methods • Close social ties with other female members of extended family- • Some access to mass media, television and radio 	<ul style="list-style-type: none"> • Lack of understanding of post-partum fertility • Low level of knowledge of the relationship between fertility and breastfeeding (LAM) • Lack of understanding of contraceptive side-effects • Limited mobility outside the home compared to men • Strained relationship with mother-in-law prior to the birth of the first child • Restricted access to mass media in husband’s family’s home • Lack of access to contraceptive methods • Difficult to conceal contraceptive use 	<ul style="list-style-type: none"> • Increase understanding of post-partum fertility, benefits of exclusive breastfeeding and LAM method during antenatal and postnatal care visits to health facilities/satellite clinic and home visits by CHWs • Increase understanding of various contraceptive methods and their side effects during antenatal care (for use immediately after delivery) and postnatal care visits by CHWs • Increase household visits and availability of a variety of short-term methods (condoms and pills) through both governmental (FWAs and FWVs) and non-governmental (CHWs) health workers • Promote “purposeful diffusion of knowledge” through one informed female family member to another, or through pregnant women’s clubs • Incorporate healthy fertility messages into mass media

Husbands of RDW		
Favorable Factors	Constraints and Barriers	Opportunities for Intervention
<ul style="list-style-type: none"> • Aware of various benefits of birth spacing, including economic and familial advantages • Knowledgeable about various types of contraceptive methods • Many husbands travel overseas for jobs, creating a birth space as a by-product of their employment • Very mobile • Strong social networks within the community • Have prime decision-making power in couples' reproductive choices 	<ul style="list-style-type: none"> • Low level of acknowledgement of the maternal health risks of short birth intervals • Lack of knowledge regarding specific links between birth spacing and health of children • Often considered birth spacing a matter solely for their wives • Misinformation regarding family planning practices, including contraceptive methods • Disallow wives to make reproductive health decisions 	<ul style="list-style-type: none"> • Improve husbands' knowledge and awareness of the health risks to both mother and child and encourage men to support partners in using family planning methods consistently through the inclusion of husbands in both antenatal and postnatal care visits • Integrate discussions about FP and HTSP into other men's health services • Create husband-only community meetings, led by male community mobilizers, to promote the economic and familial advantages of healthy fertility practices • Create social marketing messages disseminated through social networks, adapted to respond to current rumors and/or misinformation
Married Couples		
Favorable Factors	Constraints and Barriers	Opportunities for Intervention
<ul style="list-style-type: none"> • Decrease in sexual activity • Increase in the length of marriage • Increase in the age of couple at marriage 	<ul style="list-style-type: none"> • Lack of communication regarding family planning and healthy fertility practices • Lack of consistent use of contraceptive methods • Perceived lack of fertility or worry about infertility • Previous still-birth or spontaneous abortion 	<ul style="list-style-type: none"> • Increase focus on younger, lower-parity couples • Increase communication by incorporating "couples-only" meetings into antenatal care routines • Increase the role and responsibility of the husband in obtaining contraceptive methods
Mothers-in-Law (MIL)		
Favorable Factors	Constraints and Barriers	Opportunities for Intervention
<ul style="list-style-type: none"> • High level of knowledge of both benefits of birth spacing and risks of short birth intervals 	<ul style="list-style-type: none"> • Religious objections or questions of "morality" of family planning • Resistance to use of any 	<ul style="list-style-type: none"> • In some cases incorporate MILs into antenatal care • Discussion over "spacing" and

<ul style="list-style-type: none"> • Some recognition that a birth space of 2-3 years is beneficial to health of mother and baby • Has significant influence over fertility-related decisions of son and daughter-in-law 	<p>contraceptive methods, as they are often associated with limiting as opposed to spacing</p> <ul style="list-style-type: none"> • Little communication between MIL and their daughters-in-law • Wife's "duty" to provide grandchildren 	<p>"limiting" as one talks about the health of the mother and the baby</p> <ul style="list-style-type: none"> • Create an "MIL" community group, where mothers-in-law from various background can sit and discuss family planning issues together • Messages designed as parts of neonatal and maternal care package, not FP
Other Family Members		
Favorable Factors	Constraints and Barriers	Opportunities for Intervention
<ul style="list-style-type: none"> • Often provide information regarding healthy fertility practices • Female family members often provide advice on FP practices or contraceptives themselves 	<ul style="list-style-type: none"> • Resistance to use of methods, as they are often associated with limiting as opposed to spacing 	<ul style="list-style-type: none"> • Discussion groups with female family members during home visits.
Community		
Favorable Factors	Constraints and Barriers	Opportunities for Intervention
<ul style="list-style-type: none"> • Wide variety of ways to obtain family planning information • Strong social networks 	<ul style="list-style-type: none"> • Rumors and gossip may spread incorrect information regarding family planning issues • Strong social pressure, especially early in marriage and in low parity families, to prove fertility 	<ul style="list-style-type: none"> • Create social marketing campaign to distribute healthy fertility information through social networks already in place with a distinct focus on birth spacing and maternal and newborn health (as opposed to FP) • Integrate FP/HTSP messages into other community health activities such as maternal and neonatal health program and non-health activities such as microcredit programs.
Union Council Members		
Favorable Factors	Constraints and Barriers	Opportunities for Intervention
<ul style="list-style-type: none"> • Recognize benefits of healthy fertility practices on the overall health of the family • Eager to assist in promoting healthy fertility practices and trust in partnership with JHSPH 	<ul style="list-style-type: none"> • Have a tendency to overstate gains in healthy fertility practices • Difficult to determine the role of Union Council members in community family planning 	<ul style="list-style-type: none"> • Utilize Union Council as a support institution • Have monthly community meetings regarding family planning issues at their offices

<ul style="list-style-type: none"> • Can provide a physical space for meetings 		
Religious Leaders		
Favorable Factors	Constraints and Barriers	Opportunities for Intervention
<ul style="list-style-type: none"> • Many appreciate that a space after a birth is beneficial to the health of the mother and the newborn child • Resistance diminished if messages focus on the health of the mother and child • Wished to be consulted during implementation of any intervention 	<ul style="list-style-type: none"> • Will not approve of any contraceptive method use • Will not support any message that seeks to promote birth spacing as a practice (inconsistent with teachings of Islam) • Religious objections/questions of “morality” of family planning 	<ul style="list-style-type: none"> • Include religious leaders in the design of any intervention • Keep them informed through monthly meetings • Messages with reference to appropriate religious authorities need to be gleaned out from the literature... • At all points, maternal and neonatal health should have the priority over simple FP issues. Religious objections are minimized if birth spacing is promoted as way to improve well-being of mother and child, rather than as a family planning method
Health Care Services (government, NGO, local and traditional)		
Favorable Factors	Constraints and Barriers	Opportunities for Intervention
<ul style="list-style-type: none"> • Provide information about various contraceptive methods • Provide and/or administer various contraceptive methods • Infrastructure for delivery of healthy fertility messages and services in place • Government health services able to join forces with local NGOs on healthy fertility practices 	<ul style="list-style-type: none"> • Lack of family planning services provided to many RDW • Often focus on limiting the number of births rather than proper spacing • Concentrate on providing services to larger families, while ignoring families with fewer children • Contraceptive delivery is focused on more permanent methods • Local knowledge of contraception is often inconsistent with the current bio-medical understanding of fertility • Government structure has too many empty positions to fill at 	<ul style="list-style-type: none"> • Train providers to incorporate healthy fertility messages into antenatal and postnatal care • Increase the health care provider’s focus on delivery of information and methods to couples of lower parity • Train the providers to give information on all methods, both short and long term • Provide health care workers with the most current understanding of contraception and healthy fertility • Arrange short orientation sessions for informal sector providers, i.e. Village doctors, and focus on harmful behaviors and/or misinformation (i.e. cycle method...)

	the field and officer level in their FP wing	<ul style="list-style-type: none"> • Encourage health care workers to discuss FP methods with women during antenatal, postnatal and well-baby visits.
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IV.2. Ideal family size

Considerable effort has been put into promoting smaller families over the past few decades in Bangladesh. Although Sylhet is a “traditional” area, which is generally associated with a preference for larger families, few informants said that they wanted more than four children. One-fourth of women surveyed said that they wanted only 2 children, and 45% said that they wanted 3-4 children.

Table 11. Total number of children desired by recently delivered women.

Data collection method: Household survey

Population (n): Recently delivered women (n=1612)

Timing of data collection: March-June 2006

Number of Children	Frequency	Percentage	Cumulative
1	9	0.56%	0.56%
2	408	25.31%	25.87%
3	319	19.79%	45.66%
4	396	24.57%	70.22%
5	61	3.78%	74.01%
6 or More	33	2.03%	76.04%
Other	386	23.96%	100.00%
Total	1612	100.00%	100.00%

IV.3. Birth spacing ideals

“I think a delay in having a baby is good. Health will remain good, and there will be less *bhejal* (troubles, impurities) in the *shongshar* (household). If there is close childbirth, you cannot take care of the babies well. You cannot decide who to take care of, the one you have already or the one who was just born.” (RDW)

Most women said that they would prefer a gap of at least three years between births. Nearly 80% of the recently delivered women surveyed reported that the ideal length of time between births is 3 or more years (Table 12).

Table 12. Ideal length of time to wait between births, according to recently delivered women

Data collection method: Household survey

Population (n): Recently delivered women (n=1612)

Timing of data collection: March-June 2006

Answer	Frequency	Percent	Cumulative
1 Year or Less	15	0.93%	0.93%
2 Years	288	17.87%	18.80%
3 Years	630	39.08%	57.88%
4 Years or More	639	39.64%	97.52%
Not Sure	40	2.48%	100.00%
Total	1,612	100.00%	100.00%

IV.4. Birth spacing practices

Birth spacing practices can be expected to relate to a number of factors, including perceived risks and benefits associated with the timing of childbirth, communication with the family and knowledge of and access to contraceptive methods. These topics will be explored further in later sections. However, first it is useful to describe the typical pattern of childbearing with the communities.

After the first birth, women have no immediate plan to delay the next pregnancy. Often they notice after a few months of missing their period that they are pregnant again. As the number of children in the family increases, women's demand for methods or willingness to use methods increases. Likewise, it seems that family resistance to contraceptive use decreases as a greater number of children have been born. Only a few families that had many children resisted the idea of using family planning. Those that did usually did so for religious reasons.

Conversely, only a few families interviewed that had either no children or few children had families that supported contraceptive use for birth spacing. Those that did were usually of higher economic and educational status. On the other hand, if a neonatal death or stillbirth occurs, there's a tendency to want a replacement child soon, particularly if the couple has few living children. In other words, the demand for contraception in this setting seems to come more from a desire for birth limiting than for a desire for birth spacing.

Despite a stated preference for birth spacing of 2-3 years, birth intervals of this length occur mostly by chance. Nearly 75% of recently delivered women surveyed (who were not sterilized) were not using any method to prevent another pregnancy.

Wives, husbands and mothers-in-law have all said that pregnancy can occur anytime after the 40 days (*chollish din*) of "postpartum pollution" ends. In practice, though, they do not start or resume contraception until after the woman's menstrual cycle resumes.

"My husband also wanted to delay, but after the birth we did not care to use contraceptive methods. We were thinking that after menstruation begins, we will follow the rhythm method, but I didn't see menstruation. Within this time, I became pregnant again. My second child arrived one year after the first birth." (RDW)

There is not a consistent estimation of when a woman is once again fertile after giving birth. At the community level, we found no awareness of the relationship between breastfeeding the return of fertility after childbirth. Only the government health workers expressed knowledge of the Lactational Amenorrhea Method (LAM).

Shorter intervals, such as birth intervals of less than 18 months usually resulted from a lack of birth spacing intentions, but sometimes they were associated with method discontinuation or failure. For both short and long intervals, often couples have not planned the birth of their next child and these intervals were attributed either to chance or to the will of God.

"It is in Allah's hands when baby will be born. I don't have the capability to determine when it will happen." (RDW)

The overall pattern of birth spacing demonstrates that there is little to no active consideration to use contraceptives for the purpose of increasing a birth interval, nor are couples fully aware of the natural benefits of exclusive breastfeeding as a method for delaying the resumption of menses and thereby increasing the birth interval without modern contraceptive use.

IV.5. Perceived risks and benefits of birth spacing

“I had a daughter, then I prayed to Allah, ‘Oh God, give me the next child after a little while, maybe two to three years.’ I prayed because I want to take care of first child perfectly. If I got the next child earlier, then I couldn’t take care of the new baby very well. That is why I want to delay. There is no other reason.” (RDW)

Female participants (mothers and mothers-in-law) in the free-listing exercise were able to list several risks associated with closely spaced births. They named numerous risks to the physical health of both the mother and child. The risks to the mother included that the mother will “remain weak”, “broken down”, and “always suffering disease”. (See Appendix B for complete list of responses given during the free-listing exercises). In addition, they mentioned the increase in probability of death during delivery. Also, a lack of energy and weakness arising as a result of closely spaced births.

The perceived risks to the baby that the participants associated with closely spaced births included an increase in disease prevalence and incidence, “like diarrhea,” as demonstrated by comments such as “illness always keeps touch with the baby,” and “most of the time baby suffering from many kinds of disease.” They also mentioned a possible increase in probability of infant mortality, that the baby won’t receive an adequate amount of breast-milk, the baby will display weakness, a lack of energy, thinness (*rak-shukne*), the onset of *lang-lang* (flaccid stature, inability to stand), loss of blood and anemia.

In addition to the physical consequences of closely spaced births, there were also household and economic costs associated with lack of birth spacing. These included such risks as requiring more money to support child, the inability to save money, the increased difficulty in caring for the child, the lack of child-care, the difficulty to provide clothes, food, education and adequate medical care, the father must work more, the mother can’t work, there are too many hassles, household is “peaceless,” and an increase in *jamela* or trouble.

“The five years gap between two children is good, because it’s good for mother’s health, and it also allows the husband to save money. There is no problem to have a child after a delay. If the gap is big between two children, then the first child can get big easily and not make trouble for the parents, and then the mother can give attention to second child. Parents can provide children good food, clothes and education, and can take care of the children as required.” (MIL)

Despite having some level of awareness of the host of risks associated with closely-spaced births, mothers also said that birth spacing was not a very serious issue for them. Having many children within short intervals is commonly viewed as normal in their communities; as a result, the women had not questioned it previously. Moreover, this is not considered to be an issue that is to be discussed within the family. When women talk about the desire for birth spacing, they use a word that has been translated as “I wish”, as opposed to “I want”, suggesting that either their desire is not that strong, or birth spacing is something that they do not yet have to ability to act upon. At the same time, they did reflect that birth spacing was increasingly becoming a norm in their society.

For mothers-in-law, the act of birth spacing was considered of secondary importance to providing children for the grandparents and not interfering with Allah’s plan. The grandparents were viewed as there to aid in the raising of the grandchildren.

“If there are babies born with small gaps, all the babies will grow up together. We are here to help raise the children, if the couple has children every year.” (MIL)

Some recently delivered women informants mentioned benefits associated with closely spaced births. A few of the major benefits mentioned include the fact that the mother and child’s health will remain good, the mother can take care of baby properly, and the possibility of the child getting sick will be reduced.

The husbands of recently delivered women were often conflicted with regard to the risks and benefits of birth spacing. They were less forthcoming with information than were the women. Many of the husbands interviewed consider birth spacing a matter for their wives. They expressed even less sense of urgency with regard to spacing or limiting births than their wives did.

“I’ll feed the child, so what’s your problem.” (Husband of RDW)

“My second daughter is two years old. The last daughter is 8 months, so the gap is 16 months. Now, this 16 month gap, whether this gap is small or big, or it’s good or bad, I don’t know. All this happened by the order of Allah.” (Husband of RDW)

However, there were some exceptions. Some men saw an economic interest in having births spaced farther apart, as this would allow for a smaller family size. In addition, having births spaced would decrease the “*jamela*” or trouble in the household. Some of the men interviewed were also aware of the physical toll that closely spaced births would have on the health of the mother.

“If there is large gap, then mother’s health will remain okay. But if there is frequent childbirth, the mother’s body will become weak.” (Husband of RDW)

“After delivering my first child, my husband said to me ‘Now, you take method, and don’t get pregnant again.’ My husband’s desire was to have another child after 2 or 3 years of first child. He said, ‘If we get the next child later on, then the previous child’s health will be good, and the mother’s health will also remain good. If we have a small number of children, then we can raise them in a better way.’” (RDW)

However, like with the women that were interviewed, this understanding did not seem to translate into a need for action.

IV.6. Communication about timing of childbirth within the family

As with the timing of the first birth, the timing of childbirth has implications for the whole family. Women are not free to make their decisions about contraception use independently, but must get permission from their husbands (or risk using methods clandestinely.) Generally speaking, the greater the length of marriage, the better a husband and wife communicate about family planning. In addition, smaller age difference between husband and wife also appears to have the effect of improving communication.

Husbands’ attitudes toward their own role in family planning varied widely. Husbands can be dominant and actively discourage use, or they may encourage women to use a method.

“My husband told me to take a method. “Your health is not good and as strong. If you take child very soon, your health will be broken down.” (RDW)

Other husbands said that they had given little thought to the timing or number of children and that they would have and considered it to a woman’s responsibility. Overall, 55% of women said that they thought their husband approved of contraceptive use. From the qualitative data, it seems that better communication and generally happier marriage leads to greater likelihood of contraceptive use. However, the quantitative data obtained from the household survey actually shows that an increase in spousal communication leads to an increase in the percentage of pregnancies that were unplanned or unwanted.

Table 13. Spousal communication regarding family planning and percentage of unplanned/unwanted pregnancies, according to recently delivered women whom are currently pregnant

Data collection method: Household survey

Population (n): Recently delivered women whom are currently pregnant (n=178)

Timing of data collection: March-June 2006

How often couple has communicated regarding family planning in the past year	Total number of pregnant women	Total number of unplanned/unwanted pregnancies	Percentage of unplanned/unwanted pregnancies
Never	56	22	39.29%
Once or Twice	67	27	40.30%
More Often	55	30	54.55%
Total	178	79	44.38%

This inconsistency may be due to the difficulty in defining what exactly is meant by communication with regards to family planning issues.

Mothers-in-law may also exert influence in the use of family planning, but they may do indirectly. Conversation regarding family planning issues between mother-in-laws and their daughter-in-laws are very rare, as over 90% of those recently delivered women surveyed responded that they never discussed these issues. When asked to give their mother-in-law's attitude toward contraceptive use, 20% of women said their mother-in-law disapproved and 36% said they did not know.

“It’s a matter of shame. If they have *jal* (husband’s brother’s wife) or *nonod* (husband’s sister), they can discuss this with them. But we don’t discuss these sort of issues.” (MIL)

If they do discuss, however, it is much easier for them after the daughter-in-law has a few children. Some mother-in-laws interviewed, however, still hold contraceptive use as harmful, and as a sin, forbidden regardless of the number of children conceived.

“I told my daughter-in-law that these things are a matter of sin. If you stop childbirth, Allah will judge you negatively on the Day of Last Judgment. Moreover, if you use this, your body will become spoiled. You won’t be able to work. You’ll feel weak all the time. So, this is why I forbid her to use contraceptive methods.” (MIL)

“I forbid my daughter-in-law to use method, because Allah will send his *mal* (assets, good fortune) whenever he feels like. If he sends a baby, he will provide for it. This provision is not in anyone else’s hand, it’s all in Allah’s hand.” (MIL)

Communication between women, their husbands, and their mothers-in-law, or the lack thereof, significantly influences fertility practices. Improving the lines of communication between husbands and wives and between wives and their mothers-in-law regarding birth spacing may impact the adoption of health fertility practices such as modern contraceptive use and natural methods such as LAM.

IV.7. Sources of information about contraceptive methods

For women, information regarding contraceptive methods is obtained from a variety of sources, including family members, the wives of brothers and brothers-in-law, and local health care providers. Women who have already given birth often have a greater ability to move around in the community as opposed to newly married women, so they have greater access to information. As a result, in addition to communication channels such as friends, female family members and health care providers, they may also get information from media such as television and radio,

and by communication with other women in the community outside of their immediate social networks. However, like newly married women, recently delivered women said that side effects associated with modern contraceptive methods were common and could be severe. Side effects were often described as the primary reason for discontinuing a method, as will be discussed further in a later section.

Men in general have even more access to information regarding contraceptive methods. They obtain information from friends, neighbors, family members, village doctors, and pharmacists. However, some of the information that they receive is not consistent with the current biomedical understanding of fertility, for instance, in the case of the “safe days” or rhythm method of birth control, or in their understanding of the role of menses in the cycle of fertility.

“My husband asked me, ‘Do you have menstruation every month?’ and I said, ‘Yes’, and he said ‘Because you have menstruation every month, you don’t need to use any method.’” (RDW)

IV.8. Knowledge of contraceptive methods

The low reported usage of contraceptive methods cannot be attributed to a lack of knowledge that the methods exist. Knowledge of various modern contraceptive methods among recently delivered women is relatively widespread, with over 90% of surveyed women familiar with the pill or injectible method of contraception (Table 14). In addition, there is a fairly high recognition of condoms, IUDs and female sterilization procedures as contraceptive measures. Overall, 80% of women said that they approved of contraceptive use. However, results from the free-listing exercises indicate that women’s knowledge of methods is more for limiting the number of children than for birth spacing. Participants were asked to list approaches or methods for family planning and then asked to list approaches/methods for birth spacing. Contraceptive methods were more often mentioned as a method for limiting births, and family planning is associated with limiting births. Contraceptive methods were not mentioned as frequently as an approach to increase the space between births. This is especially evident for the pill, IUD, condoms and Norplant, where women listed them more frequently as family planning methods than for methods associated with birth spacing.

Men that were interviewed were generally knowledgeable about various contraceptive methods, especially injections, the pill, and condoms.

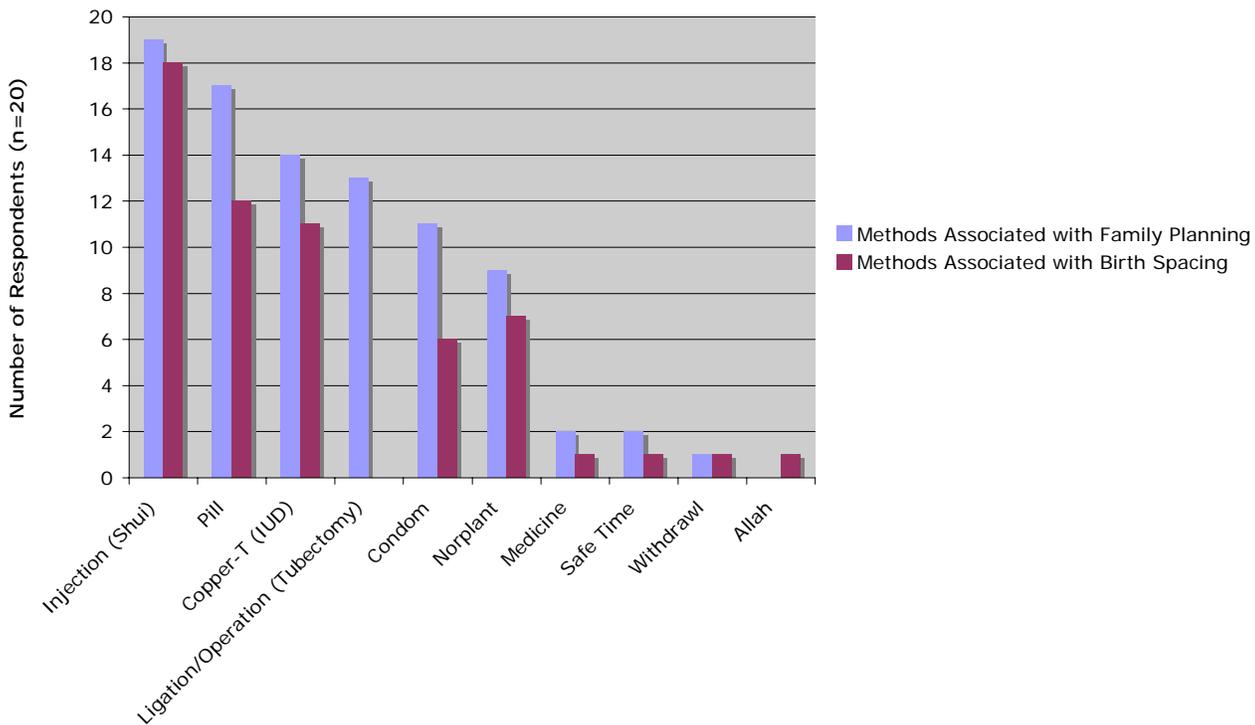
Table 14. Knowledge and use of contraceptive methods among recently delivered women

Data collection method: Household survey
 Population (n): Recently delivered women (n=1612)
 Timing of data collection: March-June 2006

Method	# RDW that have heard of method	% of RDW that have heard of method	# RDW that have used method	% of RDW that have used method
Female Sterilization	1,165	72.27%	22	1.36%
Male Sterilization	638	39.58%	3	0.19%
Pill	1,543	95.72%	377	23.39%
IUD	993	61.60%	37	2.30%

Method	# RDW that have heard of method	% of RDW that have heard of method	# RDW that have used method	% of RDW that have used method
Injectables	1,491	92.49%	204	12.66%
Implants	918	56.95%	19	1.18%
Condoms	1,004	62.28%	94	5.83%
LAM	412	25.56%	34	2.11%
Rhythm Method/Periodic Abstinence	525	32.57%	88	5.46%
Withdrawal	434	26.92%	82	5.09%
Emergency Contraception	122	7.57%	5	0.31%
Other	76	4.71%	6	0.37%

Methods Associated with Family Planning vs. Methods Associated with Birth Spacing - Recently Delivered Women



IV.9. Use of contraceptive methods

As stated previously, less than 30% of recently delivered women surveyed were currently using a contraceptive method to prevent another birth. Of those using contraceptive methods, nearly 43% are using the pill, and 21% were using injectables.

Table 15. Types of contraceptive methods currently being used among recently delivered women (allowed for more than one response)

Data collection method: Household survey
 Population (n): Recently delivered women (n=404)
 Timing of data collection: March-June 2006

Method	Frequency	Percentage
Female Sterilization	22	5.45%
Male Sterilization	3	0.74%
Pill	174	43.07%
IUD	13	3.22%
Injectables	85	21.04%
Implants	15	3.71%
Condoms	38	9.41%
LAM	10	2.48%
Rhythm Method/Periodic Abstinence	46	11.39%
Withdrawal	36	8.91%
Other	2	0.50%

“My village doctor (was actually a Projahnmo CHW) told me not to have more than two children. One daughter and one son is perfect. She also suggested that I use any one of the family planning methods. Also, my neighbor told me, ‘You should use a family planning method after first childbirth. Don’t take the next child too soon.’” (RDW)

IV.10. Barriers to contraceptive use for birth spacing purposes

There are several barriers to using contraceptives for birth spacing purposes, despite high awareness of both the benefits of birth spacing and the risks associated with closely spaced births, and knowledge of methods. Interpersonal factors such as a woman’s inability to negotiate condom use with husband or obtain permission from her mother-in-law, may contribute.

“We used condoms for two or three months, when we ran out of stock. I was busy with other family chores and affairs, and I forgot to get some more [condoms]. I used to go by myself to the FWC to get condoms. Even though we ran out of condoms, we continued having intercourse, and as a result, I became pregnant.” (RDW)

“My sister-in-law brought pills for herself, and also helped me [to get pills]. My sister-in-law’s sister’s husband bought pills for his wife. That sister used to send these pills to my sister-in-law via her son. From that, my sister-in-law gave me these pills.” (RDW)

Consistent access to family planning methods or inability to obtain contraceptives may also be a factor. Other perceived effects of using modern contraceptive methods, such as side effects of hormonal methods, and the potential of infertility were also mentioned by respondents.

IV.11. Reasons for discontinuation of contraceptive use

Among recently delivered women who had reported using contraceptives anytime after January 2003, the most common reason for discontinuation of use was perceived side effects of the methods and concern about the negative reactions to methods such as the pill or injectables.

“Injection harmed me. Period stops, menstruation stops, illness is always present. Fever, cold, stomach problem, stomach “biting”, diarrhea, bloating, lack of appetite.” (RDW)

Often these reactions would lead to inconsistent use, and women would become pregnant, another reason for discontinuation of use.

“After I had my first baby, I started menstruating after 18 months, and then I started using “Maya Bori” (the pill). I took one every day before I went to sleep. I continued like this for three months. Then I started feeling uneasy in my head. I was also not able to see things clearly with my eyes. Because of this, I would take it sometimes and not take it sometimes. I continued in this manner for the next three years, as which time, I got pregnant.” (RDW)

In addition, of those recently delivered women who were using contraceptive methods but stopped, the other major reasons for the cessation of use were due to the inconvenience of the method, disapproval of the husband, or the desire to become pregnant.

“Injection costs 20 taka. The lady doctors come to the “school” (satellite clinic) and say that this is not government, so we have to pay. If it was government, it would be good, because then poor people could afford it.” (RDW)

Table 16. Recently delivered women's reasons for discontinuation of contraceptive method: Use and discontinuation since January 2003, for each month

Data collection method: Household survey

Population (n): Recently delivered women that have used any contraceptive method since January 2003 (n=667)

Timing of data collection: March-June 2006

Reason	Number of Times Cited
Infrequent Sex/Husband Away	14
Became Pregnant While Using	42
Wanted to Become Pregnant	57
Husband/Partner Disapproved	21
Wanted More Effective Method	9
Health Concerns	3
Side Effects	119
Lack of Access/Too Far	4
Costs Too Much	2
Inconvenient To Use	53
Fatalistic	10
Difficult to Get Pregnant/Menopause	5
Marital Dissolution/Separation	0
Other	17
Don't Know	0

667 recently delivered women that have used a contraceptive method at some point over the past 3 years

8375 total person-months of contraceptive use

Table 17. Contraceptive use among multiparous couples: How often have you talked to your husband about family planning in the past year?

Data collection method: Household survey
 Population (n): Recently delivered women (n=1612)
 Timing of data collection: March-June 2006

Answer	Frequency	Percent	Cumulative
Never	540	33.50%	33.50%
Once or Twice	523	32.44%	65.94%
More Often	548	34.00%	99.94%
Unsure	1	0.06%	100.00%

IV.12. Reproductive health services

“A lady who worked in the Family Planning department came to me after I had my last baby and informed me about placing the “five stick” [Norplant] in my arm to prevent having another baby. Besides, she also informed me about taking *shui* (injection) or the pill. She told me I could take a pill every day before I go to sleep.” (RDW)

“The female doctors (*dacterni*) who used to come to the school for immunization, they said, ‘If you have no desire to have another child, you can have injection. We have these injections, so if you want you can get them from us. If you are not interested in getting injection, then you can tie your tubes (tubectomy) and stop having children. We provide this method also.’ So after that, I decided to get injection.” (RDW)

Government providers target couples that reached their desired family size, or have several children. This targeting usually focuses on long-term or permanent methods of birth control, such as IUDs, implants and sterilizations. Among the recently delivered women, only about 13% had a health workers talk with them about family planning methods in the past six months. Of this small percentage of women who had a health worker visit, 60% discussed the number of children to have and 60% discussed the importance of desired spacing between children. For those women who had a visit, the message about birth spacing is reportedly being disseminated through health workers, but the overall percentage of women who are receiving this message is small.

FWAs and FWVs (Family Welfare Assistants and Family Welfare Visitors) also generally target limiting, not birth spacing. They emphasize limiting the number of children, rather than attempting to increase the space between births. This may be a reason why there is a perceived link between methods and limiting as opposed to the concept of using methods to increase birth spacing.

A TBA that was interviewed stated that:

“I don’t advocate the use of any methods, so if somebody doesn’t want a child, then I advise the couple to sleep separately. This is better than using a method, because using a method will “block” the baby from being born (*atkaya thake*). The baby who is to come into this world cannot come due to the use of the method. The parents will be accountable to Allah for this.” (TBA)

IV.13. Consensus-building with opinion leaders

Islamic Religious Leaders

During the focus groups conducted with religious leaders, it was determined that family planning is not an idea consistent with local religious beliefs. As such, they would not agree to any intervention that proposed the idea of family planning, as they equate that with limiting the size of the family. However, promoting the idea of family welfare is an acceptable alternative, as the focus is on the care and well-being of the mother and the child already born. Framing the idea in this way would be acceptable to the local religious leaders.

The idea of birth spacing as a practice was also inconsistent with their understandings of the teachings of Islam. However, as a group, they did not feel comfortable enough to be able to speak for all Muslims, and they suggested that a higher Islamic body be consulted. Even so, they said they felt that birth spacing could prevent children from coming down from heaven, which they viewed as an affront to Allah. They also did not see the benefit in practicing birth spacing. One imam said that the families that do have health problems because they have 7 or 8 kids: the problem is not specifically that they have too many kids, the problem is that they haven't been faithful, that they haven't gone by all the rules and regulations as given in the Koran. One of the imams interviewed had 8 children, and he stated that all of his 8 children were healthy and doing well, and his wife was healthy as well. So there is a sense among many of the religious leaders that faith, and not birth spacing, is the factor that determines the health of the family.

They also had a desire to be consulted during the implementation of any intervention, as they felt the need to be informed. If the intervention was constructed with the knowledge, if not the tacit approval, of the religious leaders, they would not feel the need to cause any interference.

Government Officials

In meetings with the union council members from the study areas, they were adamant that things had changed over the last 20 years, and that contraceptive use, birth spacing and other healthy fertility practices had increased dramatically. This was due to primarily to both government actions, such as increasing the age of marriage to 18 and requiring all marriages to be registered, and the interventions of local NGOs, such as Shimantik. However, despite these improvements, they still recognized that there was much work to be done. For example, the member secretary of one union council stated that despite improvements in healthy fertility practices, 90% of newly married women will be pregnant within the first year of marriage. They were also very aware of the work of the Projahnmo project. For this reason, they expressed both a trust and a willingness to assist in any proposed intervention.

Village doctors

The focus groups conducted with village doctors (*gram daktar*) led to the discovery that their current understanding of the "safe period" method of contraception was inconsistent with current medical knowledge. As such, education of *gram daktar* about all current methods would be beneficial, especially in relation to information provided to husbands, as local medical providers have been listed as a main source of information regarding healthy fertility practices, including contraceptive methods. In addition, it was discovered that while *gram daktar* are not a common source of contraceptive methods provided to women, they are often consulted if there are complications during the pregnancy. They also perform abortions. These periods could provide a further opportunity for *gram daktar* to educate women about healthy fertility practices.

IV.14. Conclusions

The majority of Sylheti women prefer to have four or fewer children and an ideal birth space of 3 years. In addition, they have a high level of knowledge of contraceptive methods available and a relatively strong understanding of the risks, both for physical health and economic/household impact, associated with closely spaced births, as well as the benefits of practicing birth spacing. Despite this, most women do not actively plan their births and consistent

contraceptive use is extremely low. Most of the planning associated with contraceptive method use occurs when couples desire to limit the number of children in their growing family, but not to reduce the space between the births of their children. Additional factors such as side effects of methods, social and familial pressure, and religious reasons contribute to not using contraceptive methods.

Husbands, mother-in-laws, and members of a woman's social community also influence fertility decision-making. While aware of risk and benefits of birth spacing, mother-in-laws exert influence by pressuring a daughter-in-law to produce grandchildren for the sake of the continuing the growth of the family and often limiting her access to mass media and family planning services. Communication between a mother-in-law and the wife is often poor and limited to topics outside of the reproductive and fertility practices. Husbands often have a high level of knowledge and access to family planning methods, but consider birth spacing an issue for their wives to deal with, while also, contradictorily, not allowing her to make decisions about contraceptive use.

Religion plays a significant role in the decisions about using family planning methods. Islamic leaders in the community do not approve of any type of practices that decrease the family size, including both non- and traditional contraceptive methods and any type of practice that promotes birth spacing or limiting of family size. Despite this, however, the leaders are supportive of initiatives that may improve the health and well-being of mothers and newborns.

IV.15. Implications for intervention design

The issue of birth spacing is known among this population, but it is of low concern. It is similar to the level of awareness about neonatal mortality that preceded the Projahnmo intervention. Deaths during the neonatal period were given little concern at that time. Part of the intervention has been to increase the attention to this issue, to increase the value of the newborn's life.

Birth spacing ideals between mothers and mother-in-laws are relatively consistent with current public health recommendations (birth-to-pregnancy interval of at least 24 months for live births [33]), but couples rarely take action to put these ideals into practice. A key focus of any intervention should be to provide support and education to antenatal and postpartum women in obtaining and using both traditional (LAM) and modern methods of contraception in order to increase spaces between births.

Recommendations for interventions are as follows:

Linkage to Newborn Care Interventions: Information regarding healthy fertility practices, including education and counseling on birth spacing, should be integrated into current antenatal and post-partum home visits. During the home visits, CHWs should incorporate the husband through couples counseling sessions so as to involve him in the health of the woman and child, and to improve communication between the husband and wife regarding fertility issues. In addition, a separate meeting with the husband's family, particularly the mother-in-law, should be conducted to provide information on the benefits of birth spacing and other healthy fertility practices. During the post-partum visits, the CHW will incorporate couple counseling meetings, focused directly on the health benefits of birth spacing, the health risks of a short interval to both the mother and the child, the health benefit of exclusive breast feeding, both in terms of newborn care and healthy fertility, and current information regarding various contraceptive methods.

Target: Appropriate family planning methods and messages to educate on birth spacing should be integrated with messages about maternal and newborn care and disseminated to all multiparous women and their husbands, including especially newlyweds, young, low parity women and engaged couples.

Messages: Currently family planning methods are often provided more for limiting the number of births as opposed to increasing the space between them. Messages should focus on the importance of using methods to increase the spacing between births to ensure the health of the mother and the newborn. In addition, messages need to be targeted based upon the age and parity of the mother. Messages designed for younger mothers with few children will primarily target LAM and short-term contraceptive methods (including IUDs and EC) designed to increase birth intervals and ensure the health of both the child and the mother. Older women with more children will be targeted with messages informing them of more long-term or permanent methods, focusing on overall health of the mother and the entire family.

Communication: Strategies should be developed to promote better communication within married couples about birth spacing plans. This will involve couple counseling during the post-partum visits, focusing on the health of the mother and child through birth spacing practices. CHWs providing antenatal and postpartum services are able to gain rapport with couples and will be more easily able to integrate family planning/birth spacing messages during these visits. In addition, it is important to involve and incorporate the husband's family in separate counseling sessions during the antenatal and post-partum visits, to ensure that the husband's family, in particular the mother-in-law, is given information regarding the benefits of healthy fertility practices, while simultaneously allowing her voice to be heard.

Information held by recently delivered women is often obtained through communication with other female family members, either their husband's sisters or their brother's wives. Formalizing this type of communication is important to relay current and medically correct understandings of birth spacing practices, contraceptive methods and potential side-effects. During the antenatal meetings, CHWs will, in effect, "teach the women to teach" other women about healthy fertility practices, creating diffusion of information throughout the household and, potentially, the greater community using social networks already in place. Given the difficulty in reaching some young married women living in their husband's family's household due to issues of seclusion, it is essential interventions are designed to maximize on existing women's social networks to disseminate important messages regarding healthy fertility practices.

Birth spacing and family planning methods: The Lactational Amenorrhea Method was not recognized by recently delivered women as a method for birth spacing. LAM was only recognized as such by government health workers. Because of its ability to be used as both a contraceptive method as well as a way to provide nutritional health benefits to the baby, promoting exclusive breast feeding should be a focus of the CHWs during home visits. This will require both antenatal visits to discuss exclusive breastfeeding as well as consistent bi-monthly visits by CHWs after the neonatal period to ensure continued and exclusive breastfeeding for the first six months, then supplemental breast feeding thereafter.

In conjunction with the promotion of exclusive breast feeding, there needs to be a focus on the provision of the progestin-only birth control pill, Minicon. This will allow the continuous breast feeding while providing security in extending the birth space period. In addition, information must be provided about the side-effects of various contraceptive methods along with the benefits of consistent use of various contraceptive methods must be disseminated to avoid sporadic use. Finally, it is important to incorporate information about fertility and post partum return to fertility so as to correct any misconceptions about the risk of infertility due to the use of contraceptives.

Private Sector: Some women described difficulty in obtaining contraceptives from a consistent and reliable source. As such, the private sector should be involved in providing contraceptives and information to multiparous women, especially the consistent provision of the progestin-only pill, Minicon.

Religious Leaders: Women, men and mothers-in-law all cite religion as a reason not to use contraceptives. In addition, religious leaders interviewed didn't believe in using family planning to limit family size. However, messages can be framed based on the idea of family welfare as an alternative, with a focus on care and wellbeing for the mother and newborn. Religious leaders, who are extremely influential in this community, are far more likely to

support the implementation of an intervention that incorporates healthy fertility messages with newborn care interventions. Thus, an intervention should work with religious leaders and mosques to disseminate important information about healthy fertility practices, being mindful of appropriate terminology as it relates to the teachings of Islam, as it relates to the health of the mother and newborn.

V. Results: Coverage and Quality of Health Services

As stated previously, the issues regarding availability of health services and quality of care are complex and multifaceted, affecting both health outcomes and the individual perceptions of prospective clients, thereby influencing patterns of care-seeking behavior related to family planning. Improved quality of care in both antenatal and family planning programs is intended to empower individuals to make choices consistent with their own reproductive intentions, which should provide for greater contraceptive adoption and continuation rates, while prompting women to act on their intentions to seek services in areas where there is a lack of health services. Efforts to increase demand for postpartum contraceptive use must be paired with efforts to improve the quality of both antenatal care and family planning services, including both counseling and service provision.

V.1. Observation of Family Planning Service Providers

Based on observations with family planning service providers, clients were treated with kindness and respect during the visit. However, there was often a failure to address the physical well-being of the patient, as well as a failure to explain the procedures that were to be done. Just over 53% of the family planning providers asked the patient how they were feeling, and 65% of the providers explained what they were going to do. In addition, during less than half (44%) of the visits did the provider ask about or determine if there were side effects from the current method being used. In the majority of cases (78%), if the patient did complain of side effects, the provider offered suggestions on how to alleviate the problem. However, in only 39% of the cases did the provider suggest a switch to a different method, in 26% of the cases did the provider offer medical treatment, and there were no cases of the provider referring the patient for treatment of the side effects.

During the family planning visits, 55% of the time either the client or the provider specified a preference for a particular contraceptive method. Of the preferred methods, injectables were mentioned as preferred by nearly 47% of either the providers or the clients (see Table 18).

Table 18. Preferred contraceptive method of family planning provider or client

Data collection method: Structured observation

Population (n): Women visiting clinic (n=32)

Timing of data collection: March-June 2006

Method	Frequency	Percent	Cumulative
Combined Pill	7	21.88%	21.88%
Progestin-Only Pill	0	0.00%	21.88%
IUD	5	15.62%	37.50%
Injectable	15	46.88%	84.38%
Norplant	0	0.00%	84.38%
Condom	1	3.12%	87.50%
Female Sterilization	0	0.00%	87.50%
Vasectomy	4	12.50%	100.00%
Natural Family Planning	0	0.00%	100.00%
Exclusive Breastfeeding (LAM)	0	0.00%	100.00%
Other	0	0.00%	100.00%

None	0	0.00%	100.00%
Total	32	100.00%	100.00%

It was observed during the family planning sessions that alternatives to provider or client preferred contraceptive methods were offered in less than half of the sessions. During the consultation, 59% of the family planning providers observed did not suggest or mention any other alternative contraceptive methods beyond their stated preference. Of those that did offer alternatives, IUD was mentioned as an alternative in 58% of the consultations, while no other method was mentioned more than 25% of the time (see Table 19).

Table 19. Alternative contraceptive methods suggested by family planning provider

Data collection method: Structured observation

Population (n): Women visiting clinic (n=24)

Timing of data collection: March-June 2006

Method	Frequency	Percent
Combined Pill	6	25.00%
Progestin-Only Pill	1	4.17%
IUD	14	58.33%
Injectable	3	12.50%
Norplant	2	8.33%
Condom	3	12.50%
Female Sterilization	5	20.83%
Vasectomy	4	16.67%
Natural Family Planning	0	0.00%
Exclusive Breastfeeding (LAM)	2	8.33%
Other	0	0.00%
None	0	0.00%

There is a tendency for some family planning workers to stress some contraceptive methods over others. Of those providers that suggested other methods, 87% were found to overemphasize one method in particular. Of the methods overemphasized, IUD (23%), injections (10%) and the combined pill (estrogen and progestin; 5%) were found to be the methods most often overemphasized.

In the end, the client accepted a method nearly 90% of the time, with injection, the combined pill and IUD accounting for over 92% of the methods chosen.

Table 20. Preferred contraceptive method of family planning provider or client

Data collection method: Structured observation

Population (n): Women choosing contraceptive method (n=52)

Timing of data collection: March-June 2006

Method	Frequency	Percent	Cumulative
Combined Pill	12	23.08%	23.08%
Progestin-Only Pill	0	0.00%	23.08%
IUD	4	7.69%	30.77%
Injectable	32	61.54%	92.31%
Norplant	0	0.00%	92.31%
Condom	1	1.92%	94.23%
Female Sterilization	0	0.00%	94.23%
Vasectomy	2	3.85%	98.08%
Natural Family Planning	0	0.00%	98.08%
Exclusive Breastfeeding (LAM)	0	0.00%	98.08%
Other	1	1.92%	100.00%
None	0	0.00%	100.00%
Total	52	100.00%	100.00%

V.2. Observation of Antenatal Care Service Providers

Similar to the observations conducted with family planning service providers, the antenatal care providers were courteous and respectful to their patients, with observations of proper greeting and a correct general health assessment occurring between 75% and 100% of the time. However, with regards to assessing prior obstetric history, prior contraceptive use, and/or current pregnancy status, observations of these interactions fall to levels at or below 50%. This includes asking a woman about her “age” (43%); “obstetric history” (52%); “whether she has any fetal movements” (44%); “immunizations, especially tetanus toxoid” (48%); and “prior contraceptive use”, which occurred only 5% of the time during the antenatal check-up.

With regard to care provision and birth planning, basic information on nutrition (82%) and rest (59%) were given during the visit. In addition, iron and folic acid were provided during 67% of the antenatal care observations. In contrast, only 5% of the clients were provided tetanus toxoid immunizations, and only 10% of the women received counseling on breastfeeding.

V.3. Facility Audit

Thirty-two health facilities in the study area were audited, 21 government family planning clinics, 7 government health clinics, and 4 NGO-based facilities. Six of the seven government health clinics, and all four of the NGO clinics were open six days a week, while twelve of the twenty-one government family planning facilities were open five days or more. Of the facilities audited, 28 of the 32 provided family planning services, with the 4 not providing these services being government health clinics.

As with many of the health services in Sylhet, the family planning methods that did not require any surgery or specific training were available at all of the clinics that offered family planning services, including pills, condoms, IUDs and injectables. However, services that required training and/or surgical skill were less frequently available, including menstrual regulation (13 out of 28 clinics); Norplant (4 out of 28 clinics); vasectomy and tubectomy (3 out of 28 clinics).

V.4. Conclusions and Recommendations

- Through observations and audits, there appears to be a lack of information and guidance regarding alternative contraceptive methods, lack of side-effect counseling, lack of linkage between antenatal care and family planning, and a lack of knowledge regarding the benefits of Lactational Amenorrhea Method (LAM). In order to achieve a greater community understanding and acceptance of healthy fertility practices, there needs to be an incorporation of healthy fertility messages into antenatal and postnatal care; a training for the providers to give information on all methods, both short and long term, along with potential side-effects and ways to combat them; and a campaign to increase the awareness and benefits to exclusive breastfeeding both for the newborn and as a natural contraceptive method.

VI. Overall Observations and Recommendations

VI.1. Timing of marriage and first birth

Observations

- 1) Over half (53%) of the newly married women (NMW) surveyed were under the age of 18 when married. However, mixed perceptions of age at marriage exist in the community, with union council members reporting 80-90% of women marrying at 18+ and an upazila health official reporting only ~40%.
- 2) Financial constraints (larger dowries for older brides) contribute to arranging adolescent marriages.
- 3) Most marriages are arranged by parents and young couples' preferences are not factored in, though most NMW expressed 20 as ideal age for marriage.
- 4) Most first pregnancies occur immediately after marriage: 40% NMW were pregnant at the time of the survey. Nearly 90% of NMW currently pregnant became so within the first six months of marriage, 70% within the first three months of marriage.
- 5) Among NMW not already pregnant who were married under the age of 18, 52% wanted a child immediately, whereas 41% wished to wait at least one year.
- 6) Influential factors included fear of infertility, stigma, pressure from the husband and his family, ensuring a role in the husband's household, and migration of the husband.

Recommendations

- 1) Promote messages in the community about the continued prevalence of adolescent marriage and the negative health consequences of adolescent marriage and consequent childbirth.
- 2) Continue to monitor age at first marriage and timing of first birth after marriage.
- 3) Since pregnancies often occur immediately after marriage, interventions should target newly married couples and their families, especially since the decision to delay childbirth is not only an individual-level or couple-level decision.
- 4) Women under the age of 18 who are engaged to be married should also be targeted, along with the future husband and in-laws.
- 5) Risks for both the mother and newborn should be emphasized and public health messages should stress the benefits of waiting at least one year before pregnancy.

VI.2. Perceived risks and benefits of delaying first pregnancy

Observations

- 1) Men, women and mothers-in-law stated the ideal age of marriage and first child is 18-20 years.
- 2) Both men and women's perceived risks of adolescent childbearing for the mother focused on morbidity and stress for the body, but not mortality. However, there was not a high level of concern for the effects of adolescent childbearing.
- 3) Village doctors and TBAs listed physical risks to the mother such as obstetric emergencies and increased need for facility-based birth, but said that delaying first child had no impact on the child.
- 4) Benefits mentioned for delaying first birth included were economical: saving money in order to provide for the care of the child.
- 5) Some women mentioned hearing public health messages about benefits of delayed childbirth through the media.

Recommendations

- 1) Messages about the seriousness of the risk of death for both mother and newborn should be communicated, as well as other potential negative health consequences, particularly for the newborn.
- 2) Village doctors, TBAs and other health providers should be trained in how to deliver messages about consequences of early initiation of childbirth and ways to counsel couples in delaying first birth.
- 3) Mass media should be considered for behavior change communication since some women already reported hearing messages about delaying childbirth, increasing their knowledge.
- 4) Economic benefits of delaying childbirth should also be included in key messages.

VI.3. Birth spacing Ideals and practices

Observations

- 1) The desired number of children ranges from 2 to 4 for most women. One-fourth of RDW said that they wanted only 2 children, and 45% said that they wanted 3-4 children.
- 2) Women expressed a preference for a birth space of at least three years: nearly 80% of RDW reported that the ideal length of time between births is 3 or more years.
- 3) Women take no immediate action to delay pregnancy after giving birth, and often find themselves pregnant again after missing their period for a few months. Nearly 75% of non-sterilized RDW reported no current use to prevent pregnancy. The spacing of pregnancies is typically attributed either to chance or to the will of God.
- 4) If a neonatal death or stillbirth occurs, there is pressure for a replacement child, especially for couples with few or no children.
- 5) Wives, husbands and mothers-in-law have all said that pregnancy can occur anytime after the 40 days period of postpartum confinement after the woman's menstrual cycle resumes, but only the government health workers expressed knowledge of LAM.

Recommendations

- 1) Women need to be targeted immediately postpartum in order to promote using LAM or other family planning messages before waiting for the return of menses.
- 2) CHWs or other health providers should counsel women in method mix and various family planning options to achieve the desired birth spacing.
- 3) Messages about birth spacing need to include spacing after abortion or miscarriage, since pressure is strong for women to conceive soon after these events occur.
- 4) Village doctors and health providers should receive training in promoting LAM.

VI.4. Perceived risks and benefits of birth spacing

Observations

- 1) Having closely spaced births is a norm in the community and rarely discussed.
- 2) Both men and women perceived risks to the mother and child for closely spaced births, including weakness, illness, and increased probability of death during delivery.
- 3) Perceived risks to the baby included increase in disease prevalence and incidence, possible increase in probability of infant mortality.
- 4) Household troubles and economic costs to the family (difficulty in providing necessities) were risks of closely spaced births, cited by both men and women.
- 5) RDW mentioned benefits of closely spaced births having to do with caring for the baby and reduced incidence of sickness.

Recommendations

- 1) Birth spacing messages should be integrated with existing newborn care interventions in the community.
- 2) Negative consequences of closely spaced births for both the mother and child need to be communicated to women and their families, ideally through household antenatal and postnatal visits.
- 3) Misconceptions regarding “benefits” of closely spaced births need to be addressed through interventions targeting mothers.

VI.5. Contraceptive use

Observations

- 1) There is high level of knowledge of contraceptive use, but low level of ever-usage (both NMW and RDW). Only 5% of NMW reported current use and less than 30% of RDW reported current use. There is lower level of knowledge and use for NMW under 18, and more non-modern methods.
- 2) Among contraceptive methods, there is greatest knowledge and use of condoms, pills, injection and withdrawal. Of RDW using methods, 43% using the pill, 21% using injectables.
- 3) Factors contributing to non-use of contraceptives included disagreement between husband and wife about timing for first birth and opposition of the mother-in-law to using family planning measures.
- 4) Overall, 80% of RDW women said that they approved of contraceptive use.
- 5) Barriers to use included inconsistent access to family planning methods, misinformation about/fear of side effects (especially) hormonal methods and copper T, and the potential of infertility. Some health workers mentioned danger of hormonal methods for newly married couples.
- 6) Discontinuation of methods due to perceived side effects, inconvenience of the method, disapproval of the husband, or the desire to become pregnant, and access.
- 7) Common misconception among both men and women was that the most likely time to conceive was the first few days after the menstrual cycle ends.
- 6) Demand for contraception in this setting seems to come more from a desire for birth limiting than for a desire for birth spacing: Women’s demand and willingness to use methods increases as they have more children. Family resistance also declines.
- 7) Women who supported contraceptive use for birth spacing were usually of higher economic and educational status.

Recommendations

- 1) Contraceptive method messages need to be targeted based upon the age and parity of the mother. Messages designed for younger mothers with few children will primarily target LAM and short-term contraceptive methods (including IUDs and EC). Older women with more children should be targeted with messages informing them of more long-term or permanent methods.
- 2) Messages should focus on the importance of using methods to increase the spacing between births to ensure the health of the mother and the newborn.
- 3) Because of its ability to be used as both a contraceptive method as well as a way to provide nutritional health benefits to the baby, promoting exclusive breast feeding and LAM should be a focus of the CHWs during home visits.
- 4) In conjunction with the promotion of exclusive breast feeding, there needs to be a focus on the provision of the progestin-only birth control pill, Minicon. This will allow the continuous breast feeding while providing security in extending the birth space period.
- 5) Information must be provided about the side-effects of various contraceptive methods along with the benefits of consistent use of various contraceptive methods must be disseminated to avoid sporadic use.

VI.6. Sources of Information about contraception

Observations

- 1) Women obtained information primarily from social networks outside the health care sector: friends, neighbors and the wives of brothers and brother-in-laws. Secondary sources of information include radio, television, their natal kin and government health worker, although these sources were not as available to adolescent wives.
- 2) After marriage, women have limited access to information because of living in husband's house. They were secluded and isolated and not able to make independent decisions (leaving the house, purchasing items, etc).
- 3) Few women said they discussed family planning matters with their mother-in-law because they had not established a close relationship, and if health care providers come to the home, family members often discourage them from discussing matters with newly married women.
- 4) Multiparous women have a greater ability to move around in the community and greater access to information. They may also get information from media such as television and radio, and by communication with other women in the community outside of their immediate social networks.
- 5) Men's sources of information included friends, neighbors, family members, village doctors, and pharmacists. Other mentioned information due to migration to other countries. Like women, some of men's knowledge was at odds with current biomedical knowledge.

Recommendations

- 1) Community health workers should include newly married adolescent women identified during bi-monthly home visits and invite them to a meeting/information session at a local health clinic or office. During this meeting, general discussions about the future health of the mother, the newborn and the family would be the focus.
- 2) The husband's family, particularly the mother-in-law, should be involved in a separate counseling session or meeting.
- 3) Soon-be-married men could also be targeted separately, using male health informants (MHIs). Since the husband is the primary decision-maker, it is essential that he receive information about contraceptive methods and risks of early childbirth.
- 4) It is important to incorporate information about fertility and post partum return to fertility so as to correct any misconceptions about the risk of infertility due to the use of contraceptives.
- 5) Current social networks (females within the home) should be utilized for disseminating information about contraception (more on this below).

VI.7. Communication

Observations

- 1) Nearly 40% of NMW did not discuss family planning with their husband at all, and another 40% only discussed once or twice in the past year. Over 90% of RDW said that they never discussed these issues.
- 2) Husband's opinion takes priority in decisions regarding family planning. He often initiates any method use, or actively discourages or encourages the woman to use contraception.
- 3) Communication between newly married women and mother's-in-law about family planning is very rare, only occurring in about 5% of the families surveyed. Some mother-in-laws discuss methods if the woman has children, but many regard it as a sin/against religious values.
- 4) The greater the length of marriage, the more a husband and wife were reported to communicate about family planning. In addition, smaller age difference between husband and wife also appears to have the effect of improving communication.
- 5) 55% of RDW said that they thought their husband approved of contraceptive use.

Recommendations

- 1) Strategies should be developed to promote better communication within married couples about birth spacing plans. This will involve couple counseling during the post-partum visits, focusing on the health of the mother and child through birth spacing practices.
- 2) CHWs providing antenatal and postpartum services are able to gain rapport with couples and will be more easily able to integrate family planning/birth spacing messages during these visits.
- 3) Separate counseling sessions with the husband's family during the antenatal and post-partum visits may be helpful for promotion of healthy fertility practices.
- 4) Formalizing communication between female family members is important way to relay current and medically correct understandings of birth spacing practices, contraceptive methods and potential side-effects. During the antenatal meetings, CHWs should "teach the women to teach" other women about healthy fertility practices, creating diffusion of information throughout the household and, potentially, the greater community using social networks already in place.

VI.8. Reproductive health services

Observations

- 1) Providers discourage contraceptive use by newly married couples before their first child, saying that it's a risk to the mother's future fertility.
- 2) Government family planning providers target couples that reached their desired family size, or have several children, rarely NMW. Only about 10% of NMW said that a health care worker had come to their house to visit them since their marriage, and another 9% had gone to a health facility. Only 6% said a health worker had spoken with them about family planning. Even then, only about 13% of RDW had a health worker talk with them about family planning methods in the past six months.
- 3) Among women who had a health worker visit, roughly half of them reported that the health worker discussed delaying the first pregnancy, and again half report having received information on the importance of birth spacing.
- 4) FWAs and FWVs (Family Welfare Assistants and Family Welfare Visitors) also generally target limiting, not birth spacing.
- 5) Local doctors' current understanding of the "safe period" method of contraception was inconsistent with current medical knowledge.

Recommendations

- 1) Information regarding healthy fertility practices, including education and counseling on birth spacing, should be integrated into current antenatal and post-partum home visits.
- 2) The private sector should be involved in providing contraceptives and information to multiparous women, especially the consistent provision of the progestin-only pill, Minicon.
- 3) Programs should arrange short orientation sessions for informal sector providers, i.e. Village doctors, and focus on harmful behaviors and/or misinformation (i.e. cycle method...)
- 4) Education of *gram daktar* about all current methods would be beneficial, especially in relation to information provided to husbands, and side effects. Since they perform abortion, they are good contacts to provide counseling and messages about contraception.

VI.9. Opinion leaders

Observations

- 1) Family planning and birth spacing are perceived to be both not consistent with local Muslim beliefs, and Islamic leaders would not agree to an intervention that proposed the idea of limiting family size and did not see the benefit in practicing birth spacing.
- 2) Promoting the idea of family welfare is an acceptable alternative for the Islamic community.
- 3) The consensus among many of the religious leaders that faith, and not birth spacing, is the factor that determines the health of the family.
- 4) Local government recognizes need for more work to be done, and are aware and supportive of the Projahnmo project. Expressed a willingness to be involved in new interventions.

Recommendations

- 1) Framing the idea as family welfare would be acceptable to the local religious leaders.
- 2) There is potential need to consult a higher Islamic body about birth spacing.
- 3) An intervention should work with religious leaders and mosques to disseminate important information about healthy fertility practices, being mindful of appropriate terminology as it relates to the teachings of Islam, as it relates to the health of the mother and newborn.
- 4) Local government contacts should be involved in intervention planning meetings.

VI.10. Coverage and Quality of Health Services

Family Planning Service Providers

Observations

- 1) Overall, clients attending family planning services were considered well treated and respected.
- 2) During family planning sessions, procedures were explained 65% of the time, and providers asked about a patient's physical well-being only 53% of the time.
- 3) Providers did not always ask about side effects (44% of observed visits) but if a client complained, during 78% of visits the provider would offer ideas to reduce side effects, and 39% of the time would offer another method.
- 4) Family planning providers often suggested only their stated preferred method to their clients, with 59% not mentioning any other alternative contraceptive methods.
- 5) IUD was the most common method mentioned for those who gave options beyond their stated preference, and IUD, injections, and the combined pill (estrogen and progestin) were found to be the methods most often emphasized by providers as alternatives.
- 6) Of those women who chose a contraceptive method, 23% chose the combined pill, and 62% chose injectables.

Recommendations

- 1) Trainings should be conducted with family planning providers to encourage them to inquire about a patient's physical reaction to their chosen contraceptive method during consultations, and to offer them several possible alternatives and explain the side effects.
- 2) Since IUDs are typically used for long-term contraception, alternative methods such as the progestin-only pill, LAM and condoms should be promoted, especially as short-term methods for women wishing to space births or delay first birth.
- 3) Provide health care workers with the most current understanding of contraception and healthy fertility

Antenatal Care Service Providers

Observations

- 1) Clients were given a correct general health assessment occurring between 75% and 100% of the time.
- 2) Assessment of prior obstetric history, prior contraceptive use, and/or current pregnancy status, fell at levels at or below 50%, with prior contraceptive use questions happening in only 5% of check-ups.
- 3) Basic information on nutrition (82%) and rest (59%) were given during the visit, and iron and folic acid were provided during 67% of the antenatal care observations.
- 4) Only 5% of the clients were provided tetanus toxoid immunizations, and only 10% of the women received counseling on breastfeeding.

Recommendations

- 1) Effort should be made to encourage providers to keep records of prior obstetric history, prior contraceptive use, and/or current pregnancy status in order to correctly counsel their clients on a suitable contraceptive method.
- 2) Since we aim to promote LAM as a contraceptive method option, effort should be made to encourage counseling on breastfeeding in both private and public sectors.
- 3) Encourage health care workers to discuss FP methods with women during antenatal, postnatal and well-baby visits.

Facilities

Observations

- 1) Most government and NGO health clinics were open six days a week, and almost half of government family planning facilities were open five days or more.
- 2) The majority of facilities (28 of the 32) provided family planning services. The 4 that did not were government health clinics.
- 3) Family planning methods that did not require any surgery or specific training were available at all of the clinics that offered family planning services, including pills, condoms, IUDs and injectibles.
- 4) Services that required training and/or surgical skill were less frequently available, including menstrual regulation (13 out of 28 clinics); Norplant (4 out of 28 clinics); vasectomy and tubectomy (3 out of 28 clinics).

Recommendations

- 1) Capacity building should be a component of an intervention in order to increase the government health clinics' abilities to offer family planning services at all locations.
- 2) Prior to roll out of any intervention, it should be confirmed that all methods promoted by CHWs and other health providers are available at clinics (especially the progestin-only pill and other short-term methods).

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VIII. APPENDICES

VIII.1. APPENDIX A : METHODS

Method 1: Unstructured in-depth interviews with mothers, fathers and mothers-in-law

Each set of 10 women will be selected purposively to have representation from

High SES families with relatives in the United Kingdom or North America (2 women in each group),

Middle SES families without relatives abroad (3 women in each group),

Low SES families of fishermen and farmers (3 women in each group), and

Very low SES families who had migrated into the area from central Bangladesh (2 women in each group).

Method 01: In-depth interview

Type of Respondent	SES classification	Number of Interview	Proposed time for each interview	Interviewer	Quantity of questionnaire
1.1. Mothers of children 6-23 mo. old with births spaced greater than 36 months	High -02 Middle -03 Low -03 Very low -02	10 BB-5 ZK-5	1 - 1.25 hours.	03	05 pages Font -10
1.3. Mothers-in-law of these mothers	High -02 Middle -03 Low -03 Very low -02	10 BB-5 ZK-5	1 - 1.25 hours.	03	03 pages Font -10
1.4. Mothers of children 6-23 mo. old with births spaced less than 18 months	High -02 Middle -03 Low -03 Very low -02	10 BB-5 ZK-5	1 - 1.25 hours.	03	05 pages Font -10
1.6. Mothers-in-law of these mothers	High -02 Middle -03 Low -03 Very low -02	10 BB-5 ZK-5	1 - 1.25 hours.	03	03 pages Font -10
1.7. Newly married women (Married on or after January 2005)	High -02 Middle -03 Low -03 Very low -02	10 BB-5 ZK-5	1 - 1.25 hours.	03	03 pages Font -10
1.2. Husbands of mothers of children 6-23 mo. old with births spaced greater than 36 months	High -02 Middle -03 Low -03 Very low -02	10 BB-5 ZK-5	1 - 1.25 hours.	02	03 pages Font -10
1.5. Husbands of mothers of children 6-23 mo. old with births spaced less than 18 months	High -02 Middle -03 Low -03 Very low -02	10 BB-5 ZK-5	1 - 1.25 hours.	02	03 pages Font -10

1.8. Husbands of newly married women (Married on or after January 2005)	High -02 Middle -03 Low -03 Very low -02	10 BB-5 ZK-5	1 - 1.25 hours	02	2.5 pages Font -10
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Method 2: Semi-structured interviews with mothers and mothers-in-law

Each set of 10 women will be selected purposively to have representation from

Solvent SES families (5 women in each group),

Low SES families (5 women in each group),

Method 02: Semi-structured interview (free listing)

Type of Respondent	SES classification	Number of Interviewed	Proposed time for each interview	Type of questionnaire
2.1. Mothers of children 6-23 mo. old with births spaced greater than 36 months	Solvent- 05 Low -05	10 Free listing. BB-5 ZK-5	1 - 1.25 hours.	Free listing
2.2. Mothers-in-law of these women	Solvent- 05 Low -05	10 Free listing. BB-5 ZK-5	1 - 1.25 hours.	Free listing
2.3. Mothers of children 6-23 mo. old with births spaced less than 18 months	Solvent- 05 Low -05	10 Free listing. BB-5 ZK-5	1 - 1.25 hours.	Free listing
2.4. Mothers-in-law of these women	Solvent- 05 Low -05	10 Free listing. BB-5 ZK-5	1 - 1.25 hours.	Free listing

Method 03: Mapping exercise / Focus group discussion

Type of Respondent	SES classification	Number of Interviewed	Proposed time for each interview	Quantity of guideline
3.1. Mothers of 15-29 years age with children of at least 36 months of age	Not mentioned	02 groups of 10 BB-1 ZK-1	1 group meeting: 1 - 1.5 hours	6 issues discussed
3.2. Newly married women	Not mentioned	1 group of 10 ZK-1	1 group meeting: 1 - 1.5 hours	6 issues discussed

Method 4: Semi-structured interviews with health care providers

Type of Respondent	SES classification	Number of Interview	Proposed time for each interview	Quantity of questionnaire
4.01. Drug seller	No classification	02 BB-1 ZK-1	1 interview 1 to 1.25 hours	2.5
4.02 Family Welfare Assistants	No classification	03 BB-2 ZK-1	1 interview 1 to 1.25 hours	2
4.03. Family Welfare Visitors	No classification	03 BB-1 ZK-2	1 interview 1 to 1.25 hours	2
4.04. Paramedics in first-level facilities (SACMO)	No classification	03 BB-1 ZK-2	1 interview 1 to 1.25 hours	2
4.05. Senior managers from office of the civil surgeon	No classification	04 Sylhet-2 BB-1 ZK-1	1 interview 1 to 1.25 hours	2
4.06. Senior managers from the office of vDD family planning	No classification	02 Sylhet-1 BB-1	1 interview 1 to 1.25 hours	2
4.07. Homeopath	No classification	02 BB-1 ZK -1	1 interview 1 to 1.25 hours	2.5
4.08. Traditional healers: Mia-sab and kobiraj	No classification	02 BB-1 ZK -1	1 interview 1 to 1.25 hours	2.5
4.09. Unlicensed village doctors (gram daktar)	No classification	05 BB-2 ZK-3	1 interview 1 to 1.25 hours	2.5
4.10. Traditional birth attendants	No classification	05 BB-3 ZK-2	1 interview 1 to 1.25 hours	2.5

Method 5: Facility audit and observation of health facilities and care

Type of Respondent	SES classification	Number of audits/observations	Proposed time for each interview	Quantity of questionnaire
5.1. Government facilities	Not applicable	28	2 to 2.5 hours	15 pages
5.2. Private facilities	Not applicable	4	2 to 2.5 hours	15 pages

Method 6: Client exit interviews

Type of Respondent	SES classification	Proposed time for each interview	Quantity of questionnaire
6.1. Clients in government facilities	Not applicable	1 hour	7 pages
6.2. Clients in private facilities	Not applicable	1 hour	7 pages

Method 7: Household survey

Type of Respondent	SES classification	Number of Interviewed	Proposed time for each interview	Quantity of questionnaire
7.1. Newly married women	Various	740	2 to 2.5 hours	16 pages
7.2. & 7.3 Recently delivered women	Various	1612	2 to 2.5 hours	12 pages

Method 8: Meetings/focus groups with opinion leaders

Type of Respondent	SES classification	Number of Interview	Proposed time for each interview	Quantity of questionnaire
8.1. Religious leaders	No classification	1 – BB 1 - ZK	1 group meeting 1 to 1.5 hours long	Focus Group
8.2. Members of Union Councils and village governments (Gram Parishad)	No classification	1-BB 1-ZK	1 group meeting 1 to 1.5 hours long	Focus Group

VIII.2. APPENDIX B: RESULTS OF FREE-LISTING EXERCISE

BENEFITS OF BIRTH SPACING PRACTICES

Recently delivered woman's perceived benefits associated with birth spacing

<p><u>MOTHER - 1</u></p> <ol style="list-style-type: none"> 1. Mothers health remains good. 2. Fathers health remains good. Father does not need to do more hard work for one child. 3. Family requires less food. 4. Child can get more attention. 5. Childs health remains good. 	<p><u>MOTHER - 2</u></p> <ol style="list-style-type: none"> 1. Mother can be free for herself. 2. Mother can do household work attentively. 3. Mothers health remains good. 4. Childs health remains good. 5. Child can be self-dependent. 6. Mother can breast feed the child as much as required. 7. Properly taking care of the baby.
<p><u>MOTHER - 3</u></p> <ol style="list-style-type: none"> 1. Mother feels comfort to work, eat and sleep. 2. Childs health remains good. 3. Mothers health remains good. 4. Less money spent for the family. 5. Properly taking care of the baby. 6. Reduce possibility to get sick of the child. 	<p><u>MOTHER - 4</u></p> <ol style="list-style-type: none"> 1. Widely spacing birth is good for rearing the child.
<p><u>MOTHER - 5</u></p> <ol style="list-style-type: none"> 1. Widely spacing birth is good for rearing the child. 2. Mothers health remains good. 3. Properly taking care of the baby. 	<p><u>MOTHER - 6</u></p> <ol style="list-style-type: none"> 1. Good for mother and also baby. 2. Bacha boro hoi. 3. Mother can do work in the household. 4. Properly taking care of the baby. 5. Provide education to the child.
<p><u>MOTHER - 7</u></p> <ol style="list-style-type: none"> 1. Properly taking care of the baby. 2. Child stays well. 3. Easy to provide food. 4. Easy to provide clothe and etc. 5. Easy to move. 	<p><u>MOTHER - 8</u></p> <ol style="list-style-type: none"> 1. Good for mother's health. 2. Mothers health remains good. 3. Easy to rearing the baby. 4. Childs health remains good. 5. Reduce possibility to get sick of the child.
<p><u>MOTHER - 9</u></p> <ol style="list-style-type: none"> 1. Mothers health remains good. 2. Mother does not get weak. 3. Childs health remains good. 4. Reduce possibility to get sick of the child. 5. Properly taking care of the baby. 	<p><u>MOTHER - 10</u></p> <ol style="list-style-type: none"> 1. Older child can carry the younger child. 2. Older child can take care of own; don't give hard time to the mother. 3. Mother can stays calm mentally. 4. Mother does not get sick and also baby.

<p>6. All family members remain good. 7. Arising less trouble in the household.</p>	<p>5. Less mental hazard ness of the mother. 6. Properly rearing the child. 7. Proper breast-feeding. 8. voron poshon thik moto kora jay.</p>
<p><u>MOTHER - 11</u></p> <p>1. Mother can be staying calm. 2. Properly rearing the child. 3. Properly taking care of the baby. 4. Properly upbringing the baby. 5. Family stay messy less.</p>	<p><u>MOTHER - 12</u></p> <p>1. Elder one does not require taking care while the new one born. 2. Mother health remains good. 3. Child health remains good. 4. Mother gets peace.</p>
<p><u>MOTHER - 13</u></p> <p>1. Mother health remains good. 2. Properly taking care of the baby. 3. Elder child can look after the younger one if the births is widely spacing. 4. Mother stays physically strong. 5. Mother can perform well household chores.</p>	<p><u>MOTHER - 14</u></p> <p>1. Properly taking care of the baby. 2. Properly upbringing the baby. 3. Mother health remains good. 4. Mother can perform well household chores.</p>
<p><u>MOTHER - 15</u></p> <p>1. Mother health remains good. 2. Properly taking care of the baby. 3. Mother can perform well household chores. 4. Mother can perform prayer well.</p>	<p><u>MOTHER - 16</u></p> <p>1. Mother health remains good. 2. Child health remains good. 3. Child does not get disease. 4. Mother does not get disease. 5. Widely spacing birth is good for rearing the child. 6. Mother can be staying calm.</p>
<p><u>MOTHER - 17</u></p> <p>1. Properly taking care of the baby. 2. Mother stays physically strong. 3. Mother can perform well household chores. 4. Elder child can look after the younger one if the births is widely spacing.</p>	<p><u>MOTHER - 18</u></p> <p>1. Mother health remains good. 2. Happy family. 3. Child health remains good. 4. Properly upbringing the baby.</p>
<p><u>MOTHER - 19</u></p> <p>1. Properly taking care of the baby. 2. Mother can be staying calm. 3. Properly upbringing the baby.</p>	<p><u>MOTHER - 20</u></p> <p>1. Child health remains good. 2. Mother health remains good. 3. Can provide good food. 4. Properly upbringing the baby.</p>

BENEFITS OF BIRTH SPACING PRACTICES

Mother-in-law's perceived benefits associated with birth spacing

<p><u>MIL - 1</u></p> <ol style="list-style-type: none">1. Child would be strong and energetic.2. Mother would be relaxed.3. The older child gets mature, so hassle would be less for the mother.4. Mother can take more care of the baby.5. Can provide proper food to the baby.	<p><u>MIL - 2</u></p> <ol style="list-style-type: none">1. Properly taking care of the mother.2. Properly taking care of the baby.3. Mother would be physically relaxed.4. Child cannot give hard time to the mother.5. Easy to rearing the child.
<p><u>MIL - 3</u></p> <ol style="list-style-type: none">1. Older child can take care of younger one.2. Mothers health remains good.3. Mother does not have problem in her work.4. Disease stay away from woman if she would take baby in delay.	<p><u>MIL - 4</u></p> <ol style="list-style-type: none">1. Properly taking care of the baby.2. Mothers health remains good.3. Childs health remains good.4. Reduce possibility to get sick of the child.
<p><u>MIL - 5</u></p> <ol style="list-style-type: none">1. Woman feels peace if she would take baby in delay.2. Childs health remains good.3. Properly taking care of the baby.4. Reduce possibility to get sick of the child.	<p><u>MIL - 6</u></p> <ol style="list-style-type: none">1. Childs health remains good.2. Chest gets wide of the baby3. Reduce possibility to get sick of the child.
<p><u>MIL - 7</u></p> <ol style="list-style-type: none">1. Mothers health remains good.2. Choal boro hoilo.3. Mother can breast feed the child as much as required.4. Mother can take care properly of the older child.	<p><u>MIL - 8</u></p> <ol style="list-style-type: none">1. Mother can take care properly.2. Mother would be physically relaxed.3. Woman feels peace if she would take baby in delay.
<p><u>MIL - 9</u></p> <ol style="list-style-type: none">1. Mother would be relaxed.2. Mothers health remains good.3. Mother can sleep peacefully.	<p><u>MIL - 10</u></p> <ol style="list-style-type: none">1. Childs health remains good.2. Baby can survive.3. Easy to provide education.4. Healthy rearing.5. Mother can take care properly.
<p><u>MIL - 11</u></p> <ol style="list-style-type: none">1. Mother and baby stay well.2. Elder one does not require taking care while the new one born.	<p><u>MIL - 12</u></p> <ol style="list-style-type: none">1. Mother health remains good.2. Properly taking care of the baby.3. Baby looks good.

<p>3. Properly taking care of the baby.</p>	
<p><u>MIL - 13</u></p> <ol style="list-style-type: none"> 1. Safe life. 2. Properly upbringing the baby. 3. Properly taking care of the baby. 4. Mother can perform well household chores. 5. Family remain well being. 	<p><u>MIL - 14</u></p> <ol style="list-style-type: none"> 1. Mother health remains good. 2. Childs health remains good. 3. Properly upbringing the baby. 4. Family remains small size.
<p><u>MIL - 15</u></p> <ol style="list-style-type: none"> 1. Properly upbringing the baby. 2. Family remains small size. 3. Provide good food to the children. 4. Mother can stays calm physically. 5. Childs health remains good. 	<p><u>MIL - 16</u></p> <ol style="list-style-type: none"> 1. Childs health remains good. 2. Mother health remains good. 3. Properly taking care of the baby. 4. Mother can be staying calm.
<p><u>MIL - 17</u></p> <ol style="list-style-type: none"> 1. Mother can be staying calm. 2. Properly taking care of the baby. 3. Properly upbringing the baby. 4. Mother gets peace. 5. Less hassle in the family. 	<p><u>MIL - 18</u></p> <ol style="list-style-type: none"> 1. Mother health remains good. 2. Mother can be staying calm. 3. Childs health remains good. 4. Properly taking care of the baby. 5. Provide education to the children.
<p><u>MIL - 19</u></p> <ol style="list-style-type: none"> 1. Properly taking care of the baby. 2. Mother can be staying calm. 3. Provide good food to the children. 4. Less hassle in the family. 	<p><u>MIL - 20</u></p> <ol style="list-style-type: none"> 1. Properly taking care of the baby. 2. Provide education to the children. 3. Mother health remains good. 4. Mother can be staying calm. 5. Childs health remains good.

RISKS OF BIRTH SPACING PRACTICES

Recently delivered woman's perceived risks associated with short birth intervals

<p><u>MOTHER - 1</u></p> <ol style="list-style-type: none"> 1. Mothers health remains bad. 2. Baby cannot be hale and hearty (rishto pushto). 3. Family needs more money. 4. Most of the time Baby suffering from many kinds of disease. 5. Difficult to take care of the child. 	<p><u>MOTHER - 2</u></p> <ol style="list-style-type: none"> 1. Mother loss energy and also harmful for health. 2. Blood loss due to childbirth every year and that is harmful for mother. 3. It is difficult to take care, if the baby born every year. 4. More food requires. 5. Father need to more work hard work. 6. Difficult to provide education. 7. Difficult to provide food and cloths.
<p><u>MOTHER - 3</u></p> <ol style="list-style-type: none"> 1. Mothers health remains bad. 2. Always child stays sick. 3. More possibility of child's death. 4. Mother died during childbirth. 5. Stays peace less condition of the family. 6. bacha manush kora jai na. 7. Not possible to save money. 	<p><u>MOTHER - 4</u></p> <ol style="list-style-type: none"> 1. Child would not be healthy. 2. Mother face difficulty. 3. Difficult to rearing child. 4. Difficult to feed child. 5. Child often suffering disease.
<p><u>MOTHER - 5</u></p> <ol style="list-style-type: none"> 1. How many children can carry mother together. 2. Mother face difficulty. 3. Boro kora koshto. 4. Difficult to feed child. 5. Difficult to provide education and food to the child. 	<p><u>MOTHER - 6</u></p> <ol style="list-style-type: none"> 1. Difficult to do house hold work. 2. Child disturbs the mother. 3. Physically mother feels uncomfortable. 4. Child's health does not remain good. 5. Child suffering illness frequently. 6. More money needs to be spent.
<p><u>MOTHER - 7</u></p> <ol style="list-style-type: none"> 1. Difficult to visit the relative's house. 2. Difficult to arrange food for the family. 3. Due to shortage of money, not possible to arrange medicine while child get sick. 4. Difficult to provide cloths. 5. Child stays lean and thin (rak-shukne). 6. Blood loss during delivery. 7. Child would never energetic. 8. Physical impaired. 	<p><u>MOTHER - 8</u></p> <ol style="list-style-type: none"> 1. Mother cannot take rest. 2. Mother cannot sleep. 3. Mother feels weak. 4. Mother gets sick. 5. Difficult to rearing child. 6. Difficult to take care of the child. 7. Always having problem in the family.
<p><u>MOTHER - 9</u></p>	<p><u>MOTHER - 10</u></p>

<ol style="list-style-type: none"> 1. Physically mother does not get energy. 2. Mother does not have peace (janer shanti). 3. Children give hard time to the mother. 4. Difficult to proper take care of the child. 5. Child often suffering disease. 	<ol style="list-style-type: none"> 1. Harmful for the mother. 2. Lack of childcare. 3. Harmful for the household work. 4. Difficult to provide food. 5. Harmful for the education of the child. 6. Illness always keeps touch with the baby. 7. Mother cannot sleep. 8. Mother often suffering disease.
<p><u>MOTHER - 11</u></p> <ol style="list-style-type: none"> 1. Harmful for mother's health. 2. Child do not get breast milk if childbirth takes place every year. 3. Child health remains bad. 4. Mothers health remains bad. 5. Mother's health broken down. 6. Huge amount of money would spend for the rearing child. 	<p><u>MOTHER - 12</u></p> <ol style="list-style-type: none"> 1. Harmful for mother's health. 2. Too much physical hassle for the mother. 3. Mother does not get energy. 4. Mother cannot do work. 5. Family remains in poverty.
<p><u>MOTHER - 13</u></p> <ol style="list-style-type: none"> 1. Difficult to proper taking care of the baby. 2. Mothers health remains weak. 3. Child gets sick. 4. Huge amount of money would spend for the rearing child. 5. Mother suffer anemia. 	<p><u>MOTHER - 14</u></p> <ol style="list-style-type: none"> 1. Difficult to proper taking care of the baby. 2. Mother suffer anemia. 3. Mother died during delivery. 4. Mother cannot do house hold chores. 5. Mother cannot eat, sleep and do other thing.
<p><u>MOTHER - 15</u></p> <ol style="list-style-type: none"> 1. Mother suffers many kinds of disease. 2. Child remains sick for whole year. 3. Difficult to provide proper food. 4. Difficult to upbringing children as a good human being. 	<p><u>MOTHER - 16</u></p> <ol style="list-style-type: none"> 1. Difficult to rearing child. 2. Mothers health remains weak. 3. Mother face complications during delivery. 4. Difficult to take care of the child. 5. Mother gets sick. 6. Child gets sick. 7. Mother does not get energy.
<p><u>MOTHER - 17</u></p> <ol style="list-style-type: none"> 1. Child gets sick. 2. Difficult to provide treatment. 3. Mother cannot eat, sleep and do other thing. 4. Mother cannot take care of own. 5. Difficult to take care of the child. 	<p><u>MOTHER - 18</u></p> <ol style="list-style-type: none"> 1. Mother health remains weak. 2. Mother suffer anemia. 3. Child health remains sick. 4. Family remains in poverty. 5. No happiness in the family. 6. Mother cannot eat in time. 7. Difficult to provide food. 8. Difficult to upbringing children as a good human being.

<p><u>MOTHER - 19</u></p> <ol style="list-style-type: none">1. Too much physical hassle for the mother.2. Mother's health broken down.3. Uncomfortable feeling during pregnancy.4. Mother face complications during delivery.5. After delivery mother remain sick.6. Child stays thin.	<p><u>MOTHER - 20</u></p> <ol style="list-style-type: none">1. Child would die.2. Mother died during delivery.3. Child remains sick.4. Huge amount of money required for the family.5. Difficult to up bring child due to lack of money.

RISKS OF BIRTH SPACING PRACTICES

Mother-in-law's perceived risks associated with short birth intervals

<p><u>MIL - 1</u></p> <ol style="list-style-type: none"> 1. If birth takes every year, so mother loses her blood every year. As this mother's health remains weak. 2. Difficult to rear child. 3. Difficult to carry child. 4. Difficult to provide education. 	<p><u>MIL - 2</u></p> <ol style="list-style-type: none"> 1. Mother gets sick if the child born within 6-12 months of previous birth. 2. Mother gets disease (bie dhore). 3. Mother's sickness transfer to the child body. 4. Mother gets sick frequently. 5. Mother cannot decide which child she would take in her lap (konta rekhe konta kole nibe).
<p><u>MIL - 3</u></p> <ol style="list-style-type: none"> 1. Difficult to rearing child. 2. Difficult to arrange good food for mother. 3. Difficult to provide treatment. 4. Difficult to take care of the baby. 5. How many children can carry mother together. 6. Child health remains sick. 7. Difficult to provide education. 8. Mother cannot take care of own. 	<p><u>MIL - 4</u></p> <ol style="list-style-type: none"> 1. Child health remains sick. 2. Mother health remains sick. 3. Difficult to provide food. 4. Difficult to rear of the child.
<p><u>MIL - 5</u></p> <ol style="list-style-type: none"> 1. Mother's health broken down. 2. Mother's health remains weak. 3. Mother experience's difficulties during delivery. 4. Child stays thin (kimta-shukna). 5. Child health remains sick. 6. Mother cannot take care of own. 7. Child would die. 8. More still birth (mora bacha beshi hoy). 9. Tendency of abortion is high. 	<p><u>MIL - 6</u></p> <ol style="list-style-type: none"> 1. Mother's health remains sick. 2. Child gets sick. 3. Child would die. 4. There is no peace in the family. 5. To much hassle. 6. Mother died during delivery.
<p><u>MIL - 7</u></p> <ol style="list-style-type: none"> 1. Mother having the problem that which child she would rear. 2. Mother face's problem to cook. 3. Insufficient breast-feeding to the child. 4. Child would be malnourished. 5. Children always crying and it is a problem for mother to sleep and eat. 	<p><u>MIL - 8</u></p> <ol style="list-style-type: none"> 1. Harmful for both of the mother and children. 2. Difficult to rear the child. 3. Carrying the child for ten months is difficult for the mother. 4. Peace less situation. 5. Mother cannot sleep, eat and do other

<p>6. It is difficult to rear the child while it frequent birth.</p>	<p>stuffs. 6. Mother gets sick. 7. Child gets sick.</p>
<p><u>MIL - 9</u></p> <ol style="list-style-type: none"> 1. Too much physical hassle for the mother. 2. Difficult to provide food to the children. 3. Child gets sick frequently. 4. Uncertain situation of food arrangement. 5. Difficult to deposit money. 6. Peace less situation. 	<p><u>MIL - 10</u></p> <ol style="list-style-type: none"> 1. Mother having the problem that which child she would rear. 2. Mother could not work. 3. Difficult to rear the child. 4. Mother's health remains weak. 5. Child health remains sick. 6. Child gets sick. 7. Huge Amount of money would spend for the rearing child. 8. Mother cannot involve with other work (related to income). 9. Difficult to upbringing children as a good human being. 10. Difficult to provide education.
<p><u>MIL - 11</u></p> <ol style="list-style-type: none"> 1. Difficult to rearing child. 2. Mother health remains sick. 3. Child health remains sick. 4. Difficult to take care of the baby. 	<p><u>MIL - 12</u></p> <ol style="list-style-type: none"> 1. Mother's situation would be bad if she deliver child in every moment. 2. Mother health broken down. 3. Difficult to take care of the baby. 4. Child health remains sick. 5. Child gets sick. 6. Mother gets sick.
<p><u>MIL - 13</u></p> <ol style="list-style-type: none"> 1. Difficult to rearing child. 2. Mother cannot eat, sleep and do other thing. 3. Difficult to upbringing children as a good human being. 4. Difficult to affluence family. 5. High expenditure. 	<p><u>MIL - 14</u></p> <ol style="list-style-type: none"> 1. Mother suffer anemia. 2. Mother health remains weak. 3. Child health remains sick. 4. High expenditure. 5. Difficult to provide treatment due to lack of money. 6. Child would die.
<p><u>MIL - 15</u></p> <ol style="list-style-type: none"> 1. Mother gets physical hassle. 2. Mother suffer anemia. 3. Child gets sick. 4. Difficult to provide food and education. 5. Family become make bigger. 6. Too much hassle. 	<p><u>MIL - 16</u></p> <ol style="list-style-type: none"> 1. Painful for mother. 2. Painful for child. 3. Mother having problem that which child she would rear. 4. Difficult to provide bath and eat.

MIL - 17

1. Mother health broken down.
2. Difficult to take care of thy baby.
3. Difficult to doing household chore.
4. Hug amount of money would spend for the rearing child.
5. Mother cannot eat sleep and do other thing.

MIL - 18

1. Mother would die during delivery.
2. Mother gets weak.
3. Mother cannot do work.
4. Child stay sick.
5. Enormous amount of money have to spend for rearing the child.
6. No happiness in the family.

MIL - 19

1. Difficult to take care of the baby.
2. Painful for mother.
3. Peace less situation.
4. Difficult to rearing the baby.

MIL - 20

1. Mother gets many kinds of disease.
2. Mother suffer anemia.
3. Mother gets heart disease.
4. Difficult to take care of the baby.
5. Child suffers many kinds of disease.
6. Child would die.

APPROACHES/METHODS FOR FAMILY PLANNING

Recently delivered woman's methods associated with family planning

<p><u>MOTHER - 1</u></p> <ol style="list-style-type: none"> 1. Copper T 2. Ligation (Tubectomy) 3. Shui (injection) 4. Femicon (pill) 	<p><u>MOTHER - 2</u></p> <ol style="list-style-type: none"> 1. Condom 2. Injection 3. Ligation (Tubectomy) 4. Copper T 5. Insert vein in the hand for the five years (Norplant) 6. Pill (Bory)
<p><u>MOTHER - 3</u></p> <ol style="list-style-type: none"> 1. Femicon (pill) 2. Shui (injection) 3. Condom 4. Copper T 5. Ligation (Tubectomy) 6. Norplant 	<p><u>MOTHER - 4</u></p> <ol style="list-style-type: none"> 1. Ligation (Tubectomy) 2. Copper T 3. Condom 4. Pill (Bory) 5. Islamic method (Azol-withdrawal)
<p><u>MOTHER - 5</u></p> <ol style="list-style-type: none"> 1. Pill (Maya bori) 2. Injection. 	<p><u>MOTHER - 6</u></p> <ol style="list-style-type: none"> 1. Injection. 2. Copper T 3. Insert five pipes in the hand (Norplant)
<p><u>MOTHER - 7</u></p> <ol style="list-style-type: none"> 1. Copper T 2. Shui (injection) 3. Six things like injection (Norplant) 4. Ligation (Tubectomy) 5. Condom 6. Femicon (pill) 	<p><u>MOTHER - 8</u></p> <ol style="list-style-type: none"> 1. Medicine 2. Condom 3. Copper T 4. Shui (injection) 5. Operation (Tubectomy)
<p><u>MOTHER - 9</u></p> <ol style="list-style-type: none"> 1. Medicine 2. Ligation (Tubectomy) 3. Copper T 4. Shui (injection) 5. Insert vein in the hand for the five years (Norplant) 6. Safe time 	<p><u>MOTHER - 10</u></p> <ol style="list-style-type: none"> 1. Condom 2. Medicine 3. Ligation (Tubectomy) 4. Copper T 5. Shui (injection) 6. Pipe (Norplant) 7. Condom
<p><u>MOTHER - 11</u></p> <ol style="list-style-type: none"> 1. Shui (injection) 	<p><u>MOTHER - 12</u></p> <ol style="list-style-type: none"> 1. Shui (injection)

<ul style="list-style-type: none"> 2. Pill (Bory) 3. Copper T 4. Operation (Tubectomy). 	<ul style="list-style-type: none"> 2. Pill (Bory) 3. Condom 4. Copper T
<p><u>MOTHER - 13</u></p> <ul style="list-style-type: none"> 1. Ligation (Tubectomy) 2. Copper T 3. Stick (Norplant) 4. Pill (Bory) 5. Shui (injection) 	<p><u>MOTHER - 14</u></p> <ul style="list-style-type: none"> 1. Pill (Bory) 2. Shui (injection)
<p><u>MOTHER - 15</u></p> <ul style="list-style-type: none"> 1. Shui (injection) 2. Stick (Norplant) 3. Pill (Bory) 	<p><u>MOTHER - 16</u></p> <ul style="list-style-type: none"> 1. Shui (injection) 2. Pill (Bory) 3. Condom 4. Ligation (Tubectomy)
<p><u>MOTHER - 17</u></p> <ul style="list-style-type: none"> 1. Shui (injection) 2. Pill (Bory) 3. Ligation (Tubectomy) 4. Copper T 	<p><u>MOTHER - 18</u></p> <ul style="list-style-type: none"> 1. Shui (injection) 2. Pill (Bory) 3. Stick (Norplant)
<p><u>MOTHER - 19</u></p> <ul style="list-style-type: none"> 1. Shui (injection) 2. Pill (gulli) 3. Condom 4. Safe time. 	<p><u>MOTHER - 20</u></p> <ul style="list-style-type: none"> 1. Pill (Bory) 2. Shui (injection) 3. Copper T 4. Condom (beloon) 5. Ligation (Tubectomy)

APPROACHES/METHODS FOR FAMILY PLANNING

Mother-in-law's methods associated with family planning

<p><u>MIL - 1</u></p> <ol style="list-style-type: none"> 1. Injection (Shui) 2. Bory (pill) 3. ligation (tubectomy) 	<p><u>MIL - 2</u></p> <ol style="list-style-type: none"> 1. Bory (pill) 2. Shui (injection) 3. Copper T 4. Insert something like robber in the hand for the five years (Norplant) 5. Stop birthing for whole life (don't know the name)
<p><u>MIL - 3</u></p> <ol style="list-style-type: none"> 1. Pata (Bory-pill) 2. Shui (injection) 3. ligation (tubectomy) 	<p><u>MIL - 4</u></p> <ol style="list-style-type: none"> 1. Shui (injection) 2. Operation (ligation-tubectomy) 3. Bory (pill)
<p><u>MIL - 5</u></p> <ol style="list-style-type: none"> 1. Bory (pill) 2. Copper T 3. Operation (ligation-tubectomy) 4. Shui (injection) 	<p><u>MIL - 6</u></p> <ol style="list-style-type: none"> 1. Bory (pill) 2. Shui (injection)
<p><u>MIL - 7</u></p> <ol style="list-style-type: none"> 1. Ligation (tubectomy) 2. Copper T 3. Maya Bory (pill) 4. Insert vein (Norplant)-rog 5. Shui (injection) 	<p><u>MIL - 8</u></p> <ol style="list-style-type: none"> 1. Bory (pill) 2. Shui (injection)
<p><u>MIL - 9</u></p> <ol style="list-style-type: none"> 1. Bory (pill) 2. Shui (injection) 	<p><u>MIL - 10</u></p> <ol style="list-style-type: none"> 1. Copper T 2. Shui (injection) 3. Bory (pill) 4. Ligation (tubectomy)
<p><u>MIL - 11</u></p> <ol style="list-style-type: none"> 1. Injection (Shui) 2. Bory (pill) 	<p><u>MIL - 12</u></p> <ol style="list-style-type: none"> 1. Injection (Shui) 2. Maya bory (pill) 3. Copper t 4. Operation
<p><u>MIL - 13</u></p> <ol style="list-style-type: none"> 1. Norplant. 	<p><u>MIL - 14</u></p> <ol style="list-style-type: none"> 1. Injection (Shui)

<ol style="list-style-type: none">2. Copper T3. Cutting stomach side (Ligation)4. Shui (injection)5. Bory (Pill)	<ol style="list-style-type: none">2. Bory (pill)3. Stick (Norplant)
<p><u>MIL - 15</u></p> <ol style="list-style-type: none">1. Shui (injection)2. Pill (gulli)	<p><u>MIL - 16</u></p> <ol style="list-style-type: none">1. Bory (pill)2. Shui (injection)
<p><u>MIL - 17</u></p> <ol style="list-style-type: none">1. Shui (injection)2. Bory (pill)	<p><u>MIL - 18</u></p> <ol style="list-style-type: none">1. Shui (injection)2. Bory (pill)
<p><u>MIL - 19</u></p> <ol style="list-style-type: none">1. Shui (injection)2. Cut the stomach.3. Bory (pill)	<p><u>MIL - 20</u></p> <ol style="list-style-type: none">1. Shui (injection)2. Bory (pill)

APPROACHES/METHODS FOR BIRTH SPACING

Recently delivered woman's methods associated with birth spacing

<p><u>MOTHER - 1</u></p> <ol style="list-style-type: none">1. Shui marano (injection)2. Copper T3. Insert sticks in the hand (Norplant)4. Pill	<p><u>MOTHER - 2</u></p> <ol style="list-style-type: none">1. Condom2. Injection3. Pill
<p><u>MOTHER - 3</u></p> <ol style="list-style-type: none">1. Bori (pill)2. Shui (injection)3. Condom4. Copper T	<p><u>MOTHER - 4</u></p> <ol style="list-style-type: none">1. Islamic method (Azol-withdrawal)2. Safe period (Don't have intercourse, 15 days after menstruation)
<p><u>MOTHER - 5</u></p> <ol style="list-style-type: none">1. May be Allah does not give child otherwise I don't know	<p><u>MOTHER - 6</u></p> <ol style="list-style-type: none">1. Copper T2. Shui (injection)3. Pipe (Norplant)
<p><u>MOTHER - 7</u></p> <ol style="list-style-type: none">1. Copper T2. Condom3. Shui (injection)4. Femicon (pill)	<p><u>MOTHER - 8</u></p> <ol style="list-style-type: none">1. Copper T2. Shui (injection)3. Medicine
<p><u>MOTHER - 9</u></p> <ol style="list-style-type: none">1. Condom2. Shui (injection)3. Copper T4. Insert vein (Norplant)	<p><u>MOTHER - 10</u></p> <ol style="list-style-type: none">1. Condom2. Bory (pill)3. Copper T4. Shui (injection)5. Insert pipe (Norplant)
<p><u>MOTHER - 11</u></p> <ol style="list-style-type: none">1. Shui (injection)2. Copper T	<p><u>MOTHER - 12</u></p> <ol style="list-style-type: none">1. Shui (injection)2. Copper T
<p><u>MOTHER - 13</u></p> <ol style="list-style-type: none">1. Sticks (Norplant)2. Pill (Bory)3. Shui (injection)4. Copper T	<p><u>MOTHER - 14</u></p> <ol style="list-style-type: none">1. Shui (injection)2. Pill (Bory)

<p><u>MOTHER - 15</u></p> <ol style="list-style-type: none">1. Sticks (Norplant)2. Shui (injection)3. Pill (Bory)	<p><u>MOTHER - 16</u></p> <ol style="list-style-type: none">1. Shui (injection)2. Pill (Bory)
<p><u>MOTHER - 17</u></p> <ol style="list-style-type: none">1. Shui (injection)2. Copper T	<p><u>MOTHER - 18</u></p> <ol style="list-style-type: none">1. Pill (Bory)2. Shui (injection)3. Sticks (Norplant)
<p><u>MOTHER - 19</u></p> <ol style="list-style-type: none">1. Shui (injection)2. Pill (gulli)	<p><u>MOTHER - 20</u></p> <ol style="list-style-type: none">1. Shui (injection)2. Pill (Bori)3. Condom (beloon)4. Copper T

APPROACHES/METHODS FOR BIRTH SPACING
Mother-in-law's methods associated with birth spacing

<p><u>MIL - 1</u></p> <ol style="list-style-type: none"> 1. Bory (pill) 2. Have injection for five years. 	<p><u>MIL - 2</u></p> <ol style="list-style-type: none"> 1. Have injection in every three months. 2. Bory (pill) 3. Ligation (Tubectomy) for whole life.
<p><u>MIL - 3</u></p> <ol style="list-style-type: none"> 1. Pata (Bory-pill) 2. Shui (injection) 	<p><u>MIL - 4</u></p> <ol style="list-style-type: none"> 1. Shui (injection) 2. Operation (ligation-tubectomy) 3. Bory (pill)
<p><u>MIL - 5</u></p> <ol style="list-style-type: none"> 1. Copper T 2. Shui (injection) 3. Bory (pill) 	<p><u>MIL - 6</u></p> <ol style="list-style-type: none"> 1. Bory (pill) 2. Shui (injection)
<p><u>MIL - 7</u></p> <ol style="list-style-type: none"> 1. Copper T 2. Insert vein (Norplant)-rog 	<p><u>MIL - 8</u></p> <ol style="list-style-type: none"> 1. Bory (pill) 2. Shui (injection)
<p><u>MIL - 9</u></p> <ol style="list-style-type: none"> 1. Bory (pill) 2. Shui (injection) 	<p><u>MIL - 10</u></p> <ol style="list-style-type: none"> 1. Bory (pill) 2. Copper T 3. Shui (injection)
<p><u>MIL - 11</u></p> <ol style="list-style-type: none"> 1. I don't know. 	<p><u>MIL - 12</u></p> <ol style="list-style-type: none"> 1. Copper T 2. Shui (injection)
<p><u>MIL - 13</u></p> <ol style="list-style-type: none"> 1. Soloy (Norplant) 2. Copper T 3. Shui (injection) 	<p><u>MIL - 14</u></p> <ol style="list-style-type: none"> 1. Shui (injection) 2. Bory (pill)
<p><u>MIL - 15</u></p> <ol style="list-style-type: none"> 1. Shui (injection) 	<p><u>MIL - 16</u></p> <ol style="list-style-type: none"> 1. Bory (pill)
<p><u>MIL - 17</u></p> <ol style="list-style-type: none"> 1. Bory (pill) 	<p><u>MIL - 18</u></p> <ol style="list-style-type: none"> 1. Bory (pill)

2. Shui (injection)	2. Shui (injection)
<u>MIL - 19</u> 1. Shui (injection) 2. Bory (pill)	<u>MIL - 20</u> 1. Shui (injection) 2. Bory (pill)

BENEFITS OF BREASTFEEDING

Recently delivered woman's perceived benefits of breastfeeding

<p><u>MOTHER - 1</u></p> <ol style="list-style-type: none">1. For good health of child.2. Does not need to buy extra food.3. Breast milk never rotten.4. Breast milk does not need to boil.5. Whenever, however, and wherever mother feel comfort, she can breast feed the child.	<p><u>MOTHER - 2</u></p> <ol style="list-style-type: none">1. Breast milk can serve quickly.2. Child's health remains good.3. Chest gets wide of the baby.4. Child will be intelligent.5. Breast milk never rotten.
<p><u>MOTHER - 3</u></p> <ol style="list-style-type: none">1. Less possibility to get disease.2. Breast milk never rotten.3. Breast milk does not need to boil.4. Whenever, however, and wherever mother feel comfort, she can breast feed the child.5. Chest gets wide of the baby.	<p><u>MOTHER - 4</u></p> <ol style="list-style-type: none">1. Germ free.2. Breast milk does not need to boil.3. There is nothing equal to breast milk in the world.4. Breast milk does not need to prepare at night, which is difficult.5. Easy to feeding.6. Tinned powder milk is costly but breast milk is free.7. Breast milk has no risk to be old (bashi).
<p><u>MOTHER - 5</u></p> <ol style="list-style-type: none">1. Effective for baby's health.2. Child's body get nutrition.3. Child stays disease free.4. Good for the mother otherwise she needs to prepare food at night.	<p><u>MOTHER - 6</u></p> <ol style="list-style-type: none">1. Chest gets wide of the baby.2. Child can survive.3. Gets vitamin.4. Child stays disease free.5. For good health of child.
<p><u>MOTHER - 7</u></p> <ol style="list-style-type: none">1. Breathing problem will be recovered.2. Stomach remains well.3. There is no possibility to get loose defecation.4. To be healthy.5. Gets vitamin.	<p><u>MOTHER - 8</u></p> <ol style="list-style-type: none">1. Child stays disease free.2. Stomach remains well.3. There is no possibility for mother to get stomach problem.4. Child does not get stomach pain.
<p><u>MOTHER - 9</u></p> <ol style="list-style-type: none">1. Child stays disease free.	<p><u>MOTHER - 10</u></p> <ol style="list-style-type: none">1. Gets vitamin.2. Gets energy.3. Child stay well.4. Child stop crying, while she/he gets breast milk.5. Difficult to cook supplementary food.

<p><u>MOTHER - 11</u></p> <ol style="list-style-type: none"> 1. Childs health remains good. 2. Stomach remains well. 3. Child does not get stomach pain. 4. Childs health remains hale and hearty. 	<p><u>MOTHER - 12</u></p> <ol style="list-style-type: none"> 1. Stomach remains well. 2. Less possibility to get disease. 3. Difficult to feed supplementary food.
<p><u>MOTHER - 13</u></p> <ol style="list-style-type: none"> 1. Child would be brainy. 2. Chest gets wide of the baby. 3. Child would not get disease. 4. Child would get energy. 	<p><u>MOTHER - 14</u></p> <ol style="list-style-type: none"> 1. Childs health remains good. 2. Child would not get diarrhoea. 3. No need to buy extra food. 4. Saving money. 5. If the placenta would not be delivered during delivery then if baby suck the breast, placenta would be delivered.
<p><u>MOTHER - 15</u></p> <ol style="list-style-type: none"> 1. Child would not get disease. 2. Childs health remains good. 3. Child would be brainy. 4. Child would not get pneumonia. 	<p><u>MOTHER - 16</u></p> <ol style="list-style-type: none"> 1. Childs health remains good. 2. Child stays disease free. 3. Child would not get diarrhoea. 4. Child would not get pneumonia. 5. Child does not get cold.
<p><u>MOTHER - 17</u></p> <ol style="list-style-type: none"> 1. Child would not get disease. 2. Childs health remains good. 3. Child would not get pneumonia. 4. Child would not get diarrhoea. 	<p><u>MOTHER - 18</u></p> <ol style="list-style-type: none"> 1. Child would not get liver problem. 2. Childs health remains good. 3. Child would not get pneumonia. 4. Child does not get cold. 5. Breast milk would not be rotten. 6. Breast milk does not require boiling.
<p><u>MOTHER - 19</u></p> <ol style="list-style-type: none"> 1. Contains vitamin. 2. Get energy. 3. No need to give supplementary food if the baby gets breast milk properly. 4. At night, when baby used to cry then breastfeeding is the way to stop. 	<p><u>MOTHER - 20</u></p> <ol style="list-style-type: none"> 1. Chest gets wide of the baby. 2. Child does not get cold. 3. Child would not get pneumonia. 4. No need of money.

BENEFITS OF BREASTFEEDING

Mother-in-law's perceived benefits of breastfeeding

<p><u>MIL - 1</u></p> <ol style="list-style-type: none">1. Child would be healthy.2. Breast feed the child is comfortable for the mother.3. Baby does not feel hungry.4. It is easy to breast feed.5. Baby's stomach remains good.	<p><u>MIL - 2</u></p> <ol style="list-style-type: none">1. Child would be healthy.2. Without breast feeding child would not be survived.3. Child stays disease free.4. Child would not be healthy, if you give her/him supplementary food.5. Chest gets wide of the baby (energetic).
<p><u>MIL - 3</u></p> <ol style="list-style-type: none">1. Baby's body stays warm.2. Child's health remains good.3. No need to feed supplementary food.4. Stomach remains well.	<p><u>MIL - 4</u></p> <ol style="list-style-type: none">1. Difficult to feed supplementary food.2. Chest gets wide of the baby (energetic)3. There is no possibility for child to get stomach problem.4. Child does not get stomach pain.5. Mother felt appetite and that's why mother can eat sufficient food.
<p><u>MIL - 5</u></p> <ol style="list-style-type: none">1. Colostrums contains vitamin.2. Child would not get stomach problem if he/she gets colostrums.3. It is easy to breast feed.4. Child's health remains good.	<p><u>MIL - 6</u></p> <ol style="list-style-type: none">1. Child's health remains good.2. Chest gets wide of the baby.3. Baby gets sick very often.
<p><u>MIL - 7</u></p> <ol style="list-style-type: none">1. Baby gets sick very often.	<p><u>MIL - 8</u></p> <ol style="list-style-type: none">1. Breast feeding is comfortable for the baby.2. Mother's stomach remains well.3. Breast feeding is easy for the mother and also for the child.4. Child stays disease free.
<p><u>MIL - 9</u></p> <ol style="list-style-type: none">1. Child's health remains good.2. Baby gets sick very often.3. Baby's stomach does not distend.	<p><u>MIL - 10</u></p> <ol style="list-style-type: none">1. No needs to give supplementary (tola) food.2. Child's health remains good.3. Stomach remains well.4. Baby stays in piece.5. Chest gets wide of the baby.
<p><u>MIL - 11</u></p>	<p><u>MIL - 12</u></p>

<ol style="list-style-type: none"> 1. Chest gets wide of the baby (energetic). 2. Child stop crying, while she/he gets breast milk. 3. After getting colostrums, baby would be warm. 4. Child gets nourishment. 	<ol style="list-style-type: none"> 1. Child gets calcium. 2. Childs health remains good. 3. Childs health remains hale and hearty. 4. Less possibility to get disease. 5. Mother's health remains thin if she breast-feeds the child.
<p><u>MIL - 13</u></p> <ol style="list-style-type: none"> 1. Child would not get stomach problem. 2. Child would be strong. 3. Chest gets wide of the baby (energetic). 	<p><u>MIL - 14</u></p> <ol style="list-style-type: none"> 1. Childs health remains good. 2. Child would not get pneumonia. 3. Child would not get stomach problem. 4. Breast milk would not be rotten.
<p><u>MIL - 15</u></p> <ol style="list-style-type: none"> 1. Childs health remains good. 2. Less possibility to get disease. 3. Child would be brainy. 4. Child would not get stomach problem. 	<p><u>MIL - 16</u></p> <ol style="list-style-type: none"> 1. Childs health remains good. 2. Child would not get disease. 3. Chest gets wide of the baby (energetic).
<p><u>MIL - 17</u></p> <ol style="list-style-type: none"> 1. Chest gets wide of the baby (energetic). 2. Childs health remains good. 3. Child would not get stomach problem. 4. Child would not get cold. 	<p><u>MIL - 18</u></p> <ol style="list-style-type: none"> 1. Childs health remains good. 2. Child would not get disease. 3. Child would not get diarrheoa. 4. Breast milk would not be rotten.
<p><u>MIL - 19</u></p> <ol style="list-style-type: none"> 1. Chest gets wide of the baby. 2. Child would get energy. 3. Childs stomach remains good. 	<p><u>MIL - 20</u></p> <ol style="list-style-type: none"> 1. Child would not get disease. 2. Child would be brainy. 3. No need of money.

PROBLEMS WITH BREASTFEEDING

Recently delivered woman's perceived risks of breastfeeding

<p><u>MOTHER - 1</u></p> <p>1. There is no problem with the breast-feeding.</p>	<p><u>MOTHER - 2</u></p> <p>1. During the breast-feeding, If the mother has breast lump, then baby would gets loose defecation.</p>
<p><u>MOTHER - 3</u></p> <p>1. During breast feeding mother requires to eat good food. 2. Mother could not eat cold food.</p>	<p><u>MOTHER - 4</u></p> <p>1. Some times baby does not get breast milk, At that situation baby gets angry and for mother that is very bad feelings.</p>
<p><u>MOTHER - 5</u></p> <p>1. No problem with the breast-feeding.</p>	<p><u>MOTHER - 6</u></p> <p>1. During breast feeding mother requires to eat good food. 2. Mother feels bad because child always sucking the breast. 3. Mother could not eat cold food, because child could get cold (fever, cough, pneumonia).</p>
<p><u>MOTHER - 7</u></p> <p>1. No problem with the breast-feeding.</p>	<p><u>MOTHER - 8</u></p> <p>1. No problem with the breast-feeding.</p>
<p><u>MOTHER - 9</u></p> <p>1. No problem with the breast-feeding.</p>	<p><u>MOTHER - 10</u></p> <p>1. Child would get disease from mother, if mother experiences any disease. For instance, Child would get cold, if mother experiences cold. Child would get stomach problem, if mother experiences stomach problem. 2. Mother feels bad during work because child always sucking the breast.</p>
<p><u>MOTHER - 11</u></p> <p>1. There is no problem with the breast-feeding.</p>	<p><u>MOTHER - 12</u></p> <p>1. There is no problem with the breast-feeding.</p>
<p><u>MOTHER - 13</u></p> <p>1. During breast feeding mother requires to eat good food. 2. Mother become thin if she breast the child.</p>	<p><u>MOTHER - 14</u></p> <p>1. There is no problem with the breast-feeding.</p>

<p><u>MOTHER - 15</u></p> <p>1. There is no problem with the breast-feeding.</p>	<p><u>MOTHER - 16</u></p> <p>1. There is no problem with the breast-feeding.</p>
<p><u>MOTHER - 17</u></p> <p>1. There is no problem with the breast-feeding.</p>	<p><u>MOTHER - 18</u></p> <p>1. There is no problem with the breast-feeding.</p>
<p><u>MOTHER - 19</u></p> <p>1. There is no problem with the breast-feeding.</p>	<p><u>MOTHER - 20</u></p> <p>1. Child would get cold, if mother experiences cold. 2. Mother could not eat cold food.</p>

PROBLEMS WITH BREASTFEEDING

Mother-in-law's perceived risks of breastfeeding

<p><u>MIL - 1</u></p> <p>1. There is no problem with the breast-feeding.</p>	<p><u>MIL - 2</u></p> <p>1. When baby sucking the breast then mother feels uncomfortable and that's why many woman feed the child supplementary food. 2. If the child gets diarrhea then mothers need to eat selected food.</p>
<p><u>MIL - 3</u></p> <p>1. There is no problem with the breast-feeding.</p>	<p><u>MIL - 4</u></p> <p>1. If mother could not eat sufficient food, breast milk would not produce. 2. Child would get stomach problem, if mother experiences stomach problem.</p>
<p><u>MIL - 5</u></p> <p>1. There is no problem with the breast-feeding.</p>	<p><u>MIL - 6</u></p> <p>1. If mother get cold, child would get cold. 2. Mother need's to select about what to eat. 3. If baby get diarrhoea, then mother have to eat oil free food.</p>
<p><u>MIL - 7</u></p> <p>1. There is no problem with the breast-feeding.</p>	<p><u>MIL - 8</u></p> <p>1. There is no problem with the breast-feeding.</p>
<p><u>MIL - 9</u></p> <p>1. There is no problem with the breast-feeding.</p>	<p><u>MIL - 10</u></p> <p>1. If breast milk would increase for over eating of mother then child suffer for stomach problem. 2. Mother need's to select about what to eat.</p>
<p><u>MIL - 11</u></p> <p>1. There is no problem with the breast-feeding.</p>	<p><u>MIL - 12</u></p> <p>1. There is no problem with the breast-feeding.</p>
<p><u>MIL - 13</u></p> <p>1. There is no problem with the breast-feeding.</p>	<p><u>MIL - 14</u></p> <p>1. There is no problem with the breast-feeding.</p>
<p><u>MIL - 15</u></p> <p>1. There is no problem with the breast-</p>	<p><u>MIL - 16</u></p> <p>1. There is no problem with the breast-</p>

feeding.	feeding.
<u>MIL - 17</u> 1. During breast feeding mother requires to eat good food. 2. Child would get cold, if mother experiences cold.	<u>MIL - 18</u> 1. Mother could not eat cold food. Because child could get cold 2. For produce sufficient breast milk, mother needs to eat a lot.
<u>MIL - 19</u> 1. Child would get stomach problem, if mother experiences stomach problem.	<u>MIL - 20</u> 1. There is no problem with the breast-feeding.

FAMILY PLANNING PROVIDERS

Recently delivered women - health care providers associated with family planning

<u>MOTHER - 1</u> 1. Dubag Hospital (FWC) 2. BeaniBazar thana health complex 3. Anzuman apa (CHW- Projhanmo) 4. People who work with family planning.	<u>MOTHER - 2</u> 1. Any ogverment hospital 2. Family planning office 3. BeaniBazar thana health complexes 4. Shefaly (CHW) 5. Pushpo (FWV)
<u>MOTHER - 3</u> 1. Dubag Hospital (FWC) 2. Medicine shop 3. Pervine apa (CHW- Projhanmo) 4. BeaniBazar thana health complex	<u>MOTHER - 4</u> 1. Family planning hospital, Alinagar
<u>MOTHER - 5</u> 1. FWA of Chandragram 2. FWC	<u>MOTHER - 6</u> 1. Dubag Hospital (FWC) 2. BeaniBazar thana health complex 3. Pervine apa (CHW- Projhanmo)
<u>MOTHER - 7</u> 1. Health care center 2. If go to big / renown doctors 3. When CHW visit the home	<u>MOTHER - 8</u> 1. Government hospital (FWC) 2. Lipika rani (CHW- Projhanmo)
<u>MOTHER - 9</u> 1. Government hospital 2. CHW 3. Medicine shop	<u>MOTHER - 10</u> 1. Pushpo rani (CHW- Projhanmo) 2. Health office 3. Medicine shop
<u>MOTHER - 11</u> 1. Shimantic	<u>MOTHER - 12</u> 1. Shimantic
<u>MOTHER - 13</u> 1. Zakigange Hospital 2. Shimantic	<u>MOTHER - 14</u> 1. Zakigange Hospital 2. Shimantic 3. Family planning methods are available to some woman who comes to the village.
<u>MOTHER - 15</u> 1. Zakigange Hospital 2. Family planning worker	<u>MOTHER - 16</u> 1. Relative (sister in law)

3. Medicine shop at bazar	
<u>MOTHER - 17</u> 1. Neighbors	<u>MOTHER - 18</u> 1. Zakigange Hospital 2. Medicine shop at bazar
<u>MOTHER - 19</u> 1. Hindu doctor of Shoroker bazar 2. Shopna apa (CHW-Projhanmo)	<u>MOTHER - 20</u> 1. Hospital of Shoroker bazar 2. Shimantic 3. Family planning worker

FAMILY PLANNING PROVIDERS

Mother-in-laws - health care providers associated with family planning

<p><u>MIL - 1</u></p> <ol style="list-style-type: none">1. Hospital2. Woman supply family planning device to the home (Projhanmo)	<p><u>MIL - 2</u></p> <ol style="list-style-type: none">1. Hospital (FWC-Alinagar-Dhala didi)2. Shefali (CHW- Projhanmo)
<p><u>MIL - 3</u></p> <ol style="list-style-type: none">1. FWA2. Shilpi (CHW- Projhanmo)	<p><u>MIL - 4</u></p> <ol style="list-style-type: none">1. FWA
<p><u>MIL - 5</u></p> <ol style="list-style-type: none">1. FWA	<p><u>MIL - 6</u></p> <ol style="list-style-type: none">1. Hospital2. Shefali (CHW- Projhanmo)
<p><u>MIL - 7</u></p> <ol style="list-style-type: none">1. Private doctor2. Nazera (CHW- Projhanmo)3. Government hospital4. Medicine shop	<p><u>MIL - 8</u></p> <ol style="list-style-type: none">1. Government hospital (Thana health complex)2. Family planning woker3. Private doctor4. Lipika (CHW- Projhanmo)
<p><u>MIL - 9</u></p> <ol style="list-style-type: none">1. FWA2. Government Hospital3. Shefali (CHW- Projhanmo)	<p><u>MIL - 10</u></p> <ol style="list-style-type: none">1. FWA2. Private doctor
<p><u>MIL - 11</u></p> <ol style="list-style-type: none">1. Neighbors	<p><u>MIL - 12</u></p> <ol style="list-style-type: none">1. Government people come to member's house to push injection.
<p><u>MIL - 13</u></p> <ol style="list-style-type: none">1. Neighbors	<p><u>MIL - 14</u></p> <ol style="list-style-type: none">1. Zakigange Hospital2. Medicine shop
<p><u>MIL - 15</u></p> <ol style="list-style-type: none">1. Kaligange Shimantic.2. Shoroker bazar Shimantic	<p><u>MIL - 16</u></p> <ol style="list-style-type: none">1. I know form my daughter in law, who use the family planning methods.
<p><u>MIL - 17</u></p>	<p><u>MIL - 18</u></p>

<ol style="list-style-type: none">1. Kaligange Shimantic2. Zakigange Hospital	<ol style="list-style-type: none">1. Kanaighat Hospital2. Shimantic3. Medicine shop
<p><u>MIL - 19</u></p> <ol style="list-style-type: none">1. Neighbors	<p><u>MIL - 20</u></p> <ol style="list-style-type: none">1. Kanaighat Hospital2. Shoroker bazar Medicine shop3. Shimantic

VIII.3. APPENDIX C: SURVEY INSTRUMENTS

Post Partum Formative: RDW Survey

Projahnmo - Sylhet

Version: 15 June 06

Healthy Fertility Practices Module

IDENTIFICATION

	Name	Code	
UPAZILA		<input type="text"/>	If there is more than one recently delivered woman in the household, then check their code numbers and interview each of them separately. Before leaving the HH, make sure you have interviewed all of them.
UNION		<input type="text"/> <input type="text"/>	
VILLAGE		<input type="text"/> <input type="text"/> <input type="text"/>	
BARI		<input type="text"/> <input type="text"/> <input type="text"/>	
HOUSEHOLD		<input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> Check# Bari ### HH ##	

WOMAN's name _____

WOMAN of

Husband's name: _____

Interviewer's Visit and Status				
Household	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
INTERVIEWER'S NAME	_____	_____	_____	INTERVIEWER'S CODE <input type="text"/> <input type="text"/>
RESULT*	_____	_____	_____	RESULT CODE <input type="text"/> <input type="text"/>
NEXT VISIT DATE TIME	_____ _____	_____ _____		TOTAL NUMBER OF VISIT <input type="text"/>
*RESULT CODES 01. Interview over 02. Members of the HH or anybody else appropriate unavailable during the visit 03. The household has been empty for a long time now. 04. Interview cancelled 05. Refused to be interviewed 06. The address is not of a HH			07 The place has been destroyed 08 The HH could not be located 09 There is no recently delivered woman in the HH 10 Listed recently delivered woman is absent 11 Others _____ (Specify)	
How many months ago the last pregnancy end				<input type="text"/> <input type="text"/> Months
Reviewed by Supervisor Name/Code _____ <input type="text"/> <input type="text"/>		Keyed by: Name/Code _____ <input type="text"/> <input type="text"/>		
Date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		Date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		

Now I would like to ask you a few questions about your social status and pregnancy history. If any one of the questions make you uncomfortable, then you don't have to answer that question. I am assuring you once again, all of your answers will be kept confidential and will be used only for research purposes.

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1	In the last 6 months, has any health worker talked to you about family planning methods?	YES..... 1 NO 2	→6
2	Where did this health worker give you advice? ACCEPT MULTIPLE RESPONSES	PUBLIC SECTOR GOVT. HOSPITALA GOVT. HEALTH CENTERB FAMILY PLANNING CLINICC SATELLITE CLINIC.....D OTHER PUBLICE (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE HOSPITAL/CLINIC G PHARMACYH PRIVATE DOCTOR I MOBILE CLINIC J FIELDWORKERK DEPOT HOLDERL OTHER PRIVATE MEDICALM (SPECIFY) NONMEDICAL PLACE HOMEN HOME OF FRIEND/RELATIVE O NGO SECTOR NGO (NSDP) CLINICP OTHER Q (SPECIFY)	
3	What methods did she discuss with you? Do not read out the responses RECORD ALL RESPONSES THAT APPLY	FEMALE STERILIZATION.....A MALE STERILIZATIONB PILLC IUD.....D INJECTABLES.....E IMPLANTS.....F CONDOMG LACTATIONAL AMEN. METHODH PERIODIC ABSTINENCE I WITHDRAWAL J OTHER X (SPECIFY)	
4	Did she discuss number of children to have?	YES1 NO2	
5	Did she discuss the importance of desired spacing between children?	YES1 NO2	
6	Now I would like to ask you about the roles of various people in your family. In your family, who mainly decides how the money you that is earned will be used?	Respondent..... 1 Husband2 Respondent and Husband together.3 Others.....4 Specify..... Respondent and others together.....5 Not applicable.....6	
7	Who in your family usually has the final say on the following decisions:		

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
A	Your own health care?	Respondent.....1 Husband2 Respondent and Husband together.....3 Others.....4 Specify..... Respondent and others together.....5 Not applicable.....6	
B	Making large household purchases?	Respondent.....1 Husband2 Respondent and Husband together.....3 Others4 Specify..... Respondent and others together.....5 Not applicable.....6	
C	Making household purchases for daily needs?	Respondent.....1 Husband2 Respondent and Husband together.....3 Others4 Specify..... Respondent and others together.....5 Not applicable.....6	
D	Visits to family or relatives?	Respondent.....1 Husband2 Respondent and Husband together.....3 Others4 Specify..... Respondent and others together.....5 Not applicable.....6	
E	What food should be cooked each day?	Respondent.....1 Husband2 Respondent and Husband together.....3 Others4 Specify..... Respondent and others together.....5 Not applicable.....6	
8	Do you or your husband have a bank account or post office account?	Yes1 No2 Don't know.....9	→10 →10
9	Who manages the account?	Respondent.....1 Husband2 Respondent and Husband together.....3 Others4 Specify..... Respondent and others together.....5 Not applicable.....6	
10	Are you allowed to have some money set aside to use as you wish?	Yes1 No2	
11	Do you need permission to purchase the following?		
A	Household Items	Yes1 No2 Not Applicable.....7	
B	Clothing Items	Yes1 No2 Not Applicable.....7	
C	A piece of jewelry	Yes1 No2 Not Applicable.....7	
D	A gift for a relative	Yes1 No2 Not Applicable.....7	
E	Medicine	Yes1 No2 Not Applicable.....7	
12	Do you need permission to:		
A	Go to the market?	Yes1 No2 Not Applicable.....7	
B	Visit relatives or friends inside the village?	Yes1 No2 Not Applicable.....7	

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
C	Visit relatives or friends outside the village?	Yes1 No2 Not Applicable.....7	
D	Take sick child to health center?	Yes1 No2 Not Applicable.....7	

Now I would like to talk about family planning - the various ways or methods that a couple can use to delay or avoid a pregnancy. CIRCLE CODE 1 IN 13 FOR EACH METHOD MENTIONED SPONTANEOUSLY. THEN PROCEED DOWN COLUMN 13, READING THE NAME AND DESCRIPTION OF EACH METHOD NOT MENTIONED SPONTANEOUSLY. CIRCLE CODE 1 IF METHOD IS RECOGNIZED, AND CODE 2 IF NOT RECOGNIZED. THEN, FOR EACH METHOD WITH CODE 1 CIRCLED IN 13, ASK 14. THEN, FOR EACH METHOD WITH CODE 1 CIRCLED IN 13, ASK 15.

	Which ways or methods have you heard about?	13. Have you ever heard of (METHOD)?	14. Have you ever used (method)?	15. Would you say that you approve, neither approve nor disapprove, disapprove of couples using (METHOD) to avoid getting pregnant? APPROVE.....1 NEITHER APPROVE NOR DISAPPROVE.....2 DISAPPROVE.....3 DON'T KNOW/UNSURE.....9
A	FEMALE STERILIZATION Women can have an operation to avoid having any more children.	Yes 1--> 14A No.....2 --> 13B	YES.....1 NO.....2	<input type="checkbox"/>
B	MALE STERILIZATION Men can have an operation to avoid having any more children.	Yes 1--> 14B No.....2 --> 13C	YES.....1 NO.....2	<input type="checkbox"/>
C	PILL Women can take a pill every day to avoid becoming pregnant.	Yes 1--> 14C No.....2 --> 13D	YES.....1 NO.....2	<input type="checkbox"/>
D	IUD Women can have a loop or coil placed inside them by a doctor or a nurse.	Yes 1--> 14D No.....2 --> 13E	YES.....1 NO.....2	<input type="checkbox"/>
E	INJECTABLES Women can have an injection by a health provider that stops them from becoming pregnant for one or more months.	Yes 1--> 14E No.....2 --> 13F	YES.....1 NO.....2	<input type="checkbox"/>
F	IMPLANTS Women can have several small rods placed in their upper arm by a doctor or nurse which can prevent pregnancy for one or more years.	Yes 1--> 14F No.....2 --> 13G	YES.....1 NO.....2	<input type="checkbox"/>
G	CONDOM Men can put a rubber sheath on their penis before sexual intercourse.	Yes 1--> 14G No.....2 --> 13H	YES.....1 NO.....2	<input type="checkbox"/>
H	LACTATIONAL AMENORRHEA METHOD (LAM) Up to 6 months after childbirth, a woman can use a method that requires that she breastfeeds frequently, day and night, and that her menstrual period has not returned.	Yes 1--> 14H No.....2 --> 13I	YES.....1 NO.....2	<input type="checkbox"/>
I	RHYTHM OR PERIODIC ABSTINENCE Every month that a woman is sexually active she can avoid pregnancy by not having sexual intercourse on the days of the month she is most likely to get pregnant.	Yes 1--> 14I No.....2 --> 13J	YES.....1 NO.....2	<input type="checkbox"/>
J	WITHDRAWAL Men can be careful and pull out before climax.	Yes 1--> 14J No.....2 --> 13K	YES.....1 NO.....2	<input type="checkbox"/>
K	Emergency contraception (pills for 3 consecutive days)	Yes 1--> 14K No.....2 --> 13L		
L	Have you heard of any other ways or methods that women or men can use to avoid pregnancy?	YES.....1--> 14L _____ (SPECIFY) _____ (SPECIFY) NO.....2-->16	YES.....1 NO.....2 YES.....1 NO.....2	<input type="checkbox"/> <input type="checkbox"/>

16	In general, would you say that you approve or disapprove of couples using a method to avoid getting pregnant?	APPROVE1 DISAPPROVE2 DON'T KNOW/UNSURE9	
17	Now I want to ask you about your husband's views on family planning. Do you think that your husband approves or disapproves of couples using a contraceptive method to avoid pregnancy?	APPROVES1 DISAPPROVES2 DON'T KNOW9	
18	How often have you talked to your husband about family planning in the past year?	NEVER.....1 ONCE OR TWICE.....2 MORE OFTEN.....3	
19	Now I want to ask you about your mother-in-law's views on family planning. Do you think that your mother-in-law approves or disapproves of couples using a contraceptive method to avoid pregnancy?	APPROVES1 DISAPPROVES2 Not applicable.....7 → DON'T KNOW.....9	→ 21
20	How often have you talked to your mother-in-law about family planning in the past year?	NEVER.....1 ONCE OR TWICE.....2 MORE OFTEN.....3	
21	Now I would like to ask about the pregnancies you have had in your lifetime. Do you have any living children?	YES.....1 NO.....2	
22	How many times have you been pregnant?	<input type="checkbox"/>	
23	Are you pregnant now?	YES1 NO2 UNSURE9	<input type="checkbox"/> →27
24	Did you want to become pregnant at that time?	YES1 NO2 UNSURE.....9	→ 27
25	Did you want to wait until <u>later</u> , or did you <u>not want</u> to have any (more) children at all?	LATER1 NOT AT ALL.....2	→ 27
26	How much longer would you like to have waited?	MONTHS1 <input type="checkbox"/> <input type="checkbox"/> YEARS2 <input type="checkbox"/> <input type="checkbox"/> DON'T KNOW 998	
27	Now I would like to ask about your last completed pregnancy. What was the outcome of that pregnancy?	BORN ALIVE.....1 BORN DEAD2 MISCARRIAGE/ABORTION3	
28	Did you want to become pregnant at that time?	YES.....1 NO2 UNSURE.....9	→ 31
29	Did you want to wait until <u>later</u> , or did you <u>not want</u> to have any (more) children at all?	LATER1 NOT AT ALL2	→ 31
30	How much longer would you like to have waited?	MONTHS1 <input type="checkbox"/> <input type="checkbox"/> YEARS.....2 <input type="checkbox"/> <input type="checkbox"/> DON'T KNOW 998	
31	CHECK Q22 AND Q23: Q22= or < 2 AND Q23= YES → 35 Q22=2 and Q23=No → ask the question below Q22 >2 → Ask question below. Now I would like to ask about the pregnancy preceding that one. What was the outcome of that pregnancy?	BORN ALIVE.....1 BORN DEAD2 MISCARRIAGE/ABORTION3 NO PREVIOUS PREGNANCY.....9	→35

32	Did you want to become pregnant at that time?	YES.....1 NO2 UNSURE.....9	→ 35
33	Did you want to wait until <u>later</u> , or did you <u>not want</u> to have any (more) children at all?	LATER1 NOT AT ALL2	→ 35
34	How much longer would you like to have waited?	MONTHS 1 <input type="text"/> <input type="text"/> YEARS.....2 <input type="text"/> <input type="text"/> DON'T KNOW 998	
35	CHECK 14 (A): WOMAN NOT STERILIZED <input type="checkbox"/> 36 WOMAN STERILIZED <input type="checkbox"/> _____		→38
36	CHECK 23: NOT PREGNANT OR UNSURE <input type="checkbox"/> 37 PREGNANT <input type="checkbox"/> _____		→40A
37	Are you currently doing something or using any method to delay or avoid getting pregnant?	YES1 NO2	→40A
38	Which method are you using? ALLOW MORE THAN ONE RESPONSE CIRCLE 'A' FOR FEMALE STERILIZATION.	FEMALE STERILIZATION A MALE STERILIZATION..... B PILL C IUD D INJECTABLES E IMPLANTS F CONDOM G LACTATIONAL AMEN. METHOD..... H PERIODIC ABSTINENCE I WITHDRAWAL..... J OTHER _____ X (SPECIFY)	→39 →39A
39	In what month and year was the sterilization performed?	Month ----- <input type="text"/> <input type="text"/> Year ----- <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
39A	For how long have you been using (CURRENT METHOD) now without stopping? PROBE: In what month and year did you start using (CURRENT METHOD) continuously?	Year -----1 <input type="text"/> <input type="text"/> Month -----2 <input type="text"/> <input type="text"/> Don't know ----- 998	
40	CHECK 38: ENTER CODE FOR METHOD USED IN MONTH OF INTERVIEW IN COLUMN 1 OF THE CALENDAR AND IN EACH MONTH BACK TO THE DATE STARTED USING (OR THE BEGINNING OF THE CALENDAR, IF STARTED USING AFTER 2005) OR IF NOW PREGNANT, ENTER NUMBER OF MONTHS PREGNANT IN CALENDAR. ENTER METHOD SOURCE CODE IN COLUMN 2 OF CALENDAR IN MONTH STARTED USING.		
40A	Have you and your husband ever done anything or used any method to avoid or delay getting pregnant?	YES1 NO2	→42

I would like to ask you some questions about the times you or your partner may have used a method to avoid getting pregnant during the last few years.

USE CALENDAR TO PROBE FOR EARLIER PERIODS OF USE AND NONUSE, STARTING WITH MOST RECENT USE, BACK TO JANUARY 2003

USE NAMES OF CHILDREN, DATES OF BIRTH, AND PERIODS OF PREGNANCY AS REFERENCE POINTS.

IN COLUMN 1, ENTER METHOD USE CODE OR '0' FOR NONUSE IN EACH BLANK MONTH.

ILLUSTRATIVE QUESTIONS:

- COLUMN 1:
- When was the last time you used a method? Which method was that?
 - When did you start using that method? How long after the birth of (NAME)?
 - How long did you use the method then?

IN COLUMN 2, ENTER METHOD SOURCE CODE IN FIRST MONTH OF EACH USE.

ILLUSTRATIVE QUESTIONS:

- COLUMN 2:
- Where did you obtain the method when you started using it?
 - Where did you get advice on how to use the method [for LAM, rhythm, or withdrawal]?

IN COLUMN 3, ENTER CODES FOR DISCONTINUATION NEXT TO LAST MONTH OF USE.

NUMBER OF CODES IN COLUMN 3 MUST BE SAME AS NUMBER OF INTERRUPTIONS OF METHOD USE IN COLUMN 1.

ASK WHY SHE STOPPED USING THE METHOD. IF A PREGNANCY FOLLOWED, ASK WHETHER SHE BECAME PREGNANT UNINTENTIONALLY WHILE USING THE METHOD OR DELIBERATELY STOPPED TO GET PREGNANT.

ILLUSTRATIVE QUESTIONS:

- COLUMN 3:
- Why did you stop using the (METHOD)?
 - Did you become pregnant while using (METHOD), or did you stop to get pregnant, or did you stop for some other reason?

IF DELIBERATELY STOPPED TO BECOME PREGNANT, ASK:

- How many months did it take you to get pregnant after you stopped using (METHOD)? AND ENTER '0' IN EACH SUCH MONTH IN COLUMN 1.

In column 4:

- 1 = Married
- 0 = Not in union

INSTRUCTIONS:		1	2	3	4
ONLY ONE CODE SHOULD APPEAR IN ANY BOX.		'13 01 Boishak 01			01 Apr
FOR COLUMNS 1 AND 4, ALL MONTHS SHOULD BE FILLED IN.		12 Choitro 02			02 Mar
INFORMATION TO BE CODED FOR EACH COLUMN		11 FALGUN 03			03 FEB 2 0
COL. 1: <u>BIRTHS, PREGNANCIES, CONTRACEPTIVE USE</u> **		10 MAGH 04			04 JAN 0 6
12 BIRTHS	09 POUSH 05				05 DEC
13 PREGNANCIES	08 06				06 NOV
14 TERMINATIONS	AGRAHAYAN				
	07 KARTIK 07				07 OCT
0 NO METHOD	06 ASHWIN 08				08 SEP
1 FEMALE STERILIZATION	1 05 BADHRA 09				09 AUG 2
2 MALE STERILIZATION	4 04 SRABAN 10				10 JUL 0
3 PILL	1 03 ASHAR 11				11 JUN 0
4 IUD	2 02 JAISTHA 12				12 MAY 5
5 INJECTABLES	01 BAISHAK 13				13 APR
6 IMPLANTS	12 CHOITRA 14				14 MAR
7 CONDOM	11 FALGUN 15				15 FEB
8 LACTATIONAL AMENORRHEA METHOD	10 MAGH 16				16 JAN
9 PERIODIC ABSTINENCE					
10 WITHDRAWAL					
11 OTHER _____					
(SPECIFY)					
COL. 2: <u>SOURCE OF CONTRACEPTION</u>	09 POUSH 17				17 DEC
1 GOVT. HOSPITAL	08 18				18 NOV
2 GOVT. HEALTH CENTER	AGRAHAYAN				
3 FAMILY PLANNING CLINIC	07 KARTIK 19				19 OCT
4 GOVT. MOBILE CLINIC	06 ASHWIN 20				20 SEP
5 GOVT. FIELDWORKER	1 05 BADHRA 21				21 AUG 2
6 OTHER PUBLIC (GOVT.)	4 04 SRABAN 22				22 JUL 0
	1 03 ASHAR 23				23 JUN 0
	1 02 JAISTHA 24				24 MAY 4
	01 BAISHAK 25				25 APR
7 PVT. HOSPITAL/CLINIC	12 CHOITRA 26				26 MAR
8 PHARMACY	11 FALGUN 27				27 FEB
9 PRIVATE DOCTOR	10 MAGH 28				28 JAN
10 NON-GOVT. MOBILE CLINIC					
11 NON-GOVT. FIELDWORKER					
12 DEPOT HOLDER	09 POUSH 29				29 DEC
13 OTHER PRIVATE MEDICAL	08 30				30 NOV
14 HOME	AGRAHAYAN				
15 HOME OF FRIENDS/RELATIVES	07 KARTIK 31				31 OCT
16 NGO (NSDP) CLINIC	06 ASHWIN 32				32 SEP
17 Not applicable	2 05 BADHRA 33				33 AUG 2
18 OTHER _____	0 04 SRABAN 34				34 JUL 0
(SPECIFY)	0 03 ASHAR 35				35 JUN 0
	3 02 JAISTHA 36				36 MAY 3
COL. 3: <u>DISCONTINUATION OF CONTRACEPTIVE USE</u>	01 BAISHAK 37				37 APR
0 INFREQUENT SEX/HUSBAND AWAY	12 CHOITRA 38				38 MAR
1 BECAME PREGNANT WHILE USING	11 FALGUN 39				39 FEB
2 WANTED TO BECOME PREGNANT	10 MAGH 40				40 JAN
3 HUSBAND/PARTNER DISAPPROVED					
4 WANTED MORE EFFECTIVE METHOD					
5 HEALTH CONCERNS					
6 SIDE EFFECTS					
7 LACK OF ACCESS/TOO FAR					
8 COSTS TOO MUCH					
9 INCONVENIENT TO USE					
10 FATALISTIC					
11 DIFFICULT TO GET PREGNANT/MENOPAUSAL					
12 MARITAL DISSOLUTION/SEPARATION					
13 OTHER _____					
(SPECIFY)					
14 DON'T KNOW					
COL. 4: <u>MARRIAGE/UNION</u>					
1 MARRIED					
0 NOT IN UNION					

** Response categories may be added for other methods.

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
42	<p>CHECK Q23:</p> <p>NOT PREGNANT <input type="checkbox"/> OR UNSURE <input type="checkbox"/> PREGNANT <input type="checkbox"/></p> <p>Now I have some questions about the future. Would you like to have (a/another) child, or would you prefer not to have any (more) children?</p> <p>Now I have some questions about the future. After the child you are expecting now, would you like to have another child, or would you prefer not to have any more children?</p>	<p>HAVE (A/ANOTHER) CHILD..... 1 NO MORE 2 SAYS SHE CAN'T GET PREGNANT..... 3 UNDECIDED/DON'T KNOW: AND PREGNANT 4 AND NOT PREGNANT OR UNSURE 5</p>	<p>→ 44 → 47 → 47 → 46</p>
43	<p>NOT PREGNANT OR UNSURE <input type="checkbox"/> PREGNANT <input type="checkbox"/></p> <p>How long would you like to wait from now before the birth of (a/another) child?</p> <p>After the birth of the child you are expecting now, how long would you like to wait before the birth of another child?</p>	<p>MONTHS1 <input type="checkbox"/> <input type="checkbox"/></p> <p>YEARS.....2 <input type="checkbox"/> <input type="checkbox"/></p> <p>SOON/NOW 993</p> <p>SAYS SHE CAN'T GET PREGNANT.... 994</p> <p>OTHER _____ 996 (SPECIFY)</p> <p>DON'T KNOW 998</p>	<p>→NOW PREG- NANT 47</p>
44	<p>CHECK Q38: USING A CONTRACEPTIVE METHOD?</p> <p>NO, <input type="checkbox"/> NOT CURRENTLY USING</p> <p>YES, <input type="checkbox"/> CURRENTLY USING → 46</p>		

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP						
50	How many children would he like you to have?	NUMBER <input type="text"/> <input type="text"/> OTHER _____ 96 (SPECIFY)							
51	How many of these children would he like to be boys, how many would he like to be girls, and for how many would the sex not matter?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">Boys</td> <td style="width: 33%; text-align: center;">Girls</td> <td style="width: 33%; text-align: center;">Either</td> </tr> <tr> <td style="text-align: center;"> <input type="text"/> <input type="text"/> </td> <td style="text-align: center;"> <input type="text"/> <input type="text"/> </td> <td style="text-align: center;"> <input type="text"/> <input type="text"/> </td> </tr> </table> Number Don't know or don't want to say: 96	Boys	Girls	Either	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
Boys	Girls	Either							
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>							
52	Has your mother-in-law ever told you how many children she would like you to have?	YES1 NO2 Not applicable.....7 DON'T KNOW9	→ 55 → 55 → 55						
53	How many children would she like you to have?	NUMBER <input type="text"/> <input type="text"/> OTHER _____ 96 (SPECIFY)							
54	How many of these children would she like to be boys, how many would she like to be girls, and for how many would the sex not matter?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">Boys</td> <td style="width: 33%; text-align: center;">Girls</td> <td style="width: 33%; text-align: center;">Either</td> </tr> <tr> <td style="text-align: center;"> <input type="text"/> <input type="text"/> </td> <td style="text-align: center;"> <input type="text"/> <input type="text"/> </td> <td style="text-align: center;"> <input type="text"/> <input type="text"/> </td> </tr> </table> Number Don't know or don't want to say: 96	Boys	Girls	Either	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
Boys	Girls	Either							
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>							
55	Now I would like to ask you your opinion about the timing of births in a family. In your opinion, what is the best length of time to wait after giving birth before having another child?	1 YEAR OR LESS1 2 YEARS2 3 YEARS3 4 YEARS OR MORE4 NOT SURE9							
56	In your opinion, if a mother waits at least 2-3 years after having one baby before getting pregnant again, is there any benefit to the mother?	YES1 NO2 DON'T KNOW9	→ 58 → 58						
57	What are the benefits to the mother? (PROBE: Anything else?) Record all responses mentioned	Mother less likely to die/more likely to live.....A Mother less likely to be sick/have complicationsB Mother can breastfeed more easilyC Easier financially for the familyD Less mental stress for the mother if fewer babies at homeE OtherZ							
58	In your opinion, if a mother waits at least 2-3 years after having one baby before getting pregnant again, is there any benefit to the baby?	YES1 NO2 DON'T KNOW9	→ STOP → STOP						
59	What are the benefits to the baby? (PROBE: Anything else?) Record all responses mentioned	Baby less likely to die/more likely to live.....A Baby less likely to be small/underweightB Baby less likely to be sickly/more likely to be healthyC Mother can breastfeed more easilyD Easier financially for the familyE Less mental stress for the mother if fewer babies at homeF OtherZ							

Post Partum Formative: Newly Married Women Survey

Projahnmo - Sylhet

Version: 15 June 06

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IDENTIFICATION

Name	Code	
UPAZILA	<input type="checkbox"/>	If there is more than one recently married woman in the household, then check their code numbers and interview each of them separately. Before leaving the HH, make sure you have interviewed all of them.
UNION	<input type="checkbox"/> <input type="checkbox"/>	
VILLAGE	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
BARI	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
HOUSEHOLD	<input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> <small>Check# Bari ### HH ##</small>	

WOMAN's name: _____

Husband's name: _____

Interviewer's Visit and Status			
Household	1	2	FINAL VISIT
DATE	_____	_____	DAY _____ MONTH _____ YEAR _____ <input type="checkbox"/>
INTERVIEWER'S NAME	_____	_____	INTERVIEWER'S CODE <input type="checkbox"/>
RESULT*	_____	_____	RESULT CODE _____
NEXT VISIT DATE	_____	_____	TOTAL NUMBER OF VISIT
TIME	_____	_____	
*RESULT CODES 01. Interview over 02. Members of the HH or anybody else appropriate unavailable during the visit 03. The household has been empty for a long time now. 04. Interview cancelled 05. Refused to be interviewed 06. The address is not of a HH		07. The place has been destroyed 08. The HH could not be located 09. There is no recently married woman in the F 12. There is no newly married women in the HH got married within 2005 January) 13. Listed newly married woman is absent 10. Listed recently delivered woman is (RDW) ; 11. Others _____ (Specify)	
Reviewed by Supervisor Name/Code _____ <input type="checkbox"/> <input type="checkbox"/>		Keyed by: Name/Code _____	
Date <input type="checkbox"/> <input type="checkbox"/> /____/____		Date <input type="checkbox"/> <input type="checkbox"/> /____/____	

Upazila : _____

Union _____

Village _____

Page 1

Name of Data Collector _____

Household ID: _____

Check

Bari

Household

dd

mm

yyyy

Date

Line no	Usual residents and guests	Relationship with the HH head	Sex		Residence		Age		Marital status (for persons over ten years of age)				Education If five years or older				Husband's line number			
			Is [name] male or female?	Does [name] usually live in this house?	Did [name] stay of spent the night at your house last night?	What was [name]'s age in his/her last birthday? (Write in whole years; if less than one year, write "00")	What is the current marital status of [name]?	Has [name] ever been to school?	What was the highest level of school did s/he attend?	(If less than 25 years) Is [name] still going to school/college/uni.?	For married women, write the line number of the husband from column (1), otherwise write "00"									
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)									
			M	F	YES	NO	YES	NO	IN YEARS	CM	FM	NM	DN	YES	NO	LEVEL	CLASS	YES	NO	
01		<input type="text"/>	1	2	1	2	1	2	<input type="text"/>	1	2	3	9	1	2↓ 12	<input type="text"/>	<input type="text"/>	1	2	<input type="text"/>
02		<input type="text"/>	1	2	1	2	1	2	<input type="text"/>	1	2	3	9	1	2↓ 12	<input type="text"/>	<input type="text"/>	1	2	<input type="text"/>
03		<input type="text"/>	1	2	1	2	1	2	<input type="text"/>	1	2	3	9	1	2↓ 12	<input type="text"/>	<input type="text"/>	1	2	<input type="text"/>
04		<input type="text"/>	1	2	1	2	1	2	<input type="text"/>	1	2	3	9	1	2↓ 12	<input type="text"/>	<input type="text"/>	1	2	<input type="text"/>
05		<input type="text"/>	1	2	1	2	1	2	<input type="text"/>	1	2	3	9	1	2↓ 12	<input type="text"/>	<input type="text"/>	1	2	<input type="text"/>
Codes for Relationship with Household Head Relationship with HH head (Column 3)			**Notes on Marital Status (Column 8)						**Codes For Education (Column 10)											
01= HH Head 02=Wife or husband 03=Sone or daughter 04=Son or daughter in law 05=grandson or granddaughter			06=Father/Mother 07=Father or mother in law 08=Brother or sister 09=Other relatives 10=Adopted or step child 11=No relationship						CM (Currently Married) FM (Formerly Married) NM (Never Married) DK (Don't know) (Only applies to the guests) (Attention: Circle line number of the respondent) (Write G next to the line numbers of guests)											
									Level 1= Primary 2= High school 3= College or university 4= Doesn't know				‡k*Yx (Class) 00= Lower than class one 99= Doesn't know							

Line no	Usual residents and guests	Relationship with the HH head	Sex		Residence		Age		Marital status (for persons over ten years of age)			Education If five years or older				Husband's line number			
			Is [name] male or female?	Does [name] usually live in this house?	Did [name] stay of spent the night at your house last night?	What was [name]'s age in his/her last birthday? (Write in whole years; if less than one year, write "00")	What is the current marital status of [name]?	Has [name] ever been to school?	What was the highest level of school did s/he attend?	(If less than 25 years) Is [name] still going to school/college/uni.?	For married women, write the line number of the husband from column (1), otherwise write "00"								
(1)	(2)	(3)	(4)		(5)		(6)		(7)	(8)			(9)		(10)		(11)		(12)
			M	F	YES	NO	YES	NO	IN YEARS	CM	FM	NM	YES	NO	LEVEL	CLASS	YES	NO	
06		<input type="text"/> <input type="text"/>	1	2	1	2	1	2	<input type="text"/> <input type="text"/>	1	2	3	1	2↓ 12	<input type="text"/> <input type="text"/> <input type="text"/>		1	2	<input type="text"/> <input type="text"/>
07		<input type="text"/> <input type="text"/>	1	2	1	2	1	2	<input type="text"/> <input type="text"/>	1	2	3	1	2↓ 12	<input type="text"/> <input type="text"/> <input type="text"/>		1	2	<input type="text"/> <input type="text"/>
08		<input type="text"/> <input type="text"/>	1	2	1	2	1	2	<input type="text"/> <input type="text"/>	1	2	3	1	2↓ 12	<input type="text"/> <input type="text"/> <input type="text"/>		1	2	<input type="text"/> <input type="text"/>
09		<input type="text"/> <input type="text"/>	1	2	1	2	1	2	<input type="text"/> <input type="text"/>	1	2	3	1	2↓ 12	<input type="text"/> <input type="text"/> <input type="text"/>		1	2	<input type="text"/> <input type="text"/>
10		<input type="text"/> <input type="text"/>	1	2	1	2	1	2	<input type="text"/> <input type="text"/>	1	2	3	1	2↓ 12	<input type="text"/> <input type="text"/> <input type="text"/>		1	2	<input type="text"/> <input type="text"/>
11		<input type="text"/> <input type="text"/>	1	2	1	2	1	2	<input type="text"/> <input type="text"/>	1	2	3	1	2↓ 12	<input type="text"/> <input type="text"/> <input type="text"/>		1	2	<input type="text"/> <input type="text"/>
12		<input type="text"/> <input type="text"/>	1	2	1	2	1	2	<input type="text"/> <input type="text"/>	1	2	3	1	2↓ 12	<input type="text"/> <input type="text"/> <input type="text"/>		1	2	<input type="text"/> <input type="text"/>
13		<input type="text"/> <input type="text"/>	1	2	1	2	1	2	<input type="text"/> <input type="text"/>	1	2	3	1	2↓ 12	<input type="text"/> <input type="text"/> <input type="text"/>		1	2	<input type="text"/> <input type="text"/>
Codes for Relationship with Household Head					**Notes on Marital Status (Column 8)					**Codes For Education (Column 10)									
Relationship with HH head (Column 3)					Marital status														
01= HH Head 02=Wife or husband 03=Son or daughter 04=Son or daughter in law 05=grandson or granddaughter			06=Father/Mother 07=Father or mother in law 08=Brother or sister 09=Other relatives 10=Adopted or step child 11=No relationship		CM (Currently Married) FM (Formerly Married) NM (Never Married) DK (Don't know) (Only applies to the guests)					Level 1= Primary 2= High school 3= College or university 4= Doesn't know					Class 00= Lower than class one 99= Doesn't know				
(Attention: Circle line number of the respondent)										(Write G next to the line numbers of guests)									

Line no	Usual residents and guests	Relationship with the HH head	Sex		Residence		Age		Marital status (for persons over ten years of age)			Education If five years or older				Husband's line number					
			Is [name] male or female?	Does [name] usually live in this house?	Did [name] stay of spent the night at your house last night?	What was [name]'s age in his/her last birthday? (Write in whole years; if less than one year, write "00")	What is the current marital status of [name]? Look at the codes below			Has [name] ever been to school?	What was the highest level of school did s/he attend? Look at the codes below	(If less than 25 years) Is [name] still going to school/college/uni.?									
(1)	(2)	(3)	(4)		(5)		(6)		(7)	(8)			(9)		(10)		(11)		(12)		
			M	F	YES	NO	YES	NO	IN YEARS	CM	FM	NM	DN	YES	NO	LEVEL	CLASS	YES	NO		
14		<input type="text"/> <input type="text"/>	1	2	1	2	1	2	<input type="text"/> <input type="text"/>	1	2	3	9	1	2↓	<input type="text"/>	<input type="text"/> <input type="text"/>	1	2	<input type="text"/> <input type="text"/>	
15		<input type="text"/> <input type="text"/>	1	2	1	2	1	2	<input type="text"/> <input type="text"/>	1	2	3	9	1	2↓	<input type="text"/>	<input type="text"/> <input type="text"/>	1	2	<input type="text"/> <input type="text"/>	
16		<input type="text"/> <input type="text"/>	1	2	1	2	1	2	<input type="text"/> <input type="text"/>	1	2	3	9	1	2↓	<input type="text"/>	<input type="text"/> <input type="text"/>	1	2	<input type="text"/> <input type="text"/>	
17		<input type="text"/> <input type="text"/>	1	2	1	2	1	2	<input type="text"/> <input type="text"/>	1	2	3	9	1	2↓	<input type="text"/>	<input type="text"/> <input type="text"/>	1	2	<input type="text"/> <input type="text"/>	
18		<input type="text"/> <input type="text"/>	1	2	1	2	1	2	<input type="text"/> <input type="text"/>	1	2	3	9	1	2↓	<input type="text"/>	<input type="text"/> <input type="text"/>	1	2	<input type="text"/> <input type="text"/>	
19		<input type="text"/> <input type="text"/>	1	2	1	2	1	2	<input type="text"/> <input type="text"/>	1	2	3	9	1	2↓	<input type="text"/>	<input type="text"/> <input type="text"/>	1	2	<input type="text"/> <input type="text"/>	
Codes for Relationship with Household Head					**Notes on Marital Status (Column 8)					**Codes For Education (Column 10)											
Relationship with HH head (Column 3)					Marital status					Level				(Class)							
01= HH Head 02=Wife or husband 03=Sone or daughter 04=Son or daughter in law 05=grandson or granddaughter					06=Father/Mother 07=Father or mother in law 08=Brother or sister 09=Other relatives 10=Adopted or step child 11=No relationship					CM (Currently Married) FM (Formerly Married) NM (Never Married) DK (Don't know) (Only applies to the guests)					1= Primary 2= High school 3= College or university 4= Doesn't know				00= Lower than class one 99= Doesn't know		
					(Attention: Circle line number of the respondent) (Write G next to the line numbers of guests)																

Household ID: --
check bari household

Name of the HH head: _____

SECTION ON HOUSEHOLD INFORMATION: Interview HH head or otherwise an adult

QUESTIONS	CODING CATEGORIES	SKIP
<p>13. Where do you get the water to do your dishes?</p> <p>(Try to be certain about the source. There is very unlikely for people to have pipe-water or supply water in the villages. If the response is pipe-water, then probe for the source and circle the appropriate code.)</p>	<p>Pipe-water/ supply water:</p> <p>Tap water inside the house..... 11</p> <p>Tap water outside the house..... 12</p> <p>Well water:</p> <p>Tube well21</p> <p>Deep tube well22</p> <p>Well23</p> <p>Surface water:</p> <p>Ponds/closed waterbody/ ditches/ lakes/etc.31</p> <p>River/canal/fountain.....32</p> <p>Rainwater.....41</p> <p>Bottled-water51</p> <p>Filtered water61</p> <p>Others98</p> <p>(Specify)</p>	
<p>14 What kind of water do the members of the HH usually use as drinking water?</p> <p>(Try to be certain about the source. There is very unlikely for people to have pipe-water or supply water in the villages. If the response is pipe-water, then probe for the source and circle the appropriate code.)</p>	<p>Pipe-water/ supply water:</p> <p>Tap water inside the house..... 11</p> <p>Tap water outside the house..... 12</p> <p>Well water:</p> <p>Tube well21</p> <p>Deep tube well22</p> <p>Well23</p> <p>Surface water:</p> <p>Ponds/closed waterbody/ ditches/ lakes/etc.31</p> <p>River/canal/fountain.....32</p> <p>Rainwater.....41</p> <p>Bottled-water51</p> <p>Filtered water61</p> <p>Others98</p> <p>(Specify)</p>	
<p>15 Is the water boiled before drinking?</p>	<p>Yes 1</p> <p>No 2</p>	
<p>16 What kind of arrangement do you have for latrine?</p>	<p>Septic tank/moder latrine (comode/pan)11</p> <p>Pit latrine:</p> <p>Water sealed/slab latrine21</p> <p>Pit latrine.....22</p> <p>Open latrine23</p> <p>Hanging latrine24</p> <p>No latrine/bushes/field.....31</p> <p>Others (specify).....98</p>	
<p>17 Do you have electricity in your HH?</p>	<p>Yes 1</p> <p>No 2</p>	

<p>18 How many of the following (useable) do you have in your household? For example: Almira/wardrobe and so on...</p> <p>Record all the numbers mentioned</p>	<p>Almira/wardrobe..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Table <input type="checkbox"/> <input type="checkbox"/></p> <p>Dressing table <input type="checkbox"/> <input type="checkbox"/></p> <p>Dining table <input type="checkbox"/> <input type="checkbox"/></p> <p>Bench/chair <input type="checkbox"/> <input type="checkbox"/></p> <p>Clock/wall clock <input type="checkbox"/> <input type="checkbox"/></p> <p>Bed/chouki..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Radio..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Television..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Blankets <input type="checkbox"/> <input type="checkbox"/></p> <p>Matterss <input type="checkbox"/> <input type="checkbox"/></p> <p>Refrigerator..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Motor cycle..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Sewing machine..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Telephone <input type="checkbox"/> <input type="checkbox"/></p> <p>Mobile phone <input type="checkbox"/> <input type="checkbox"/></p> <p>Bicycle..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Car/microbus/van..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Ricksha <input type="checkbox"/> <input type="checkbox"/></p> <p>Boat..... <input type="checkbox"/> <input type="checkbox"/></p> <p>If "don't know, then write "99Ó If there is none then write "00Ó</p>	
<p>19 How many of the following animals to your own? Example: Cow</p> <p>Record all the numbers mentioned</p>	<p>Cow..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Water buffalo <input type="checkbox"/> <input type="checkbox"/></p> <p>Goat <input type="checkbox"/> <input type="checkbox"/></p> <p>Sheep <input type="checkbox"/> <input type="checkbox"/></p> <p>Chicken..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Ducks <input type="checkbox"/> <input type="checkbox"/></p> <p>Pigeons..... <input type="checkbox"/> <input type="checkbox"/></p> <p>If "don't know, then write "99Ó If there is none then write "00Ó</p>	
<p>20 How many rooms are there in this HH?</p>	<p>Number <input type="checkbox"/> <input type="checkbox"/></p>	
<p>21 Is the kitchen separate from the house?</p>	<p>Yes 1</p> <p>No 2</p>	
<p>22 What is the main material of the roof? (Observe and write)</p>	<p>Natural roof: Katcha (Bamboo/thatched) 11</p> <p>Rudimentary roof: Tin..... 21</p> <p>Finished roof - pacca: Cement/Concrete/Tiles 31</p> <p>Others..... 98 (specify)</p>	
<p>23 What is the main material of the walls? (Observe and write)</p>	<p>Natural Wall: Jute/bamboo/mud 11</p> <p>Rudimentary wall: Wood 21</p> <p>Finished Wall: Brick/cement..... 31</p> <p>Tin..... 32</p> <p>Others 98 (Specify)</p>	
<p>24 What is the material of the floor? (Observe and write)</p>	<p>Natural floor: Mud/bamboo (kachcha) 11</p> <p>Rudimentary floor: Wood 21</p> <p>Finished floor: Concrete..... 31</p> <p>Others..... 98 (specify)</p>	

25	Do you have homestead land? If "no", then PROBE: Do you have homestead land anywhere else?	Yes 1 No 2	
26	Do you have any land besides the homestead?	Yes 1 No 2	→28
27	how much land is there under the ownership of the family members? Area _____ Decimal _____ Specify	Acres 1 <input type="checkbox"/> <input type="checkbox"/> Decimal..... 2 <input type="checkbox"/> <input type="checkbox"/> (one kiar = 30 decimal), If there is no land then write 00	
28	Does anyone from your household live or work abroad?	Yes 1 No 2	→34
29	What is the relationship between the person living abroad and the HH head? (If there is more than one person living abraod, then circle all the appropriate codes)	Husband or wife..... A Son B Daughter C Son or daughter in law D Grand children E Father/mother..... F Father or mother in law G Brother or sister H Other relatives..... I Adopted or step children J Others..... Y (Specify) Don't know..... Z	
30	Now tell me: Who lives in UK/London/Europe: How many in North America/USA? How many in Middle East? How many in Malaysia/Singapore/Brunei? Write numbers for each of the countries, if there is none, then write "00"	UK/London/Europe <input type="checkbox"/> <input type="checkbox"/> North America/USA <input type="checkbox"/> <input type="checkbox"/> Middle East <input type="checkbox"/> <input type="checkbox"/> malaysia/Singapore/Brunei <input type="checkbox"/> <input type="checkbox"/> Others (specify) <input type="checkbox"/> <input type="checkbox"/>	
31	Do they send money to you?	Yes 1 No 2 Don't know 9	→34 →34
32	How many times did he/she/they send money?	How many times <input type="checkbox"/> <input type="checkbox"/> Don't know 9 If they didn't send once, then write "00"	
33	Can you spend or use the money in case you need to?	Yes 1 No 2	
34	Is anyone from your HH is a member of: Grameen Bank BRAC BRDB Mothers' club Any other (i.e. micro-credit)	Grameen Bank A BRAC B BRDB C Mothers' club D Others (specify)..... E Not member of any org. Z	
35	What is your religion?	Islam 1 Hindu 2 Buddhist 3 Christian 4 Others (specify)..... 8	

36.	<p>What is the primary occupation of the head of household?</p> <p>(IF MORE THAN ONE OCCUPATION, RECORD THE MAIN ONE)</p> <p>Occupation _____</p> <p>Write here and record the appropriate code on the right hand side</p>	<p>Works in the field - his own or as a share cropper 01</p> <p>Day laborer/unskilled labor (Domestic, agricultural, or migrant) 02</p> <p>Fisherpeople..... 03</p> <p>Contracted labor (long term), carpenter, mason..... 04</p> <p>Own business (shopkeeper, vendor, rickshapuller/vanpuller, artisan..... 05</p> <p>Private service (salaried job/factory, skilled labor, sales person) 06</p> <p>All kinds of governmental job/s..... 07</p> <p>Unemployed..... 08</p> <p>Permanent employee of EPZ..... 10</p> <p>Others..... 98</p> <p>(Specify)</p>	<p>--> If HH is husband, -> 39</p>
37	<p>(If HH head is husband -----> 38)</p> <p>What is your husband's profession?</p> <p>(IF MORE THAN ONE OCCUPATION, RECORD THE MAIN ONE)</p> <p>Occupation-----</p> <p>Write here and record the appropriate code on the right hand side</p>	<p>Works in the field - his own or as a share cropper..... 01</p> <p>Day laborer/unskilled labor (Domestic, agricultural, or migrant) 02</p> <p>Fisherpeople 03</p> <p>Contracted labor (long term), carpenter, mason 04</p> <p>Own business (shopkeeper, vendor, rickshapuller/vanpuller, artisan 05</p> <p>Private service (salaried job/factory, skilled labor, sales person)..... 06</p> <p>All kinds of governmental job/s 07</p> <p>Housewife 08</p> <p>Unemployed 09</p> <p>Permanent employee of EPZ 10</p> <p>Others 98</p> <p>(Specify)</p>	<p>--> 39</p>
38	<p>Where does your husband usually work?</p>	<p>Within Sylhet district..... 1</p> <p>Outside Sylhet in some other district in Bangladesh 2</p> <p>Outside Bangladesh 3</p> <p>Unemployed 4</p>	
39	<p>Do you and your husband live in the same house now?</p>	<p>Yes 1</p> <p>No..... 2</p>	
40	<p>Are you involved in any income generating activities?</p>	<p>Yes 1</p> <p>No..... 2</p>	
41	<p>Now I will ask you about your family members and their roles.</p> <p>Who in your family decides how the money earned in the family will be spent?</p>	<p>Respondent 1</p> <p>Husband..... 2</p> <p>Respondent and Husband together. 3</p> <p>Others 4</p> <p>Specify.....</p> <p>Respondent and others together 5</p> <p>Not applicable 6</p>	

Now I would like to ask you a few questions about your social status and pregnancy history. If any one of the questions make you uncomfortable, then you don't have to answer that question. I am assuring you once again, all of your answers will be kept confidential and will be used only for research purposes.

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
42	Are you a usual resident of this household? (Need to find out and explain the definition of "usual resident")	YES.....1 NO.....2	→STOP
43	Have you ever been married?	YES.....1 NO.....2	→STOP
44	Are you currently married?	YES.....1 NO.....2	→STOP
45	Is this your first marriage?	YES.....1 NO.....2	→STOP
46	What was your date of marriage? (Write the date of marriage, NOT of any other associated events) (If the answer is DK, then write 9 in all the boxes)	<input type="checkbox"/> <input type="checkbox"/> DATE <input type="checkbox"/> <input type="checkbox"/> MONTH <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> YEAR DON'T KNOW..... 9	
47	CONFIRM THAT MARRIAGE WAS ON OR AFTER JANUARY 2005	YES.....1 NO.....2	→STOP
48	Do you have any living children?	YES.....1 NO.....2	→STOP
49	In what month and year were you born?	Year <input type="checkbox"/> <input type="checkbox"/> Month <input type="checkbox"/> <input type="checkbox"/>	
50	Who in your family usually has the final say on the following decisions:		
A	Your own health care?	Respondent..... 1 Husband..... 2 Respondent and Husband together..... 3 Others..... 4 Specify..... Respondent and others together..... 5 Not applicable 6	
B	Making large household purchases?	Respondent..... 1 Husband..... 2 Respondent and Husband together..... 3 Others..... 4 Specify..... Respondent and others together..... 5 Not applicable 6	
C	Making household purchases for daily needs?	Respondent..... 1 Husband..... 2 Respondent and Husband together..... 3 Others..... 4 Specify..... Respondent and others together..... 5 Not applicable 6	
D	Visits to family or relatives?	Respondent..... 1 Husband..... 2 Respondent and Husband together..... 3 Others..... 4 Specify..... Respondent and others together..... 5 Not applicable 6	
E	What food should be cooked each day?	Respondent..... 1 Husband..... 2 Respondent and Husband together..... 3 Others..... 4 Specify..... Respondent and others together..... 5 Not applicable 6	
51	Do you or your husband have a bank account or post office account?	Yes.....1 No.....2 Don't know.....9	→53 →53

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
52	Who manages the account?	Respondent..... 1 Husband..... 2 Respondent and Husband together..... 3 Others 4 Specify..... Respondent and others together..... 5 Not applicable 6	
53	Are you allowed to have some money set aside to use as you wish?	Yes1 No2 Not Applicable.....7	
54	Do you need permission to purchase the following?		
A	Household Items	Yes1 No2 Not Applicable.....7	
B	Clothing Items	Yes1 No2 Not Applicable.....7	
C	A piece of jewelry	Yes1 No2 Not Applicable.....7	
D	A gift for a relative	Yes1 No2 Not Applicable.....7	
E	Medicine	Yes1 No2 Not Applicable.....7	
55	Do you need permission to:		
A	Go to the market?	Yes1 No2 Not Applicable.....7	
B	Visit relatives or friends inside the village?	Yes1 No2 Not Applicable.....7	
C	Visit relatives or friends outside the village?	Yes1 No2 Not Applicable.....7	
D	Take sick child to health center?	Yes1 No2 Not Applicable.....7	
56	Since you were married, have you talked to any health worker or has any health worker come to talk to you?	No, never met any health worker.....A Came to my house to talk to me.....B I went over to talk to the health worker.....C	
57	Now I would like to talk to you about your use of health services. Since you were married, has any health worker talked to you about family planning methods?	YES..... 1 NO 2	→ 63

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
58	<p>Where did this health worker give you advice?</p> <p>ACCEPT MULTIPLE RESPONSES</p>	<p>GOVT. HOSPITAL.....A GOVT. HEALTH CENTERB FAMILY PLANNING CLINIC C MOBILE CLINIC D FIELDWORKERE OTHER PUBLIC..... F (SPECIFY)</p> <p>PRIVATE MEDICAL SECTOR PRIVATE HOSPITAL/CLINIC..... G PHARMACY H PRIVATE DOCTOR.....I MOBILE CLINIC J FIELDWORKERK DEPOT HOLDERL OTHER PRIVATE MEDICAL M (SPECIFY)</p> <p>NONMEDICAL PLACE HOME N HOME OF FRIEND/RELATIVE O</p> <p>NGO SECTOR NGO (NSDP) CLINICP</p> <p>OTHER Q (SPECIFY)</p>	
59	<p>What methods did she discuss with you?</p> <p>Do not read out the responses Probe: Anything else? Multiple responses possible RECORD ALL RESPONSES THAT APPLY</p>	<p>FEMALE STERILIZATION.....A MALE STERILIZATION B PILL C IUD..... D INJECTABLES..... E IMPLANTS F CONDOM G LACTATIONAL AMEN. METHOD H PERIODIC ABSTINENCE I WITHDRAWAL J</p> <p>OTHER X (SPECIFY)</p>	
60	Did she discuss number of children to have?	YES1 NO2	
61	Did she discuss whether to delay first birth?	YES1 NO2	
62	Did she discuss the importance of desired spacing between children?	YES1 NO2	

Now I would like to talk about family planning - the various ways or methods that a couple can use to delay or avoid a pregnancy. CIRCLE CODE 1 IN 63 FOR EACH METHOD MENTIONED SPONTANEOUSLY. THEN PROCEED DOWN COLUMN 63, READING THE NAME AND DESCRIPTION OF EACH METHOD NOT MENTIONED SPONTANEOUSLY. CIRCLE CODE 1 IF METHOD IS RECOGNIZED, AND CODE 2 IF NOT RECOGNIZED. THEN, FOR EACH METHOD WITH CODE 1 CIRCLED IN 63, ASK 64. THEN, FOR EACH METHOD WITH CODE 1 CIRCLED IN 63, ASK 65.

	Which ways or methods have you heard about?	63. Have you ever heard of (METHOD)?	64. Have you ever used (method)?	65. Would you say that you approve, neither approve nor disapprove, disapprove of couples using (METHOD) to avoid getting pregnant? APPROVE.....1 NEITHER APPROVE NOR DISAPPROVE.....2 DISAPPROVE.....3 DON'T KNOW/UNSURE.....9
A	FEMALE STERILIZATION Women can have an operation to avoid having any more children.	Yes.....1--> 64A No2--> 63B	YES.....1 NO.....2	<input type="checkbox"/>
B	MALE STERILIZATION Men can have an operation to avoid having any more children.	Yes.....1--> 64B No2--> 63C	YES.....1 NO.....2	<input type="checkbox"/>
C	PILL Women can take a pill every day to avoid becoming pregnant.	Yes.....1--> 64C No2--> 63D	YES.....1 NO.....2	<input type="checkbox"/>
D	IUD Women can have a loop or coil placed inside them by a doctor or a nurse.	Yes.....1--> 64D No2--> 63E	YES.....1 NO.....2	<input type="checkbox"/>
E	INJECTABLES Women can have an injection by a health provider that stops them from becoming pregnant for one or more months.	Yes.....1--> 64E No2--> 63F	YES.....1 NO.....2	<input type="checkbox"/>
F	IMPLANTS Women can have several small rods placed in their upper arm by a doctor or nurse which can prevent pregnancy for one or more years.	Yes.....1--> 64F No2--> 63G	YES.....1 NO.....2	<input type="checkbox"/>
G	CONDOM Men can put a rubber sheath on their penis before sexual intercourse.	Yes.....1--> 64G No2--> 63H	YES.....1 NO.....2	<input type="checkbox"/>
H	LACTATIONAL AMENORRHEA METHOD (LAM) Up to 6 months after childbirth, a woman can use a method that requires that she breastfeeds frequently, day and night, and that her menstrual period has not returned.	Yes.....1--> 64H No2--> 63I	YES.....1 NO.....2	<input type="checkbox"/>
I	RHYTHM OR PERIODIC ABSTINENCE Every month that a woman is sexually active she can avoid pregnancy by not having sexual intercourse on the days of the month she is most likely to get pregnant.	Yes.....1--> 64I No2--> 63J	YES.....1 NO.....2	<input type="checkbox"/>
J	WITHDRAWAL Men can be careful and pull out before climax.	Yes.....1--> 64J No2--> 63K	YES.....1 NO.....2	<input type="checkbox"/>
K	EMERGENCY CONTRACEPTION Women can take pills up to three days after sexual intercourse to avoid becoming pregnant.	Yes.....1--> 64K No2--> 63L	YES.....1 NO.....2	<input type="checkbox"/>
L	Have you heard of any other ways or methods that women or men can use to avoid pregnancy?	YES.....1--> 64L _____ (SPECIFY) _____ (SPECIFY) NO.....2--> 66	YES.....1 NO.....2 YES.....1 NO.....2	<input type="checkbox"/> <input type="checkbox"/>

66	Would you say that you approve or disapprove of couples using a method to avoid getting pregnant?	APPROVE 1 DISAPPROVE 2 DON'T KNOW/UNSURE 9	
67	Now I want to ask you about your husband's views on family planning. Do you think that your husband approves or disapproves of couples using a contraceptive method to avoid pregnancy?	APPROVES 1 DISAPPROVES 2 DON'T KNOW 9	
68	How often have you talked to your husband about family planning in the past year?	NEVER 1 ONCE OR TWICE 2 MORE OFTEN 3	
69	Now I want to ask you about your mother-in-law's views on family planning. Do you think that your mother-in-law approves or disapproves of couples using a contraceptive method to avoid pregnancy?	APPROVES 1 DISAPPROVES 2 Not applicable 7 DON'T KNOW 9	
70	How often have you talked to your mother-in-law about family planning in the past year?	NEVER 1 ONCE OR TWICE 2 MORE OFTEN 3	
71	CHECK 64 (A): WOMAN NOT STERILIZED <input type="checkbox"/> WOMAN STERILIZED <input type="checkbox"/> _____		→78
72	Now I would like to ask you about your plans to have children. Are you pregnant now?	YES 1 NO 2 UNSURE 8	↓→77
73	How many months pregnant are you?	<input type="checkbox"/>	
74	Before you became pregnant, did you want to become pregnant at that time?	YES 1 NO 2	→ 80
75	Did you want to wait until <u>later</u> , or did you <u>not want</u> to have any children at all?	LATER 1 NOT AT ALL 2	→ 77
76	How much longer would you like to have waited?	MONTHS 1 <input type="checkbox"/> <input type="checkbox"/> YEARS 2 <input type="checkbox"/> <input type="checkbox"/>	
77	(Check Q 72: If pregnant then → 80 A) Are you currently doing something or using any method to delay or avoid getting pregnant?	YES 1 NO 2	→80A
78	Which method are you using? ALLOW MORE THAN ONE RESPONSE CIRCLE 'A' FOR FEMALE STERILIZATION.	FEMALE STERILIZATION A MALE STERILIZATION B PILL C IUD D INJECTABLES E IMPLANTS F CONDOM G LACTATIONAL AMEN. METHOD H PERIODIC ABSTINENCE I WITHDRAWAL J OTHER _____ X (SPECIFY)	↓→79 ↓→79A

79	In what month and year was the sterilization performed?	MONTH..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> YEAR..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>							
79A	For how long have you been using (CURRENT METHOD) now without stopping? PROBE: In what month and year did you start using (CURRENT METHOD) continuously?	Month <input type="checkbox"/> <input type="checkbox"/> Year <input type="checkbox"/> <input type="checkbox"/> Don't know.....998							
80	CHECK 79/79A: ENTER CODE FOR METHOD USED IN MONTH OF INTERVIEW IN COLUMN 1 OF THE CALENDAR AND IN EACH MONTH BACK TO THE DATE STARTED USING (OR THE BEGINNING OF THE CALENDAR, IF STARTED USING AFTER 2005) OR IF NOW PREGNANT, ENTER NUMBER OF MONTHS PREGNANT IN CALENDAR. ENTER METHOD SOURCE CODE IN COLUMN 2 OF CALENDAR IN MONTH STARTED USING. THEN CONTINUE WITH 81								
80A	Have you and your husband ever done anything or used any method to avoid or delay getting pregnant?	YES1 NO2	—>82						
81	I would like to ask you some questions about the times you or your husband may have used a method to avoid getting pregnant during the last few years. USE CALENDAR TO PROBE FOR EARLIER PERIODS OF USE AND NONUSE, STARTING WITH MOST RECENT USE, BACK TO DATE OF MARRIAGE IN COLUMN 1, ENTER METHOD USE CODE OR '0' FOR NONUSE IN EACH BLANK MONTH. ILLUSTRATIVE QUESTIONS: COLUMN 1: <ul style="list-style-type: none"> • When was the last time you used a method? Which method was that? • When did you start using that method? How long after the birth of (NAME)? • How long did you use the method then? IN COLUMN 2, ENTER METHOD SOURCE CODE IN FIRST MONTH OF EACH USE. ILLUSTRATIVE QUESTIONS: COLUMN 2: <ul style="list-style-type: none"> • Where did you obtain the method when you started using it? • Where did you get advice on how to use the method [for LAM, rhythm, or withdrawal]? IN COLUMN 3, ENTER CODES FOR DISCONTINUATION NEXT TO LAST MONTH OF USE. NUMBER OF CODES IN COLUMN 3 MUST BE SAME AS NUMBER OF INTERRUPTIONS OF METHOD USE IN COLUMN 1. ASK WHY SHE STOPPED USING THE METHOD. IF A PREGNANCY FOLLOWED, ASK WHETHER SHE BECAME PREGNANT UNINTENTIONALLY WHILE USING THE METHOD OR DELIBERATELY STOPPED TO GET PREGNANT. ILLUSTRATIVE QUESTIONS: COLUMN 3: <ul style="list-style-type: none"> • Why did you stop using the (METHOD)? • Did you become pregnant while using (METHOD), or did you stop to get pregnant, or did you stop for some other reason? IF DELIBERATELY STOPPED TO BECOME PREGNANT, ASK: <ul style="list-style-type: none"> • How many months did it take you to get pregnant after you stopped using (METHOD)? AND ENTER '0' IN EACH SUCH MONTH IN COLUMN 1. In column 4: Marriage 1 Married 0 Not in union								

INSTRUCTIONS:
 ONLY ONE CODE SHOULD APPEAR IN ANY BOX.
 FOR COLUMNS 1 AND 4, ALL MONTHS SHOULD BE FILLED IN.

INFORMATION TO BE CODED FOR EACH COLUMN

COL. 1: PREGNANCIES, CONTRACEPTIVE USE **

- 12 Birth
- 13 PREGNANCIES
- 14 TERMINATIONS

- 0 NO METHOD
- 1 FEMALE STERILIZATION
- 2 MALE STERILIZATION
- 3 PILL
- 4 IUD
- 5 INJECTABLES
- 6 IMPLANTS
- 7 CONDOM
- 8 LACTATIONAL AMENORRHEA METHOD
- 9 PERIODIC ABSTINENCE
- 10 WITHDRAWAL
- 11 OTHER _____
(SPECIFY)

COL. 2: SOURCE OF CONTRACEPTION

- 1 GOVT. HOSPITAL
- 2 GOVT. HEALTH CENTER
- 3 FAMILY PLANNING CLINIC
- 4 GOVT. MOBILE CLINIC
- 5 GOVT. FIELDWORKER
- 6 OTHER PUBLIC (GOVT.)

- 7 PVT. HOSPITAL/CLINIC
- 8 PHARMACY
- 9 PRIVATE DOCTOR
- 10 NON-GOVT. MOBILE CLINIC
- 11 NON-GOVT. FIELDWORKER
- 12 DEPOT HOLDER
- 13 OTHER PRIVATE MEDICAL
- 14 HOME
- 15 HOME OF FRIENDS/RELATIVES
- 16 NGO (NSDP) CLINIC
- 17 Not applicable
- 18 OTHER _____
(SPECIFY)

COL. 3: DISCONTINUATION OF CONTRACEPTIVE USE

- 0 INFREQUENT SEX/HUSBAND AWAY
- 1 BECAME PREGNANT WHILE USING
- 2 WANTED TO BECOME PREGNANT
- 3 HUSBAND/PARTNER DISAPPROVED
- 4 WANTED MORE EFFECTIVE METHOD
- 5 HEALTH CONCERNS
- 6 SIDE EFFECTS
- 7 LACK OF ACCESS/TOO FAR
- 8 COSTS TOO MUCH
- 9 INCONVENIENT TO USE
- 10 FATALISTIC
- 11 DIFFICULT TO GET PREGNANT/MENOPAUSAL
- 12 MARITAL DISSOLUTION/SEPARATION
- 13 OTHER _____
(SPECIFY)
- 14 DON'T KNOW

COL. 4: MARRIAGE/UNION

- 1 MARRIED
- 0 NOT IN UNION

* For fieldwork beginning in 2006, the years should be adjusted.

** Response categories may be added for other methods.

	1	2	3	4	
'13 01 Boishak 01					01 Apr
12 Choitro 02					02 Mar
11 FALGUN 03					03 FEB 2
					0
10 MAGH 04					04 JAN 0
					6
09 POUISH 05					05 DEC
08 AGRAHAYAN 06					06 NOV
07 KARTIK 07					07 OCT
06 ASHWIN 08					08 SEP
1 05 BADHRA 09					09 AUG 2
4 04 SRABAN 10					10 JUL 0
1 03 ASHAR 11					11 JUN 0
2 02 JAISTHA 12					12 MAY 5
01 BAISHAK 13					13 APR
12 CHOITRA 14					14 MAR
11 FALGUN 15					15 FEB
10 MAGH 16					16 JAN

09 POUISH 17					17 DEC
08 AGRAHAYAN 18					18 NOV
07 KARTIK 19					19 OCT
06 ASHWIN 20					20 SEP
1 05 BADHRA 21					21 AUG 2
4 04 SRABAN 22					22 JUL 0
1 03 ASHAR 23					23 JUN 0
1 02 JAISTHA 24					24 MAY 4
01 BAISHAK 25					25 APR
12 CHOITRA 26					26 MAR
11 FALGUN 27					27 FEB
10 MAGH 28					28 JAN

82	<p>CHECK Q72:</p> <p>NOT PREGNANT <input type="checkbox"/> OR UNSURE</p> <p>Now I have some questions about the future. Would you like to have (a/another) child, or would you prefer not to have any (more) children?</p> <p>PREGNANT <input type="checkbox"/></p> <p>Now I have some questions about the future. After the child you are expecting now, would you like to have another child, or would you prefer not to have any more children?</p>	<p>HAVE (A/ANOTHER) CHILD..... 1</p> <p>NO MORE/NONE 2 → 84</p> <p>SAYS SHE CAN'T GET PREGNANT..... 3 → 86</p> <p>UNDECIDED/DON'T KNOW:</p> <p>AND PREGNANT..... 4 → 86</p> <p>AND NOT PREGNANT OR UNSURE 5 → 86</p>	
83	<p>NOT PREGNANT <input type="checkbox"/> OR UNSURE</p> <p>How long would you like to wait from now before the birth of (a/another) child?</p> <p>PREGNANT <input type="checkbox"/></p> <p>After the birth of the child you are expecting now, how long would you like to wait before the birth of another child?</p>	<p>MONTHS 1 <input type="checkbox"/> <input type="checkbox"/></p> <p>YEARS 2 <input type="checkbox"/> <input type="checkbox"/></p> <p>SOON/NOW 993 → 87</p> <p>SAYS SHE CAN'T GET PREGNANT.... 994</p> <p>OTHER _____ 996 (SPECIFY)</p> <p>DON'T KNOW 998 → NOW PREG-NANT 87</p>	
84	<p>CHECK Q77: USING A CONTRACEPTIVE METHOD?</p> <p>NO, <input type="checkbox"/> NOT CURRENTLY USING</p> <p>YES, <input type="checkbox"/> CURRENTLY USING</p> <p style="text-align: center;">↓</p> <p style="text-align: center;">86</p>		

85	<p>CHECK Q82:</p> <p>WANTS TO HAVE <input type="checkbox"/> A/ANOTHER CHILD</p> <p>You have said that you are not using any method to avoid pregnancy.</p> <p>Can you tell me why?</p> <p>Any other reason?</p> <p>RECORD ALL REASONS MENTIONED.</p>	<p>WANTS NO MORE <input type="checkbox"/> OR NONE</p> <p>You have said that you are not using any method to avoid pregnancy.</p> <p>Can you tell me why?</p> <p>Any other reason?</p> <p>RECORD ALL REASONS MENTIONED.</p>	<p>FERTILITY-RELATED REASONS</p> <p>NOT HAVING SEX..... A</p> <p>INFREQUENT SEXB</p> <p>HUSBAND NOT LIVING WITH HER ..C</p> <p>MENOPAUSAL/HYSTERECTOMY..... D</p> <p>SUBFECUND/INFECUND.....E</p> <p>POSTPARTUM AMENORRHEIC.....F</p> <p>BREASTFEEDINGG</p> <p>FATALISTIC H</p> <p>OPPOSITION TO USE</p> <p>RESPONDENT OPPOSED.....I</p> <p>HUSBAND/PARTNER OPPOSEDJ</p> <p>OTHERS OPPOSED..... K</p> <p>RELIGIOUS PROHIBITION.....L</p> <p>LACK OF KNOWLEDGE</p> <p>KNOWS NO METHODM</p> <p>KNOWS NO SOURCE N</p> <p>METHOD-RELATED REASONS</p> <p>HEALTH CONCERNS.....O</p> <p>FEAR OF SIDE EFFECTS P</p> <p>LACK OF ACCESS/TOO FARQ</p> <p>COSTS TOO MUCH..... R</p> <p>INCONVENIENT TO USE..... S</p> <p>INTERFERES WITH BODY'S NATURAL PROCESSES.....T</p> <p>OTHER _____ X (SPECIFY) Z</p>							
86	<p>If you had another pregnancy in the near future, how happy would you feel about that pregnancy? Please look at this picture and tell me how happy or unhappy you would be to be pregnant.</p> <p> </p> <p>1 2 3 4 5 6 7 8 9 10</p> <p>Very Unhappy Very Happy</p> <p> </p>									
87	<p>If you could choose exactly the number of children to have in your whole life, how many would that be?</p>	<p>NUMBER <input type="checkbox"/> <input type="checkbox"/></p> <p>OTHER _____ 96 (SPECIFY)</p>								
88	<p>How many of these children would you like to be boys, how many would you like to be girls, and for how many would the sex not matter?</p>	<table border="1"> <tr> <td>Boys</td> <td>Girls</td> <td>Either</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/></td> <td><input type="checkbox"/> <input type="checkbox"/></td> <td><input type="checkbox"/> <input type="checkbox"/></td> </tr> </table> <p>Number</p> <p>Don't know or don't want to say: 96</p>		Boys	Girls	Either	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
Boys	Girls	Either								
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>								
89	<p>Has your husband ever told you how many children he would like you to have?</p>	<p>YES1</p> <p>NO2</p> <p>DON'T KNOW9</p>		<p>→ 92</p> <p>→ 92</p>						

90	How many children would he like you to have?	NUMBER <input type="text"/> <input type="text"/> OTHER _____ 96 (SPECIFY)							
91	How many of these children would he like to be boys, how many would he like to be girls, and for how many would the sex not matter?	<table border="1"> <tr> <td>Boys</td> <td>Girls</td> <td>Either</td> </tr> <tr> <td><input type="text"/> <input type="text"/></td> <td><input type="text"/> <input type="text"/></td> <td><input type="text"/> <input type="text"/></td> </tr> </table> Number Don't know or don't want to say: 96	Boys	Girls	Either	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
Boys	Girls	Either							
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>							
92	Has your mother-in-law ever told you how many children she would like you to have?	YES1 NO2 Not applicable.....7 DON'T KNOW9	→ 95 → 95 → 95						
93	How many children would she like you to have?	NUMBER <input type="text"/> <input type="text"/> OTHER _____ 96 (SPECIFY)							
94	How many of these children would she like to be boys, how many would she like to be girls, and for how many would the sex not matter?	<table border="1"> <tr> <td>Boys</td> <td>Girls</td> <td>Either</td> </tr> <tr> <td><input type="text"/> <input type="text"/></td> <td><input type="text"/> <input type="text"/></td> <td><input type="text"/> <input type="text"/></td> </tr> </table> Number Don't know or don't want to say: 96	Boys	Girls	Either	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
Boys	Girls	Either							
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>							
95	Now I like to ask you opinion about the timing of children in a family. In your opinion, what is the best length of time to wait after giving birth before having another child?	1 YEAR OR LESS1 2 YEARS2 3 YEARS3 4 YEARS OR MORE4 NOT SURE9							
96	In your opinion, if a mother waits at least 2-3 years after having one baby before getting pregnant again, is there any benefit to the mother?	YES1 NO2 DON'T KNOW9	→ 98 → 98						
97	What are the benefits to the mother? (PROBE: Anything else?) Record all responses mentioned	Mother less likely to die/more likely to live.....A Mother less likely to be sick/have complicationsB Mother can breastfeed more easilyC Easier financially for the familyD Less mental stress for the mother if fewer babies at homeE Mother regains her health sooner.....F OtherZ							
98	In your opinion, if a mother waits at least 2-3 years after having one baby before getting pregnant again, is there any benefit to the next baby?	YES1 NO2 DON'T KNOW9	→ END → END						
99	What are the benefits to the baby? (PROBE: Anything else?) Record all responses mentioned	Baby less likely to die/more likely to live.....A Baby less likely to be small/underweightB Baby less likely to be sickly/more likely to be healthyC Mother can breastfeed more easilyD Easier financially for the familyE Less mental stress for the mother if fewer babies at homeF The family and the mother can pay more attention...G OtherZ							

Observation Guided for Interaction Between Family Planning Clients and Service Providers

INSTRUCTIONS TO OBSERVER: Obtain the consent of both client and provider before proceeding to observe the interaction between them. Make sure that the provider knows that you are not there to evaluate her/him and that you are not an "expert" who can be consulted during the session. When observing: try to sit so that you are behind the client but not directly in view of the provider, and make notes quickly. For each question, circle the response that most appropriately represents your observation of what happened during the interaction. *As discussed in the training, you may witness behavior that poses a serious risk to the client's health. Please keep in mind the guidelines for when to intervene in the consultation on behalf of the client's welfare.*

Client Info:

Name:

years

Sex: Male/ Female

Age:

Greeting and Assessing the Client
--

	Did the provider:	
1	Greet the client in a friendly manner?	Yes.....1 No2
2	Ask the patient how she is feeling?	Yes.....1 No2
3	Encourages the patient to ask questions and listen to what she has to say?	Yes.....1 No2
4	Pays attention when patient talks?	Yes.....1 No2
5	Explains to the patient what is going to be done?	Yes.....1 No2
6	Explain in a language easily understood?	Yes.....1 No2
7	Uses calm, respectful tone of voice.	Yes.....1 No2
8	Smiles and makes eye contact as appropriate.	Yes.....1 No2
9	Prepare necessary supplies and equipments?	Yes.....1 No2

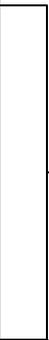
Discussion of Family Planning

Discussion of Family Planning			SKIP
10	Did the provider ask about or did the client spontaneously mention any current method use?	Yes1 No2	→ 20
11	Which method is the client currently using? (Circle all that apply.)	Combined pill.....1 Progestin-only pill.....2 IUD.....3 Injectable.....4 NORPLNT5 Condom6 Female sterilization7 Vasectomy8 Natural family planning9 Exclusive breastfeeding (LAM) ..10 Other: _____11 None77	
12	Did the provider ask about or did the client spontaneously mention any problems or side effects with her current method?	Yes1 No2	→ 19
13	Did the provider offer any suggestions for managing problems or side effects?	Yes1 No2	
14	Did the provider offer any medical treatment for the problems or side effects?	Yes1 No2	
15	Did the provider refer the client elsewhere for treatment of problems/side effects?	Yes1 No2	
16	Did the provider ask about or did the client spontaneously mention wanting to change methods or stop using?	Yes1 No2	
17	Did the provider offer any methods to use as an alternative to the current method?	Yes1 No2	
18	What methods were suggested?	Combined pill.....1 Progestin-only pill.....2 IUD.....3 Injectable.....4 NORPLNT5 Condom6 Female sterilization7 Vasectomy8 Natural family planning9 Exclusive breastfeeding (LAM) ..10 Other: _____11 None77	
19	Was the client offered more supply of the current method?	Yes1	→ 24

		No2	→ 24
		Not applicable for this method or not needed at the time of visit ...9	→ 24
20	Did the provider ask about or did the client spontaneously mention any previous (discontinued) method use?	Yes1 No2	→ 22
21	Did the provider ask about or did the client spontaneously mention the reason for discontinuing the previous method?	Yes1 No2	
22	Did the provider ask or did the client spontaneously mention a specific preference for a contraceptive method?	Yes1 No2	→ 24

			SKIP
23	Which method?	Combined pill.....1 Progestin-only pill.....2 IUD.....3 Injectable.....4 NORPLNT5 Condom6 Female sterilization7 Vasectomy8 Natural family planning9 Exclusive breastfeeding (LAM) ..10 Other:11 None77	
24	Did the provider suggest or mention any other methods?	Yes1 No2	→ 27
25	Which methods did the provider suggest? (Circle all that apply.)	Combined pill.....1 Progestin-only pill.....2 IUD.....3 Injectable.....4 NORPLNT5 Condom6 Female sterilization7 Vasectomy8 Natural family planning9 Exclusive breastfeeding (LAM) ..10 Other:11 None77	
26	Did the provider overemphasize one method in particular?	Yes1 No2	→ 28
27	Which method was overemphasized?	Combined pill.....1 Progestin-only pill.....2 IUD.....3 Injectable.....4 NORPLNT5 Condom6 Female sterilization7	

		Vasectomy8 Natural family planning9 Exclusive breastfeeding (LAM) ..10 Other:11 None77	
28	Did the client accept a method?	Yes1 No2	→ 34

			SKIP
29	Which method?	Combined pill.....1 Progestin-only pill.....2 IUD.....3 Injectable.....4 NORPLNT5 Condom6 Female sterilization7 Vasectomy8 Natural family planning9 Exclusive breastfeeding (LAM) ..10 Other: _____.....11 None77	 31
30	(FOR LAM ONLY) Did the provider mention any of these points? (Circle all that apply.)	Client must not have had menses since delivery...1 Infant must be less than six months old2 Client must be fully/nearly fully breastfeeding3 None of these points77	
31	For the new method accepted, did the provider talk about any of these issues? (Circle all that apply.)	How to use method1 Advantages2 Disadvantages3 Medical side effects (e.g. bleeding, nausea, etc.) ...4 What to do if client has problem with method5 Possibility of switching6 Ability of method to prevent STDs/HIV7	
32	Did the provider perform any of the following:	Pregnancy test1 Blood pressure check2 Physical exam3 Taking medical history verbally.....4	
33	Did the provider tell the client when to return for a check-up?	Yes1 No2	
34	Did the provider tell the client when and how to obtain additional supply of the method?	Yes1 No2 Not applicable for this method9	
35	Which IEC materials, if any, were used during the consultation? (Circle all that apply.)	Flipchart1 Brochure/pamphlets2 Contraceptive samples.....3 Posters4 Other: _____.....5 None.....77	
36	During the consultation, did the provider explicitly mention that the condom protects against STDs/HIV/AIDS?	Yes1 No2	
37	Did the client report any of the STD symptoms? (Circle all that apply)	Smelly discharge1 Lower abdominal pain2 Itching3 Fever of 38+C4 Others _____.....5 Not mentioned77	

			SKIP
38	Which symptoms, if any, did the provider ask to diagnose STDs? (Circle all that apply)	Smelly discharge1 Lower abdominal pain2 Itching3 Fever of 38+C4 Others _____5 Not mentioned77	
39	What did the provider do? (Circle all that apply. Circle 99 if Q37=77 and Q38=77)	Request laboratory tests1 Treat2 Refer elsewhere3 Provide counseling4 Other: _____5 No actions taken77 No symptoms reported99	
40	What other health issues were mentioned at any time during the consultation? (Circle all that apply.)	HIV/AIDS1 Child immunization2 Child growth monitoring3 Infertility4 Oral rehydration therapy5 Abortion6 Nutrition7 Curative services – client8 Curative services – child9 Breastfeeding	

	<p>.....10</p> <p>Sexual relations</p> <p>.....11</p> <p>Social/economic factors</p> <p>.....12</p> <p>Pregnancy testing</p> <p>.....13</p> <p>Other: _____</p> <p>....14</p> <p>None of these issues</p> <p>.....77</p>	
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**Observation Guide for Interaction during Antenatal check up
Between pregnant women and Service Provider**

Evaluator will ask: Now please perform each step to get yourself ready and also perform each step of history taking that you would do in your real life. And let me know when you have finished.

Patient Information

Name: _____ Age: _____ Parity: _____
 Length of pregnancy: _____ weeks _____ Number of previous ANC
 visit: _____

Greeting and assessing the client

1. Prepares necessary supplies and equipments.	1 = Yes 2 = No
2. Greets the patient respectfully and introduces her politely.	1 = Yes 2 = No
3. Asks the patient how she is feeling.	1 = Yes 2 = No
4. Encourages the patient to ask questions and listen to what she has to say.	1 = Yes 2 = No
5. Pays attention when patient talks.	1 = Yes 2 = No
6. Explains to the patient what is going to be done.	1 = Yes 2 = No
7. Explains in language easily understood.	1 = Yes 2 = No
8. Uses calm, respectful tone of voice.	1 = Yes 2 = No
9. Smiles and makes eye contact as appropriate.	1 = Yes 2 = No

10. Asks the patient her name	1 = Yes 2 = No
11. Asks the patient her age	1 = Yes 2 = No
12. Asks the patient her obstetric history	1 = Yes 2 = No
13. Asks the woman her contraceptive history	1 = Yes 2 = No
14. Calculates the EDD	1 = Yes 2 = No
15. Asks the patient if she has any fetal movements (If pregnancy more than 6 months)	1 = Yes 2 = No
16. Asks the patient whether she has any health problem related to her present pregnancy	1 = Yes 2 = No
17. Ask the patient about general health problems.	1 = Yes

	2 = No
18. Asks the patient about immunization (especially tetanus toxoid)	1 = Yes 2 = No

Evaluator will ask: Now please perform the steps of physical examination (general examination and abdominal examination) that you would do in real life. Please let me know when you have finished.

Physical examination	
19. Ensures the patient's privacy as best as possible	1 = Yes 2 = No
20. Pulls curtain around the patient during examination.	1 = Yes 2 = No
21. Takes the weight of the patient	1 = Yes 2 = No
22. Takes the patient's BP	1 = Yes 2 = No
23. Feels the patient's pulse	1 = Yes 2 = No
24. Checks the patient for pallor	1 = Yes 2 = No
25. Looks for any swelling, feels for pitting edema	1 = Yes 2 = No
26. Examines breasts.	1 = Yes 2 = No
27. Estimates fundal-height,	1 = Yes 2 = No
28. Feels fetal presentation (after 36 weeks)	1 = Yes 2 = No
29. Listens to fetal heart (second & third trimester)	1 = Yes 2 = No
30. Tests for protein in urine	1 = Yes 2 = No

Evaluator will ask: Now please perform the steps of care, treatment and counseling that you would provide in real life. Please let me know when you have finished.

Care provision	
31. Provides tetanus toxoid	1 = Yes 2 = No

32. Provides iron and folic acid	1 = Yes 2 = No
33. Provides advice on nutrition	1 = Yes 2 = No
34. Advises on 5 pregnancy danger signs and necessary topics	1 = Yes 2 = No
35. Advises about rest & sleep	1 = Yes 2 = No
36. Counsels the patient on breast feeding	1 = Yes 2 = No
37. Counsels the patient on post-partum lactation	1 = Yes 2 = No
38. Asks the patient if she has any further questions or concerns	1 = Yes 2 = No
Birth planning	
39. Educates the patient about the value of a skilled attendant at delivery	1 = Yes 2 = No
40. Informs the patient about the closest EmOC.	1 = Yes 2 = No
41. Educates the patient about the importance of saving money for an emergency	1 = Yes 2 = No
42. Discusses emergency transportation	1 = Yes 2 = No
43. Advises the patient when she should come for next antenatal visit	1 = Yes 2 = No

Postpartum Healthy Fertility Study: Facility Audit

IDENTIFICATION

	Name	Code	
UPAZILA		<input type="text"/>	
UNION		<input type="text"/> <input type="text"/>	
VILLAGE		<input type="text"/> <input type="text"/> <input type="text"/>	
NAME AND TYPE OF FACILITY		<input type="text"/>	UHC(MCH/FP UNIT)=1, MCH/FWC=2, RURAL DISP=3; SATELLITE=4; NGO=5; PRIVATE=6)
INTERVIEWER POSITION OF PERSON INTERVIEWED		<input type="text"/> <input type="text"/>	(1=MO; 2=nurse/midwife; 3=SACMO; 4=FWV; 5=other)
		<input type="text"/>	

Visit and Status				
	1	2	3	FINAL VISIT
DATE	<input type="text"/>	<input type="text"/>	<input type="text"/>	DAY <input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	MONTH <input type="text"/> <input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
RESULT*	<input type="text"/>	<input type="text"/>	<input type="text"/>	RESULT CODE <input type="text"/>
NEXT VISIT DATE	<input type="text"/>	<input type="text"/>		TOTAL NUMBER OF VISIT <input type="text"/>
TIME	<input type="text"/>	<input type="text"/>		
*RESULT CODES 1. Completed interview 2. Incomplete 3. Others _____ Specify				
Beginning time:			Hour: <input type="text"/> <input type="text"/>	Minutes: <input type="text"/> <input type="text"/>

		NO.....2	
111	What is the source of water for this facility?	TUBEWELL..... 1 TAP.....2 NONE.....3 OTHER.....9	
112	Are hand-washing services available inside the facility?	YES..... 1 NO.....2	
113	Is there a toilet in the compound/building that is being used?	YES NO MALE TOILET..... 1 2 FEMALE TOILET..... 1 2 UNISEX TOILET..... 1 2	
114	How far is the nearest referral centre (in km)?	Distance in kilometers..... <input type="text"/> <input type="text"/>	
115	Does this facility provide overnight observation facility for patients?	YES..... 1 NO.....2	► 117
116	Causes of overnight observation	Causes.....YES.....NO.....DK Delivery care.....1.....2.....99 Tubectomy.....1.....2.....99 Vasectomy.....1.....2.....99 Sick newborn care.....1.....2.....99 Others: _____ (SPECIFY)	
117.	Does this facility offer inpatient care?	YES..... 1 NO..... 2	► 119
118	How many total beds are available for inpatient care in this facility?	NUMBER..... .. <input type="text"/> <input type="text"/>	
119	Does this facility provide laboratory testing?	YES..... 1 NO.....2	► 121
120	What types of tests are performed at this facility?	YES NO DK BLOOD.. 1 2 99 (Routine test, TC/DC/ESR) URINE (Routine test).....1 2 99 STOOL (Routine test) 1 2 99 PREGNANCY TEST1 2 99 OTHER.....1 2 99 (SPECIFY)	
121	Does this facility have an outreach program?YES.....NO....DK STAFF VISIT.....1.....2.....99 SATELLITE CLINIC...1.....2.....99	►124
122	How often is this facility supposed to implement satellite clinics?	NO. OF TIMES PER MONTH <input type="text"/> <input type="text"/>	
123	How often did this facility implement satellite clinics last month?	NO. OF TIMES LAST MONTH <input type="text"/> <input type="text"/>	
124	Does this facility offer family planning services?	YES..... 1 NO..... 2	

Section 2. Service Availability and Service Statistics

A. FAMILY PLANNING METHODS AVAILABILITY IN THE FACILITY :

Now I would like to ask you about the family planning methods available in this facility and information about each method:

SERVICES	201. Is this SERVICE available to clients at this facility?	202. How many days per week/month is it available?	203. Does this facility refer to other facilities for this SERVICE?	204. Where do you refer?
A. Pill	YES.....1 NO.....2 → 203A	<input type="checkbox"/> <input type="checkbox"/> Week <input type="checkbox"/> <input type="checkbox"/> Month <input type="checkbox"/> <input type="checkbox"/> Year	YES.....1 NO.....2	Sylhet Medical College FP model clinic.....1 Upazila Health Complex2 MCWC, Sylhet3 Private Health Clinic4 NGO facility5 Others6
B. Condom	YES.....1 NO.....2 → 203B	<input type="checkbox"/> <input type="checkbox"/> Week <input type="checkbox"/> <input type="checkbox"/> Month <input type="checkbox"/> <input type="checkbox"/> Year	YES.....1 NO.....2	Sylhet Medical College FP model clinic.....1 Upazila Health Complex2 MCWC, Sylhet3 Private Health Clinic4 NGO facility5 Others6
C. IUD	YES.....1 NO.....2 → 203C	<input type="checkbox"/> <input type="checkbox"/> Week <input type="checkbox"/> <input type="checkbox"/> Month <input type="checkbox"/> <input type="checkbox"/> Year	YES.....1 NO.....2	Sylhet Medical College FP model clinic.....1 Upazila Health Complex2 MCWC, Sylhet3 Private Health Clinic4 NGO facility5 Others6
D. Injectable	YES.....1 NO.....2 → 203D	<input type="checkbox"/> <input type="checkbox"/> Week <input type="checkbox"/> <input type="checkbox"/> Month <input type="checkbox"/> <input type="checkbox"/> Year	YES.....1 NO.....2	Sylhet Medical College FP model clinic.....1 Upazila Health Complex2 MCWC, Sylhet3 Private Health Clinic4 NGO facility5 Others6
E. Norplant	YES.....1 NO.....2 → 203E	<input type="checkbox"/> <input type="checkbox"/> Week <input type="checkbox"/> <input type="checkbox"/> Month <input type="checkbox"/> <input type="checkbox"/> Year	YES.....1 NO.....2	Sylhet Medical College FP model clinic.....1 Upazila Health Complex2 MCWC, Sylhet3 Private Health Clinic4 NGO facility5 Others6
F. Vasectomy	YES.....1 NO.....2 → 203F	<input type="checkbox"/> <input type="checkbox"/> Week <input type="checkbox"/> <input type="checkbox"/> Month <input type="checkbox"/> <input type="checkbox"/> Year	YES.....1 NO.....2	Sylhet Medical College FP model clinic.....1 Upazila Health Complex2 MCWC, Sylhet3 Private Health Clinic4 NGO facility5 Others6
G. Tubectomy	YES.....1 NO.....2 → 203G	<input type="checkbox"/> <input type="checkbox"/> Week <input type="checkbox"/> <input type="checkbox"/> Month <input type="checkbox"/> <input type="checkbox"/> Year	YES.....1 NO.....2	Sylhet Medical College FP model clinic.....1 Upazila Health Complex2 MCWC, Sylhet3 Private Health Clinic4 NGO facility5 Others6
H. Menstrual Regulation (MR)	YES.....1 NO.....2 → 203H	<input type="checkbox"/> <input type="checkbox"/> Week <input type="checkbox"/> <input type="checkbox"/> Month	YES.....1 NO.....2	Sylhet Medical College FP model clinic.....1 Upazila Health Complex2 MCWC, Sylhet3 Private Health Clinic4 NGO facility5

204	How many hours per day does this facility offer family planning services?	TIME in hour <input type="text"/> <input type="text"/>																													
205	In this facility, how many of the following types of staff work in family planning?	Doctor/medical officer..... <input type="checkbox"/> SACMO/medical assistant..... <input type="checkbox"/> Family welfare visitor (FWV)..... <input type="checkbox"/> Family planning Inspector..... <input type="checkbox"/> Nurses / Paramedics <input type="checkbox"/> Medical aides..... <input type="checkbox"/> Counselor/service promoter <input type="checkbox"/>																													
206	Is there at least one staff at this facility trained in: A) IUD insertion and removal? B) Administering FP injection? C) Providing Pill? D) Implant insertion and removal? C) Counseling on Side effects (all methods)?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">YES</th> <th style="text-align: center;">NO</th> <th style="text-align: center;">DK</th> </tr> </thead> <tbody> <tr> <td>IUD</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">99</td> </tr> <tr> <td>INJECTION</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">99</td> </tr> <tr> <td>PILL</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">99</td> </tr> <tr> <td>IMPLANT</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">99</td> </tr> <tr> <td>SIDE EFFECTS</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">99</td> </tr> </tbody> </table>		YES	NO	DK	IUD	1	2	99	INJECTION	1	2	99	PILL	1	2	99	IMPLANT	1	2	99	SIDE EFFECTS	1	2	99					
	YES	NO	DK																												
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INJECTION	1	2	99																												
PILL	1	2	99																												
IMPLANT	1	2	99																												
SIDE EFFECTS	1	2	99																												
208	Does the facility receive family planning clients referred by other facilities or providers?	YES..... 1 NO..... 2																													
209	Does the facility provide FP counseling to:	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">YES.....</th> <th style="text-align: center;">NO.....</th> <th style="text-align: center;">DK</th> </tr> </thead> <tbody> <tr> <td>NEW USERS</td> <td></td> <td></td> <td></td> </tr> <tr> <td>(FEMALE).....</td> <td style="text-align: center;">1.....</td> <td style="text-align: center;">2.....</td> <td style="text-align: center;">9</td> </tr> <tr> <td>CONTINUING USERS</td> <td></td> <td></td> <td></td> </tr> <tr> <td>(FEMALE).....</td> <td style="text-align: center;">1.....</td> <td style="text-align: center;">2.....</td> <td style="text-align: center;">9</td> </tr> <tr> <td>ADOLESCENTS.....</td> <td style="text-align: center;">1.....</td> <td style="text-align: center;">2.....</td> <td style="text-align: center;">9</td> </tr> <tr> <td>MEN.....</td> <td style="text-align: center;">1.....</td> <td style="text-align: center;">2.....</td> <td style="text-align: center;">9</td> </tr> </tbody> </table>		YES.....	NO.....	DK	NEW USERS				(FEMALE).....	1.....	2.....	9	CONTINUING USERS				(FEMALE).....	1.....	2.....	9	ADOLESCENTS.....	1.....	2.....	9	MEN.....	1.....	2.....	9	
	YES.....	NO.....	DK																												
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(FEMALE).....	1.....	2.....	9																												
ADOLESCENTS.....	1.....	2.....	9																												
MEN.....	1.....	2.....	9																												
210	What does this counseling cover? (CIRCLE ALL MENTIONED)	Side-effects..... 1 Education on HIV/STDs 2 Don't know 8 Others _____ (Specify)																													
211	Does this facility provide STD/RTI/HIV consultations (counseling, diagnosis and treatment)?	YES..... 1 NO..... 2	→213																												
212	What is the usual fee charged for STD/RTI/HIV consultation?	TK																													

213	Does this facility charge FP clients for any FP services provided?	YES..... 1 NO..... 2	→ 219
214	Is there a consultation fee for new FP clients?	YES..... 1 NO..... 2	→ 216
215	How much is this fee?	FEE..... TK.	
216	Is there a consultation fee for continuing FP clients?	YES..... 1 NO..... 2	→ 219
217	How much is this fee?	FEE..... TK.	
218	How much do you charge a new FP client for (METHOD)? (IF METHOD UNAVAILABLE WRITE 99996, IF FEE UNKNOWN WRITE 99998)		
	METHOD:		
	A) Pill	CYCLE PRICE TK.	.
	B) Male condom	UNITS PRICE TK.	.
	C) IUD insertion	PRICE..... TK.	.
	D) IUD removal	PRICE..... TK.	.
	E) Injection	DOSE PRICE TK.	.
	F) Norplant	PRICE..... TK.	.
	G) Male sterilization (Vasectomy)	PRICE..... TK.	.
	H) Female sterilization (Tubectomy)	PRICE..... TK.	.
	I) Menstrual Regulation	PRICE..... TK.	.

B) MATERNAL AND CHILDHEALTH SERVICES AVAILABLE IN THE FACILITY:

Now I would like to ask you about the maternal and child health services including newborn care available in this facility.

SERVICES	219. Is this SERVICE available to clients at this facility?	220. How many days per week/month is it available?	221. Does this facility refer to other facilities for this SERVICE?
A. CHILD IMMUNIZATION	YES..... 1 NO..... 2 → 221(A)	<input type="checkbox"/> <input type="checkbox"/> Week <input type="checkbox"/> <input type="checkbox"/> Month <input type="checkbox"/> <input type="checkbox"/> Year	YES..... 1 NO..... 2
B. ORAL REHYDRATION PACKETS	YES..... 1 NO..... 2 → 221(B)	<input type="checkbox"/> <input type="checkbox"/> Week <input type="checkbox"/> <input type="checkbox"/> Month <input type="checkbox"/> <input type="checkbox"/> Year	YES..... 1 NO..... 2
C. VITAMIN A CAPSULE	YES..... 1 NO..... 2 → 221(C)	<input type="checkbox"/> <input type="checkbox"/> Week <input type="checkbox"/> <input type="checkbox"/> Month <input type="checkbox"/> <input type="checkbox"/> Year	YES..... 1 NO..... 2
D. ANTENATAL CARE	YES..... 1 NO..... 2 → 221(D)	<input type="checkbox"/> <input type="checkbox"/> Week <input type="checkbox"/> <input type="checkbox"/> Month <input type="checkbox"/> <input type="checkbox"/> Year	YES..... 1 NO..... 2
E. DELIVERY SERVICE	YES..... 1 NO..... 2 → 221(E)	<input type="checkbox"/> <input type="checkbox"/> Week <input type="checkbox"/> <input type="checkbox"/> Month <input type="checkbox"/> <input type="checkbox"/> Year	YES..... 1 NO..... 2
F. POSTPARTUM CARE	YES..... 1 NO..... 2 → 221(F)	<input type="checkbox"/> <input type="checkbox"/> Week <input type="checkbox"/> <input type="checkbox"/> Month <input type="checkbox"/> <input type="checkbox"/> Year	YES..... 1 NO..... 2
G. NEWBORN CARE	YES..... 1 NO..... 2 → 221(G)	<input type="checkbox"/> <input type="checkbox"/> Week <input type="checkbox"/> <input type="checkbox"/> Month <input type="checkbox"/> <input type="checkbox"/> Year	YES..... 1 NO..... 2
H. GROWTH MONITORING	YES..... 1 NO..... 2 → 221(H)	<input type="checkbox"/> <input type="checkbox"/> Week <input type="checkbox"/> <input type="checkbox"/> Month <input type="checkbox"/> <input type="checkbox"/> Year	YES..... 1 NO..... 2
I. TETANUS INJECTION	YES..... 1 NO..... 2 → 221(I)	<input type="checkbox"/> <input type="checkbox"/> Week <input type="checkbox"/> <input type="checkbox"/> Month <input type="checkbox"/> <input type="checkbox"/> Year	YES..... 1 NO..... 2
J. GENERAL HEALTH SERVICES	YES..... 1 NO..... 2 → 221(J)	<input type="checkbox"/> <input type="checkbox"/> Week <input type="checkbox"/> <input type="checkbox"/> Month <input type="checkbox"/> <input type="checkbox"/> Year	YES..... 1 NO..... 2
K. HEALTH EDUCATION	YES..... 1 NO..... 2 → 221(K)	<input type="checkbox"/> <input type="checkbox"/> Week <input type="checkbox"/> <input type="checkbox"/> Month <input type="checkbox"/> <input type="checkbox"/> Year	YES..... 1 NO..... 2
L. OTHER _____ (SPECIFY)	YES..... 1 NO..... 2 221(L)	<input type="checkbox"/> <input type="checkbox"/> Week <input type="checkbox"/> <input type="checkbox"/> Month <input type="checkbox"/> <input type="checkbox"/> Year	

Maternal and Newborn Health Services

222	What are the services that this facility offers to pregnant women during their antenatal visits? [CIRCLE IF MENTIONED]	Obtain medical and reproductive history?.....1 Measure weight?.....2 Measure height?.....3 Take blood pressure (BP)?.....4 Give TT injection?.....5 Check for anemia (by looking at eyes/palms)?.....6 Check for edema?.....7 Provide iron-folate tablets.....8 Others.....9 (Specify)	
223	What kind of counseling is provided during antenatal care? [CIRCLE IF MENTIONED]	Nutritional needs during pregnancy.....1 Breast feeding.....2 Danger signs during pregnancy.....3 Newborn care.....4 Childbirth preparation.....5 Anemia during pregnancy.....6 Need for iron tablets.....7 Family planning.....8 Need for postnatal care.....9 Vitamin A.....10 Need for iodized salt.....11 Others..... (Specify)	
224	What's the normal charge at this facility for antenatal care?	TK	
225	Does this facility offer any delivery care services?	YES.....1 NO.....2	→ 227
226	What's the charge for a normal vaginal delivery?	TK	
227	Does this facility offer the following delivery care services? A) Normal vaginal delivery B) Management of postpartum hemorrhage C) Retained placenta	YES.....NO.....DK NVD.....1.....2.....99 PPH.....1.....2.....99 Retained Placenta...1.....2.....99	
228	Does this facility refer women for delivery care services?	YES.....1 NO.....2	→ 404
229	Where does this facility refer women for delivery care services?	Medical College hospital.....A Upazila Health Complex.....B MCWC, Sylhet.....C Red crescent Maternity hospital.....D Private Clinic.....E Other (specify).....X Don't Know.....Z	
230	Does this facility offer postnatal check-ups for women?	YES.....1 NO.....2	→ 231

	What's the normal charge for a postnatal check-up?	TK	
231	Does this facility offer following newborn care services? A) immediate newborn care B) newborn resuscitation C) sick newborn management	YES....NO....DK INC.....1.....2.....99 Resuscitation.....1.....2.....99 Sick management .1.....2.....99	
232	Does this facility refer sick newborn?	YES.....1 NO.....2	→ 408

233	Where does this facility refer sick babies?	Medical College hospital..... A Upazila Health Complex..... B MCWC, Sylhet..... C Red Crescent Maternity hospital...D Private Clinic..... E Other (specify)..... X Don't Know.....Z	
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Section-3. Availability of Supplies and Equipment

A. MEDICINE AVAILABLE IN THE FACILITY:

Now I would like to ask you about the medications-available in this facility. When we are finished, I will need to see your stock of the medications that we discuss.

ASK NO. 301 FOR EACH MEDICATION AND IF IT IS NOT AVAILABLE, SKIP TO THE NEXT MEDICATION.

MEDICATION	301 Do you provide this MEDICATION here?	302 Do you have this MEDICATION now?	303. At any time in the last 6 months did this facility run out of this MEDICATOIN?	304. MEDICATION SEEN (WTH EXPIRATION DATE)/ NOT SEEN
A. Metronidazole tab.	YES.....1 NO..... 2→2	YES.....1 NO..... 2→2	YES.....1 NO..... 2	SEEN, UNEXPIRED.....1 SEEN, EXPIRED.....2 NOT SEEN.....3
B. Paracetamol tab.	YES.....1 NO..... 2→3	YES.....1 NO..... 2→3	YES.....1 NO..... 2	SEEN, UNEXPIRED.....1 SEEN, EXPIRED.....2 NOT SEEN.....3
C. Butapen tab.	YES.....1 NO..... 2→4	YES.....1 NO..... 2→4	YES.....1 NO..... 2	SEEN, UNEXPIRED.....1 SEEN, EXPIRED.....2 NOT SEEN.....3
D. Ferrous sulphate tab.	YES.....1 NO..... 2→5	YES.....1 NO..... 2→5	YES.....1 NO..... 2	SEEN, UNEXPIRED.....1 SEEN, EXPIRED.....2 NOT SEEN.....3
E. Ampicillin Capsule.	YES.....1 NO..... 2→6	YES.....1 NO..... 2→6	YES.....1 NO..... 2	SEEN, UNEXPIRED.....1 SEEN, EXPIRED.....2 NOT SEEN.....3
F. Ergometrine Tab.	YES.....1 NO..... 2→7	YES.....1 NO..... 2→7	YES.....1 NO..... 2	SEEN, UNEXPIRED.....1 SEEN, EXPIRED.....2 NOT SEEN.....3
G. Cloxacillin Cap.	YES.....1 NO..... 2→8	YES.....1 NO..... 2→8	YES.....1 NO..... 2	SEEN, UNEXPIRED.....1 SEEN, EXPIRED.....2 NOT SEEN.....3
H. Amoxycillin cap.	YES.....1 NO..... 2→9	YES.....1 NO..... 2→9	YES.....1 NO..... 2	SEEN, UNEXPIRED.....1 SEEN, EXPIRED.....2 NOT SEEN.....3
I. Syntocenon inj.	YES.....1 NO..... 2→10	YES.....1 NO..... 2→10	YES.....1 NO..... 2	SEEN, UNEXPIRED.....1 SEEN, EXPIRED.....2 NOT SEEN.....3
J. Ergometrin inj.	YES.....1 NO..... 2→11	YES.....1 NO..... 2→11	YES.....1 NO..... 2	SEEN, UNEXPIRED.....1 SEEN, EXPIRED.....2 NOT SEEN.....3

K. Procaine Penicillin inj.	YES.....1 NO.....2→12	YES.....1 NO.....2→12	YES.....1 NO.....2	SEEN, UNEXPIRED.....1 SEEN, EXPIRED.....2 NOT SEEN.....3
L. Gentamycin inj	YES.....1 NO.....2→13	YES.....1 NO.....2→13	YES.....1 NO.....2	SEEN, UNEXPIRED.....1 SEEN, EXPIRED.....2 NOT SEEN.....3
M. Hydrocortisone inj.	YES.....1 NO.....2→14	YES.....1 NO.....2→14	YES.....1 NO.....2	SEEN, UNEXPIRED.....1 SEEN, EXPIRED.....2 NOT SEEN.....3
N. Diazepam inj.	YES.....1 NO.....2→15	YES.....1 NO.....2→15	YES.....1 NO.....2	SEEN, UNEXPIRED.....1 SEEN, EXPIRED.....2 NOT SEEN.....3
O. Metronidazole inj.	YES.....1 NO.....2→16	YES.....1 NO.....2→16	YES.....1 NO.....2	SEEN, UNEXPIRED.....1 SEEN, EXPIRED.....2 NOT SEEN.....3
P. G. Magsulf inj.	YES.....1 NO.....2→17	YES.....1 NO.....2→17	YES.....1 NO.....2	SEEN, UNEXPIRED.....1 SEEN, EXPIRED.....2 NOT SEEN.....3
Q. Paracetamol syp.	YES.....1 NO.....2→18	YES.....1 NO.....2→18	YES.....1 NO.....2	SEEN, UNEXPIRED.....1 SEEN, EXPIRED.....2 NOT SEEN.....3
R. Cloxacillin syp.	YES.....1 NO.....2→19	YES.....1 NO.....2→19	YES.....1 NO.....2	SEEN, UNEXPIRED.....1 SEEN, EXPIRED.....2 NOT SEEN.....3
S. IV fluid	YES.....1 NO.....2→20	YES.....1 NO.....2→20	YES.....1 NO.....2	SEEN, UNEXPIRED.....1 SEEN, EXPIRED.....2 NOT SEEN.....3
T. 0.5% gentian violet	YES.....1 NO.....2→21	YES.....1 NO.....2→21	YES.....1 NO.....2	SEEN, UNEXPIRED.....1 SEEN, EXPIRED.....2 NOT SEEN.....3
U. Savlon	YES.....1 NO.....2 → 304	YES.....1 NO.....2	YES.....1 NO.....2	SEEN, UNEXPIRED.....1 SEEN, EXPIRED.....2 NOT SEEN.....3

B. FAMILY PLANNING METHODS AVAILABLE IN THE FACILITY:

Now I would like to ask you about the family planning methods available in this facility. When we are finished, I will need to see your stock of the methods that we discuss.

METHOD	305. Does this facility have this METHOD now? CHECK Q 201. IF NOW CIRCLED FOR YES, THEN CIRCLE "7".	306. Have you had a stock-out of this METHOD or been unable to provide this METHOD in the past 6 months?	307. How many days in the last 6 months have you been out of this METHOD or unable to provide this METHOD?	308. METHOD SEEN/NOT SEEN
A) Pill	YES..... 1 NO....2→308a NA....7→308a	YES..... 1 NO....2→307a	DAYS <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW....99	SEEN.....1 NOT SEEN...2 304b ←
B) Condoms	YES..... 1 NO....2→308b NA....7→308b	YES..... 1 NO....2→307b	DAYS <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW....99	SEEN.....1 NOT SEEN...2 304c ←
C) IUD	YES..... 1 NO....2→308c	YES..... 1 NO....2→307c	DAYS <input type="text"/> <input type="text"/> <input type="text"/>	SEEN.....1 NOT SEEN...2

	NA....7→308c		DON'T KNOW....99	304d ←
D) Injectable	YES..... 1 NO....2→308d NA....7→308d	YES..... 1 NO....2→307d	DAYS <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> DON'T KNOW....99	SEEN.....1 NOT SEEN...2 304e ←
E) NORPLANT	YES..... 1 NO....2→308e NA....7→308e	YES..... 1 NO....2→307e	DAYS <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> DON'T KNOW....99	SEEN.....1 NOT SEEN...2 304f ←
F) Tubectomy	YES..... 1 NO....2→308f NA....7→308f	YES..... 1 NO....2→307g	DAYS <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> DON'T KNOW....99	
G) Vasectomy	YES..... 1 NO....2→308g NA....7→308g	YES..... 1 NO....2→307h	DAYS <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> DON'T KNOW....99	
H) Menstrual Regulation?	YES..... 1 NO....2→308h NA....7→308h	YES..... 1 NO....2→310	DAYS <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> DON'T KNOW....99	

C. AVAILABILITY OF EQUIPMENT IN THE FACILITY:

Now I would like to ask you about the equipment available in this facility.

EQUIPMENT	309. Is this EQUIPMENT available and operational?	310. Has the EQUIPMENT been broken at any time in the last 6 months?	311. May I see the EQUIPMENT?
A. Blood pressure instrument	YES.....1 NO..... 2→2	YES.....1 NO..... 2	SEEN.....1 NOT SEEN.....2
B. Height-weight machine	YES.....1 NO..... 2→3	YES.....1 NO..... 2	SEEN.....1 NOT SEEN.....2
C. Stethoscope	YES.....1 NO..... 2→4	YES.....1 NO..... 2	SEEN.....1 NOT SEEN.....2
D. Baby Weighing scale	YES.....1 NO..... 2→5	YES.....1 NO..... 2	SEEN.....1 NOT SEEN.....2
E. Disposable needles	YES.....1 NO..... 2→6	YES.....1 NO..... 2	SEEN.....1 NOT SEEN.....2
F. Sterilizer/autoclave	YES.....1 NO..... 2→7	YES.....1 NO..... 2	SEEN.....1 NOT SEEN.....2
G. Vaccine carrier/cold chain equipment	YES.....1 NO..... 2→8	YES.....1 NO..... 2	SEEN.....1 NOT SEEN.....2
H. Safe delivery kit	YES.....1 NO..... 2→9	YES.....1 NO..... 2	SEEN.....1 NOT SEEN.....2
I. MCH kit	YES.....1 NO..... 2→10	YES.....1 NO..... 2	SEEN.....1 NOT SEEN.....2
J. Tubectomy kit	YES.....1 NO..... 2→11	YES.....1 NO..... 2	SEEN.....1 NOT SEEN.....2
K. Vasectomy kit	YES.....1 NO..... 2→END	YES.....1 NO..... 2	SEEN.....1 NOT SEEN.....2
L. DDS kit	YES.....1 NO..... 2→END	YES.....1 NO..... 2	SEEN.....1 NOT SEEN.....2
M. FWC kit	YES.....1 NO..... 2→END	YES.....1 NO..... 2	SEEN.....1 NOT SEEN.....2

Section: Experience and Training in MCH/FP Services

Now I would like to ask you about the training that staff in this facility has received.

NAME OF THE TRAINING COURSE	312. Did this training include (COURSE)?	313 Who received this training in this facility	314. How long ago did this training (most recent) take place? (IF YEAR IS LESS THAN A YEAR CODE "00" DK = "98")
A. MCH care	YES.....1 NO...2→312B	MO Yes..1 No..2 None present 9 SACMO/MA Yes..1 No..2 None present 9 FWV Yes..1 No..2 None present 9 NURSE/PARAMEDIC Yes..1 No..2 None present 9	<input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO
B. EPI	YES.....1 NO...2→312C	MO Yes..1 No..2 None present 9 SACMO/MA Yes..1 No..2 None present 9 FWV Yes..1 No..2 None present 9 NURSE/PARAMEDIC Yes..1 No..2 None present 9	<input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO
C. ARI	YES.....1 NO...2→312 D	MO Yes..1 No..2 None present 9 SACMO/MA Yes..1 No..2 None present 9 FWV Yes..1 No..2 None present 9 NURSE/PARAMEDIC Yes..1 No..2 None present 9	<input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO
D. Diarrhea	YES.....1 NO...2→312E	MO Yes..1 No..2 None present 9 SACMO/MA Yes..1 No..2 None present 9 FWV Yes..1 No..2 None present 9 NURSE/PARAMEDIC Yes..1 No..2 None present 9	<input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO
E. Logistic Management training	YES.....1 NO...2→312F	MO Yes..1 No..2 None present 9 SACMO/MA Yes..1 No..2 None present 9 FWV Yes..1 No..2 None present 9 NURSE/PARAMEDIC Yes..1 No..2 None present 9	<input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO
F. HEALTH/FP MIS	YES.....1 NO...2→312 G	MO Yes..1 No..2 None present 9 SACMO/MA Yes..1 No..2 None present 9 FWV Yes..1 No..2 None present 9 NURSE/PARAMEDIC Yes..1 No..2 None present 9	<input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO
G. Low-dose oral pill	YES.....1 NO...2→312 H	MO Yes..1 No..2 None present 9 SACMO/MA Yes..1 No..2 None present 9 FWV Yes..1 No..2 None present 9 NURSE/PARAMEDIC Yes..1 No..2 None present 9	<input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO
H. IUD insertion and FP injectable	YES.....1 NO...2→312I	MO Yes..1 No..2 None present 9 SACMO/MA Yes..1 No..2 None present 9 FWV Yes..1 No..2 None present 9 NURSE/PARAMEDIC Yes..1 No..2 None present 9	<input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO
I. MR	YES.....1 NO...2→312J	MO Yes..1 No..2 None present 9 SACMO/MA Yes..1 No..2 None present 9 FWV Yes..1 No..2 None present 9 NURSE/PARAMEDIC Yes..1 No..2 None present 9	<input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO
J.1 months Safe delivery refresher training (Projahmo)	YES.....1 NO...→312K	MO Yes..1 No..2 None present 9 SACMO/MA Yes..1 No..2 None present 9 FWV Yes..1 No..2 None present 9 NURSE/PARAMEDIC Yes..1 No..2 None present 9	<input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO
K. 6 months Midwifery training	YES.....1 NO...2→312L	MO Yes..1 No..2 None present 9 SACMO/MA Yes..1 No..2 None present 9 FWV Yes..1 No..2 None present 9 NURSE/PARAMEDIC Yes..1 No..2 None present 9	<input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO
L.FP method distribution	YES.....1 NO...2→312 M	MO Yes..1 No..2 None present 9 SACMO/MA Yes..1 No..2 None present 9 FWV Yes..1 No..2 None present 9 NURSE/PARAMEDIC Yes..1 No..2 None present 9	<input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO
M. 6 days Essential Newborn Care training	YES.....1 NO...2→312	MO Yes..1 No..2 None present 9 SACMO/MA Yes..1 No..2 None present 9	<input type="checkbox"/> YEARS AGO <input type="checkbox"/> YEARS AGO

(Projahnmo)	N	FWV Yes..1 No..2 None present 9	<input type="checkbox"/> <input type="checkbox"/> YEARS AGO
		NURSE/PARAMEDIC Yes..1 No..2 None present 9	<input type="checkbox"/> <input type="checkbox"/> YEARS AGO
N. Essential Services Package (ESP)	YES.....1	MO Yes..1 No..2 None present 9	<input type="checkbox"/> <input type="checkbox"/> YEARS AGO
	NO.....2→40	SACMO/MA Yes..1 No..2 None present 9	<input type="checkbox"/> <input type="checkbox"/> YEARS AGO
	1	FWV Yes..1 No..2 None present 9	<input type="checkbox"/> <input type="checkbox"/> YEARS AGO
		NURSE/PARAMEDIC Yes..1 No..2 None present 9	<input type="checkbox"/> <input type="checkbox"/> YEARS AGO

Record Review

401	How many cases/patients did you serve in this facility during last one week (last 6 working days)?	Number
A	Family Planning	
B	Antenatal care	
C	Delivery services	
D	Postnatal care	
E	TT	
F	Immunization	
G	FP counseling	
H	Health education	
I	Nutrition counseling	
J	Other-1 (specify)	
K	Other-2 (specify)	
L	Other-3 (specify)	
M	Total number of patients seen in the facility	

Record keeping and reporting

402	Do you maintain client records in your facility?	Yes 1 No 2 (go to 406)
403	DON'T ASK – OBSERVE ONLY: How are client records kept in the facility?	Registers 1 Cards 2 Others 3
404	Are the following registers present in the facility?	General patient1 Pregnant women2 Pediatric3 Stock4 Issue Voucher5 Attendance6 IUD7 Injection.....8 Contraceptive (pill +others)9 Inventory Control10 Antenatal care11 No registers used77
405	Are service statistics reports for the following services sent to a supervisor or higher unit?	Tick if reports sent
A	Reproductive health	Yes No
B	Family planning	Yes No
C	STD/RTI	Yes No
D	EPI	Yes No

Section 3. Management and Supervision

406	How many times in the last six months has a supervisor come to this SDP for supervisory purposes?	
		(Times)
406A	How many times in the last one month has a supervisor come to this SDP for supervisory purposes?	
		(Times)
406B	Who came to supervise the activities?	Designation a. b. c. d.
407	When visiting this facility, what did the supervisor do? (Do not read, but probe by asking, "Any other actions?")	Tick if mentioned
	1. Observe delivery of all services	Yes No
	2. Observe only service he/she is responsible for	Yes No
	3. Inquire about service problems	Yes No
	4. Examine the records.	Yes No
	5. Make suggestions for improvements	Yes No
	6. Offer praise for good works	Yes No
	7. Make actions for punishments	Yes No
	8. Other: _____ (Specify)	Yes No
408	How many times in the last six months has a supervisor observed your work?	
		(Times)
408A	How many times in the last six months has a supervisor observed you providing family planning services?	
		(Times)
409A	How are your activities being supervised and monitored?(Note detailed description)	
409B	Is any check-list or form being used for supervision and monitoring? What are those? Can you show me a sample of that check-list or form? (collect sample)	

COMMENTS:

ENDING TIME

HOUR.....

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MINUTES.....

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COMMENT:

END OF INTERVIEW TIME

HOUR.....

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MINUTE.....

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VIII.4. APPENDIX D: TABLES

Table 21. Newly married women's contact with health/family planning worker: Where did this health worker give you advice? (accept multiple answers)

Data collection method: Household survey

Population (n): Newly married women (n=46)

Timing of data collection: March-June 2006

Location	Frequency	Percent
Public Sector		
Government Hospital	4	8.70%
Government Health Center	3	6.52%
Family Planning Clinic	2	4.35%
Mobile Clinic	0	0.00%
Fieldworker	2	4.35%
Other Public	1	2.17%
Private Medical Sector		
Private Hospital/Clinic	4	8.70%
Pharmacy	2	4.35%
Private Doctor	3	6.52%
Mobile Clinic	2	4.35%
Fieldworker	22	47.83%
Depot Holder	1	2.17%
Other Private Medical	0	0.00%
Non-Medical Place		
Home	23	50.00%
Home of Friend/Relative	2	4.35%
NGO Sector		
NGO (NSDP) Clinic	0	0.00%
Other	1	2.17%

Table 22. Newly married women's contact with health/family planning worker: What methods did she discuss with you?

Data collection method: Household survey
 Population (n): Newly married women (n=46)
 Timing of data collection: March-June 2006

Method	Frequency	Percent
Female Sterilization	3	6.52%
Male Sterilization	2	4.35%
Pill	39	84.78%
IUD	10	21.74%
Injectables	32	69.57%
Implants	3	6.52%
Condom	23	50.00%
Lactational Amen. Method	1	2.17%
Periodic Abstinence	1	2.17%
Withdrawal	1	2.17%
Other	6	13.04%

Table 23. Recently delivered women's contact with health/family planning worker: Where did this health worker give you advice? (accept multiple answers)

Data collection method: Household survey
 Population (n): Recently delivered women (n=200)
 Timing of data collection: March-June 2006

Location	Frequency	Percent
Public Sector		
Government Hospital	32	16.00%
Government Health Center	32	16.00%
Family Planning Clinic	11	5.50%
Satellite Clinic	2	1.00%
Other Public	0	0.00%
Private Medical Sector		
Private Hospital/Clinic	4	2.00%
Pharmacy	1	0.50%
Private Doctor	1	0.50%
Mobile Clinic	4	2.00%

Fieldworker	119	59.50%
Depot Holder	0	0.00%
Other Private Medical	0	0.00%
Non-Medical Place		
Home	142	71.00%
Home of Friend/Relative	1	0.50%
NGO Sector		
NGO (NSDP) Clinic	12	6.00%
Other	1	0.50%

Table 24. Recently delivered women's contact with health/family planning worker: What methods did she discuss with you?

Data collection method: Household survey

Population (n): Recently delivered women (n=200)

Timing of data collection: March-June 2006

Method	Frequency	Percent
Female Sterilization	46	23.00%
Male Sterilization	31	15.50%
Pill	167	83.50%
IUD	55	27.50%
Injectables	146	73.00%
Implants	42	21.00%
Condom	62	31.00%
Lactational Amen. Method	13	6.50%
Periodic Abstinence	2	1.00%
Withdrawal	0	0.00%
Other	3	1.50%