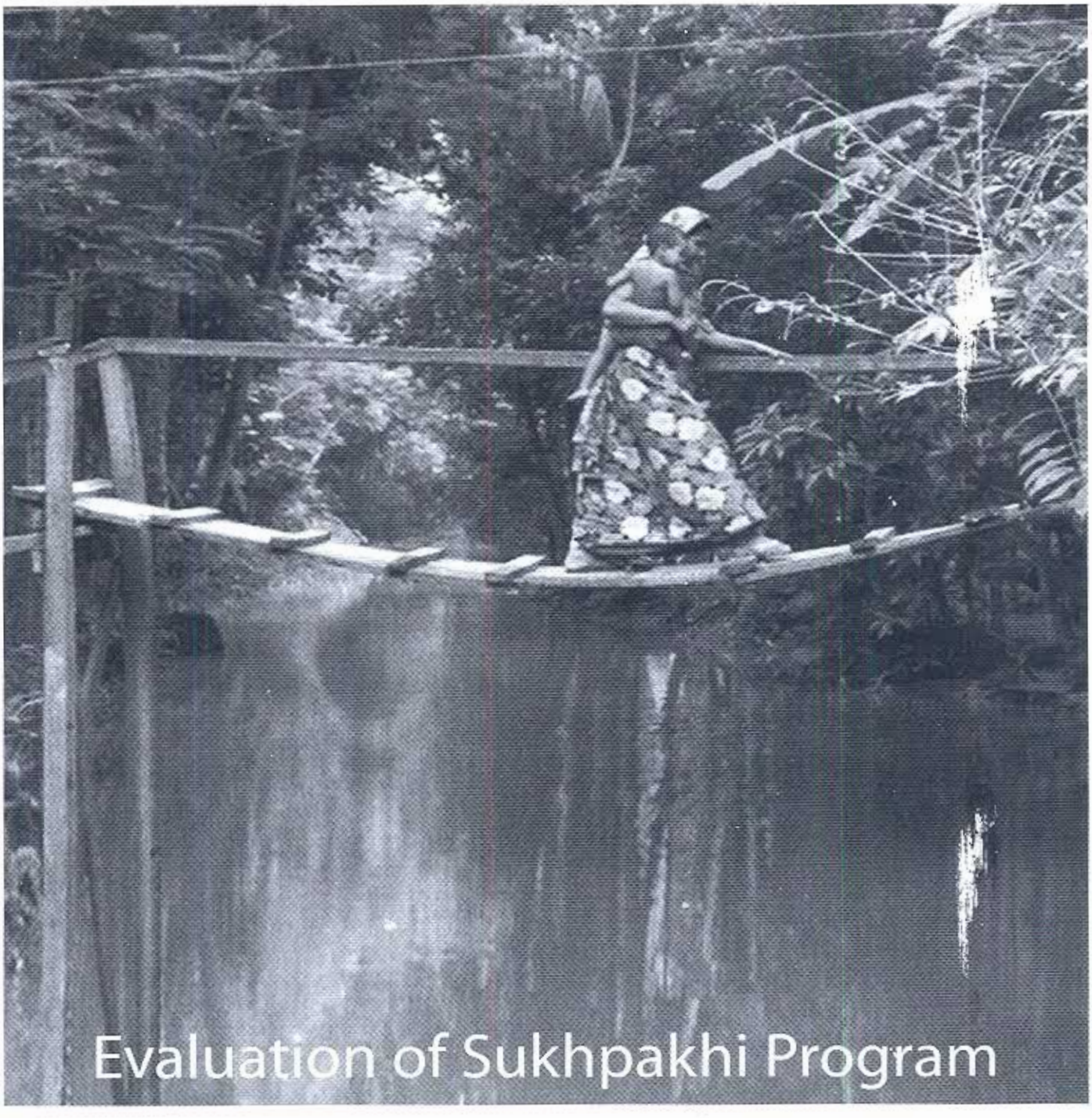

Evaluation of Sukhpakhi Program

Social Marketing Company (SMC)
2012

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Key Words

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Study Conducted By

eminence
Center for Health and Development Intelligence

Hena Nibash, 2nd floor,
3/6, Asad Avenue, Dhaka-1207
Bangladesh
eminenceassociates@yahoo.com
www.eminence-bd.org

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With great pleasure, joy and enthusiasm, I am writing this acknowledgment page for the report of "Evaluation of Sukhpakhi Program" for Social Marketing Company (SMC). We, the project team, believe if this document is worth of any use to design further plan will make sense more of it.

We are expressing our heartfelt thanks to SMC colleagues who provided their assistance and advice in various steps of conducting the study. This study was made possible by the generous support of the Social Marketing Company – Mr. Toslim Uddin Khan (Genaral Manager, Program), Dr. AZM Zahidur Rahman (Head of BCC), and Md. Billal Hossain (Senior Research and ME). We are also grateful to the data collectors, supervisors. We are grateful to the clients of Sukhpakhi program and also to non-clients who participated in this study.

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Dr. Md. Shamim Hayder Talukder
Chief Executive Officer
Eminence
Hena Nibash, 3/6 Asad Avenue
Mohammadpur, Dhaka – 1207.

ABBREVIATIONS

BDHS	Bangladesh Demographic and Health Survey
FGD	Focus Group Discussion
MWRA	Married Women at Reproductive Age
NGO	Non Government Organization
CYP	Contraceptive for Young People
HTSP	Healthy Timing and Spacing of Pregnancy
NPC	National Population Council
TFR	Total Fertility Rate
IUD	Intra Uterine Device
BCC	Behavior Change Communication
HPNSDP	Health, Population, Nutrition Sector Development Program
OP	Operational Plan
CPR	Contraceptive Prevalence Rate
LAPM	Long Acting Permanent Method
NSV	No-scalpel Vasectomy
MCH	Maternal Child Health
FP	Family Planning
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor

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Executive Summary

BACKGROUND

Bangladesh is now Asia's fifth and the world's eighth most populous country (about 142.3 million). The total fertility rate (TFR) declined from 6.3 births per woman in 1970-1975 to the current rate of 2.3, a decline of 63.49 in just 35 years. The trend in contraceptive use over the past four decades has increased several folds as well, from 8 to 61 percent. In spite of all these progresses, Bangladesh is still facing tremendous challenges with the family planning programs. The biggest challenges include Regional difference of TFR (Sylhet-3.1, Khulna-1.9) as well as of high unmet need for contraception (Chittagong-19 percent, Khulna and Rangpur-8 percent). Also low male participation in contraception is imposing a tremendous challenge in terms of success of the family planning programs.

As BDHS 2007 shows, 34 percent of the modern contraceptive users reported that they use SMC (Social Marketing Company) brand contraceptives. In 2005, SMC as its part of ongoing special education and marketing program initiated a special family planning campaign program **"Shukh Pakhi"** as a pilot project in two of the low performing divisions, Sylhet and Chittagong.

SMC has been implementing **"Shukh Pakhi"** program in Bangladesh to increase demand and utilization of family planning services in low performing Sylhet and Chittagong divisions. The goal of the program is to improve maternal and child health through building awareness on Healthy Timing and Spacing of Pregnancy (HTSP) which in turn will increase contraceptive usages in these low-performing areas. The key strategies that have been taken into consideration are:

- Involving local communities to reach most of the people and for the ownership and sustainability of the programme
- Using local dialects and local media Positioning contraceptive methods to improve maternal and child health
- Generic promotion of family planning methods

Major program activities:

1. Courtyard meeting (Uthan Baithak) with female audience
2. Community support meeting with male audience
3. Using local Kazi (marriage registrar) as an advocate to counsel about FP methods
4. Miking, film shows and leaflet distribution through SMC's Mobile Film Units
5. Home visits to counsel newlyweds
6. Distribution of audio cassettes in local dialect
7. Use of local communication channel

OBJECTIVE

The overall objective of the study is to conduct a follow-up Knowledge Attitude and Practice (KAP) study in the **"Shukh Pakhi"** program areas among the Married Women of Reproductive Age to assess the effectiveness of the **"Shukh Pakhi"** program against selected indicators.

The specific objectives of the Study are

- To assess the effectiveness of the "Shukh Pakhi" program. In doing so the study aims to:
  - To identify and assess the existing level and pattern of knowledge, attitude and practices regarding appropriate method mix (which method is suitable for what type of MWRA) among the of MWRA
  - Determine the level of awareness of increased risks associated with early a . late pregnancy to mothers and children
  - Determine the knowledge of the MWRA about the benefit of birth spacing
  - To understand the views and perception of the beneficiaries about the " Shukh Pakhi" program

Cross-sectional statistical design with an integrated approach combining qualitative and quantitative method was followed. The study used Structured Interview (SI) as quantitative tool and, Focus Group Discussion (FGD) as qualitative tool for achieving the objectives. The respondents were:

1. Married Women of reproductive age from Sukhpakhi operating areas and control areas (2 divisions, 4 districts, 7 upazillas)
2. Male population to collect qualitative information.

The sample size for Chittagong Division was 736 (Experimental group 368+ Control group 368) and Sylhet Division was 734 (Experimental group 367+ Control group 367).

It is found that women in experimental group (88%) have better knowledge and understanding in ns of knowing the methods of contraception, about appropriate method mix and also on other indic ors than of the control group. A slightly higher than half of the respondents in control and experimer al area believe that public sectors are the pre dominant sources for getting the information but it is evident that the public sector effort alone is not enough to increase the awareness level. There is a need for outreach programs by the non-public sector like NGO, private sector or others sectors. The findings of the Sukhpakhi program indicate the relevance of that kind of program. Women also have the knowledge that the information of family planning and contraceptive is available in the local pharmacies but they are not much aware of the SMC activities done in the locality like Blue Star program. Only few women mentioned about the Blue star Pharmacy (1.3%).

A very common finding reveled in the study that the peoples in both areas know more about temporary methods and also agreed to adopt those methods (oral pill, injectables) however the knowledge on long term method is not clear to them. Inadequate knowledge on long term method keep them away to adopt those kind of methods like (IUD or Norplant). Also the female have very little knowledge on male oriented methods like condom or male sterilization.

Although the women from experimental area have higher knowledge than the women of the control area but it is significantly noted in the findings that probing response is higher than self response. en

the answer is open for the respondent to tell about the information, the proportion is very low who provided the specific information but when the interviewers probe them with the specific information they can recall the information. From the logistic regression analysis it is examined that the women with high education preserve more knowledge and there is a direct relation between education and knowledge.

Audio visual communication is the most preferred method for the respondent to get the information as majority of the women are not that much educated. If the information is provided through drama or in some entertaining way it attract more peoples to receive the messages. Qualitative findings also show that the group oriented way of communication is more fruitful like Uthan Baithak.

In terms of contraceptive method, Current use rate of any method is lower compared to the knowledge level. The findings show that the women have the knowledge but a large portion of the women are not using though they know the methods. Still the male domination is a big factor to adopt FP method which keep the women away to use any method and also finding show that in experimental area a big proportion of male is deciding which method will be adopted instead of taking joint decision. There are some issues founded from qualitative discussion those are very sensitive like religious retribution, and fear of physical problems that are related to side effects. Some women strongly believe that they will not be taken to heaven if they use contraceptive methods or if they die with the stick of implant they will not be buried after death. Women have lack of adequate knowledge on which method is suitable for whom also prevent the women to take contraceptive which is very much related with side effect and fear.

Incentive is a very common aspiration of the people to get motivated. When they are asked to spend some time to listen to something they expect they must be awarded with some incentive. From the findings it is revealed that majority of the respondents told that prize giving (The prize which was given for a quiz competition) was the most attracted part of the Sukhpakhi program while majority of the women asked that they did not like that the prizes were not given to everyone. It is evident from the study that if there were some token of incentives was given to everyone then the participation would be more effective.

Though there is some dissatisfaction among the women however Sukhpakhi program was considered as the effective one by most of the women. Findings from qualitative discussion revealed that both male and female group think that this program helped them to learn many things and implementing of the information they obtained from the program will make their like easier.

Based on the discussion above from the findings and also from the findings of the numerous study, it is evident that though population sector program is the highest priority for the government however only programmatic approaches taken by the government alone will not be enough to increase access of family planning services in low performing area like Chittagong and Sylhet. There need some outreach programs or joint effort with the government can contribute in accessing the peoples in family planning services. The gaps in knowledge of the peoples of control area justify the program intervention by the private sector as the knowledge of experimental area is in better level.

The education of the women has direct relation with the knowledge level. Intervention needs only for family planning services rather advocacy on to be educated can bring positive results towards the success of family planning programs.

The peoples from experimental group are very happy with the performance of Sukhpakhi progra . They have liked the way of communication of the program. Most of the respondent liked Mobile t and group discussion like Hat Baithak and Uthan Baithak). The local peoples have the demand of this pe of program. They considered it as their means of keeping their family happy and also taking care f their child properly. Also a significant change has been occurred in decision making process am ng the couples regarding taking children and adopting any method of family planning. Now the couples preferred to take any decision jointly.

RECOMMENDATIONS

Communication technique

- Knowledge did not reflect into action related to permanent method, so communication need to be focused on practice issues as well as change in behavior from one service to another
- Use of audio visual BCC materials as a means of advocacy (Using tablets).
- The people needs to be communicated that other than health benefits, use of contraception has an economical benefit, this issues need to discuss with more emphasize.
- Increase knowledge intensive activity so that the self response could be increased at the level of probing response.
- Discuss different health related issues in relation with contraception, gynecological diseases sexually transmitted etc.
- The literature and survey data leave little doubt that men in Bangladesh are suitable targets for family planning programs. Male participation is very much important to make decision for a female client. Male participation in family planning and couple's reproductive health can be increased through couple counseling and targeted BCC activities.

Make link up with the Government

- Public health sector is the predominant sector for the sources of information and services of family planning. Make link up with the government sources to make the program more feasible.
- The operational plans under HPNSDP of the governments needs to be followed, here the lead OPs are CCSD and FPFSD with strong supportive functions in OPs PME-FP, MIS, IEC, PSSM-FP, and NIPORT
- Use the local government infrastructure to deliver the messages as it is the most preferred sources

Expansion of SMC's related activities

- The population has the knowledge about pharmacy but very few know about the blue star pharmacy. Initiatives need to be taken to bring more pharmacies under the umbrella of blu star or SMC.

Chapter One: Introduction and Objectives

1.1 Background

Bangladesh is now Asia's fifth and the world's eighth (http://www.dgfp.gov.bd) most populous country with an estimated population of about 142.3 million and with a population density of 964 per sq. km. (BBS: preliminary result of census 2011). The population is expected to stabilize by 2050 at around 258 million. Bangladesh has achieved remarkable progress in population and health over the past 3[illegible] ars. Beginning in 1972 the family planning program received virtually unanimous, high-level political [illegible]pport. All subsequent governments that have come into power in Bangladesh have identified population [illegible]ntrol as the top priority for government action. Population planning was seen as an integral part of t[illegible]e total development process and was incorporated into successive five-year plans. Recently, the gove[illegible]nment adopted the Bangladesh Population Policy. Its goals are to improve the status of family planning and maternal and child health, including reproductive health services. Over the past three decades, Bangladesh has made impressive gains in indicators related to population and family planning. The total fertility rate (TFR) declined from 6.3 births per woman in 1970-1975 to the current rate of 2.3, a decline of 63.49 in just 35 years. The trend in contraceptive use over the past three decades has increased several folds as well, from 8 to 61 percent. In spite of all these progresses, Bangladesh is still facing tremendous challenges with the family planning programs. The biggest challenges include Regional difference of TFR (Sylhet-3.1, Khulna-1.9) as well as of high unmet need for contraception (Chittagong-19 percent, Khulna and Rangpur-8 percent). Also low male participation in contraception is imposing a tremendous challenge in terms of success of the family planning programs. Government has taken numerous strategies to tackle the challenges like, emphasize on increasing/ achieving the projection target of long-acting and permanent family planning methods, reducing the dropout rate of temporary methods of contraception, building awareness and special motivational activities to increase male involvement in contraception, up gradation of Union Health & Family Welfare Centers (H&FWCs) , Special IEC campaign for the low performing & hard to reach areas, Initiatives to fill up the vacancies at all level and so on. But still the discrepancy is remarkable. Beside the government, NGOs and [illegible]vate sectors have also been playing a vital role behind the success in the population sector and [illegible]vide specific policy recommendations based on their research based intervention. Social Marketing C[illegible]npany (SMC) which is the largest privately managed social marketing organization, has been sign[illegible]icantly contributing to the overall successes of national reproductive and child health programs. In F[illegible] 2010, SMC provided 3.6 million CYP (Contraceptive for Young People) through offering three modern methods- oral pills, condoms, injectable. As BDHS 2007 shows, 34 percent of the modern contraceptive users reported that they use SMC brand contraceptives. In 2005, SMC as its part of ongoing special education and marketing program, initiated a special family planning campaign program **"Shukh Pakhi"** as a pilot project in two of the low performing divisions, Sylhet and Chittagong.

1.2 Description of the program

Social Marketing Company (SMC) is the largest privately managed social marketing organization in the world for a single country. SMC's mission is to improve the quality of lives of vulnerable and less privileged population primarily in public health through sustainable social marketing efforts in collaboration with national and International governments and donors. The concept of Social Marketing came to Bangladesh in 1974 when the social marketing project was initiated to challenge rapid population growth through BCC/IEC program and by making contraceptive products widely acc[illegible]ssible

at a price affordable to the general people. It has been significantly contributing to the overall success of national reproductive and child health.
SMC has been implementing **"Shukh Pakhi"** program in Bangladesh to increase demand and utilization of family planning services in low performing Sylhet and Chittagong divisions. The goal of the program is to improve maternal and child health through building awareness on Healthy Timing and Spacing of Pregnancy (HTSP) which in turn will increase contraceptive usages in these low-performing areas.

SMC has been implementing Sukhpakhi programs through different activities in its Strategies using best appropriate methods for those areas:

The key strategies that have been taken into consideration are:

- Involving local communities to reach most of the people and for the ownership and sustainability of the programme
- Using local dialects and local media Positioning contraceptive methods to improve maternal and child health
- Generic promotion of family planning methods

Major Programme Activities:

1. Courtyard meeting (Uthan Baithak) with female audience
2. Community support meeting with male audience
3. Using local Kazi (marriage registrar) as an advocate to counsel about FP methods
4. Miking, film shows and leaflet distribution through SMC's Mobile Film Units
5. Home visits to counsel newlyweds
6. Distribution of audio cassettes in local dialect
7. Use of local communication channel (messages on prescription pads, wall painting, outlet branding, location board, employing Peer Educators, etc.).

1.2 Governments Initiatives towards Family Planning

Population and family planning policies in Bangladesh

Socio-economic development for all citizens is the cornerstone of Bangladesh's Constitution. According to the articles 15-18 in part II of the Constitution, the State has the responsibility to ensure to its citizens certain basic needs such as health, education, food, security etc. In order to translate these constitutional aims into reality, Bangladesh Government has adopted different policies. Realizing the high population growth rate was the nation's "number one problem", the Government prepared a Population Policy Outline in 1976.
Family planning was introduced in Bangladesh (then East Pakistan) in the early 1950s through the voluntary efforts of social and medical workers. The government, recognizing the urgency of moderating population growth, adopted family planning as a government-sector program in 1965. Beginning in 1972 the family planning program received virtually unanimous, high-level political support. Population planning was seen as an integral part of the total development process and was incorporated into successive five-year plans. Policy guidelines and strategies for the population program are formulated by the National Population Council (NPC), which is chaired by the prime minister.

As the continuation of the population program and policy, recently the government has adopted the Bangladesh Population Policy 2009 (draft). Its goals are to improve the status of family planning and

maternal and child health, including reproductive health services, and to improve the living standard of the people of Bangladesh by striking a desired balance between population and development in the context of the Millennium Development Goals (MDGs) and a Poverty Reduction Strategy Paper (PRSP). The objectives of the population policy promulgated in 2009 (draft) are to:

- Reduce the total fertility rate (TFR).
- Increase the use of family planning methods among eligible couples by raising awareness of family planning.
- Attain a net reproduction rate equal to one by the year 2015 in order to stabilize population around 2070;
- Develop Family planning, maternal, child and reproductive health and ensure equality among population and development by focusing on national and international policies and strategies to improve the quality of livelihood of the peoples.
- Ensure adequate availability of and access to reproductive health services, especially family planning services, for all—including information, counseling, and services for adolescents

Since 1980 the program has stressed functionally integrated health and family planning programs. The goal is to provide an essential package of high quality, client-centered reproductive and child health care, family planning, communicable disease control, and limited curative services at a one-stop service point. The Health and Population Sector Program (HPSP) was formulated as part of the Fifth Five-Year Plan (1998-2003), keeping in view the principles of the Health and Population Sector Strategy (HPSS) that called for a single sector for both health and population. The main objective of the HPSP was to ensure universal access to essential health care services of acceptable quality and to further slow population growth. For 2011-16, Government has adopted five year plans under Health, Population, Nutrition Sector Development Program (HPNSDP). This strategic document has set out several drivers, and strategies as follows:

- Addressing population growth with vigorous, fully integrated family planning services, and crosscutting, multi-sector interventions.
- Revitalize various family planning interventions to attain replacement levels.
- Strengthen contraceptive security and additional staff to improve procurement and distribution.

The objectives of this program are to

- To promote a more effective method-mix CPR with increased share (20) / proportion of longer acting and permanent family planning methods through:
  a. Attaining replacement level fertility by 2016 at the earliest and its continuation;
  b. Shifting and increase share of LAPM in CPR.

- To increase male participation specially for No-scalpel Vasectomy (NSV)
- To provide quality of care of family planning methods
- To ensure contraceptive security.

To achieve the above mentioned objectives the document has outlined the main components of its activities as follows:

Component 1: Strengthening LAPM Services.

To provide 20 share of LAPM in CPR-72 and TFR-2.0 by the year 2016 with increase male participation in family planning.

Component-2: Ensuring availability of Contraceptives and MSR of LAPM

Component -3: To Provide quality of care of family planning services

Component -4: To provide capacity development.

Component -5: To Provide support to NGOs for LAPM services

Many factors have contributed to the increase in contraceptive use over the past 20 years. Eleme that have contributed to the success of the program include: 1) strong political commitment t nily planning programs by successive governments, 2) successful promotion of a small family norm rough information and educational activities and other multi-sectoral programs, 3) establishme of a widespread infrastructure for delivering family planning and health services down to the village vel, 4) increased involvement of nongovernmental organizations to supplement and complement the government's efforts, 5) flexibility to make policy and programmatic adjustments in response to emerging needs, and 6) strong support of the program by the international aid community (GOB, 1994:36).

The success achieved so far in the national family planning program is encouraging and has increased confidence that it is possible to achieve further progress. However, there remain several issues of concern. By addressing the challenges identified form different experience, the family planning could appear as the successful program for Bangladesh.

Family Planning Service delivery of the country:

To achieve the objective of the population policy, the government has adopted strategies from national level in the policy in its service delivery mechanism:

1. Recipient based services: Ensure family planning, maternal, child and reproductive health services through **wide range of service outlets have been including union and upazilla based serving providing centers.**
2. Among all couples especially among the poor population, the field worker will visit every household to ensure service for the recipient.
3. Priority is being given to Young couple, couples with less children, newly married couple and couples with unmet needs for family planning to receive services and encourage them to chose their own methods.
4. Give priority to the couples with one child to encourage the couples to have a planned family.

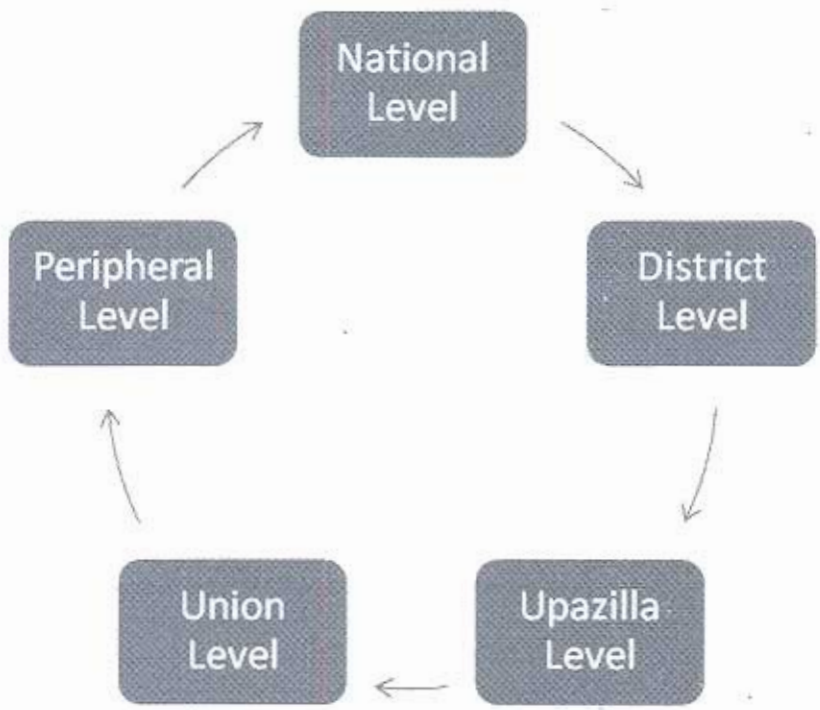
The services are available from National Level to union level institutions. **A wide range of service outlets have been established throughout the country.**

1. National Level

- Azimpur Maternity and Child Health Training Center
- Mohammadpur Fertility Service and Training Center
- Two Model Clinics attached to two Medical College Hospitals
- Family Welfare Visitors Training Institute (FWVTI) - 12
- NGO Clinics -05
- Population, Health and Nutritional Cell - Bangladesh Betar

- Population Cell - Bangladesh Television

2. District Level
    - Model Clinics attached to Medical College Hospitals - 06
    - MCH-FP Clinics at District Hospitals - 64
    - Mother and Child Welfare Centers (MCWC) - 62*
    - Regional Training Center (RTC) - 20
3. Upazila Level
    - MCH-FP Units at Upazila Health Complex (UHC): - 407*
    - Mother and Child Welfare Centers (MCWC) - 12*
    - NGO Clinics - 68
4. Union Level
    - Union Health and Family Welfare Centers (UH&FWC) – 3,500*
    - Rural Dispensaries (RD) - 1,275
    - Mother and Child Welfare Centers (MCWC) - 23*
5. Peripheral Level
    - Satellite Clinic (Organized 30,000 per month);
    - Domiciliary Services (CBD) 23,500 unit).
    - Mother and Child Welfare Centers (MCWC) - 23



1.3 Rationale of the Study

Numerous research findings showed that Sylhet & Chittagong Divisions are lagged behind other divisions in many of the health & family planning indicators. Sylhet and Chittagong Divisions have higher Maternal Mortality Ratio and Under Five Child Mortality Rate. Moreover these divisions have much lower demand for family planning and as a result they have registered lower Contraceptive Prevalence Rate (CPR) and higher Total Fertility Rate (TFR) than other divisions. The peoples of these areas are not

motivated enough to use the contraceptive and also there is the lack of awareness as well. Another key concern for family planning programs is the rate at which contraceptive users discontinue using their method. Almost three in five (57 percent) contraceptive users in Bangladesh stop using their method within 12 months of starting (BDHS 2007). SMC is working continuously to increase the awareness level on family planning.

Through "**Sukhi Pakhi**" project SMC has been working to increase awareness about the importance of well being of the mothers and children in the family, position impact of delayed pregnancy and [illegible]cing on mother and child health, knowledge about family planning methods and availability in o[illegible] to increase the usage of contraceptives among the Married Women of Reproductive Age (M[illegible]RAs). Through e Evaluation of Sukh Pakhi program will

1.4 Objectives of the Study

Overall Objective

The overall objective of the study is to conduct a follow-up Knowledge Attitude and Practice (KAP) study in the **" Shukh Pakhi"** program areas among the Married Women of Reproductive Age to assess the effectiveness of the **" Shukh Pakhi"** program against selected indicators.

Specific Objectives

The specific objectives of the Study are

- To assess the effectiveness of the "Shukh Pakhi" program. In doing so the study aims to:
  - To identify and assess the existing level and pattern of knowledge, attitude and pra[illegible]tices regarding appropriate method mix (which method is suitable for what type of M[illegible]RA) among the of MWRA
  - Determine the level of awareness of increased risks associated with early a[illegible]d late pregnancy to mothers and children
  - Determine the knowledge of the MWRA about the benefit of birth spacing
  - To understand the views and perception of the beneficiaries about the " Shukh Pakhi" program

Chapter Two: Methodology

2.1 Study Design

This section explored the different tools, techniques and analytical approaches that were engaged to conduct this study at various scales. This research was founded upon both quantitative and qualitative data collection methods, where most of the sources selection was done randomly from the target population. This study was systematically conducted comprising activities categorized under several steps.

Cross-sectional statistical design with an integrated approach combining qualitative and quantitative method was followed here. The study will use Structured Interview (SI) as quantitative tool and, Focus Group Discussion (FGD) as qualitative tool for achieving the objectives of the study.

2.2 Study Population

For achieving the objective of Evaluation of Sukhpakhi Program, the population included Women of reproductive age from selected areas where the Population has received the messages form Sukhpakhi program. The study also covered the male participants of Sukhpakhi programs from the selected areas. To meet the best output of the objective, the population also covered from control area to make the comparison with experimental areas where the Sukhpakhi program was operating.

The following categories of subjects have been included in the study:

3. Married Women of reproductive age from Sukhpakhi operating areas and control areas (2 divisions, 4 districts, 7 upazillas) were included in the study as respondents to collect quantitative and qualitative information.
4. Male population from both areas to collect qualitative information.

2.3 Sampling Procedure

For this Evaluation study, Systematic random sampling was followed to select the beneficiaries from the intervention area. The list of the Sukhpakhi project areas including village names were provided by SMC. The samples were selected from those areas purposively who have participated in any component of the Sukhpakhi program.
For each Division, similar size samples of control group were selected from the adjacent to compare the program result which will be an adjacent union of the intervention areas. A total of 735 MWRA samples were selected randomly to collect quantitative information.

Sample Size Calculation

For the Survey with structured questionnaire, the sample size is determined by using the following standard statistical formula:

$$N=Z^2 [P(1-P)/d^2]*D_{eff}$$

Where,

N=sample size

Z=slandered normal vitiate at 95 confidence level (1.96)

P=indicator percentage

d= Desired Precision

D_{eff}=design effect

In our calculation expected prevalence rate p = 61 of contraceptive users (BDHS preliminary ·eport 2011) with 4 desired precision and 2.5 design effect. By this calculation, we get 1428 **sam·ple** 95 confidence levels. To meet the requirement of the study and achieve the targeted objectives, the sample was 1470. The households were selected by using probability proportionate sampling.

In both divisions, control area was selected from the adjacent areas of the experimental areas. In each division, equal sample was selected purposively by using multistage cluster sampling.

So in total, the sample size was,

Chittagong Division 736 (Experimental group 368+ Control group 368)

Sylhet Division 734 (Experimental group 367+ Control group 367)

2.4 Study Area

SMC has been implementing the "Sukhi pakhi" Program Chittagong and Sylhet Division in some selected areas. For this Evaluation study the study areas are as follows. As per area list provided by SMC · ·otal of Therefore, 17 from the Sukhpakhi program areas were selected as the study area for this Ev ·ion study. In addition to the program intervention areas, 17 more adjacent unions were includec ·n the study in order to construct a more reliable comparative framework. All together, thus, a tot of 34 unions were selected as the study area for this study.

Division	District	Upazilla	Name of Union	
			Experimental	Control
Chittagong	Chittagong	Lohagara	Amirabad, Chunati, Padua	Charamba, Kalauzan, Putibilia
		Total	3	3
		Banshkhali	Kalipur, Pukuria, Saral	Silkup, Chambal, Gandamara
		Total	3	3
	Cox's Bazar	Ukhia	Ukhia Sadar, Ratna Plang, Haludia Plang	Raja Palong, Pa ng Khali
		Total	3	2
		Teknaf	Teknaf Sadar, Nihilla, Sabrang	Whykong, Baharchara, Saint Martin
		Total	3	3
Sylhet	Sylhet	Kanaighat	Chutul, Dokkin Banigram, Jhingabari	Purba Dighirpar, Pashchim Dighirpar, Paschim, Purba
		Total	3	4
		Companyganj	1 no west Islampur, Telikhal	East Islampur, Ranikhali 1 & 2
		Total	2	2
	Habiganj	Lakhai	Bamai, 6 no Bulla, Karab	Muriauk, Marak ıri, Lakhai Sadaı
		Total	3	3
Total	3	7	17	17

2.5 Data Collection Method

Study tools

Eminence has employed different tools for this study purpose and objective which included toc ı'om both quantitative and qualitative research methods. These tools enabled the research team to as ss the quality of the program and also enabled in comparing the study result with the control areas.

a. Document Review
b. Structured Questionnaire
c. Focus Group Discussion

Document Review:

The study has reviewed relevant literatures including different Reproductive Health /Family Planning / MNH Projects related documents, reports, and previous report of similar type of surveys/studies etc.

Comprehensive literature review has been conducted from relevant sources and web portals such as; related directorates of MoHFW (http://www.mohfw.gov.bd), WHO (http://www.who.int/en/), PUBMED (www.ncbi.nlm.nih.gov/PubMed), Articles and journals from Lancet (www.the**lancet**.com), National level survey (Like as, BDHS), Sukhpakhi program details at http://www.smc-bd.org/shukh_pakhi.html different report and publications from other countries of South Asia and Published and unpublished document.

Structured Questionnaire

Aforementioned sampling procedure was followed to select 1500 ever married women for this ırvey. A questionnaire was prepared to ask the samples with a sufficient number of questions which ‹ ɔvered all related issues and helped the research team to learn relevant information from the questionna ıre.

Focus Group Discussion

FGDs were conducted in the study areas with 18 FGDs in each division. So there were a total of (18*2) 36 FGDs for this study. The FGDs were equally conducted among male and female and also in experimental group and control group. In this calculation 18 FGDS were conducted in experimental group and 18 FGDS were conducted in control group.

Study Tools		
Respondents	SQ Survey	FGD
Women of reproductive age in experimental group	A survey with a sample size of 750	9
Women of reproductive age in experimental group	A survey with a sample size of 750	9
Male from experimental group	0	9
Male from Control group	0	9
Total		36

2.6 Organization of the Study

Sample Design

The survey is designed to obtain 1500 interviews with women at reproductive age 15-49. According to the sample design, 750 interviews were allocated to urban areas and 750 to rural areas with an equal distribution of the sample. Also the interviews covered a number of service providers and also the community leaders who have been selected as the Key Informant Interviews.

Questionnaire

This particular study has used the structured questionnaire to collect quantitative data from the selected respondent. But for the Focused group discussion the guideline has been developed to obtain the accurate data. The draft questionnaire was shared with the SMC and it was finalized after incorpc ng all of their feedback. The structured questionnaire was designed targeting to cover the following pics to ask the respondents:

a. General Information
b. Socio-economic Condition
c. Knowledge on Family Planning Issues
d. Attitude and Practice
e. Barriers to access in family planning services
f. Perception about Sukhpakhi program
g. Benefits of participating in Sukhpakhi program

The FGD Guideline has been designed to get some specific data from the respondents which include:

a. Knowledge on Family Planning Issues
b. Attitude and Practice
c. Barriers to access in family planning services
d. Perception about Sukhpakhi program
e. Benefits of participating in Sukhpakhi program

All relevant information was gathered by using these questionnaire and guidelines.

Training of the Data Collectors

For getting accurate data, 7 days training was arranged for the data collectors to familiarize them with the methodology and overall process. A number of Twenty-seven field staffs were trained and organized into 2 teams to carry out the study. Of them 25 were data collectors and 4 were supervisors to check and verify the work of the listing teams. Training included the lecture on research objective, research tools and how to use the developed tools in the field and also on what to do and what not to do in conducting a field research as well. The training part also covered role play as part of practical training. This has ensure the quality data collection. The senior delegates from SMC visited the training sessions, guided the data collectors with their experience of the program.

Pre test of the Questionnaire

The questionnaires were pretested on 25 samples in Vashantek Slum, Mohammadpur in Dhaka. Based on the observation and suggestion made by the pretest team, the questionnaires were revised with corrections in wording and other relevant areas.

Field Work

Field work for this study was carried out by 25 interviewees divided into 2 teams, one for Chittagong division and one for Sylhet division. The teams worked for 15 days to collect data from field. Chittagong team consists of twelve female members and two male members. The Sylhet team comprised of nine female members and four male members. The female members were entitles to collect quantitative data as all the respondents were women. Also they conducted FGDs with the women. The male members conducted the FGDs with the male. In addition, senior team members from Eminence monitored the field work with another set of quality control teams. Fieldwork was carried out from June 4 to June 18, 2012.

Data Processing

All the filled questionnaire started to return Dhaka periodically to Eminence. The processing of data collected in the field began shortly after fieldwork commenced. Data processing consisted of office editing, coding of open-ended questions, data entry, and editing inconsistencies found by the computer program.

Data Entry

The data entries were done by nine data entry operators in nine computers using epi-info computer program. The Qualitative data was put in FGD matrix.

Data Analysis

All the survey data were entered using Epi Info. Data were analyzed using SPSS version 16.0. Descriptive analyses were performed to examine the demographic information, socio-economic information, knowledge on family planning, attitude and practice related to family planning and knowledge on Sukhpakhi program . Cross tabulations were determined for categorical variables and mean for continuous variables. A wealth index was constructed from data on household assets including ownership of durable goods (such as electricity, almirah, televisions and bicycles), ownership of the household, number of living rooms in the households and land asset including cultivable land using principal component analysis. Statistical differences in each variables between experimental and control were sought using t-test to compare means for continuous variables and two-sample test of proportions to test the equality of proportions for categorical variables. Logistic regression model was used to identify associations between knowledge on family planning with different demographic and socio economic variables.

Report Writing

The study team has designed dummy tables and share with SMC before finalization, and also generated summary formats for report writing. Both quantitative data analysis using statistical techniques (S and

EPI) and qualitative data analysis in calculating progress at outcome and Goal level indicators was used. Afterwards, the report was be written using error free data, survey observations, findings and analysis obtained from other analytical computer packages. This draft report was sent to SMC for feedback and the final report is submitted when these feedbacks are properly incorporated.

2.7 Quality Control Mechanism

A multi stage quality control mechanism was followed to ensure the quality of the study. The tools were prepared and finalized after having intensive consultation with SMC and field-test. There were two field supervisors to guide and supervise the teams. They were responsible for ensuring quality of data, guiding enumerators during data collection, checking some randomly chosen data that were interviewed by the field investigators, checking the entire completed data sheet, holding discussion meetings at the end of the day with the team members. They were also be responsible to verify 15 filled questionnaire. There was a key person to ensure the validity and reliability of data. This Quality Control Officer verified 15 filled questionnaire. Thus a total of 30 filed questionnaires were verified by the supervisors and Quality Control Officer.

Data were double entered using EpiInfo 2000 software and cross-matched to clean and maintain the weight. Standard analysis package SPSS 16.0 was used for analyzing data.

Chapter Three: Findings of the Study

3.1 Quantitative Findings

3.1.1 Background Characteristics: Demographic Situation

In this evaluation study, the samples were the Married Women at Reproductive Age (MWRA) from 15-49. As shown in table 1, in experimental area majority of the respondents belong to the age group 25-29 which is 27.2%, in control area 25.3% women belong to the age group 20-24 and it is the highest group for this area. Mean age of the respondents in experimental area and control area is 28.19 and 28.5 years respectively.

In the sample, the study found that 96.7% women in experimental area and 94.1% women in control area are living with husband, 1.2% in experimental area and 2.1% in control area are divorced, .4% in experimental area and .7% percent in control area are abandoned. The proportion for the separated women is 1.7% in experimental area and 3.1% in control area.

Table 1: Percentage distribution of women at reproductive age with demographic characteristics and by residence

Characteristics	Experimental area n=750	Control area n=750	p-value
Average age of the respondents (Year)	28.19	28.50	0.396
Age Group			
15-19	5.3%	8.5%	0.014*
20-24	26.9%	25.3%	0.481
25-29	27.2%	20.8%	0.004*
30-34	18.8%	19.2%	0.843
35-39	12.3%	14.8%	0.157
40-44	7.1%	8.1%	0.465
45-49	2.4%	3.2%	0.348
Average duration of Married life (Year)	11.76	11.76	0.999
Number of Living Children			
0	6.5	10.3	0.008*
1	19.3	18.5	0.692
2	23.7	19.1	0.[illegible]*
3	20.1	19.6	0.[illegible]08
4+	30.3	32.5	0.359
Average member of household	6.17	6.32	0.370

*: <0.05, **: <0.001

The table shows that in experimental area 93.5 % women and 89.7% women in control area own children with majority of the women having 4 and more than 4 children for both area. For each area, the average number of family member is more than 6. This number also indicates the number of children is more than 2 which is conflicting with the Family planning campaign. The families are headed by the males in majority households. Only 4.9% households in experimental area and 6.5% in control area are headed by the female.

Socio Economic Condition

Marital Status:

All of the women who are were selected as the respondents for this study and majority of the respondents are living with their husbands. 96.7% women in experimental area and 94.1% women in control area are living with their husband. There are also some divorced and abandoned women who are not very significant in number.

Religion:

With regard to religion, a total of four religions have been identified. By and large, Islam represents the highest proportion in both experimental and control area (85.3%) and 86.7 respectively, followed by Hinduism 13.1% in experimental area and 11.7% in control area. The believers of Buddhism are 1.5 in each area%. The study did not find any Christian in its sample as shown in table 2.

Education:

Education is considered as one of the major socio economic component that influence the person's attitude and behavior towards consciousness on and use of health services, family planning and the health care for the children. In the experimental area, more than 25% women are literate but in control area the literacy rate is 24.3%. Majority of the women have attended in school in the study area. Only 13.4% women in experimental area and 18.9% women in control area do not have educational attainment. Though majority of the women attended school but they are limited up to grade 1 . Only 7.2%women in experimental area and 9.6% women in control area have education level above grade 10. For the education level of the husband, it is more likely with the education of the women but a little bit higher in terms of grade 10 or above. In experimental area, 13.1% men and 15.1% men in control area have education level above grade 10.

Occupation:

In terms of occupation, for more than 90% women, occupation has been identified as housewife in the study areas, 95.7% and 94% in experimental area and in control area respectively. Very few women are occupied in other profession which is not very remarkable. Others category consist of Day Labor, Tailor, Teacher, Shop owner etc also found in the study areas but not very significant to mention.

Table 2: Percentage distribution of women at reproductive age with Socio Economic characteristics and by residence

Characteristics	Experimental area n=750	Control area n=750	p-value
Marital Status			
Married (Living with husband)	96.7	94.1	0.016*
Divorced	1.2	2.1	0.171
Others (Abandoned, Separated)	2.1	3.8	0.432
Religious Status			
Islam	85.3	86.7	0.435
Hindu	13.1	11.7	0.411
Others	1.5	1.5	1.0[illegible]
Head of Household			
Male	95.1	93.5	0.1[illegible]
Female	4.9	6.5	0.18[illegible]
Educational Status			
No education	12.9	18.4	0.003*
Literate	27.6	24.3	0.145
Read & write but no institutional education	.5	.5	1.000
1-4	8.9	8.3	0.679
5	17.7	15.6	0.275
5-10	25.1	23.3	0.416
SSC/Dakhil and Above	7.2	9.6	0.094
Occupation of the respondent			
Housewife	95.7	94.0	0.136
Service Holder	.8	1.3	0.342
Household Worker	.3	1.1	0.063
Others (Day Labor, Tailor, Teacher, Shop owner etc)	3.3	3.6	0.7[illegible]
Wealth Quintile			
Lowest	18.3	21.7	0.1[illegible]
Second	20.1	19.9	0.923
Middle	21.9	18.1	0.066
Fourth	20.8	19.2	0.439
Highest	18.9	21.1	0.287

*: <0.05, **: <0.001

Wealth Index:

One of the background characteristics identified in this study is the wealth index which was de[illegible]ped and tested based on the household economic status. Table 2 shows the wealth index status [illegible] the respondent. Majority of the women are in the middle wealth index in experimental area but it is [illegible]lightly different from control area. In control area, majority of the respondents belong to both low[illegible]st and highest wealth index which is 21.7 for lowest and 21.1 for highest.

3.1.2 Objective 1: Knowledge, attitude and practices regarding appropriate method mix (which method is suitable for what type of MWRA) among the of MWRA

Knowledge on family planning who knows at least one method of family planning

One of the most cost-effective health interventions is family planning, which can significantly improve the health of women and their families. Table 3 demonstrates the awareness level of the respondents about family planning who knows at least one method of family planning. In this study, it is found that in experimental area 88% women are aware of the family planning who knows about at least one method of family planning. In contrast, the proportion for the control area is 78.1%. National family-planning programs have proved effective in making awareness among the peoples about different issues of family planning like delay or avoid pregnancy, birth spacing, development of maternal and child health etc but still some additional effort is needed. It is evident that outreach family planning programs have the [illegible]igher effect on the peoples than in those that had access only to standard government family planning s[illegible]ces. The respondents of the experimental area who are exposed to Sukhpakhi program have [illegible]gher knowledge (88%) than the respondents of the control area (78.1%). The difference is highly si[illegible]ficant between the two areas (p value: 0.000).

The findings show that, the most known method in both areas is oral pill. But the significant difference is seen in using the other methods. The knowledge rate for the other methods is significantly very high in experimental area. 65.9% women in experimental area and 53.4% women in control area told that they know about condom for contraception. Almost 92% women (91.8%) in experimental group are familiar with injectables which are significantly high than the control group (84.8%) with a p value 0.000. Knowledge on permanent methods is more likely significantly high in experimental area. For Implant, 41.4% and 25.1% women know about the Implant respectively in experimental area and control area. The proportion for having knowledge on IUD is 51.4% in experimental area and 37.4% women in control area. Knowledge on permanent method is proportionately high in experimental area which is highly significant for both female and male sterilization with p value 0.000. 73.5% and 57.8% women for female sterilization, 32.0% and 21.3% women have knowledge on male sterilization respectively in experimental and control area.

It is significantly noted that along with the modern methods, women in experimental group also having high knowledge on traditional methods. In experimental area 9.1% women and in control ar[illegible] [illegible].3% women know about the periodic abstinence. For withdrawal method, the proportion for expe[illegible]ental area is 9.4% and for control area is 5.6%.

Table 3: Percentage distribution of women who have Knowledge of family planning by residence and by methods

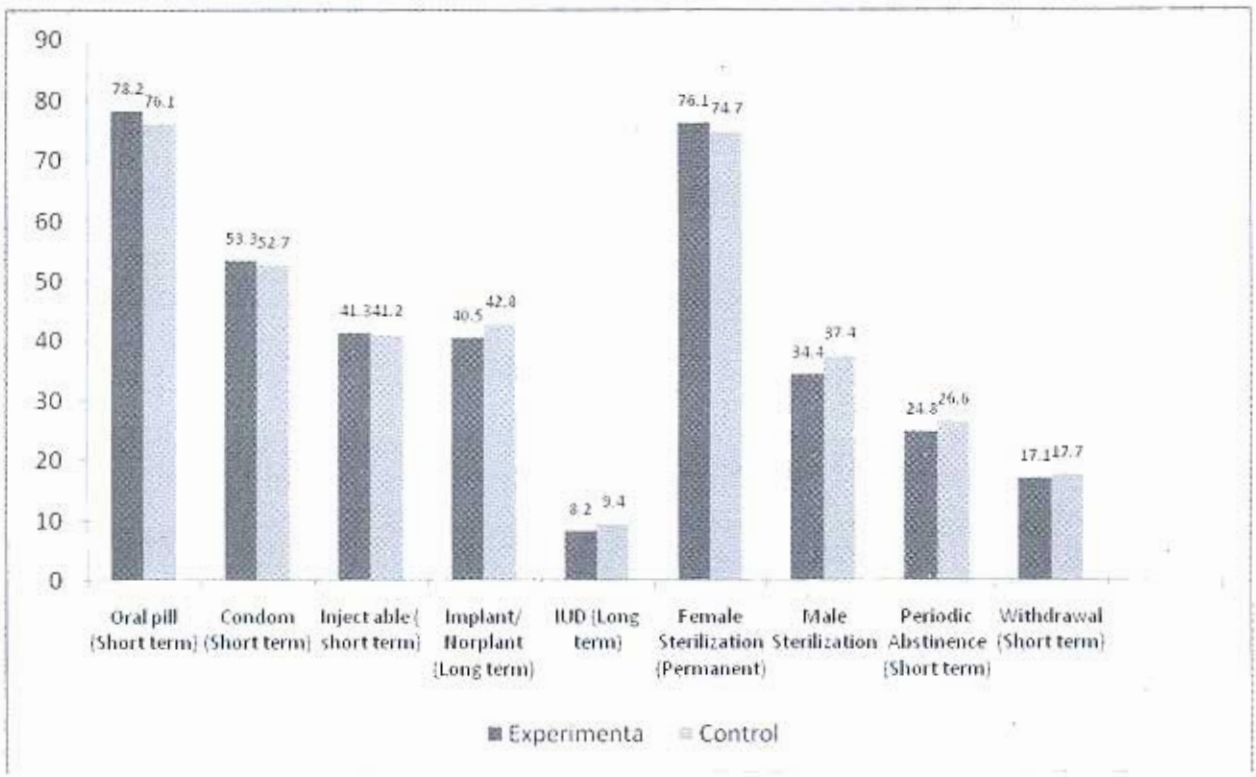
Women who know at least one method of family planning by residence	**Experimental area n=750**	**Control area n=750**	**p-value**
% of women	88.0	78.1	0.000**
Knowledge on specific method			
Methods	**Experimental area n=660**	**Control area n=586**	**p-valu**
Any modern method			
Oral Pill	96.7	96.9	0.844
Condom	65.9	53.4	0.000**
Injectable	91.8	84.8	0.000**
Implant / Norplant	41.4	25.1	0.000**
IUD	51.4	37.4	0.000**
Female Sterilization	73.5	57.8	0.000**
Male Sterilization	32.0	21.3	0.000**
Any Traditional Method			
Periodic Abstinence	9.1	5.3	0.012*
Withdrawal	9.4	5.6	0.014*
other	0.9	0.9	1.000

*: <0.05, **: <0.001

Knowledge on Type of contraceptive method

The knowledge on the type of contraceptive method were measured by asking the respondents name wise specific method and in which type the method belong to such as short term, long term or permanent method type. For three most popular and mostly used methods, the proportion is higher in experimental area than in control area. 78.2%, 53.3% and 40.3% women in experimental area correctly know the type of these three methods, oral pill, condom and injectables respectively whilst the proportion for control area is 76.5% for oral pill, 52.7% for condom and 39.2% for injectables.

Figure 1: Percentage distribution of women at reproductive age having Knowledge on Type of contraceptive method



Knowledge on source of family planning information and services

The women were asked whether they know about from where they can get family planning information and services. Table 4 shows that majority of the women from both area know the Government hospital/clinics as the main source for the family planning information and services. In experimental area 54.9% women and 56.3% women in control area told Government hospital/clinics as the source. Also 32.9% women in experimental area and 24.4% women in control area know government field worker as the important source for the family planning information and services.

Table 4: Percentage of women at reproductive age having knowledge on source of family planning services and information by residence

Source	Experimental area n=750	Control area n=750	p-valu
Pharmacy	37.9	36.4	0.54
Blue Star Pharmacy	8.5	1.3	0.00(**
Departmental Store	5.3	3.7	0.135
Government Hospital/Clinic	54.9	56.3	0.585
Government Field worker	32.9	24.4	0.000**
NGO/Clinic/NGO Hospital	6.8	3.9	0.013*
NGO Field worker	7.5	3.1	0.000***
Village Doctor	17.1	15.1	0.292
MBBS Graduate Doctor	3.3	3.1	0.826
Others	7.2	3.1	0.000**
Don't Know	4.8	13.3	0.000**

*: <0.05, **: <0.001

The local pharmacies are considered as the source by 37.9% women in experimental area and 36.4% women in control area. But difference is highly significant in knowledge level regarding the Blue Star Pharmacy which is run by SMC. In experimental area, **8.5% respondents believe that Blue Star Pharmacy is the important source; in contrast only 1.3% respondents know about th lue Star Pharmacy.** Another remarkable finding is that in experimental area, more women cons r the NGO sector (NGO/Clinic/NGO Hospital, NGO Field worker) as the source of family anning information and services than control area. The women from control area do not know alm st any source is 3 times (13.3%) than the experimental area (4.8). There are some doctors in the rural area who do not have any professional degree but they serve to the community people as the doctor having some related training. In this study, 17.1% women in experimental area and 15.1% women in control area are reported that they consider those village doctor as the source of the family planning information and services.

Knowledge on appropriate method mix (which method is suitable for what type of MWRA)

Use of different method of contraception depends on the age, number of living children, and also on marital duration. Also it has a direct relation with the tolerance of the physical condition. Respondents have mixed opinion regarding this. For the most used methods, majority of the respondents answered correctly like for oral pill, condom and injectables. Oral pill can take all married women, 62.9% women in experimental area and 64.2% women in control area gave this answer as they know. 20.0% and 10.6% respondents know that oral pill is suitable for those who want break between two child for experiential area and control area respectively. Here a significant number of respondents me ioned about others. It is important to note that which they mentioned is newly married women can t e oral

pill. This is the correct answer provided by 19.8% women in experimental area and 12.8% women in control area. Here the difference is scientifically significant as tested with the Pearson's chi squire test (p value= 0.001).

Regarding condom use, women in control area have higher knowledge than control area. 43.6% women in experimental area know it as for the all married men whist the proportion in control area is 31.7% (p value=0.000). For other right answers the table shows that the respondents from experimental area have more knowledge than control area, Who wants to take a very effective temporary method of contraception (Ex-10.6%, Con-6.5%), Either one or both of husband and wife has sexually transmitted diseases (Ex-6.7%, Con-3.6%) and so on. The significant number of respondents mentioned rightly in others that condom is suitable for those whose wife gave birth of child very recently. 1[illegible] in experimental area and 12.8% in control area with p value 0.004.

Table 5: Percentage of women at reproductive age having knowledge about the appropriate method mix (which method is suitable for what type of MWRA)

Methods	Experimental area n=660	Control area n=586	p-value
Oral pill			
All married women	62.9	64.2	0.634
All married women who are under 49 years	4.5	6.8	0.078
Who has irregular periodical cycle	4.5	5.6	0.375
Who wants to have break between two children	20.0	20.6	0.793
Lactating Mothers	4.1	3.9	0.857
Others (newly married)	19.8	12.8	0.0[illegible]*
Do not Know	8.3	11.3	0[illegible]
Condom			
All married Men	43.6	31.7	0.0[illegible]0**
Who wants to take a very effective temporary method of contraception	10.6	6.5	0.010*
Those whose wives can not have pills or other methods	7.0	8.4	0.354
Either one or both of husband and wife has sexually transmitted diseases	6.7	3.6	0.014*
To prevent sexually transmitted diseases	5.6	4.3	0.293
Others (Whose wife gave birth of child recently)	12.0	7.2	0.004*
Do not Know	34.5	50.0	0.000**
Injectable			

Who has at least one living children	27.9	21.2	0.006
Who has two or more child but do not want to take permanent method	29.4	22.4	0.005*
Lactating Mothers	4.2	3.8	0.720
Who cannot tolerate mixed oral pill/prohibited to use oral pill/ Forget to take pill everyday	22.3	18.6	0.107
Others	18.6	12.3	0.002*
Do not Know	16.4	32.9	0.000**
Methods	**Experimental area n=660**	**Control area n=586**	**p-value**
IUD			
Married women having at least one living child	27.4	12.8	0.000**
Who cannot use hormonal contraceptive method	2.6	2.4	0
Others (Lactating mothers and women who cannot use hormonal method)	12.1	5.6	0.000**
Do not Know	59.7	80.9	0.000**
Norplant			
Those who want to take a very effective long term temporary method	9.7	4.9	0.001*
Married women having at least one child	6.4	4.3	0.102
Want long term break to take a child	15.8	10.1	0.003*
Those who cannot use Estrogen type (mixed oral pill) contraceptive method	1.4	1.4	1.000
Lactating Mother	1.1	1.0	0.863
Others	4.5	1.7	0.005*
Do not Know	70.6	82.4	0.000**

*: <0.05, **: <0.001

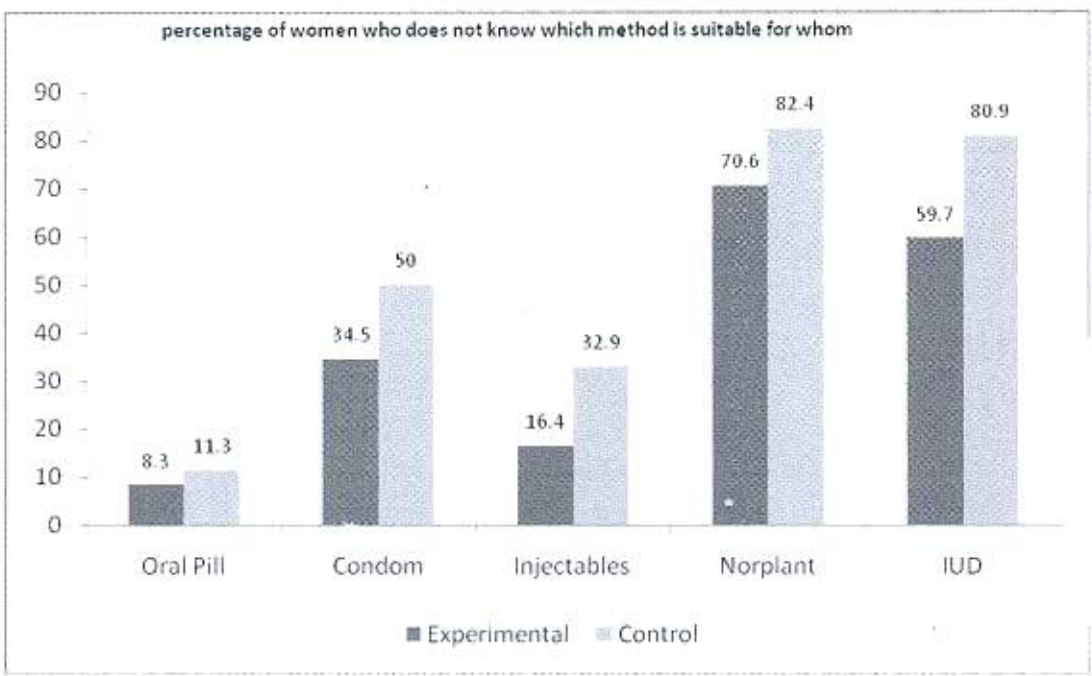
As presented in table 5, majority of the women know correctly for whom Injectable is suitable. In experimental area the proportion is high than that of control area. 27.9% women in experimental area and 21.2% women in control area answered for the woman who has at least one child. Women who has two or more child but do not want to take permanent method, 29.4% in experimental area and 22.4% in control area reported as suitable for injectable (p value= 0.005)

The proportion is significantly high in experimental area who told IUD is suitable for the women for Married women having at least one living child, 27.4% in contrast the rate is 12.8% in control area with p value=0.000. 2.6% and 2.4% has reported that IUD is suitable for the women who cannot use hormonal contraceptive method respectively in experimental area and control area. Others consist of the type of

women who are lactating and who cannot use any hormonal method were answered correctly by 12.1% women in experimental area and 5.6% women in control area which significantly differentiate in knowledge in these two areas with a p value=0.000. It indicates that women in experimental area have higher knowledge than control area regarding the use of IUD.

Norplant is a long term method and it is suitable for those women who want to take a very ‹ tive long term temporary method is reported by 9.7% women in experimental area and 4.9% w‹ ıen in control area (p value=0.001). Correctly stated by 6.4% women in experimental area and 4.3% w‹ nen in control area that Norplant is suitable for the Married women who have at least one living child.

Figure 2: Percentage distribution of women who don't know about appropriate method mix



In experimental area, the respondents answered the questions what they know but in control area a significant proportion admitted that they don't know which method is suitable for whom. Other than the oral pill the difference is highly significant as shown in table 8, extreme right column presents the p value of the study. The study found in all cases the p value is <0.001. For condom 34.5% and 50.0%, 16.4% and 32.9% for injectables, 59.7% and 80.9% for IUD, for implant 70.6% and 82.4% women stated the answers an do not know in experimental area and control area respectively.

Wishes for more children

Table 6 represents about the wishes of the women to have more child who has children alread. The findings show that 40.4% women in experimental area and 38.5% women in control area whish ·ave more children. Wishing for more children depends on various issues like age group; which is ' : high time to take the child. In experimental area a total of 59.4% women belong to the age grou 15-29

whereas in control are the number is in total 54.6% (Reff: Table 1). In this span of time generally the women give birth most of their child.

Table 6: Percentage distribution of women at reproductive age wishing to have more children by residence and by background characteristics

Wishes for more child	Experimental area n= 701	Control area n= 673	p-value
% of women	40.4	38.5	0.471
Background Characteristics	**Experimental area**	**Control area**	p-value
Age Group			
15-19	85.0	77.8	0.001*
20-24	57.8	55.8	0.454
25-29	45.8	40.3	0.040*
30-34	26.6	33.3	0.007*
35-39	23.3	21.8	0.506
40-44	15.1	23.7	0.000**
45-49	22.2	8.3	0.000**
Number of Living Children			
1	73.8	76.3	0.285
2	47.2	41.3	0.028*
3	29.8	27.9	0.437
4+	20.7	21.7	0.650
Educational Status			
No education	38.7	24.8	0.000**
Literate	32.0	31.8	0.937
Read & write but no institutional education	25.0	50.0	0.000**
1-4	37.5	42.9	0.041*

Wishes for more child	Experimental area n= 701	Control area n= 673	p-value
5	39.8	43.1	0.214
5-10	51.5	47.7	0.159
SSC/Dakhil and Above	46.8	53.6	0.012*
Wealth Quintile			
Lowest	38.8	32.2	0.011*
Second	34.7	40.4	0.029*
Middle	39.2	34.7	0.084
Fourth	48.6	43.9	0.081
Highest	40.8	41.7	0.735

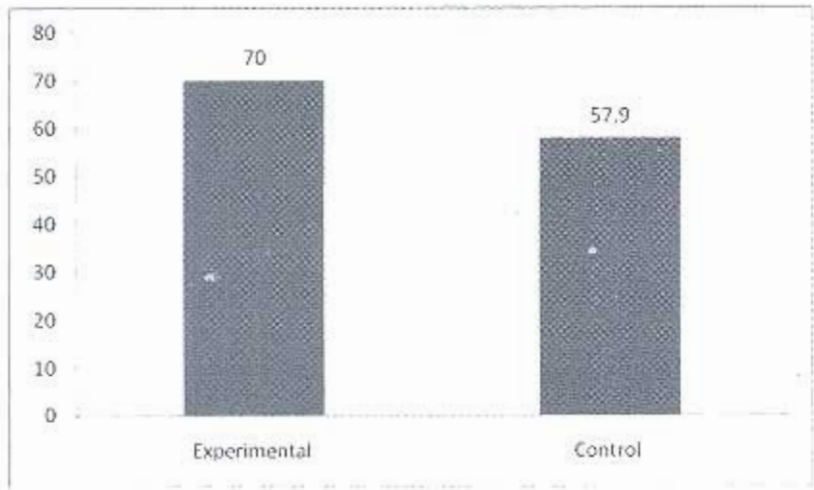
*: <0.05, **: <0.001

It also depends on the number of living children. If we look at the table 1, we will see that more women in experimental area have 1 (19.3%) and 2 (23.7%) children that that of the control area. Economic status also leads the family to go for more children. They feel secure with more children. Table 9 shows that in experimental area respondents with fourth and highest wealth index prefer to have more children. In experimental area 48.6% women belong to fourth wealth Index and 40.8% women belong to the highest wealth index who wants to have more children. The rate for the control area is 43.9% for fourth index and 41.7% for highest wealth index.

Ever Use of Contraception

The respondents who told that they have heard at least one method of contraception were asked whether they have ever used any method in their entire life considering past and present. These data indicates that a woman used any method at least once in her life. Figure 3 shows that 7 in every 10 women in experimental area and 5.7 in every 10 women in control area used contraception at least once in life.

Figure 3: Percentage distribution of women at reproductive age who have told whether they ever used any contraceptive methods



Current Use of Contraception

The current use of contraception was measured by asking women whether they are currently using any method or not. The findings as shown in figure 2, that currently overall 55.6% women in experimental area and 46.4% women in control area are using any method of contraception. This rate is the combination of Chittagong and Sylhet division. If we compare this rate with the rate of BDHS 2011, the finding shows that it is average 40% together with Sylhet and Chittagong division. Again if we compare with the overall national rate it is found that the rate of the experimental area is very close to the national rate.

Figure 4: Percentage distribution of women at reproductive age who are currently u: any contraceptive

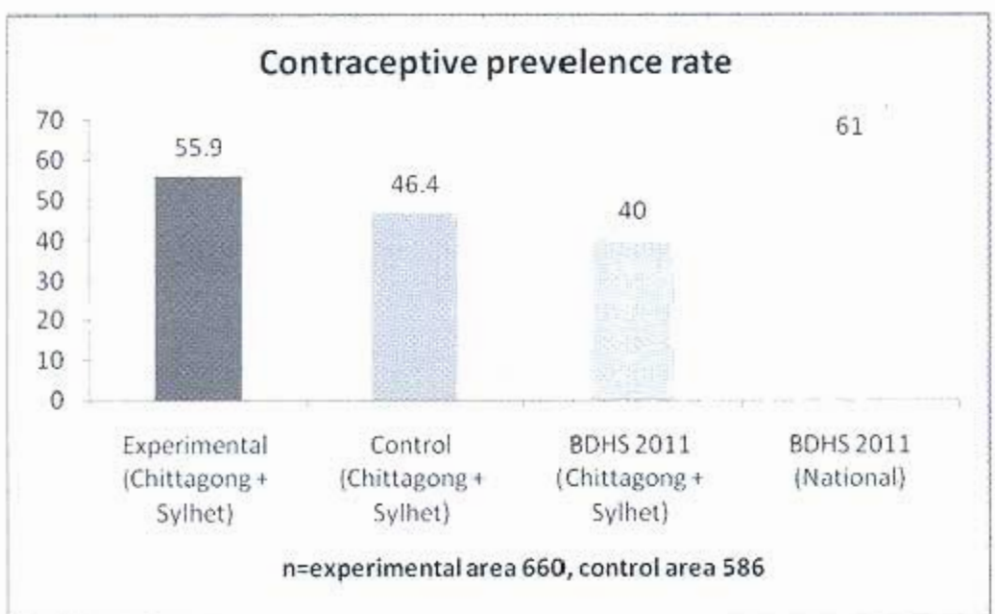


Table 7: Percentage distribution of women at reproductive age who are currently using any contraceptive by methods and by residence

Methods	Experimental area n= 419	Control area n=348	p-value
Oral pill	52.7	55.5	0.439
Condom	5.7	6.0	0.860
Injectable	32.0	29.6	0.474
Implant/Norplant	2.9	1.1	0.082
IUD	.2	.0	0.404
Female Sterilization	6.4	3.2	0.0[illegible]
Male Sterilization	.2	1.7	0.0[illegible]
Periodic Abstinence	.7	.9	0.7[illegible]6
Withdrawal	1.9	1.1	0.370
other	.2	.0	0.404
Don't know	6.9	.3	0.000*

*: <0.05, **: <0.001

As shown in table 7, oral pill is the most popular method and more than 50% women using oral pill currently followed by injectable 32% in experimentall area and 29.6% in control area, condom 5.7% in experimental area and 6.0% in control area. Use of IUD and male sterilization is less than 1% for both areas. More than double women use female sterilization in experimental area (6.4%) than in the control area (3.2%). The women are Majority of the women are familiar with the modern method and very few know about traditional method. For traditional method highest rate is for the withdrawal method which is 1.9% in experimental area and 1.1% in control area.

Reasons for not using contraceptive method

Table 8 presents the main reasons for not intending to use contraception by the women. Th most common reason identified is the wish for more children. One eighth women in experimental a ea and 41.1% women in control area are wishing to have more children. The other reasons are husbai d does not like (Ex-13.6%, Con-12.3%), don't feel good (Ex-25.9%, Con-23.7%), husband lives in abroad (Ex-10.1%, Con-13.2%), and there are some currently pregnant women (Ex-7.0%, Con-4.4%) who actually do not need to use contraceptive method.

Table 8: Percentage distribution of women at reproductive age who have told about the reasons of not using contraceptive methods by residence

Reasons	Experimental area n= 331	Control area n= 402	P value
Want to take more children	40.2	41.4	0.742
Husband does not like	13.6	12.3	0.601
Do not feel good	25.9	23.7	0.492
Others	4.9	6.3	0.415
Husband Lives in abroad	10.1	13.2	0.195
Currently Pregnant	7.0	4.4	0.127

*: <0.05, **: <0.001

Decision making process

Table 9: Percentage distribution of women at reproductive age told about the discussion about family planning between husband and decision making

discuss about family planning with their husband for adopting any method by residence	Experimental area n= 750	Control area n= 750	P value
% of women	87.2	79.5	0.000**
Getting cooperation of husband regarding adopting family planning methods	**Experimental area n= 750**	**Control area n= 750**	**P value**
% of women	84.8	78.7	0.002*
Who has taken the decision of using the current method	**Experimental area n= 419**	**Control area n= 348**	**P value**
Husband	9.9	4.6	0.006*
Myself	13.1	15.3	0.383
Together husband and wife	77.0	80.1	0.[illegible]

*: <0.05, **: <0.001

The respondents were asked whether they discuss family planning methods with their husbands, 87% women in experimental area and 79.5% in control area reported that, they discuss about family planning with their husband for adopting any method. It is very important to discuss about family planning between spouse and it is significantly high in experimental area, p value= 0.000. Also regarding getting cooperation from husband for using any method, 84.8% women in experimental area and 78.7% women in control area told that they got cooperation from their husband. This proportion is significantly high in experimental area with p value= 0.002.

Regarding discussions and cooperation with husbands, decisions is made whether by husband, by the women herself or by the husband and wife together.

In experimental area, more women rely on their husband in decision making, 9.9% women told th hey accept the decision which is made by their husband, and the number of that kind of women is 4.6 control area. 13.1% and 15.3% women take the decision by themselves in experimental area and ntrol area respectively. Regarding joint decision making it is 77% in experimental area and 80.1% in con rol area.

Logistic Regression Analysis on the determinants of knowledge on family planning

Study area

The logistic regression analysis presents the knowledge on family planning in experimental area is two time more likely than control area (OR=2.0 and 95% CI=1.5, 2.7). The middle age category of the respondents had significant knowledge on family planning compared to the reference category.

Age Category

Respondents who were 35-39 age category had four times knowledge on family planning than 15-19 age category (OR=4.0 and 95% CI=2.1, 7.5).

Education

Education had the linear relation on knowledge on family planning. Like the women wit ore education has more knowledge on family planning. Respondents who has education SSC and ab e are 4.3 times than the respondents has no education (OR=4.3 and 95% CI=2.0, 9.4). Wealth index ad no significant impact on family planning (Table 10).

Table 10: Logistic regression model showing the determinants of knowledge on family planning

Characteristics	Knowledge on family planning n/N (%)	Odds Ratio (95% CI)	P value
Study area			
Experiment	660/750 (88.0)	2.0 (1.5 – 2.7)	0.000**
Control	586/750 (78.1)	1	
Age category			
15-19	76/104 (73.1)	1	
20-24	323/392 (82.4)	1.7 (1.0 - 2.8)	0.060
25-29	315/360 (87.5)	2.9 (1.7 – 5.1)	0.000**
30-34	239/285 (83.9)	2.5 (1.4 – 4.4)	0.00[illegible]*
35-39	179/203 (88.2)	4.0 (2.1 – 7.5)	0.0[illegible]
40-44	85/114 (74.6)	1.6 (0.9 - 3.2)	0.[illegible]2
45-49	29/42 (69.0)	1.2 (0.5 – 2.8)	0.[illegible]39
Education of the respondent			
No education	174/234 (74.0)	1	
Literate	308/389 (79.2)	1.2 (0.8 – 1.7)	0.486
Read & write but no institutional education	7/8 (87.5)	2.2 (0.3 – 18.7)	0.479
1-4	109/129 (84.5)	2.0 (1.1 – 3.5)	0.027*
5	215/350 (86.0)	2.2 (1.3 – 3.5)	0.003*
5-10	317/363 (87.3)	2.5 (1.5 – 4.1)	0.000**
SSC/Dakhil and Above	116/126 (92.1)	4.3 (2.0 – 9.4)	0.000**
Wealth quintile			
Lowest	230/300 (76.7)	1	
Second	249/300 (83.0)	1.4 (0.9 -2.0)	0.[illegible]3
Middle	252/300 (84.0)	1.3 (0.8 – 1.9)	0.[illegible]00
Fourth	250/300 (83.3)	1.1 (0.7 – 1.7)	0.614
Highest	265/300 (88.3)	1.4 (0.9 – 2.3)	0.176

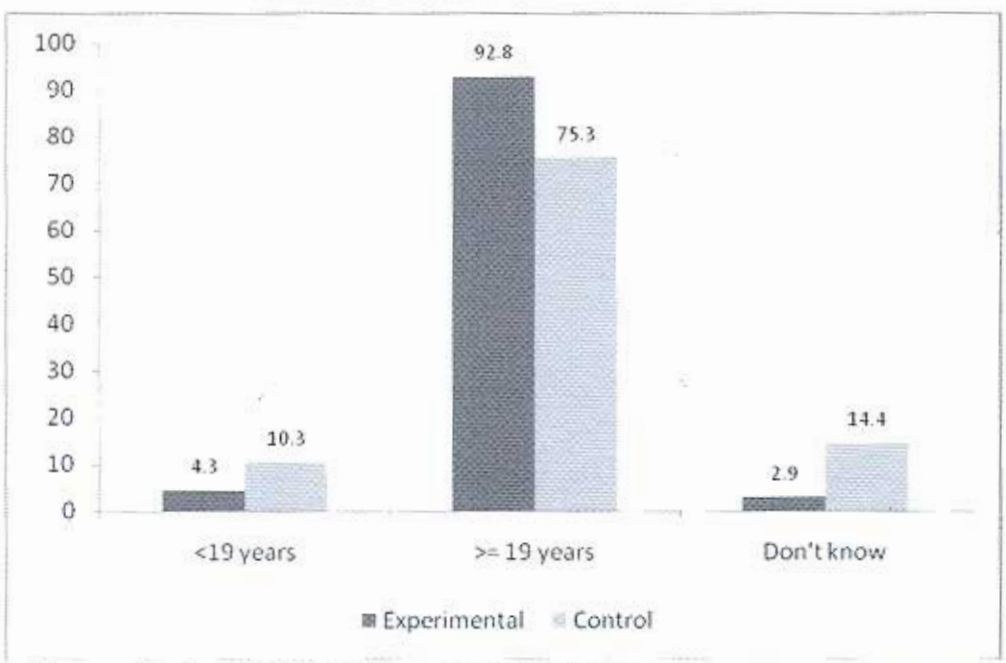
3.1.3 Objective Two: Determine the level of awareness of increased risks associated with early and late pregnancy to mothers and children

Proper age of first pregnancy

Pregnancy is the opportunity for the women and welcome by the women and family. But if the proper age is not maintained it could impact on mother and children health and on family as well very negatively. Sukhpakhi program was designed to aware the women about the proper age of first pregnancy in which the negative impact will be avoided.

It is a remarkable finding that more than 92% women are aware of the proper age of the first pregnancy and they defined as above 19 years. In contrast, in control area this proportion is 75.3%. This difference of knowledge indicate the significance of the findings (p value=0.000) that the women of the experimental area are having higher knowledge than that of the control area.

Figure 5: Percentage distribution of Women told about the proper age of first pregnancy



<19 years-P value= 0.000, >=19 years-p value=0.000, Don't Know- pvalue=0.000

Problems of early pregnancy

Before age 20, a girl is not physically ready to give birth of the child and having pregnancy before the age 20, many types of complications could be occurred including mothers and children's health and malnourishment. Regarding the knowledge on the problems of early pregnancy women in the experimental area 72.4% reported that mother suffers from health problem which is higher than 65.2% of the control area (p value= 0.003). Child suffers from health problem is known by 45.9% wome

experimental area and 36.9% in control area. As tested with the Pearson's chi squre, this is appered as the significant in difference in knowledge level between the two areas.

Significant difference is also seen in the knowledge level regarding the health problem for both mother and child which was reported as 36.4% in experimental area and 27.3% in control area (p value= 0.000).

Table 11: Percentage distribution of women knowing about the problems of early pregnancy

Problems	Experimental area n= 750	Control area n= 750	P value
Mother suffers from health problem	72.4%	65.2%	0.003*
Child suffers from health problem	45.9%	36.9%	0.00[illegible]
Mothers and Child suffers from health problem	36.4%	27.3%	0.00[illegible]
Mother and child stays in good health	2.4%	1.1%	0.05[illegible]
Both mother and child suffers from malnutrition	21.5%	16.8%	0.021*
Others	17.3%	15.3%	0.294
Don't know	2.8%	7.6%	0.000**

*: <0.05, **: <0.001

Another problem identified by the respondents is both mother and child suffers from malnutrition. 21.5% and 16.8% women in experimental and control area respectively know about this.

The proportion for don't know is 3 times high in control area than experimental area.

3.1.4 Objective Three: Knowledge of the MWRA about the benefit of birth spacing

Knowledge on birth Spacing

The respondents were asked to tell at least how many years a mother should wait to get pregna : after having a baby. The findings, as presented in table 12 shows that the majority of the women told a out at least two years and above two years. In experimental area 26.1% respondents told that it shou d be at least 2 years, in contrast 15.1% women in control area suggested so (p value: 0.000). Three year s were told by 17.5% women in experimental area and 22.4% in control area. It is remarkably noted that more than 40% respondents answered for 5 years for birth spacing. A significant proportion of respondents form control area told that they don't know the answer, .9% in experimental area and 6.3% in control area (p value: 0.000).

Table 12: Percentage distribution of women at reproductive age by knowledge they have about the healthy timing of birth spacing

Time duration	Experimental area n= 750	Control area n= 750	P value
12	1.2	3.2	0.008*
18	.0	.3	0.133
24	26.1	15.1	0.000**
30	.5	.5	1.000
36	17.5	22.4	0.018*
48	8.3	10.5	0.144
60	44.5	40.5	0.117
60+	.9	1.2	0.569
Don't Know	.9	6.3	0.000**

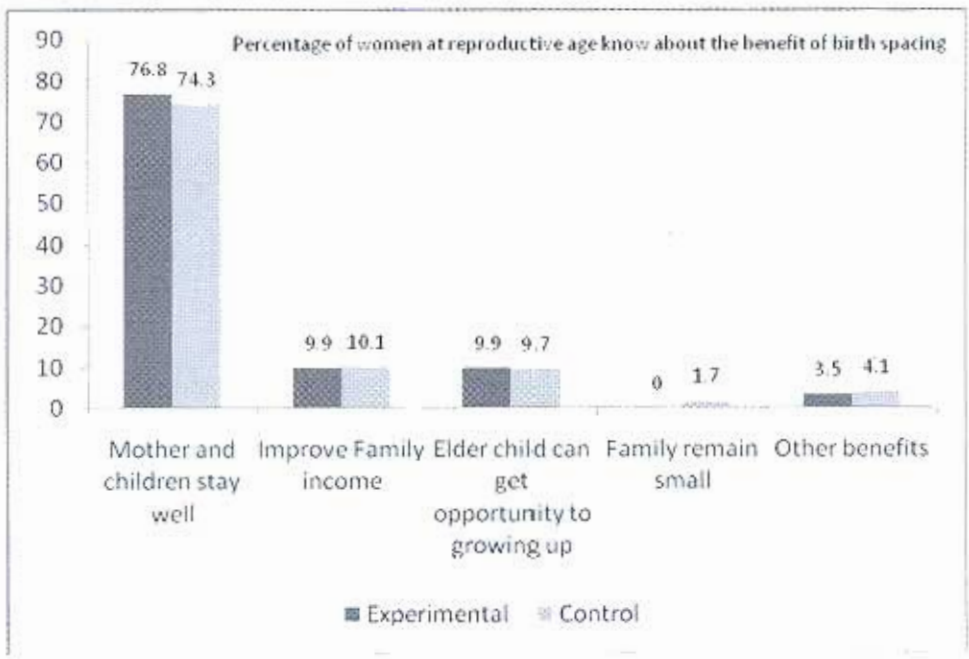
*: <0.05, **: <0.001

Benefit of Birth Spacing

Numerous findings proved that healthy timing of birth spacing gives benefits to the mother and chil health. Figure 6 shows that the respondents from experimental area have higher knowledge than trol area, 76.8% and 74.3% respectively in health related issues that mother and children stay well. Th her issues were mentioned by the respondents. Improve family income was told by 9.9% women in experimental area and 10.1% in control area. Another benefit found in the study is that elder chil can

get opportunity to grow up, the respondents of the experimental area a little more than the control area.

Figure 6: Percentage distribution of women having knowledge about the benefit of Birth Spacing



3.1.5 Objective 4 understand the views and perception of the beneficiaries about the "Shukh Pakhi" program

Knowledge obtained from different component of Sukhpakhi program

The respondents were asked to tell what information they have got from Sukhpakhi program. The question was asked in two ways. One was they told spontaneously about what information they received. Another way was asking them specific information whether they have got that information from Sukhpakhi Program. Findings presented in table 13 shows that probing knowledge is remarkably higher than Spontaneous Knowledge. Regarding information on breastfeeding of a child up to 2 years, in Chittagong division, 22.7% women told spontaneously that they got this information whereas when they were asked by specific information name that whether they got information on breastfeeding up to 2 years or not, 94.4% women told that they obtained that information. Same findings were obtained from Sylhet division, percentage of probing answers (94.4%) were more than 4 times than of the spon[illegible]ous answers (21.6%). Information obtained on contraceptive methods was told spontaneously b[illegible].0% women in Chittagong division, in contrast probing answers were given by 93.9% wom[illegible] The proportion in Sylhet division is 27.5% for spontaneous answer, 92.3% for probing answer [illegible] 17.3% respondents in Chittagong division told spontaneously that they obtained information on taking care of the children however 78.7% respondents answered when they were probed with specific information name. In Sylhet division, it was 9.9% and 74.6% for spontaneous and probing answers respectively.

Table 13: Percentage distribution of women at reproductive age obtained different information from Sukhpakhi Program by residence and by more of response

Type of Information	Spontaneous Knowledge			Probing Knowledge		
	Chittagong n=375	Sylhet n=375	P value	Chittagong n=375	Sylhet n=375	P value
Breastfeeding up to 2 years	22.7	21.6	0.717	94.4	93.9	0.770
Decision making process for Adopting Contraceptive methods	20.0	27.5	0.016*	93.9	92.3	0.387
Taking care of the children	17.3	9.9	0.003*	78.7	74.7	[illegible]95
Proper age of marriage	40.0	41.1	0.759	97.9	96.0	[illegible].130
Age of first Pregnancy	-	-	-	96.5	95.7	0.571
Birth Spacing	-	-		95.2	94.9	0.850

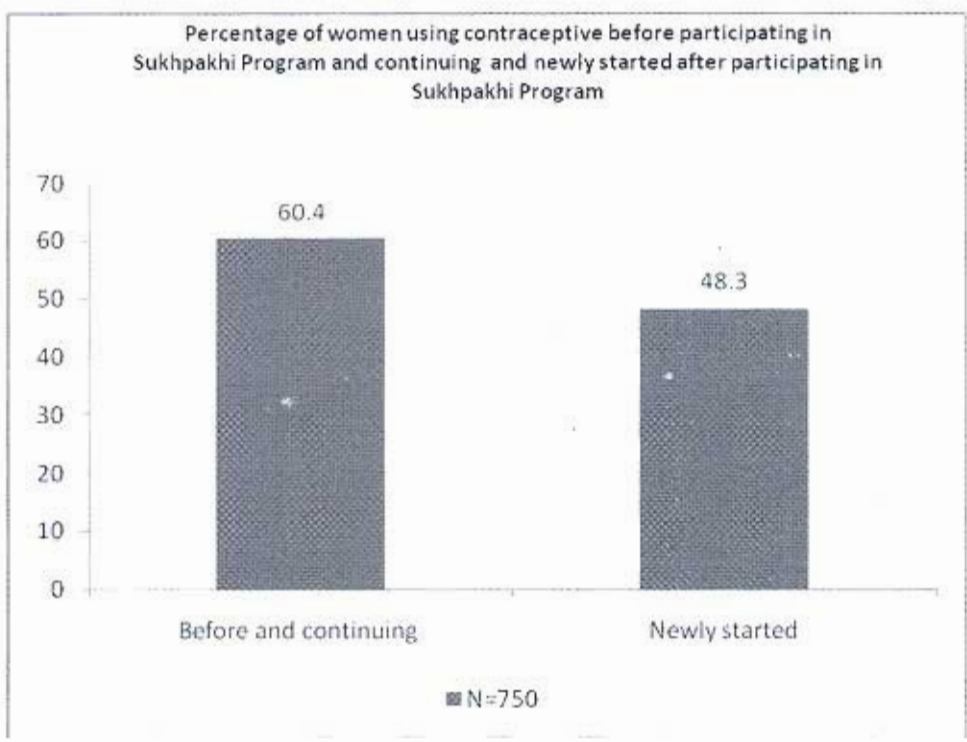
More than 96% women in both divisions (Cht-97.9%, Sylt-96.0%) told after probing that they got information on proper age for the boys and girls to get married, the spontaneous answers were 40.0% women in Chittagong division and 41.1% in Sylhet division.

The most remarkable answer was found for two answers. When the respondents were asked what information they obtained from Sukhpakhi Program, no respondents were answered for the proper age of first pregnancy and also for birth spacing. But when the interviewers asked them with the specific information name, almost 95% respondents for both cases in each area have answered that the information was provided by Sukhpakhi program and they received it. Regarding those information, the respondents gave the answers specifically what they learnt from Sukhpakhi Program (Annex- Table 7).

Use of Contraception before participate in Sukhpakhi program and continuing and after participating in Sukhpakhi program

Figure 7 shows that almost 50% (48.3%) women have newly started using contraceptive after participating in Sukhpakhi program with the motivation received from the program. 60.4% women were using from before and they are continuing to use although some women discontinued to use but they again started after participating the program.

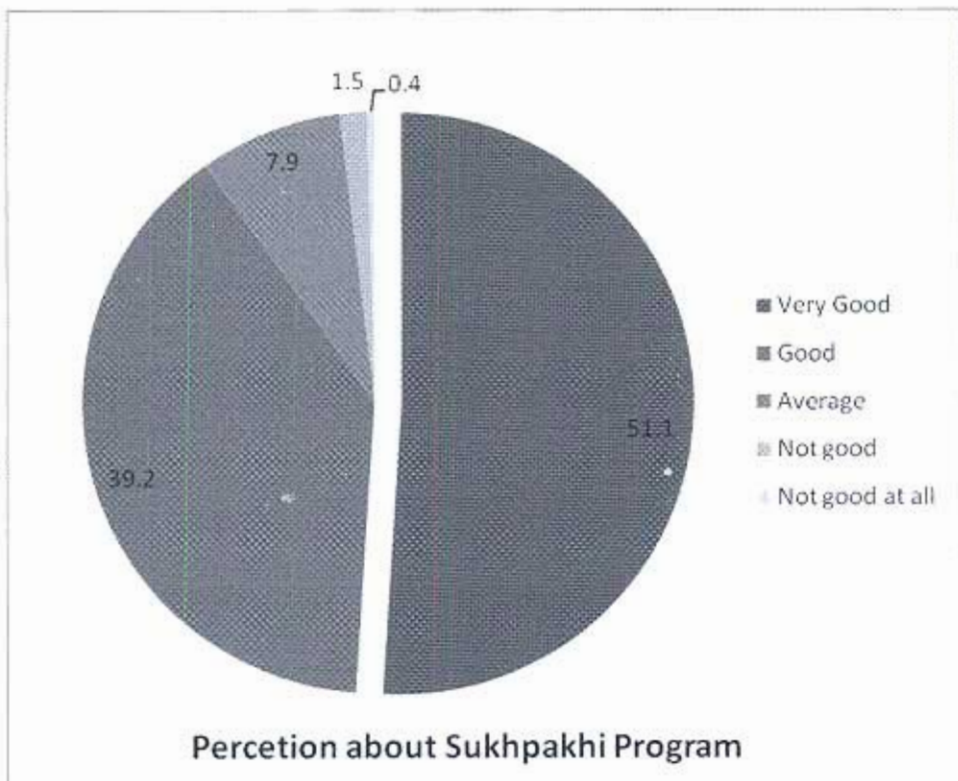
Figure 7: Percentage distribution of women using Contraceptive before participating in Sukhpakhi Program and continuing and newly started after participating in Sukhpakhi Program



Perception about Sukhpakhi Program

Figure 8 shows the perception of the respondents about Sukhpakhi program. Majority of the women consider it as a very good program, 51.1% answered with it as Sukhpakhi program has helped them by providing a number of necessary information such as family planning, child bearing process, age of marriage etc (Table 18). It was a good program was told by 39.2% respondents. It is significant to note that, almost 99% respondents reported in favor of good (very good-51.1%, good-39.2%, More less good-7.9%).

Figure 8: Percentage distribution of women at reproductive age who have told how they perceived Sukhpakhi program



The respondents were asked how the Sukhpakhi program helped them. The result as shown in table 14, majority of the women told about the family planning information. 68% women in Chittagong division and 50% women in Sylhet division think that the information they received from Sukhpakhi program helped them to make the right choice to adopt a method as it was discussed in detail about the method and appropriate method mix. Information on taking care of the children including birth spacing helped them was mentioned by 16.1% and 14.3% respondents in Chittagong division and Sylhet division respectively. The other sides, mentioned by the respondents were information on proper age of marriage in experimental area and control area respectively 5% and 9.3%. Learnt many things which are helping in our daily life was told by 10.9% women in Chittagong division and 23.3% women in Sylhet division. With the term "many things" the respondents actually covered all the information which was covered in Sukhpakhi program include the above mentioned information and additionally they mentioned about taking decision for adopting any method, while they were asked to explain what does Many things mean.

Table 14: Percentage distribution of women at reproductive age who have told that how the obtained information from Sukhpakhi Program helped them and what they like/dislike by residence

How the information helped them	Chittagong n=375	Sylhet n=375	P value
Have understand about Family Planning methods	68.0	50.0	0.000**
Taking care of child and birth spacing	16.1	14.3	0.4[illegible]
Age of marriage	5.0	9.3	0.0[illegible]
Learnt many things	10.9	23.3	0.0[illegible]**
Nothing happened	.0	3.1	0.0[illegible]1*
Components which they likeed most	**Chittagong n=375**	**Sylhet n=375**	**P value**
Mobile film	41.1	35.7	0.128
Uthan Baithak	27.5	24.8	0.400
Prize that was given	15.7	13.6	0.416
Discussion on necessary information	15.7	25.9	0.001
Components which they did not like	**Chittagong n=375**	**Sylhet n=375**	**P value**
Prizes were not given to everyone	50.4	19.7	0.000*
No bad side, all were good	36.5	68.8	0.000*
Nothing was good	6.1	7.5	0.4[illegible]
Can't remember	6.9	4.0	0.0[illegible]
Reasons of liking/disliking	**Chittagong n=375**	**Sylhet n=375**	**P value**
Learnt many things	60.0	60.5	0.839
Learned about maternal and child health care	10.7	10.1	0.788
Learnt about Family planning methods	21.9	24.3	0.436
Learnt about proper age of marriage	4.0	4.8	0.593
It did not help (Do not like)	3.5	.3	0.001*

*: <0.05, **: <0.001

The highest proportion of the women expressed their opinion in favor of Mobile film which they like most of the Sukhpakhi Program. 41.1% respondents in Chittagong division and 35.7% respondents in Sylhet division reported for this audio visual way of communication they liked most. Uthan Baithak (Courtyard meeting) was liked by 27.5% and 24.8% respondents respectively in Chittagong division and Sylhet division.

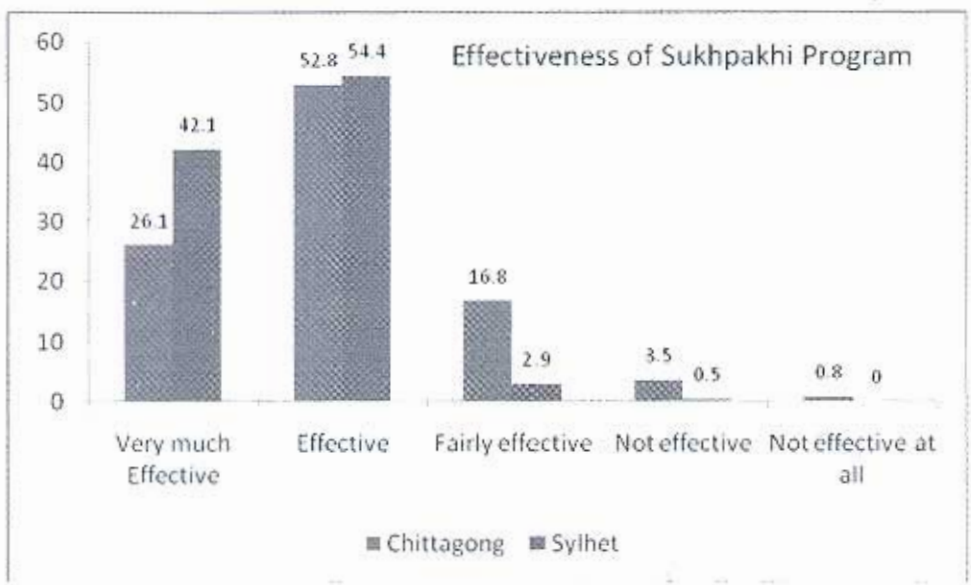
Incentive can contribute to motivate the peoples more. Sukhpakhi program arranged quiz com[illegible]tion for the respondents and gave some incentive to the winner. These incentives were considered b[illegible].7% respondents in Chittagong division and 13% women in Sylhet division as the good side of the P[illegible]gram.

In this relation, while asking about the bad side, 50.4% women in Chittagong division and 19.7% women in Sylhet division told that the bad side of this program which they did not like was the prizes were not given to every participant of the program. This was the only side identified they did not like by the respondents. All things of the Sukhpakhi program were good was reported by 36.5% women in Chittagong division and 68.8% women in Sylhet division.

Effectiveness of Sukhpakhi Program

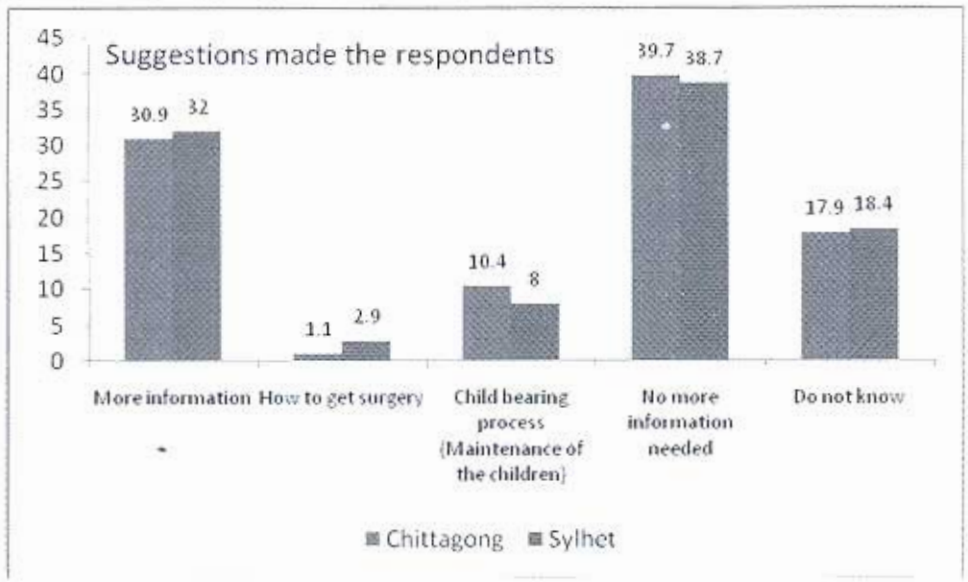
The information received from Sukhpakhi program were effectively contribute to the daily life of the respondents including making choice for the appropriate contraceptive method, child bearing process, birth spacing, proper age of marriage etc. The overall findings as shown in figure 6 present that majority of the women considered it as an effective program for their life. 26.1% respondents in Chittagong division and 42.1% in Sylhet division told that the program is very much effective. It was reported as effective program by 52.8% respondents in Chittagong division and 54.4% respondents in Sylhet Division. 16.8% and 2.9% respondents respectively in Chittagong division and Sylhet division told that it was fairly effective. Overall 95.7% respondents in Chittagong division and 99.4% in Sylhet division believe that it is helping them as an effective program.

Figure 9: Percentage of women told about how effective the program was



Suggestions to make Sukhpakhi program more successful

Figure 10: Suggestions made by the respondents to make Sukhpakhi program more successful



3.2 Qualitative Findings

Experimental Group

Perception about Sukhpakhi Program

The respondents have the clear idea about the Sukhpakhi program. One of the respondents of this study Mr. Sohel Ahmed from Jhingabari union, Kanaighat Upazilla, Sylhet division who has participated in Hat baithak and Mobile film is very happy with the Sukhpakhi program. He learnt everything on family planning and on how to make a happy family from this program. According to him, the way of communication that were used in Sukhpakhi program is very much effective for the population. It gave us the entertainment along with the useful information. This type of communication system helps to remember the information for a long time.

37 years old Ms. Shahina Akter expressed very nicely about the program that she learnt the very important information from Sukhpakhi program that not only make my life happy, it is also helpfu .o save my children who will start new life through getting married. She said, "Now I know the right age of marriage of my children. If I do accordingly, they will also be happy in their life. So, it has a longter m effect on my life."

Most of the participants are satisfied with the program. They want this type of program even if it is for very short time.

Participate in Sukhpakhi programs and Information they get

All of the respondents of the FGD were the participants of any of the components of the Sukhpakhi program. The male participants participated in Hat Baithak and Mobile film. Along with the mobile film the female participants participated in Uthan Baithak (Courtyard meeting). They have got all related information about family planning. Ms. Jasmin Akter from 6 no bulla union, Lakhai, Habiganj told that "It is very easy to understand the information from mobile film which is shown in from of drama. I learnt about the advantage of keeping family size small and it made my life easy."

Md. Shahiduzzaman who participated in Hat Baithak and Mobile film program gave his opinion tha knew about age of marriage, taking care of the children, birth spacing, keeping family size small an relevant information which makes his family life easier. He told that, "Hat Baithak is a very effecti to share the information. Here we all learn about the process, if anyone forget another one can hel to remind this.

Control Group

Family Planning related Information

The peoples get the family planning related information from the government health workers. Sometimes they get the information from the nearest health complex. Ahmed Kabir a 35 years aged person from Kalauzan union of Lohagar, Chittagong told that they get family planning related information from the government filled worker who tells them to use contraceptive methods to keep

the family size small. He told, "We know the information and we use the family planning method. Before going to any method I discuss it with my wife."

Age of Marrige and Pregnancy related information

The respondents do not know the exactly which is the right are of marriage and first pregnancy. Some respondents told the right one for girls but did wrong for boys. No one gave the right answer for both of them. Monowara Begum from Jaliapalang union, Ukhia, Cox'sbazar told, "The age of marriage for girls is 18 and for boys it is 30. The first baby should be born at the age of 25."

Family planning method related information, Agree/Disagree

Regarding this issues, most of the respondents answered that they do not know the answers perfe tly. They use oral pill which they get free from the government. Most of them know about only oral p It makes nausea sometimes but they are not aware about it. The other methods, they are not willir use. Mamataz from Kalauzan, Lohara, Chittagong told, "The newly married couple can take oral p . I am not agreed with this opinion. If anyone take the pill, she will never conceive in future."

Suggestions on Family planning programs

The respondents think that they need more information on family planning. If the information is given through Uthan Bathak, it would be more helpful. Another effective way could be to give the information along with any entertaining communication way.

3.3 Discussion on the findings

From the findings we see that, Women in experimental group have better knowledge and understanding in terms of knowing the methods of contraception, about appropriate method mix and also on other indicators than of the control group. In both areas, majority of the respondents believe that public sectors are the pre dominant sources for getting the information but it is evident that the public sector effort alone wills not enough to increase the awareness level. There need some outreach programs by the private sector like NGO or others sectors. The findings of the Sukhpakhi program indicate the relevance of that kind of program. Knowledge on Specific method of contraception is also significantly high in experimental area. Other than oral pill, knowledge for other methods including mod and traditional method is high in experimental area than control area.

A very common finding reveled in the study that the peoples in both areas know more about ter porary methods and also agreed to adopt those methods (oral pill, injectables) however the knowledge on long term method is not clear to them. Inadequate knowledge on long term method keep them away to adopt those kind of methods like (IUD or Norplant). Also the female have very little knowledge on male oriented methods like condom or male sterilization.

Regarding the knowledge on source of family planning, a significant finding could be noted that in experimental area where the Sukhpakhi program is running, the respondents of that area know the government sector and also NGO sectors are the available source for the information. It could be concluded that the presence of Sukhpakhi program also encouraged other sectors to perform more effectively. Another remarkable finding show that Women have the knowledge that the information of family planning and contraceptive is available in the local pharmacies but they are not much aware of the

SMC activities done in the locality like Blue Star program. Only few women mentioned about the Blue star Pharmacy.

Although the women from experimental area have higher knowledge than the women of the control area but it is significantly noted in the findings that probing response is higher than self response. When the answer is open for the respondent to tell about the information, the proportion is very low who provided the specific information but when the interviewers probe them with the specific information they can recall the information. From the logistic regression analysis it is examined that the women with high education preserve more knowledge and there is a direct relation between educati and knowledge.

Audio visual communication is the most preferred method for the respondent to get the inform ion as majority of the women are not that much educated. If the information is provided through dran a or in some entertaining way it attract more peoples to receive the messages. Qualitative findings also show that the group oriented way of communication is more fruitful like Uthan Baithak.

In terms of contraceptive method, Current use rate of any method is lower compared to the knowledge level. The findings show that the women have the knowledge but a large portion of the women are not using though they know the methods. Still the male domination is a big factor to adopt FP methods which keep the women away to use any method and also finding show that in experimental area still a big proportion of male is deciding which method will be adopted instead of taking joint decision. There are some issues founded from qualitative discussion those are very sensitive like religious retribution, and fear of physical problems that are related to side effects. Some women strongly believe that they will not be taken to heaven if they use contraceptive methods or if they die with the stick of implant they will not be buried after death. Women have lack of adequate knowledge on which method is suitable for whom also prevent the women to take contraceptive which is very much related with side effect and fear.

Education is a very significant factor that influences the knowledge of family planning. Women wi ore education preserve more knowledge. Also age group has the direct impact on the issue c family planning. From the logistic regression analysis, it is seen that the middle aged group of women a more aware of the issues and they have significantly more knowledge than the reference group.

Incentive is a very common aspiration of the people to get motivated. When they are asked to spend some time to listen to something they expect they must be awarded with some incentive. From the findings it is revealed that majority of the respondents told that prize giving (The prize which was given for a quiz competition) was the most attracted part of the Sukhpakhi program while majority of the women asked that they did not like that the prizes were not given to everyone. It is evident from the study that if there were some token of incentives was given to everyone then the participation

Chapter Four: Conclusion and Recommendation

4.1 Conclusion

Based on the discussion above from the findings and also from the findings of the numerous study, it is evident that though population sector program is the highest priority for the government however only programmatic approaches taken by the government alone will not be enough to increase access of family planning services in low performing area like Chittagong and Sylhet. There need some outreach programs or joint effort with the government can contribute in accessing the peoples in family planning services. The gaps in knowledge of the peoples of control area justify the program intervention by the private sector as the knowledge of experimental area is in better level.

The education of the women has direct relation with the knowledge level. Intervention needs only for family planning services rather advocacy on to be educated can bring positive results towards the success of family planning programs.

The peoples from experimental group are very happy with the performance of Sukhpakhi program. They have liked the way of communication of the program. Most of the respondent liked Mobile film and group discussion like Hat Baithak ad Uthan Baithak). The local peoples have the demand of this type of program. They considered it as their means of keeping their family happy and also taking care of their child properly. Also a significant change has been occurred in decision making process among the couples regarding taking children and adopting any method of family planning. Now the couples preferred to take any decision jointly.

4.2 Recommendation

Communication technique

- Knowledge did not reflect into action related to permanent method, so communication need to be focused on practice issues as well as change in behavior from one service to another
- Audio visual BCC materials need to be used as a means of advocacy (Using tablets) of the peoples as most of the peoples feel attracted to those materials like mobile film and they can remember those information.
- The people needs to be communicated that other than health benefits, use of contraception has an economical benefit, this issues need to discuss with more emphasize. Economical benefits will motivate the people more effectively
- Increase knowledge intensive activity so that the self response could be increased at the level of probing response. Also knowledge will help the people to perceive
- Discuss different health related issues in relation with contraception, gynecological diseases, sexually transmitted etc.

- The literature and survey data leave little doubt that men in Bangladesh are suitable targets for family planning programs. Male participation is very much important to make decision for a female client. Male participation in family planning and couple's reproductive health can be increased through couple counseling and targeted BCC activities.

Make link up with the Government

- Public health sector is the predominant sector for the sources of information and services of family planning. Make link up with the government sources to make the program more feasible.
- The operational plans of the governments needs to be followed, here the lead OPs are CC[illegible] and FPFSD with strong supportive functions in OPs PME-FP, MIS, IEC, PSSM-FP, and NIPORT
- Use the local government infrastructure to deliver the messages as it is the most preferred sources

Expansion of SMC's related activities

- The population has the knowledge about pharmacy but very few know about the blue star pharmacy. Initiatives need to be taken to bring more pharmacies under the umbrella of blue star or SMC.

Annexure

Annex 1: Findings of the Study

Table 1: Percentage of women at reproductive age having Knowledge on the duration of different methods by definition and by residence

Knowledge	Experimental Group	Control group
Short Term		
For short time	34.5	26.8
Oral Pill	14.5	10.7
Injection	2.8	3.3
Everyday Using method	1.5	1.7
Don't know/Can't say	46.7	57.5
Long Term		
For long time	36.4	27.3
IUD	10.3	2.4
Method using for three month	.7	.0
Injection	1.1	3.7
Method using for late conceive	.8	2.3
Don't know/Can't say	50.8	64.3
Permanent		
For permanent	22.8	18.1
Female Sterilization	16.9	12.9
Male Sterilization	6.8	4.3
Remain with body for lifetime	2.1	2.1
Don't know/Can't say	51.3	62.5

Table 2: Percentage of women at reproductive age having knowledge about the side effect of contraceptive method whether they agreed or not by residence

Methods	Agree		Partially agreed		Disagree	
	Experimental	Control	Experimental	Control	Experimental	Control
Oral Pill						
oral pill can create weakness and nausea but if regularly taken, it cures automatically	70.9	66.9	3.9	2.8	16.3	18.3
Pregnancy is possible at any time after stop taking oral pill	90.1	89.0	3.9	2.8	5.9	8.2
oral pill can be taken as long as wish	81.2	80.8	5.1	5.9	13.7	13.3
newly married women can take oral pill, there is no problem in it	45.9	37.9	7.7	7.5	46.5	54.6
Concern about oral pill						
	Experimental			Control		
Worried	25.2			22.6		
Little bit worried	30.1			24.0		
Not worried	44.8			53.4		
Condom						
condom does not create any problem in intercourse	61.6	65.0	10.0	10.3	28.4	24.7
condom needs to be used by the couple who has sexually transmitted diseases	68.5	67.1	8.6	5.3	22.9	27.5
Injectables						
Any eligible women having one children can use Injectable	73.0	71.9	10.4	8.9	16.6	19.2

Methods	Agree		Partially agreed		Disagree	
	Experimental	Control	Experimental	Control	Experimental	Control
Lactating mothers can use Injectable	53.2	46.6	13.2	16.0	33.6	37.4
Injectable could be used as a long term method if there is no side effect	74.2	73.3	12.1	7.6	13.7	19.1
Implant						
Norplant can be installed very easily with the help of trained health worker	63.8	68.1	10.1	7.7	26.1	24.2
Someone can become pregnant within months of removing Norplant	74.2	81.3	8.8	8.8	17.0	9.9
IUD						
Women can use IUD who want long term birth spacing or do not want any more children	72.8	78.3	5.9	5.0	21.3	16.7
After removal of IUD the ability to became pregnant women comes back fast	67.3	72.0	9.2	7.6	23.5	20.3
IUD does not create any problem in intercourse	45.2	44.9	17.4	13.1	37.3	42.1
Female Sterilization						
Female Sterilization /tubectomy does not reduce sexual desire of women	52.2	63.6	10.0	13.4	37.8	23.0
Female Sterilization does not create any problem in household activities	46.5	39.7	11.4	18.1	42.0	42.2

Male Sterilization						
Male Sterilization does not create any problem in doing physical heavy works	39.6	39.0	11.6	10.4	48.8	50.6
Male Sterilization does not reduce the sexual ability	31.6	37.0	16.1	6.8	52.3	56.2

Figure 1 Knowledge on Age of marriage according to Government law and problems of early marriage

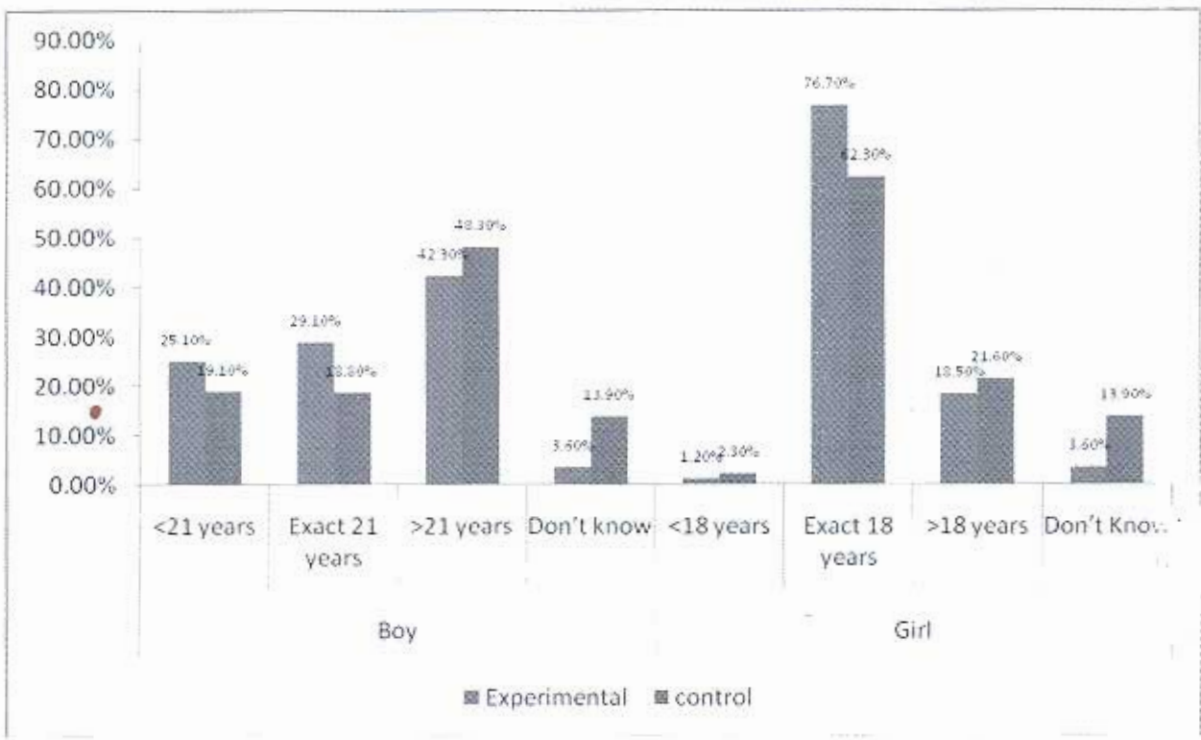


Table 3 Percentage of women having Knowledge on problems of early marriage

Problems	Experimental Group	Control group
Possibility to have early pregnancy	26.5	24.5
Get good health	3.2	1.7

Get bad health				82.5				74.7
Others				24.8				21.5
Don't know				2.5				7.2
Methods	Agree		Not Agree		Partially agreed		Disagree	
	Experimental	Control	Experimental	Control	Experimental	Control	Experimental	Control
The age of the marriage of the boys at least 21	82.0	74.7	3.1	6.8	5.5	6.9	9.5	11.6
The age of the marriage of the girls at least 18	91.6	87.6	1.7	2.4	2.4	4.5	4.3	5.5

Table: 4 Percentage distribution of women at reproductive age by knowledge they have about how long a child should be feed breast milk

Time duration (Months)	Experimental group	Control group
6	2.0	2.5
12	2.9	3.9
18	2.0	1.3
24	71.9	62.3
30	6.7	9.6
36	9.3	15.3
36+	2.5	3.1
Don't Know	2.3	1.6

Table: 5 Percentage of women at reproductive age who have ever used any contraceptive by methods and by residence

Methods	Experimental Group	Control group
Oral pill	80.2	82.0
Condom	14.3	10.4
Injectable	37.0	30.6
Implant/Norplant	1.5	2.3
IUD	1.5	1.2
Female Sterilization	4.4	3.2
Male Sterilization	.2	.5
Periodic Abstinence	1.1	1.4
Withdrawal	1.9	.7
Don't know	.2	.0
other	.2	.2

Table 6: Percentage of women at reproductive age who have told that they face constraint about the using contraceptive methods by residence

% of women who are facing the constraints	Experimental Group	Control group
	13.9	13.5
Reasons	**Experimental Group**	**Control group**
Scolded by Husband	37.5	32.7
Husband does not want to buy	13.5	22.8
Family members does not take it easily	12.5	8.9
Create physical problems	40.4	31.7
Parents in law does not like	18.3	8.9
Others	14.4	4.0
N	**104**	**101**

Table 7: Percentage distributions of women at reproductive age told about Perception and views about Sukhpakhi program

% of women attended in any component of Sukhpakhi Program	Chittagong	Sylhet
Inter personal Communication	69.9	29.1
Uthan Baithak (Court yard Meeting)	87.5	87.7
Mobile Film	66.4	56.0
Others	2.1	.3
% of women told about the proper age of marriage	**Chittagong**	**Sylhet**
Boy 21, girl 18	34.6	43.6
Boy 20, girl 18	12.8	2.2
Boy 22, girl 18	36.5	36.7
Boy 25, girl 18	16.1	17.5
% of women told about the proper age of first pregnancy	**Chittagong**	**Sylhet**
19 years	10.8	11.1
20 years	61.0	69.1
22 years	10.5	6.4
25 years	17.7	13.4
% of women told about the healthy timing of birth spacing	**Chittagong**	**Sylhet**
2 years	59.1	51.4
3years	13.2	7.3
5 years	27.7	37.9
% of women told about taking proper care of the children	**Chittagong**	**Sylhet**

Proper care of the children	46.1	54.3
Exclusive breastfeed up to 6 months	40.0	33.6
Antenatal and Postnatal care	6.8	5.0
Taking nutritious food during pregnancy	7.1	7.1
% of women told about duration of breastfeeding	**Chittagong**	**Sylhet**
2 years	61.6	71.9
3 years	25.4	21.9
Girls 2.5 years, boys 2 years	13.0	6.2
% of women Participated in Mobile Film Program	**Chittagong**	**Sylhet**
	78.9	56.5
Information obtained from Mobile film program	**Chittagong**	**Sylhet**
No marriage before 18, no children before 20	61.8	37.7
Birth spacing between two child	13.5	22.2
No to take children in less age	4.4	10.8
Use contraceptive methods	20.3	29.2
% of women told that they have obtained necessary information from Sukhpakhi Program		
	90.9	94.9

ANNEX 2: Questionnaire

Evaluation Study for Sukhpakhi Program

সাক্ষাৎকার গ্রহনকারীর তথ্য	
ক্রমিক নং:	
সাক্ষাৎকার গ্রহনকারীর নাম:.....	
সাক্ষাৎকার গ্রহনের তারিখ:.....	
সাক্ষাৎকার শুরর সময়(ঘন্টা/মিনিট).....	
সাক্ষাৎকার শেষ হওয়ার সময় (ঘন্টা / মিনিট):	
	সুপারভাইজার নাম:..... তারিখ:.....

SOCIAL MARKETING COMPANY

Study Conducted for
Social Marketing Company (SMC)
SMC Tower
33 Banani C/A, Dhaka-1213

Study Conducted by
Eminence
3/6 Asad Avenue
Mohammadpur, Dhaka-1207

SOCIAL MARKETING COMPANY

Study Conducted for	*Study Conducted by*
Social Marketing Company (SMC)	**Eminence**
SMC Tower	3/6 Asad Avenue
33 Banani C/A, Dhaka-1213	Mohammadpur, Dhaka-1207

সম্মতিপত্র

আস্‌সালামু আলাইকুম/ আদাব,

আমার নাম .....। আমিএমিনেন্স নামক একটি জনসেবামূলক সংস্থায় কাজ করছি। বর্তমানে আমরা SMC এর পক্ষ থেকে এস.এম.সি-র সুখ পাখী প্রোগ্রাম এর আওতাধীন "Evaluation of Sukhpakhi Program" এর উপর একটি জরিপ করছি। এই জরিপের উদ্দেশ্য হলো সুখ পাখী প্রোগ্রাম এর অবস্থা কেমন, এর কার্যকারিতা এবং জন্মবিরোতিকরণ পদ্ধতি ব্যবহারের ক্ষেত্রে মহিলাদের আচরণ, কি ধরনের সেবা দিলে জনগনের মাঝে জন্মবিরোতিকরণ সেবার মানকে আরও উন্নত করা যায় সে বিষয়ে আপনার মতামত জানা। এই জরিপ থেকে সংগৃহীত ব্যক্তিগত তথ্য সম্পূর্ণ গোপন রাখা হবে এবং শুধুমাত্র সুখ পাখী প্রোগ্রাম এর আওতাধীন জন্মবিরতিকরণ সেবার মানকে আরও উন্নত করার লক্ষ্যে এই তথ্য ব্যবহার করা হবে। আপনি এই জরিপের একজন উত্তরদাতা হিসেবে গণ্য হয়েছেন। এই গবেষণায় আপনার অংশগ্রহন সম্পূর্নরূপে ঐচ্ছিক। আপনি ইচ্ছা করলে কোন প্রশ্নের বা সব প্রশ্নের উত্তর নাও দিতে পারেন। আপনি অনুমতি প্রদান করলে আমি আপনাকে কিছু প্রশ্ন জিজ্ঞাসা ককরতে চাই।

আমি....., এই মর্মে শপথ করছি যে, আমার সংগৃহীত নিম্নক্ত তথ্য গুলো উত্তরদাতার দেয়া তথ্য অনুযায়ী সম্পূর্ণ সত্য এবং আমি কোন মিথ্যার আশ্রয় নেইনি।

সাক্ষাৎকার গ্রহনকারীর স্বাক্ষর

.....

তারিখ

Division	
Sylhet	1
Chittagong	2

District	
Sylhet	1
Habiganj	2
Chittagong	3
Cox'sbazar	4

Upazillas	
Companiganj	1
Kanaighat	2
Lakhai	3
Ukhia	4
Teknaf	5
Lohagara	6
Banskhali	7

Section 1: General Information

১. ইউনিয়নের নাম:	
২. গ্রামের নাম	
৩. উত্তরদাতার নাম:	
৪. উত্তরদাতার বয়স (বছরে):	
৫. মোবাইল নম্বর:	
৬. ধর্ম: (01) ইসলাম (02) হিন্দু (03) খ্রিষ্টান (04) বৌদ্ধ (05) অন্যান্য (উলেণ্টখ করুন)	
৭. বৈবাহিক অবস্থা: (01) তালাকপ্রাপ্তা (02) স্বামী পরিত্যাক্তা (03) আলাদা বসবাস (04) স্বাভাবিক অবস্থা	
৮. আপনার বিবাহিত জীবন কত বছরের?	উত্তর:.....
৯. আপনার কি কোন সন্তান আছে? (জীবিত) (01) হ্যাঁ (02) না	
১০. যদি উত্তর 'হ্যাঁ ' হয় তাহলে কতজন সন্তান আছে?	(01)ছেলে:.....

	(02)মেয়ে: ..... (03) মোট: .....
১১. শিক্ষাগত যোগ্যতা (যত বৎসর পড়াশোনা করেছে):.. (01) কোন শিক্ষা নেই (02) স্বাক্ষর জ্ঞান (03) লিখতে ও পড়তে পারে তবে প্রাতিষ্ঠানিক শিক্ষা নেই (04) ১ম - ৪র্থ শ্রেনী (05) ৫ম শ্রেনী (06) ৬ষ্ঠ - ১০ম শ্রেনী (07) এস.এস.সি/দাখিল (08) এইচ.এস.সি/কামিল (09) বিএ/বিকম/বিএসসি/ফাজিল (10) এমএ/এমকম/এমএসসি/কামিল/টাইটেল (11) ডাক্তার/ইঞ্জিনিয়ার/উকিল/ব্যরিষ্টার ইত্যাদি (12) অন্যান্য	
১২. আপনার পেশা কি? (01) গৃহিণী (02) কৃষি শ্রমিক (03) অকৃষি শ্রমিক (04) বেতনভুক্ত চাকুরে/ কর্মী (05) ইলেক্ট্রিক মিস্ত্রী/ মেকানিক (06) দোকানদার (07) ব্যবসা (08) দর্জি (09) গ্রাম্য ডাক্তার (10) অন্যের বাড়ীর কাজে সহায়তাকারী (11) শিক্ষক (12) অবসরপ্রাপ্ত চাকুরিজীবী (13) ছাত্র (14) বেকার (15) অন্যান্য (নির্দিষ্ট করুন)	
১৩. আপনার স্বামীর শিক্ষাগত যোগ্যতা (*** ১১ নং প্রশ্ন লক্ষ্য করুন)	

১৪. আপনার স্বামীর পেশা কি? (01) কৃষক/চাষী (02) কৃষি শ্রমিক (03) অকৃষি শ্রমিক (04) বেতনভুক্ত চাকুরে/ কর্মী (05) রিক্সা/ভ্যান চালক (06) দোকানদার (07) ক্ষুদ্র ব্যবসায়ী (08) ব্যবসা (09) দর্জি (10) ড্রাইভার (11) ঈমাম/ পুরোহিত (12) অন্যের বাড়ীর কাজে সহায়তাকারী (13) শিক্ষক (14) অবসরপ্রাপ্ত চাকুরিজীবী (15) ছাত্র (16) বেকার (17) প্রবাসী (বিদেশে কাজ করে) (18) অন্যান্য (নির্দিষ্ট করুন)	
১৫. আপনার খানার মোট সদস্যসংখ্যা?	
১৬. খানা প্রধান কে? (01) পুরুষ (02) মহিলা	

Section 2: Socio-Economic Condition

১৭. আপনার খানার সকল সূত্র থেকে আনুমানিক মাসিক আয়ের পরিমান কত? (টাকায়)	
১৮. আপনার পরিবারের আনুমানিক মাসিক ব্যয়ের পরিমান কত? (টাকায়):	
১৯. আপনার নিজস্ব মাসিক আয় কত? (যদি থাকে তাহলে টাকায় উলেণ্ডখ কর্ন):	

২০. আপনার পরিবারে নিম্নোক্ত কোন কোন জিনিস আছে ? (উত্তর একাধিক হতে পারে) (01)বিদ্যুতের লাইন (02)) আলমিরা (03)টেবিল (04)চেয়ার / বেঞ্চ (05)হাত ঘড়ি/দেয়াল ঘড়ি (06)খাট / চৌকি (07)রেডিও (08)টেলিভিশন (09)বাই-সাইকেল (10)মোটর-সাইকেল (11)সেলাই মেশিন (12) ইলেকট্রিক ফ্যান (13)টেলিফোন/মোবাইল (14)টিউবওয়েল	
২১. বর্তমানে আপনার বাড়ির মালিকানার ধরন ? (01) নিজস্ব বাড়ি (02) ভাড়া বাড়ি (03) আশ্রিত (04) অন্যান্য (নির্দিষ্ট করুন)	
২২. আপনার খানার জন্য বসবাসযোগ্য কয়টি রুম রয়েছে? (সংখ্যা)	
২৩. আপনার কি নিজের জমি আছে ? (01) হ্যাঁ (02) না	
২৪. খানার কতটুকু জমি আছে (শতাংশ)?	
২৫. খানার আবাদী জমির পরিমান কত? (শতাংশ):	

Section 3: Knowledge on Family Planning

২৬. সরকারী আইনে ছেলে এবং মেয়ের বিয়ের বয়স কত?	(01)ছেলে:..... (02)মেয়ে: ..... (03) জানি না/ বলতে পারি না

২৭. অল্প বয়সে মেয়েদের বিয়ে হলে কি কি অসুবিধা হয়? (উত্তর একাধিক হতে পারে) (01) অপ্রাপ্ত বয়সে গর্ভবতী হওয়ার সম্ভাবনা থাকে (02) স্বাস্থ্য ভালো হয় (03) স্বাস্থ্যের ক্ষতি হয় (04) অন্যান্য (99) জানি না	
২৮. কমপক্ষে কত বছর বয়স হলে একজন মহিলা প্রথম বাচ্চা নিতে পারে? উত্তর:..... (99) জানি না/ বলতে পারি না	
২৯. সঠিক বয়সের আগে/অল্পবয়সে গর্ভধারন হলে কি ধরনের অসুবিধা হতে পারে? (উত্তর একাধিক হতে পারে) (01) মায়ের স্বাস্থ্যের ক্ষতি হয় (02) শিশুর স্বাস্থ্যের ক্ষতি হয় (03) মা ও শিশুর ক্ষতি হয় (04) মা ও শিশু ভালো থাকে (05) মা ও শিশু উভয়ই অপুষ্টিকে ভোগে (06) অন্যান্য (99) জানি না	
৩০. আপনার মতে পর পর দুই সন্তান জন্মের মধ্যে কমপক্ষে কত বছরের বিরতি দেয়া উচিত? উত্তর:..... (99) জানি না/ বলতে পারি না	
৩১. পর পর দুই সন্তান জন্মের মধ্যে সঠিক সময় পর্যন্ত বিরতি দেয়া হলে কি কি ধরনের সুবিধা রয়েছে বলে আপনি মনে করেন? (উত্তর লিখুন)	উত্তর: ....
৩২. শিশুর জন্মের কমপক্ষে কত বছর পর্যন্ত একজন মা তাঁর শিশুকে বুকের দুধ খাওয়ানো উচিত বলে আপনি মনে করেন? উত্তর.....	

৩৩. আপনি কি পরিবার পরিকল্পনার কোন পদ্ধতি সর্ম্পকে জানেন?
(01)হ্যাঁ
(02) না

৩৪. দয়া করে বলুন আপনি জন্মবিরতিকরণের কোন কোন পদ্ধতি সর্ম্পকে জানেন/শুনেছেন? (উত্তর একাধিক হতে পারে)

(01) খাবার বড়ি
(02) কনডম
(03) ইঞ্জেকশন
(04) ইমপন্ডান্ট/ নরপন্ডান্ট
(05) আই ইউ ডি
(06) মহিলা বন্ধ্যাকরণ বা লাইগেশন
(07) এন.এস.ভি/পুরুষ বন্ধ্যাকরণ
(08) আজল পদ্ধতি
(09) নিরাপদ সময়/কাল
(10) অন্যান্য (উল্লেখ করুন)---------
(99) জানি না

(উত্তর দাত্রী যে সকল পদ্ধতির নাম নিজ থেকে বলে নাই সে সকল পদ্ধতির নামসমূহ এক এক করে বলুন, যদি উত্তর দাত্রী বলেন যে তিনি এ পদ্ধতিসমূহের নাম জেনেছেন বা শুনেছেন তাহলে ২ নং কলামে লিখে ফেলুন)

নিজ থেকে	বলার পর	মোট
(01)	(01)	(01)
(02)	(02)	(02)
(03)	(03)	(03)
(04)	(04)	(04)
(05)	(05)	(05)
(06)	(06)	(06)
(07)	(07)	(07)
(08)	(08)	(08)
(09)	(09)	(09)
(10)	(10)	(10)
(99)	(99)	(99)

৩৫. এবার আমি আপনাকে কয়েকটি জন্মবিরতিকণের কয়েকটি পদ্ধতির নাম বলছি। আপনি শুধু বলেন কোনটি কোন ধরনের পদ্ধতি। উত্তরদাত্রীকে কার্ড দেখান এবং ৩, ৪, ৫ নং কলামে লিখুন):

(01)স্বল্প মেয়াদী
(02)দীর্ঘমেয়াদী
(03)স্থায়ী পদ্ধতি
(99) জানি না/ বলতে পারি না

	স্বল্প মেয়াদী	দীর্ঘ মেয়াদী	স্থায়ী পদ্ধতি	জানি না/ বলতে পারি না
(01) খাবার বড়ি	(01)	(02)	(03)	(99)
(02) কনডম	(01)	(02)	(03)	(99)
(03) ইঞ্জেকশন	(01)	(02)	(03)	(99)
(04) ইমপন্ডান্ট/ নরপন্ডান্ট	(01)	(02)	(03)	(99)
(05) আই ইউ ডি	(01)	(02)	(03)	(99)
(06) মহিলা বন্ধ্যাকরণ বা লাইগেশন	(01)	(02)	(03)	(99)
(07) এন.এস.ভি/পুরুষ বন্ধ্যাকরণ	(01)	(02)	(03)	(99)
(08) আজল পদ্ধতি	(01)	(02)	(03)	(99)
(09) নিরাপদ সময়/কাল	(01)	(02)	(03)	(99)

৩৬. দয়া করে বলবেন কি জন্মবিরতিকণের স্বল্পমেয়াদী পদ্ধতি বলতে আপনি কি বুঝেন? উত্তর: .... (99) জানি না/ বলতে পারি না	
৩৭. জন্মবিরতিকণের দীর্ঘমেয়াদী পদ্ধতি বলতে আপনি কি বুঝেন? উত্তর: .... (99) জানি না/ বলতে পারি না	
৩৮. জন্মবিরতিকণের স্থায়ী পদ্ধতি বলতে আপনি কি বুঝেন? উত্তর: .... (99) জানি না/ বলতে পারি না	
৩৯. জন্মবিরতি করণ পদ্ধতি ও সন্তান সংখ্যা নির্ধারণের ক্ষেত্রে স্বামী ও স্ত্রী একত্রে সিদ্ধান্ত নেওয়া উচিৎ। এই ব্যাপারে (01) একমত (02) কিছুটা একমত (03) দ্বিমত	

৪০. আপনার জানা মতে, কোথায় কোথায় জন্মবিরতিকণের তথ্য ও সেবা পাওয়া যায়?

ফার্মেসি	(01)
ব্লু ষ্টার ফার্মেসি	(02)
মুদী দোকান	(03)
সরকারী হাসপাতাল/ ক্লিনিক	(04)
সরকারী মাঠকর্মী	(05)
এনজিও/ ক্লিনিক/এনজিও হাসপাতাল	(06)
এনজিও মাঠ কর্মী	(07)
গ্রাম্য ডাক্তার	(08)
এমবিবিএস/গ্রাজুয়েট ডাক্তার	(09)
অন্যান্য.....	(10)
জানি না	(99)

৪১. আপনার মতে, জন্মবিরতিকণের খাবার বড়ি কাদের জন্য উপযোগী? *(একাধিক উত্তর হতে পারে)*

(01) বিবাহিত সকল মহিলাদের জন্য
(02) বিবাহিত সকল মহিলা যাদের বয়স ৪৯ বছরের কম
(03) যাদের মাসিক চক্র অনিয়মিত
(04) যারা ২ সন্তানের মাঝে বিরতী নিতে চান
(05) যারা বাচ্চাকে বুকের দুধ খাওয়াচ্ছেন
(06) অন্যান্য.....
(99) জানি না

৪২. আপনার মতে, কনডম কাদের জন্য উপযোগী? *(একাধিক উত্তর হতে পারে)*

(01) বিবাহিত সকল পুরুষদের জন্য
(02) যারা জন্ম নিয়ন্ত্রণের কার্যকরী একটি অস্থায়ী পদ্ধতি নিতে চান
(03) যাদের স্ত্রীরা জন্মবিরতিকরন বড়ি / অন্য পদ্ধতি ব্যবহার করতে পারে না
(04) স্বামী বা স্ত্রীর মধ্যে যদি কারো বা উভয়ের যৌন বাহিত রোগ থাকে
(05) যৌন রোগ প্রতিরোধের জন্য
(06) অন্যান্য.....
(99) জানি না

৪৩. জন্মবিরতিকণে ইঞ্জেকশন কাদের জন্য উপযোগী? *(একাধিক উত্তর হতে পারে)*

(01) যাদের কমপক্ষে একটি জীবিত সন্তান আছে
(02) যাদের দুই বা ততোধিক সন্তান আছে কিন্তু স্থায়ী পদ্ধতি নিতে আগ্রহী নন
(03) যেসকল মা তার সন্তানকে বুকের দুধ খাওয়াচ্ছেন
(04) যাদের মিশ্র খাবার বড়ি সহ্য হয় না/বড়ি ব্যবহার নিষিদ্ধ/নিয়মিত বড়ি খেতে ভুলে যান
(05) অন্যান্য.....
(99) জানিনা / বলতে পারি না

৪৪. জন্মবিরতিকণে আইইউডি/কপার -টি কাদের জন্য উপযোগী?? *(একাধিক উত্তর হতে পারে)*

(01) বিবাহিত এবং কমপক্ষে ১টি জীবিত সন্তানের মা এবং দীর্ঘদিনের জন্য জন্মবিরতী চান
(02) যেসব মহিলা হরমন সমৃদ্ধ পদ্ধতি ব্যবহার করতে পারেন না
(03) অন্যান্য .....
(99) জানিনা / বলতে পারি না

৪৫. জন্মবিরতিকণে ইমপণ্ডান্ট / নরপণ্ডান্ট কাদের জন্য উপযোগী?? *(একাধিক উত্তর হতে পারে)*

(01) যারা জন্ম নিয়ন্ত্রণের অত্যন্ড় কার্যকরী একটি দীর্ঘ মেয়াদী অস্থায়ী পদ্ধতি নিতে চান
(02) বিবাহিত এবং কমপক্ষে ১টি জীবিত সন্তানের মা
(03) দীর্ঘদিনের জন্য জন্মবিরতি চান
(04) এস্ট্রোজেন জাতীয় (যেমন মিশ্র খাবার বড়ি) গর্ভনিরোধক ব্যবহার করতে পারে না
(05) প্রসবোত্তর বুকের দুধ খাওয়ান যেসব মা
(06) অন্যান্য .....
(99) জানি না / বলতে পারি না

Section 3: Attitude and Practice

৪৬. ছেলেদের বিয়ের বয়স কম পক্ষে ২১বৎসর। এই ব্যাপারে

(01) আপনি কি একমত
(02) এক মত নয়
(03) কিছুটা একমত
(04) নাকি দ্বিমত পোষন করেন

৪৭. মেয়েদের বিয়ের বয়স কম পক্ষে ১৮ বছর । এই ব্যাপারে

(01) আপনি কি একমত
(02) এক মত নয়
(03) কিছুটা একমত
(04) নাকি দ্বিমত পোষন করেন

৪৮. স্ত্রীর বয়স ২০ এর অধিক হলে সংসারে প্রথম সন্তান নেওয়া উচিৎ। এই ব্যাপারে

(01) একমত
(02) কিছুটা একমত
(03) নাকি দ্বিমত পোষন করেন

৪৯. দুইবৎসরের বেশী বিরতি দিয়ে দ্বিতীয় সন্তান গ্রহণ করা উচিৎ। এই ব্যাপারে (01) একমত (02) কিছুটা একমত (03) নাকি দ্বিমত পোষন করেন	
৫০. (৩৪ নং প্রশ্নে যাদের ১ কোড হয়েছে তাদের জন্য প্রযোজ্য) খাবার বড়ি খেলে মাথা ঘোরা ও বমি বমি ভাব হতে পারে ,তবে নিয়মিত বড়ি খেলে দুই তিন মাস পর এই অসুবিধা গুলি এমনিতেই সেরে যায় । এই ব্যাপারে (01) একমত (02) কিছুটা একমত (03) নাকি দ্বিমত পোষন করেন	
৫১. যে কোন সময় বড়ি খাওয়া ছেড়ে দিলে গর্ভধারণ করা যায়। এই ব্যাপারে (01) একমত (02) কিছুটা একমত (03) নাকি দ্বিমত পোষন করেন	
৫২. খাবার বড়ি একনাগারে যতদিন ইচ্ছা ব্যবহার করা যায়। এই ব্যাপারে (01) একমত (02) কিছুটা একমত (03) নাকি দ্বিমত পোষন করেন	
৫৩. আপনি খাবার বড়ির পার্শ্ব প্রতিক্রিয়া নিয়ে কি খুবই চিন্তিত। এই ব্যাপারে (01)খুবই চিন্তিত (02) কিছুটা চিন্তিত (03) চিন্তিত নই	
৫৪. নব বিবাহিতরা খাবার বড়ি খেতে পারেন, তাতে কোন অসুবিধা নাই। এই ব্যাপারে (01) একমত (02) কিছুটা একমত (03) নাকি দ্বিমত পোষন করেন	

৫৫. (৩৪ নং প্রশ্নে যাদের ২ কোড হয়েছে তাদের জন্য প্রযোজ্য) কমডম স্বামী স্ত্রীর সহবাসে কোন অসুবিধার সৃষ্টি করেনা। এই ব্যাপারে (01) একমত (02) কিছুটা একমত (03) নাকি দ্বিমত পোষন করেন	
৫৬. যাদের যৌনবাহিত রোগ আছে তাদের কনডম ব্যবহার করা উচিৎ। এই ব্যাপারে (01) একমত (02) কিছুটা একমত (03) নাকি দ্বিমত পোষন করেন	
৫৭. (৩৪ নং প্রশ্নে যাদের ৩ কোড হয়েছে তাদের জন্য প্রযোজ্য) কমপক্ষে একটি সন্ড়ান থাকলে যে কোন সক্ষম মহিলাই জন্মবিরতি করণের ইনজেকশন নিতে পারেন। এই ব্যাপারে (01) একমত (02) কিছুটা একমত (03) নাকি দ্বিমত পোষন করেন	
৫৮. যে সব মহিলা তাদের সন্ড়ানকে বুকের দুধ খাওয়াচ্ছেন তাদের জন্য জন্মবিরতি করনের ইনজেকশন একটি কার্যকরী পদ্ধতি। এই ব্যাপারে (01) একমত (02) কিছুটা একমত (03) নাকি দ্বিমত পোষন করেন	
৫৯. কোন পার্শ্বপ্রতিক্রিয়া না হলে জন্মবিরতিকরণের ইনজেকশন স্থায়ী ভাবে সঠিকভাবে বন্ধ না হওয়া পর্যন্ড় ব্যবহার করা যায়। এই ব্যাপারে (01) একমত (02) কিছুটা একমত (03) নাকি দ্বিমত পোষন করেন	
৬০. (৩৪ নং প্রশ্নে যাদের ৪ কোড হয়েছে তাদের জন্য প্রযোজ্য) নর পন্ট্যান্ট প্রশিক্ষন প্রাপ্ত সেবাদানকারীর সাহায্যে সহজেই স্থাপনা এবং খুলে ফেলা যায়। এই ব্যাপারে (01) একমত (02) কিছুটা একমত (03) নাকি দ্বিমত পোষন করেন	

৬১. নর পণ্ড্যান্ট খুলে ফেলার কয়েক মাসের মধ্যে গর্ভধারণ করা যায়। এই ব্যাপারে (01) একমত (02) কিছুটা একমত (03) নাকি দ্বিমত পোষন করেন	
৬২. (৩৪ নং প্রশ্নে যাদের ৫ কোড হয়েছে তাদের জন্য প্রযোজ্য) যাদের দীর্ঘদিন অথবা আর কোন বাচ্চা নৌয়ার ইচ্ছা নেই তারা আই ইউডি ব্যবহার করতে পারেন। এই ব্যাপারে (01) একমত (02) কিছুটা একমত (03) নাকি দ্বিমত পোষন করেন	
৬৩. আই ইউডি খুলে ফেলার পর দ্রুত সন্তান ধারণ ক্ষমতা ফিরে আসে। এই ব্যাপারে (01) একমত (02) কিছুটা একমত (03) নাকি দ্বিমত পোষন করেন	
৬৪. আইইউডি ব্যবহারে যিনিমিলনে কোন অসুবিধার সৃষ্টি করে না। এই ব্যাপারে (01) একমত (02) কিছুটা একমত (03) নাকি দ্বিমত পোষন করেন	
৬৫. (৩৪ নং প্রশ্নে যাদের ৬ কোড হয়েছে তাদের জন্য প্রযোজ্য) মহিলা বন্ধাকরণ /টিউবেকটমী মহিলাদের যৌনমিলনের ইচ্ছা কমায় না। এই ব্যাপারে (01) একমত (02) কিছুটা একমত (03) নাকি দ্বিমত পোষন করেন	
৬৬. টিউবেকটমী করলে মহিলাদের স্বাভাবিক কাজ কর্মে কোন অসুবিধা হয়না । এই ব্যাপারে (01) একমত (02) কিছুটা একমত (03) নাকি দ্বিমত পোষন করেন	

৬৭. (৩৪ নং প্রশ্নে যাদের ৭ কোড হয়েছে তাদের জন্য প্রযোজ্য) ভ্যাসেটমী /এন এসভি করার পর শারীরিক পরিশ্রম করতে পুর"ষের কোন অসুবিধা হয় না । এই ব্যাপারে (01) একমত (02) কিছুটা একমত (03) নাকি দ্বিমত পোষন করেন	
৬৮. এটা কোন ভাবেই পুর"ষের যৌন ক্ষমতা কমায় না। এই ব্যাপারে (01) একমত (02) কিছুটা একমত (03) নাকি দ্বিমত পোষন করেন	
৬৯. (সন্তান থাকলে) আপনি কি আরও সন্তান নিতে চান? (01) হ্যাঁ (02) না	
৭০. আপনি কি জীবনে কখনও কোন জন্মবিরতিকরণ পদ্ধতি ব্যবহার করেছেন? এ পর্যন্ত কি কি পদ্ধতি গ্রহন করেছেন? (উত্তর না হলে ৭২ নং প্রশ্নে চলে যান?) (01)খাবার বড়ি, (02)কনডম,(03)ইঞ্জেকশন, (04) ইমপণ্ঢান্ট/ নরপণ্ঢান্ট (05) আই ইউ ডি (06) মহিলা বন্ধ্যাকরণ বা লাইগেশন (07) এন.এস.ভি/পুরুষ বন্ধ্যাকরণ (08) আজল পদ্ধতি (09) নিরাপদ সময়/কাল (10) জানি না (11) অন্যান্য (উলেণ্ঢখ কর"ন)--------- (01) হ্যাঁ (02) না	
৭১. যদি উত্তর হ্যাঁ হয়,তাহলে বিয়ের কত বছর থেকে আপনি জন্মবিরতিকরণ পদ্ধতি ব্যবহার শুর" করেছিলেন?	উত্তরঃ (বছরে).....
৭২. আপনি বা আপনার স্বামী বর্তমানে জন্মবিরতিকরণ কি কোন পদ্ধতি ব্যবহার করছেন? (উত্তর না হলে ৭৭ নং প্রশ্নে চলে যান?) (01) হ্যাঁ (02) না	

৭৩. আপনি বর্তমানে জন্মবিরতিকরণ কোন পদ্ধতি ব্যবহার করছেন? (উত্তর একাধিক হতে পারে) (01) খাবার বড়ি (02) কনডম (03) ইঞ্জেকশন (04) ইমপন্ডান্ট/ নরপন্ডান্ট (05) আই ইউ ডি (06) মহিলা বন্ধ্যাকরণ বা লাইগেশন (07) এন.এস.ভি/পুরুষ বন্ধ্যাকরণ (08) আজল পদ্ধতি (09) নিরাপদ সময়/কাল (10) অন্যান্য (উলেণ্টখ করুন)--------- (99) জানি না (11) বর্তমানে কোন পদ্ধতি ব্যবহার করছি না	
৭৪. আপনি বর্তমানে যে জন্মবিরতিকরণ পদ্ধতি ব্যবহার করছেন এটি ব্যবহার করার ক্ষেত্রে কে সিদ্ধান্ত নিয়েছেন/গ্রহন করেছেন? (01) আমার স্বামী (02) আমি নিজে (03) আমরা দু'জন মিলে	
৭৫. সুখপাখী প্রোগ্রামে অংশগ্রহন করার ঠিক পূর্বে আপনি কি জন্মবিরতিকরণ এর কোন পদ্ধতি ব্যবহার করতেন? (01) হ্যাঁ (02) না	
৭৬. সুখপাখী প্রোগ্রামে অংশগ্রহন করার ঠিক পর আপনি কি জন্মবিরতিকরণ এর কোন পদ্ধতি ব্যবহার করেছেন? (01) হ্যাঁ (02) না	
৭৭. (৭২ নং প্রশ্নের উত্তর যদি না হয়) আপনি কেন বর্তমানে পরিবার পরিকল্পনা পদ্ধতি ব্যবহার করছেন না? (উত্তর একাধিক হতে পারে) (01) সন্তান নিতে চাই (02) স্বামী পছন্দ করেন না (03) ভালো লাগে না (04) অন্যান্য(উলেখ করুন)----------	

৭৮. পরিবার পরিকল্পনার পদ্ধতি গ্রহন করার ক্ষেত্রে আপনি কি কোন ধরনের বাঁধার সম্মুখীন হন? (উত্তর না হলে ৮০ নং প্রশ্নে চলে যান?) (01) হ্যাঁ (02) না	
৭৯. যদি উওর হ্যাঁ হয়,তাহলে কি ধরনের বাঁধার সম্মুখীন হন? (উত্তর একাধিক হতে পারে) (01) স্বামী রাগারাগি করেন (02) স্বামী কিনে দিতে চান না (03) পরিবারের অন্যান্যরা ভালো চোখে দেখেন না (04) শারিরীক সমস্যা হয় (05) শশুড় শাশুড়ী পছন্দ করেন না (06) অন্যান্য(উলেখ করুন)----------	
৮০. আপনি কি কখনও পরিবার পরিকল্পনা নিয়ে আপনার স্বামীর সাথে আলোচনা করেছেন? (01) হ্যাঁ (02) না	
৮১. (উত্তর যদি না হয়) কেন পরিবার পরিকল্পনা নিয়ে আপনার স্বামীর সাথে আলোচনা করেন নি?	উত্তর: ....
৮২. আপনার স্বামী কি পরিবার পরিকল্পনা গ্রহন করার ক্ষেত্রে আপনাকে সহযোগীতা করে? (01) হ্যাঁ (02) না	
৮৩. আপনি কি মনে করেন জন্মনিয়ন্ত্রণ পদ্ধতি, সংসারের পরিকল্পনা ও সন্তান সংখ্যা নির্ধারনের ক্ষেত্রে স্বামী ও স্ত্রী একত্রে সিদ্ধান্ত নেয়া উচিত? কেন একত্রে সিদ্ধান্ত নেয়া উচিত? (01) হ্যাঁ (02) না উত্তর:	

Section 4: Knowledge on Sukhpakhi Program

৮৪. আপনি সুখ পাখী প্রোগ্রাম এর কোন কোন কার্যক্রম এ অংশগ্রহন করেছিলেন/ নিয়েছিলেন? (উত্তর একাধিক হতে পারে) (01) আন্তব্যক্তিক সংযোগ (02) উঠান বৈঠক (03) মোবাইল ফিল্ম (04) অন্যান্য(উলেখ করুন)----------	
৮৫. সুখ পাখী প্রোগ্রাম থেকে আপনি কি কি ধরনের তথ্য পেয়েছেন?	উত্তর: ....
৮৬. সুখ পাখী প্রোগ্রাম থেকে আপনি কি বিয়ের সঠিক বয়স সম্পর্কে জেনেছেন? (01) হ্যাঁ (03) না উত্তর:	
৮৭. সুখ পাখী প্রোগ্রাম থেকে আপনি কি গর্ভধারনের সঠিক বয়স সম্পর্কে জেনেছেন? (01) হ্যাঁ (02) না উত্তর:	
৮৮. সুখ পাখী প্রোগ্রাম থেকে আপনি কি দুই বাচ্চা নেয়ার মধ্যে কমপক্ষে কত বছরের বিরতি দেয়া উচিত সে সম্পর্কে জেনেছেন? (01) হ্যাঁ (02) না উত্তর:	

৮৯. সুখ পাখী প্রোগ্রাম থেকে আপনি কি বাচ্চার যত্ন নেয়ার বিষয়ে জেনেছেন? (01) হ্যাঁ (02) না উত্তর:	
৯০. সুখ পাখী প্রোগ্রাম থেকে আপনি কি বাচ্চাকে কত বছর পর্যন্ত দুধ খাওয়ানো উচিত সে সম্পর্কে জেনেছেন? (01) হ্যাঁ (02) না উত্তর:	
৯১. সুখ পাখী প্রোগ্রাম থেকে আপনি কি জন্মনিয়ন্ত্রণ পদ্ধতি, সংসারের পরিকল্পনা ও সন্তান সংখ্যা নির্ধারনের ক্ষেত্রে স্বামী ও স্ত্রী একত্রে সিদ্ধান্ত গ্রহন সম্পর্কে জেনেছেন? (01) হ্যাঁ (02) না উত্তর:	
৯২. আপনি কি সুখ পাখী প্রোগ্রাম মোবাইল ফিল্ম দেখেছেন? (না হলে ৭০ নং প্রশ্নে চলে যান) (01) হ্যাঁ (02) না	
৯৩. (হ্যাঁ হলে) মোবাইল ফিল্ম দেখে আপনি কি কি ধরনের তথ্য পেয়েছেন?	উত্তর: ....

৯৪. আপনি কি মনে করেন সুখ পাখী প্রোগ্রাম থেকে আপনি পরিবার পরিকল্পনা সম্পর্কে প্রয়োজনীয় তথ্য পেয়েছেন? (01) হ্যাঁ (02) না	
৯৫. সুখ পাখী প্রোগ্রাম থেকে পাওয়া তথ্য আপনাকে কিভাবে সাহায্য করছে বলে আপনি মনে করেন?	উত্তর: ....
৯৬.সুখ পাখী প্রোগ্রাম এর কোন বিষয়টি আপনার ভালো লেগেছে? (উত্তর একাধিক হতে পারে)	উত্তর: ....
৯৭. সুখ পাখী প্রোগ্রাম এর কোন বিষয়টি আপনার খারাপ লেগেছে? (উত্তর একাধিক হতে পারে)	উত্তর: ....
৯৮. আপনার মতে, সার্বিকভাবে সুখ পাখী প্রোগ্রাম আপনার কেমন লেগেছে? (01) খুবই ভালো লেগেছে (02) ভালো লেগেছে (03) মোটামুটি ভালো লেগেছে (04) ভালো লাগেনি (05) একেবারে ভালো লাগেনি	

৯৯. ভালো লাগলে কেন ভালো লেগেছে?/ ভালো না লাগলে কেন ভালো লাগে নাই?	উত্তর: ....
১০০. আর কি কি ধরনের তথ্য পেলে ভালো হতো বলে আপনি মনে করেন? (উত্তর একাধিক হতে পারে)	উত্তর: ....
১০১.আপনার মতে, সুখ পাখী প্রোগ্রাম কতটুকু কার্যকরী? (01) খুবই কার্যকরী (02) কার্যকরী (03) মোটামুটি কার্যকরী (04) কার্যকরী নয় (05) একেবারেই কার্যকরী নয়	[ ][ ]
১০২. কার্যকরী হলে কেন কার্যকরী / কার্যকরী না হলে কেন কার্যকরী নয়?	উত্তর: ....
১০৩. সুখ পাখী প্রোগ্রাম ছাড়া আর অন্য কোন জায়গা থেকে কি উপরোক্ত বিষয়ে তথ্য পেয়েছেন? (01) হ্যাঁ (02) না	[ ][ ]

১০৪. পেলে কোথা থেকে পেয়েছেন?	উত্তর: ....
১০৫. কি ধরনের তথ্য পেয়েছেন?	উত্তর: ....

(সাক্ষাৎকার শেষ করার পূর্বে প্রশ্নপত্রটি ভালভাবে যাচাই করে নিন। যদি কোন প্রশ্নের উত্তর বাদ থাকে তাহলে উত্তরটি গ্রহন করুন এবং ধন্যবাদ দিয়ে সাক্ষাৎকার শেষ করুন।)

সাক্ষাৎকার গ্রহনকারীর সাক্ষর:..... তারিখ:.....

"Evaluation of Shukh Pakhi Program"
for
Social Marketing Company (SMC)
Conducted By: Eminence
FGD Guideline for Female
Control Group

- ফোকাস গ্রুপ ডিসকাশন ফ্যাসিলিটেশন দলের সদস্যঃ

ফ্যাসিলিটেটর ০১ জন র‍্যাপোর্টিয়ার এবং রেকর্ডার ০১ জন সুপারভাইজার ০১ জন

- **সময়ঃ** প্রতিটি সেশনের জন্য নির্ধারিত সময় সর্বোচ্চ ১.৩০ ঘন্টা। ফ্যাসিলিটেটর দলকে অবশ্যই মনে রাখতে হবে যে কোন সেশনকে কোনমতেই দুই ঘন্টার বেশী দীর্ঘায়িত করা যাবে না।
- **আলোচনায় সকলের সর্বোচ্চ অংশগ্রহন** নিশ্চিত করার জন্য ফ্যাসিলিটেটরদের খুবই সতর্ক মনোযোগ দিতে হবে
- **অংশগ্রহনকারীঃ** আলোচনায় অংশগ্রহনকারীদের সংখ্যা সর্বোনিম্নে ০৬ জন এবং সর্বোচ্চ ১০ জন।

আলোচনার বিষয়ঃ

১. পরিবার পরিকল্পনা সম্পর্কিত তথ্য:

- আপনারা সাধারনত কোথা থেকে তথ্য পেয়ে থাকেন
- আপনাদের এলাকায় কি পরিবার পরিকল্পনা কর্মীরা আসেন/ নিয়মিত কিনা
- তারা কি ধরনের পরামর্শ দেয়
- এই ধরনের পরামর্শ কি আপনাদের দরকার আছে
- আর কি কি ধরনের পরামর্শ আপনাদের প্রয়োজন
- পরিবার পরিকল্পনা পদ্ধতি ব্যবহার করা হয় কিনা।
- পরিবার পরিকল্পনা পদ্ধতি ব্যবহারী
- পরিবার পরিকল্পনা পদ্ধতি ব্যবহারের ক্ষেত্রে সিদ্ধান্ত গ্রহন প্রক্রিয়া।

২. বিয়ের সঠিক বয়স এবং গর্ভধারন সম্পর্কিত তথ্য:

- ছেলেমেয়েদের বিয়ের সঠিক বয়স সম্পর্কে ধারনা
- প্রথম গর্ভধারনের ক্ষেত্রে সঠিক বয়স সম্পর্কে ধারনা
- বাচ্চাদের সঠিক পরিচর্যা করার বিষয়ে ধারনা
- দুই বাচ্চা নেয়ার মধ্যে বিরতি দেয়া বিষয়ে ধারনা

৩. জন্মনিয়ন্ত্রন পদ্ধতি সম্পর্কিত তথ্য, নীচের বিষয়গুলোর সাথে আপনারা একমত কিনা

- ছেলেদের বিয়ের বয়স কম পক্ষে ২১বৎসর এবং মেয়েদের বিয়ের বয়স কম পক্ষে ১৮ বছর
- স্ত্রীর বয়স ২০ এর অধিক হলে সংসারে প্রথম সন্তান নেওয়া উচিৎ।
- দুইবৎসরের বেশী বিরতি দিয়ে দ্বিতীয় সন্তান গ্রহণ করা উচিৎ।

- খাবার বড়ি খেলে মাথা ঘোরা ও বমি বমি ভাব হতে পারে ,তবে নিয়মিত বড়ি খেলে দুই তিন মাস পর এই অসুবিধা গুলি এমনিতেই সেরে যায় ।
- খাবার বড়ি একনাগারে যতদিন ইচ্ছা ব্যবহার করা যায় এবং যে কোন সময় বড়ি খাওয়া ছেড়ে দিলে গর্ভধারণ করা যায়।
- নব বিবাহিতরা খাবার বড়ি খেতে পারেন, তাতে কোন অসুবিধা নাই।
- কমডম স্বামী স্ত্রীর সহবাসে কোন অসুবিধার সৃষ্টি করেনা যাদের যৌনবাহিত রোগ আছে তাদের কনডম ব্যবহার করা উচিৎ।
- কমপক্ষে একটি সন্তান থাকলে যে কোন সক্ষম মহিলাই জন্মবিরতি করণের ইনজেকশন নিতে পারেন।যে সব মহিলা তাদের সন্তানকে বুকের দুধ খাওয়াচ্ছেন তাদের জন্য জন্মবিরতি করনের ইনজেকশন একটি কার্যকরী পদ্ধতি।কোন পার্শ্বপ্রতিক্রিয়া না হলে জন্মবিরতিকরণের ইনজেকশন স্থায়ী ভাবে সঠিকভাবে বন্ধ না হওয়া পর্যন্ত ব্যবহার করা যায়।
- নর পণ্যান্ট প্রশিক্ষন প্রাপ্ত সেবাদানকারীর সাহায্যে সহজেই স্থাপনা এবং খুলে ফেলা যায়। নর পণ্যান্ট খুলে ফেলার কয়েক মাসের মধ্যে গর্ভধারণ করা যায়।
- যাদের দীর্ঘদিন অথবা আর কোন বাচ্চা নৌয়ার ইচ্ছা নেই তারা আই ইউডি ব্যবহার করতে পারেন। আই ইউডি খুলে ফেলার পর দ্রুত সন্তান ধারণ ক্ষমতা ফিরে আসে। আইইউডি ব্যবহারে যিনিমিলনে কোন অসুবিধার সৃষ্টি করে না।
- মহিলা বন্ধাকরণ /টিউবেকটমী মহিলাদের যৌনমিলনের ইচ্ছা কমায় না। টিউবেকটমী করলে মহিলাদের স্বাভাবিক কাজ কর্মে কোন অসুবিধা হয়না ।

৪. আপনারা এই সকল তথ্য কোথা থেকে পেয়েছেন?

৫. সার্বিকভাবে আপনারা কি মনে করেন আপনাদের আরো বেশী তথ্য ও সেবা দরকার। কি কি বাঁধা রয়েছে এবং কিভাবে এগুলো দূর করা যায় বলে আপনারা মনে করেন।

"Evaluation of Shukh Pakhi Program"
for
Social Marketing Company (SMC)
Conducted By: Eminence
FGD Guideline for Male
Control Group

- ফোকাস গ্রুপ ডিসকাশন ফ্যাসিলিটেশন দলের সদস্যঃ

ফ্যাসিলিটেটর ০১ জন র‍্যাপোর্টিয়ার এবং রেকর্ডার ০১ জন সুপারভাইজার ০১ জন

- **সময়ঃ** প্রতিটি সেশনের জন্য নির্ধারিত সময় সর্বোচ্চ ১.৩০ ঘন্টা। ফ্যাসিলিটেটর দলকে অবশ্যই মনে রাখতে হবে যে কোন সেশনকে কোনমতেই দুই ঘন্টার বেশী দীর্ঘায়িত করা যাবে না।
- **আলোচনায় সকলের সর্বোচ্চ অংশগ্রহন** নিশ্চিত করার জন্য ফ্যাসিলিটেটরদের খুবই সতর্ক মনোযোগ দিতে হবে
- **অংশগ্রহনকারীঃ** আলোচনায় অংশগ্রহনকারীদের সংখ্যা সর্বোনিম্নে ০৬ জন এবং সর্বোচ্চ ১০ জন।

আলোচনার বিষয়ঃ

১. পরিবার পরিকল্পনা সম্পর্কিত তথ্য:
   - আপনারা সাধারনত কোথা থেকে তথ্য পেয়ে থাকেন
   - আপনাদের এলাকায় কি পরিবার পরিকল্পনা কর্মীরা আসেন/ নিয়মিত কিনা
   - তারা কি ধরনের পরামর্শ দেয়
   - এই ধরনের পরামর্শ কি আপনাদের দরকার আছে
   - আর কি কি ধরনের পরামর্শ আপনাদের প্রয়োজন
   - পরিবার পরিকল্পনা পদ্ধতি ব্যবহার করা হয় কিনা।
   - পরিবার পরিকল্পনা পদ্ধতি ব্যবহারী
   - পরিবার পরিকল্পনা পদ্ধতি ব্যবহারের ক্ষেত্রে সিদ্ধান্ত গ্রহন প্রক্রিয়া।

২. বিয়ের সঠিক বয়স এবং গর্ভধারন সম্পর্কিত তথ্য:
   - ছেলেমেয়েদের বিয়ের সঠিক বয়স সম্পর্কে ধারনা
   - প্রথম গর্ভধারনের ক্ষেত্রে সঠিক বয়স সম্পর্কে ধারনা
   - বাচ্চাদের সঠিক পরিচর্যা করার বিষয়ে ধারনা
   - দুই বাচ্চা নেয়ার মধ্যে বিরতি দেয়া বিষয়ে ধারনা

৩. জন্মনিয়ন্ত্রন পদ্ধতি সম্পর্কিত তথ্য, নীচের বিষয়গুলোর সাথে আপনারা একমত কিনা

   - ছেলেদের বিয়ের বয়স কম পক্ষে ২১বৎসর এবং মেয়েদের বিয়ের বয়স কম পক্ষে ১৮ বছর

- স্ত্রীর বয়স ২০ এর অধিক হলে সংসারে প্রথম সন্তান নেওয়া উচিৎ।
- দুইবৎসরের বেশী বিরতি দিয়ে দ্বিতীয় সন্তান গ্রহণ করা উচিৎ।
- খাবার বড়ি খেলে মাথা ঘোরা ও বমি বমি ভাব হতে পারে ,তবে নিয়মিত বড়ি খেলে দুই তিন মাস পর এই অসুবিধা গুলি এমনিতেই সেরে যায় ।
- খাবার বড়ি একনাগারে যতদিন ইচ্ছা ব্যবহার করা যায় এবং যে কোন সময় বড়ি খাওয়া ছেড়ে দিলে গর্ভধারণ করা যায়।
- নব বিবাহিতরা খাবার বড়ি খেতে পারেন, তাতে কোন অসুবিধা নাই।
- কমডম স্বামী স্ত্রীর সহবাসে কোন অসুবিধার সৃষ্টি করেনা যাদের যৌনবাহিত রোগ আছে তাদের কনডম ব্যবহার করা উচিৎ।
- কমপক্ষে একটি সন্তান থাকলে যে কোন সক্ষম মহিলাই জন্মবিরতি করণের ইনজেকশন নিতে পারেন।যে সব মহিলা তাদের সন্তানকে বুকের দুধ খাওয়াচ্ছেন তাদের জন্য জন্মবিরতি করনের ইনজেকশন একটি কার্যকরী পদ্ধতি।কোন পার্শ্বপ্রতিক্রিয়া না হলে জন্মবিরতিকরণের ইনজেকশন স্থায়ী ভাবে সঠিকভাবে বন্ধ না হওয়া পর্যন্ত ব্যবহার করা যায়।
- নর পন্ট্যান্ট প্রশিক্ষন প্রাপ্ত সেবাদানকারীর সাহায্যে সহজেই স্থাপনা এবং খুলে ফেলা যায়। নর পন্ট্যান্ট খুলে ফেলার কয়েক মাসের মধ্যে গর্ভধারণ করা যায়।
- যাদের দীর্ঘদিন অথবা আর কোন বাচ্চা নৌয়ার ইচ্ছা নেই তারা আই ইউডি ব্যবহার করতে পারেন। আই ই খুলে ফেলার পর দ্রুত সন্তান ধারণ ক্ষমতা ফিরে আসে। আইইউডি ব্যবহারে যিনিমিলনে কোন অসুবিধার সৃষ্টি কে না।
- ভ্যাসেটমী /এন এসভি করার পর শারীরিক পরিশ্রম করতে পুরুষের কোন অসুবিধা হয় না । এটা কোন ভাবেই পুরুষের যৌন ক্ষমতা কমায় না।

৪. আপনারা এই সকল তথ্য কোথা থেকে পেয়েছেন?

৫. সার্বিকভাবে আপনারা কি মনে করেন আপনাদের আরো বেশী তথ্য ও সেবা দরকার। কি কি বাঁধা রয়েছে এবং কিভাবে এগুলো দূর করা যায় বলে আপনারা মনে করেন।

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FGD Guideline for Female
Experimental Group

- ফোকাস গ্রুপ ডিসকাশন ফ্যাসিলিটেশন দলের সদস্যঃ

ফ্যাসিলিটেটর ০১ জন র‍্যাপোর্টিয়ার এবং রেকর্ডার ০১ জন সুপারভাইজার ০১ জন

- **সময়ঃ** প্রতিটি সেশনের জন্য নির্ধারিত সময় সর্বোচ্চ ১.৩০ ঘন্টা। ফ্যাসিলিটেটর দলকে অবশ্যই মনে রাখতে হবে যে কোন সেশনকে কোনমতেই দুই ঘন্টার বেশী দীর্ঘায়িত করা যাবে না।
- **আলোচনায় সকলের সর্বোচ্চ অংশগ্রহন** নিশ্চিত করার জন্য ফ্যাসিলিটেটরদের খুবই সতর্ক মনোযোগ দিতে হবে
- **অংশগ্রহনকারীঃ** আলোচনায় অংশগ্রহনকারীদের সংখ্যা সর্বোনিম্নে ০৬ জন এবং সর্বোচ্চ ১০ জন।

আলোচনার বিষয়ঃ

১. সুখ পাখী প্রোগ্রাম সম্পর্কে ধারনা

২. আপনারা কি সুখ পাখী প্রোগ্রাম এর উঠান বৈঠক এবং মোবাইল ফিল্ম প্রোগ্রাম এ অংশ নিয়েছিলেন?

৩. এই প্রোগ্রাম এর মাধ্যমে প্রাপ্ত তথ্য সম্পর্কিত ধারনা
   - ছেলেমেয়েদের বিয়ের সঠিক বয়স সম্পর্কে ধারনা
   - প্রথম গর্ভধারনের ক্ষেত্রে সঠিক বয়স সম্পর্কে ধারনা
   - বাচ্চাদের সঠিক পরিচর্যা করার বিষয়ে ধারনা
   - দুই বাচ্চা নেয়ার মধ্যে বিরতি দেয়া বিষয়ে ধারনা

   পরিবার পরিকল্পনা সম্পর্কিত তথ্য:
   - পরিবার পরিকল্পনা পদ্ধতি ব্যবহার করা হয় কিনা।
   - পরিবার পরিকল্পনা পদ্ধতি ব্যবহারী
   - পরিবার পরিকল্পনা পদ্ধতি ব্যবহারের ক্ষেত্রে সিদ্ধান্ত গ্রহন প্রক্রিয়া।
   - পরিবার পরিকল্পনার সেবা সমূহ কোথায় পাওয়া যায়?

৪. নীচের বিষয়গুলোর সাথে আপনারা একমত কিনা
   - ছেলেদের বিয়ের বয়স কম পক্ষে ২১বৎসর এবং মেয়েদের বিয়ের বয়স কম পক্ষে ১৮ বছর
   - স্ত্রীর বয়স ২০ এর অধিক হলে সংসারে প্রথম সন্তান নেওয়া উচিৎ।
   - দুইবৎসরের বেশী বিরতি দিয়ে দ্বিতীয় সন্তান গ্রহণ করা উচিৎ।
   - খাবার বড়ি খেলে মাথা ঘোরা ও বমি বমি ভাব হতে পারে ,তবে নিয়মিত বড়ি খেলে দুই তিন মাস পর এই অ[illegible] গুলি এমনিতেই সেবে যায় ।

- খাবার বড়ি একনাগারে যতদিন ইচ্ছা ব্যবহার করা যায় এবং যে কোন সময় বড়ি খাওয়া ছেড়ে দিলে গর্ভধারণ করা যায়।
- নব বিবাহিতরা খাবার বড়ি খেতে পারেন, তাতে কোন অসুবিধা নাই।
- কমডম স্বামী স্ত্রীর সহবাসে কোন অসুবিধার সৃষ্টি করেনা যাদের যৌনবাহিত রোগ আছে তাদের কনডম ব্যবহার করা উচিৎ।
- কমপক্ষে একটি সন্ড়ান থাকলে যে কোন সক্ষম মহিলাই জন্মবিরতি করণের ইনজেকশন নিতে পারেন।যে সব মহিলা তাদের সন্ড়ানকে বুকের দুধ খাওয়াচ্ছেন তাদের জন্য জন্মবিরতি করনের ইনজেকশন একটি কার্যকরী পদ্ধতি।কোন পার্শ্বপ্রতিক্রিয়া না হলে জন্মবিরতিকরণের ইনজেকশন স্থায়ী ভাবে সঠিকভাবে বন্ধ না হওয়া পর্যন্ড় ব্যবহার করা যায়।
- নর পণ্যান্ট প্রশিক্ষন প্রাপ্ত সেবাদানকারীর সাহায্যে সহজেই স্থাপনা এবং খুলে ফেলা যায়। নর পণ্যান্ট খুলে ফেলার কয়েক মাসের মধ্যে গর্ভধারণ করা যায়।
- যাদের দীর্ঘদিন অথবা আর কোন বাচ্চা নৌয়ার ইচ্ছা নেই তারা আই ইউডি ব্যবহার করতে পারেন। আই ইউ ড খুলে ফেলার পর দ্রুত সন্ড়ান ধারণ ক্ষমতা ফিরে আসে। আইইউডি ব্যবহারে যিনিমিলনে কোন অসুবিধার সৃষ্টি কে
- মহিলা বন্ধাকরণ /টিউবেকটমী মহিলাদের যৌনমিলনের ইচ্ছা কমায় না। টিউবেকটমী করলে মহিলাদের স্বাভ কাজ কর্মে কোন অসুবিধা হয়না ।

৫. সুখ পাখী প্রোগ্রাম সম্পর্কে অভিজ্ঞতা

- সুখ পাখী প্রোগ্রাম এর কর্মীদের ব্যবহার
- সুখ পাখী প্রোগ্রাম আপনাদের ভালো লেগেছে কিনা। ভালো লাগলে কেন ভালো লেগেছে/ ভালো না লাগলে কেন লাগে নাই।
- এই প্রোগ্রাম আপনাদের কোন উপকারে এসেছে কিনা। উপকারে আসলে কি ধরনের উপকারে এসেছে/ না আসলে কেন আসে নাই।
- সুখ পাখী প্রোগ্রাম কতটুকু কার্যকরী । কেন এরকম মনে করছেন?
- সুখ পাখী প্রোগ্রাম থেকে আর কি কি ধরনের তথ্য পেলে ভালো হতো বলে আপনারা মনে করেন।

৬. সুখ পাখী প্রোগ্রাম ছাড়া পরিবার পরিকল্পনা সম্পর্কিত তথ্য পাওয়ার অন্য কোন উৎস

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- ফোকাস গ্রুপ ডিসকাশন ফ্যাসিলিটেশন দলের সদস্যঃ

ফ্যাসিলিটেটর ০১ জন র‍্যাপোর্টিয়ার এবং রেকর্ডার ০১ জন সুপারভাইজার ০১ জন

- **সময়ঃ** প্রতিটি সেশনের জন্য নির্ধারিত সময় সর্বোচ্চ ০২ ঘন্টা। ফ্যাসিলিটেটর দলকে অবশ্যই মনে রাখতে হবে যে কোন সেশনকে কোনমতেই দুই ঘন্টার বেশী দীর্ঘায়িত করা যাবে না।
- **আলোচনায় সকলের সর্বোচ্চ অংশগ্রহন** নিশ্চিত করার জন্য ফ্যাসিলিটেটরদের খুবই সতর্ক মনোযোগ দিতে হবে
  অংশগ্রহনকারীঃ আলোচনায় অংশগ্রহনকারীদের সংখ্যা সর্বোনিম্নে ০৬ জন এবং সর্বোচ্চ ১০ জন।

আলোচনার বিষয়ঃ

১. সুখ পাখী প্রোগ্রাম সম্পর্কে ধারনা

২. আপনারা কি সুখ পাখী প্রোগ্রাম এর হাট বৈঠক এবং মোবাইল ফিল্ম প্রোগ্রাম এ অংশ নিয়েছিলেন?

৩. এই প্রোগ্রাম এর মাধ্যমে প্রাপ্ত তথ্য সম্পর্কিত ধারনা
   - ছেলেমেয়েদের বিয়ের সঠিক বয়স সম্পর্কে ধারনা
   - প্রথম গর্ভধারনের ক্ষেত্রে সঠিক বয়স সম্পর্কে ধারনা
   - বাচ্চাদের সঠিক পরিচর্যা করার বিষয়ে ধারনা
   - দুই বাচ্চা নেয়ার মধ্যে বিরতি দেয়া বিষয়ে ধারনা

   পরিবার পরিকল্পনা সম্পর্কিত তথ্য:
   - পরিবার পরিকল্পনা পদ্ধতি ব্যবহার করা হয় কিনা।
   - পরিবার পরিকল্পনা পদ্ধতি ব্যবহারী
   - পরিবার পরিকল্পনা পদ্ধতি ব্যবহারের ক্ষেত্রে সিদ্ধান্ত গ্রহন প্রক্রিয়া।
   - পরিবার পরিকল্পনার সেবা সমূহ কোথায় পাওয়া যায়?

৪. নীচের বিষয়গুলোর সাথে আপনারা একমত কিনা

   - ছেলেদের বিয়ের বয়স কম পক্ষে ২১বৎসর এবং মেয়েদের বিয়ের বয়স কম পক্ষে ১৮ বছর
   - স্ত্রীর বয়স ২০ এর অধিক হলে সংসারে প্রথম সন্তান নেওয়া উচিৎ।
   - দুইবৎসরের বেশী বিরতি দিয়ে দ্বিতীয় সন্তান গ্রহণ করা উচিৎ।
   - খাবার বড়ি খেলে মাথা ঘোরা ও বমি বমি ভাব হতে পারে ,তবে নিয়মিত বড়ি খেলে দুই তিন মাস পর এই অসুবিধা গুলি এমনিতেই সেরে যায় ।

- খাবার বড়ি একনাগারে যতদিন ইচ্ছা ব্যবহার করা যায় এবং যে কোন সময় বড়ি খাওয়া ছেড়ে দিলে গর্ভধারণ করা যায়।
- নব বিবাহিতরা খাবার বড়ি খেতে পারেন, তাতে কোন অসুবিধা নাই।
- কমডম স্বামী স্ত্রীর সহবাসে কোন অসুবিধার সৃষ্টি করেনা যাদের যৌনবাহিত রোগ আছে তাদের কনডম ব্যবহার করা উচিৎ।
- কমপক্ষে একটি সন্ড়ান থাকলে যে কোন সক্ষম মহিলাই জন্মবিরতি করণের ইনজেকশন নিতে পারেন।যে সং মহিলা তাদের সন্ড়ানকে বুকের দুধ খাওয়াচ্ছেন তাদের জন্য জন্মবিরতি করনের ইনজেকশন একটি কার্যকরী প কোন পার্শ্বপ্রতিক্রিয়া না হলে জন্মবিরতিকরণের ইনজেকশন স্থায়ী ভাবে সঠিকভাবে বন্ধ না হওয়া পর্যন্ড় ব্যবহার করা ।।
- নর পন্ড্যান্ট প্রশিক্ষন প্রাপ্ত সেবাদানকারীর সাহায্যে সহজেই স্থাপনা এবং খুলে ফেলা যায়। নর পন্ড্যান্ট খুলে ফে এ কয়েক মাসের মধ্যে গর্ভধারণ করা যায়।
- যাদের দীর্ঘদিন অথবা আর কোন বাচ্চা নৌয়ার ইচ্ছা নেই তারা আই ইউডি ব্যবহার করতে পারেন। আই ই টডি খুলে ফেলার পর দ্রুত সন্ড়ান ধারণ ক্ষমতা ফিরে আসে। আইইউডি ব্যবহারে যিনিমিলনে কোন অসুবিধার সৃষ্টি করে না।
- ভ্যাসেটমী /এন এসভি করার পর শারীরিক পরিশ্রম করতে পুরুষের কোন অসুবিধা হয় না । এটা কোন ভাবেই পুরুষের যৌন ক্ষমতা কমায় না।

৫. সুখ পাখী প্রোগ্রাম সম্পর্কে অভিজ্ঞতা

- এই তথ্যগুলো কতবার জানানো হয়েছে?
- সুখ পাখী প্রোগ্রাম এর কর্মীদের ব্যবহার
- সুখ পাখী প্রোগ্রাম আপনাদের ভালো লেগেছে কিনা। ভালো লাগলে কেন ভালো লেগেছে/ ভালো না লাগলে কেন লাগে নাই।
- এই প্রোগ্রাম আপনাদের কোন উপকারে এসেছে কিনা। উপকারে আসলে কি ধরনের উপকারে এসেছে/ না আসলে কেন আসে নাই।
- সুখ পাখী প্রোগ্রাম কতটুকু কার্যকরী । কেন এরকম মনে করছেন?
- সুখ পাখী প্রোগ্রাম থেকে আর কি কি ধরনের তথ্য পেলে ভালো হতো বলে আপনারা মনে করেন।

৬. সুখ পাখী প্রোগ্রাম ছাড়া পরিবার পরিকল্পনা সম্পর্কিত তথ্য পাওয়ার অন্য কোন উৎস

Annex 3: Research Team

Sl No	Name of the Person	Position Assigned
1	Dr. Shamim Hayder Talukder	Principal Investigator
2	Nazme Sabina	Co-Principal Investigator
3	Farhana Afrose Jahan	Research Associate
4	Quality Control Officer	-
5	Field Supervisors	-
6	Field Investigators	-

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