SOCIAL BEHAVIOURAL CHANGE (SBC) EVALUATION

FAMILY PLANNING IN BANGLADESH

– IMPROVING QUALITY AND ACCESS

MIDLINE REPORT

November 2019

Acknowledgement

Ipas Bangladesh would like to extend its gratitude to Department for International Development (DFID) for giving us the opportunity to complete this midline evaluation on the social behavioural change activities within the QFP project (Family Planning in Bangladesh - Improving Quality and Access). The midline study provides valuable insights to the knowledge, perception and use of MR, PAC and FP services among the participants in the study areas, which will be helpful for the future of the QFP programme as well as other programmes and initiatives. We are thankful to all officials of DFID, DGHS and DGFP for extending necessary cooperation and facilitation in the process of conducting the evaluation.

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Excecutive Summary

Although Bangladesh has made noticeable progress in reducing maternal mortality and morbidity over the past decades the total fertility rate is higher than the wanted fertility rate and the use of modern contraceptives is lower than the demand, indicating unmet need for family planning. Further, the use of long-acting and permanent methods in Bangladesh is low and misconception on family planning methods is prevalent. Women's and girls' ability to access sexual and reproductive health service, including family planning services, and their utilization of these services are influenced by a number of factors, amongst others, cultural and societal norms and personal knowledge and beliefs. Social behavioural change interventions can contribute to creating an enabling environment for women and girls to access and use sexual and reproductive health service. Therefore, Ipas Bangladesh inititated social and behavioural change interventions at community level as part of a DFID funded programme titled "Family Planning in Bangladesh - Improving Quality and Access", with the aim to increase the awareness of and access to menstrual regulation, post-abortion care and family planning at the community level. To better understand changes in the knowledge of and attitude towards menstrual regulation, post-abortion care and family planning and women's and girls' ability to access services at the community level, Ipas Bangladesh has evaluated the social behavioural change intervention at baseline and at midline. Further, this midline evaluation also assesses the level of participation in the social behavioural change activities.

The midline evaluation finds that that the knowledge levels of long-acting and permanent methods among women, adolescents and men were higher at midline than at baseline and that the difference between baseline and midline was statisitically significant. However, misconceptions and fear about side effects prevails. The use of long-acting and permanent methods was higher at midline than at baseline among women and adolescents and higher than the national average. Further, the study finds that although a majority of women and girls knew where to access menstrual regulation services less than half felt able to. The social behavioural change activities in the form of educational sessions most frequently covered family planning methods. The participation in the sessions, regardless of focus, was highest in the group of women. When it came to the social behavioural change activities in the form of radio sessions this study finds that the particpnats preferred to listen to songs and news programmes and that among those who listen to radio about a third of the participants in all groups had listened to a radio programme covering FP and/or MR and PAC. Further the study finds that there was a difference in the time the different groups preferred to listened to radio.

In conclusion, the findings suggest that ongoing awareness activities on family planning methods are needed to overcome and prevent misconceptions about family planning methods and how they work. Further, that activites also need to focus on stigma reduction in relation to menstrual regulation services and practices.

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I. List of Figures and Tables

I. Abbreviations

AHI	Assistant Health Inspector (AHI)
BAPSA	Bangladesh Association for Prevention of Septic Abortion
BASA	Bangladesh Association for Social Advancement
BDHS	Bangladesh Demographic and Health Survey
BNNRC	Bangladesh NGO Network for Radio Communication
CHCP	Community Health Care Provider
DFID	Department for International Development
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Service
FWV	Family Welfare Visitor
GoB	Government of Bangladesh
HA	Health Assistant
HI	Health Inspector (HI)
IUD	Intra-Uterine Device
LAPM	Long-Acting and Permanent Method (of Family Planning)
LARC	Long acting and reversible contraceptive
MO	Medical Officers
MR	Menstrual Regulation
MRM	Menstrual regulation with medicine
MVA	Manual vacuum aspiration
NGO	Non-governmental Organization
PAC	Post-abortion Care
PAFP	Post-abortion Family Planning
PPFP	Post-partum Family Planning
RA	Research Assistant
SBC	Social Behavioral Change
SRH	Sexual and Reproductive Health
TFD	Theatre for Development
TFR	Total Fertility Rate
UHFPO	Upazila Family Planning Officer

Operational Definition

Community Engagement

Community Engagement (CE), refers to the process by which community and organizations collectively build ongoing relationships for social benefits and outcomes. Further CE facilitates communication, interaction, *involvement*, and exchange between an organization and a *community* for a range of social and organizational outcomes.

BASA, the partner organization under the QFP project is performing the Community Engagement activities in selected areas of Bangladesh.

Community Radio

Community radio is a radio service offering a model of radio broadcasting in addition to commercial and public broadcasting. Community stations serve geographic communities and communities of interest. All community radios are running through the Frequency Modulation (FM) band with a coverage of 30 kilometer radius.

The project signed agreement with BNNRC to manage 7 community radios with project information.

Community Access

The Community Access is a holistic term that includes mobilization, awareness raising, engagement and knowledge sharing.

Here, Community Access indicates the whole behavior change components of the project.

Misconception

Misconception is a view or opinion that is incorrect because based on faulty thinking or understanding.

Myths

a traditional story, especially one concerning the early history of a people or explaining a natural or social phenomenon.

1. Background

Unintended pregnancies, whether mistimed or unwanted, contributes to maternal mortality and morbidity globally by exposing women to physical and/or phycological risks related to unsafe abortion, pregnancy, childbirth and motherhood [1]. Access to comprehensive sexual and reproductive health, including comprehensive abortion and family planning services, is imperative to meet the sexual and reproductive needs of women and to reduce mortality and morbidity.

Bangladesh has made noticeable progress in reducing maternal mortality and morbidity over the past decades. Although still high, the maternal mortality ratio (MMR) fell from 322 per 100 000 live births in 2001 to 194 deaths per 100 000 live births in 2010. The use of modern contraceptives among married women of reproductive age has increased from 5 percent in 1975 to 53.8 percent in 2010 and during the same period the total fertility rate (TFR) fell from 6.3 to 2.5. [2]. Despite this progress the TFR is higher than the wanted fertility rate and the use of modern contraceptives is lower than the demand, indicating unmet need for family planning. In 2014 the TFR for women in Bangladesh was 2.3 and the wanted fertility rate was 1.6. The unmet need for family planning among married women and girls of reproductive age was 12 percent [3]. However, the unmet need of family planning does not take into consideration the use of traditional methods as an indicator for unmet need, neither the effectiveness of a method or user adherence. Additionally, 48 percent of all pregnancies in Bangladesh in 2014 were unintended, indicating a high unmet need of family planning [4].

Ipas Bangladesh, in partnership with the Directorate General of Health Services (DGHS), the Directorate General of Family Planning (DGFP), non-governmental organisations (NGOs), and local stakeholders, work to improve women's and girls' access to quality sexual and reproductive health services. As part of this work Ipas Bangladesh is implementing a 5-year programme funded by DFID titled "Family Planning in Bangladesh - Improving Quality and Access", herein QFP. The objective of QFP is to increase the use of modern contraceptive methods especially by postpartum and post abortion women, including adolescents and young women. To reach the objective of the QFP programme Ipas Bangladesh provide technical support to the government of Bangladesh and stakeholders at the local level, on sustainable logistics, record keeping and data collection. Further, Ipas Bangladesh conduct training and capacity building of healthcare providers within the public and private health sector on menstrual regulation, post-abortion care and contraceptive provision and counselling. Training of healthcare providers is one of Ipas Bangladesh core activities within the QFP programme. Skill based training of healthcare providers is crucial to enable them to provide quality SRH care that are safe and according to evidence-based guidelines. However, women's and girls' ability to access SRH service and their utilization of SRH services are also influenced by cultural and societal norms, by personal knowledge and beliefs about SRH, and by providers' attitude towards SRH services. Although,

training of health care providers is crucial to improve women's and girls' access to SRH services, Ipas Bangladesh recognizes the importance of creating awareness at the community level. Social behavioural change interventions can contribute to creating an enabling environment for sexual and reproductive health. Ipas Development Foundation (IDF) in India implemented a social behavioural change intervention to create awareness of abortion and contraceptive services at the community level. The evaluation of the SCB intervention showed a significant increase in the percentage of women and men who knew about the legality of abortion and where to access safe abortion services. There was also an increase in the utilization of services at all intervention sites [5]. Awareness at the community level can contribute to the empowerment of women and girls and enable them to make informed sexual and reproductive health choices. Therefore, Ipas Bangladesh initiated social and behavioural change (SBC) interventions at community level as part of the QFP programme. The aim of the SBC interventions is to increase the awareness of and access to MR, PAC and FP at the community level, with a special emphasis on post-abortion family planning (PAFP), post-partum family planning (PPFP) and adolescents SRH. Further, the SBC interventions aim to increase the knowledge of best practice among community health workers and to create awareness of societal and communal norms of and attitudes towards MR, PAC and FP and how these attitudes and norms affect women's, girls' and couples' access to and use of MR, PAC and FP.

The SBC activities are implemented by two partner organisations of Ipas Bangladesh, Bangladesh Association for Social Advancement (BASA) and Bangladesh NGOs Network for Radio and Communication (BNNRC). BASA implements community mobilization activities on MR, PAC and FP through a number of community level interventions and capacity building initiatives in 8 upazilas. Community interventions include Community Group meetings in community clinic, advocacy to local council members and local leaders, and capacity building of DGHS field workers. BNNRC implements community mobilization activities through community radios programs including radio magazines, live talk shows and publications in local newspapers in 9 upazilas.

To better understand changes in the knowledge of and attitude towards MR, PAC and FP and the ability to access SRH services at the community level, the SBC intervention will be evaluated at community level. For that purpose, Ipas Bangladesh carried out a baseline study in six randomly selected upazilas exposed to the SBC intervention, at the start of the implementation of the SBC interventions in 2017. Part of the aim of the baseline study was to assess community members and health care providers' knowledge of and attitude towards MR, PAC and FP. The baseline study will be followed by an endline study, which will measure the changes in knowledge of and access to MR, PAC and FP. Further, the end line study will also assess changes in attitudes towards MR, PAC and FP among community members and health care providers. Additionally, Ipas Bangladesh decided, in consultation with stakeholders, to carry out a midline study. The purpose of the midline study is programmatic, that is to monitor and evaluate the SBC activities

within the QFP programme and to gain more knowledge of SBC activities for design and implementation of future MR, PAC and FP services at facility level and awareness activities at the community level.

2. Social Behavioural Change Activities

Between baseline and midline, Social Behavior Change (SBC) activities were implemented in 17 upazilas. Ipas' community access partner Bangladesh Association for Social Development (BASA) worked with DGHS field workers, local union Parishad body and community group members in community clinics in 8 upazilas to increase awareness on MR, PAC and FP services. Bangladesh NGO Network for Radio Communication (BNNRC), another community access partner of Ipas Bangladesh worked in 9 upazilas through 9 community radio stations with the same purpose. During this period Ipas' partners have trained 569 DGHS field workers including Community Health Care Provider (CHCP), Health Assistant (HA), Assistant Health Inspector (AHI), and Health Inspector (HI) to provide MR, PAC and FP service information to the community. Additionally, Ipas' partners have attended 166 monthly meetings of the field workers to follow up after-training activities. Further, they have organized 56 stakeholder meeting with local union Parishad members where 1102 local leaders were sensitized on MR, PAC and FP issues and organized 29 Theatre for Development (TFD) shows where approximate 7000 people received information regarding MR, PAC and FP. Ipas' partners have attended 567 Community Group meetings in Community Clinics and oriented around 6000 community people (a member of community groups), organized 28 Expanded Programme on Immunization (EPI) mother sessions where information on MR, PAC and FP was provided to the mothers. These activities were implemented by BASA in 8 upazilas.

In the remaining 9 upazilas, 9 community radio stations telecasted 71 magazine program and 168 talk shows focusing on MR, PAC and FP services where Medical Officers (MOs), Upazila Family Planning Officers (UHFPOs), Family Welfare Visitors (FWVs) and satisfied long-term FP method users shared information and experiences related to MR, PAC and FP services. Each community radio stations cover approximately 150,000 people. Additionally, these radio stations organized 152 courtyard sessions with their listening club members where around 3000 listening club members were oriented on MR, PAC and FP services. Further, they published features in local newspapers on FP services on a quarterly basis. Two upazilas were dropped before the midline study started as these radios did not cover the study area.

3. Objective

The overall objective of the SBC study is to better understand changes in the participants' knowledge, attitudes, and ability to access FP, MR-PAC, support, and care. The evaluation will also look at changes among community members: attitudes and positive behaviours in support of

women, especially young women and members of other underserved populations like adolescents, and their access to SRH information, support, and care.

Specific objectives of the midline study:

- To measure the changes of women's knowledge about availability of the FP, MR-PAC services in QFP health facilities through community-based interventions
- To determine what extent the community-based interventions, enable women to feel confident about their ability to seek FP and MR-PAC services
- To assess the changes in women's and men's attitudes for improving access to FP and MR-PAC services through community-based interventions
- To measure changes in women's access to FP and MR-PAC services community-based interventions
- To assess the level of participation in the health education session with women, adolescents and youth by Ipas-trained community health workers

4. Methodology

The SBC evaluation is a mixed method study, including quantitative cross-sectional surveys and qualitative in-depth interviews. Qualitative in-depth interviews were carried out at baseline and will be carried out at end line. The midline study is a quantitative cross-sectional study.

4.1. Sampling

Six upazilas where SBC interventions are implemented were randomly selected for the midline study. In order to determine the statistically significant sample size for the study, the following method was used:

$$n = \frac{\left[Z_{1-\alpha}\sqrt{2P(1-P)} + Z_{1-\beta}\sqrt{P_1(1-P_1)+P_2(1-P_2)}\right]^2}{(P_2-P_1)^2} \times D$$

Where:

D = design effect;

P_1= the estimated proportion at the time of the first survey;

P_2= the target proportion at some future date; P= $(P_1 + P_2)/2$;

$Z_{1-\alpha}$= z-score corresponding to desired level of significance;

$Z_{1-\beta}$= z-score corresponding to the desired level of power.

Considering the knowledge of any two long-acting/permanent method (LAPM) of family planning in community intervention areas as p_1 (29/8% for women, 16.6% for men and 6.7% for adolescent). Using 5 percent level of significance, 80 percent power of the test and design effect of 1.5 and also expecting 15 percent detectable change during the project period and 5 percent non-response rate, the required sample size for women is 256, for men is 200 and adolescent is 132. The study respondents of the quantitative study e.g. women, men, and adolescents interviewed at the household level.

The baseline study provided us with the prevalence of knowledge of any two LAPM of FP which was used to determine the statistically significant sample size for the midline study. For the midline study Ipas Bangladesh randomly select 257 women of reproductive aged (15-49 yrs.), 200 married men and 134 married adolescents from the selected areas where Ipas Bangladesh's partners implement community-based program activities.

4.2. Study Area

Midline survey conducted in six randomly selected upazilas where SBC activities were being implemented namely Chapainawbgonj Sadar upazila, Moulavibazar Sadar upazila, Gaibandha Sadar upazila, Amtoli upzila, Chakaria upazila and Ghatail upazila.

4.3. Data Collection

For the midline study, the data was collected in June 2019. Semi-structured questionnaires developed by the study team was administered in-person to the participants of the study. As some of the questions asked to women and adolescents differed from the questions asked to men two questionnaires were developed, one for women and adolescents (appendix 1) and one for men (appendix 2). The questionnaires included questions about demographics, socioeconomic status, women's sexual and reproduction history, exposure to community access interventions, FP and MR-PAC knowledge, and men's and women's attitudes toward MR-PAC, women's self-efficacy to seek FP and MR-PAC services, and women's family planning history. The questionnaire was pre-tested for clarity and content. Interviewers were trained by the study team on ethical considerations, informed consent, survey implementation and data quality assurance. Supervisors from the partner organization and Ipas staff reviewed the surveys for quality assurance throughout the data collection. The interviews were carried out in the study participants' house at a time convenient to the participant.

4.4. Study Population

The participants of the SBC programme constitute the study population and comprise of married adolescents and married women of reproductive age – between 15-49 and married men of reproductive age – between 18-59.

4.5. Data Processing and Analysis

The data processing began shortly after fieldwork commenced. Data processing consisted of office editing, coding of open-ended questions, data entry, and editing of inconsistencies found by the computer program. The cross-sectional data was deidentified and exported from the database to Stata version 14.0 for advanced cleaning and analysis. When applicable, the categorical answers 'strongly disagree' and 'disagree' was combined to 'disagree' and 'strongly agree' and 'agree' was combined to 'agree'. The midline study is a descriptive study and univariate and bivariate analysis using the chi-squared test has been conducted on knowledge of LAPM, PPFP and PPAP, belief about MR and women's self efficacy. Further, chi-square test has

been conducted on knowledge of FP and LAPM in Cmmunity Engagement upazilas and Community Radio upazilas respectively. The chi-square test was performed to determine whether the difference observed between baseline and midline for each group respectively (women, adolescents and men) were statistically significant or not. Fisher exact test was carried out on use of FP in Cmmunity Engagement upazilas and Community Radio upazilas respectively to determined whether the difference observed between baseline and midline for each group respectively (women, adolescents and men) were statistically significant or not.

5. Result

5.1. Demographics

At midline, the mean age of women participating in the study was 31.6 years, the mean age of adolescent study participants was 17.7 years and the mean age of men participating in the study was 40 years (Table 1). When it comes to education, 63.8 percent of the women had completed primary education, in the adolescents group 85.9 percent had completed primary education and for men the percent was 57 percent. The highest percentage of respondents who had completed secondary education was found in the adolescent group (25.4 percent). A majority of the women (90.2 percent) *did not work* outside their home, meanwhile 98 percent of the men reported that they *did work* outside their home.

Table 1: Demographics: women, adolescents and men

Age in years	**Women**		**Adolescent**		**Men**	
	Baseline	Midline	Baseline	Midline	Baseline	Midline
	(N=420)	(N=257)	(N=90)	(N=134)	(N=120)	(N=200)
	%	%	%	%	%	%
15-19	0.2	0.4	100	100	0.0	0.0
20-24	18.3	16.3	0.0	0.0	2.3	6.5
25-29	22.4	19.5	0.0	0.0	11.2	11.5
30-34	23.3	20.6	0.0	0.0	23.6	12.5
35-39	18.3	22.9	0.0	0.0	23.6	19.5
40-44	10.7	9.7	0.0	0.0	19.1	15.0
45+	6.7	10.5	0.0	0.0	40.8	35.0
Mean	31.6	32.8	17.6	17.7	41.9	40.0
Education						
No education	22.9	14.8	2.2	4.5	28.3	21.0
Primary Incomplete	16.9	21.4	8.9	9.6	21.7	22.0
Primary complete	14.7	18.7	12.2	14.2	6.7	16.0
Secondary incomplete	33.3	28.8	52.2	46.3	25.8	21.0
Secondary and higher	12.1	16.3	24.4	25.4	17.5	20.0
Total	100	100	100	100	100	100

Do you work outside your home?						
Yes	8.3	9.8	1.1	1.5	91.67	98.0
No	91.7	90.2	98.9	98.5	8.33	2.0
Total	100	100	100	100	100	100

5.2. **Family Planning: Knowledge and Use**

Knowledge of Family Planning Methods

Table 2 shows that pill was the most commonly known family planning method across all groups, over 90 percent of the respondents in the three groups were able to name pill as a family planning method without probing, at midline and at baseline. Implant was the most commonly known LARC among the respondents at midline and at baseline. At midline, 69.7 percent of the women, 52.2 percent of the adolescents and 35.5 percent of the men were able to name implant as a FP method without probing. Across the three groups the percentage was higher at midline than at baseline. The percentage of respondents who could name IUD as a FP method without probing was also higher at midline than at baseline, across all three groups. Fifty-four percent of women could name IUD without probing at midline, and 26.2 percent at baseline, for adolescents the percent was 28.4 percent at midline and 5.6 percent at baseline and for men, 21.0 percent at midline and 5.8 percent at baseline.

Among the women 63.8 percent were able to name at least two LAPM methods without probing at midline, at baseline the percent was 29.8 percent (Figure 1). Two fifths (39.5 %) of the adolescent study participants were able to name at least two LAPM at midline, at baseline the percent was 6.7 percent. Thirtyeight percent of the men at midline were able to name two LAPM methods a higher percentage than at to 16.6 percent at baseline. Chi-square test was carried out to see the association between baseline and midline knowledge of LAPM. The p-value indicates that there is a statisitically significant difference between baseline and midline knowledge of LAPM for all three groups with a p-value < 0.05.

Table 2: Knowledge of family planning method: women, adolescent and men

Family planning method		Women		Adolescent		Men	
		Baseline	Midline	Baseline	Midline	Baseline	Midline
		(N=420)	(N=257)	(N=90)	(N=134)	(N=120)	(N=200)
		%	%	%	%	%	%
Condom	Yes(spont.)	58.3	85.2	50.0	86.6	67.5	92.5
	Yes(prob.)	36.4	14.0	41.1	12.7	31.7	7.5
	No	5.2	0.8	8.9	0.8	0.8	-
Pill	Yes(spont.)	97.4	99.2	91.1	97.8	95.8	98.0
	Yes(prob.)	1.9	0.4	4.4	1.5	4.2	1.5
	No	0.7	0.4	4.4	0.8	0.0	0.5
Emergency contraception	Yes(spont.)	1.7	2.3	2.2	2.2	3.3	3.5
	Yes(prob.)	10.5	29.6	10.0	19.4	10.8	23.5
	No	87.9	68.1	87.8	78.4	85.8	73.0
Injectable	Yes(spont.)	74.8	89.9	51.1	72.4	59.2	68.5
	Yes(prob.)	24.5	9.3	36.7	24.6	35.8	25.0
	No	0.7	0.8	12.2	3.0	5.0	6.5
IUCD/Copper-T	Yes(spont.)	26.2	54.9	5.6	28.4	5.8	21.0
	Yes(prob.)	49.3	36.2	25.6	26.9	47.5	50.5
	No	24.5	8.9	68.9	44.8	46.7	28.5
Implant	Yes(spont.)	44.8	69.7	23.3	52.2	15.0	35.5
	Yes(prob.)	46.7	27.2	50.0	31.3	45.0	44.0
	No	8.6	3.1	26.7	16.4	40.0	20.5
Periodic abstinence	Yes(spont.)	10.7	24.9	4.4	16.4	14.2	21.0
	Yes(prob.)	56.2	65.4	36.7	52.2	58.3	62.5
	No	33.1	9.7	58.9	31.3	27.5	16.5
Withdrawal	Yes(spont.)	2.4	12.5	5.6	12.7	5.0	18.0
	Yes(prob.)	42.4	65.4	32.2	50.0	53.3	70.5
	No	55.2	22.2	62.2	37.3	41.7	11.5
Male sterilization	Yes(spont.)	11.2	27.6	2.2	20.2	15.8	31.0
	Yes(prob.)	63.1	60.7	42.2	50.0	70.8	48.0
	No	25.7	11.7	55.6	29.8	13.3	21.0
Female sterilization	Yes(spont.)	22.4	53.7	4.4	37.3	15.8	43.0
	Yes(prob.)	71.4	44.8	72.2	53.8	74.2	49.5
	No	6.2	1.6	23.3	8.9	10.0	7.5

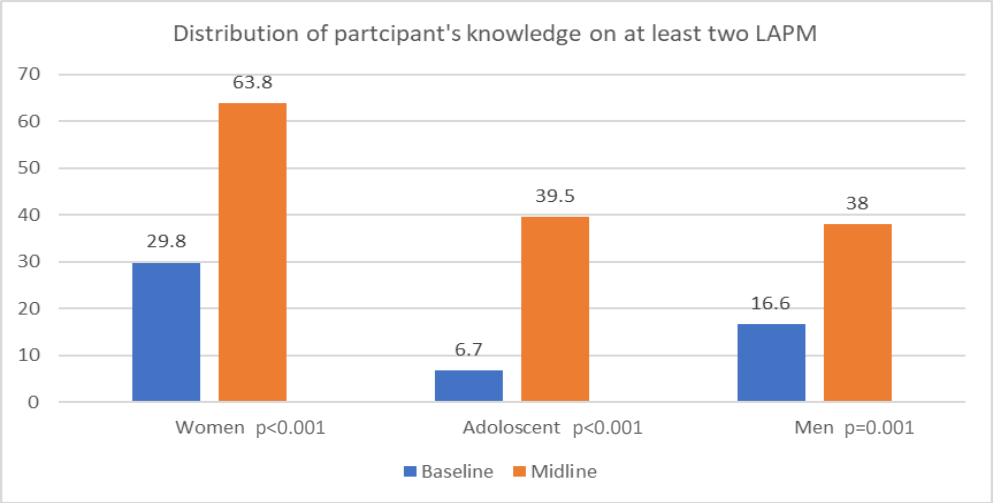

Figure 1: Knowledge of at least two LAPM FP methods: women, adolescent and Men.

Knowledge of Post-Partum and Post-Abortion Family Planning

Table 3 illustrates that the percent of the participants who reported having heard of PPFP at midline was higher than the percentage reported at baseline. Among women 81.3 percent had heard of PPFP at midline, at baseline the percent was 76.9 percent. For adolescents, the percent was 62.7 percent at midline and 53.3 at baseline. For men, 70.0 percent at midline and 61.7 percent at baseline. When it comes to PAFP the percent of women who reported having heard of it was higher at midline than at baseline. However, the percentage of the adolescent study participants who reported having heard of PAFP was lower at midline than at baseline. Among the men the percentage at midline was slightly higher than at baseline. Chi-square test was carried out to see the association between baseline and midline knowledge of PPFP and PAFP. The p-value indicates that there is a statisitically significant difference between baseline and midline knowledge of PAFP for women and PPFP for men with a p-value < 0.05.

Table 3: Knowledge of post-partum and post-abortion FP: women, adolescent and men

Heard of PPFP	**Women**			**Adolescent**			**Men**		
	Baseline (N=420) %	Midline (N=257) %	P-value	Baseline (N=90) %	Midline (N=134) %	P-value	Baseline (N=120) %	Midline (N=200) %	P-value
Yes	76.9	81.3		53.3	62.7		61.7	70.0	
No	23.1	18.7	0.174	46.7	37.3	0.504	38.3	30.0	0.026
Total	100	100		100	100		100	100	
Heard of PAFP									
Yes	58.3	60.9		37.8	34.3		38.1	39.5	
No	41.7	39.1	0.019	62.2	65.7	0.597	61.8	60.5	0.790
Total	100	100		100	100		100	100	

Current Use of Family Planning Method

The percent of the participant who at the time of the survey answered that they were actively trying to avoid pregnancy was 80.9 percent at midline and 76.7 percent at baseline in the group women and 69.3 percent at midline and 51.9 percent at baseline in the group adolescents (Table 4). For men the percent was 87.9 percent at midline and 88.1 percent at baseline. Figure 2 indicates that the percent of the respondents in the group women and in the group adolescents who reported current use of LARC method was higher at midline than what was reported at baseline. For women participating in the study the current use of LARC was 14.2 at midline and 6.9 percent at baseline, for adolescent the percent of current use of LARC at midline was 5.1 percent and 2.5 percent at baseline (Figure 3). Chi-square test was carried out to see the association between baseline and midline contraceptive method-mix. The p-value indicates a statisitically significant difference between baseline and midline for women with a p-value<0.05. For adolescents the p-value>0.05, thus not statistifally significant.

Table 4: Currently using a FP method: women, adolescent and men

Currently doing something to avoid getting pregnant?	**Women**		**Adolescent**		**Men**	
	Baseline	Midline	Baseline	Midline	Baseline	Midline
	(N=420)	(N=242)	(N=90)	(N=134)	(N=109)	(N=183)
	%	%	%	%	%	%
Yes	76.7	80.9	51.9	69.3	88.1	87.9
No	23.3	19.0	48.1	30.7	11.9	12.1
Total	100	100	100	100	100	100

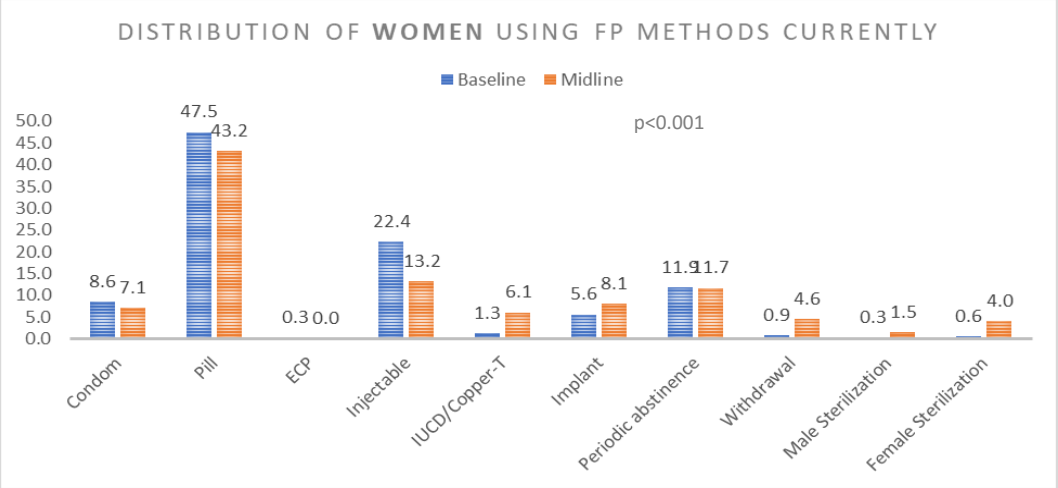

Figure 2: Current use of FP method: women

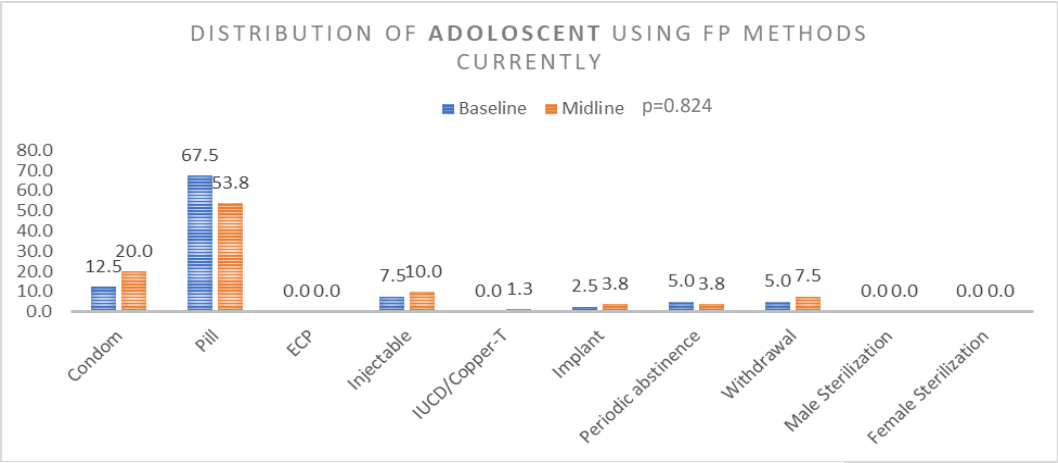

Figure 3: Current use of FP method: adolescents

5.3. Family Planning: Perception of Methods

Table 5 shows that the percent of women and adolescents who agreed with the statement that pills causes infertility was lower at midline (10.2 percent of women and 10.6 percent of adolescent) than at baseline (38.1 percent of women and 32.6 percent of adolescents). For injectables, the percent of women and of adolescents who agreed with the statement that injectables can cause infertility was also lower at midline (13.3 percent of women and 13.8 percent of adolescents) than at baseline (32.1 percent of and 32.9 percent of adolescents).

When it comes to the perceived relation between contraceptive method and cancer the percent of women and of adolescents who agreed with the statement that injectables can cause cancer was lower at midline (9 percent of women and 5.4 percent of adolescents) than what was reported at baseline (30.2 percent of women and 24.1 percent of adolescents). The percent of women who were uncertain of the relation between injectables and cancer was more or less the same at midline as at baseline, for adolescent the percentage unsure at midline was higher than at baseline. The percent of women and of adolescents who agreed with the statement that implant can cause cancer was also lower at midline (17.3 percent of women and 9.1 percent of adolescents) than at baseline (24.2 percent of women and 25.8 percent of adolescents). The percent of women who were unsure about the relation between implant and cancer was about the same at midline as at baseline and for adolescents the percent was lower at midline than at baseline.The percent of women who agreed with the statement that implant breaks down or are displaced within the body was more or less the same at midline (47.4 percent) as at baseline (47.7 percent). Among the adolescents the percent was slightly lower at midline (42.7 percent) than at baseline (45.4 percent). The percent of women and of adolescents who agreed with the statement that a tubectomy reduces the ability to work hard was lower at midline (40.3 percent of women and 41.7 percent of adolescents) than at baseline (65 percent of women and 53.6 percent of adolescents).

Table 5: Perception of family planning: women and adolescents

Pill can cause infertility	**Women**		**Adolescent**	
	Baseline	Midline	Baseline	Midline
	n(%)	n(%)	n(%)	n(%)
Disagree	217(52.0)	212(82.8)	42(48.8)	90(68.2)
Unsure	41(9.9)	18(7.0)	16(18.6)	28(21.2)
Agree	159(38.1)	26(10.2)	28(32.6)	14(10.6)
Total	417(100)	256(100)	86(100)	132(100)
Injectables can cause cancer				
Disagree	186(44.6)	161(63.1)	39(49.4)	72(55.4)
Unsure	105(25.2)	71(27.9)	21(26.5)	51(39.2)
Agree	126(30.2)	23(9.0)	19(24.1)	7(5.4)
Total	417(100)	255(100)	79(100)	130(100)
Injectables can cause infertility				
Disagree	215(51.6)	190(74.5)	34(43.1)	76(58.5)
Unsure	68(16.3)	31(12.2)	19(24.0)	36(27.7)
Agree	134(32.1)	34(13.3)	26(32.9)	18(13.8)
Total	417(100)	255(100)	79(100)	130(100)
Implant can cause cancer				
Disagree	181(47.2)	135(54.2)	22(33.4)	58(52.7)
Unsure	110(28.7)	71(28.5)	27(40.9)	42(38.2)
Agree	93(24.2)	43(17.3)	17(25.8)	10(9.1)
Total	384(100)	249(100)	66(100)	110(100)
Implant breaks down/displaced				
Disagree	125(32.5)	67(26.9)	13(19.7)	27(24.6)
Unsure	76(19.8)	64(25.7)	23(34.9)	36(32.7)
Agree	183(47.7)	118(47.4)	30(45.4)	47(42.7)
Total	384(100)	249(100)	66(100)	110(100)
Tubectomy reduces ability to work hard				
Disagree	85(21.6)	96(38.0)	19(27.5)	38(31.6)
Unsure	53(13.5)	55(21.7)	13(18.8)	32(26.7)
Agree	256(65.0)	102(40.3)	37(53.6)	50(41.7)
Total	394(100)	253(100)	69(100)	120(100)
IUD users can conceive after having their IUD removed				
Disagree	11(3.5)	16(6.9)	4(14.2)	5(6.8)
Unsure	31(9.8)	11(4.7)	0(0.0)	4(5.4)
Agree	275(86.7)	206(88.4)	24(85.7)	65(87.8)
Total	317(100)	233(100)	28(100)	74(100)

5.4. Menstrual Regulation: Knowledge

Knowledge of the legal status of menstrual regulation

On the legality of MR in Bangladesh, the percent of women who reported that MR is legal was 43.2 percent at midline and 41.2 percent at baseline (Table 6). Among the adolescent, the percent who reported that MR is legal was higher at midline (44 percent) than at baseline (33.3 percent). However, there was almost no difference in the percent of women who were under the perception that MR is illegal, (41.3 percent at midline and 41.9 percent at baseline). The percent of adolescents who were uncertain of the legality of MR was about the same at midline as at baseline. The percent of men who were under the perception MR is legal was about the same at midline (41 percent) as at baseline (41.7 percent).

Table 6: Knowledge of legality of MR: women, adolescents and men

Do you think menstrual regulation is legal	**Women**		**Adolescent**		**Men**	
	Baseline (N=420)	Midline (N=257)	Baseline (N=90)	Midline (N=134)	Baseline (N=120)	Midline (N=200)
	%	%	%	%	%	%
Yes	41.2	43.2	33.3	44.0	41.7	41.0
No	41.9	41.3	43.3	32.8	51.7	40.0
Don't Know	16.9	15.6	23.3	23.1	6.7	19.0
Total	100	100	100	100	100	100

Perception of Menstrual Regulation

Table 7 illustrates that the percent of women who reported that MR causes infertility was 20.3 percent at midline and 35.7 percent at baseline. For adolescents, the percent was lower at midline (18 percent) than at baseline (38.9 percent). When it came to whether or not repeated MR is harmful to women's health, the percent of women who agreed with the statement at midline was lower (92.6 percent) than at baseline (96.7 percent of women). For adolescents the percent was higher at midline (87.1 percent) than it was at baseline (91.1 percent).

At midline, 61.5 percent of women reported that MR cost more than other procedures, at baseline the percent was 59.1 percent. For adolescents, the percent at midline was lower (45.5 percent) than at baseline (46.7 percent).

Table 7: Perception of MR: women and adolescents

Menstrual regulation causes infertility	**Women**		**Adolescent**	
	Baseline	Midline	Baseline	Midline
	n (%)	n (%)	n (%)	n (%)
Disagree	161(38.4)	123(47.9)	28(31.1)	50(37.6)
Unsure	109(25.9)	82(31.9)	27(30.0)	59(44.4)
Agree	150(35.7)	52(20.3)	35(38.9)	24(18.0)
Total	420(100)	257(100)	90(100)	133(100)
Repeated menstrual regulation is harmful to women's health				
Disagree	10(2.3)	8(3.1)	4(4.4)	8(6.1)
Unsure	4(0.9)	11(4.3)	4(4.4)	9(6.8)
Agree	406(96.7)	238(92.6)	82(91.1)	115(87.1)
Total	420(100)	257(100)	90(100)	132(100)
Menstrual regulation usually costs more than any other treatment				
Disagree	72(17.2)	41(15.9)	11(12.2)	19(14.2)
Unsure	100(23.8)	58(22.6)	37(41.1)	54(40.3)
Agree	248(59.1)	158(61.5)	42(46.7)	61(45.5)
Total	420(100)	257(100)	90(100)	134(100)

5.5. Menstrual Regulation: Beliefs and Attitudes

Beliefs

Among the women and the adolescent study participants the percentage who viewed MR as a sin was lower at midline than at baseline (Table 8). At midline, 53.7 percent of the women and 55.2 percent of the adolescents reported MR to be a sin, at baseline 79.8 percent of the women and 82.2 percent of the adolescents reported MR to be a sin. Among the men the percent of study participants who viewed MR as a sin was 52.5 percent at midline and 72.5 percent at baseline. Chi-square test was carried out to see the association between baseline and midline belief on MR. The p-value indicates a statisitically significant difference between baseline and midline for all groups with a p-value<0.05.

Table 8: Belief about MR: women, adolescents and men

A woman who has MR is committing a sin	Women			Adolescent			Men		
	Baseline (N=420)	Midline (N=257)	P-value	Baseline (N=90)	Midline (N=134)	P-value	Baseline (N=120)	Midline (N=200)	P-value
	%	%		(%	%		%	%	
Disagree	18.6	42.9	<0.001	14.5	38.1	<0.001	23.3	42.5	<0.001
Unsure	1.7	3.5		3.3	6.7		4.2	5	
Agree	79.8	53.7		82.2	55.2		72.5	52.5	
Total	100	100		100	100		100	100	

Attitude

At midline, the percent of the study participants who reported that a woman who has an MR will bring shame to her family was lower across all three groups (men, women, adolescents) than at baseline (Table 9).For women the percent of the study participant who reported that an MR will bring shame to the family was 24.9 percent at midline and 28.1 percent at baseline, for adolescents the percent of study participant who reported that an MR will bring shame to the family was 21.6 percent at midline and 36.7 percent at baseline and for men the percent of study participant who reported that an MR will bring shame to the family was 26 percent at midline and 37.5 percent at baseline. When it came to the view on whether or not a woman who has had a MR would bring shame to her community the percentage among study participants who did agree with the statement was lower at midline than at to baseline, across all groups. The percent of women who reported that a woman who has had an MR should be treated the same as everyone else was 79.8 percent at midline and 83.8 percent at baseline. Among adolescents the percent was about the same at midline (82.1 percent) and baseline (81.1 percent) and for men the percent was lower at midline (79.5 percent) than at baseline (82.5 percent).

Table 9: Attitudes towards MR: women, adolescents and men

A woman who has MR brings shame to her family	Women		Adolescent		Men	
	Baseline (N=420)	Midline (N=257)	Baseline (N=90	Midline (N=134)	Baseline (N=120)	Midline (N=200)
	%	%	%	%	%	%
Disagree	69.3	72	61.1	73.9	60	72.0
Unsure	2.6	3.1	2.2	4.5	2.5	2.0
Agree	28.1	24.9	36.7	21.6	37.5	26.0
Total	100	100	100	100	100	100
A woman who has a MR brings shame to her community						
Disagree	75.7	83.7	70.0	78.3	65	77.5
Unsure	1.7	1.6	2.2	3.7	2.5	3.5
Agree	22.6	14.8	27.8	17.9	32.5	19
Total	100	100	100	100	100	100
A woman who has a MR should be treated the same as everyone else						
Disagree	15.4	17.2	18.9	15.6	17.5	20.5
Unsure	0.7	3.1	0.0	2.2	0.0	0.5
Agree	83.8	79.8	81.1	82.1	82.5	79.5
Total	100	100	100	100	100	100

5.6. Menstrual Regulation: Women's Self Efficacy

The percent of women and of adolescents who reported being able to access MR services was higher at midline than to baseline.Table 10 shows that at midline, 44.3 percent of the women and 23.8 percent of the adolescents reported being able to access MR, at baseline 21.7 percent of the women and 13.3 percent of the adolescents reported being able to access MR. At midline, 93.4 percent of the women knew where in their community they could access MR services, this percent was slightly higher than at baseline (90.2 percent). In the adolescent group the percent at midline was 90.3 percent and at baseline the percent was 71.1 percent.

Among the women, 88 percent reported knowing the difference between a safe and an unsafe MR provider at midline, this was lower than at baseline (91.7 percent). The percentage of adolescent study participants was also lower at midline (73.8 percent) than at baseline (84.4 percent). At midline 58.4 percent of the women included in the study reported they were able to pay for an MR procedure, the corresponding figure among adolescents was 50.7 percent. Thus, the percent was higher at midline than at baseline for both groups. A majority of the participants in both groups reported being able to pay for the transportation cost involved in accessing MR services. Chi-square test was carried out to see the association between baseline and midline of the variables related to women's self efficacy. The p-value indicates a statisitically significant difference between baseline and midline for women's and adolescents' report of being able to

have an MR if she wanted with a p-value<0.05 for both groups. A statistically significant difference was also found between baseline and midline for women's and adolescents' report of being able to pay for the cost of a MR, including cost of travel. A statistically significant difference between baseline and midline was found for women but not found for adolescents' report of being able to tell their families.

Table 10: Women's self-efficacy: women and adolescents

If I wanted to have MR I could	**Women**			**Adolescent**		
	Baseline (N=420)	Midline (N=257)	P-value	Baseline (N=90)	Midline (N134)	P-value
	%	%		%	%	
Disagree	78.1	53.3	<0.001	86.7	73.9	0.046
Unsure	0.2	2.3		0	2.2	
Agree	21.7	44.3		13.3	23.8	
Total	100	100		100	100	
I know where to get MR in my community						
Disagree	7.2	5.1	0.354	17.8	3.7	<0.001
Unsure	2.6	1.6		11.1	5.9	
Agree	90.2	93.4		71.1	90.3	
Total	100	100		100	100	
I am able to pay the cost to travel to get MR						
Disagree	64.8	33.4	<0.001	70	39.5	<0.001
Unsure	0.2	1.2		0	3.7	
Agree	35	65.4		30	56.7	
Total	100	100		100	100	
I am able to pay the cost to have the MR procedure						
Disagree	73.4	37.8	<0.001	81.1	44.8	<0.001
Unsure	0.5	3.9		0	4.5	
Agree	26.1	58.4		18.9	50.7	
Total	100	100		100	100	
I know the difference between safe/unsafe MR provider						
Disagree	5.5	5.8	0.097	14.5	14.2	0.011
Unsure	2.9	6.2		1.1	11.9	
Agree	91.7	88		84.4	73.8	
Total	100	100		100	100	
I could tell my family if I wanted to have MR						
Disagree	63.8	49.4	<0.001	56.7	45.5	0.092
Unsure	0	1.2		0	2.9	
Agree	36.2	49.5		43.3	51.5	
Total	100	100		100	100	

5.7. Community Access: Community Engagement

At midline, 22.5 percent (n=58) of the women had attended at least one FP related educational session (Table 11). Among those women, 58.6 percent attended two to five sessions. In the group of adolescents, 16.4 percent (n=22) attended at least one FP session and among those 63.6 percent attended two to five sessions. Fifteen percent (n=30) of the men attended at least one session and of those 36.7 percent attended two to five session.

The most commonly covered topic of the educational sessions, as reported across all groups, was family planning methods. The source of contraceptives was also a common topic as reported by the women (48.2 percent) and the adolescents (40.9 percent) who attended the sessions. For the women the sessions also commonly covered how to use contraceptives (44.8 percent), this topic was not as commonly reported by the adolescents (18.1 percent).

The percent of the study participants in the group of women who attended a session on MR/PAC was 10.5 percent and of those 29.5 percent attended two to five sessions. The percent of the adolescents who attended a session on MR/PAC was 5.9 percent and of those 62.5 percent attended two to five sessions. The percent of men who attended a session on MR/PAC was 6 percent and of those 41.7 percent attended one session. The most commonly covered topic reported by women and adolescents was ‘where to get menstrual regulation’ (88.8 percent of women,100 percent of adolescents and 83.3 percent of men). Among the women, 44.4 percent attended sessions covering the topic of methods of menstrual regulations and among the adolescents, 50 percent attended sessions on stories from women who had an induced MR. The cost of MR was less commonly reported as a topic in the group om women and adolescents than it was in the group of men.

Table 11: Community access educational sessions at midline: women, adolescent and men[9]

Attended at least one FP related educational session	Women		Adolescent		Men	
	Baseline	Midline	Baseline	Midline	Baseline	Midline
	n(%)	n(%)	n(%)	n(%)	n(%)	n(%)
Yes	16(3.8)	58(22.5)	2(2.2)	22(16.4)	3(1.8)	30(15.0)
No	404(96.2)	199(77.4)	88(97.8)	112(83.5)	157(98.1)	170(85.0)
Total	420(100)	257(100)	90(100)	134(100)	160(100)	200(100)
Number of sessions						
One	8(50.0)	18(31)	1(50)	7(31.8)	1(33.3)	19(63.3)
Two or five	8(50.0)	34(58.6)	1(50)	14(63.6)	2(66.6)	11(36.7)
Six to Ten	0(0.0)	3(5.1)	0(0.0)	1(4.5)	0(0.0)	0(0.0)
More than 10	0(0.0)	3(5.1)	0(0.0)	0(0.0)	0(0.0)	0(0.0)
Total	16(100)	58(100)	2(100)	22(100)	3(100)	30(100)
Topics covered in the education session						
Family planning Methods	15(93.7)	52(89.6)	2(100)	18(81.8)	2(66.6)	29(96.7)
Source of contraceptive/FP services	3(18.7)	28(48.2)	0(0)	9(40.9)	1(33.3)	6(20)
Cost of contraceptive/FP methods	1(0.1)	4(6.9)	1(50.0)	3(13.6)	1(33.3)	2(6.7)
How to use contraception/FP methods	8(50.0)	26(44.8)	2(100)	4(18.1)	1(33.3)	7(23.3)
Possible side effects from the use of contraception/FP methods	3(18.7)	6(10.3)	1(50.0)	3(13.6)	0(0)	2(6.7)
Other		0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)
Attended at least one MR/PAC related educational session						
Yes	0(0.0)	27(10.5)	1(1.1)	8(5.9)	0(0.0)	12(6.0)
No	420(100)	230(89.5)	89(98.8)	126(94.1)	160(100)	188(94.0)
Total	420(100)	257(100)	90(100)	134(100)	160(100)	200(100)
Number of sessions						
One	-	15(55.5)	0(0.0)	3(37.5)	-	7(58.3)
Two or five	-	8(29.6)	1(100)	5(62.5)	-	5(41.7)
Six to Ten	-	3(11.1)	0(0.0)	0(0.0)	-	0(0.0)
More than 10	-	1(3.7)	0(0.0)	0(0.0)	-	0(0.0)
Total	-	27(100)	1(100)	8(100)	-	12(100)
Topics covered in the education session						
Where to get MR	-	24(88.8)	1(100)	8(100)	-	10(83.3)
Possible complications	-	4(14.8)	0(0.0)	2(25.0)	-	4(33.3)
Cost of MR	-	5(18.5)	0(0.0)	2(25.0)	-	5(41.7)

[9] Baseline data not available for all groups and all questions, indicated by -, some questions are multiple choice and thus the percentages does not add to 100 percent

Methods of MR	-	12(44.4)	0(0.0)	2(25.0)	-	4(33.3)
Stories of women who had induced MR	-	4(14.8)	0(0.0)	4(50)	-	1(8.3)
Legality of MR service	-	3(11.1)	0(0.0)	2(25)	-	0(0.0)

5.7.1. Community Mobilization and Capacity Building, Community Upazilas

The following section show results from Cmmunity Engagement upazila, that is upazilas where community mobilization and capacity building interventions took place in the form of inter-personal communication (IPC) included group meeting, advocacy with local leaders, community group meetings.

Knowledge of family planning method for participants in community mobilization areas:
In the community mobilization areas, the percentage of the participants who were able to name FP methods without probing were higher at midline than at baseline across all groups for all methods except, emercency contraception and periodic abstinence. For IUD, 63.8 percent of women could name IUD without probing at midline, at baseline the percent was 26.2 percent (Table 12). Among adolescents 40.7 percent could name IUD without probing at midline, at baseline the percent was 11.6 percent and among men 19 percent could name IUD without probing at midline, a higher percent than at baseline. Looking at implant the percent of participants who were able to name implant as a method of FP without probing was higher at midline than at baseline across all groups. Chi square test was carried out for Cmmunity Engagement upazilas to see association between baseline and midline of knowledge of family planning methods. A p-value <0.05 indicates that the knowledge of IUD and Implant varied (decrease or increase) significantly between baseline and midline.

Further, the p-value indicates a statistically significant difference between baseline and midline for the following methods, condoms (all groups), pill (adolescents), emergency contraceptives (women and men), injectables (all groups), periodic abstinence (women and adolescents), withdrawal (all groups), male sterilization (all groups), female sterilization (all groups) with a p-value<0.05. A p-value <0.05 indicates that knowledge of FP method varied (decrease or increase) significantly between baseline and midline. Important to bear in mind is that the p-value may indicate a significant difference if the percentage of any category (yes(spont.), yes(probe) or no) varied significantly.

Table 12: Knowledge of family planning methods in Cmmunity Engagement Upazilas

Contraceptive method		Women			Adolescent			Men		
		Baseline (N=210) %	Midline (N=127) %	P value	Baseline (N=43) %	Midline (N=59) %	P value	Baseline (N=60) %	Midline (N=100) %	P value
Condom	Yes(spont.)	52.4	78.0	<0.001	53.5	83.1	0.004	60.0	88.0	<0.001
	Yes(prob.)	41.0	20.5		39.5	15.3		38.3	12.0	
	No	6.7	1.6		7.0	1.7		1.7	0.0	
Pill	Yes(spont.)	96.7	100.0	0.115	86.1	98.3	0.034	93.3	96.0	0.411
	Yes(prob.)	2.9	0.0		4.7	1.7		6.7	3.0	
	No	0.4	0.0		9.3	0.0		0.0	1.0	
Emergency contraception	Yes(spont.)	1.4	0.8	<0.001	4.7	1.7	0.097	0.0	3.0	0.009
	Yes(prob.)	7.1	31.5		11.6	28.8		13.3	32.0	
	No	91.4	67.7		83.7	69.5		86.7	65.0	
Injectable	Yes(spont.)	68.6	91.3	<0.001	48.8	78.0	0.008	55.0	81.0	0.001
	Yes(prob.)	30.5	7.1		41.9	18.6		38.3	13.0	
	No	0.95	1.6		9.3	3.39		6.7	6.0	
IUCD/ Copper-T	Yes(spont.)	26.2	63.8	<0.001	11.6	40.7	0.001	6.7	19.0	0.012
	Yes(prob.)	51.0	29.1		25.6	30.5		50.0	57.0	
	No	22.8	7.1		62.8	28.8		43.3	24.0	
Implant	Yes(spont.)	38.1	73.2	<0.001	23.3	64.4	<0.001	18.3	41.0	0.002
	Yes(prob.)	51.9	21.3		62.8	28.8		43.3	41.0	
	No	10.0	5.5		14.0	6.8		38.3	18.0	
Periodic abstinence	Yes(spont.)	9.1	22.8	<0.001	2.3	18.6	0.001	20.0	14.0	0.23
	Yes(prob.)	58.6	68.5		44.2	59.3		60.0	73.0	
	No	32.4	8.7		53.5	22.0		20.0	13.0	
Withdrawal	Yes(spont.)	1.43	15.0	<0.001	7.0	10.2	0.032	3.3	19.0	<0.001
	Yes(prob.)	43.3	68.5		30.2	52.5		53.3	75.0	
	No	55.2	16.5		62.8	37.3		43.3	6.0	
Male sterilization	Yes(spont.)	9.5	35.4	<0.001	2.33	32.2	0.001	15.0	32.0	<0.001
	Yes(prob.)	63.8	48.0		51.2	40.7		73.3	35.0	
	No	26.7	16.5		46.5	27.1		11.6	33.0	
Female sterilization	Yes(spont.)	21.9	58.3	<0.001	7.0	42.4	<0.001	15.0	48.0	<0.001
	Yes(prob.)	71.0	39.4		76.7	47.5		80.0	40.0	
	No	7.14	2.4		16.3	10.2		5.0	12.0	

Knowledge of LAPM for participants in Cmmunity Engagement upazilas

Table 13 indicates that among the women 70 percent were able to name two LAPM methods without probing at midline, at baseline the percent was 27.1 percent. Almost half (49.1 percent) of the adolescent participants were able to name at least two LAPM at midline, at baseline the

percent was 11.6 percent. Among men 42 percent were able to name at least two LAPM methods, at baslien the percent was 15 percent. Chi-square test was carried out to see the association between baseline and midline knowledge of LAPM. The p-value $p<0.05$ indicates that there is a statistically significant difference between baseline and midline knowledge of LAPM for all three groups. Impoartnat to note is that this is for knowledge of <2 LAPM and knowledge of at least 2 LAPM.

Table 13 Knowledge of LAPM

Knowledge of LAPM	Women			Adolescent			Men		
	Baseline (N=210) %	Midline (N=127) %	P value	Baseline (N=43) %	Midline (N=59) %	P value	Baseline (N=60) %	Midline (N=100) %	P value
<2 LAPM	72.9	29.9	<0.001	88.3	50.8	<0.001	85.0	58.0	<0.001
At least 2 LAPM	27.1	70.1		11.6	49.1		15.0	42.0	

Current use of FP methods in Cmmunity Engagement upazilas

Among the study participants who reported using a FP method the distribution of the type of method is shown in table 14. The percent of women using implant was 12.7 percent at midline and 7.1 percent at baseline, for the adolescents the percentage was 4.3 percent at midline and 5 percent at baseline, for men the percent of participants using implant at midline was 11.4 percent at 6.2 percent at baseline. Fisher exact test was performed and the p-value for women ($p=0.006$) and men ($p=0.028$) indicate that the use of FP methods varied significantly between baseline and midline for those two groups.

Table 14 Distribution of current use of FP in Cmmunity Engagement area

FP method	Women		P value	Adolescent		P value	Men		P value
	Baseline (N=141) (%)	Midline (N=102) (%)		Baseline (N=20) (%)	Midline (N=46) (%)		Baseline (N=48) (%)	Midline (N=88) (%)	
Condom	7.0	4.9	0.006	20	10.9	0.668	2.1	7.9	0.028
Pill	44.6	32.3		70	65.2		47.9	36.4	
Injectables	24.8	18.6		0.0	10.8		16.7	18.9	
Emergency pill	0.7	0		0.0	0.0		0.0	0.0	
IUCD	1.4	9.8		0.0	2.2		2.1	9.1	
Implant	7.1	12.7		5.0	4.3		6.2	11.4	
Periodic abstinence	10.6	10.8		0.0	0.0		18.7	5.7	
Withdrawal	0.7	4.9		5.0	6.5		0.0	6.8	
Male sterilization	0.7	0.9		0.0	0.0		2.1	0.0	
Female sterilization	1.4	4.9		0.0	0.0		2.1	4.5	

5.8. Community Awareness: effectiveness of Community Radio

At midline 26.5 percent (n=68) of the women, 30 percent (n=40) of the adolescents and 40 percent (n=80) of the men listen to radio (Table 15). Of those who listened to the radio 51.4 percent of women, 85.0 percent of adolescents and 21.3 percent of the men were able to name the community radio station serving their area. The most popular radio programmes among the participants who listened to radio were songs and news. Over 80 percent of the women and of the men and over 90 percent of the adolescents who listened to radio reported that one of their favourite programmes were songs. More than 50 percent of both women and adolescent reported news as another favourite programme, among men over 70 percent reported news to be a favourite programme. About one third of the women (35.2 percent), of the adolescents (30.0 percent) and of the men (31.2 percent) who were listening to radio had heard a programme where MR, PAC and FP were discussed. One woman and none of the adolescents or men who listened to radio were member of a radio community group.

Among the particpants who listened to a programme covering MR, PAC and FP the majority had listen to 2 – 5 programmes on the topic during the last year. The topics most commonly covered in the programmes was FP (91.6 percent of women, 66.6 percent of adolescents and 92 percent of men), source of FP was another commonly covered topic in the programmes the participants listened to (50 percent of women, 83.3 percent of adolescents and 44 percent of men). The use of FP was covered in about one fourth to one third of the programmes that women, adolescents and men listened to and the place of MR was covered in about one fourth to one third of the programmes that women and adolescents listened to.

The preferred time for listening to radio differed between women and adolescents. More than two thirds of the women (70.8 percent) and of the men (68 percent) preferred listening late in the evening, between 18.00 and 24.00. Although 50 percent of the adolescents also reported they preferred the later time frame about 40 percent of adolescents also preferred afternoon hours.

Table 15: Community radio at midline: women, adolescent and men[10]

Type of radio	**Women**		**Adolescent**		**Men**	
	Baseline	**Midline**	**Baseline**	**Midline**	**Baseline**	**Midline**
	n(%)	n(%)	n(%)	n(%)	n(%)	n(%)
Bangladesh Betar	-	25(9.7)	-	5(3.7)	-	22(11.0)
Community Radio	-	43(16.7)	-	35(26.1)	-	58(29.0)
Don't listen radio	-	189(73.5)	-	94(70.1)	-	120(60)
Total		257(100)		134(100)		200(100)
Mentioned the name of the community radio station served by this area						
Yes	-	35(51.4)	-	34(85.0)	-	17(21.3)

[10] Some questions are multiple choice therefore the percentage will not add up to 100

No	-	33(48.5)	-	6(15.0)	-	63(78.7)
Total	-	68(100)	-	40(100)	-	80(100)
Favourite radio program						
Song	-	59(86.7)	-	37(94.8)	-	69(86.3)
Talk shows	-	24(35.2)	-	13(33.3)	-	30(37.5)
News	-	39(57.3)	-	20(51.2)	-	61(76.3)
Magazine program	-	8(11.7)	-	6(15.3)	-	6(7.6)
Drama	-	12(17.6)	-	15(38.4)	-	19(24.4)
Total	-	68(100)	-	39(100)	-	80(100)
Heard a community radio program where FP and MR/PAC was discussed in the last year						
Yes	1(0.2)	24(35.2)	0(0.0)	12(30.0)	0(0.0)	25(31.2)
No	419(99.7)	44(64.8)	90(100.0)	28(70.0)	160(100.0)	55(68.8)
Total	420(100)	68(100)	90(100)	40(100)	160(100)	80(100)
Member of community radio program						
Yes	-	1(4.1)	-	0(0.0)	-	0(0.0)
No	-	23(95.8)	-	12(100.0)	-	25(100.0)
Total	-	24(100)	-	12(100)	-	25(100)
Number of times respondents listen to the community radio program in last year						
One	-	2(8.3)	-	0(0.0)	-	3(12.0)
Two to Five	-	11(45.8)	-	9(75.0)	-	16(64.0)
Six to Ten	-	3(12.5)	-	2(16.6)	-	0(0.0)
More than ten	-	8(33.3)	-	1(8.3)	-	6(24.0)
Total	-	24(100)	-	12(100)	-	25(100)
Time preferred to listen program of community radio						
9.00-12.00	-	2(8.3)	-	2(16.6)	-	4(16.0)
12.00-15.00	-	3(12.5)	-	3(25.0)	-	4(16.0)
15.00-18.00	-	8(33.3)	-	5(41.6)	-	8(32.0)
18.00-24.00	-	17(70.8)	-	6(50.0)	-	17(68.0)
All time	-	0(0.0)	-	1(8.3)	-	0(0.0)
Total	-	24(100)	-	12(100)	-	25(100)
Topics that respondents heard about on the radio program						
Contraceptive or family planning	1(100.0)	22(91.6)	-	8(66.6)	-	23(92.0)
Source of contraceptive /FP services	-	12(50.0)	-	10(83.3)	-	11(44.0)

Cost of contraceptive/ FP methods	-	4(16.6)	-	2(16.6)	-	5(20.0)
Use of contraceptive/ FP methods	-	7(29.1)	-	3(25.0)	-	9(36.0)
Possible side effects from the use of contraception / FP methods	-	4(16.6)	-	0(0.0)	-	2(8.0)
Place of MR service	-	7(29.1)	-	3(25.0)	-	3(12.0)
Possible side effect of MR	-	1(4.1)	-	2(16.6)	-	1(4.0)
Cost of MR service	-	4(16.6)	-	0(0.0)	-	1(4.0)
Process of MR	-	3(12.5)	-	1(8.3)	-	1(4.0)
Stories of other women who had induced menstrual regulation	-	3(12.5)	-	1(8.3)	-	2(8.0)
Legality of menstrual regulation	-	1(4.1)	-	1(8.3)	-	0(0.0)
Total	-	24(100)	-	12(100)	-	25(100)

5.8.1. Effectiveness of Community Radio

The following section show results from community radio areas.

Knowledge of family planning method for participants in Community Radio upazilas

Table 16 illlustrates that in the Community Radio upazilas the percentage of the participants who were able to name FP methods without probing were higher at midline than at baseline across all groups for all methods except, injectables and emergency contraceptives. For IUD, 46.2 percent of women could name IUD without probing at midline, at baseline the percent was 26.2 percent. Among adolescents 18.7 percent could name IUD without probing at midline, at baseline the percent was 0 percent and among men 23 percent could name IUD without probing at midline, a higher percent than at baseline. Looking at implant the percent of participants who were able to name implant as a method of FP without probing was higher at midline than at baseline across all groups. Chi square test was carried out for Community Radio upazilas to see association between baseline and midline of knowledge of LARC. A p-value <0.05 indicates that the knowledge of IUD and Implant varied (decrease or increase) significantly between baseline and midline. There was a statistically significant difference between baseline and midline knowledge of IUD for all groups and a statistically significant difference between baseline and midline knowledge of Implant for the group women and for the group men.

Further, the p-value indicates a statistically significant difference between baseline and midline for the following methods, condoms (all groups), emergency contraceptives (women), injectables (adolescents), periodic abstinence (all groups), withdrawal (all groups), male sterilization (women and adolescents), female sterilization (all groups) with a p-value<0.05. A p-value <0.05 indicates that knowledge of FP method varied (decrease or increase) significantly between

baseline and midline. Important to bear in mind is that the p-value may indicate a significant difference if the percentage of any category (yes(spont.), yes(probe) or no) varied significantly.

Table 16 Knowledge of family planning methods in Community Radio Upazilas

Contraceptive method		Women			Adolescent			Men		
		Baseline	Midline	P value	Baseline	Midline	P value	Baseline	Midline	P value
		(N=210)	(N=130)		(N=47)	(N=75)		(N=60)	(N=100)	
		%	%		%	%		%	%	
Condom	Yes(spont.)	64.3	92.3	<0.001	46.8	89.3	<0.001	75.0	97.0	<0.001
	Yes(prob.)	31.9	7.7		42.6	10.7		25.0	3.0	
	No	3.8	0.0		10.6	0.0		0.0	0.0	
Pill	Yes(spont.)	97.6	98.5	0.847	95.7	97.3	0.445	98.3	100.0	0.195
	Yes(prob.)	1.4	0.8		4.3	1.3		1.7	0.0	
	No	1.0	0.8		0.0	1.3		0.0	0.0	
Emergency contraception	Yes(spont.)	1.9	3.9	0.003	0.0	2.7	0.415	6.7	4.0	0.379
	Yes(prob.)	13.8	27.7		8.51	12.0		8.3	15.0	
	No	84.3	68.5		91.5	85.3		85.0	81.0	
Injectable	Yes(spont.)	81.0	88.5	0.16	53.2	68	0.034	63.3	56.0	0.501
	Yes(prob.)	18.6	11.5		31.9	29.3		33.3	37.0	
	No	0.5	0.0		14.9	2.7		3.3	7.0	
IUCD/ Copper-T	Yes(spont.)	26.2	46.2	<0.001	0.0	18.7	0.009	5.0	23.0	0.006
	Yes(prob.)	47.6	43.1		25.5	24		45.0	44.0	
	No	26.2	10.8		74.5	57.3		50.0	33.0	
Implant	Yes(spont.)	51.4	66.2	0.003	23.4	42.7	0.087	11.7	30.0	0.007
	Yes(prob.)	41.4	33.1		38.3	33.3		46.7	47.0	
	No	7.0	1.0		38.0	24.0		42.0	23.0	
Periodic abstinence	Yes(spont.)	12.4	26.9	<0.001	6.4	14.7	0.027	8.3	28.0	0.005
	Yes(prob.)	53.8	62.3		29.8	46.7		56.7	52.0	
	No	33.8	10.8		63.8	38.7		35.0	20.0	
Withdrawal	Yes(spont.)	3.3	10.0	<0.001	4.3	14.7	0.021	6.7	17.0	0.003
	Yes(prob.)	41.4	62.3		34.0	48.0		53.3	66.0	
	No	55.2	27.7		61.7	37.3		40.0	17.0	
Male sterilization	Yes(spont.)	12.9	20.0	<0.001	2.1	10.7	0.002	16.7	30.0	0.124
	Yes(prob.)	62.4	73.1		34.0	57.3		68.3	61.0	
	No	24.8	6.9		63.8	32.0		15.0	9.0	
Female sterilization	Yes(spont.)	22.9	49.2	<0.001	2.1	33.3	<0.001	16.7	38.0	0.001
	Yes(prob.)	72.0	50.0		68.0	59.0		68.3	59.0	
	No	5.2	0.8		29.8	8.0		15.0	3.0	

Knowledge of LAPM for participants in Community Radio upazilas

Among the women 57.7 percent were able to name two LAPM methods without probing at midline, at baseline the percent was 32.9 percent (Table 17). A third (32 percent) of the adolescent participants were able to name at least two LAPM at midline, at baseline the percent was 2.1 percent. Among men 34 percent were able to name at least two LAPM methods, at baseline the percent was 18.3 percent. Chi-square test was carried out to see the association between baseline and midline knowledge of LAPM. The p-value $p<0.05$ indicates that there is a statistically significant difference between baseline and midline knowledge of LAPM for all three groups. Important to note is as with the Cmmunity Engagement upazilas is that this is for knowledge of <2 LAPM and knowledge of at least 2 LAPM.

Table 17 Knowledge of LAPM in Community Radio upazilas

Knowledge on LAPM	**Women**			**Adolescent**			**Men**		
	Baseline (N=210)	Midline (N=130)	P value	Baseline (N=47)	Midline (N=75)	P value	Baseline (N=60)	Midline (N=100)	P value
<2 LAPM	67.1	42.3	<0.001	97.9	68.0	<0.001	81.7	66.0	<0.001
At least 2 LAPM	32.9	57.7		2.1	32.0		18.3	34.0	

Current use of FP methods in Community Radio upazilas

Among the study participants who reported using a FP method the distribution of the type of method is shown in table 18. The percent of women using implant was 3.2 percent at midline and 4.3 percent at baseline, for the adolescents the percentage was 2.9 percent at midline and 0 percent at baseline, for men the percent of participants using implant at midline was 2.7 percent and at baseline it was 6.2 percent. Fisher exact test was performed and the p-value for women ($p=0.013$) indicate that the use of FP methods varied significantly between baseline and midline for women as $p<0.05$.

Table 18 Current use of FP methods in Community Radio upazilas

FP method	**Women**		**P value**	**Adolescent**		**P value**	**Men**		**P value**
	Baseline (N=162) (%)	Midline (N=94) (%)		Baseline (N=20) (%)	Midline (N=34) (%)		Baseline (N=48) (%)	Midline (N=73) (%)	
Condom	9.9	9.6	0.013	5.0	32.3	0.107	4.2	15.1	0.178
Pill	50.0	55.3		65.0	38.2		56.2	56.1	
Injectables	20.3	7.4		15.0	8.8		16.7	6.9	
Emergency pill	0.0	0.0		0.0	0.0		0.0	0.0	
IUCD	1.2	2.1		0.0	0.0		4.8	2.7	
Implant	4.3	3.2		0.0	2.9		6.2	2.7	
Periodic abstinence	13	12.7		10.0	8.8		10.4	5.5	
Withdrawal	1.2	4.1		5.0	8.8		2.1	4.1	
Male sterilization	0.0	2.1		0.0	0.0		0.0	2.7	
Female sterilization	0.0	3.1		0.0	0.0		0.0	4.1	

6. Methodological Considerations

There are a number of limitations to consider. As the study is cross-sectional no casual inference can be made. In the upazila where the SBC activities took place there are other community access and awareness activities taking place. The study relies on self-reported data which can lead to social desirability bias where the respondent answers in a way that is viewed favourable to others. The presence of an interviewer can also affect the respondent answers. Therefore, the field data collectors received training on data collection procedures and also received support from study team throughout the data collection period. A few of the questions in the English questionnaire were ambiguous (appendix I, questions 512 and 517) and could be interpreted in two ways and thus measure two different components, posing reliability and validity issues. However, when asked in Bangla the meaning and interpretation of the questions were not ambiguous and no accounts of confusion over the questions have been detected, from pilot testing to data collection.

Further, it is important to bear in mind that the respondents from the three groups (women, adolescents and men) can belong to the same household which mean that respondents' answers might be influenced by contextual factors within the household. Therefore, we cannot compare the groups. Additionally, as the SBC interventions focuses on married women and men the perspective of unmarried women and men are not included in the study. Despite these limitations this study provides valuable insights to current use of FP and knowledge of and attitudes towards MR, PAC and FP among the respondents.

7. Discussion

Looking at the results from all upazilas, the study shows that the knowledge level of LAPM in all groups were higher at midline than at baseline and that the difference in observation between midline and baseline was statistically significant. The use of LAMP is lower than the use of short acting methods, which is expected and in line with national level data [3]. The study show that there are misconceptions and/or fear about side effects which confirmes findings from previous research [6]. The perception of whether implants breaks down or not was quite high, with almost half of the respondents agreeing with the statement both at baseline and midline. At midline, pill was still the most commonly known FP method across all groups. Further, pill was the most commonly used method of FP for women and adolescent who were actively doing something to avoid getting pregnant. This study finds that the usage of LARCs was higher among both women and adolescents at midline than at to baseline. At midline, 14 percent of the women were either using implant or IUD, which is higher than the national average of 3 percent (combined for implant and IUD) [3].The difference in the observation for women was statistically significant. Although the percentage of adolescents was higher than national average it is still quite low and the difference in the observation was not statistically significant, thus we cannot determine the observed changes to be real. The low use of IUD among adolescents might be due to the restriction on IUD, that is that a woman needs to have at least one living child to be eligible for

IUD. Nonetheless, 67 percent of the adolescents at midline had given birth to at least one child and were thus eligible for IUD.

As reported in the result section, the knowledge level of PPFP was higher at midline than at baseline for the three groups, the observed difference between baseline and midline was only statistically significant for men. Among the women the knowledge of PAFP was also higher at midline than at with baseline the observed difference was statistically significant. However, the percentage of adolescents who had heard about PAFP was lower at midline compared with baseline, the observed difference was not statistically significant, thus we cannot determine the observated changes to be real. Although no association can be drawn, the percentage among women attending an educational session on MR and PAC was higher than the percentage among the adolescents who attended such sessions.

Although the percentage of women and of adolescents who reported being able to get a MR if she wanted was higher at midline than at baseline, it was less than 50 percent for women and less than 30 percent for adolescents. This even though over 90 percent of both the women and the adolescents knew where in the community they could get an MR. The aim of this study was not to assess the relationship between variables and this is worth bearing in mind, but a possible explanation to the above can be found in previous research which show that women in Bangladesh lack both economic and reproductive decision-making power. This study finds that almost 37.8 percent of the women and 44.8 percent of the adolescents were unable to pay for the cost of a MR procedure, about 90 percent of the women and 98 percent of the adolescents were not earning an income of their own and about half of the respondents in both groups were not able to tell their family if they wanted to have an MR. In addition, 61.5 percent of the women and 45 percent of the adolescents were under the perception that an MR costs more than other treatments. These are factors that can affect women's self-efficacy.

The FP educational sessions most frequently covered FP methods. Women and adolescents also attended educational sessions covering topics on the sources of FP services and on how to use the methods. A majority of the women and the adolescents who attended an educational session on FP continued to attend sessions after the first session, which could indicate that they were satisfied with the sessions or wanted to learn more. The study shows that about one fourth of the women, one third of the adolescents, and two fifths of the men listened to the radio. The study finds that there is a difference in the time for when women, adolescent and men prefer to listen to the radio. Additionally, the study finds that the favourite radio programmes were songs and news. Important findings for the design to SBC interventions.

Looking at the results from the analysis of Community Radio upazilas and Cmmunity Engagement upazilas separately the study shows that the knowledge level of LAPM in the

Cmmunity Engagement upazilas varied significantly between baseline and midline for all groups. This was also observed in the Community Radio upazilas. For knowledge of at least two LAPM the proportion of women in the Cmmunity Engagement upazila who could name at least two LAPM was 70 percent and the proportion of women in the Community Radio upazilas was 57.7 percent, among adolescents the proportion in the Cmmunity Engagement upazila was 49.1 percent and the proportion of adolescents in the Community Radio upazilas was 32 percent, among men the proportion in the Cmmunity Engagement upazila was 42 percent and the proportion of men in the Community Radio upazilas was 34. For use of FP methods, the observed proportion of the participants in all three groups reporting using LARC methods were higher at midline in the Cmmunity Engagement upazilas than the observed proportion in the Community Radio upazilas.

8. Conclusion and Recommendation

In conclusion, the study shows that the knowledge level of LAPM for all respondent groups in the QFP community intervention upazilas was noticeably higher at midline than at baseline. Knowledge and practice are closely related which is apparent in the result of current use of LARC among women and adolescents. For women participating in the study the current use of LARC was 14.2 at midline and 6.9 percent at baseline, for adolescent, the percent of the current use of LARC at midline was 5.1 percent and 2.5 percent at baseline.

The overall objective of SBC intervention was to create an environment that supports women and girls in accessing a full range of family planning (FP) services, menstrual regulation (MR) and post-abortion care (PAC) services. The study results suggest that the SBC interventions strengthened the environment around FP, MR and PAC in the target communities through delivering the right knowledge on FP, MR and PAC services, and continuous advocacy on its adaptation. Overall, the interventions seem to have contributed to a change in knowledge and practice level, improved perceptions regarding FP methods and MR and seem to have contributed to improved positive attitudes towards LAPM and MR.Additionally, the government's regular SBC interventions mainly implemented by the DGFP may have contributed/strengthened the changes detected.

Recommendations:

1. Ongoing community awareness and SBC interventions on FP, MR and PAC and on women's and girls' self-efficacy in relation to MR and FP are needed
2. More collaboration and co-ordination with the government health system is needed to strengthen the interventions

3. Mainstreaming community mobilization activities in government health system need to be considered with high priority for program sustainability.

4. Training on FP, MR and PAC services should be provided to the community leaders and youths to make themselves as a spokesman within their community.

5. Any future intervention should address stigma around LAPM and MR,

9. References

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10. Appendix 1: Questionnaire at midline: Women and Adolescents – English

SBC Midline Evaluation
WOMEN'S QUESTIONNAIRE

PSU IDENTIFICATION	**CODES**
1. Name of Division: _____	☐
2. Name of District: _____	☐☐
3. Name of Upazila: _____	☐☐
4. Name of Village: _____	☐☐
5. Name of PSU: _____	☐☐
RESPONDENT IDENTIFICATION	
6. Household Identification Number:_____	☐☐☐
7. Relationship to household head _____	☐☐
8. Respondent Identification Number: _____	☐
INTERVIEW STATUS	
Date of Interview: Day Month Year ☐☐☐☐☐☐ 9. Interview Status: 1. Completed 2. Partly completed 3. Refused by respondent 4. Refused by husband/other 5. Not at home 6. Not eligible (specific): _____ 7. Other (State reason	

Name and Code	**Interviewer**	**Reviewed By**	**Entered By**
	☐☐	☐☐	☐☐

	Start time ☐☐☐☐	End time ☐☐☐☐	

SECTION 1: DEMOGRAPHICS

Q #	QUESTION	CODES	Go to Q
101	How old were you at your last birthday? [COLLECT AGE IN COMPLETED YEARS]	Age in completed years ☐☐	
102	Have you ever attended school?	Yes .....1 No 2	 105
103	What is the highest grade/year you completed at that level?	Highest grade/year ☐☐	106
104	Can you read and write?	Read only .....1 Write only .....2 Read and write .....3 Can't read and write.....4	
105	What is your current marital status?	Currently married.....1 Separated/divorced.....2 Widowed.....3 Unmarried 4	 109
106	How old were you at the time of your marriage?	Age in completed years ☐☐	
107	How old is your husband?	Age in completed years ☐☐	
108	What is your religion ?	Islam.....1 Hindu.....2	

		Buddhist .....3 Other (specify)_____ 4	

SECTION 2: SOCIOECONOMIC STATUS

Q #	QUESTION	CODES	Go to Q
201	Have you done any work in the last year for which you have been paid in cash, in kind, or both?	Yes, only cash.....1 Yes, only kind.....2 Yes, both cash and kind.....3 No, not working.....4 Don't know/refused 99	
202	Do you work outside your home?	Yes .....1 No 2	205
203	What is your occupation? ***PROBE: What kind of work do you mainly do?***	_____ _____	
203a	What is your monthly income?	Total in local currency_____ Don't know/ Refused.....…99	
205	What is the average monthly income of your household?	Total in local currency_____ Don't know/ Refused.....…99	

Section 3: Reproductive History

301	Have you ever been pregnant?	Yes..... No ..... Refused.....	401
302	How many times have you become pregnant (include all pregnancies including the recent one)?	Total number of pregnancies Not sure/can't say.....	☐

303	Among all your live births, how many children are alive now?	_____ Male live births _____ Female live births _____ Total live births	
304	Have you ever done anything to try to terminate an unwanted pregnancy?	Yes ..... No	401
		Do not know	
305	If yes, how many pregnancies have you tried to terminate?	Total number	☐
306	Who provided the termination? **(CIRCLE ALL RESPONSES GIVEN)**	Doctor ..... FWV ……..……2 Nurse ..... TBA ..... Pharmacist/Drug sellers....…… 5 Relative..... Self..... Other (specify).....	
307	What are all the ways you tried to terminate a pregnancy? **(DO NOT PROMPT, CIRCLE ALL RESPONSES GIVEN)**	MRM ..... MVA..... D&C ..... Took medicine from a pharmacy/drug seller ..... Inserted something into vagina ..... Trauma to the abdomen ..... Other (specify)_____.....	

SECTION 4: WOMEN'S FAMILY PLANNING HISTORY

401	Have you ever heard of anything a person can do to avoid getting pregnant?	Yes ..... No	
402 403	402: Which methods of preventing/avoiding pregnancy have you heard about? Allow participants to name methods without any prompting. Which methods have you heard about? Read (method) for those who did not answer spontaneously		403: Have you ever used (Method)
	1 Condom	Yes (spont)..... 1 Yes (prob) ..... 2 No ..... 3 ↴	Yes ..... 1 No 2
	2 Pills	Yes (spont)..... 1 Yes (prob) ..... 2 No ..... 3 ↴	Yes ..... 1 No 2
	3 Emergency contraception	Yes (spont)..... 1 Yes (prob) ..... 2 No ..... 3 ↴	Yes ..... 1 No 2
	4 Injectable	Yes (spont)..... 1 Yes (prob) ..... 2 No ..... 3 ↴	Yes ..... 1 No 2
	5 IUCD/Copper-T	Yes (spont)..... 1 Yes (prob) ..... 2 No ..... 3 ↴	Yes ..... 1 No 2
	6 Implant	Yes (spont)..... 1 Yes (prob) ..... 2 No ..... 3 ↴	Yes ..... 1 No 2
	7 Periodic abstinence	Yes (spont)..... 1 Yes (prob) ..... 2 No ..... 3 ↴	Yes ..... 1 No 2
	8 Withdrawal	Yes (spont)..... 1 Yes (prob) ..... 2 No ..... 3 ↴	Yes ..... 1 No 2
	9 Male sterilization	Yes (spont)..... 1	Yes 1

		Yes (prob) ..... 2 No ..... 3 ↴	No 2
	10 Female sterilization	Yes (spont)..... 1 Yes (prob) ..... 2 No ..... 3 ↴	Yes ..... 1 No 2
	11 Other (specify)_____	Yes (spont)..... 1 No ..... 3 ↴	Yes ..... 1 No 2
404	Are you currently pregnant?	Yes ..... 408 No ..... Never had sex ..... 408 Do not know	
405	Are you currently doing anything to delay or avoid getting pregnant?	Yes ..... No 407	
406	Which method are your currently using to delay or avoid pregnancy?	Condom ..... Pills ..... Emergency Contraception (EC) ..... Injectables ..... IUCD ..... Implant ..... Periodic abstinence ..... Withdrawal ..... Male sterilization ..... 408 Female sterilization ..... Other (specify)_____	

407	If no, what are your reasons for not delaying/avoiding getting pregnant? PROBE: Any other reason? **(CIRCLE ALL RESPONSES GIVEN)**	**Fertility related reasons** Want more children ..... Had hysterectomy/female sterilization ..... Sub fecund/infecund..... **Opposition to use** Opposed to contraception ..... Husband or boyfriend opposed.. Other family members/friends opposed..... Against religion ..... **Access/Knowledge** Knows no method..... Knows no source ..... Hard to get method/provider too far away/clinic hours restrictive ..... **Method related reasons** Health concerns ..... Fears side effects ..... Fears insertion/procedure/treatment.... Not effective ..... Inconvenient ..... Costs too much ..... Don't like existing methods..... Embarrassed ..... **Not having sex** Not having sex/infrequent sex/partner away..... **Other reasons** Other (specify) _____20 Do not know	
408	From one menstrual period to the next, when is a woman more likely to become pregnant if she has sexual relations? For example, the time just before her period begins, during her period, right after her period has ended, or mid-way between two periods?	Just before her period ..... During her period..... Right after her period..... Half way ..... Other (specify)_____ ..... Do not know	

409	What are the symptoms of pregnancy? **(CIRCLE ALL RESPONSES GIVEN)**	A missed period..... Tender or enlarged breasts .... Nausea ..... Frequent urination ..... Increased or decreased appetite ..... Do not know .....
410	Have you ever heard of post-partum family planning?	Yes…… ……...1 No…… ……2
411	Have you ever heard of post-abortion family planning?	Yes…… ……...1 No…… ……2
412	***Ask 412-414 if respondent answered "Yes" to any of the questions in above (410-411), Otherwise skip to 501)*** What are post-partum or post abortion family planning methods	Condom ..... Pills..... Emergency Contraception (EC) ..... Injectables..... IUCD ..... Implant..... Periodic abstinence..... Withdrawal ..... Male sterilization..... Female sterilization ..... Other (specify)_____ .....
413	From where one can get PPFP and PAFP methods?	Public hospital ..... Private hospital ..... FWC ..... Community Clinic ..... NGO Clinic..... Get pills from pharmacy..... CSBA..... Medical doctor..... Nurse ..... TBA ..... Other traditional Healer (Kabiraj) ..... Village practitioner (unqualified) ..... Other (specify) ..... No idea/Do not know .....

414	Why it is important to use a method immediately after abortion/delivery?	To avoid getting pregnant again immediately after abortion/delivery…..01 Ohers……02 No idea/Do not know……... 98

Section 5: Perception/myth on FP method					
Interviewer, please read to the respondent: The purpose of this portion of the interview is to gain information about women's feelings and experiences around FP methods. There are no right or wrong answers. First, I'd like to ask you about things you may have been thinking about in regards to pill. The possible responses are: strongly disagree, disagree, agree or strongly agree.					
Number	**Items**	**Response Options**			
	Statement	**Strongly disagree**	**Disagree**	**Agree**	**Strongly agree**
501	Pills burn the uterus	1	2	3	4
502	Pill can cause infertility	1	2	3	4
503	Newly-wed couples should take Pill	1	2	3	4
504	Women with no child should take Pill	1	2	3	4
505	Combined Pill can cause cancer	1	2	3	4
505a	Pill cause crippled children	1	2	3	4
Interviewer, please read to the respondent who heard about condom: The possible responses are: strongly disagree, disagree, agree or strongly agree.					
506	Condom may reduce pleasure of sex	1	2	3	4
507	Condom can cause a man to become weak and impotent (Problem of erection of penis)	1	2	3	4
Interviewer, please read to the respondent who heard about injectables: The possible responses are: strongly disagree, disagree, agree or strongly agree.					
508	Breastfeeding mothers can use injectables	1	2	3	4
509	All women, irrespective of age, with no children can use injectables	1	2	3	4
510	Injectables can cause cancer	1	2	3	4
511	Injectables can cause infertility	1	2	3	4
511.a	Injectable causes irreguler meanstruation	1	2	3	4
Interviewer, please read to the respondent who heard about Implant: The possible responses are: strongly disagree, disagree, agree or strongly agree.					
512	Women, irrespective of age, having no children can use implant	1	2	3	4

513	Implant can cause cancer	1	2	3	4
514	Obese women should refrain from using implant	1	2	3	4
515	Implant breaks down/displaced	1	2	3	4
516	Woman can work normally after adopting implant	1	2	3	4

Interviewer, please read to the respondent who heard about IUD/Copper-T: The possible responses are: strongly disagree, disagree, agree or strongly agree.

		Strongly disagree	**Disagree**	**Agree**	**Strongly agree**
517	Women, irrespective of age, having no children can use IUD/Copper-T	1	2	3	4
518	IUD users can conceive after having their IUD removed	1	2	3	4
519	Women of all age can use IUD/Copper-T	1	2	3	4
520	One can use/adopt IUD immediately after abortion	1	2	3	4

Interviewer, please read to the respondent who heard about Tubectomy: The possible responses are: strongly disagree, disagree, agree or strongly agree.

		Strongly disagree	**Disagree**	**Agree**	**Strongly agree**
521	Tubectomy does not affect sexual power	1	2	3	4
522	Tubectomy reduces ability to work hard	1	2	3	4

Section 6: Reproductive Health and menstrual regulation Knowledge, Attitudes and Skills

I'm now going to ask you more general questions about the availability of menstrual regulation in Bangladesh and attitudes about menstrual regulation. Please know that this is not a test and that your answers will be put together anonymously with the answers of many other women your age.

Q. #	**Question**	**Codes**	**Go to Q**
601	Do you think menstrual regulation is legal?	Yes .....1 No .....2 Do not know 8	 603 603
602	Up to what length (month or weeks of menstruation stops) is menstrual regulation legal in Bangladesh?	Up to (weeks) ☐☐ No idea / Do not know.....98	

Q. #	Question	Codes	Go to Q
	(PROBE & TRANSFER MONTHS INTO WEEKS)		
603	Do you think menstrual regulation is legal only for married women?	Yes .....1 No .....2 Do not know 8	
604	**Now, I would like to talk about different methods by which menstrual regulation can be performed – the various ways in which a couple can end an unwanted pregnancy.** Have you ever heard of any menstrual regulation method?	Yes .....1 No 2	606
605	If yes, what? **PROBE FOR OTHERS UNTIL THEY HAVE NO MORE.** Any other? **(CIRCLE ALL RESPONSES GIVEN)**	MRM.....1 MVA .....2 D&C .....3 Other (specify)_____ 4	
606	Where do women go in your community if they want to end an unwanted pregnancy? **(CIRCLE ALL RESPONSES GIVEN)**	Public hospital .....1 Private hospital .....2 FWC .....3 Community Clinic .....4 NGO Clinic.....5 Get pills from pharmacy .....7 CSBA.....8 Medical doctor.....9 Nurse.....10 TBA .....11 Other traditional Healer (Kabiraj) .. 12 Village practitioner (unqualified) ... 13 Other (specify) .....14 No idea/Do not know..... 98	
607	How did you learn about the MR provider? (SELECT ALL THAT APPLY)	Friend…….1 Family member……..2 Medical provider……3 Pharmacist……..4 Traditional Birth Attendant……....5 Community Health Provider……..6	

Q. #	Question	Codes	Go to Q
		Radio…… .7 Television……...8 Internet……...9 Newspaper……10 Theater for drama show……11 Poster/billboard/painting……...12 Information Pamphlets……..13 Telephone hotline……..14 Peer Educator……15 Community leader…….16 Women's Group……17 Other (Specify)…….88 Don't know/Refused……99	
608	**For all locations indicated in the chart, please fill in the following chart:**		

	Location	**Would you go to the following locations for abortion services?**		**Why or why not?**
		Yes	No	
608.1	The nearby local hospital/clinic	1	2	
608.2	Pharmacist/chemical seller in the community	1	2	
608.3	The traditional birth attendant in the community	1	2	
608.4	Midwife/nurse's place for medicine	1	2	
608.5	A friend's place to get medication	1	2	
608.6	Someone else (Please specify ……..	1	2	

609	In your knowledge, what is the nearest location where someone can access menstrual regulation services from a health care provider?	_____ (Write name of the place) Do not know 98	
610	What are the key barriers to women of your community accessing safe MR services? *(Choose all that apply)*	Attitude of friends and relatives …..……..1 Attitude of health care providers …..…….2 Fear of pregnancy being exposed at health facility……..…...3 Insults and ridicule by community members..4 Lack of knowledge of where to go ..…….5 Financial difficulties …..……...6 Distance to facilities …….7 Inconvenient hours at facilities…..……8 Their status as unmarried girls ……..9 Their status as students …..……..10 Parental consent ……...11 Other (specify)……12 …	701 701
611	If a woman experiences a complication after an unsafe MR, where will she go for help? *(Choose all that apply)*	Public hospital .....1 Private hospital .....2 FWC .....3 Community Clinic.....4 NGO Clinic .....5 Get pills from pharmacy.....7 CSBA .....8 Medical doctor .....9 Nurse .....10 TBA .....11 Other traditional Healer (Kabiraj)..... 12 Village practitioner (unqualified)..... 13 Other (specify) .....14 No idea/Do not know 98	

SECTION 7: WOMEN'S SELF EFFICACY TO SEEK A MR

Q #	QUESTION	CODES				
701	**For the following questions, please indicate whether you agree or disagree with the statement.**	**Strongly Disagree**	**Disagree**	**Unsure**	**Agree**	**Strongly Agree**
A	If I wanted to have MR I could	1	2	3	4	5
B	I know where to get MR in my community	1	2	3	4	5
C	I am able to pay the cost to	1	2	3	4	5

	travel to get MR					
D	I am able to pay the cost to have the MR procedure	1	2	3	4	5
E	I could speak with MR provider (doctor, nurse, midwife) if I wanted have MR	1	2	3	4	5
F	I could tell my husband if I wanted to have MR	1	2	3	4	5
G	I could tell my friend if I wanted to have MR	1	2	3	4	5
H	I could tell my family if I wanted to have MR	1	2	3	4	5
I	I could tell other members of my community if I wanted to have MR	1	2	3	4	5
J	I know the difference between a safe MR provider and an unsafe MR provider	1	2	3	4	5

SECTION 8: WOMEN'S ATTITUDES TOWARD MR

		Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
801	A woman who has had a MR should be prohibited from going to religious services.	1	2	3	4	5
802	A woman who has MR is committing a sin.	1	2	3	4	5
803	Once a woman has one MR, she will make it a habit.	1	2	3	4	5
804	A woman who has had MR cannot be trusted.	1	2	3	4	5
805	I would tease a woman who has had MR so that she will be ashamed about her decision.	1	2	3	4	5
806	A woman who has MR brings shame to her family.	1	2	3	4	5
807	A woman who has MR can make other people fall ill or get sick.	1	2	3	4	5

808	I would try to disgrace a woman in my community if I found out she'd had MR.	1	2	3	4	5
809	A woman who has MR should be isolated from other people in the community for at least 1 month after having MR.	1	2	3	4	5
810	A woman should be able to have MR if she cannot afford the child.	1	2	3	4	5
811	A man should not marry a woman who has had MR because she may not be able to bear children.	1	2	3	4	5
812	I would stop being friends with someone if I found out that she had MR.	1	2	3	4	5
813	A woman who has had MR might encourage other women to get abortions.	1	2	3	4	5
814	A young girl or woman should be able to have MR if she wants to continue her studies.	1	2	3	4	5
815	A woman should be able to have MR if she does not want any more children.	1	2	3	4	5
816	A woman who has a MR brings shame to her community.	1	2	3	4	5
817	I would point my fingers at a woman who had a MR so that other people would know what she has done.	1	2	3	4	5
818	A woman who has a MR should be treated the same as everyone else.	1	2	3	4	5
819	Menstrual regulation usually costs more than any other treatment.	1	2	3	4	5
820	Doctors usually charge more for menstrual regulation if a woman is unmarried.	1	2	3	4	5
821	In this community, menstrual regulation among **unmarried** women are usually treated as being acceptable.	1	2	3	4	5
822	In this community, menstrual regulation among **married** women usually treated as acceptable.	1	2	3	4	5
823	I alone can decide when I want to have children.	1	2	3	4	5

824	I feel comfortable initiating discussions about issues related to menstrual regulation with my friends.	1	2	3	4	5
825	Having menstrual regulation with an untrained provider can result in severe complications for women, including death.	1	2	3	4	5
826	There is a negative risk to a woman's health if menstrual regulation is performed when she is more than 12 weeks pregnant.	1	2	3	4	5
827	Menstrual regulation causes infertility.	1	2	3	4	5
828	Repeated menstrual regulation is harmful to women's health.	1	2	3	4	5

SECTION 9: Exposure to the Community Access Program

Q #	QUESTION	CODES	Go to Q
901	Have you attended at least one educational session in your community about FP including PPFP and PAFP in the last year?	Yes ..... 1 No 2	 905
902	What was the name of the person or group who led the session(s) on FP FP including PPFP and PAFP? (***Interviewer****: choose all that apply. If respondent names an organization, please indicate by the appropriate category*)	Medical provider (nurse, doctor, CSBA, FWV, midwife, etc.)…… ……..01 CHCP (Community Health Care Provider)… 02 Pharmacist/drug sellers……03 Traditional birth attendant/ Dai/ traditional healers/ village doctors……04 FWA……05 HA……...06 NGO community health worker……. 07 HI (Health Inspector)……..……08 AHI (Assistant Health Inspector)……09 FPI (Family Planning Inspector)…….10 Theater for drama (TFD) show …..…… 11 Community leader(s)……. …….12 Women's group……. ..13 Community based organization…….. 14 Listener club meeting…… .15 Stakeholders meeting……..16 Imam or religious leader…….17 Other (specify) _____.....18 Don't know/Refused…….. 99	
903	How many educational sessions on FP including PPFP and PAFP have you attended in the last year?	One ..... 1 Two to Five ..... 2 Six to Ten ..... 3 More than ten 4	
904	What are some of the topics that were covered in the educational session(s)?	Contraceptive or family planning methods ..... 1 Source of contraceptive /FP services 2 Cost of contraceptive/ FP methods ... 3 How to use contraception /FP methods ..... 4 Possible side effects from the use of contraception / FP methods..... 5 Other (specify)_____ 6	
905	Have you attended any educational	Yes 1	

	sessions in your community about MR/PAC in the last year?	No 2	909
906	What was the name of the person or group who led the session(s) on MR/PAC? (***Interviewer:*** *choose all that apply. Ask respondent to name specific examples of each organization or community group they choose*)	Medical provider (nurse, doctor, CSBA, FWV, midwife, etc.)…… ……...01 CHCP (Community Health Care Provider)… 02 Pharmacist/drug sellers……03 Traditional birth attendant/ Dai/ traditional healers/ village doctors……04 FWA……05 HA……...06 NGO community health worker……. 07 HI (Health Inspector)……..……08 AHI (Assistant Health Inspector)……09 FPI (Family Planning Inspector)…….10 Theater for drama (TFD) show …..…… 11 Community leader(s)……. …….12 Women's group……. ..13 Community based organization…….. 14 Listener club meeting…… .15 Stakeholders meeting……..16 Imam or religious leader…….17 Other (specify) _____.....18 Don't know/Refused…….. 99	
907	How many educational sessions on MR/PAC have you attended in the last year?	One ..... 1 Two to Five ..... 2 Six to Ten ..... 3 More than ten 4	
908	What are some of the topics that were covered in the educational session(s)?	Where to get menstrual regulation .... 1 Possible complications ..... 2 Cost of menstrual regulation ..... 3 Methods of menstrual regulation ..... 4 Stories of other women who had induced menstrual regulation ..... 5 Legality of menstrual regulation ..... 6 Other (specify)_____ 7	
909. a	What types of Radio you listen most?	Bangladesh Betar.....1 Community Radio……..2 FM band.....3 Don't listen radio…….....4	**END**
909. b	Radio set or mobile phone ; what do you use to listen to radio ?	Radio set..... ……..1 Mobile ..... ……..2 Both..... ……..3	

		Other(Please mention.....4	
909. c	Do you know the name of the local community radio station?	Yes ..... …….1 (If yes,please mention.....) No 2	
909. d	What type of radio program do you like most ? (Select all that apply)	Music..... …….1 Talk show..... …….2 News..... …….3 Magazine program ..... …….4 Drama..... …….5 Others(Please mention).....…..6	
909	Have you heard a community radio program where FP and MR/PAC was discussed in the last year?	Yes ..... 1 No..... 2	END
910	How many times did you listen to the community radio program in the last year?	One ..... 1 Two to Five ..... 2 Six to Ten ..... 3 More than ten……..4	
911	What were the topics that you heard about on the radio program?	Contraceptive or family planning methods ..... 1 Source of contraceptive /FP services 2 Cost of contraceptive/ FP methods ... 3 How to use contraception /FP methods ..... 4 Possible side effects from the use of contraception / FP methods..... 5 Where to get menstrual regulation .... 6 Possible complications..... 7 Cost of menstrual regulation ..... 8 Methods of menstrual regulation ..... 9 Stories of other women who had induced menstrual regulation ..... 10 Legality of menstrual regulation ..... 11 Other (specify)_____ .. 12	
912	What time do you prefer to listen program of community radio? (Select all that apply)	9.00-12.00 ..... 1 12.00-15.00 ..... 2 15.00-18.00 ..... 3 18.00-24.00 ..... 4 Always 5	

913	Are you the member of Radio listener group/club ?	Yes ..... ……1 No 2	**END**
914	How often the member of radio listeners group/club sit together for discussion?	Once in a week..... ……..1 Once in a 15 days..... ……..2 Monthly or more ..... ……..3 Don't know ..... ……..4	
915	Mainly where the meeting of radio listen's group/club is held ?	Courtyard of member's house ……..1 Office of community radio..... ……..2 Office of public representative……..3 Others..... ……..4 (Please mention----------)	

Thank You

11. Appendix 2: Questionnaire at midline: Men – English

SBC Midline Evaluation
MEN'S QUESTIONNAIRE

PSU IDENTIFICATION	**CODES**
6. Name of Division: _____	☐
7. Name of District: _____	☐☐
8. Name of Upazila: _____	☐☐
9. Name of Union:_____	☐☐
10. Name of Village: _____	☐☐
11. Name of PSU: _____	☐☐
RESPONDENT IDENTIFICATION	
6. Household Identification Number:_____	☐☐☐
7. Relationship to household head _____	☐☐
8. Respondent Identification Number: _____	☐
INTERVIEW STATUS	
Date of Interview: Day Month Year ☐☐☐☐☐☐ 9. Interview Status: 8. Completed 9. Partly completed 10. Refused by respondent 11. Refused by husband/other 12. Not found at home 13. Not eligible (specific): _____ 14. Other (State reason	

Name and Code	**Interviewer**	**Reviewed By**	**Entered By**
	☐☐	☐☐	☐☐

	Start time ☐☐☐☐	End time ☐☐☐☐	

SECTION 1: DEMOGRAPHICS

Q #	QUESTION	CODES	Go to Q
101	How old were you at your last birthday? [COLLECT AGE IN COMPLETED YEARS]	Age in completed years ☐☐	
102	Have you ever attended school?	Yes ..... 1 No 2	 104
103	What is the highest grade/year you completed at that level?	Highest grade/year ☐☐	105
104	Can you read and write?	Read only ..... 1 Write only ..... 2 Read and write ..... 3 Can't read and write..... 4	
105	What is your current marital status?	Currently married..... 1 Separated/divorced..... 2 Widowed..... 3 Unmarried..... 4	 108
106	How old were you when your marriage?	Age in years ☐☐	
107	How old is your wife	Age in completed years ☐☐	
108	What is your religion?	Islam ..... 1 Hindu ..... 2 Buddhist..... 3 Other (specify)_____ 4	

SECTION 2: SOCIOECONOMIC STATUS

Q #	QUESTION	CODES	Go to Q
201	Have you done any work in the last week for which you have been paid in cash, in kind, or both?	Yes, only cash ..... 1 Yes, only kind ..... 2 Yes, both cash and kind..... 3 No, not working..... 4 Don't know/refused..... 99	
202	Do you work or study outside your home?	Yes ..... 1 No 2	
203	What is your occupation?	Manager……1 Professional ……..2 Technician…….3 Clerical support ……....4 Service and Sale ……...5 Skilled agriculture ……6 Craft and related trades…….7 Plant and Machine operators…….8 Manual/Elementary worker …… ….9 Student…….10 Other(specify)_____.....88	
204	What is the average monthly income of your household?	Total in local currency_____ Don't know/ Refused ..... …99	

SECTION 3: MEN'S SEXUALITY AND MR EXPERIENCE

Q #	QUESTION	CODES	Go to Q
301	Have you **ever** assisted wife in a MR?	Yes .....1 No .....2 Don't know/Refused……99	 401 401
302	Have you assisted wife in a MR in the **last year**?	Yes .....1 No .....2 Don't know/Refused……99	 401 401

303	Who provided the (last) MR your wife had? (CIRCLE ALL THAT APPLY)	Doctor .....1 Nurse.....2 Midwife .....3 Traditional birth attendant……..4 Friend.....5 Self.....6 Other (specify)_____ 88	
304	How did you learn about the MR provider? (SELECT ALL THAT APPLY)	Friend……1 Family member……..2 Medical provider……3 Pharmacist……..4 Traditional Birth Attendant……....5 Community Health Provider……..6 Radio…… .7 Television……...8 Internet……...9 Newspaper……10 Theater for drama show……11 Poster/billboard/painting……...12 Information Pamphlets……..13 Telephone hotline……..14 Peer Educator……15 Community leader…….16 Women's Group……17 Other (Specify)…….88 Don't know/Refused……99	
305	What were the ways you used to MR? (DO NOT PROMPT, CIRCLE ALL RESPONSES GIVEN)	MRM .....1 MVA.....2 D&C .....3 Took medicine from a pharmacy/drug seller .....4 Herbs .....5 Homemade concoction .....6 Inserted something in the vagina.....7 Trauma to the abdomen .....8 Other tablets (not MA) (specify)_____ 9 Other (specify)_____88	

SECTION 4: MEN'S FAMILY PLANNING HISTORY

401	Have you ever heard of any things a person can do to avoid getting pregnant?	Yes .....1 No 2	404

402 403	<u>402:</u> Which methods of preventing/avoiding pregnancy have you heard about? Allow participants to name methods without any prompting. Which methods have you heard about? Read (method) for those who did not answer spontaneously		<u>403:</u> Have you ever used the method with your current wife?
	1. Condom	Yes (spont) .....1 Yes (prob).....2 No.....3 ↴	Yes .....1 No 2
	2. Pills	Yes (spont) .....1 Yes (prob).....2 No.....3 ↴	Yes .....1 No 2
	3. Emergency contraception	Yes (spont) .....1 Yes (prob).....2 No.....3 ↴	Yes .....1 No 2
	4. Depo provera	Yes (spont) .....1 Yes (prob).....2 No.....3 ↴	Yes .....1 No 2
	5. IUCD	Yes (spont) .....1 Yes (prob).....2 No.....3 ↴	Yes .....1 No 2
	6. Implant	Yes (spont) .....1 Yes (prob).....2 No.....3 ↴	Yes .....1 No 2
	7. Periodic abstinence	Yes (spont) .....1 Yes (prob).....2 No.....3 ↴	Yes .....1 No 2
	8. Withdrawal	Yes (spont) .....1 Yes (prob).....2 No.....3 ↴	Yes .....1 No 2
	9. Male sterilization	Yes (spont) 1	Yes 1

		Yes (prob).....2 No.....3 ↴	No 2	
	10. Female sterilization	Yes (spont) .....1 Yes (prob).....2 No.....3 ↴	Yes .....1 No 2	
	11. Other (specify)_____ ___	Yes (spont) .....1 Yes (prob).....2 No.....3	Yes .....1 No 2	
404	Is your current wife pregnant now?	Yes .....1 No .....2 Never had sex .....3 Do not know 4		408 408
405	Are you currently doing anything to delay or avoid getting your wife pregnant?	Yes .....1 No 2		407
406	Which method are you currently using to delay or avoid pregnancy?	Condom.....1 Pills .....2 Emergency contraception .....3 Depo provera .....4 IUCD.....5 Implant.....6 Periodic abstinence .....7 Withdrawal .....8 Male sterilization .....9 Female sterilization.....10 Other (specify)_____88		
07	If no, what are your reasons for not delaying/avoiding getting your current partner/wife pregnant? (CIRCLE ALL RESPONSES GIVEN)	**Fertility related reasons** Want more children .....1 Hysterectomy/female sterilization .....2 Sub fecund/infecund .....3 **Opposition to use** Opposed to contraception .....4 Partner/Wife opposed .....5 Other family members opposed.....6 Against religion .....7 **Access/Knowledge**		

		Knows no method.....8 Knows no source.....9 Difficult to get a method/ provider lives far away/ Service center remains open for limited time, cannot go during opening time……10 **Method related reasons** Health concerns .....11 Fear of side effects.....12 Fears insertion/procedure/treatment 13 Not effective .....14 Inconvenient .....15 Costs too much .....16 Don't like existing methods.....17 Embarrassed.....18 Not have sex/ Irregular sex/ Husband stays away…….19 Other (specify)_____88 Don't Know……..99	
408	From one menstrual period to the next, when is a woman more likely to become pregnant if she has sexual relations? For example, the time just before her period begins, during her period, right after her period has ended, or mid-way between two periods?	Just before her period.....1 During her period.....2 Right after her period.....3 Half way.....4 Other (specify)_____88 Do not know 99	
409	What are the signs of pregnancy? (CIRCLE ALL RESPONSES GIVEN)	A missed period .....1 Tender or enlarged breasts.....2 Nausea.....3 Frequent urination.....4 Increased or decreased appetite .....5 Others…….6 Do not know 99	
410	Have you ever heard of post-partum family planning?	Yes…… ……...1 No……	

		…….2	
411	Have you ever heard of post-abortion family planning?	Yes…… ……...1 No…… …….2	
412	***Ask 412-414 if respondent answered "Yes" to any of the questions in above (410-411), Otherwise skip to 501)*** What are post-partum or post abortion family planning methods	Condom.....1 Pills .....2 Emergency Contraception (EC) .....3 Injectables .....4 IUCD.....5 Implant.....6 Periodic abstinence .....7 Withdrawal .....8 Male sterilization .....9 Female sterilization.....10 Other (specify)_____ 11	
413	From where one can get PPFP and PAFP methods?	Public hospital .....1 Private hospital .....2 FWC .....3 Community Clinic .....4 NGO Clinic.....5 Get pills from pharmacy .....6 CSBA.....7 Medical doctor.....8 Nurse.....9 TBA .....10 Other traditional Healer (Kabiraj) .. 11 Village practitioner (unqualified) ... 12 Other (specify) .....13 No idea/Do not know..... 98	
414	Why it is important to use a method immediately after abortion/delivery?	To avoid getting pregnant again immediately after abortion/delivery…..01 Ohers…….. 02 No idea/Do not know..... 98	
SECTION 5: ACCESS TO MR SERVICES			

501	Are men of your community able to access MR services for their wives in this community?	Yes……1 No…….2 Don't know……..3	
502	If yes, where do men of your community access these services? *(**Interviewer**: choose all that apply. If respondent names a facility, please indicate by the appropriate category)*	Public hospital ..... 1 Private hospital ..... 2 FWC ..... 3 Community Clinic..... 4 NGO Clinic ..... 5 Get pills from pharmacy..... 6 CSBA ..... 7 Medical doctor ..... 8 Nurse ..... 9 TBA ..... 10 Other traditional Healer (Kabiraj).. 11 Village practitioner (unqualified)... 12 Other (specify) ..... 13 No idea/Do not know 98	
503	What are the key barriers to men of your community accessing safe MR services for wives? *(Choose all that apply)*	Attitude of friends and relatives …..…..1 Attitude of health care providers …..….2 Fear of pregnancy being exposed at health facility …..……...3 Insults and ridicule by community members …..……..4 Lack of knowledge of where to go ..….5 Financial difficulties ..…..……..6 Distance to facilities ……7 Inconvenient hours at facilities…..……8 Their status as unmarried girls ……..9 Their status as students …..…….10 Parental consent ……..11 Other (specify)…….12	
504	If your wife experiences a complication after an unsafe MR, where will you take her to for help? *(Choose all that apply)*	Public hospital ..... 1 Private hospital ..... 2 FWC ..... 3 Community Clinic..... 4 NGO Clinic ..... 5 Get pills from pharmacy..... 6 CSBA ..... 7 Medical doctor ..... 8 Nurse 9	

		TBA ..... 10 Other traditional Healer (Kabiraj).. 11 Village practitioner (unqualified)... 12 Other (specify) ..... 13 No idea/Do not know 98	
505	Do you think MR is legal in Bangladesh?	Yes ..... 1 No..... 2 Do not know..... 99	 507 507
506	Up to what length (months or weeks) of pregnancy is MR legal? **(PROBE & TRANSFER MONTHS INTO WEEKS)**	Up to (weeks) ..... ☐☐ No idea / Do not know 99	
507	Do you think MR is legal only for married women?	Yes ..... 1 No..... 2 Do not know..... 99	
508	**Now, I would like to talk about different methods by which MR can be performed – the various ways in which an unwanted pregnancy can be terminated.** Have you ever heard of any MR method?	Yes ..... 1 No..... 2	 510
509	If yes, what method? **PROBE FOR OTHERS UNTIL THEY HAVE NO MORE:** Any other? **(CIRCLE ALL THAT APPLY)**	MVA ..... 1 EVA……2 MRM..... 3 D&C ..... 4 Don't have any choice..... 5 Other (specify)_____6 Don't know/ refused……7	
510	Up to what length (month or weeks) of pregnancy is MR safest? **(PROBE & TRANSFER MONTHS INTO WEEKS)**	Up to (weeks) ..... ☐☐ No idea / Do not know 99	
511	**For all locations indicated in the chart, please fill in the following chart:**		

	Location	Would you go to the following locations for abortion services for your wife?		Why or why not?
		Yes	No	
511.1	The nearby local hospital/clinic	1	2	
511.2	Pharmacist/chemical seller in the community	1	2	
511.3	The traditional birth attendant in the community	1	2	
511.4	Midwife/nurse's place for medicine	1	2	
511.5	A friend's place to get medication	1	2	
511.6	Someone else (Please specify ……)	1	2	
511.7	How far away is the nearest place one can get MR services in this area? (Please select one)	_____ (Write name of the place) Do not know..... 98		

SECTION 6: MEN'S ATTITUDES TOWARD MR

		Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
601	A woman who has had a MR should be prohibited from going to religious services.	1	2	3	4	5
602	A woman who has a MR is committing a sin.	1	2	3	4	5
603	Once a woman has a MR, she will make it a habit.	1	2	3	4	5
604	A woman who has had a MR cannot be	1	2	3	4	5

	trusted.					
605	I would tease a woman who has had a MR so that she will be ashamed about her decision.	1	2	3	4	5
606	A woman who has a MR brings shame to her family.	1	2	3	4	5
607	A woman who has a MR can make other people fall ill or get sick.	1	2	3	4	5
608	I would try to disgrace a woman in my community if I found out she'd had a MR.	1	2	3	4	5
609	A woman who has an MR should be isolated from other people in the community for at least 1 month after having a MR.	1	2	3	4	5
610	A woman should be able to have a MR if she cannot afford the child.	1	2	3	4	5
611	A man should not marry a woman who has had a MR because she may not be able to bear children.	1	2	3	4	5
612	I would stop being friends with someone if I found out that she had a MR.	1	2	3	4	5
613	A woman who has had a MR might encourage other women to get MRs.	1	2	3	4	5
614	A young girl or woman should be able to have a MR if she wants to continue her studies.	1	2	3	4	5
615	A woman should be able to have a MR if she does not want any more children.	1	2	3	4	5
616	A woman who has a MR brings shame to her community.	1	2	3	4	5
617	I would point my fingers at a woman who had a MR so that other people would know what she has done.	1	2	3	4	5
618	A woman who has a MR should be treated the same as everyone else.	1	2	3	4	5

SECTION 7: MEN'S SELF EFFICACY TO SEEK MR

Q #	QUESTION	CODES				
701	**For the following questions, please indicate whether you agree or disagree with the statement.**	**Strongly Disagree**	**Disagree**	**Unsure**	**Agree**	**Strongly Agree**
A	If my wife wanted to have a MR without my consent she could	1	2	3	4	5
B	I know where my wife can get MR in my community	1	2	3	4	5
C	I am able to pay the cost to travel for my partner/wife to get an MR	1	2	3	4	5
D	I am able to pay the cost for my wife to have the MR procedure	1	2	3	4	5
E	I could speak with an MR provider (doctor, nurse, midwife) if my wife wanted to have MR	1	2	3	4	5
F	I could tell my family members if wife wanted to have MR	1	2	3	4	5
G	I could tell my friend if my wife wanted to have MR	1	2	3	4	5
H	I could tell other members of my community if my wife wanted to have MR	1	2	3	4	5
I	I know the difference between a safe MR provider and an unsafe MR provider	1	2	3	4	5

J	If my wife has MR without telling me I will ……. SELECT ALL THAT APPLY	Beat her up……1 Leave her (Separation) …….2 Disgrace her. ……3 Support her……...4 Understand her ……5	

SECTION 8: Exposure to the Community Access Program

Q #	QUESTION	CODES	Go to Q
801	Have you attended at least one	Yes 1	

	educational session in your community about FP including PPFP and PAFP in the last year?	No 2	805
802	What was the name of the person or group who led the session(s) on FP including PPFP and PAFP? (***Interviewer****: choose all that apply. If respondent names an organization, please indicate by the appropriate category*)	Medical provider (nurse, doctor, CSBA, FWV, midwife, etc.) ...…….....01 CHCP (Community Health Care Provider).....02 Pharmacist/drug sellers……03 Traditional birth attendant/ Dai/ traditional healers/ village doctors……04 FWA……05 HA……...06 NGO community health worker……..07 HI (Health Inspector)……..…….08 AHI (Assistant Health Inspector)……09 FPI (Family Planning Inspector)…….10 Theater for drama (TFD) show …..…… 11 Community leader(s)……. …….12 Women's group……. ..13 Community based organization…….....14 Listener club meeting……..15 Stakeholders meeting……..16 Imam or religious leader…….17 Other (specify) .....18 Don't know/Refused…….. 99	
803	How many educational sessions on FP including PPFP and PAFP have you attended in the last year?	One ..... 1 Two to Five ..... 2 Six to Ten ..... 3 More than ten 4	
804	What are some of the topics that were covered in the educational session(s)?	Contraceptive or family planning methods ..... 1 Source of contraceptive /FP services 2 Cost of contraceptive/ FP methods ... 3 How to use contraception /FP methods ..... 4 Possible side effects from the use of contraception / FP methods..... 5 Other (specify)_____ 6	
805	Have you attended any educational sessions in your community about MR/PAC in the last year?	Yes ..... 1 No 2	809
806	What was the name of the person or group who led the session(s) on MR/PAC?	Medical provider (nurse, doctor, CSBA, FWV, midwife, etc.)…… ……..01 CHCP (Community Health Care Provider)… 02	

	(***Interviewer:*** *choose all that apply. Ask respondent to name specific examples of each organization or community group they choose*)	Pharmacist/drug sellers……03 Traditional birth attendant/ Dai/ traditional healers/ village doctors……04 FWA……05 HA……...06 NGO community health worker……. 07 HI (Health Inspector)……..……08 AHI (Assistant Health Inspector)……09 FPI (Family Planning Inspector)…….10 Theater for drama (TFD) show …..…… 11 Community leader(s)……. …….12 Women's group……. ..13 Community based organization…….. 14 Listener club meeting…… .15 Stakeholders meeting……..16 Imam or religious leader……..17 Other (specify) _____.....18 Don't know/Refused…….. 99	
807	How many educational sessions on MR/PAC have you attended in the last year?	One ..... 1 Two to Five ..... 2 Six to Ten ..... 3 More than ten 4	
808	What are some of the topics that were covered in the educational session(s)?	Where to get menstrual regulation .... 1 Possible complications ..... 2 Cost of menstrual regulation ..... 3 Methods of menstrual regulation ..... 4 Stories of other women who had induced menstrual regulation ..... 5 Legality of menstrual regulation ..... 6 Other (specify)_____ 7	
809. a	What types of Radio you listen most?	Bangladesh Betar.....1 Community Radio……..…..2 FM band ….....3 Don't listen radio.....4	**END**
809. b	Radio set or mobile phone ; what do you use to listen to radio ?	Radio set..... …….1 Mobile ..... …….2 Both..... …….3 Other(Please mention.....4	
809. c	Do you know the name of the local community radio station?	Yes ..... …….1 (If yes, please mention.....) No 2	

809.d	What type of radio program do you like most ? (Select all that apply)	Song ..... ……..1 Talk show..... ……..2 News..... ……..3 Magazine program ..... ……..4 Drama..... ……..5 Others(Please mention).....…..6	
809	Have you heard a community radio program where FP and MR/PAC was discussed in the last year?	Yes ..... 1 No..... 2	END
810	How many times did you listen to the community radio program in the last year?	One ..... 1 Two to Five ..... 2 Six to Ten ..... 3 More than ten……..4	
811	What were the topics that you heard about on the radio program?	Contraceptive or family planning methods ..... 1 Source of contraceptive /FP services 2 Cost of contraceptive/ FP methods ... 3 How to use contraception /FP methods ..... 4 Possible side effects from the use of contraception / FP methods..... 5 Where to get menstrual regulation .... 6 Possible complications..... 7 Cost of menstrual regulation ..... 8 Methods of menstrual regulation ..... 9 Stories of other women who had induced menstrual regulation ..... 10 Legality of menstrual regulation ..... 11 Other (specify)_____ .. 12	
812	What time do you prefer to listen program of community radio? (Select all that apply)	9.00-12.00 ..... 1 12.00-15.00 ..... 2 15.00-18.00 ..... 3 18.00-24.00 ..... 4 Always 5	
813	Are you the member of Radio listener group/club ?	Yes ..... ……1 No 2	**END**
814	How often the member of radio listeners group/club sit together for discussion?	Once in a week..... …….1 Once in a 15 days..... …….2 Monthly or more ..... …….3	

		Don't know ..... ……..4	
815	Mostly where the meeting of radio listen's group/club is held ?	Courtyard of member's house ……..1 Office of community radio..... ……..2 Office of public representative……..3 Others ..... ……..4 (Please mention----------)	

Thank You